Tool for Measurement of Assertive Community Treatment (TMACT) PROTOCOL

Appendices

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TMACT Appendices

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Appendix A. Sample Fidelity Orientation Letter

[DATE]

Dear XXX:

We look forward to meeting with you and your ACT team on [DATE]. Since a lot of information is collected during a fidelity assessment from multiple sources, we greatly appreciate you and your team's hard work to prepare the following data prior to our fidelity assessment. This advanced preparation allows us to reference these hard numbers and direct our interviews to include specific follow-up questions. Toward this end, we would like your assistance in completing the following attached documents prior to your next fidelity visit: **(1)** The Team Survey and **(2)** Client-level data in the Excel spreadsheet. Please note that the Excel spreadsheet includes worksheet tabs at the bottom for two different spreadsheets - the first outlines directions and definitions and the second is for the team to enter their client-level service data for all clients currently served. ** Please make sure to read the directions and definitions **before** completing the client-level data in the Excel spreadsheet. In particular, we ask that you create a unique client identifier for each person you serve and use that unique ID to fill out the client-level data in the Excel spreadsheet. Please make sure to have a copy of the actual client names and their corresponding unique client ID's available for each interview during the fidelity review, as team members will be asked to talk about their experience in working with several of the clients listed. We will also be asking for a copy to have on hand while we are visiting your team.

We find that it is most helpful for the team leader to work with various team members when completing the client-level service data (e.g., working with the co-occurring disorders specialist to fill out which clients are receiving integrated treatment for co-occurring disorders services). We would like to receive both sets of completed documents by **[DATE]**. As much as possible, it is important that we observe your ACT team conducting "business as usual" during the fidelity review. As a result, we will strive to avoid altering your daily activities in order to accommodate our visit. We will plan to build an agenda for the day tailored to your team, but generally, here are the components of the two-day review (with a few questions embedded in red font below to help us build our agenda):

- **Chart reviews** -- As part of the review, we will randomly select and examine approximately 20% of your client charts, or a minimum of 10 charts, for clients currently served within the ACT team (i.e., 20 charts on 100-client teams). We will need access to all parts of the chart, including assessments, and progress notes. Do you use an electronic medical record or will we be accessing hard copy charts? We would appreciate it if you could reserve a room that is spacious and private so that we may conduct our chart review, which requires some spreading out of materials, and hold our staff interviews as well.
- **Review of daily team meeting tools and documentation -** This documentation may include Weekly Client Schedules, Daily Staff Schedules, and any communication logs used by the team. We will ask for access to these documents throughout the review, depending on when they are not in active use by the team.
- **Team member interviews** - We will plan to interview the team leader for approximately 1 ½ hours in the morning of the first day and 30 minutes the afternoon of the second day. We will also interview the psychiatric care provider (45 minutes), nurse(s) (30 minutes), employment specialist (60 minutes), co-occurring disorders specialist (60 minutes), and peer specialist (45 minutes). If your team has a housing specialist, we would like to spend up to 30 minutes interviewing that person as well. If there are multiple people in each position, we would like to interview all of them at once, if possible. We would also like to interview the two most veteran clinicians not otherwise in a specialty role, with at least one in a therapist role. One may also be someone who assumes more of a role in providing psychiatric rehabilitation (90 minutes). Please note that if you have any team members who are in a secondary role within a certain specialty area (for example, you have one person designated as the employment specialist, but you have another team member who also provides a significant amount of

employment and educational services), please let us know so that we can also include them in our scheduling of various team members. Further, do you have any particular staff who only work one of the days we're there, and whom we need to make sure to schedule during that day?

- **Client interviews** - We would like to speak with a group of clients all at once if there happens to be a scheduled group during one of the days of our visit. If such a group is scheduled, we ask that the group leader set aside the last 20 minutes for us to speak with consenting clients during this time. Questions will be focused on the services they receive from the team. Do you have such a group scheduled during our two-day fidelity review, and if so, what time and on which day is it scheduled? If not, when would be a good time to schedule a group interview with 3-5 clients during our visit?
- **Observation of the daily team meeting** – At what time is yours currently held?
- **Observation of a treatment planning meeting** -- Do you currently have any scheduled during one of the days of the fidelity review? If not, would it be possible to schedule one that was supposed to be held close to that date?
- **Community/home visits with one to two team members while they work with clients** -- We would also like the opportunity to accompany one or two team members on a community/home visit with a client for 30 minutes to 1 hour. Once we build the agenda, I will fill in possible times for these visits and see if that fits with your staff schedules.

Lastly, if your team uses any of the following forms, please provide two copies of these materials when we are onsite for your team's fidelity review:

- **Admission**: Admission criteria and screening tools;
- **Assessments**: Any ongoing assessments used by team members (e.g., co-occurring disorders, employment, functional, health/nursing);
- **Plans**: Treatment plan template, crisis plan template;
- **Discharge**: Transition-readiness (i.e., graduation) assessment or a list of transition-readiness criteria;
- **Daily Team Meeting forms**: A recently completed daily team schedule, an example of a team member individual schedule, a de-identified (i.e., cross-out name[s]) copy of a client log or an individual client log page depending on how your team logs daily contacts, a de-identified copy of a weekly client schedule; and
- **Other**: Any health communication forms used to correspond with non-ACT providers.
- **Client ID reference key** listing client names for reference while on-site

During the afternoon of our second day, we will plan to hold a debrief meeting with you, your team, and any agency administrators you would like to include to share initial impressions from the fidelity review. While we will not yet have ratings available, this will at least provide the opportunity for us to share our initial feedback regarding the team's strengths and recommendations for future training and improvement. We will then follow-up after our visit with a feedback report, which we will review with you during a formal feedback session at a later date.

Please do not hesitate to contact us if you have any questions at all regarding these materials. Many thanks again for your assistance in preparing for this upcoming visit with you and your team.

Thanks again,
XXX

Appendix B: ACT TEAM SURVEY

Team Name:		
Team Leader:	Year of Team Start-Up:	Today's Date:

Please answer each question about your ACT team as best as you can.

1. Please complete Table 1 below regarding your current ACT team staffing. **[OS1, OS5, CT1, CT3, CT6, ST1, ST4, ST7; H1 on DACTS]**

Table 1. ACT Team Staffing

Staff Name	Position	Date of Hire	Number of hours the staff member works with the ACT team per week[1]	Highest Level of Education	Specialized training, clinical experience, and Board Certification[2]	Number of years of experience with adults with SMI including their work with the ACT team	Daily Team Meetings per week. Note typical days of attendance (MTWRF)

[1]Include the number of hours each team member actually works, not just whether they are available (and may be holding another role in the Agency at that time).

[2] Specialized training (e.g., licensure, training in co-occurring disorders) and # of years of clinical experience. Please note if Psychiatric Care Provider is Board Certified in Psychiatry, and/or if any physician extenders have specialized certification and training in psychiatry.

1(a) Are any of the staff above interns or Residents? ☐ **YES** ☐ **NO**

(b) If yes, please specify length of time for the rotation of each staff person who is an intern or Resident:

Name: _____ Length of time in rotation: _____

2. In the past 2 years, how many staff members have left the team? If your team has been in existence for a shorter period, please indicate the time frame that corresponds to the length of time your team has been operating (e.g., in the past 1 year) **[H5 on DACTS]**

_____ **# staff members** _____**Time frame (if not in the past 2 years)**

3. In the past year, how many vacant positions did you have on the team each month? Please specify which positions were vacant. **[H6 on DACTS]**

Table 2. ACT Staff Vacancies

Month	# of Vacancies	Positions Vacant
January		
February		
March		
April		
May		
June		
July		

Table 2. ACT Staff Vacancies		
Month	# of Vacancies	Positions Vacant
August		
September		
October		
November		
December		

4. In the past year, how many staff members have been on leave for more than one month? (Include any extended absences, e.g., sick leave or leave after the birth of a child.) **[H5 on DACTS]**
   _____ **# staff on extended leave for more than one month in the past year**

5. In the past month, about how many hours on average did the team leader spend providing direct services to clients and natural supports each week? Direct services include face-to-face services and assessments, phone contacts, and treatment planning meetings that include clients and/or natural supports. **[CT2]**
   _____ **# hours per week providing direct services to clients/families**

6. In the past month, how often did the team leader meet with each of the two staff to whom he/she consistently provides the most clinical supervision? Clinical supervision is defined as the provision of guidance, feedback, and training to team members to assure that quality services are provided to clients (e.g., following evidence-based practices, negotiating ethical quandaries) and maintaining and facilitating the supervisee's competence and capability to best serve clients in an effective manner. Examples include mentoring in the field, review of clinical cases, and providing feedback on tools such as assessments and treatment plans. Only count meetings that were scheduled (vs. impromptu), regardless of whether the meeting took place within a group setting (i.e., weekly clinical meeting) or individually, or in the office or in the field. [**CT2]**

   Please indicate the number of times over the past month the team leader provided clinical supervision to each of the two staff most consistently supervised:

   _____ **# times you provided scheduled supervision to clinician #1 over past month**

   Team member name:_____

   _____ **# times you provided scheduled supervision to clinician #2 over past month**

   Team member name:_____

7. Client caseload size: **[OS1, OS5, OS10]**
   (a) How many clients are currently enrolled on your team? _____
   (b) How many clients is your team equipped to serve at capacity (i.e., caseload cap)? _____
   (c) How many clients were enrolled one year ago? _____

8. Do you currently serve any clients who you think do NOT meet ACT admission criteria and/or are inappropriate for ACT? Please mark one. **[OS6]** ☐ **YES** ☐ **NO**

9. If you answered yes, how many clients do you estimate do NOT meet ACT admission criteria? **[OS6]** _____**# clients who do NOT meet ACT admission criteria**

10. Approximately how many of your current clients were "stepped-up" to ACT from a less intensive program or service within your agency (i.e., client was enrolled with another program and eventually referred to ACT to receive more intensive services than s/he was receiving)? Do not count clients who went from a less intensive program to the hospital, and then were referred to ACT from the hospital. **[OS7]** _____**# clients "stepped up" to ACT from a less intensive program or service** [Note to evaluator: calculate the inverse, representing # of clients who were not stepped up to ACT from a less intensive program or service for rating OS7].

11. In the past 6 months, what is the highest number of clients admitted to the ACT team per month? **[OS8]** _____
Highest number of clients admitted per month, in past 6 months

12. In the past year, how many clients were discharged for the following reasons? **[OS9, OS10]**
_____# unable to locate client
_____# incarcerated
_____# discharged as a result of not receiving authorization from managed care organization
_____# transferred to a more restrictive service setting (e.g., hospital, nursing home, residential treatment center)
_____# refused services and/or requested discharge
_____# moved out of service area <u>without</u> assistance from team
_____# moved out of service area <u>with</u> assistance
_____# transitioned to less intensive services/graduated (i.e., was discharged because of significant improvement)
_____# deceased
_____# other: (please specify)_____

13. Please list all groups provided by your team.

Group Name/Type	Group Facilitator(s)	Frequency/Duration	Average # of Participants

14. Please list the last 10 client <u>psychiatric</u> hospitalizations, noting both the admission and discharge dates. A single client may be listed more than once. Include a brief description of the team's involvement in the decision-making process, clearly indicating whether team was involved in the admission/discharge process (note that "involvement" in an admission is not limited to directly facilitating a voluntary or involuntary admission). Additional questions will be asked about the team's role in the admission and discharge during the interview. **[OS11; OS5 and OS6 on DACTS]**.

Last 10 Client Psychiatric Hospitalizations (note that there may be repeated clients).			
Unique Client Identifier	**Approx. Admission Date**	**Approx. Discharge Date**	**Was team involved in the decision-making process around this admission and/or discharge? (indicate yes/no for each and provide brief summary)**
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Appendix B. Excel Spreadsheet

DIRECTIONS & DEFINITIONS:
BACKGROUND: Your responses will be used to guide follow-up questions during the interviews and will be cross-referenced with the progress notes, assessments, and treatment plans in client charts. The chart review will be used to help verify that the services recorded in this spreadsheet are actually provided with relative consistency. Credit will not be given for services that are reported in this spreadsheet, but not clearly reflected in other data sources, per Protocol guidelines noted in TMACT Part II. **TO BEGIN COMPLETING THIS SPREADSHEET:** Please assign a unique identifier to all clients served by your team. Please keep a list of those unique identifiers so that we can ask about the work you are doing with each client during the on-site fidelity review. In the next spreadsheet, list all clients you serve using that unique identifier - DO NOT LIST NAMES OR USE INITIALS. Please indicate whether or not the client meets stated criteria and/or is receiving the listed services. While it is important to be accurate, please do not spend too much time laboring over completion of this spreadsheet (e.g., going through each client's chart); most ACT teams know the clients they serve well enough to be able to complete this information relatively quickly and accurately. Also be sure to delegate various team members to complete sections that are most in line with the services they provide and/or are most familiar (e.g., substance abuse specialist completes list of clients who receive integrated substance abuse services, nurses complete list of clients who receive daily and depot medications).
• Many items prompt you to document and reflect on services directly provided by the ACT team. Therefore, it is important to determine the boundaries of your ACT team staff, which is defined here as a staff member who is employed with the team at least 16 hours a week and attends at least 2 daily team meetings per week. Psychiatric care providers, when the team has more than one, must be employed with the team for at least 8 hours per week to be considered as part of the team. For example, there may be an agency therapist who provides services to several clients and this provider has frequent contact with ACT team members, but does not regularly attend daily team meetings and rarely participates in treatment planning. This provider would NOT be considered part of the ACT team and clients receiving services from this provider should be noted as "non-ACT." For some items, clients may receive a particular service (e.g., vocational services) from both ACT team and non-ACT team staff. If this is the case, please note BOTH.
STAGES OF CHANGE READINESS (Column A): **Early stage of change readiness** includes clients who are actively using substances, regardless of whether they view their use as a problem or not. These individuals may have expressed some desire to reduce or quit, but have not enacted the change. **Late stage of change readiness** includes clients who are committed to reducing or quitting substance and are seeking treatment to help make this change. Individuals may have experienced several trials of abstinence or significant reductions in use (with lapses/relapses) or may have maintained abstinence for an extended period of time (e.g., more than 6 months). **NOTE:** As individuals may use several substances (e.g., alcohol, marijuana, cocaine), stage of change is often substance-specific. Report each client's stage based on what seems to be the most problematic substance, excluding nicotine and caffeine abuse, which is addressed elsewhere. Assessments and treatment plans will

DIRECTIONS & DEFINITIONS:
be reviewed and cross-referenced with this item on the spreadsheet. Please do not leave this section blank. If your team does not assess for stages of change readiness or if the team has not yet assessed a specific client, please indicate this in the appropriate space.
INTEGRATED SUBSTANCE ABUSE TREATMENT (Column B): These include services provided by the Co-Occurring Disorder Specialist as well as other team members well-versed in integrated, stage-wise treatment for co-occurring substance use disorders. Core services include: (1) systematic and integrated screening and assessment and interventions tailored to those in (2) strategies to assist those in early stages of change readiness (e.g., outreach, motivational interviewing) and (3) and strategies to assist those in later stages of change readiness (e.g., motivational interviewing, CBT, relapse-prevention). Integrated substance abuse treatment reported here should be reflected across other data sources (e.g., progress notes, treatments plans, client schedules). Where someone is in a pre-contemplation stage of change readiness, the use of outreach should be strategic and there are clear efforts by the team to pay attention to substance use for the sake of ongoing assessment. NOTE: To be considered a group participant, client attends group at least 1 time per month. To be considered an individual substance abuse service recipient (inclusive of deliberate outreach aiming to eventually address substance use while using motivational interviewing efforts), at least 20 minutes per week is spent with the person attending to and/or addressing substance use. Substance abuse services, including deliberate engagement efforts, reported here should be reflected across other data sources (e.g., progress notes, treatments plans, weekly client schedules).
PSYCHIATRIC SERVICES (Column C): Core psychiatric services include psychopharmacologic treatment and regular assessment of clients' symptoms & response to medications, including side effects, provided by the team's psychiatric care provider; and medication monitoring and supports provided by other ACT team members. If the team has more than one psychiatric care provider, please indicate who the client typically sees (Provider 1 as "Pr1" or Provider 2 "Pr2," etc.). If the client receives psychiatric services from Non-ACT provider, please indicate "Non-ACT." NOTE: If a team has a psychiatric care provider that does not meet the inclusion criteria noted in CP3 (e.g., employed with team less than 8 hours per week if the team has more than one psychiatric care provider), then that psychiatric care provider is not to be counted as a Team Provider -- clients receiving services exclusively from this provider may not count as receiving psychiatric services directly from the team).
EMPLOYMENT AND EDUCATIONAL SERVICES (Column E): These include all services provided by the employment specialist as well as other team members well-versed in supported employment and supported education services. Core services include: (1) engagement; (2) employment and educational assessment; (3) job development; (4) job placement (including going back to school, classes); & (5) job coaching & follow-along supports (including supports in academic/school settings). Supported education services also should be noted in this column. Employment and educational services reported here should be reflected across other data sources (e.g., progress notes, treatments plans, weekly client schedules).
COMPETITIVE EMPLOYMENT (Column F): Any paid job that is accessible to **anyone** in the population (not just individuals with disabilities). **"Other"** employment positions include volunteer, transitional employment, work crew, sheltered employment. Please also make note of anyone enrolled in school.

