

ATTACHMENT B

STANDARDS AND GUIDELINES

This section establishes the standards for the provision of Assertive Community Treatment programs. These standards are consistent with the National Program Standards for ACT Teams and prescribe the minimum requirements for ACT program start-up and implementation. Successful ACT model implementation and demonstrated improvements in consumer outcome are best accomplished by close adherence to the ACT Standards.

SECTION I: GENERAL PROVISIONS

Service Description: ACT is a service delivery model for providing comprehensive community-based treatment to persons with serious mental illness. It is a self-contained mental health program made up of a multidisciplinary mental health staff, including a peer specialist, who work as a team to provide the majority of treatment, rehabilitation, and support services consumers need to achieve their goals. The most current version of the Dartmouth Assertive Community Treatment Scale (DACTS), as identified by OMHSAS, is the instrument that will be used to assess the fidelity of the programs to the ACT model. DACTS quantifies the requirements related to the team's organization, structure, and provision of direct services. For example, to meet the fidelity requirement for rehabilitation services, at least 90% of the consumers in need of rehabilitation services shall receive those services from the team, rather than from an external provider. ACT services are targeted to individuals with serious mental illnesses that cause symptoms and impairments in basic mental and behavioral processes. Consumers are not excluded from ACT services because of severity of illness, disruptiveness in the community or in the hospital, or failure to participate in or respond to traditional mental health services. ACT services are individually tailored for each consumer through relationship building, individualized assessment and planning, and active involvement with consumers to enable each to find and live in their own residence, to find and maintain work in community jobs, to better manage symptoms, to achieve individual goals, and to maintain optimism and recover. The ACT team should be a strong advocate for consumer's self-determination and independence in day-to-day activities.

Organization: The ACT team shall be organized or identified as a separate service within the organization of the agency. To deliver the type and intensity of services to achieve positive clinical outcomes for consumers, sufficient numbers of personnel is essential to maintain the required staff-to-consumer ratio.

Consistent with the concept of urban and rural teams in the National ACT Standards, this bulletin defines two sizes of ACT teams. For the purpose of clarity of definitions, urban and rural teams are designated as Full-size teams and Modified teams respectively.

- Full-size team (Urban)
- Modified team (Rural)

Modified teams may be developed in areas where there are fewer consumers with serious mental illness who can benefit from the program. In this construct, it may not be practical to maintain a full size team. However, if there are sufficient numbers of consumers in a rural area, the ACT team should be a full-size team. Modified teams may also be developed as specialty teams in urban or rural settings to serve targeted groups of consumers eligible for ACT (examples: ACT teams for forensics consumers, homeless persons, older adults, etc.)

Organizational and staffing requirements vary for full-size and modified teams as outlined below:

The **full-size team** shall employ a minimum of 10 and up to 12 Full Time Equivalent (FTE) multidisciplinary clinical staff persons (excluding the psychiatrist), including the team leader, 1 FTE peer specialist, and other required staff (as described in *Section V: Staff Requirements*). The team shall provide 32 hours of psychiatrist time per week for every 100 consumers on the team. In

addition, the team should have 1 to 1.5 FTE program assistants that do not count in the minimum number of multidisciplinary clinical staff positions.

The **modified team** shall employ a minimum of 7 and up to 8 FTE multidisciplinary clinical staff persons (excluding the psychiatrist), including one team leader, 1 FTE peer specialist, and other required staff (as described in *Section V: Staff Requirements*). The team shall provide 16 hours of psychiatrist time per week for every 50 consumers on the team. In addition, the team should have 1 FTE program assistants that do not count in the minimum number of multidisciplinary clinical staff positions.

For both full-size as well as modified teams, the psychiatrist and the program assistant positions are not counted in the minimum number of multidisciplinary clinical staff positions.

