

## ATTACHMENT A

### DEFINITIONS

**ACT Service Coordination** is a process of organization and coordination within the multidisciplinary team to carry out the range of treatment, rehabilitation, and support services each consumer expects to receive per his or her written individualized treatment plan. Service coordination also includes coordination with community resources, including consumer self-help and advocacy organizations that promote recovery.

**ACT Service Coordinator** is the team member who has the primary responsibility for establishing and maintaining a therapeutic relationship with the consumer on a continuing basis, whether the consumer is in the hospital, in the community, or involved with other agencies. In addition, the service coordinator leads and coordinates the activities of the individual treatment team (ITT). The service coordinator collaborates with the consumer to develop and write the treatment plan, offers options and choices in the treatment plan, ensures that immediate changes are made as the consumer's needs change, and advocates for the consumer's wishes, rights, and preferences. The service coordinator also works with community resources, including the County MH/MR and consumer-run services, to coordinate and integrate these activities into the consumer's overall service plan. The service coordinator provides primary support and education to the family, support system, and/or other significant people. The service coordinator shares these tasks with other ITT members who are responsible to perform them when the service coordinator is not working. Although the service coordinator has the primary responsibility for the consumer, all team members should work with consumer and be conversant with the individual's strengths, background, and treatment plan.

**Clinical Supervision** is a systematic process to review each consumer's clinical status and to ensure that the individualized services and interventions that team members (including the peer specialist) provide are effective and planned with, purposeful for, and satisfactory to the consumer. The team leader and the psychiatrist have the responsibility to provide clinical supervision that occurs during daily organizational staff meetings, treatment planning meetings, and in individual meetings with team members. Clinical supervision also includes review of written documentation (e.g., assessments, treatment plans, progress notes, correspondence).

**Community Support Plan Review** also known as **Treatment Plan Review** is a thorough, written summary describing the consumer's and the individual treatment team's evaluation of the consumer's progress/goal attainment, the effectiveness of the interventions, and satisfaction with services since the last treatment plan.

**Community Support (Treatment) Planning meeting** is a scheduled meeting conducted under the supervision of the team leader and the psychiatrist. The purpose of these meetings is for the staff, as a team, to thoroughly prepare for their work with each consumer. The team meets together to present and integrate the information collected through assessment in order to learn as much as possible about the consumer's life, their experience with mental illness, and the type and effectiveness of the past treatment they have received. The presentations and discussions at these meetings make it possible for all staff to be familiar with each consumer and their goals and aspirations; to participate in the ongoing assessment and reformulation of issues/problems; to problem-solve treatment strategies and rehabilitation options; and to fully understand the treatment plan rationale in order to carry out the plan for each consumer. Consumers shall be encouraged to attend these meetings, and they should be allowed to invite members of their natural support network to participate. If a staff member is unable to be physically present at the meeting due to extenuating circumstances, he/she may participate in the discussions through telephone, video conferencing, or any other means of communication.

**Comprehensive Assessment** is the organized process of gathering and analyzing current and past information with each consumer and the family, support system, and/or other significant people to evaluate: 1) mental and functional status; 2) effectiveness of past treatment; and 3) current treatment, rehabilitation and support needs to achieve individual goals and support recovery. The results of the

information gathering and analysis are used with each consumer to establish immediate and longer-term service needs, to set goals, and to develop the first individualized treatment plan with each consumer.

**Consumer** is a person who has agreed to receive services and is receiving consumer-centered treatment, rehabilitation, and support services from the ACT team.

**Consumer-Centered Community Support Plan**, also known as **Consumer-Centered Individualized Treatment Plan**, is the culmination of a continuing process involving each consumer, his or her family with the consumer's consent and/or consumer's identified support network, and the ACT team, which individualizes service activity and intensity to meet consumer-specific treatment, rehabilitation, and support needs. The written community support plan (treatment plan) documents the consumer's self-determined goals and the services necessary to help the consumer achieve them. The plan also delineates the roles and responsibilities of the team members who will carry out the services.