DIRECTIONS & DEFINITIONS:
PSYCHIATRIC REHABILITATION SERVICES (Column J): 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 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). NOTE: Assessment and services focused on education or employment should be reflected in the Vocational Services column. Delivery of Illness Management and Recovery (IMR) services should be reflected in the Wellness Management and Recovery column.
WELLNESS MANAGEMENT AND RECOVERY SERVICES (Column K): 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 development of Wellness Recovery Action Plans (WRAP) and provision of the Illness (or Wellness) Management and Recovery (IMR) curriculum. Wellness management and recovery services reported here should be reflected across other data sources (e.g., progress notes, treatment plans). NOTE: When completing the column for the provision of wellness management services, please specify the type of manualized or formal approach the client is receiving (e.g., IMR group, individual WRAP).
EVIDENCE-BASED PSYCHOTHERAPY (Column M): These services include formal therapeutic approaches that are based on established theory and techniques. Therapies are selected and employed given the presenting problem (e.g., behavioral activation for depression; cognitive behavioral therapy for psychosis; dialectical behavioral therapy for emotion dysregulation). Psychotherapy sessions are tied to clients' goals and written into the client's treatment plan and Weekly Client Schedule. Sessions are planned, are a minimum of 20 minutes in length every other week, and are conducted by a trained therapist. Psychotherapy services reported here should be reflected across other data sources (e.g., progress notes, treatments plans, weekly client schedules). NOTE: Report any clients who have received formal psychotherapy in the past year and specify what type of therapy was provided (e.g., CBT, interpersonal therapy). Do not count motivational interviewing in both this column and in the Integrated Substance Abuse Treatment column, unless the client is receiving MI to address both substance abuse and other areas of his/her life where they may be in an earlier stage of change readiness (e.g., in precontemplation about moving from unsafe housing). Both sets of interventions must be documented separately in the treatment plan.
HEALTH/LIFESTYLE INTERVENTIONS (Column N): These services include skills or strategies targeting positive changes in health and/or lifestyle (e.g., smoking cessation, weight management, diabetes management). Indicate the specific type of program or strategies and the health/lifestyle target (e.g., Learning About Healthy Living for smoking cessation, Integrated-Illness Management and Recovery [I-IMR] for health behaviors in general, InShape for weight management, individual weekly walk for cardiovascular health).

DIRECTIONS & DEFINITIONS:
CURRENT HOUSING (Column O): Clients live in many different residential settings. We are interested in knowing which clients are residing in an environment where a large proportion of fellow residents (whether referred to as "patients," "tenants," or "residents") also likely have a disability. Please simply indicate with a "Yes" if client lives in a residence where at least 25% of neighbors/roommates also likely have a disability and that housing is DESIGNATED for serving this particular population. Follow-up questions will further clarify whether this environment is an institution, substance abuse treatment facility, nursing home, group home, congregate housing (e.g., apartment complex or boarding home), family home, or other type of organization. **AFFORDABLE AND SAFE HOUSING (Columns P and Q):** We are interested in clients who are residing in housing that is affordable and safe. Most clients who receive ACT services rely on disability benefits alone and a large proportion of their money goes toward housing expenses; they are then left with few choices other than unsafe housing that is more affordable. Subsidized housing is one of the ways in which clients gain access to more affordable and safe housing. Indicate in Column O if a client is currently receiving a housing subsidy, or is at least on a waitlist to receive such a subsidy. For those who are not indicated as not currently receiving or waitlisted to receive a subsidy, indicate in Column P if they are paying less than 30% of their income on housing expenses (rent and utilities). NOTE: We do NOT expect teams to conduct precise calculations to determine whether a client meets criteria for Column P. Instead, we recommend that teams consider a client's approximate income, then calculate what 30% of that income amounts to, and judge whether housing expenses are less than that amount (resulting in an "X" for that client in Column P). Exclude clients who may be paying less than 30%, but are living in unsafe housing. For example, Mary is not receiving, nor waitlisted to receive, a housing subsidy (nothing marked in Column O). The team knows that Mary only receives disability benefits for $610 per month. Thirty percent of $610 is $183 (610 * 0.30); the team knows that Mary is definitely paying more than $200 per month in housing subsidies, resulting in no mark ("X") for Column P.
NATURAL SUPPORTS (Column X): Contacts with informal natural supports include face-to-face, telephone, or email. This includes people in the client's life who are NOT paid service providers (e.g., family, friends, landlord, employer, clergy - if a family member is also a paid service provider, they are counted as a natural support). Contacts with primary care physicians, parole officers, residential staff, and employed payees should NOT be counted in this item. Do not answer yes or no for this item. Please provide a specific number of contacts (in past month) for each client listed.

Snapshot of ACT Client & Service Data (to be collected at the individual client level for each team) (Excel Spreadsheet P.1)						
		A	**B**	**C**	**D**	**E**
ACT Client (Use unique identifier, NOT name).	In the column below, note whether the client has been enrolled in ACT services for at least 90 days.	For each client with a **co-occurring disorder**, indicate whether they are in an 'early' or 'late' stage of change readiness. See definitions.	Does the client receive **integrated treatment for co-occurring disorders directly from the ACT team**? Indicate 'individual' (more than 20 mins per week), 'group' (more than 1 time per month), or 'both.' If client receives co-occurring disorders services from non-ACT providers, note as 'non-ACT.'	Does the client receive **psychiatric services** directly from the ACT psychiatric care provider? Indicate 'yes' for single team prescriber and 'Pr1' and 'Pr2,' etc. for multiple team psychiatric care providers. If client sees non-ACT provider, note as 'non-ACT.'	Does the client live in a **supervised residential setting** where **medication monitoring services** are received from non-ACT staff? Indicate 'yes' or 'no.'	Does the client receive **employment and educational services directly from the ACT team?** (see definition) If receives employment and educational services from non-ACT providers, note 'non-ACT.'
Relevant TMACT items		*ST2*	*ST1; ST2; EP1*	*CP7*	*CP7*	*ST4; ST5; EP2*
Client 1						
Client 2						
Client 3						

Snapshot of ACT Client & Service Data (Excel Spreadsheet p.2)							
	F	**G**	**H**	**I**	**J**	**K**	**L**
ACT Client (Use unique identifier, NOT name)	Is the client **currently employed and/or enrolled in school?** If employed, indicate whether it is competitive employment, school, or 'other.' (see definition).	For working clients, specify where they currently work.	For working clients, specify the **type of position** they currently hold.	For working clients, indicate whether they got the job themselves or the team assisted with getting the position. Indicate 'self' or 'team.'	Does the client receive **psychiatric rehabilitation services directly from the ACT team?** (PLEASE carefully read definition provided). If receives psychiatric rehabilitation services from non-ACT providers, note 'non-ACT.'	Does the client receive **formal and/or manualized wellness management and recovery services directly from the ACT team?** (See definition) If yes, please specify the type of WMR service used and whether it is group or individual.	Does the client attend clubhouse, day treatment, drop-in center services or a partial hospitalization program? (Specify which type)
Relevant TMACT items	*ST5; EP2*	*ST5; EP2*	*ST5; EP2*	*ST5;EP2*	*CP8; PP4*	*ST7; ST8; EP3*	*ST5; CP8; EP2*
Client 1							
Client 2							
Client 3							

ACT Client & Service Data (Excel Spreadsheet p.3)						
	M	**N**	**O**	**P**	**Q**	**R**
ACT Client (Use unique identifier, NOT name)	Has the client received **individual and/or group psychotherapy in the past year from ACT team?** (See definition) If yes, please specify the type of therapeutic strategies used. If sees a non-ACT provider for therapy, note 'non-ACT.'	Does the client receive **health/lifestyle intervention services directly from the ACT team** (See definition)? If yes, please specify the type of service provided and targeted condition or behavior.	Indicate whether the client's **current housing is in a residence where 25% or more of the other residents or tenants likely have a known disability** (See definition). If the client is currently unsheltered (street homeless) or emergency sheltered, please type in HOMELESS)	Indicate whether the client is currently receiving a **housing subsidy** ("subsidy") or is on a waitlist for a subsidy ("waitlist").	Of those clients who do not receive a housing subsidy, mark ('x') which clients **pay 30% of their income or less on safe housing**, including rent and utilities. (NOTE: Exclude individuals in affordable, but clearly unsafe, housing.)	Indicate whether **treatment participation is a condition of their housing/ residence** and further note if the requirement is that they receive any services (note **'any'**), or specifically ACT (note **'ACT'**).
Relevant TMACT items	*EP7*	*CT7*	*EP8*	*EP8*	*EP8*	*CP2; EP8; PP4*
Client 1						
Client 2						
Client 3						

ACT Client & Service Data (Excel Spreadsheet p.4)						
	S	**T**	**U**	**V**	**W**	**X**
ACT Client (Use unique identifier, NOT name)	Is the client on **involuntary outpatient commitment** or conditional release? If yes, please specify which one.	If the client has a **representative payee,** indicate if the payee is agency/team, natural support, or independent organization/individual. Also note whether money is disbursed weekly or more or less often (e.g., individual receives allowance weekly or two times per week). E.g., "Indep Org; Weekly."	Does this client have a legal **guardian**?	Please indicate how individuals are receiving oral psychiatric medications: (1) on own; (2) from natural supports; (3) from residential staff; (4) from ACT Team. If from ACT Team, please also indicate the **amount of oral medications the individual receives at a given time** (e.g., daily, 2X/wk, weekly, monthly)	Is this client on an **antipsychotic depot medication** (i.e., injection)? Please state the medication name.	Indicate the number of contacts the team had with clients' **natural supports** this past month (see definition). Please indicate the **number** of contacts (i.e., do NOT answer yes or no).
Relevant TMACT items	*CP2; PP4*	*CP2; PP4*	*CP2; PP4*	*CP2; PP4*	*PP4*	*CP5*
Client 1						
Client 2						

Appendix C. Sample Fidelity Review Agenda

ACT Team:_____ Date:_____

TMACT Fidelity Review
FINAL SCHEDULE

Day 1: [DATE]

8:00 – 8:30 AM	Fidelity reviewer check-in/review of agenda
8:30 – 10:00 AM	Interview with team leader (*note: team leader phone interview completed before onsite evaluation)
10:00– 10:45 AM	Interview with psychiatric care provider (one reviewer) Simultaneous interview with nurses (one reviewer)
10:45 – 1:00 PM	Chart reviews/working lunch
1:00 – 1:45 PM	Observe treatment planning meeting
2:00 – 3:00 PM	Interview with co-occurring disorders specialist
3:00 – 3:30 PM	Continue chart review
3:30 – 4:30 PM	Observe daily team meeting

Day 2 [DATE]

8:00 – 9:00 AM	Fidelity reviewer check-in/review of agenda/finish chart reviews
9:00 – 9:45 AM	Interview with peer specialist
9:45 – 11:00 AM	Interview with mental health clinicians
11:00 – 11:30 AM	Interviews with clients (during last 20 minutes of scheduled group)
11:30 – 12:30 AM	Observation of community visits with mental health clinician (one reviewer) Simultaneous interview with employment specialist (one reviewer)
12:30–1:00	Follow-up interview with team leader regarding assertive engagement (CP2) and any other remaining questions
1:00 – 2:00 PM	Working lunch on our own/prep for debrief
2:00 – 2:30 PM	Debrief with ACT team and agency

County East ACT Team
Fidelity Assessment
November 29th and 30th, 2017

On 11/29/17 and 11/30/17, Lorna Moser, Ph.D. of UNC Institute for Best Practices and Maria Monroe-DeVita, Ph.D. of University of Washington Seattle visited the County East ACT Team in [Some City] for assessing the team's adherence to the Assertive Community Treatment (ACT) model, a requirement of DHHS. This report documents the findings and recommendations of this fidelity evaluation.

The Tool for Measurement of Assertive Community Treatment (TMACT)

Evaluators assessed the County East ACT Team's fidelity to the ACT program using the Tool for Measurement of Assertive Community Treatment (TMACT).[1] The TMACT is an enhanced version of the Dartmouth Assertive Community Treatment Scale (DACTS).[2] The scale has been piloted in several states and countries. The TMACT and DACTS are very similar in structure and organization. Each item is rated on a 5-point behaviorally-anchored scale, ranging from 1 (not implemented) to 5 (fully implemented). The ratings are based on the *current* structure and activities of the team (i.e., not future plans).

The TMACT includes the following six subscales:

1. Operations & Structure (OS)
2. Core Team (CT)
3. Specialist Team (ST)
4. Core Practices (CP)
5. Evidence-Based Practices (EP)
6. Person-Centered Planning & Practices (PP)

Data Sources

During this fidelity evaluation, the reviewers examined a variety of data sources. We reviewed 14 charts of enrolled clients who had been served by the team for at least three months. Chart data were examined for a recent four-week service period from 10/22/17 – 11/18/17, in addition to the most recent assessments and treatment plans. The fidelity evaluation team also interviewed the following team members:

- Team Leader – Stella McCartney
- Psychiatric Care Providers – Dr. Wilson Owen and Marissa del Toro
- Co-Occurring Disorders Specialist – Josie Crane
- Nursing staff – Matt Tesla and Gail Simone
- Employment Specialist – John Parker
- Peer Specialists – N/A
- Clinicians – Lucy Strong and Dave Bowie
- Program Assistant – Odeleen Kay

We observed one daily team meeting and one treatment planning meeting and conducted a group interview with 4 clients. Considering information gathered from all data sources, we rated the County East ACT Team across all items of the TMACT, except for ST8, as TMACT protocol states this item cannot be scored if the Peer Specialist position has been posted, but unfilled for fewer than 6 months.

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[1] Monroe-DeVita, M., Moser, L. L., & Teague, G. B. (2011). The tool for measurement of assertive community treatment (TMACT). Unpublished measure.

[2] Teague, G. B., Bond, G. R., & Drake, R. E. (1998). Program fidelity in assertive community treatment: Development and use of a measure. *American Journal of Orthopsychiatry*, *68*, 216-232.

Overall Fidelity Score

The total **TMACT fidelity rating** for **County East ACT Team** is **3.7.** A summary of all item scores can be found in Table 1 below. This total rating suggests that the team is implementing ACT at a moderately high level of quality and adherence, which is an improvement from the previous review where the team was rated as 3.2. Excellent job on making important improvements!