The staff-to-consumer ratio of full-sized ACT teams shall not exceed 1:10, excluding the psychiatrist and the program assistant. New teams that are building their caseloads shall still maintain sufficient staff to cover all the shifts. The recommended maximum number of consumers in a full-size team is 100, and under no circumstances shall the team serve more than 120 consumers. For modified teams, the staff to consumer ratio shall not exceed 1:8, excluding the psychiatrist and the program assistant. The recommended maximum number of consumers in a modified team is 50, and under no circumstances shall the team serve more than 64 consumers. A modified team may be expanded to become a full-size team if the team identifies opportunities and resources for serving more consumers. Teams serving more than the recommended maximum number of consumers shall provide at least 1.6 hours of additional psychiatrist time for every five additional consumers. Staff to Consumer ratios should take into account the severity/complexity of the populations served and may need to be adjusted to a lower ratio (fewer consumers per staff) based upon need. This means that a full-size team may need to have a staff to consumer ratio lower than 1:10, and a modified team may need to have a ratio lower than 1:8, if the severity/complexity of the populations served warrants it.

SECTION II: ELIGIBILITY

Provider Participation: All ACT programs will be licensed/approved by the Office of Mental Health and Substance Abuse Services (OMHSAS). Additionally, the ACT provider shall complete a PROMISE enrollment application and list each service location that will be performing ACT. The PROMISE enrollment application can be found at:

<http://www.dpw.state.pa.us/omap/promise/enroll/omappromiseenroll.asp>.

Consumer Eligibility: Following are the eligibility requirements for Assertive Community Treatment Services:

Adults, 18 years of age or older, who have serious and persistent mental illness. A person shall be considered to have a serious and persistent mental illness when all of the following criteria for diagnosis, treatment history, and functioning level are met.

A. Diagnosis: Primary diagnosis of schizophrenia or other psychotic disorders such as schizoaffective disorder, or bipolar disorder as defined in the Diagnostic and Statistical Manual of Mental Disorders (DSM IV-R or any subsequent revisions thereafter). Individuals with a primary diagnosis of a substance use disorder, mental retardation, or brain injury are not the intended consumer group;

AND

B. Functioning level: Global Assessment of Functioning Scale (as specified in DSM IV-R or revisions thereafter) ratings of 40 or below;

AND

C. Consumers who meet at least two of the following criteria:

- a. At least two psychiatric hospitalizations in the past 12 months or lengths of stay totaling over 30 days in the past 12 months that can include admissions to the psychiatric emergency services;
- b. Intractable (i.e., persistent or very recurrent) severe major symptoms (e.g., affective, psychotic, suicidal);
- c. Co-occurring mental illness and substance use disorders with more than six months duration at the time of contact;
- d. High risk or recent history of criminal justice involvement which may include frequent contact with law enforcement personnel, incarcerations, parole or probation;
- e. Literally homeless, imminent risk of being homeless, or residing in unsafe housing;
- f. Residing in an inpatient or supervised community residence, but clinically assessed to be able to live in a more independent living situation if intensive services are provided, or requiring a residential or institutional placement if more intensive services are not available;

AND

D. Difficulty effectively utilizing traditional case management or office-based outpatient services, or evidence that they require a more assertive and frequent non-office based service to meet their clinical needs.

An individual who needs to receive ACT services, but who does not meet the requirements identified above may be eligible for ACT services upon written prior approval by the Behavioral Health Managed Care Organization or the County MH/MR Office, as applicable. In order to meet the DACTS fidelity standard related to admission criteria, at least 90% of the consumers admitted to the program shall meet the eligibility criteria outlined in the bulletin.

Discharge: The programs shall not have any arbitrary time limits for clients admitted to the program and the team shall remain the point of contact for all clients indefinitely as needed. The service shall have a “no drop out” policy and work to retain clients at a mutually satisfactory level. In order to meet the DACTS fidelity standards for consumer retention, at least 95% of the caseload has to be retained over a 12 month period. Discharges from the ACT team may occur when consumers and program staff mutually agree to the termination of services. This shall occur when consumers:

- A. Have successfully reached individually established goals for discharge, and when the consumer and program staff mutually agree to the termination of services.
- B. Have successfully demonstrated an ability to function in all major role areas (i.e., work, social, self-care) without ongoing assistance from the program, without significant relapse when services are withdrawn, and the consumer requests for the termination of services. When consumers are discharged to lower levels of care, based on a careful assessment of their readiness and on mutual agreement, the process should involve a gradual transition period, including at least 30 days of overlap of responsibility for monitoring the consumer’s status and progress. The consumers should also have the option to re-enroll in the ACT team. Even after the transition period has ended, the ACT team should periodically monitor the consumers’ engagement with the new program until the consumers are assessed to have fully and successfully engaged with the new program.
- C. Move outside the geographic area of the ACT team’s responsibility. In such cases, the ACT team shall arrange for transfer of mental health service responsibility to an ACT program or other provider within the consumer’s new geographic location. The

ACT team shall maintain contact with the consumer until this service transfer is implemented.

