

(based on the Tool for Measurement of Assertive Community Treatment (TMACT))¹

TMACT Item	Page	TMACT Item	Page
Subscale #1: Operations and Structure (OS)	Subs	ST6. Role of Employment Specialist within Team	
OS1. Low Ratio of Clients to Staff		ST7. Peer Specialist on Team	
OS2. Team Approach		ST8. Role of Peer Specialist	
OS3. Daily Team Meeting (Freq. & Attend.)		Subscale #4: Core Practices (CP)	18
OS4. Daily Team Meeting (Quality)		CP1. Community-Based Services	
OS5. Program Size		CP2. Assertive Engagement Mechanisms	
OS6. Priority Service Population		CP3. Intensity of Service	
OS7. Active Recruitment		CP4. Frequency of Contact	
OS8. Gradual Admission Rate		CP5. Frequency of Contact with Natural Supports	
OS9. Transition to Less Intensive Services		CP6. Responsibility for Crisis Services	
OS10. Retention Rate		CP7. Full Responsibility for Psychiatric Services	
OS11. Involvement in Psychiatric Hospitalization Decisions		CP8. Full Responsibility for Psychiatric Rehabilitation Services	
OS12. Dedicated Office-Based Program Assistance		Subscale #5: Evidence-based Practices (EP)	22
Subscale #2: Core Team (CT)	8	EP1. Full Responsibility for Integrated Treatment for Co-Occurring	
CT1. Team Leader on Team		EP2. Full Responsibility for Employment and Educational Services	
CT2. Team Leader is Practicing Clinician		EP3. Full Responsibility for Wellness Management and Recovery	
CT3. Psychiatric Care Provider on Team		EP4. Integrated Treatment for Co-Occurring Disorders	
CT4. Role of Psychiatric Care Provider in Treatment		EP5. Supported Employment and Education	
CT5. Role of Psychiatric Care Provider within Team		EP6. Engagement & Psychoeducation with Natural Supports	
CT6. Nurses on Team		EP7. Empirically-Supported Psychotherapy	
CT7. Role of Nurses		EP8. Supportive Housing	
Subscale #3: Specialist Team (ST)	12	Subscale #6: Person-Centered Planning and Practices (PP)	26
ST1. Co-Occurring Disorders (COD) Specialist on Team		PP1 Strengths Inform Treatment Plan	
ST2. Role of COD Specialist in Treatment		PP2. Person-Centered Planning	
ST3. Role of COD Specialist within Team		PP3. Interventions Target a Broad Range of Life Domains	
ST4. Employment Specialist on Team			
ST5. Role of Employment Specialist in Services			

¹ Unless otherwise noted, scale aligns with TMACT: Monroe-DeVita, M., Teague, G. B., & Moser, L. L. (2011). The TMACT: a new tool for measuring fidelity to assertive community treatment. *Journal of the American Psychiatric Nurses Association, 17*(1), 17–29. <https://doi.org/10.1177/1078390310394658>

Subscale #1: Operations and Structure

OS1. LOW RATIO OF CLIENTS TO STAFF	Not Implemented	← ← ←	TMACT Rating	→ → →	Fully Implemented
	1	2	3	4	5
The team maintains a low client-to-staff ratio, not to exceed 10:1, which includes all <u>direct service</u> staff except for the psychiatric care provider. The staff count does NOT include other administrative staff, such as the program assistant or other managers assigned to provide administrative oversight to the team.	26 clients per team member or more.	19 – 25 clients per team	14 – 18 clients per team	11 – 13 clients per team	10 clients per team member or fewer.
	50-Client Team: 10 clients per team member or more.	14-18 clients per team	10-13 clients per team	5-6 clients per team	50-Client Team: 7 clients per team member or fewer.
	30-Client* Team (or below) 12 clients per team member or more.	9-11 clients per team	7-9 clients per team	6 clients per team	30-Client Team: 5 clients per team member or fewer.

**Per TMACT Methodology for establishing minimal coverage for smaller teams to allow for enough staff to be available 24 hours a day, seven days a week (See Supplemental Grid for Teams with a Caseload Cap Different than 50 or 100 Clients, page 16 of TMACT-Protocol-Part-II-1.0rev3_2018_final)*

OS2. TEAM APPROACH	Not Implemented	← ← ←	TMACT Rating	→ → →	Fully Implemented
	1	2	3	4	5
ACT staff work as a transdisciplinary team rather than as independent team members; ACT staff know and work with all clients rather than carry individual caseloads. Although the entire team shares responsibility for each client, each team member contributes expertise as determined by client goals and needs identified in the person-centered plan, and carried out by each individual treatment team [ITT].	Fewer than 25% of clients have face-to-face contacts with at least 3 team members in 4 weeks.	25 – 52%	53 - 74%	75 - 89%	90% or more clients have face-to-face contact with at least 3 team members in 4 weeks.

OS3. DAILY TEAM MEETING (FREQUENCY & ATTENDANCE):	Not Implemented	← ← ←	TMACT Rating	→ → →	Fully Implemented
	1	2	3	4	5
The team meets daily to review and plan services. To this end, most team members should be present to effectively carry out such a review. To constitute a daily team meeting, it must meet the following criteria: there is a review of each client's status; there is planning for future services; most team members are present.	Team meets fewer than 2 days a week.	Team meets 2 days a week.	Team meets 3 days a week with or without full attendance OR team meets 4 days a week, but without full attendance.	Team meets 4 days a week with full attendance OR team meets 5 days a week, but without full attendance.	Team meets 5 days a week with full attendance.
OS4. DAILY TEAM MEETING (QUALITY):	Not Implemented	← ← ←	TMACT Rating	→ → →	Fully Implemented
	1	2	3	4	5
The team uses its daily team meeting to: (1) Conduct a brief, but clinically-relevant review of all clients & contacts in the past 24 hours AND (2) Record the status of all clients. The team develops a daily staff schedule for the day's contacts based on: (3) Weekly/monthly client schedules, (4) Emerging needs, (5) Need for proactive contacts to prevent future crises; (6) Staff are held accountable for follow-through.	The daily team meeting serves no more than 3 functions.	4 functions are performed at least PARTIALLY (2 are absent).	5 functions are performed at least PARTIALLY (1 is absent), OR ALL 6 functions are performed with 4 or more PARTIALLY performed.	ALL 6 functions are performed, with up to 3 PARTIALLY performed.	ALL 6 daily team meeting functions are FULLY performed.