Table 1. Summary of TMACT Items and Ratings – County East ACT Team

ITEM		RATING	
OPERATIONS & STRUCTURE (OS) SUBSCALE			
		March 2016	**November 2017**
OS1	LOW RATIO OF CLIENTS TO STAFF	4	**5**
OS2	TEAM APPROACH	3	3
OS3	DAILY TEAM MEETING (FREQUENCY & ATTENDANCE)	4	**5**
OS4	DAILY TEAM MEETING (QUALITY)	3	3
OS5	PROGRAM SIZE	4	**5**
OS6	PRIORITY SERVICE POPULATION	3	**5**
OS7	ACTIVE RECRUITMENT	4	4
OS8	GRADUAL ADMISSION RATE	4	**5**
OS9	TRANSITION TO LESS INTENSIVE SERVICES	3	3
OS10	RETENTION RATE	3	**4**
OS11	INVOLVEMENT IN PSYCHIATRIC HOSPITALIZATION DECISIONS	3	**4**
OS12	DEDICATED OFFICE-BASED PROGRAM ASSISTANCE	2	**4**
	OS Subscale Average Rating	**40/12 = 3.33**	**50/12 = 4.17**
CORE TEAM (CT)			
CT1	TEAM LEADER ON TEAM	5	5
CT2	TEAM LEADER IS PRACTICING CLINICIAN	4	4
CT3	PSYCHIATRIC CARE PROVIDER ON TEAM	4	**5**
CT4	ROLE OF PSYCHIATRIC CARE PROVIDER IN TREATMENT	2	**3**
CT5	ROLE OF PSYCHIATRIC CARE PROVIDER WITHIN TEAM	2	**3**
CT6	NURSES ON TEAM	5	4
CT7	ROLE OF NURSES	3	**4**
	CT Subscale Average Rating	**25/7 = 3.57**	**28/7 = 4.00**

Table 1. Summary of TMACT Items and Ratings – County East ACT Team			
ITEM		**RATING**	
SPECIALIST TEAM (ST)			
ST1	CO-OCCURRING DISORDERS SPECIALIST ON TEAM	3	**5**
ST2	ROLE OF CO-OCCURRING DISORDERS SPECIALIST IN TREATMENT	N/A	**4**
ST3	ROLE OF CO-OCCURRING DISORDERS SPECIALIST WITHIN TEAM	N/A	**4**
ST4	EMPLOYMENT SPECIALIST ON TEAM	1	**2**
ST5	ROLE OF EMPLOYMENT SPECIALIST IN SERVICES	1	**2**
ST6	ROLE OF EMPLOYMENT SPECIALIST WITHIN TEAM	1	**3**
ST7	PEER SPECIALIST ON THE TEAM	4	1
ST8	ROLE OF PEER SPECIALIST	4	N/A
	ST Subscale Average Rating	**14/6 = 2.33**	**21/7 = 3.00**
CORE PRACTICES (CP)			
CP1	COMMUNITY-BASED SERVICES	4	**5**
CP2	ASSERTIVE ENGAGEMENT MECHANISMS	4	4
CP3	INTENSITY OF SERVICE	3	**4**
CP4	FREQUENCY OF CONTACT	2	**3**
CP5	FREQUENCY OF CONTACT WITH NATURAL SUPPORTS	3	2
CP6	RESPONSIBILITY FOR CRISIS SERVICES	4	4
CP7	FULL RESPONSIBILITY FOR PSYCHIATRIC SERVICES	4	**5**
CP8	FULL RESPONSIBILITY FOR PSYCHIATRIC REHABILITATION SERVICES	3	3
	CP Subscale Average Rating	**27/8 = 3.38**	**30/8 = 3.75**
EVIDENCE-BASED PRACTICES (EP)			
EP1	FULL RESPONSIBILITY FOR INTEGRATED TREATMENT FOR CO-OCCURRING DISORDERS	3	**5**
EP2	FULL RESPONSIBILITY FOR EMPLOYMENT & EDUCATIONAL SERVICES	2	**3**
EP3	FULL RESPONSIBILITY FOR WELLNESS MANAGEMENT AND RECOVERY SERVICES	5	3
EP4	INTEGRATED TREATMENT FOR CO-OCCURRING DISORDERS	3	**4**
EP5	SUPPORTED EMPLOYMENT & EDUCATION	3	3
EP6	ENGAGEMENT & PSYCHOEDUCATION WITH NATURAL SUPPORTS	3	3
EP7	EMPIRICALLY-SUPPORTED PSYCHOTHERAPY	3	**4**
EP8	SUPPORTIVE HOUSING MODEL	4	4
	EP Subscale Average Rating	**26/8 = 3.25**	**29/8 = 3.63**

Table 1. Summary of TMACT Items and Ratings – County East ACT Team			
ITEM		RATING	
PERSON-CENTERED PLANNING & PRACTICES (PP)			
PP1	STRENGTHS INFORM TREATMENT PLAN	3	4
PP2	PERSON-CENTERED PLANNING	2	3
PP3	INTERVENTIONS TARGET A BROAD RANGE OF LIFE DOMAINS	2	3
PP4	CLIENT SELF-DETERMINATION AND INDEPENDENCE	3	3
	PP Subscale Average Rating	**10/4 = 2.50**	**13/4 = 3.25**
	TMACT OVERALL RATING	**142/45 = 3.12**	**171/46 = 3.72**

This report provides a summary of strengths and recommendations, followed by individual item ratings and a brief rationale for each rating. As depicted in Table 1, relative areas of strength include Operations and Structure (4.17) and Core Team (4.00). Scales in need of most improvement include Specialist Team (3.00) and Person-Centered Planning & Practices (3.25).

Strengths

The County East ACT Team has shown significant growth since the review conducted nearly two years ago. Following some team member turn-over, most positions are now filled and overall, the compliment of the team includes a majority of veteran team members. The team was observed to have a formidable team dynamic, where trust and reliance amongst each other was evident. Josie, the co-occurring disorders (COD) specialist was hired shortly before the last review. Josie brings many strengths to this team, helping them further enhance their own understanding of integrated COD treatment, ultimately resulting in a greater penetration of this service. Overall, we found the team to be compassionate, patient and oriented towards clients' strengths. Under Stella's leadership and with greater involvement of Dr. Owen, the team has modified their efforts around screening and intakes, which has resulted in the team serving individuals who would appear to be more of a clinical priority for ACT services. Similarly, they have limited the number of new intakes per month, which likely had positive impacts across staff burnout and practices. During the previous review (March 2016), evaluators found that the team was serving a higher number of individuals with more non-specific mood disorders and personality disorders. Relatedly, the team has made some inroads in working with their local managed care entity to help ensure those most needing and benefiting from ACT are able to access this service. The team's advocacy efforts and commitment are appreciated and recognized by evaluators; at the time of the review, the team was serving two people *pro bono* as utilization management staff would not issue a re-authorization for services as they judged milestone success, such as employment or staying out the hospital, as significant indicators for discharge from ACT (as opposed to understanding the ACT team's role in helping clients gain and sustain successes, while continuing to manage and avoid risks to recovery).

Recommendations

The following recommendations are to help the County East ACT Team consider areas to further develop. The listed recommendations reflect a select number of areas that would likely result in the biggest changes in the team's operations, and therefore are not an exhaustive list. For the below recommendations to be successfully implemented and sustained, agency and team leadership, which should include Stella, Dr. Owen, Marissa, and other agency leadership, will need to assume a pro-active role in overseeing these changes, first educating staff about the importance of the change to gain

some “buy-in.” Change takes time; we encourage the County East ACT Team to use these recommendations to create a strategic plan over the course of one to two years. Some recommendations will be quicker to implement than others. A team that can advance from a 3.7 to at least a 4.0 on the next TMACT review would be showing good progress.

We focus our recommendations on the following major areas: 1) Individual Placement and Support (IPS) model of supported employment; 2) Revise the planning and staff scheduling process to better use team members to meet clients’ needs; 3) Hire a Peer Support Specialist and expand wellness management and recovery services; 4) Enhance and expand work with clients’ natural supports; and 5) Continue expanding work of integrated medical team.

Recommendation #1: Individual Placement and Support (IPS) model of supported employment. A critical area of development within the team is their understanding and practice of IPS. Many individuals are interested in, or at least ambivalent about, working or returning to school. Taking such a step may be key to their recovery. John is relatively still new to this team and role. He came with little specific training and experience in delivering employment services, let alone IPS. Despite his lack of training, he does have a positive attitude and values how employment can be key to someone’s recovery. In addition to his need for additional training and supervision to further his competency, he is underutilized in his role. We estimated that about 50% of his time is dedicated to employment related services, which includes engagement and outreach. More strategic scheduling of his time, as we speak to further in Recommendation # 2 below, will help John have opportunities to practice his skills and yield greater results by having more concentrated employment services. The team as a whole varied greatly in their understanding and practice of key elements of IPS. For example, departures included: some team members expecting greater symptom stability before assisting with employment goals (or even attempting to engage in discussion of employment as an option); variation in efforts to try to understand what someone is wanting for employment, which would be assisted if a Career Profile was completed and used; and strategic use of ongoing supports to help people keep employment. John’s efforts around job development are applauded; he would benefit from more focused training on how to approach employers with key follow-up steps to groom those relationships.

Although John has been exposed to the Career Profile and informally tries to gather information captured in this tool, we strongly recommend that he receive more training in how to work with clients to complete and use a Career Profile, as it is at the core of many IPS practices (e.g., person-centered job searches, planning and delivering thoughtful supports). Some individuals would benefit from and desire job coaching, but John expressed concern for his lack of ability to provide such services. Benefits counseling was also not provided. Many individuals hesitate returning to work for many reasons, which can include fear of losing their benefits and not understanding work incentive options, Being skillful in benefits counseling (in addition to having warm connections with local experts on the topic) is not only necessary to assisting someone once they have a job, but can be an important part of the initial engagement effort. Likewise, John and the team using motivational interviewing skills to help people consider employment and school, especially in light of other recovery goals, is strongly recommended. In addition to John devoting more concentrated time to employment services, we offer recommendations in Recommendation #2 about designing individualized treatment teams given client needs and goals. These individualized teams assume a more active role in ongoing assessment, planning, and service delivery. Lastly, as this team recruits and hires a Peer Support Specialist (see Recommendation #3), consider the ways in which the peer specialist can play an intentional supportive role to delivering employment services.

The **best resource** to refer to is www.ipsworks.org. On this site, there are online trainings in which John and other team members (particularly Stella, the team leader) can participate. As County teams have other employment specialists, we also strongly encourage opportunities to routinely gather for group supervision, peer mentorship, and sharing of resources. Other resources that may be helpful include:

- The free Supported Employment Toolkit on the SAMHSA website: http://store.samhsa.gov/product/Supported-Employment-Evidence-Based-Practices-EBP-KIT/SMA08-4365
- The book: Supported Employment: A Practical Guide for Practitioners and Supervisors, Second Edition by Swanson, Becker, Drake and Merrens (2008).
- The manual: Supported Employment: Applying the Client Placement and Support (IPS) Model to Help Clients Compete in the workforce by Swanson and Becker (2011)
- Institute for Best Practices website: www.institutebestpractices.org

Recommendation #2. Revise the planning and staff scheduling process to better use team members to meet client's needs. Given that ACT is a "one-stop treatment shop" serving people who we presume to have complex and wide-ranging needs, the establishment and careful use of more personalized individual treatment teams (ITTs) is recommended. ITTs carry out specific directions laid out in the person-centered plan (PCP), which in turn should result in both a Team Approach, but also a broader range of services being delivered to a given client (see PP3, OS2, and all Full Responsibility items: CP8, EP1, EP2, and EP3). The team has been working to revamp their planning process as of five months ago and have been attempting to create and use ITTs. The ITTs have been composed of a primary worker, a secondary staff, and one nurse. The team is headed in a good direction in this regard, but we suggest the team consider less rigid team member assignments to be accommodating to client needs.

Relatedly, as the team continues to build on their own repertoire of what they have to offer (skill enhancement) and further builds in more routine assessment practices, the actual planning and consequential delivery of a range of individualized services happens with greater ease. This entails a last step of "walking over" planned interventions into staff and client schedules and then using the daily team meeting to help hold people accountable to those schedules as much as possible (given the nature of ACT, emerging needs, and proactive contacts coming up).

Scheduling Interventions by way of the ITT and daily team meeting. In review of plans, listed interventions varied in the extent they were individualized, personal, and specific, which can limit the ultimate instructions carried out through the daily team meeting, With expansion of the team's skills and treatment focus (via assessment), we believe this will only get stronger. The next step is for planned and specifically stated interventions to "walk into" a client schedule that then drives the day-to-day scheduling. Documented interventions not only specify the "what," but also the "when" and the "who." This level of planning, when put into practice, will also be taking into consideration the logistics of staff availability and efforts to maximize on direct time and limit indirect time (travel). Scheduling should reflect several tools that intersect: client schedules, staff schedules, and daily team schedules, which are basically pre-populated with planned interventions and contacts, but modified given assessment data shared during the meeting.

In planning the client's schedule, we recommend that the team consider the overall level of support and oversight a client may benefit from. This level of support and oversight may consider safety risks (i.e., benefitting from more frequent staff check-ins to monitor status), cognitive challenges, including disorganization (i.e., benefitting from more frequent contacts as staff visits help organize and anchor the client), and complexity of needs (i.e., what is needed cannot be effectively delivered in two visits in a week).

What follows is making a list of the client's needs (interventions, which may include supportive check-ins and medication deliveries for those with a high number of planned contacts), priority staff to deliver (ITT), and transplanting these visits onto staff schedules. As geography and location will likely assume some role in scheduling, also consider how to maximize staff time by weighing in geography (ideally, last, after attempting to schedule per the ideal arrangement). When clients need a high frequency of visits, we encourage that ITT staff take the lead. Other staff may fill in to help with the higher demand of

visits during a week, but try to minimize the rotation of all staff. Ultimately, what results should be both client schedules and staff schedules that cross-walk with each other, and where daily team schedules are essentially prepopulated with planned interventions and contacts. This process lends to easier checks on how ITTs are not only formed but used in service delivery.

The daily team meeting is a place where the planned schedule may be revised and flexed, as needed, to accommodate for emerging needs, proactive contacts, and staff time away. Also, it can be the place to capture (in a snapshot) what is being provided and relevant reactions for a given client in a given month. This, too, provides a way to review the range of services, level of care, and use of a team approach for a given client and, in turn, further helps the team "right course" its service delivery.

When developing interventions, pay close attention to functional skill deficits that would benefit from more ongoing teaching, coaching, role-playing, and rehearsal, as well as ways to involve, intervene with, and/or help develop natural supports. Many individuals would also benefit from more deliberately delivered therapy to address a behavior challenge and/or distorted thinking. Stella and Lucy are doing a good job of assuming this role within the team, but penetration would increase with better assessment and planning around which clients would best benefit from therapy.

Person-Centered Planning. In the actual development of a person-centered plan, we encourage the team to host two meetings. In the first meeting, ITT staff come together to share, review, and consider targets for intervention that will help a client move towards their larger life goals. Use the assessment data the team has collected along the way, with Stella remaining "in-the-know" regarding assessment data across all clients served by the team. The goal of this meeting is to synthesize and interpret assessment data and essentially come up with a draft plan. The next step is to then host a formal planning meeting that includes the client. In this meeting, the drafted plan is presented and then likely revised/enhanced. We recommend only including those who are part of the ITT, team leadership (including psychiatry, when available), client, and natural supports. More intimate groups (rather than the whole team or nearly the whole team) tend to be more productive and for some people, less intimidating.

In the meeting that involves the client, we recommend it begins with an emphasis on the person's strengths and elicits thoughts from the client. Then, invite others to offer their observations. Consider writing this up on a board so that the individual has it to reflect on throughout the meeting (use visuals/pictures if the person is illiterate). When proceeding to clarify recovery goals, spend time trying to understand what matters most to the individual and defining what that is with the person. It is not uncommon for teams to unintentionally move too quickly past what one expresses as a personal value or goal, inserting our own ideas for what should be in the plan (e.g., overlooking the importance of reconnecting with family, instead focusing a great deal on healthy living behaviors and medications). We observed this to be the case in the meeting we sat in on; the team directed conversation back to diabetes management, not working with the client to help him consider and give responses beyond "I don't know."