**Daily Log** is a notebook or database which the ACT team maintains on a daily basis to provide: 1) a roster of consumers served in the program; and 2) for each consumer, a brief documentation of any treatment or service contacts which have occurred during the last 24 hours and a concise behavioral description of the consumer's clinical status and any additional needs.

**Daily Organizational Staff Meeting** is a daily staff meeting held at regularly scheduled times under the direction of the team leader (or designee) to: 1) briefly review the service contacts which occurred the previous day and the status of all program consumers; 2) review the service contacts which are scheduled to be completed during the current day and revise as needed; 3) assign staff to carry out the day's service activities; and 4) revise treatment plans and plan for emergency and crisis situations as needed. The daily log and the daily staff assignment schedule are used during the meeting to facilitate completion of these tasks. If a staff member is unable to be physically present at the meeting due to extenuating circumstances, he/she may participate in the discussions through telephone, video conferencing, or any other means of communication.

**Daily Staff Assignment Schedule** is a written, daily timetable summarizing all consumer treatment and service contacts to be divided and shared by staff working on that day. The daily staff assignment schedule will be developed from a central file of all weekly consumer schedules.

**Dartmouth Assertive Community Treatment Scale (DACTS)** is a research-based instrument developed to assess the fidelity of programs to the ACT model. OMHSAS will identify the version of DACTS for use in assessing fidelity to the ACT model, which at the time of this bulletin's publication is the Washington-DACTS (WA-DACTS) and is being piloted by the State of Washington across multiple sites nationally. Once the final version of the WA-DACTS becomes available, OMHSAS will distribute it to the counties, providers, and managed care organizations.

**Full Time Equivalent (FTE)** means (in the context of this bulletin) an employee, or more than one employee who work(s) the time equivalent to 40 hours per week.

**Homeless Individual (literally homeless)** is an individual who lives outdoors (street, abandoned or public building, automobile etc.), or whose primary residence during the night is a supervised public or private facility that provides temporary living accommodations (short-term shelter).

**Homeless Individual (at imminent risk of being homeless)** should meet at least one of the following criteria: doubled-up living arrangement where the individual's name is not on the lease, living in a condemned building without a place to move, arrears in rent/utility payments with no ability to pay, having received an eviction notice without a place to move, living in temporary or transitional housing that carries time limits, being discharged from a health care or criminal justice institution without a place to live.

**Individual Treatment Team (ITT)** is a group or combination of minimum of three to five ACT staff members who together have a range of clinical and rehabilitation skills and expertise. The ITT

members are assigned to work with a consumer by the team leader and the psychiatrist by the time of the first treatment planning meeting or thirty days after admission. The core members are the service coordinator, the psychiatrist, and one clinical or rehabilitation staff person who backs up and shares case coordination tasks and substitutes for the service coordinator when he or she is not working. The individual treatment team has continuous responsibility to: 1) be knowledgeable about the consumer's life, circumstances, goals and desires; 2) collaborate with the consumer to develop and write the treatment plan; 3) offer options and choices in the treatment plan; 4) ensure that immediate changes are made as a consumer's needs change; and 5) advocate for the consumer's wishes, rights, and preferences, and support the consumer in articulating their goals and plans. The ITT is responsible to provide much of the consumer's treatment, rehabilitation, and support services. Individual treatment team members are assigned to take separate service roles with the consumer as specified by the consumer and the ITT in the treatment plan.

**Individual Supportive Therapy and Psychotherapy** are verbal therapies that help people make changes in their feelings, thoughts, and behavior in order to move toward recovery, clarify goals, and address self-stigma. Supportive therapy and psychotherapy also help consumers identify and achieve personal goals, understand and identify symptoms in order to find strategies to lessen distress and symptomatology, improve role functioning, and evaluate treatment and rehabilitative services. Current psychotherapy approaches include cognitive behavioral therapy, personal therapy, and psychoeducational therapy.