OS5. PROGRAM SIZE	Not Implemented	← ← ←	TMACT Rating	→ → →	Fully Implemented
	1	2	3	4	5
The team is of a sufficient size to consistently provide for necessary staffing diversity and coverage. NOTE: Some items include separate parameters for minimal coverage for smaller teams to allow for enough staff to be available 24 hours a day, seven days a week.	100-Client Team: Includes fewer than 5.5 FTE direct clinical staff	5.5 - 6.9 FTE	7.0 - 8.4 FTE	8.5 - 9.9 FTE	100-Client Team: Includes at least 10.0 FTE direct clinical staff
	50-Client Team: Includes fewer than 5.5 FTE direct clinical staff	5.5 - 5.9 FTE	6.0 - 6.4 FTE	6.5 - 6.9 FTE	50-Client Team: Includes at least 7.0 FTE direct clinical staff
	30-Client* Team (or below) Includes fewer than 5.5 FTE direct clinical staff	5.5 FTE	5.6 FTE	5.7 FTE	30-Client Team: Includes at least 5.8 FTE direct clinical staff

**Per TMACT minimal coverage for smaller teams to allow for enough staff to be available 24 hours a day, seven days a week. (See Supplemental Grid for Teams with a Caseload Cap Different than 50 or 100 Clients, page 16 of TMACT-Protocol-Part-II-1.0rev3_2018_final)*

	Not Implemented	← ← ←	TMACT Rating	→ → →	Fully Implemented
	1	2	3	4	5
OS6. PRIORITY SERVICE POPULATION					
ACT teams serve a specific, high-service-need population of adults with serious mental illness and are able to make decisions about who is served by the team. (1) The team has specific admission criteria, inclusive of schizophrenia & other psychotic disorders or bipolar I disorder, significant functional impairments, and continuous high service needs, and exclusive of a sole or primary diagnosis of a substance use disorder, intellectual development disorder, brain injury or personality disorders. (2) The team/agency has the authority to be the gatekeeper on admissions to the team (including screening out inappropriate referrals) and discharges from the team.	The team at least PARTIALLY meets criterion #2 only OR does not meet either criterion.	The team PARTIALLY meets criterion #1 only.	The team PARTIALLY meets criterion #1, and at least PARTIALLY meets criterion #2.	Team FULLY meets criterion #1, and PARTIALLY meets criterion #2.	Team FULLY meets both criteria.
OS7. ACTIVE RECRUITMENT	Not Implemented	← ← ←	TMACT Rating	→ → →	Fully Implemented
	1	2	3	4	5
(1) The team (or its organizational representative) actively recruits new clients who could benefit from ACT, including assertive outreach to referral sites for regular screening and planning for new admissions to the team. (2) The team is primarily comprised of clients from referral sources and sites outside of usual community mental health settings (e.g., state & community hospitals, ERs, prisons/jails, shelters, street outreach). (3) The team works to fill open slots when they are not at full capacity and/or the client-to-staff ratio is well below 10:1 on more mature teams.	The team PARTIALLY meets 1 criterion or less.	Criterion is FULLY met (2 are absent) OR criteria met, with both criteria PARTIALLY met OR 1 criterion is PARTIALLY met and 1 FULLY met (1 is absent).	2 criteria are FULLY met (1 is absent) OR ALL 3 criteria are met, with 2 or 3 PARTIALLY met.	ALL 3 criteria are met, with 2 FULLY and 1 PARTIALLY met.	ALL 3 criteria FULLY met.

	Not Implemented	← ← ←	TMACT Rating	→ → →	Fully Implemented
OS8. GRADUAL ADMISSION RATE	1	2	3	4	5
The team admits new clients at a low rate to maintain a stable service environment.	Highest monthly admission rate in the last 6 months is greater than 15 clients per month.	12 -15	8 - 11	5-7	Highest monthly admission rate in the last 6 months was no greater than 4 clients per month
OS9. TRANSITION TO LESS INTENSIVE SERVICES	Not Implemented	← ← ←	TMACT Rating	→ → →	Fully Implemented
	1	2	3	4	5
(1) The team conducts a regular assessment of the need for ACT services; (2) The team uses explicit criteria or markers to assesses need to transfer to less intensive service option; (3) Transition is gradual & individualized, with assured continuity of care; (4) Status is monitored following transition, per individual need; and (5) The team has a procedure to expedite a referral for a recently discharged client ² to the team if necessary.	Up to 1 criterion is met OR 2 criteria are met, with 1 or 2 PARTIALLY met.	2 criteria are FULLY met (3 are absent) OR 3 criteria are met, with 1 to 3 PARTIALLY met (2 are absent).	3 criteria are FULLY met (2 are absent) OR 4 criteria are met, at least PARTIALLY met (1 is absent).	4 criteria are FULLY met (1 is absent or only partially met).	ALL 5 criteria FULLY met.
OS10. RETENTION RATE	Not Implemented	← ← ←	TMACT Rating	→ → →	Fully Implemented
	1	2	3	4	5
The team retains a high percentage of clients given that they enroll clients appropriate for ACT, utilize appropriate engagement techniques, and deliver individualized services. Referral to a more restrictive setting/program would normally be considered an adverse outcome.	Less than 65% of the caseload is retained over a 12-month period.	65 - 76%	77 – 86%	87 - 94%	95% or more of caseload is retained over a 12-month period.

² Re-admission definition is TBD by OHA

OS11. INVOLVEMENT IN PSYCHIATRIC HOSPITALIZATION DECISIONS	Not Implemented	← ← ←	TMACT Rating	→ → →	Fully Implemented
	1	2	3	4	5
The ACT team is closely involved in psychiatric hospitalizations and discharges. This includes involvement in the decision to hospitalize the client (e.g., activating a crisis plan to employ alternative strategies before resorting to hospitalization, assessment of need for hospitalization, and assistance with both voluntary and involuntary admissions), contact with the client during their hospital stay, collaboration with hospital staff throughout the course of the hospital stay, as well as coordination of discharge medications and community disposition (e.g., housing, service planning).	The team is involved in fewer than 15% of admissions & discharges.	The team is involved in 15% - 44% of admissions & discharges.	The team is involved in 45- 69% of admissions & discharges.	The team is involved in 70% - 89% of admissions & discharges.	The team is involved in 90% or more admissions & discharges.

OS12. DEDICATED OFFICE-BASED PROGRAM ASSISTANCE	Not Implemented	← ← ←	TMACT Rating	→ → →	Fully Implemented
	1	2	3	4	5
The team has 1.0 FTE of office-based program assistance available ³ to facilitate the day's operations in a supportive manner for the team, clients, natural supports, and other ancillary service providers (e.g., landlords, social security). Primary functions include the following: (1) Providing direct support to staff, including monitoring & coordinating daily team schedules and supporting staff both in the office and field; (2) Serving as a liaison between clients and staff, such as attending to the needs of office walk-ins and calls from clients/natural supports; and (3) Actively participating in the daily team meeting.	Less than 0.50 FTE program assistance is available to the team OR 0.50 - 1.0 FTE program assistance is available, but not meeting rating "2" performance.	0.50 - 0.99 FTE program assistance is available, at least PARTIALLY performing 2 functions OR 1.0 FTE program assistance is available and performing 1 function ONLY.	0.50 - 0.99 FTE program assistance is available, at least PARTIALLY performing ALL functions OR 1.0 FTE program assistance is available, at least PARTIALLY performing 2 functions.	1.0 FTE program assistance is available, at least PARTIALLY performing ALL functions.	1.0 FTE program assistance is available, FULLY performing ALL functions.