We **append several handouts** for reference. We include two client schedules and a related daily team schedule. The daily team meeting handout is an example of how it may be set up; larger teams can do the same but use legal paper to capture all staff columns. We also attach two example client logs for two clients. We understand that the team is accustomed to using electronic medical records and Excel to assist with daily meeting tools. We share these handouts to help show how these tools should be intersecting with one another. We also refer the team to the following resources:

- Neal Adams and Diane Grieder site, which includes information on their 2nd Ed. Book: http://www.personcenteredtreatmentplanning.com
- Diane Grieder, Janis Tondora, and Valerie Way's workbook on PCP development https://www.omh.ny.gov/omhweb/pros/Person_Centered_Workbook/

- Refer to this Presentation delivered by Janis Tondora: http://www.ct.gov/dmhas/lib/dmhas/publications/CSP-PCPdocumentationTraining.pdf
- UNC Institute for Best Practices: www.institutebestpreactices.org

Recommendation #3. Hire a Peer Support Specialist and expand wellness management and recovery services. Although this position has been vacant for about one month at the time of the review, the vacancy was experienced during the review in both the type of services delivered and the culture within the team. We applaud the team's efforts to continue supporting individuals in developing and using Wellness Recovery Action (WRAPs). We understand that agency leadership has entertained the idea of not filling this position with a full-time peer specialist, which we believe would be to the detriment of this team's practices. The perspective of the peer specialist is valuable for the culture and practice of the team. Not to say that current team members don't come with their own lived experience (as many of us do!), a Peer Support Specialist is a central voice that helps anchor the team in the perspective of what it is like to experience what many of the clients served experience: involuntary commitment, feeling alienated, homeless, helpless and hopeless. Peers are an asset to the clients, providing emotional support, further normalizing clients' experiences, teaching advocacy skills, and serving as a beacon of hope for clients' recovery. One area of expertise we encourage the peer support specialist to have is in wellness management and recovery (WMR) activities, which can also be delivered by anyone on the team. Empirically supported WMR programs, which address a broader range of wellness areas that promote more independence, include topics related to psychoeducation about mental illness and the stress-vulnerability model, building social support, recognizing signs of decompensation and heading off crises, coaching to help clarify treatment preferences, coping with stress, symptom management, and getting needs met within the mental health system and community. Assisting individuals in creating WRAPs and/or following WMR curriculum are ideally formally delivered to interested participants both individually and via groups. Resources that may be helpful to further educate the team on wellness management approaches include:

- The IMR Toolkit on the Substance Abuse and Mental Health Services Administration (SAMHSA) website: http://mentalhealth.samhsa.gov/cmhs/CommunitySupport/toolkits/illness/
- The manual: IMR: Personalized Skills and Strategies for Those with Mental Illness (3rd edition) by Gingerich and Mueser (2011).
- The book, Wellness Recovery Action Plan by Copeland (2000).
- Whole Health Action Management (WHAM): http://www.integration.samhsa.gov/health-wellness/wham
- The website: The National Resource Center on Psychiatric Advance Directives at http://www.nrc-pad.org/
- Temple University Collaborative on Community Inclusion: http://tucollaborative.org/

Recommendation #4. Enhance and expand work with clients' natural supports. The team reported having contact with the natural supports of 35% of their client caseload. Work in this area seemed inconsistent for those who were receiving some contact by the team. ACT teams are positioned to help clients work toward their goals by deliberately including natural supports as part of the broader treatment team while also proactively looking for opportunities to educate and influence the natural supports in a manner that ultimately is best for the client. Teams often struggle with prioritizing engagement and treatment efforts that target the natural supports of clients. It is within the responsibility of the team to assist clients in developing a network of natural supports, which may be inclusive of only non-family members (e.g., friends, romantic partners, church members, neighbors, friendly and supportive employers) where the client has long-severed ties with family or vice versa. The team can also work with the client to rebuild family relationships. When natural supports do indeed exist, there are several interventions that the team can and should be providing (all with client consent, which should be persistently sought even if client initially declines). First, the team plays a role in educating natural supports about their loved one's illness and effective treatments for that illness. Doing so both educates the natural supports as well as primes them to be attentive to signs of

decompensation and progress. Second, the team provides more proactive interventions to address behaviors that may serve to exacerbate client's symptoms and works with family and loved ones to develop healthy problem-solving skills. The team is a key source of support for helping natural supports truly understand the potential for clients and emphasizing the importance of a recovery-perspective. Finally, the team maintains a list of written local resources that may be of help to family members/natural support, routinely providing these resources to family members/natural supports.

Below are resources that can help develop family psychoeducation and supports:

- The Family Psychoeducation Toolkit on the Substance Abuse and Mental Health Services Administration (SAMHSA) website: http://mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/familypsychoeducation
- Multifamily Groups in the Treatment of Severe Psychiatric Disorders by McFarlane, WR (2002).
- Family Psychoeducation for Serious Mental Illness by Lefley, HP (2009).
- The Complete Family Guide to Schizophrenia by Mueser, KT and Gingerich, S (2006)
- Family-to-Family Education Program offered by National Alliance on Mental Illness (NAMI)

Recommendation #5. Continue expanding work of integrated medical team. Following recommendations from the last review, we want to continue to stress the importance of the role of the medical team within ACT. By way of who is eligible and would benefit most from ACT, teams are serving individuals with complicated and severe psychiatric symptoms and often present with serious and multiple health concerns (which can be secondary to lifestyle [smoking, diet, poverty], treatment [medication side effects], and interactions with the healthcare system [not seeking out services, not receiving adequate care]). We are encouraged by the increase in psychiatric care provider time, with Dr. Owen at 0.40 FTE and Marissa at 0.20 FTE. Nursing time is temporarily down as the team has yet to staff up given the increased caseload. This no doubt puts more strain on Matt, RN and Gail, LPN.

Dr. Owen works closely with Stella in a co-leadership role and embraces his role as an educator to the team. We want to encourage the team to consider the trade-offs of having a full day in which Dr. Owen and Marissa are with the team (which allows for collaboration and coordination between the two) compared with more coverage, where the team has more in-person access to a psychiatric care provider across the week. As of now, the team does not have a psychiatric care provider present Thursday through Monday. Also, we encourage Stella to work with the nurses to streamline and integrate scheduling for both providers' time in a manner that ensures clients are receiving the appropriate level of follow-up support from Dr. Owen and Marissa. At the time of the review, both were independently managing their own schedules. Relatedly, we encourage the team to consider a broader array of planned interventions both Dr. Owen and Marissa could be assisting with, which could include delivering planned, brief therapies to a subset of clients as well as working in closer collaboration with nursing staff in delivering integrated healthcare. Nursing staff are not completing ongoing health assessments and client needs in terms of health concerns are variably being addressed. Clients would benefit from the medical team assessing and tracking such needs and making such interventions a higher priority in their work. We appreciate the concerns of Dr. Owen and Marissa to not be a default primary care provider, however, many clients struggle to get adequate care through traditional healthcare. There are many key ways the ACT team can be screening, assessing, and reasonably (safely) meeting these needs while continuing to link and coordinate with other providers. Nursing staff had many examples of their work around diabetes management. We encourage them to expand their health promotion and prevention in both individual and group formats. For example, nursing staff could cover topics in decreasing sedentary behaviors, improving diet and nutrition, safe sex practices, and smoking cessation.

TMACT Items Organized by Subscale. For each item, the criteria considered for a high-fidelity ACT team are noted. For many items, options for Full or Partial credit are available and indicated with an F (full credit), P (partial credit), or N (no credit) in the absence of supporting data for that practice. In the Comments section, evaluators may note observations unique to the team that influenced the ratings.		
Item	**Rating**	**Comments**
OS1. Low Ratio of Clients to Staff. Definition: The team maintains a low client-to-staff ratio, not to exceed 10:1, which includes all direct service staff except 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.	**5**	The team is comprised of 8.0 FTE direct service staff (excluding psychiatric care providers, interns, and program assistant) serving 71 clients, resulting in a staff to client ratio of 1.0: 8.9.
OS2. Team Approach. Definition: ACT staff work as a transdisciplinary team rather than as individual 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 appropriate (i.e., by way of a person-centered plan, forming and using individual treatment teams [ITTs]).	**3**	Of the 14 charts randomly selected for review where there was at least one face-to-face contact, 10 client charts (71%) in this sample had face-to-face contact with at least three ACT staff in the four-week review period. The percent of clients seeing five or more staff in the four-week period was 44%, which may not reflect best practice and can further fragment services and negatively impact relationship building.
OS3. Daily Team Meeting (Frequency & Attendance) Definition: 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 clients' statuses; there is planning for future services; most team members are present.	**5**	The team holds a daily team meeting to review recent client contacts and plan the daily schedule at 11:00 AM Monday through Friday. Staff are expected to attend and participate, which was observed to be the case. The team had a protocol where absent staff passed on reports via secure email and another team member reported on their behalf. The team's psychiatric care providers each attended one day per week for the full meeting, which is an improvement from the last review where they only attended briefly for updates.
OS4. Daily Team Meeting (Quality). Definition: A high-fidelity ACT Team uses the Daily Team Meeting to fully serve the following functions:	**3**	We observed a Tuesday Daily Team Meeting. The team commences their meeting with Stella reviewing and updating "dashboard" information, such as who is in jail, hospital, upcoming IM injections, and pending admissions and discharges. She also inquired about crisis calls, of which none were reported. The team continued with roll call, where two team members (in this case, Dave and John) managed the client log books, each taking turns calling out client names (and then entering information into the log). Information the team shared tended to be clinically
Function #1: Conduct a brief, but clinically-relevant review of all client contacts in the past 24 hours;	P	

Function #2: Record status of all clients;	P	relevant and brief enough to keep the pace of the meeting going (we observed a couple of reports that would have benefited from "parking" and discussing more at length at the end of the meeting). Further, information shared was mostly focused on the last 24 hours except for the team re-sharing updates with Dr. Owen, who had not been with the team the previous three business days. In review of the client logs, they were organized nicely by person and by month and included space to note who (team member) and the nature of visit/summary. However, instead of being pre-dated, team members entering information made a new entry if there was information to enter; this format missed out on being able to visually capture days the client was not seen, which included attempts. Also, the quality of content documented varied considerably across who made the entries (some would just note, "doing ok," as an example). Client schedules existed but were somewhat vague; key team members working with the individual were listed as well as days of the week the client was scheduled to be seen. What was significantly lacking was specifying interventions to be carried out. A draft daily team schedules (M – F) are created the previous week (Friday), and then updated each day of the meeting. After the meeting, final mark-ups were quickly integrated into a master schedule and reprinted, handed out to all team members. Stella did appear on top of ensuring that emerging needs were on the schedule and being addressed. The team uses a central schedule where they input dentist, doctor/PCP, court, etc. appointments and Odeleen and Stella work to be sure this is integrated into the daily team schedule. We also observed one instance where the team shared an update on a client whose paranoia appears to be increasing. Dr. Owen led the brainstorming on next steps, which included reaching out to the client's aunt to enlist in more assertive outreach efforts to address problems appearing to be associated with the client not consistently taking medications (Criterion #5). Finally, although Stella handed out the previous day's schedule for reference during the roll call and appeared to be checking off that visits occurred, there was no mechanism in place to ensure that staff were held accountable to carrying out planned interventions.
Function #3: Daily Staff Schedule is based on person-centered plan-informed Client Schedules;	P	
Function #4: Daily staff schedule is based on clients' emerging needs;	F	
Function #5: Daily Staff Schedule is based on need for proactive contacts to prevent future crises;	F	
Function #6: Staff are held accountable for follow-through	P	
OS5. Program Size. Definition: 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 to allow for enough staff to be available 24 hours a day, seven days a week.	**5**	The team is staffed with 8.6 clinical FTE staff, with a current caseload cap of 75 clients.

OS6. Priority Service Population. Definition: A high-fidelity ACT team serves 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.	**5**	Diagnostic information was reviewed for all clients served. This information suggested that approximately all clients (97%) may represent a clinical population who typically needs and/or benefits from ACT. The team reported that two clients may not be appropriate for the team; both are presenting with significant substance use challenges and the documented primary psychiatric diagnoses are currently being evaluated. Stella, team leader, and Dr. Owen each assume a proactive role in reviewing referrals and conducting initial intake assessments. The team indicated that they feel empowered to refuse inappropriate referrals and make decisions about who is to be discharged with minimal external pressure. A cited concern is some pressure to discharge clients before the team believes they are ready. The team has been exhausting all appeal processes in such cases, including deciding to serve two such individuals *pro bono.* See OS9 for further description.
Criterion #1: 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.	F	
Criterion #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.	F	
OS7. Active Recruitment. Definition: There is often more individuals of need of ACT services than there are ACT services. Team makes an effort to seek out those most in need of this level of care.	**4**	The team is not currently at capacity, reported to be 75, with 5% open slots (Criterion #3). Of those clients currently served by the team, approximately 85% of clients appeared not to be "stepped up" from a less intensive agency program (Criterion #2). The agency operates targeted case management and outpatient therapy programs who have referred clients to ACT in the past. Most referrals are coming from their local hospital, other behavioral health providers who do not offer ACT, and their managed care organization (MCO). Stella reported that the team is familiar with staff at the local shelter, crisis center and jail, but have not conducted strategic outreach efforts to help these potential referral sources understand ACT and to help foster appropriate referrals. Stella does participate in a community stakeholder board that meets quarterly, which does involve various representation across community groups, and cited two examples where that participation resulted in referrals to the team.
Criterion #1: A high-fidelity 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. The team regularly visits specific referral sources for outreach (e.g., community inpatient units, jail, shelters, system-wide community meetings where various referral sources meet regularly). Team conducts regular screening and planning for new admissions. Non-ACT staff (e.g., local government entity, or agency administration) may perform these outreach functions on behalf of the team; however, team must still actively build and maintain relationships with common referral sources. If team is at capacity, there is a mechanism for prioritizing admissions to the team (e.g.,	P	

waiting list) to ensure that new clients can be admitted to the team once there is an open slot. Also, if at full capacity, there may be less of a need to be doing active community outreach, but there is clear evidence that the team has developed and actively maintains positive relationships with referral sites.		
Criterion #2: Team is comprised of clients from common referral sources and sites outside of the usual community mental health settings (e.g., state & community hospitals, ERs, prisons/jails, shelters, street outreach) or more restrictive agency programs. For Full Credit, at least 75% of clients from outside agencies/referral sources or from within more restrictive programs administered by parent agency (e.g., mobile crisis team) vs. less restrictive programs administered by parent agency (e.g., adult case management program). Partial Credit if 50% - 74%.	F	
Criterion #3: A high-fidelity team works to fill open slots when they are not at full capacity and/or the staff-to-client ratio is well below 1:10 on more mature teams. Full Credit if no more than 5% of slots are open. Partial credit for teams with 6% - 10% of slots open. Teams that are at least 2 years old with a client-to-staff ratio less than 6:1 (see OS1) does not qualify for full credit as the assumption is that there should be more slots available (i.e., capacity should be increased).	F	
OS8. Gradual Admission Rate. Definition: Program takes clients in at a low rate to maintain a stable service environment.	**5**	The highest number of clients admitted in a given month in the past six months is four. The team typically tries to not enroll more than two individuals per month to avoid overextending the team's resources, and/or diverting resources away from other clients. Stella reported that the unusual month of admitting four individuals was in response to an MCO request and that agency middle management stepped in to help the team for two months. Great job!
OS9. Transition to Less Intensive Services. Definition: The team has a reliable process for transitioning clients from the team who have demonstrated and maintained improvement and not requiring this level of care.	**3**	The team reported that six clients transitioned from the team in the past year, four of which appeared to be spurred by the MCO. The team did not agree with the MCO that these individuals were ready to graduate from ACT. The team uses a semi-structured transition readiness assessment tool to determine where individuals are at across various functional and