**Initial Assessment and Consumer-Centered Individualized Treatment Plan** is the initial evaluation of: 1) the consumer's mental and functional status; 2) the effectiveness of past treatment; and 3) the current treatment, rehabilitation, and support service needs. The results of the information gathering and analysis are used to establish the initial treatment plan to support recovery and help the consumer achieve individual goals. Completed the day of admission, the consumer's initial assessment and treatment plan guide team services until the comprehensive assessment and treatment plan are completed.

**Medication Distribution** is the physical act of giving medication to ACT program consumers by the prescribed route which is consistent with state law and the licenses of the professionals qualified to prescribe, order, store, and administer medication.

**Medication Management** is a collaborative effort between the consumer and the psychiatrist with the participation of the Individual Treatment Team (ITT) to: 1) carefully evaluate the consumer's previous experience with psychotropic medications and side-effects; 2) identify and discuss the benefits and risks of psychotropic and other medication; 3) choose a medication treatment; and 4) establish a method to prescribe and evaluate medication according to evidence-based practice standards. The goal of medication management is consumer self-medication management.

**Mental Health Advance Directive** is a written document that describes a consumer's advance directions and preferences for treatment in the event that the consumer's mental illness makes him/her unable to make decisions.

**Mental Health Professional** is a person trained in a generally recognized clinical discipline including, but not limited to, psychiatry, social work, psychology, nursing, rehabilitation, counseling, or activity therapies who has a graduate degree and at least two years clinical experience.

**Peer Support** is supportive intervention provided by a certified peer specialist (CPS) who has experience as a recipient of mental health services for serious mental illness. Drawing on common experiences as well as using and sharing his/her own practical experiences and knowledge gained as a recipient, a certified peer specialist can validate consumers' experiences. A certified peer specialist can provide guidance and encouragement to consumers to take responsibility and actively participate in their own recovery.

**Psychiatric and Social Functioning History Time Line** is a format or system which helps ACT staff to chronologically organize information about significant events in a consumer's life, their experience with mental illness, and their treatment history. This format allows staff to more systematically

analyze and evaluate the information with the consumer, to formulate hypotheses for treatment with the consumer, and to determine appropriate treatment and rehabilitation approaches and interventions with the consumer.

**Psychotropic Medication** is any drug used to treat, manage, or control psychiatric symptoms or disordered behavior, including but not limited to antipsychotic, antidepressant, mood-stabilizing or anti-anxiety agents.

**Recovery** is defined by OMHSAS as a self-determined and holistic journey that people undertake to heal and grow. Recovery is facilitated by relationships and environments that provide hope, empowerment, choices and opportunities that promote people reaching their full potential as individuals and community members.

**Shift Manager** is the individual (assigned by the team leader) in charge of developing and implementing the daily staff assignment schedule, making all daily assignments; ensuring that all daily assignments are completed or rescheduled, and managing all emergencies or crises that arise during the course of the day. This is done in consultation with the team leader and the psychiatrist.

**Stakeholder Advisory Committee** supports and enhances the local ACT team through assistance with start-up, implementation and on-going operations. The committee membership should be representative of the populations served by the ACT team, and should also include representation from various stakeholder groups in the community. At least 51% of the committee shall be comprised of the recipients (or former recipients) of mental health services and family members.

**Wellness Recovery Action Plan (WRAP)** is a tool designed for self-management of illness and wellness. WRAP should be facilitated only by those who have completed Copeland Center approved training.

**Weekly Consumer Schedule** is a written schedule of the specific interventions or service contacts (i.e., by whom, when, for what duration, and where) which fulfill the goals and objectives in a given consumer's treatment plan. The individual treatment team (ITT) shall maintain an up-to-date weekly consumer contact schedule for each consumer per the consumer-centered individualized treatment plan.