³ For rural & frontier teams: Team lead can assume these responsibilities or delegate. If assumed, FTE dedicated to admin assistance would be deducted from dedicated Team Lead FTE.

Subscale #2: Core Team

CT1. TEAM LEADER ON TEAM	Not Implemented	← ← ←	TMACT Rating	→ → →	Fully Implemented
	1	2	3	4	5
The team has 1.0 full-time (i.e., works 40 hours a week) team leader with full clinical, administrative, and supervisory responsibility to the team. The team leader has no responsibility to any other programs during the 40-hour workweek. The team lead must have at least a QMHP-Certification with the additional two years of experience* to qualify as a clinical supervisor. Team leader cannot fill more than one role on the team.	100-Client Team: Less than 0.25 FTE team leader OR less than 0.75 FTE team leader with inadequate qualifications.	0.25 - 0.74 FTE team leader who meets at least minimal qualifications.	0.75 - 1.0 FTE team leader who does not meet minimal qualifications for education and experience	0.75 – 0.99 FTE team leader who meets at least minimal qualifications OR 1.0 full-time team leader who meets all qualifications except having a clinical license.	100-Client Team: 1.0 FTE team leader who meets at least minimal qualifications, including licensure, and has full assigned responsibility to the team.
	50-Client Team: Less than .18 FTE OR less than 0.35 FTE with inadequate qualifications	.18-.35 FTE and meets at least minimal qualifications	.36-.53 FTE, but does <u>not</u> meet minimal qualifications	.54-.70 FTE and meets at least minimal qualifications OR .71 FTE, but lacks a clinical license.	50-Client Team: .71 FTE or above and meets all qualifications and has full assigned responsibility for team.
	30-Client Team (or below)**: Less than .10 FTE OR less than 0.25 FTE with inadequate qualifications	.10-.24 FTE and meets at least minimal qualifications	.25-.31 FTE, but does <u>not</u> meet minimal qualifications	.32-.42 FTE and meets at least minimal qualifications OR .43 FTE, but lacks a clinical license.	30-Client Team (or below): .43 FTE or above and meets all qualifications and has full assigned responsibility for team.

*Meets local standard for certification. Reduced from TMACT criteria of at least a master's degree and license in a clinical field and at least three years of experience.

**Per TMACT Methodology for establishing minimal coverage for smaller teams (See Supplemental Grid for Teams with a Caseload Cap Different than 50 or 100 Clients, page 16 of TMACT-Protocol-Part-II-1.0rev3_2018_final)

CT2. TEAM LEADER AS PRACTICING CLINICIAN	Not Implemented	← ← ←	← TMACT Rating →	→ → →	Fully Implemented
	1	2	3	4	5
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.	Neither direct clinical services nor clinical supervision is provided at a frequency meeting low level standard.	A low level of frequency for both direct clinical services and clinical supervision OR one practice is not provided.	Both practices are provided at a moderate level of frequency OR one practice is provided at a high or moderate level, and one at a low level of frequency.	One practice is provided at a moderate level, and one practice is at a high level of frequency.	A high level of frequency for both direct clinical services and clinical supervision.

CT3 PSYCHIATRIC CARE PROVIDER ON TEAM	Not Implemented	← ← ←	← TMACT Rating →	→ → →	Fully Implemented
	1	2	3	3	5
The team has at least 0.80 FTE psychiatric care provider time to directly work with a 100-client team. Minimal qualifications: (1) Licensed by state law to prescribe medications; & (2) Board certified or eligible (i.e., completed psychiatric residency) in psychiatry/mental health by a national certifying body recognized and approved by the state licensing entity. <u>Oregon Guidance for Physician Extenders</u> : Must have received at least one year of supervised training (pre- or post-degree) in working with people with serious mental illness.	100-Client Team Less than 0.20 FTE psychiatric care provider(s)	0.20- 0.39 FTE psychiatric care provider meeting at least minimal qualifications OR criteria for a "3" rating met, except communication standard if two or more providers, OR at least 0.20 FTE with inadequate qualifications cited.	0.40- 0.59 FTE psychiatric care provider meeting at least minimal qualifications with demonstrated communication & collaboration if two providers. OR criteria for a "4" rating met, except communication standard if two or more providers.	0.60- 0.79 FTE psychiatric care provider meeting at least minimal qualifications with demonstrated communication & collaboration if multiple providers. OR criteria for a "5" rating met, except communication standard if two or more providers.	100-Client Team At least 0.80 FTE psychiatric care provider meeting at least minimal qualifications. Two or more providers must demonstrate a mechanism for adequate communication & collaboration between/among providers
	50-Client Team: Less than .10 FTE psychiatric care provider(s)	.10-.19 FTE and20-.29 FTE and30-.39 FTE and ...	50-Client Team: .40 FTE or above and ...
	30-Client Team (or below)*: Less than .06 FTE psychiatric care provider(s)	.06-.11 FTE and12-.17 FTE and18-.23 FTE and ...	30-Client Team (or below): .24 FTE or above and ...

** Per TMACT p.42: 100 clients need 32 hrs/week (.80 FTE). 50 clients need 16 hrs/week (.40 FTE) [Ratio=.008 FTE per client]. (Ratio per client continues for smaller teams).