- D. If an individual declines or refuses services and requests discharge despite the team's persistent and caring attempts to engage the individual in treatment, discharge or transfer to a lower level of care should not occur automatically. In such situations, a thorough review of the circumstances, the clinical situation, the risk factors, and strategies to reengage the individual shall be reviewed and documented before discharge is considered.

SECTION III: RESPONSIBILITIES

Responsibilities of County Administrators: County Mental Health Administrators in partnership with their Managed Care Organization are responsible for identifying the need for Assertive Community Treatment services and for developing a program and fiscal plan to address that need. County Administrators shall ensure that the latest version of the Dartmouth Assertive Community Treatment Scale (DACTS), as stipulated by OMHSAS, is completed annually for each ACT team either by the Managed Care Organization or a consultant familiar with the DACTS fidelity tool. The results of the most recent DACTS shall be made available to OMHSAS. OMHSAS field office staff will monitor the compliance of ACT providers under their jurisdiction with the provisions of these guidelines and standards. The County Administrators and Managed Care Organizations are also responsible for providing fiscal and program outcome reports as requested by OMHSAS.

Responsibilities of Providers: Providers shall adhere to the requirements set forth in these guidelines and submit reports as required by the Department and the County Administrator. The ACT team shall maintain written admission and discharge policies and procedures. The ACT provider agency has the responsibility to write policies and procedures for each of the areas identified in the standards. Once policies and procedures are in place, they maintain the organizational and services structure that supports the work and are useful in orienting and training new staff.

The Providers shall utilize systems to collect and analyze data pertaining to the ACT program that include data required to complete annually the latest version of the DACTS fidelity scale stipulated by OMHSAS. This system shall be capable of measuring outcomes, and the data analysis results from the system shall be used to improve services and processes.

The ACT programs provide intensive services to consumers in community settings. The ACT Standards not only establish a minimum staff-to-consumer ratio but also establish the minimum number of staff required to cover the shifts, set the frequency of staff services contacts with consumers, and require gradual admission of consumers to the team. The following guidelines establish the responsibilities of the providers:

- A. Each ACT team shall have the organizational capacity to provide a minimum staff-to-consumer ratio of at least one full-time equivalent (FTE) staff person for every 10 consumers (not including the psychiatrist and the program assistant) for a full-size team. Modified teams shall have the organizational capacity to provide a minimum staff-to-consumer ratio of at least one full-time equivalent (FTE) staff person for every 8 consumers (not including the psychiatrist and the program assistant). The staff-to-consumer ratio may need to be adjusted to a lower ratio in settings where the consumers are consistently acutely ill, have spent long periods of time in institutional settings, are being released from correctional settings, or have complicating medical conditions that require more service contacts.
- B. Each ACT team shall have sufficient numbers of staff to provide treatment, rehabilitation, and support services 24 hours a day, seven days per week. Staff coverage is a different measurement of service intensity than staff-to-consumer ratio and is very important to successful ACT implementation. Staff coverage gets at the critical mass of ACT staff needed to cover the 24 hours. Sufficient numbers of staff, as outlined in the "Organizational Requirements" of this bulletin is necessary to: 1) staff two overlapping 8-hour shifts operating a minimum of 12 hours per day on

weekdays; 2) staff one 8-hour shift each weekend day and holidays; 3) schedule staff for on-call duty to provide services beyond the shift hours; and 4) have psychiatric backup available all hours the psychiatrist is not regularly scheduled to work.