Criterion #1: Team conducts regular assessment of need for ACT services;	F	engagement domains. These assessments are typically completed every six months at the time of planning. In speaking with various team members, there were inconsistencies in the team members' understandings of what constitutes readiness to graduate (some cited "medication adherence" and "staying out of the hospital and jail" without accompanying growth-oriented outcomes). Individuals whose graduation were spurred by the MCO tended to be individuals who had stayed out of the hospital the past two years and were in part-time employment. The team asserts that its ongoing efforts have helped the clients maintain these successes and retracting ACT risks setbacks with these gains, per these individuals' histories. Examples were provided for the team's transition plans for two people currently in a transition phase; plans included titrating down contacts, clients taking public transportation to the office for scheduled meetings; and introduction to a new provider. Overall, the transition plan spanned a year. Team members were inconsistent in their reporting of whether and who would be followed post-transition, with Stella reporting that policy indicates all graduated individuals receive one phone call one month after discharge. We suggest modifying this policy to individualize who benefits from follow-up contacts and what this may look like for those individuals (e.g., some may benefit from more check-ins over a longer period, which can include a Memorandum of Agreement with the current provider). There is no waitlist and examples were offered where the team is able to immediately serve those who re-enroll, prior to getting initial authorization.
Criterion #2: Team uses explicit criteria or markers for need to transfer to less intensive service option;	P	
Criterion #3: Transition is gradual & individualized, with assured continuity of care;	F	
Criterion #4: Status is monitored following transition, per individual need;	P	
Criterion #5: Team expedites re-admission to the team if necessary.	F	
OS10. Retention Rate. Definition: 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.	**4**	Considering the data provided on clients who were discharged for reasons other than death and transitions/graduations, we rated this item based on seven "drop-outs," per the protocol's definition (90% retention rate considering the average of current (71) and past year's (75) caseload sizes). Of note, the team originally reported that one individual went to jail, two went to more restrictive settings (nursing homes), and one refused services and was discharged. In addition to those four, we judged that three others that were originally reported to be "transitions/graduations" are a result of an MCO denial for service as the team clearly did not agree with the MCO's decision (we exclude from this drop-out calculation one person as the team sought to appeal the decision, per TMACT protocol).
OS11. Involvement in Psychiatric Hospitalization Decisions Definition: The ACT team is closely involved in psychiatric hospitalizations and discharges. This includes involvement in the decision to hospitalize the client (e.g., activating crisis plan to employ alternative strategies before resorting to hospitalization, assessment of need for hospitalization, and assistance with both voluntary	**4**	The team was credited for being appropriately involved in the decision-making surrounding seven of the last 10 hospital events, which includes decisions resulting in admissions and discharges. The team reported that they are often able to assume an active role around admission decisions, with examples such as consulting with family members in decisions to hospitalize the client, consulting with admission staff at the hospital, sharing current records and offering clinical opinions, attempting to divert one admission as the ACT team assessed and believed the person could "ride out" their acute crisis at home with team's increased support

and involuntary admissions), contact with the client 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).		(this person presents to the ER fairly often). The team struggles more in being consistently involved in discharge planning, reportedly due to hospital staff not welcoming ACT's role in assessment of disposition and planning for aftercare.
OS12. Dedicated Office-Based Program Assistance Definition: 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 clients. 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 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.	**4**	Office-based program assistance is provided by Odeleen, who has been the team's program assistant for the past six years. Odeleen is full-time and is solely appointed to support the team at this time, which is a significant improvement from the last review where Odeleen was tasked with providing administrative supports to multiple agency programs. Stella and Odeleen described her responsibilities: she helps track key due dates, maintains the charts, assists with authorizations and billing, helps with document sharing across provider groups, and ensures that Release of Information and Disclosures are up to date and signed. She is situated in the office where walk-ins encounter Odeleen first and she can either meet their need or connect with a team member. Odeleen also receives all ACT phone calls. In terms of providing direct support to staff, particularly when in the field, information varied. Examples included team members reaching out to Odeleen for information such as addresses and phone numbers. The team also relied on texting each other and some examples reflected problematic consequences of not keeping communication more centralized with Odeleen involved. She does assume an active role in the daily team meeting, she tracks key performance and outcomes (e.g., notes hospitalizations, incarcerations, employment, housing episodes), and we observed her report out on her own client contact, which other sources indicated as typical.
Team has 1.0 FTE;	F	
Function #1: Provides direct support to staff, including monitoring & coordinating daily team schedules and supporting staff both in office and field;	P	
Function #2: Serves as a liaison between clients and staff, such as attending to the needs of office walk-ins and calls from clients/natural supports;	F	
Function #3: Actively participates in the daily team meeting.	F	
CT1. Team Leader on Team. Definition: The team has 1.0 FTE (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 clinical related field, and a license in their respective field, and at least three years of experience. The team leader cannot	**5**	Stella is the team leader. She is full-time and meets minimal qualifications; Stella is a licensed clinical social worker who also has her LCAS. She has 16 years of experience working with adults with severe mental illness. She does not assume any significant agency role that detracts from her full-time status with this team.

fill more than one role on the team.		
CT2. Team Leader is Practicing Clinician. Definition: 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.	**4**	Stella reports spending about 14 hours a week providing direct services to clients and/or natural supports, which includes seeing five clients routinely for therapy. Other data sources indicated that this estimate was accurate. She reported providing scheduled clinical supervision twice a month to the two staff most in need of supervision, which was listed as Josie and Lucy. Other data sources suggested that these estimates were accurate. Ned, the program manager who supervises Stella, also provides some clinical supervision to team members. Ned is not considered part of the team, but will at times step in to provide direct services when the team is feeling overwhelmed. We encourage Stella to consider ways to increase the rate at which she is providing clinical supervision to the team, which can also include group supervision (outside of the daily team meeting). Her level of direct clinical work meets criteria, but also may be high and resulting in less time in her administrative and supervisor roles.
CT3. Psychiatric Care Provider on Team. Definition: The team has at least 0.8 FTE psychiatric care provider time to directly work with a 100-client team. Minimum 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 and approved by the state licensing entity; and (3) has relevant experience working with people with serious mental illness.	**5**	Dr. Owen and Marissa del Toro, a psychiatric nurse practitioner, are the team's psychiatric care providers. Dr. Owen works with the team 16 hours per week, at 0.40 FTE, and Marissa works with the team eight hours per week, at 0.20 FTE. Both meet qualifications for ACT team psychiatric care provider and have considerable experience within this role; Dr. Owen is board certified in psychiatry and Marissa has 10 years of experience working with individuals with serious mental illness, including two years of supervised work while in training. Although the team is short on nursing staff (see CT6), we did not find Marissa substituting her time in to fulfill more typical nursing responsibilities. In total, the 24 hours of psychiatric care provider time is prorated as 0.85 FTE given a 100-client team. Further, their schedules involve some overlap (Dr. Owen works Tuesday and Wednesday and Marissa works Wednesday), where the two can have consistent communication. Although the team has sufficient psychiatric care coverage by adding Marissa when growing to a midsize team, it is of concern that the team operates from Thursday – Monday without the presence of a psychiatric care provider team member. If possible, consider alternative ways to provide more psychiatric coverage to the team throughout the week while not sacrificing communication between the two.
CT4. Role of Psychiatric Care Provider (In Treatment) Definition: In addition to providing psychopharmacologic treatment, the psychiatric care provider performs the following functions in treatment:	**3**	Because Marissa works fewer hours and is the primary provider for about 1/3 of the team's caseload, we give more weight to Dr. Owen's fulfillment of the listed functions. The psychiatric care providers met all of the listed functions at least partially. In review of all 14 charts, we found that eight (57%) were seen within six weeks and one (7%) had timespans of more than

Function #1: Typically provides at least monthly assessment and treatment of client's symptoms and response to the medications, including side effects;	P	three months between face-to-face meetings with an ACT psychiatric care provider (this person was in jail). In review of data sources, we found that neither Dr. Owen nor Marissa provided brief therapy, but provided more supportive therapy. They try to keep in the loop of what other team members are doing and reinforce those strategies, but could not cite specific examples that reflected brief therapy (Function #2). Data sources indicated that a shared decision-making paradigm is practiced with the following examples: their descriptions of how they approach medication decisions highlighted the importance of understanding the person's view and experience with medications and educating them on options. The use of IMs appeared to be largely driven by client choice, with some exceptions of clients who otherwise refuse all medications (and no medications resulted in worse outcomes). They were serving two individuals who were currently refusing all medications and continued to have scheduled meetings with them to monitor and attempt to address symptoms with alternative options (e.g., one client only wants to try alternative medicine options for now) (Criterion #3). We also found that Dr. Owen and Marissa are utilizing Clozaril as part of their medication options (this medication is widely under-used and, theoretically, would be well-suited for some individuals served by ACT). Data indicated that the providers partly assumed a proactive role monitoring and addressing non-psychiatric medical conditions and medications, with the following examples: being aware of who has diabetes or is pre-diabetic, or hypertension and trying to coordinate care with other providers (Criterion #4). Along with nursing staff, they conduct routine lab work and monitor vitals. There was expressed hesitation to bridge medications and assume too active of a role around healthcare, citing concerns that clients and the team will default to them as the PCP. There is no systematic tracking of health-related data. When clients are in a psychiatric hospital, both provided many examples of direct coordination with inpatient staff, including visiting clients while hospitalized (most recent example was three weeks earlier). As with the team, both cited frustrations with inpatient staff not always appearing to value their input (Criterion #5). It appeared that both Marissa and Dr. Owen do see clients in the community (both at approximately 40%). Dr. Owen typically leaves for community visits by noon and has a few people he will see on his way in when it is their scheduled time. Marissa, too, spends most of her day in the community. We applaud the modifications the team has made in not having a nurse accompany Dr. Owen on all of his visits (Function #6)!
Function #2: Provides brief therapy;	P	
Function #3: Provides diagnostic and medication education to clients, with medication decisions based in a shared decision-making paradigm;	F	
Function #4: Monitors all clients' non-psychiatric medical conditions and non-psychiatric medications;	P	
Function #5: If clients are hospitalized, communicates directly with clients' inpatient psychiatric care provider to ensure continuity of care;	F	
Function #6: Conducts home and community visits.	F	
CT5. Role of Psychiatric Care Provider (Within Team) Definition: The psychiatric care provider performs the following functions WITHIN THE TEAM: (1) Collaborates with the team leader in sharing overall clinical	**3**	We credit Dr. Owen and Marissa for meeting all of the listed within Team Functions, except for #3, attending the majority of treatment planning meetings (they reportedly provide consultation around planning, but rarely directly attend planning sessions with client) and #4, attending daily team meetings (a team this size would require participation in at least three

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 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 clients' current status and medical records/current medications).		meetings per week, whereas they only have access two days per week [Tuesday and Wednesday]). Dr. Owen works closely with Stella; the two have had a strong working relationship for the past five years, per multiple sources, and are viewed as clinical co-leaders of the team. We heard and observed examples of education with the team, including a monthly "seminar" Dr. Owen holds with the team and covers specific topics relevant to ACT (e.g., recent months he presented on akathisia and restlessness and use of Clozaril). They both appear to collaborate closely with nursing staff and provide psychiatric back-up after hours (Dr. Owen is default for his own clients and Marissa for her clients; both provide back-up for each other).
CT6. Nurses on Team. Definition: The team has at least 2.85 FTE registered nurses (RNs) assigned to work within a 100-client team. At least 1 full-time RN on the team has a minimum of 1-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 they go even slightly above the 100-client team.	**4**	Matt and Gail are the ACT team nurses, both full-time with the team. Matt is an RN who has worked with the team for the past three years and has a total of 18 years of experience working with adults with serious mental illness. Gail is an LPN and has over 10 years of experience working with adults with serious mental illness, both inpatient and outpatient. Per TMACT Rating Protocol, Gail's time is adjusted to 75% of the FTE, or 0.75 FTE, as LPNs have a more limited scope of practice. In total, the team has a total of 1.75 nursing FTE, which is prorated to 2.46 FTE given a 100-client team.
CT7. Role of Nurses. Definition: Team nurses perform the following critical roles (in collaboration with the psychiatric care provider):	**4**	We credit nursing staff for all listed functions at least partially. Nursing staff are partially credited for managing the medication system, which includes administering and documenting medication treatment. In review of the level of medication supports provided by nursing staff, we found that few (20%) clients receiving oral medications are either managing oral medications on their own (e.g., picking up from pharmacy, or delivered by pharmacy with little immediate intersection from nursing) or receive significant oversight from residential staff. We observed mixed evidence for nursing staff assuming a proactive role in screening and monitoring clients for medical problems/side-effects. Nursing staff complete a nursing assessment near intake, but this assessment is not routinely updated throughout enrollment. Nursing staff, along with psychiatric care providers, assess vitals, but there was not a clear and consistent occasion for when vitals are assessed, nor was there any tracking of age-related health screens (Function #2). Data indicated strong support for the nursing staff role in communicating and coordinating services with other medical providers; the nurses have divided the caseload, so each assumes more responsibility for a subset of the caseload. Nursing staff
Function #1: Manage the medication system, administer and document medication treatment;	F	
Function #2: Screen and monitor clients for medical problems/side effects;	P	
Function #3: Communicate and coordinate services with the other medical providers;	F	
Function #4: Engage in health promotion, prevention, and education activities;	P	

Function #5: Educate other team members to help them monitor psychiatric symptoms and medication side effects;	F	had many recent examples of accompanying individuals to doctor and dental appointments and provided examples of a health communication form they routinely use to share information with other providers. Examples of nursing staff engaging in health promotion, prevention, and educational activities indicated less consistent practice (Function #4), with most examples focused on diabetes management (we did not observe examples related to nutrition, exercise, or safe sex practices). We heard examples of nursing staff providing education to team members, such as how to use a glucose monitor, side-effects to watch for with a new medication, and how to assist with redressing a wound for a client. For those clients willing to take medications but not consistently doing so, nursing staff have assisted with medication adherence using the following strategies: setting up alarms, identifying morning behavioral patterns and integrating medications into routine, using team phone call reminders, modifying packaging to be more visually clear, modifying timing of medications. These examples were judged to be robust, therefore resulting in full credit for Function #6.
Function #6: When clients are in agreement, develop strategies to maximize the taking of medications as prescribed.	F	
ST1. Co-Occurring Disorders Specialist on Team Definition: The team has at least 1.0 FTE team member designated as a co-occurring disorders 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.	**5**	Josie Crane is designated as the team's Co-Occurring Disorders Specialist. Josie is full-time with the team and meets minimal qualifications as she has her MSW, LCAS, and five years of experience working with this population. Josie estimated that approximately 90% of her contacts involve a co-occurring disorders (COD) service relevant to specialty area. Other data sources supported this estimate; she is the primary or on the ITT for 22 individuals, all of whom have a COD, and we found that nearly all (86%) of her progress note entries reviewed in the chart sample reflected some COD intervention. Of note, although we do not count her effort here, Stella, the team leader, is also a LCAS and provides some direct care to clients.
ST2. Role of Co-Occurring Disorders Specialist in Treatment. Definition: The co-occurring disorders specialist provides integrated dual disorders treatment to ACT clients who have a substance use problem. Core services include:	**4**	We fully credit Josie for all listed services except for Service #1, which received partial credit. In review of the charts and interview data, it appeared that the extent to which substance use is assessed, especially in relationship with mental health, is occurring near the time of enrollment by Josie. The assessment tool she is using appeared to gather helpful information and examined the interrelationship between substance use and mental health. She reported that she is trying to complete it within the first six months of clients' enrollment. There is a follow-up assessment available, but we found that it was inconsistently completed per our review of charts. Stages of change readiness are being assessed and documented in progress notes, stand-alone SUDs filed in charts, and tracked by way of a document used in the daily team meeting. Josie leads the team monthly in a staging discussion where they review about four clients at a time, updating their stages of change readiness and, more importantly, discussing strategies and interventions. Application of motivational interviewing techniques and use of strategic outreach with those in earlier stages of change readiness were clearly evident. Josie is
Service #1: Conducting ongoing comprehensive substance use assessments that consider the relationship between substance use and mental health;	P	
Service #2: Assessing and tracking clients' stages of change readiness and stages of treatment;	F	