CT4 ROLE OF PSYCHIATRIC CARE PROVIDER IN TREATMENT	Not Implemented	← ← ←	← TMACT Rating →	→ → →	Fully Implemented
	1	2	3	4	5
In addition to providing psychopharmacologic treatment, the psychiatric care provider performs the following functions in treatment:(1) Typically provides at least monthly assessment and treatment of clients' symptoms and response to the medications, including side effects; (2) Provides brief therapy; (3) Provides diagnostic and medication education to clients, with medication decisions based in a shared decision- making paradigm; (4) Monitors clients' non-psychiatric medical conditions and non- psychiatric medications; (5) If clients are hospitalized, communicates directly with clients' inpatient psychiatric care provider to ensure continuity of care; and (6) Conducts home and community visits.	The psychiatric care provider performs 2 or fewer functions total.	4 functions PARTIALLY performed (2 are absent) OR 3 functions are performed (3 are absent).	4 functions are performed (2 are absent), but up to 3 are only PARTIALLY performed OR 5 functions are performed (1 is absent) OR ALL 6 functions are performed, but more than 2 are PARTIALLY performed.	ALL 6 functions are performed, but up to 2 functions are only PARTIALLY performed.	ALL 6 treatment functions FULLY performed
CT5 ROLE OF PSYCHIATRIC CARE PROVIDER WITHIN TEAM	Not Implemented	← ← ←	← TMACT Rating →	→ → →	Fully Implemented
	1	2	3	4	5
The psychiatric care provider performs the following functions within the team: (1) Collaborates with the team leader in sharing overall clinical responsibility for monitoring client treatment and team member service delivery; (2) Educates non-medical staff on psychiatric and non-psychiatric medications, their side effects, and health-related conditions; (3) Attends the majority of treatment planning meetings; (4)Attends daily team meetings in proportion to the minimum time expected for caseload size; (5) Actively collaborates with nurses; and (6) Provides psychiatric back-up to the program after-hours and weekends (Note: may be on a rotating basis as long as other psychiatric care providers who share on-call have access to clients' current status and medical records/current medications).	The psychiatric care provider performs no more than 2 team functions total.	3 team functions are performed.	4 team functions are performed.	5 team functions are performed.	ALL 6 team functions are performed.

CT6 NURSE ON TEAM	← ← ← TMACT Rating → → →				Fully Implemented
	Not Implemented 1	2	3	4	
At least 2.0* full-time Nurses assigned per 100 ACT participant. At least one Nurse is an RN who has a minimum of one year of experience working with adults with severe mental illness.	100-Client Team Less than .48 FTE RNs per 100 participants	.48 - .97 FTE RNs per 100 clients.	.98 - 1.39 FTE RNs per 100 clients OR Criteria for "4" or "5" rating met; however, no full-time RNs have a minimum of 1 year experience working with adults with severe mental illness	1.40 - 1.99 FTE per 100 participants	100-Client Team: 2.0 FTE Nurses or more per 100 participants
	50-Client**Team: Less than .24 FTE RNs per 50 participants	.24-.48 FTE RNs per 50 clients.	.49-.69 FTE RNs per 50 clients OR Criteria for "4" or "5" rating met; however, no full-time RNs have a minimum of 1 year experience working with adults with severe mental illness	.70-.99 FTE per 50 participants	50-Client Team: .1.0 FTE per 50 participants
	30-Client**Team (or below): Less than .10 FTE RNs per 30 participants	.10-.28 FTE RNs per 30 clients.	.29-.41 FTE RNs per 30 clients OR Criteria for "4" or "5" rating met; however, no full-time RNs have a minimum of 1 year experience working with adults with severe mental illness	.42-.59 FTE per 30 participants	30-Client Team (or below): .60 FTE per 30 participants

*Oregon Rating adjusted down from TMACT 2.85 FTE nurses per 100 clients served. **Per TMACT Methodology for establishing minimal coverage for smaller teams (See page 16 of TMACT-Protocol-Part-II-1.0rev3_2018_final) and calculated based on full implementation in Oregon (Oregon level 5) being 2.0 Nurse FTE for teams serving 100, following the TMACT calculation of every 30% reduction in FTE resulting in a one level reduction in rating

CT7 ROLE OF NURSES	← ← ← TMACT Rating → → →				Fully Implemented
	Not Implemented 1	2	3	4	
The team nurses perform the following critical roles (in collaboration with the psychiatric care provider): (1) Manage the medication system, administer and document medication treatment; (2) Screen and monitor clients for medical problems/side effects; (3) Communicate and coordinate services with the other medical providers; (4) Engage in health promotion, prevention, and education activities (i.e., assess for risky behaviors and attempt behavior change); (5) Educate other team members to help them monitor psychiatric symptoms and medication side effects; and (6) When clients are in agreement, develop strategies to maximize the taking of medications as prescribed (e.g., behavioral tailoring, development of individual cues and reminders).	Nurses perform 2 or fewer functions total.	4 functions PARTIALLY performed (2 are absent) OR 3 functions are performed (3 are absent).	4 functions are performed (2 are absent), but up to 3 are only PARTIALLY performed OR 5 functions are performed (1 is absent) OR ALL 6 functions are performed, but more than 3 are PARTIALLY performed.	ALL 6 functions, with up to 3 functions are PARTIALLY performed.	ALL 6 functions are FULLY performed.

Subscale #3: Specialist Team

STI CO-OCCURRING DISORDER SPECIALIST	Not Implemented	← ← ←	← TMACT Rating →	→ → →	Fully Implemented
	1	2	3	4	5
The team has at least one 1.0 FTE team member designated as a co-occurring disorders (COD) specialist who has at least a CADCI ^{II} * and is certified in Oregon. Preferably this specialist has training or experience in integrated treatment for COD.	100-Client Team Less than 0.25 (actual or adjusted) FTE COD specialist with at least minimal qualifications OR criteria for a "2" rating met, except qualifications standards.	0.25 - 0.49 (actual or adjusted) FTE COD specialist with at least minimal qualifications OR criteria for a "3" rating met, except qualifications standards.	0.50 - 0.74 (actual or adjusted) FTE COD specialist with at least minimal qualifications OR criteria for a "4" rating met, except qualifications standards.	0.75 - 0.99 (actual or adjusted) FTE COD specialist with at least minimal qualifications OR criteria for a "5" rating met, except qualifications standards.	100-Client Team At least 1.0 (actual or adjusted) FTE COD specialist with at least minimal qualifications
	30-Client** Team (or below): Less than 0.10 (actual or adjusted) FTE	.10-.20 (actual or adjusted) FTE	.21-.31 (actual or adjusted) FTE	.32-.42 (actual or adjusted) FTE	30-Client Team (or below): At least .43 (actual or adjusted) FTE COD specialist with at least minimal qualifications

*Fulfills TMACT guidance for fulfilling local standard for certification as a COD specialist. (See p 64 of TMACT-Protocol-Part-II-1.0rev3_2018_final)

**Per TMACT Methodology for establishing minimal coverage for smaller teams (See Supplemental Grid for Teams with a Caseload Cap Different than 50 or 100 Clients, page 16 of TMACT-Protocol-Part-II-1.0rev3_2018_final)

ST2. ROLE OF CO-OCCURRING DISORDERS SPECIALIST IN TREATMENT	Not Implemented	← ← ←	← TMACT Rating →	→ → →	Fully Implemented
	1	2	3	4	5
The co-occurring disorders (COD) specialist provides integrated treatment for COD to ACT clients who have a substance use problem. Core services include the following: (1) Conducting ongoing comprehensive substance use assessments that consider the relationship between substance use and mental health; (2) Assessing and tracking clients' stages of change readiness and stages of treatment; (3) Using outreach and motivational interviewing (MI) techniques; (4) Using cognitive behavioral approaches and relapse prevention; and (5) Applying treatment approaches consistent with clients' stage of change readiness.	The COD specialist provides 1 or fewer integrated treatment for co-occurring disorder services.	2 integrated treatments for COD services are provided (3 are absent).	3-4 integrated treatment for COD services are provided, (1 or 2 are absent) OR ALL 5 services are provided, with 3 or more services PARTIALLY provided.	ALL 5 integrated treatment for COD services are provided, but up to 2 services are only PARTIALLY provided.	ALL 5 integrated treatment for COD services are FULLY provided.