- C. When a modified team does not have sufficient staff numbers to operate the second shift on weekdays and one 8-hour shift on weekends/holidays, staff should be regularly scheduled to provide the necessary services on a consumer-by consumer basis (per the consumer-centered comprehensive assessment and the individualized treatment plan) in the evenings and on weekends. In addition, the modified ACT team staff should provide crisis services at least during regular work hours. The crisis intervention service staff should be expected to go out and personally see consumers who need face-to-face contact. For locations that do not have adequate crisis intervention services, appropriate steps will have to be taken by the ACT team to implement their own system.
- D. The staff size may need to be adjusted to a larger number in settings where the consumers are consistently acutely ill, have spent long periods of time in institutional settings, are being released from correctional settings, or have complicating medical conditions.
- E. The ACT team should systematically identify need for assertive engagement strategies, use motivational interventions, and employ therapeutic limit setting interventions only when needed.
- F. The ACT team shall have the capacity to provide multiple contacts a week with consumers experiencing severe symptoms, trying a new medication, experiencing a health problem or serious life event, trying to go back to school or starting a new job, making changes in living situation or employment, or having significant ongoing problems in daily living. These multiple contacts may be as frequent as two to three times per day, seven days per week and depend on consumer need and a mutually agreed upon plan between consumers and program staff. Many, if not all, staff shall share responsibility for addressing the needs of all consumers requiring frequent contact. The ACT team shall have the capacity to rapidly increase service intensity to a consumer when his or her status requires it, or when requested by a consumer.
- G. The ACT team shall provide an average of three face-to-face contacts per week across all consumers (total number of face-to-face contacts per week for all consumers divided by number of consumers).
- H. The ACT team shall provide an average of two hours of face-to-face contacts per week across all consumers (total hours of face-to-face contacts per week for all consumers divided by number of consumers).
- G. ACT varies the intensity of service to meet the changing needs of consumers with serious mental illness, to support consumers in normal community settings, and to provide a sufficient level of service as an alternative to the consumer needing to be hospitalized to receive that level of care. This is a radical departure from how traditional services are organized. ACT services are delivered continuously and "titrated," meaning that when a consumer needs more services, the team provides them. Conversely, when the consumer needs fewer services, the team lessens service intensity.
- H. The ACT team shall provide ongoing contact for consumers who are hospitalized for substance abuse or psychiatric reasons. To assist the continuity of care of those consumers, the ACT team shall: a) assist in admission process; b) make contact with the consumer and inpatient provider within 48 hours of knowing of the inpatient admission to provide information, conduct appropriate assessment, assist with consumer's needs, and to begin discharge planning; c) maintain at least weekly face-

to-face contact with the consumer and the inpatient treatment team staff; d) transition the consumer from the inpatient setting to the community; and e) maintain at least three face-to-face contacts per week for one month following discharge.

- I. Each new ACT team shall stagger consumer admissions, admitting no more than 6 consumers per month. The teams should gradually build up capacity to serve the maximum recommended number of consumers, which is 100 consumers for a full-size team, and 50 consumers for a modified team. Under no circumstances shall the maximum number of consumers admitted exceed 120 for a full-size team, and 64 for a modified team. The ACT team follows a systematic process in beginning to work with individual consumers which includes screening consumers referred for admission; arranging and having an admission meeting to begin to establish a relationship with each consumer and their family; conducting an initial assessment and establishing an initial treatment plan in collaboration with each consumer and their family; providing immediate treatment, rehabilitation and support services; and conducting the comprehensive assessment and establishing the first individualized treatment plan with each consumer, all of which takes time to carry out. Therefore, the consumers shall be admitted gradually rather than starting out at full capacity. Due to smaller team size and geographical distances, admission rates of modified teams may need to be lower than a full-size team.
- J. ACT teams shall not use telephone answering devices as a primary method to receive calls. ACT consumers shall have direct phone access to the ACT office Monday through Friday, 8.00 AM to 5.00 PM. The program assistant or other ACT team members shall be available to answer all incoming calls. ACT team members shall be scheduled for on-call duty to provide crisis and other services after the regular shift hours.
- K. Since ACT is a self-contained mental health program, the ACT team shall have adequate procedural safeguards to ensure that services are not duplicated with consumers independently seeking services outside of the ACT program. As part of the procedural safeguards, the ACT team shall establish collaborative agreements with emergency/crisis services and other providers of mental health services in the county of their operation.
- L. Individuals who are being considered to be admitted to the ACT program should be screened for disorders such as brain injury before they are admitted to the program. This screening is done to ensure that individuals with the primary diagnosis of brain injury, who are not the intended target group for ACT services, are not erroneously admitted to the program. Links to tools for screening for brain injury are included in the "Resources" Section of this bulletin.
- M. The ACT team (or its organizational representative) shall actively recruit new consumers who could benefit from ACT from referral sources that commonly serve individuals who meet the ACT admission criteria.