Service #3: Using outreach and motivational interviewing (MI) techniques;	F	on the ITT for several clients in earlier stages of change readiness. In describing MI-related techniques, she was able to provide specific examples in how she has worked with these individuals, including focusing on basic needs, keeping attention on understanding what mattered most to people and finding gentle ways to explore how behaviors help or hinder those goals. She carries scaling tools with her to help use visuals in these discussions. Understanding and applying CBT approaches, especially in context of substance use counseling and relapse prevention, was also evident. She helps clients complete and use relapse prevention plans, assist people who are interested locate and attend self-help groups, and co-facilitate a weekly substance use counseling group with Stella, targeting those in action and maintenance stages of change. In review of data sources, it appears that she is consistently applying strategies according to the clients' stages of change readiness.
Service #4: Using cognitive behavioral therapy (CBT) approaches and relapse prevention;	F	
Service #5: Applying treatment approaches consistent with clients' stage of change readiness;	F	
ST3. Role of Co-Occurring Disorders Specialist within Team. Definition: The co-occurring disorders specialist is a key team member in the service planning for clients with dual disorders. The co-occurring disorders 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 majority treatment planning meetings for clients with dual disorders.	**4**	We credit Josie in meeting all of the listed Within Team Functions except for Functions #4. She is attending all daily team meetings and we heard and observed examples of her providing consultation and modeling, such as around stage-appropriate approaches and interventions. She recently provided cross-training on potency of marijuana on the street and issues related to synthetic marijuana. The team is inconsistent in how planning meetings are conducted; most clients have a planning meeting annually that includes the ITT members, then interim six-month meetings with just the primary care provider on the ITT.
ST4. Employment Specialist on Team. Definition: 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 program within the agency.	**2**	John Parker is designated as the team's Employment Specialist. John is full-time with the team but does not meet minimal qualifications at the time of review. John's training has been in social work and of the various jobs he has held, none have been specific to employment services. He was hired into this position approximately six months ago. Both he and Stella spoke to his positive attitude and eagerness to help people return to work. There is no other employment program at County, but he has gotten together with the County West ACT team Employment Specialist on two occasions. He has attended local IPS trainings in the past three months. John estimated that approximately 60% of his time involved an employment and education service. Other data sources did not support this high of an estimate; 38% of John's progress note entries reflected employment services and the rate at which he is doing any job development activities is moderate. In review of his assignment to ITTs, he counted 20 individuals. Of those individuals, it appeared that six of them were unclear what employment

		service he was delivering. We therefore adjusted to 50%, reflecting a 0.60 FTE, which tentatively rates a "3," but is further reduced due to John not yet meeting the qualifications standard.
ST5. Role of Employment Specialist in Services Definition: The employment specialist provides supported employment and education services. Core services include:	**2**	John appears eager to assume this role despite his lack of training in employment an education services. Attitudinally, we heard and observed an embrace of the value of work–competitive work–as part of individuals' recovery, but also some hesitation for those viewed as possibly too symptomatic to work. In review of charts and interview data, efforts to engage individuals in considering competitive employment and education as a personal goal or objective were inconsistent and appeared dependent on John's evaluation of the person's abilities to work (e.g., relatively well-managed symptoms, personal hygiene skills). Further, how John is scheduled does not fully support utilizing him in this effort to strategically engage clients (an issue that undercuts practice in several areas). In examining charts and seeking examples of assessments, we found that there is limited assessment of vocational history and interests in the intake, with no stand-alone assessment conducted in a more timely and ongoing manner. Further, John is not the one conducting any assessment beyond the highly informal questioning and notes he takes when working with someone who is wanting a job (John is aware of the Career Profile, but was not sure if his agency allowed him to use it so he recalled questions from the Profile when conducting his own very informal assessments). Regarding job development, examples provided indicated that there has been concerted efforts to outreach to local employers to understand needs and develop relationships, but this has been a relatively new practice and John is continuing to develop his skills (he has attended several IPS-related trainings that covered job development). He offered a log for our review that showed seven employers he has approached (two more than one time) in the past four weeks. Majority were in the service industry. When asked about his pitch, John provided a nice opening that focused on his role trying to both help people return to work and get to know employers' needs and struggles to see how he can be of help. The jobs that clients get hired into also do not consistently appear to reflect a person-centered approach and the pace at which the employment specialist assists clients interested in working does not appear to meet "rapid placement" criteria, where there is typically fewer than 30 days between expression of interest and first contact with an employer. In review of the information provided, half of those in competitive employment (four of eight) reportedly got the job on their own and the ones with assistance were highly concentrated in Walmart. Conversely, client and staff interview data spoke to John's effort to find a right-fit job and he was working with one woman to access equipment to set up her own tattoo business. Once employed, the types of follow-along
Service #1: Engagement;	P	
Service #2: Vocational assessment following SE principles;	N	
Service #3: job development;	P	
Service #4: job placement (including going back to school, classes);	P	
Service #5: job coaching & follow-along supports (including supports in academic settings);	N	
Service #6: benefits counseling	N	

		supports provided by John included periodic check-ins with other staff in the daily team meeting or in-person if John is scheduled to see those individuals. There were no reports of job coaching or more strategically planned and delivered follow-along supports to address emerging, anticipated, or current challenges. Benefits counseling is very minimally provided by John, who shared that he knows little about how work impacts benefits and work incentive programs.
ST6. Role of Employment Specialist within Team Definition: 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 approaches with clients in the team; (3) attending all daily team meetings; and (4) attending majority treatment planning meetings for clients with employment goals.	**3**	We credit John for meeting two Within Team Functions. He provided cross-training to the team following an IPS training he attended, where he educated team on job development, including ways they can assist with job development activities. The team reported increased efforts to observe and share job openings posted and efforts to approach and gather more information from employers. This training was held three months ago. John also routinely attends the daily team meeting. Although his participation in the employment specialist role could be improved, we were able to identify him as being in this role by way of his exchanges. We do not credit him for attending most of the planning meetings for those with employment goals, nor do we credit him for consulting and modeling. John's understanding and practice of evidence-based supported employment is still in early development. Team member interviews did not support crediting him in a role as a team expert.
ST7. Peer Specialist on Team. Definition: 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 management and recovery interventions.	**1**	At the time of the review, the team's Peer Specialist position was vacant for one month and the team was actively recruiting to fulfill this position.
ST8. Role of Peer Specialist. Definition: The peer specialist performs the following functions:	**N/A**	Per TMACT protocol, we do not rate the team on this item given that the position has been vacant for less than six months.
Function #1: Coaching and consultation to clients to promote recovery and self-direction		
Function #2: Facilitating wellness management and recovery strategies		

Function #3: Participating in all team activities equivalent to fellow team members		
Function #4: Modeling skills for and providing consultation to fellow team members		
Function #5: Providing cross-training to other team members in recovery principles and strategies		
CP1. Community-Based Services. Definition: The team works to monitor status and develop skills in the community, rather than in office. Team is oriented to bringing services to the client, who, for various reasons, has not effectively been served by office-based treatment.	**5**	Of the 14 charts randomly selected for review where there was at least one face-to-face contact, the average (median) rate at which services were provided in the community (vs. the office) was 100%.
CP2. Assertive Engagement Mechanisms. Definition: The team uses an array of techniques to engage difficult-to-treat clients. These techniques include:	**4**	In efforts to engage individuals who clearly need ACT but are actively or passively resisting or refusing services, the following strategies were provided or observed: team focuses on what the client is wanting (e.g., food, housing, help getting Social Security benefits, dissolving guardianship) and tries to avoid topics that appear to be clear triggers (e.g., medications, substance use, personal hygiene). Specific client examples were shared, which includes caring and persistent outreach efforts. The team has access to a petty cash fund that they use in several ways, including offering tangible items to enhance the attractiveness of a visit (e.g., bringing by $10 grocery cards; Gatorade; socks). We also heard nice examples of the team appearing to appropriately resort to therapeutic limit-setting strategies, including leveraging power of a family member guardian or court order. They provided examples of the team deciding to initiate a pick-up order for involuntary commitment and have worked closely with representative payeeships to help increase service engagement. In review of rating criteria, we found that the team met full credit criteria for motivational interventions and full credit for therapeutic limit-setting strategies. Of note, skillful teams should be willing and prepared to use therapeutic limit-setting strategies, but are adept at creative, person-centered motivational approaches where therapeutic limit-setting is needed less often. Data did not, however, indicate that a reliable process is in place for assessing the success of engagement strategies, where this information is used to determine necessary changes in intervention strategies. We encourage the team to utilize the current "dashboard" on the daily team meeting as part of this process.
Practice #1: Motivational interventions;	F	
Practice #2: Therapeutic limit-setting;	F	
Practice #3: Thoughtful application and withdrawal of engagement practices	N	

CP3. Intensity of Services. Definition: The team delivers a high amount of face-to-face service time as needed.	**4**	To rate this item, we calculated the average weekly time spent with each of the 14 clients selected for chart review. A four-week period was reviewed. The mean times across the 14 charts were rank-ordered and the median duration was calculated to avoid bias of outliers (i.e., extremely high ACT service users or low service users). We found that, on average, staff spent 95 minutes each week with clients, which results in a "4" rating.
CP4. Frequency of Contact. Definition: The team delivers a high number of face-to-face service contacts, as needed.	**3**	The team averaged 1.8 face-to-face contacts per week per client during the four weeks sampled for this review. As with item CP3, we rank ordered the 14 client charts by average number of weekly contacts and then calculated the median, which controls for both high and low outliers. On the lower end, one client was seen only two times, but had three attempts by the team that month. On the higher end, three clients were seen five to seven times per week by the team. The reason for these visits appeared to be largely driven by medication and symptom monitoring.
CP5. Frequency of Contact with Natural Supports Definition: 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).	**2**	Per the team's report, approximately 25 of the 71 enrolled clients (or 35%) have natural supports with whom the team has had contact with in the past month, resulting in a "2" rating.
CP6. Responsibility for Crisis Services. Definition: The team has 24-hour responsibility for directly responding to psychiatric crises, including meeting the following criteria:	**4**	The team does operate an on-call crisis services line (Criterion #1) and calls coming in are immediately received by the team (Criterion #2). The team rotates the on-call responsibility across all staff on a weekly basis with the team leader and psychiatric care providers available as back-up and support. In review of crisis plans, we found that three of six (50%) were judged to be practical and individualized and that team members do have access to crisis plans when on-call. Although we hope for it not to be a frequent event when delivering proactive and planful services, the team's willingness to address crises in person outside of typical 1st shift hours was indicated, with two relatively recent examples provided (one where team member met the client at the hospital admission at 9pm and another where the on-call staff, Stella, and client's mother met with the client at her residence while in distress and reporting suicidal thoughts).
Criterion #1: The team is available to clients in crisis 24 hours a day, 7 days a week;	F	
Criterion #2: The team is the first-line crisis evaluator and responder (if another crisis responder screens calls, there is very minimal triaging);	F	
Criterion #3: The team accesses practical, individualized crisis plans;	P	
Criterion #4: The team is able and willing to respond to crises in person, when needed	F	

CP7. Full Responsibility for Psychiatric Services Definition: 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.	**5**	It is assumed that at least 90% of people served by ACT will need some type of psychiatric services from the team. The team reports that all (100%) clients are receiving psychiatric services directly from the team, which includes meeting with Dr. Owen and Marissa. We did not further adjust this item as the team had very few (10%) clients currently living in residential settings where residential staff provide medications. In these residences, ACT nursing staff are routinely checking MARs and group home records. Also, no adjustment was made due to psychiatric care providers having infrequent follow-up; most are being seen approximately monthly and no one is seen less frequently than every three months (with one exception of a person in jail). Thus, 100% + (100%/90%) was calculated for this item, resulting in a "5" rating.
CP8. Full Responsibility for Psychiatric Rehabilitation Services. Definition: The team assumes responsibility for providing psychiatric rehabilitation services to clients, where there is little need for clients to have to access such services outside of the team. Psychiatric rehabilitation services include social and communication skills training and functional skills training to enhance independent living (e.g., activities of daily living, safety planning, transportation planning/navigation skill building, and money management). The delivery of these services should be based on an initial assessment of functional deficits, followed by 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.	**3**	It is assumed that at least 90% of clients served by an ACT team will benefit from psychiatric rehabilitation interventions that involve functional skill-building. The team reported that 55 of 71 (77%) clients were receiving psychiatric rehabilitative interventions from the team. In review of 14 charts, we found evidence of any such psychiatric rehabilitation in eight charts (57%) and when looking at those that were judged to reflect a higher quality example, 50% met that criteria and 75% were systematic (a psychiatric rehabilitation intervention was delivered more than one time in a four-week period). When we looked explicitly at the sampled charts of clients the team endorsed as getting psychiatric rehabilitation from the team, we found that seven of those 10 charts, 70% had documentation indicating this service. Further, interview data provided several examples of psychiatric rehabilitation, but in some ways limited to budgeting, grocery shopping, and cooking (no examples related to social skill development, grooming and hygiene, mobility and leisure). Given this information, the team's original report was not fully supported. Following rating guidelines, we adjust the team's original report down to 65% of clients receiving psychiatric rehabilitation from the team. The resulting service rate is 72% (65%/90%), rating a "3."

EP1. Full Responsibility for Integrated Treatment for Co-Occurring Disorders. Definition: The team assumes responsibility for providing integrated treatment for co-occurring disorders within ACT, 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 Substance Abuse Specialist will assume the majority of responsibility for delivering DD treatment, but ideally other team members also provide some DD 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).	**5**	The team reported that 42 of the 71 clients (59%) have a comorbid substance abuse disorder, which is consistent with rates found in research. The team reported that 41 (58%) clients are consistently receiving individual and/or group integrated co-occurring disorders (COD) treatment from the team (one client has been in jail for past two months). In review of 14 charts, we found evidence of integrated COD treatment in seven charts (50%) and when looking at those that were judged to reflect a higher quality example, 71% met that criteria and 86% were systematic (a COD intervention was delivered more than one time in a four-week period). Of note, the random sample included eight charts (57%) of individuals the team endorsed as getting COD services from the team, a representative sample. Further, interview data provided many examples, such as providing a weekly substance abuse group (topics included coping skills to work through cravings and review of various self-report groups in areas), various team members using harm reduction strategies for those actively using, and supporting individuals as they are in a period of abstinence. Given this information, the team's original report was supported. The resulting service rate is 98% (58%/59%), rating a "5."
EP2. Full Responsibility for Employment and Educational Services. Definition: The team assumes responsibility for providing employment and education 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 supportive employment and education services, but ideally other team members also provide some of these services.	**3**	It is assumed that at least 40% of clients served by an ACT team want employment and education services. The team reported that 28 of 71 (39%) clients were receiving such services from the team. In review of 14 charts, we found evidence of supported employment and education services in three charts (21%) and when looking at those that were judged to reflect a higher quality example, 33% met that criteria and 33% were systematic (a supported employment or education service was delivered more than one time in four-week period). Looking only at those sampled charts the team endorsed, we found that six such charts were sampled and only three (50%) had any documentation of employment or education services. Given all this information, the team's original report was not supported. Following rating guidelines, we adjust the team's original report down to 20% of clients are receiving supported employment and education services from the team. The resulting service rate is 50% (20%/40%), rating a "3."