ST3. ROLE OF CO-OCCURRING DISORDERS SPECIALIST WITHIN TEAM	Not Implemented	← ← ←	← TMACT Rating →	→ → →	Fully Implemented
	1	2	3	4	5
The co-occurring disorders (COD) specialist is a key team member in the service planning for clients with COD. The COD specialist performs the following functions WITHIN THE TEAM: (1) Modeling skills and consultation; (2) Cross-training to other staff on the team to help them develop co-occurring disorder assessment and treatment skills; (3) Attending all daily team meetings; and (4) Attending the majority of treatment planning meetings for clients with COD.	The COD specialist does not perform any of the 4 functions within the team.	1 function is performed within the team.	2 functions are performed within the team.	3 functions are performed within the team.	ALL 4 functions are performed within the team.

ST4 EMPLOYMENT SPECIALIST ON TEAM	Not Implemented 1	← ← ← 2	← TMACT Rating → 3	→ → → 4	Fully Implemented 5
<p>The team has at least 1.0 FTE team member designated as an employment specialist, with at least 6 Months* of experience providing employment services (e.g., job development, job coaching, supported employment). Ideally, the ACT employment specialist is a part of a larger supported employment & education (SEE) program within the agency</p>	<p>100-Client Team: Less than 0.25 (actual or adjusted) FTE employment specialist with at least minimal qualifications OR criteria for a “2” rating met, except qualifications standards.</p>	<p>0.25 - 0.49 (actual or adjusted) FTE employment specialist with at least minimal qualifications OR criteria for a “3” rating met, except qualifications standards.</p>	<p>0.50 - 0.74 (actual or adjusted) FTE employment specialist with at least minimal qualifications OR criteria for a “4” rating met, except qualifications standards.</p>	<p>0.75 - 0.99 (actual or adjusted) FTE employment specialist with at least minimal qualifications OR criteria for a “5” rating met, except qualifications standards.</p>	<p>100-Client Team: At least 1.0 (actual or adjusted) FTE employment specialist with at least minimal qualifications</p>
	<p>30-Client** Team (or below): Less than 0.10 (actual or adjusted) FTE</p>	<p>.10-.20 (actual or adjusted) FTE</p>	<p>.21-.31 (actual or adjusted) FTE</p>	<p>.32-.42 (actual or adjusted) FTE</p>	<p>30-Client Team (or below): At least .43 (actual or adjusted) FTE COD specialist with at least minimal qualifications</p>

*TMACT requirement of one year reduced to 6 months per Oregon Administrative Rules

**Per TMACT Methodology for establishing minimal coverage for smaller teams (See Supplemental Grid for Teams with a Caseload Cap Different than 50 or 100 Clients, page 16 of TMACT-Protocol-Part-II-1.0rev3_2018_final)

ST5. ROLE OF EMPLOYMENT SPECIALIST IN SERVICES	Not Implemented	← ← ←	← TMACT Rating →	→ → →	Fully Implemented
	1	2	3	4	5
The employment specialist provides supported employment & education services. Core services include the following: (1) Engagement; (2) Vocational assessment; (3) Job development; (4) Job placement (including going back to school, classes); (5) Job coaching & follow-along supports (including supports in academic settings); and (6) Benefits counseling.	The employment specialist provides 2 or fewer employment services.	3 employment services are provided (3 are absent) OR 4 services are PARTALLY provided (2 are absent).	4 employment services are provided (2 are absent), but up to 3 services are only PARTIALLY provided OR 5 employment services are provided (1 is absent) OR ALL 6 services are provided, with 4 or more PARTIALLY provided.	ALL 6 employment services are provided, but up to 3 services are only PARTIALLY provided.	ALL 6 employment services are FULLY provided.

ST6. ROLE OF EMPLOYMENT SPECIALIST WITHIN TEAM	Not Implemented	← ← ←	← TMACT Rating →	→ → →	Fully Implemented
	1	2	3	4	5
The employment specialist is a key team member in the service planning for clients who want to work or are currently working. The employment specialist performs the following functions WITHIN THE TEAM: (1) Modeling skills and consultation; (2) Cross-training to other staff on the team to help them to develop supported employment & education approaches with clients in the team; (3) Attending all daily team meetings; and (4) Attending all treatment planning meetings for clients with employment goals.	The employment specialist does not perform any of the 4 functions within the team.	1 function is performed within the team.	2 functions are performed within the team.	3 functions are performed within the team.	ALL 4 functions are performed within the team.

ST7 PEER SPECIALIST ON TEAM	Not Implemented	← ← ←	← TMACT Rating →	→ → →	Fully Implemented
	1	2	3	4	5
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.	100-Client Team: Less than 0.25 (actual or adjusted) FTE peer specialist with at least minimal qualifications OR criteria for a “2” rating met, except qualifications standards.	0.25 - 0.49 (actual or adjusted) FTE peer specialist with at least minimal qualifications OR criteria for a “3” rating met, except qualifications standards.	0.50 - 0.74 (actual or adjusted) FTE peer specialist with at least minimal qualifications OR criteria for a “4” rating met, except qualifications standards.	0.75 - 0.99 (actual or adjusted) FTE peer specialist with at least minimal qualifications OR criteria for a “5” rating met, except qualifications standards.	100-Client Team: At least 1.0 (actual or adjusted) FTE peer specialist with at least minimal qualifications
	30-Client** Team (or below): Less than 0.10 (actual or adjusted) FTE	.10-.20 (actual or adjusted) FTE	.21-.31 (actual or adjusted) FTE	.32-.42 (actual or adjusted) FTE	30-Client Team (or below): At least .43 (actual or adjusted) FTE COD specialist with at least minimal qualifications

***Per TMACT Methodology for establishing minimal coverage for smaller teams (See Supplemental Grid for Teams with a Caseload Cap Different than 50 or 100 Clients, page 16 of TMACT-Protocol-Part-II-1.0rev3_2018_final)*