SECTION IV: PROGRAM ORGANIZATION AND COMMUNICATION

Hours of Operation and Staff Coverage

- A. Full-size Teams: The ACT team shall be available to provide treatment, rehabilitation, and support activities seven days per week including holidays. This means:
 - a. Regularly operating and scheduling staff Monday thru Friday to work two overlapping 8-hour shifts for a total of 12 hours of coverage per day, with a minimum of 2 staff in the last four hours of operation;

- b. Regularly operating and scheduling staff to work one 8-hour shift with a minimum of 2 staff each weekend day and every holiday;
 - c. Regularly scheduling ACT staff for on-call duty to provide crisis and other services the hours when staff are not working. ACT team staff who are experienced in the program and skilled in crisis-intervention procedures shall be on call and available to respond to consumers by telephone or in person;
 - d. Regularly arranging for and providing psychiatric backup all hours the psychiatrist is not regularly scheduled to work. If availability of the ACT psychiatrist during all hours is not feasible, alternative psychiatric backup should be arranged (e.g., mental health center psychiatrist, emergency room psychiatrist).
- B. Modified Teams: The ACT team shall be available to provide treatment, rehabilitation, and support activities seven days per week. When a modified team does not have sufficient staff numbers to operate the second shift on weekdays and one 8-hour shift on weekends/holidays, staff should be regularly scheduled to provide the necessary services on a consumer-by-consumer basis (per the consumer-centered comprehensive assessment and the individualized treatment plan) in the evenings and on weekends/holidays.

A modified team shall regularly schedule ACT staff for on-call duty to provide crisis and other services for the hours when staff are not working. ACT team staff who are experienced in the program and skilled in crisis-intervention procedures shall be on call and available to respond to consumers by telephone or in person.

A modified team shall regularly arrange for and provide psychiatric backup for all hours the psychiatrist is not regularly scheduled to work. If availability of the ACT psychiatrist during all hours is not feasible, alternative psychiatrist backup should be arranged (e.g., mental health center psychiatrist, emergency room psychiatrist).

Place of Treatment

Each full-size ACT team shall provide at least 75 percent of service contacts in the community in non-office-based (office-based includes telephone contacts also) or non-facility-based settings, while each modified team shall provide 85 percent of services in the community in non-office based or non-facility based settings. Data regarding the percentage of consumer contacts in the community will be collected and reviewed to verify that goals are being met as part of the program's Continuous Quality Improvement (CQI) plan.

An essential ingredient in the way that services are delivered in the ACT program is "assertive outreach." The majority of treatment and rehabilitation interventions take place "in the community," that is, in the consumer's own place of residence and neighborhood, at employment sites in the community, and in the same sites of recreation and leisure activities that all citizens use (e.g., parks, movie houses, and restaurants). The rationale for use of assertive outreach is to enable the provision of psychosocial services where consumers need to use them. The latter factor eliminates the need for transfer of learning, which has been difficult to achieve for many persons with serious mental illnesses.

Staff Communication and Planning

- A. The ACT team shall conduct daily organizational staff meetings at regularly scheduled times per a schedule established by the team leader. These meetings will be conducted in accordance with the following procedures:
 - a. The ACT team shall maintain a written daily log which will provide:
 - I. A roster of the consumers served in the program, and