EP3. Full Responsibility for Wellness Management and Recovery Services. Definition: 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.	**3**	It is assumed that at least 20% of clients served by an ACT team want a manualized wellness management and recovery service, which may include Wellness Recovery Action Plan (WRAP), Illness Management and Recovery (IMR), or other more manualized and studied approaches. The team reported that seven of 71 (10%) clients were receiving such services, particularly from Lucy Strong, the team's therapist, who had been trained in helping people develop WRAPs (and previously co-facilitated a WRAP group with former Peer Specialist). In review of 14 charts, we sampled two charts of individuals the team endorsed as receiving this service and indeed saw evidence of such in both charts. Further, client interview data supported not only Lucy's assistance with WRAP, but other team members reinforcing information in clients' plans. Given this information, the team's original report was supported. The resulting service rate is 50% (10%/20%), rating a "3."
EP4. Integrated Treatment for Co-Occurring Disorders Definition: The FULL TEAM uses a stage-wise treatment model that is non-confrontational and the FULL TEAM:	**4**	The implementation of integrated treatment for co-occurring disorders within the team was evident. Across data sources, we observed clear evidence for the team attending to the interaction of mental health symptoms and substance use. In one example staffed in the daily team meeting, team members had "parked" one client for further discussion and reviewed what they knew to be reinforcing current drug using behaviors (certain people she was hanging with, current isolation from family, numbing effects, access to money). With prompting, interviewed team members could easily recount related stories of randomly selected clients from the list. The team appears to fully apply harm reduction tactics, providing a range of examples (e.g., clean needle exchange, working with a man to drink in private at home to avoid fights and legal problems, helping find a one-story living situation to help reduce chance of falls for one man, reducing amount and potency of substances). The team annually brings in trainers from the local Harm Reduction Coalition to keep the team abreast of harm reduction strategies. Dr. Owen and Marissa had examples of using psychopharmacological interventions to help with cravings, prescribed naltrexone, and supported one client on Methadone. Both are careful in prescribing potentially addictive medications. Evidence for the team both understanding and applying stages of change readiness information in practice was also relatively strong. Josie is doing a good job, supported by Stella and Dr. Owen, in leading more systematic discussions about stages of change, which appeared to infuse the language of this team. Overall, we found the team to be well-versed in common motivational interviewing language, but inconsistent in practice. The team has such a solid foundation here that we strongly encourage the agency to find a Motivational Interviewing Network Trainer (MINT) to provide team-supervision. Finally, when examining the team's use of CBT techniques, particularly for those needing more active
Criterion #1: Considers interactions between mental illness and substance abuse;	F	
Criterion #2: Does not have absolute expectations of abstinence and supports harm reduction;	F	
Criterion #3: Understands and applies stages of change readiness in treatment;	F	
Criterion #4: Is skilled in motivational interviewing (MI);	P	
Criterion #5: Follows cognitive-behavioral therapy (CBT) principles	F	

		substance use counseling and relapse prevention, evidence was also strong. Overall, we found the team actively working with people who were working on sustaining abstinence. Several team members shared stories of assisting people to find a good-fit self-help group, helping people create and use relapse prevention plans, assessing and addressing precipitators for use, and coping skill techniques.
EP5. Supported Employment and Education (SEE) Definition: The FULL TEAM embraces and practices for an evidence-based supported employment model, as evidenced by the following criteria:	**3**	Across data sources, we observed inconsistent evidence for the team valuing competitive work as a goal for all clients. Although John and other team members were supportive of work and articulated work's role in a person's recovery, the team was lacking in strong champions for competitive employment specifically (versus encouraging activities to provide structure and meaning, which includes volunteer work). The team appears to partly value a person's expressed interest in working as the primary criteria for eligibility for supported employment services through ACT. Some interviewed staff shared concerns about the severity of symptoms, anticipating they would interfere with employment too much. In contrast, other staff did not appear to hold such beliefs and cited practice examples to the contrary (e.g., working with a woman with very active and disruptive hallucinations find employment in loud machine repair shop). Also, the team was fairly in agreement that active substance use was not something that would give them pause in assisting someone in employment. As for Criteria #3, we did not hear examples of overt intermediate assessment steps clients are expected to take before provided help moving towards competitive employment. There was a clear mixed approach across team members in how much they valued gathering the most critical information and moving clients along promptly towards active job seeking. One interviewed team member expressed regret the team can no longer refer clients to local vocational rehabilitation for more lengthy assessment. Team practices appear to partly support individualized placements that reflect the person's preferences for work and practices in a manner that does not result in significant delays in contacting employers. Although most clients currently working were working at Walmart, we did observe several practice examples of the team working to support clients find employment best fitting with interests. As for pace of movement, it seemed to depend in part on who the primary care team member was (some were more active than others) and what role John assumed in services (on occasion, if John was looped in, he may move quickly to help with finding employers). Evidence for the team's practices in providing deliberate and ongoing supports to assist people in keeping employment were not evident. In addition to the team not offering any on-site job coaching, we heard very few examples of team members providing services strategically to support people in keeping employment, which could include offering assertiveness training, relaxation skills to practice during breaks, and time management
Criterion #1: Values competitive work as a goal for all clients;	P	
Criterion #2: Believes and supports that a client's expressed desire to work is the only eligibility criterion for SE services;	P	
Criterion #3: Believes and supports that on-the-job assessment is more valuable than extensive prevocational assessment;	P	
Criterion #4: Believes and supports that placement should be individualized and tailored to a client's preferences;	P	
Criterion #5: Believes that ongoing supports and job coaching should be provided when needed and desired by client	N	

		strategies. The absence of the team developing and using Career Profiles is likely having a significant impact on overall practice.
EP6. Engagement and Psychoeducation with Natural Supports. Definition: The FULL TEAM works in partnership with clients' natural supports. As part of their active engagement of natural supports, the team**:**	**3**	Overall, we found the team's work with natural supports to be inconsistent. In review of multiple data sources, examples of the team providing psychoeducation to clients' natural supports were often reactive to current crises. We did hear a nice example from Josie regarding educating the families of two clients about their mental health and substance use. Similarly, Dr. Owen and Marissa had stories related to those with COD. Examples of team members assuming a role around problem-solving tended to also reflect reactive efforts when clients are in crises or generally natural supports reaching out to the team for assistance. Stella expressed interest in learning how to facilitate family psychoeducation groups as well as acknowledgement that the team could do much better attending to the social needs of clients in general, which includes helping them connect with natural supports. Finally, the team does help natural supports access local support groups, such as NAMI and Al-Anon. The team keeps materials in the lobby. One client's mother is active in the local NAMI Chapter and Stella is in frequent contact with her, including presenting to NAMI on ACT four months ago.
Strategy #1: Provides education about their loved one's illness;	P	
Strategy #2: Teaches problem-solving strategies for difficulties caused by illness;	P	
Strategy #3: Provides &/or connects natural supports with social & support groups	F	
EP7. Empirically-Supported Psychotherapy Definition: The team offers empirically supported psychotherapy to select clients who would benefit from such approaches. The team meets the following criteria:	**4**	We evaluate whether the team has at least one licensed therapist providing deliberate psychotherapy to clients or whether the team is adept at core therapeutic techniques. In addition to Stella, a licensed therapist, Lucy is the team's licensed therapist. Several team members also appeared clinically adept in their use of CBT techniques. For Criterion #2, we are evaluating the extent to which data sources indicate that the team clinicians and/or broader team are skillful in using evidence-based practices, particularly CBT. We found that to be the case; Lucy shared a range of materials she has been using in her work, consistent with CBT materials. She and the team have received training in trauma-informed care, but shared she is not trained in trauma-specific therapies and has referred out to another non-ACT team therapist for a handful of clients with significant trauma. Per the team report, 19 (27%) clients have received deliberate and planned empirically-supported psychotherapeutic interventions from the team in the past year.
Criterion #1: deliberately provides individual and/or group psychotherapy, as specified in the treatment plan	F	
Criterion #2: uses empirically-supported techniques to address specific symptoms and behaviors	F	
Criterion #3: maintains an appropriate penetration rate in providing deliberate empirically-supported psychotherapy to clients in need of such services.	P	
EP8. Supportive Housing. Definition: The team embraces the supportive housing model, including:	**4**	The percent of clients who are living in settings where at least 25% of the units/rooms are designated for tenants who meet disability related eligibility criteria (Criterion #1) was reported

Criterion #1: Client Choice: clients typically live in housing of their choice (e.g., ideally living in residences typical of the community, without clustering people with disabilities and/or other special needs such as homelessness). Such community integration is assumed to reflect the team's efforts to assist clients to find housing of their choice. The percent of clients living in settings where at least 25% of the units/rooms are designated for and/or occupied by tenants who meet disability related eligibility criteria: is 26% - 69% (Partial Credit) or is less than 25% (Full Credit).	F	to be 14% by the team. Many of these individuals appeared to be living in congregate apartment-type settings, smaller adult foster care placements, and group homes. At the time of the review, two people were reported to be street homeless and the team was actively working with them to secure housing. We observed no instances where clients did not have control over whether staff entered their residence; for those in supervised settings, staff worked to ensure their visits were by invitation of the client. The percent of clients who are receiving a housing subsidy, on a waitlist for such a subsidy, or paying less than 30% of income on housing, all of which is judged to be safe and decent (Criterion #3) was reported to be 67%. The percent of clients living in housing where treatment is a condition of the lease (Criterion #4) is 10%, which only reflected those in supervised settings where they did not have to work with the ACT team but needed to be enrolled with a service provider.
Criterion #2: Privacy: clients have control over whether and when staff enter their residence. ACT staff may not enter the client residence unless client invites them or if team has reason to believe the client is in crises and/or has advanced directive for mental health conditions or other high needs. NO PARTIAL CREDIT OPTION;	F	
Criterion #3: Affordable, safe, decent housing: The team makes an effort to assist clients in accessing affordable and safe housing, as indicated by the total percent who are receiving a housing subsidy, on a waitlist for such a subsidy, or paying less than 30% of income on housing, all of which is judged to be safe and decent. The proportion of clients who are living in (or waitlisted to live in) affordable and safe housing is between 26% - 74% (Partial Credit) or at least 75% (Full Credit)	P	

Criterion #4: Tenancy rights: The degree to which tenancy is contingent on participation in ACT or other services: client-tenants are required to participate in ACT services, but failure to do so does not lead to eviction OR client-tenants are required to participate in some service program, not necessarily ACT (Partial Credit); or tenancy is not contingent in any way upon their progress or success in ACT service (i.e., tenancy may be contingent on very basic contact with outreach program for the purpose of very minimal monitoring and engagement opportunities) (Full Credit).	F	
PP1. Strengths Inform Treatment Plan. Definition: The Team practices from a strengths model, as evidence by meeting the following criteria:	**4**	Of the six charts reviewed more qualitatively, five (83%) were judged to have assessed client strengths where the documented strengths were clearly personal and relatively exhaustive (e.g., kind to others, good cook, resourceful, strong-willed, attends to details, enjoys music, good memory, no major physical health concerns – all for one client). One reviewed chart was much more limited and documented "strengths" tended to reflect more provider-valued attributes, such as "attends appointments, takes medications, engaged in treatment." Overall, we found the team to intermittently emphasize clients' strengths in their broader work, including team discussions. In assessing the extent to which strengths are informing treatment planning, we found that three (50%) of reviewed charts incorporated these strengths into goals, objectives, and/or planning of interventions. With the example client above, this client was seeking to become more socially engaged and have a best friend. The team did a good job of integrating strengths by planning for social skill interventions that involved asking questions of people to get to know them, practicing ways to bring those "things learned" about someone back into conversation when meeting again. They are also exploring avenues related to her interest in food and music, which includes employment.
Criterion #1: The team is oriented toward clients' strengths and resources.	F	
Criterion #2: clients' strengths and resources inform treatment plan development.	P	
PP2. Person-Centered Planning. Definition: The team conducts treatment planning according to the ACT model using a person-centered approach, including:	**3**	We rated this item given data collected from review of plans, interview data, and observation of a planning meeting. Plans come to be created by the primary care coordinator within the team assigned to work with the client. All clients are assigned a primary team member, one additional

Element #1: development of formative treatment plan ideas based on initial inquiry and discussion with the client (prior to the formal treatment planning meeting)	P	team member, and one nurse. The primary, chosen typically because of the client's major focus and need, then meets with the client to review/develop the plan. The Individual Treatment Team (ITT; in this case, the two team members and nurse) will meet with the client annually for a broader discussion about goals and progress. This process was instituted approximately five months ago (Criteria #2 and #3). As far as efforts to gather relevant assessment and treatment planning data leading up to this meeting, we did not find evidence this is occurring consistently. We observed processes where the team has some brief discussion about a client and upcoming plan (sharing updates on goals, needs, brainstorming on possible interventions), but this was informally interwoven into the daily team meeting and when asking about other clients who recently had planning meetings, it did not appear to be a consistent process. Odeleen appeared to be doing a good job of alerting team members that plan due dates are approaching by giving them adequate time to prepare (Criteria #1). Efforts to help clients understand their roles in planning and ensure their voices remain the focus of planning were inconsistent across sources. In the one meeting we observed, where the client was in attendance along with Lucy (primary), Dave, and Matt (RN), no one clearly assumed a role to help provide coaching and support to the client to ensure that his voice was being heard. Several times, the client nodded or responded with "I don't know," where there was opportunity to pause, take a break, offer some reflections, and prompt client to offer more input. Although the staff did a nice job drilling down further around issues related to the client's father (which seemed to be important to the client), there were moments where team members' agendas seemed to drive the meeting (e.g., conversation related to diabetes management). In review of the content of plans themselves, they variably appeared to capture and reflect the client's preferences and wishes, with some plans being very good in this manner and others lacking considerably. It appeared that the quality of plans relied heavily on the skills of the primary team member developing the plan (Criterion #5).
Element #2: conducting regularly scheduled treatment planning meetings	F	
Element #3: attendance by key staff, the client, and anyone else s/he prefers, tailoring number of participants to fit with the client's preferences	P	
Element #4: provision of guidance and support to promote self-direction and leadership within the meeting, as needed	P	
Element #5: treatment plan is clearly driven by the client's goals and preferences and is structured in a manner to inform person-centered practices	P	
PP3. Interventions Target Broad Range of Life Domains Definition: 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.	**3**	Of the six client charts reviewed more thoroughly, the team was judged to have addressed in the person-centered plans at least three life domains in 67% of the charts and at least two life domains in 100% of the charts (Criterion #1). Likewise, they were judged to have provided services that addressed at least three life domains in 33% of the charts and at least two life domains in 67% of the charts (Criterion #2). In comparing what was planned for and what was delivered, the evaluators found that three of the six charts (50%) had such alignment.

Criterion #1: The team specifies interventions that target a range of life domains in person-centered plans. - 30-64% of plans reviewed have interventions targeting at least 3 life domains identified above OR at least 65% of plans have interventions targeting at least 2 life domains (Partial Credit); At least 65% of person-centered plans reviewed have interventions targeting at least 3 life domains identified above. (Full Credit)	F	
Criterion #2: and these planned interventions are carried out in practice, resulting in a sufficient breadth of services tailored to clients' needs. Approximately half of all clients (30-64%) receive interventions targeting at least 3 life domains identified above OR at least 65% of plans have interventions targeting at least 2 life domains. (Partial Credit). Nearly all clients (65% of charts reviewed) receive interventions targeting at least 3 life domains identified above. (Full Credit)	P	
There is alignment between practices that are planned for and carried out, with at least 60% of the charts having some appreciable continuity between planned interventions (Criterion #1) and implemented interventions. No /Yes (Alignment can impact ratings for anchors "4' and "5").	N	
PP4. Client Self Determination and Independence Definition: A high-fidelity ACT team promotes clients' independence and self-determination by:	**3**	The team's approach to actively promoting clients' self-determination and independence is examined across data sources. Our review of data found that the team inconsistently helps people make meaningful informed choices in their lives (Criterion #1). Where this came through most prominently as an issue is around employment and school, but also at times related to choices in which they were living. Conversely, we observe the team to do a nice job of helping clients make informed choices related to their substance use. It appeared that the team honors client's day-to-day decisions, thereby exercising restraint in directing client behaviors viewed as potentially problematic and instead approaching with respect and therapeutic skillfulness (Criterion #2). Finally, we found the team varies in the extent to which
Practice #1: helping clients develop greater awareness of meaningful choices available to them;	P	
Practice #2: honoring day-to-day choices, as appropriate;	F	

Practice #3: teaching clients the skills required for independent functioning. 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.	P	they are proactive in both helping people acquire independent living skills to be more self-reliant, but also "right-fits" supportive services given the client's apparent needs (Criterion #3). We found some clients would benefit from more frequent oversight and support, including what is provided by the medical team. Although we observed some nice examples of psychiatric rehabilitation, we found many areas in need of greater attention to help people be more independent, including greater attention to social skills, relationships, and addressing boredom. As noted earlier, enlisting clients more in the planning process and hiring and using a Peer Support Specialist will also bolster the team's work. Relatedly, the team's limited work with clients' natural supports, or citing that many do not have natural supports, lends to problems supporting clients in being more self-determined and independent.