	Not Implemented	← ← ←	← TMACT Rating →	→ → →	Fully Implemented
ST8. ROLE OF PEER SPECIALIST	1	2	3	4	5
<p>The peer specialist performs the following functions: (1) Coaching and consultation to clients to promote recovery and self-direction (e.g., preparation for role in treatment planning meetings); (2) Facilitating wellness management and recovery strategies (e.g., Wellness Recovery Action Plans (WRAP), Illness Management and Recovery (IMR), or other deliberate wellness strategies); (3) Participating in all team activities (e.g., treatment planning, chart notes) equivalent to fellow team members; (4) Modeling skills and providing consultation to fellow team members; and (5) Providing cross-training to other team members in recovery principles and strategies.</p>	<p>The peer specialist performs 1 or fewer functions on the team.</p>	<p>2 functions are FULLY performed (3 are absent) OR 2 to 3 functions performed, 1 to 2 PARTIALLY.</p>	<p>3 functions are FULLY performed (2 are absent or PARTIAL) OR to 5 functions PARTIALLY.</p>	<p>4 functions are FULLY performed (1 is absent or PARTIAL).</p>	<p>ALL 5 functions are FULLY performed.</p>

Subscale #4: Core Practices

	Not Implemented	← ← ←	← TMACT Rating →	→ → →	Fully Implemented
CP1. COMMUNITY-BASED SERVICES:	1	2	3	4	5
The team works to monitor status and develop skills in the community, rather than in-office. The team is oriented to bringing services to the client, who, for various reasons, has not effectively been served by office-based treatment.	Less than 40% of face-to-face contacts in community.	40 - 54%	55 - 64%	65 - 74%	At least 75% of total face-to-face contacts in community.

	Not Implemented	← ← ←	← TMACT Rating →	→ → →	Fully Implemented
CP2. ASSERTIVE ENGAGEMENT MECHANISMS	1	2	3	4	5
The team uses an array of techniques to engage difficult-to- treat clients. These techniques include the following:(1) Collaborative, motivational interventions to engage clients and build intrinsic motivation for receiving services from the team, and, where necessary; and (2) Therapeutic limit-setting interventions to create extrinsic motivation for receiving services deemed necessary to prevent harm to client or others. When therapeutic limit-setting interventions are used, there is a focus on instilling autonomy as quickly as possible. In addition to being proficient in a range of engagement interventions, (3) the team has a thoughtful process for identifying the need for assertive engagement, measuring the effectiveness of chosen techniques, and modifying approach when indicated	Very little assertive engagement is evident (#1 and #2 are largely absent).	Team primarily relies on #1 OR #2, not both (1 approach is FULLY or PARTIALLY used and 1 is not used at all (No Credit)).	A more limited array of assertive engagement strategies is used (PARTIAL #1 and #2).	Team uses #1 and #2 (at least 1 approach is FULLY used). Thoughtful application/ withdrawal of engagement strategies may be present or absent (#3 is absent).	Team is proficient in assertive engagement strategies, including thoughtful application/with drawal of engagement strategies, applying all 3 practices.

CP3. INTENSITY OF SERVICE	Not Implemented	← ← ←	← TMACT Rating →	→ → →	Fully Implemented
	1	2	3	4	5
The team delivers a high amount of face-to-face service time as needed.	Average of less than 15 min/week or less of face-to-face contact per client.	15 - 49 minutes/week.	50 - 84 minutes/week.	85 - 119 minutes/week.	Average of 2 hours/week or more of face-to-face contact per client.

CP4. FREQUENCY OF CONTACT	Not Implemented	← ← ←	← TMACT Rating →	→ → →	Fully Implemented
	1	2	3	4	5
The team delivers a high number of face-to-face service contacts, as needed.	Average of less than 0.5 face-to-face contact / week or fewer per client.	0.6 - 1.3 / week.	1.4 - 2.1 / week.	2.2 - 2.9 / week.	Average of 3 or more face-to-face contacts/week per client.

CP5. FREQUENCY OF CONTACT WITH NATURAL SUPPORTS	Not Implemented	← ← ←	← TMACT Rating →	→ → →	Fully Implemented
	1	2	3	4	5
The team has access to clients' natural supports. These supports either already existed, and/or resulted from the team's efforts to help clients develop natural supports. Natural supports include people in the client's life who are NOT paid service providers (e.g., family, friends, landlord, employer, clergy).	For less than 25% of clients, the natural support system is contacted by team at least 1 time per month.	26% - 50%	51% - 75%	76% -89%	For at least 90% of clients, the natural support system is contacted by team at least 1 time per month.

CP6. RESPONSIBILITY FOR CRISIS SERVICES	Not Implemented	← ← ←	← TMACT Rating →	→ → →	Fully Implemented
	1	2	3	4	5
The team has 24-hour responsibility for directly responding to psychiatric crises, including meeting the following criteria: (1) The team or delegated entity* is available to clients in crisis 24 hours a day, seven days a week; (2) The team is the first-line crisis evaluator and responder (if another crisis responder screens calls, there is very minimal triaging); (3)The team accesses practical, individualized crisis plans to help them address crises for each client or provides the delegated entity with their crisis plan for continuity of care and (4) The team is able and willing to respond to crises in person, when needed.	Team has no responsibility for directly handling crises afterhours.	Team meets up to 2 criteria at least PARTIALLY OR criterion #1 is not met.	Team meets criterion #1 and at least PARTIALLY meets 2 to 3 criteria.	Team meets 3 criteria FULLY and 1 PARTIALLY.	Team FULLY meets all 4 criteria without delegating responsibility to another entity.

*TMACT requirement of 24/7 direct response reduced to delegated response, though delegation is not best practice so a 5 rating is not possible with delegation.

CP7. FULL RESPONSIBILITY FOR PSYCHIATRIC SERVICES	Not Implemented	← ← ←	← TMACT Rating →	→ → →	Fully Implemented
	1	2	3	4	5
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 is also considered in this assessment, especially when evaluating psychiatric services provided to clients residing in supervised settings where non-ACT staff also manage medications; the expectation is that ACT staff play an active role in monitoring medication management even when a client is in a residential setting.	Less than 20% of clients in need of psychiatric services are receiving them from the team.	20 - 49% of clients in need of psychiatric services are receiving them from the team.	50 - 74% of clients in need of psychiatric services are receiving them from the team.	75 - 89% of clients in need of psychiatric services are receiving them from the team.	90% or more of clients in need of psychiatric services are receiving them from the team.

CP8. FULL RESPONSIBILITY FOR PSYCHIATRIC REHABILITATION SERVICES	Not Implemented 1	← ← ← 2	← TMACT Rating → 3	→ → → 4	Fully Implemented 5
<p>These services focus on targeted skills training in the areas of community living, which includes skills needed to maintain independent living (e.g., shopping, cooking, cleaning, budgeting, and transportation) and socialization (e.g., enhancing social and/or romantic relationships, recreational and leisure pursuits that contribute to community integration). Psychiatric rehabilitation should address functional deficits, environment, as well as the lack of necessary resources, all of which are identified through the assessment process. As such, deliberate and consistent skills training which typically includes staff demonstration, client practice/role-plays, and staff feedback, as well as ongoing prompting and cueing for learned skills in more generalized settings. Psychiatric rehabilitation services reported here should be reflected across other data sources (e.g., progress notes, treatment plans, and weekly client schedules).</p>	<p>Less than 20% of clients in need of psychiatric rehabilitation services are receiving them from the team.</p>	<p>20 - 49% of clients in need of psychiatric rehabilitation services are receiving them from the team.</p>	<p>50 - 74% of clients in need of psychiatric rehabilitation services are receiving them from the team.</p>	<p>75 - 89% of clients in need of psychiatric rehabilitation services are receiving them from the team.</p>	<p>90% or more of clients in need of psychiatric rehabilitation services are receiving them from the team.</p>

Subscale #5: Evidence-Based Practices

EPI. FULL RESPONSIBILITY FOR INTEGRATED TREATMENT FOR CO-OCCURRING DISORDERS	Not Implemented	← ← ←	← TMACT Rating →	→ → →	Fully Implemented
	1	2	3	4	5
The team assumes responsibility for providing integrated treatment for co-occurring disorders (COD) services within the larger framework of integrated treatment for COD, where there is little need for clients to have to access such services outside of the team. Core services include systematic and integrated screening and assessment and interventions tailored to those in early stages of change readiness (e.g., outreach, motivational interviewing) and later stages of change readiness (e.g., CBT, relapse prevention). It is expected that the ACT COD specialist will assume the majority of responsibility for delivering integrated treatment for co-occurring disorders, but ideally other team members also provide some integrated treatment for co-occurring disorders services. Integrated treatment for co-occurring disorders reported here from the Excel spreadsheet should be reflected across other data sources (e.g., progress notes, treatment plans).	Less than 20% of clients in need of integrated treatment for COD are receiving them from the team.	20 - 49% of clients in need of integrated treatment for COD are receiving them from the team.	50 - 74% of clients in need of integrated treatment for COD are receiving them from the team.	75 - 89% of clients in need of integrated treatment for COD are receiving them from the team.	90% or more of clients in need of integrated treatment for COD are receiving them from the team.

EP2. FULL RESPONSIBILITY FOR EMPLOYMENT AND EDUCATIONAL SERVICES	Not Implemented	← ← ←	← TMACT Rating →	→ → →	Fully Implemented
	1	2	3	4	5
The team assumes responsibility for providing employment and educational (EE) services to clients, where there is little need for clients to have to access such services outside of the team. Core services include engagement, vocational assessment, job development, job placement (including going back to school, classes), and job coaching & follow-along supports (including supports in academic/school settings). It is expected that the ACT Employment Specialist will assume the majority of responsibility for delivering EE services, but ideally other team members also provide some EE services. Employment and educational services reported here from the Excel spreadsheet should be reflected across other data sources (e.g., progress notes, treatment plans).	Less than 20% of clients in need of employment and educational services are receiving them from the team.	20 - 49% of clients in need of EE services are receiving them from the team.	50 - 74% of clients in need of EE services are receiving them from the team.	75 - 89% of clients in need of EE services are receiving them from the team.	90% or more of clients in need of EE services are receiving them from the team.

EP3. FULL RESPONSIBILITY FOR WELLNESS MANAGEMENT AND RECOVERY SERVICES	Not Implemented	← ← ←	← TMACT Rating →	→ → →	Fully Implemented
	1	2	3	4	5
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 and utilizing Informal Supports. Examples of such services include the development of Wellness Recovery Action Plans (WRAP) and provision of the Illness Management and Recovery (IMR) curriculum. WMR services reported here from the Excel spreadsheet should be reflected across other data sources (e.g., progress notes, treatment plans).	Less than 20% of clients in need of WMR services are receiving them from the team.	20 - 49% of clients in need of WMR services are receiving them from the team.	50 - 74% of clients in need of WMR services are receiving them from the team.	75 - 89% of clients in need of WMR services are receiving them from the team.	90% or more of clients in need of WMR services are receiving them from the team.

EP4. INTEGRATED TREATMENT FOR CO-OCCURRING DISORDERS	Not Implemented	← ← ←	← TMACT Rating →	→ → →	Fully Implemented
	1	2	3	4	5
The TEAM practices from a model aligning with integrated treatment for co-occurring disorders (COD) where the TEAM (1) considers interactions between mental illness and COD; (2) does not have absolute expectations of abstinence and supports harm reduction; (3) understands and applies stages of change readiness in treatment; (4) is skilled in motivational interviewing; and (5) follows cognitive-behavioral principles.	Criteria are not met.	Only 1 - 3 criteria are met.	4 criteria met at least PARTIALLY (1 absent) OR criteria met with 3 or more PARTIALLY met.	Team primarily operates from integrated treatment for COD, meeting all 5 criteria, with up to 2 PARTIALLY met.	Team is fully based in integrated treatment for COD principles, FULLY meeting all 5 criteria.

EP5. SUPPORTED EMPLOYMENT AND EDUCATION	Not Implemented	← ← ←	← TMACT Rating →	→ → →	Fully Implemented
	1	2	3	4	5
The TEAM practices from a model aligning with evidence-based supported employment and education (SEE) and the TEAM: (1) Values competitive work as a goal for all clients; (2) Believes and supports that a client's expressed desire to work is the only eligibility criterion for SEE services; (3) Believes and supports that on-the-job assessment is more valuable than extensive prevocational assessment; (4) Believes and supports that placement should be individualized and tailored to a client's preferences; and (5) Believes that ongoing supports and job coaching should be provided when needed and desired by client, and has provided such supports.	Criteria are not met.	Only 1 - 3 criteria are met.	4 criteria met at least PARTIALLY (1 absent) OR criteria met with 3 or more PARTIALLY met.	Team primarily embraces SEE, meeting all 5 criteria, with up to 2 PARTIALLY met.	Team fully embraces SEE and FULLY meets all 5 criteria.

EP6. ENGAGEMENT & PSYCHOEDUCATION WITH NATURAL SUPPORTS	Not Implemented	← ← ←	← TMACT Rating →	→ → →	Fully Implemented
	1	2	3	4	5
The FULL TEAM works in partnership with clients' natural supports. As part of their active engagement of natural supports, the team: (1) Provides education about their loved one's illness; (2) Teaches problem-solving strategies for difficulties caused by illness; and (3) Provides &/or connects natural supports with social & support groups.	Team does not provide any of the specified services with clients' natural supports.	1 or 2 services are provided.	ALL 3 services are provided, but 2-3 services only PARTIALLY.	ALL 3 services are provided but 1 only PARTIALLY.	ALL 3 services are FULLY provided by team.