Appendix E. DACTS-TMACT Crosswalk

CRITERION		RATINGS / ANCHORS (1)	(2)	(3)	(4)	(5)	TMACT DATA SOURCE
HUMAN RESOURCES: STRUCTURE & COMPOSITION							
H1	SMALL CASELOAD: client/provider ratio of 10:1.	50 clients/clinician or more.	35 - 49	21 - 34	11 - 20	10 clients/clinician or fewer	Refer to Team Survey Items #1 and #7; or TMACT Item OS1
H2	TEAM APPROACH: Provider group functions as team rather than as individual practitioners; clinicians know and work with all clients.	Fewer than 10% clients with multiple staff face-to-face contacts in reporting 2-week period.	10 - 36%.	37 - 63%.	64 - 89%.	90% or more clients have face-to-face contact with > 1 staff member in 2 weeks.	Refer to Chart Review Tally Sheet, Team Approach Column
H3	PROGRAM MEETING: Program meets frequently to plan and review services for each client.	Program service-planning for each client usually occurs once/month or less frequently.	At least twice/month but less often than once/week.	At least once/week but less often than twice/week.	At least twice/week but less often than 4 times/week.	Program meets at least 4 days/week and reviews each client each time, even if only briefly.	Refer to relevant information collected to rate TMACT Items OS3 and OS4
H4	PRACTICING TEAM LEADER: Supervisor of front line clinicians provides direct services.	Supervisor provides no services.	Supervisor provides services on rare occasions as backup.	Supervisor provides services routinely as backup, or less than 25% of the time.	Supervisor normally provides services between 25% and 50% time.	Supervisor provides services at least 50% time.	Refer to Team Survey Item #5 or TMACT Item CT2. NOTE: We recommend that "time," per the DACTS protocol, be interpreted as expected billable hours for general staff, which is typically 20 hours per week. Thus, to rate a "5" on the DACTS, team leaders are ideally spending at least 10 hours per week providing direct services.

CRITERION		RATINGS / ANCHORS					TMACT DATA SOURCE
		(1)	(2)	(3)	(4)	(5)	
H5	CONTINUITY OF STAFFING: program maintains same staffing over time.	Greater than 80% turnover in 2 years.	60-80% turnover in 2 years.	40-59% turnover in 2 years.	20-39% turnover in 2 years.	Less than 20% turnover in 2 years.	Refer to Team Survey Item #2 and use formula in DACTS Protocol for this item.
H6	STAFF CAPACITY: Program operates at full staffing.	Program has operated at less than 50% of staffing in past 12 months.	50-64%	65-79%	80-94%	Program has operated at 95% or more of full staffing in past 12 months.	Refer to Team Survey Item #3 and use formula in DACTS Protocol for this item.
H7	PSYCHIATRIST ON STAFF: there is at least one full-time psychiatrist per 100 clients assigned to work with the program.	Program for 100 clients has less than .10 FTE regular psychiatrist.	.10-.39 FTE per 100 clients.	.40-.69 FTE per 100 clients.	.70-.99 FTE per 100 clients.	At least one full-time psychiatrist is assigned directly to a 100-client program.	Refer to Team Survey Items #1 and #7; or TMACT Item CT3
H8	NURSE ON STAFF: there are at least two full-time nurses assigned to work with a 100-client program.	Program for 100 clients has less than .20 FTE regular nurse.	.20-.79 FTE per 100 clients.	.80-1.39 FTE per 100 clients.	1.40-1.99 FTE per 100 clients.	Two full-time nurses or more are members of a 100-client program.	Refer to Team Survey Items #1 and #7; or TMACT Item CT6
H9	CO-OCCURRING DISORDERS SPECIALIST ON STAFF: a 100-client program includes at least two staff members with 1 year of training or clinical experience in co-occurring disorders treatment.	Program has less than .20 FTE S/A expertise per 100 clients.	.20-.79 FTE per 100 clients.	.80-1.39 FTE per 100 clients.	1.40-1.99 FTE per 100 clients.	Two FTEs or more with 1 year S/A training or supervised S/A experience.	Refer to Team Survey Item #1 or TMACT Item ST1; Use formula in DACTS Protocol for this item.

CRITERION		RATINGS / ANCHORS					TMACT DATA SOURCE
		(1)	(2)	(3)	(4)	(5)	
H10	EMPLOYMENT SPECIALIST ON STAFF: the program includes at least two staff members with 1 year training/ experience in employment and educational services and support.	Program has less than .20 FTE employment and education services expertise per 100 clients.	.20-.79 FTE per 100 clients.	.80-1.39 FTE per 100 clients.	1.40-1.99 FTE per 100 clients.	Two FTEs or more with 1 year voc. rehab. training or supervised VR experience.	Refer to Team Survey Item #1; or TMACT Item ST4; Use formula in DACTS Protocol for this item
H11	PROGRAM SIZE: program is of sufficient absolute size to provide consistently the necessary staffing diversity and coverage.	Program has fewer than 2.5 FTE staff.	2.5 - 4.9 FTE	5.0 - 7.4 FTE	7.5 - 9.9	Program has at least 10 FTE staff.	Refer to Team Survey Items #1 and #7; or TMACT Item OS5
ORGANIZATIONAL BOUNDARIES							
O1	EXPLICIT ADMISSION CRITERIA: Program has clearly identified mission to serve a particular population and has and uses measurable and operationally defined criteria to screen out inappropriate referrals.	Program has no set criteria and takes all types of cases as determined outside the program.	Program has a generally defined mission but the admission process is dominated by organizational convenience.	The program makes an effort to seek and select a defined set of clients but accepts most referrals.	Program typically actively seeks and screens referrals carefully but occasionally bows to organizational pressure.	The program actively recruits a defined population and all cases comply with explicit admission criteria.	Extrapolate from data collected to rate TMACT items OS6 and OS7

CRITERION		RATINGS / ANCHORS					TMACT DATA SOURCE
		(1)	(2)	(3)	(4)	(5)	
O2	INTAKE RATE: Program takes clients in at a low rate to maintain a stable service environment.	Highest monthly intake rate in the last 6 months = greater than 15 clients/month.	13 -15	10 - 12	7 - 9	Highest monthly intake rate in the last 6 months no greater than 6 clients/month.	Refer to Team Survey Item #11; or TMACT Item OS8
O3	FULL RESPONSIBILITY FOR TREATMENT SERVICES: in addition to case management, program directly provides psychiatric services, counseling / psychotherapy, housing support, integrated treatment for co-occurring disorders, employment/rehabilitative services.	Program provides no more than case management services.	Program provides one of five additional services and refers externally for others.	Program provides two of five additional services and refers externally for others.	Program provides three or four of five additional services and refers externally for others.	Program provides all five of these services to clients.	Extrapolate from data collected to rate TMACT Items CP7 (psychiatric services), EP7 (counseling/psychotherapy), EP8 (housing support), and EP1 (integrated treatment for co-occurring disorders). ***Note that more stringent criteria are used to rate these TMACT items; DACTS ratings should be approximations given DACTS protocol (e.g., the DACTS does not specify 'supportive housing' or EBP-driven psychotherapy).
O4	RESPONSIBILITY FOR CRISIS SERVICES: program has 24-hour responsibility for covering psychiatric crises.	Program has no responsibility for handling crises after hours.	Emergency service has program-generated protocol for program clients.	Program is available by telephone, predominantly in consulting role.	Program provides emergency service backup; e.g., program is called, makes decision about need for direct program involvement.	Program provides 24-hour coverage.	Refer to TMACT Item #CP6
O5	RESPONSIBILITY FOR HOSPITAL ADMISSIONS: program is involved in hospital admissions.	Program has involvement in fewer than 5% decisions to hospitalize.	ACT team is involved in 5% -34% of admissions.	ACT team is involved in 35% - 64% of admissions.	ACT team is involved in 65% - 94% of admissions.	ACT team is involved in 95% or more admissions.	Refer to Team Survey Item #14 and TMACT Item OS11

CRITERION		RATINGS / ANCHORS					TMACT DATA SOURCE
		(1)	(2)	(3)	(4)	(5)	
O6	RESPONSIBILITY FOR HOSPITAL DISCHARGE PLANNING: program is involved in planning for hospital discharges.	Program has involvement in fewer than 5% of hospital discharges.	5% - 34% of program client discharges are planned jointly with the program.	35 - 64% of program client discharges are planned jointly with the program.	65 - 94% of program client discharges are planned jointly with the program.	95% or more discharges are planned jointly with the program.	Refer to Team Survey Item #14 and TMACT Item OS11
O7	TIME-UNLIMITED SERVICES (GRADUATION RATE): Program rarely closes cases but remains the point of contact for all clients as needed.	More than 90% of clients are expected to be discharged within 1 year.	From 38-90% of clients are expected to be discharged within 1 year.	From 18-37% of clients are expected to be discharged within 1 year.	From 5-17% of clients are expected to be discharged within 1 year.	All clients are served on a time-unlimited basis, with fewer than 5% expected to graduate annually.	Refer to Team Survey Item #12 (# who transitioned to less intensive services); or TMACT Item OS9
NATURE OF SERVICES							
S1	COMMUNITY-BASED SERVICES: program works to monitor status, develop community living skills in the community rather than the office.	Less than 20% of face-to-face contacts in community.	20 - 39%.	40 - 59%.	60 - 79%.	80% of total face-to-face contacts in community	Refer to TMACT Item CP1
S2	NO DROPOUT POLICY: program retains a high percentage of its clients	Less than 50% of the caseload is retained over a 12-month period.	50- 64%.	65 - 79%.	80 - 94%.	95% or more of caseload is retained over a 12-month period.	Refer to Team Survey Item #12 and/or TMACT Item OS10

CRITERION		RATINGS / ANCHORS					TMACT DATA SOURCE
		(1)	(2)	(3)	(4)	(5)	
S3	ASSERTIVE ENGAGEMENT MECHANISMS: as part of assuring engagement, program uses street outreach, as well as legal mechanisms (e.g., probation/parole, OP commitment) as indicated and as available.	Program passive in recruitment and re-engagement; almost never uses street outreach legal mechanisms.	Program makes initial attempts to engage but generally focuses efforts on most motivated clients.	Program attempts outreach and uses legal mechanisms only as convenient.	Program usually has plan for engagement and uses most of the mechanisms that are available.	Program demonstrates consistently well-thought-out strategies and uses street outreach and legal mechanisms whenever appropriate.	Extrapolate from TMACT Item CP2
S4	INTENSITY OF SERVICE: high total amount of 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.	Refer to TMACT Item CP3
S5	FREQUENCY OF CONTACT: high number of service contacts as needed.	Average of less than 1 face-to-face contact / week or fewer per client.	1 - 2 / week.	2 - 3 / week.	3 - 4 / week.	Average of 4 or more face-to-face contacts / week per client.	Refer to TMACT Item CP4
S6	WORK WITH INFORMAL SUPPORT SYSTEM: with or without client present, program provides support and skills for client's support network: family, landlords, employers.	Less than .5 contact per month per client with support system.	.5-1 contact per month per client with support system in the community.	1-2 contact per month per client with support system in the community.	2-3 contacts per months per client with support system in the community.	Four or more contacts per month per client with support system in the community.	Refer to Excel Spreadsheet, Column T, where frequency of contacts is recorded for the purpose of DACTS calculation.

CRITERION		RATINGS / ANCHORS					TMACT DATA SOURCE
		(1)	(2)	(3)	(4)	(5)	
S7	INDIVIDUALIZED TREATMENT FOR CO-OCCURRING DISORDERS: one or more members of the program provide direct treatment and co-occurring disorders treatment for clients with co-occurring disorders.	No direct, individualized co-occurring disorders treatment is provided by the team.	The team variably addresses co-occurring disorders concerns with clients; no formal, individualized co-occurring disorders treatment provided.	While the team integrates some co-occurring disorders treatment into regular client contact, they provide no formal, individualized co-occurring disorders treatment.	Some formal individualized co-occurring disorders treatment is offered; clients with co-occurring disorders spend less than 24 minutes/week in such treatment.	Clients with co-occurring disorders spend, on average, 24 minutes / week or more in formal co-occurring disorders treatment.	Refer to Excel Spreadsheet, Column C. The directions specify to note whether clients receive individual therapy at least 20 minutes each week. To calculate average, according to DACTS protocol, we suggest assuming an average of 30 minute a week therapy sessions for those noted as receiving individual therapy (marked "individual" or "both"). Formula: (#clients receiving individual therapy X 30/total # of co-occurring disorder clients) = average weekly minutes.
S8	INTEGRATED TREATMENT FOR CO-OCCURRING DISORDERS TREATMENT GROUPS: program uses group modalities as a treatment strategy for people with co-occurring disorders.	Fewer than 5% of the clients with co-occurring disorders attend at least one co-occurring disorders treatment group meeting during a month.	5 - 19%	20 - 34%	35 - 49%	50% or more of the clients with co-occurring disorders attend at least one co-occurring disorders treatment group meeting during a month.	Refer to Excel Spreadsheet, Column C. Count all clients noted as receiving "group" or "both" and divide by the total number of clients noted as having a co-occurring disorder (Column A)

CRITERION		RATINGS / ANCHORS					TMACT DATA SOURCE
		(1)	(2)	(3)	(4)	(5)	
S9	INTEGRATED TREATMENT FOR CO-OCCURRING DISORDERS: program uses a stage-wise treatment model that is non-confrontational, follows behavioral principles, considers interactions of mental illness and co-occurring disorders, and has gradual expectations of abstinence.	Program fully based on traditional model: confrontation; mandated abstinence; higher power, etc.	Program uses primarily traditional model: e.g., refers to AA; uses inpatient detox & rehabilitation; recognizes need for persuasion of clients in denial or who don't fit AA.	Program uses mixed model: e.g., integrated treatment for co-occurring disorders principles in treatment plans; refers clients to persuasion groups; uses hospitalization for rehab; refers to AA, NA.	Program uses primarily integrated treatment for co-occurring disorders: e.g., integrated treatment for co-occurring disorders principles in treatment plans; persuasion and active treatment groups; rarely hospitalizes for rehab. or detox except for medical necessity; refers out some s/a treatment.	Program fully based in integrated treatment for co-occurring disorders principles, with treatment provided by program staff.	Refer to data collected to rate TMACT Item EP4
S10	ROLE OF CLIENTS ON TREATMENT TEAM: Clients are involved as members of the team providing direct services.	Clients have no involvement in service provision in relation to the program.	Client(s) fill client-specific service roles with respect to program (e.g., self-help).	Client(s) work part-time in case-management roles with reduced responsibilities.	Client(s) work full-time in case management roles with reduced responsibilities.	Client(s) are employed full-time as clinicians (e.g., case managers) with full professional status.	Refer to data collected to rate TMACT Items ST7 and ST8