EP7. EMPIRICALLY-SUPPORTED PSYCHOTHERAPY	Not Implemented	← ← ←	← TMACT Rating →	→ → →	Fully Implemented
	1	2	3	4	5
(1) deliberately provides individual and/or group psychotherapy, as specified in the treatment plan; (2) uses empirically-supported techniques to address specific symptoms and behaviors; and (3) maintains an appropriate penetration rate in providing deliberate empirically-supported psychotherapy to clients in need of such services. Although all team members can be trained to effectively use therapeutic techniques, such as cognitive behavioral therapy and motivational interviewing, the team also ideally has a licensed therapist.	Team does not provide psychotherapy to clients. No criteria are met.	1 to 2 criteria are PARTIALLY met.	Criterion #1 is PARTIALLY met and criteria #2 and #3 is at least PARTIALLY met OR Team FULLY meets both criteria #1 and #2, but does not meet criterion #3.	Team FULLY meets criterion #1, PARTIALLY meets criterion #2, and at least PARTIALLY meets criterion #3 OR Team FULLY meets both criteria #1 and #2 and only PARTIALLY meets criterion #3.	Team FULLY meets all 3 criteria.

EP8. SUPPORTIVE HOUSING	Not Implemented	← ← ←	← TMACT Rating →	→ → →	Fully Implemented
	1	2	3	4	5
The team embraces supportive housing, including: (1) assisting clients in locating housing of their choice (e.g., providing multiple housing options, including integrated housing); (2) respect for clients' privacy within residence; (3) assistance in accessing affordable, safe/decent, and permanent housing; and (4) assured ongoing tenancy rights, regardless of clients' progress or success in ACT services.	Team meets no more than 1 criterion.	3 criteria PARTIALLY met OR 2 criteria met, at least PARTIALLY.	4 criteria met, with at least 2 PARTIALLY met OR 3 criteria met, with at least 1 criterion FULLY met.	ALL 4 criteria met, with up to 1 criterion PARTIALLY met (remaining 3 criteria are FULLY met).	ALL 4 criteria FULLY met.

Subscale #6: Person-Centered Planning and Practices

PPI STRENGTHS INFORM TREATMENT PLAN	Not Implemented	← ← ←	← TMACT Rating →	→ → →	Fully Implemented
	1	2	3	4	5
(1) The team is oriented toward clients' strengths and resources, and (2) clients' strengths and resources inform treatment plan development.	Strengths are not assessed (Criteria #1 not included).	Team variably attends to clients' strengths and resources and strengths/resources do not inform planning (Partial #1 only).	Team is clearly attentive to clients' strengths and resources, but clients' strengths and resources do not typically inform plan development (Full #1 and No credit #2) OR Team is variably attentive to strengths and uses this information to inform plans, but less systematically (Partial #1 and Partial #2).	Team is clearly attentive to clients' strengths and resources, which informed plan development for some (Full #1 and Partial #2).	Team is highly attentive to clients' strengths and resources, and gathers such information for the purpose of treatment planning (Full #1 and Full #2).

PP2. PERSON-CENTERED PLANNING	Not Implemented	← ← ←	← TMACT Rating →	→ → →	Fully Implemented
	1	2	3	4	5
The team creates treatment plans using a person-centered approach, including: (1) Development of formative treatment plan ideas based on initial inquiry and discussion with the client (prior to the formal treatment planning meeting) and with the team; (2) Conducting regularly scheduled treatment planning meetings; (3) Attendance by key staff, informal support system*, the client, and anyone else they prefer (e.g., family/natural supports), tailoring number of participants to fit with the client's preferences; (4) Provision of guidance and support to promote self-direction and leadership within the meeting, as needed; and (5) Treatment plan is clearly driven by the client's goals and preferences.	No more than 1 function of person-centered planning is performed OR 2 functions are performed, but not fully	2 functions of person-centered planning are FULLY performed (3 are absent) OR 3 functions are performed at least PARTIALLY (2 are absent).	4 functions of person-centered planning are performed (1 absent) OR 5 functions performed, with 3 or more PARTIALLY performed.	ALL 5 functions of person-centered planning are performed, with up to 2 PARTIALLY performed.	ALL 5 functions of person-centered planning are FULLY performed.

*Reference to inclusion of ITTs (smaller treatment teams within larger ACT Teams) removed due to smaller nature of Oregon teams. Replaced with inclusion of informal supports (an ITT component). (See page 179-180 of TMACT-Protocol-Part-II-1.Orev3_2018_final)

PP3. INTERVENTIONS TARGET A BROAD RANGE OF LIFE DOMAINS	Not Implemented	← ← ←	← TMACT Rating →	→ → →	Fully Implemented
	1	2	3	4	5
The team attends to a range of life domains (e.g., physical health, employment/education, housing satisfaction, legal problems) when planning and implementing interventions. (1) The team specifies interventions that target a range of life domains in treatment plans and (2) these planned interventions are carried out in practice, resulting in a sufficient breadth of services tailored to clients' needs	The team does not plan for and/or deliver interventions that reflect a breadth of life domains.	Team minimally plans for and/or delivers interventions that reflect life domains (PARTIAL credit for one criterion only) OR Team plans for but does not deliver a breadth of services (Full #1 only).	Team plans for and delivers interventions that reflect a breadth of life domains, but less systematically (PARTIAL #1 and PARTIAL #2) OR a larger breadth of services are planned for, but not in turn delivered (FULL #1 and PARTIAL #2).	Team delivers interventions that reflect a range of life domains to all clients (FULL #2), but interventions targeting a breadth of life domains are not systematically specified in treatment plans (PARTIAL #1 OR FULL #1, but lacking alignment).	Team specifies interventions that target a range of life domains in treatment plans and these interventions are carried out in practice (FULL criteria #1 and #2 with alignment).

PP4. CONSUMER SELF-DETERMINATION & INDEPENDENCE	Not Implemented	← ← ←	← TMACT Rating →	→ → →	Fully Implemented
	1	2	3	4	5
The team promotes clients' independence and self-determination by: (1) helping clients develop greater awareness of meaningful choices available to them; (2) honoring day-to-day choices, as appropriate; and (3) teaching clients the skills required for independent functioning. The team recognizes the varying needs and functioning levels of clients; level of oversight and care is commensurate with need in light of the goal of enhancing self-determination	None of the 3 practices are employed OR only 1 is employed (FULLY or PARTIALLY).	2 practices are employed (FULLY or PARTIALLY), with 1 absent.	3 practices are employed, with 2 to 3 PARTIALLY.	Team generally promotes clients' self-determination and independence. All 3 practices are employed, but 1 PARTIALLY employed.	Team is a strong advocate for clients' self-determination and independence. All 3 practices FULLY employed.