- II. For each consumer, a brief documentation of any treatment or service contacts that have occurred during the last 24 hours and a concise, behavioral description of the consumer's status that day.
 - b. The daily organizational staff meeting shall commence with a review of the daily log to update staff on the treatment contacts which occurred the day before and to provide a systematic means for the team to assess the day-to-day progress and status of all consumers.
 - c. ACT team, under the direction of the team leader, shall maintain a weekly consumer schedule for each consumer. The weekly consumer schedule is a written schedule of all treatment and service contacts that staff shall carry out to fulfill the goals and objectives in the consumer's treatment plan. The team will maintain a central file of all weekly consumer schedules.
 - d. The ACT team, under the direction of the team leader, shall develop a daily staff assignment schedule from the central file of all weekly consumer schedules. The daily staff assignment schedule is a written timetable for all the consumer treatment and service contacts and all indirect consumer work (e.g., medical record review, meeting with collaterals (such as employers, social security), job development, treatment planning, and documentation) to be done on a given day, to be divided and shared by the staff working on that day.
 - e. The daily organizational staff meeting will include a review by the shift manager of all the work to be done that day as recorded on the daily staff assignment schedule. During the meeting, the shift manager will assign and supervise staff to carry out the treatment and service activities scheduled to occur that day, and the shift manager will be responsible for assuring that all tasks are completed.
 - f. During the daily organizational staff meeting, the ACT team shall also revise treatment plans as needed, plan for emergency and crisis situations, and add service contacts to the daily staff assignment schedule per the revised treatment plans.
- B. The ACT team shall conduct treatment planning meetings under the supervision of the team leader and the psychiatrist. Consumers should be encouraged to attend these meetings. These treatment planning meetings shall:
 - a. Convene at regularly scheduled times per a written schedule set by the team leader.
 - b. Occur and be scheduled when the majority of the team members can attend, including the psychiatrist, team leader, and all members of the Individual Treatment Team (ITT).
 - c. Require individual staff members to present and systematically review and integrate consumer information into a holistic analysis and prioritize issues.
 - d. Occur with sufficient frequency and duration to make it possible for all staff: 1) to be familiar with each consumer and their goals and aspirations; 2) to participate in the ongoing assessment and reformulation of issues/problems; 3) to problem-solve treatment strategies and rehabilitation options; 4) to participate with the consumer and the ITT in the development and the revision of the treatment plan; and 5) to fully understand the treatment plan rationale in order to carry out each consumer's plan.

Staff Supervision

Each ACT team shall develop a written policy for clinical supervision of all staff providing treatment, rehabilitation, and support services. The team leader, psychiatrist, and/or their designee (the

designee shall be a current member of the team and shall meet the qualifications to be a team leader as outlined in *Section V: Staff Requirements*) shall assume responsibility for supervising and directing all staff activities. This supervision and direction shall consist of:

- A. Individual, side-by-side sessions in which the supervisor accompanies an individual staff member to meet with consumers in regularly scheduled or crisis meetings to assess staff performance, give feedback, and model alternative treatment approaches;
- B. Participation with team members in daily organizational staff meetings and regularly scheduled treatment planning meetings to review and assess staff performance and provide staff direction regarding individual cases;
- C. Regular meetings with individual staff to review their work with consumers, assess clinical performance, and give feedback;
- D. Regular reviews, critiques, and feedback of staff documentation (i.e., progress notes, assessments, treatment plans, community support plan reviews / treatment plan reviews); and,
- E. Written documentation of all clinical supervision provided to ACT team staff.

The ACT team shall maintain written program organization policies and procedures, including required hours of operation and coverage, staff communication and planning, emphasis on team approach, and staff supervision, as outlined in this section.

SECTION V: STAFF REQUIREMENTS

The following table outlines the minimum staff requirements:

Position	Full-size	Modified
Team leader	1 FTE	1 FTE
Psychiatrist	32 Hours/week for 100 consumers	16 Hours/week for 50 consumers
Registered Nurse	3 FTE	2 FTE
Peer Specialist	1 FTE	1 FTE
* Master's level	4 FTE (in addition to the Team Leader)	2 FTE (in addition to the Team Leader)
* Other level	1-3 FTE	1-2 FTE
Program/Administrative Assistant	1-1.5 FTE	1 FTE

* "Master's" level and "Other" level clinicians fill various clinical positions in the team, including those of Vocational Specialist, Substance Abuse Specialist, as well as other required/recommended positions described in this Section.

Team Leader: A full-time team leader/supervisor who is the clinical and administrative supervisor of the team and who also functions as a practicing clinician on the ACT team. Practicing clinician means that the team leader is a competent clinician, who leads consumer-centered assessment and individualized treatment planning by working side-by-side with the consumer and team members. The team leader shall be a Mental Health Professional as defined in Attachment A (Definitions) of this bulletin, or is a psychiatrist. The team leader shall also have a minimum of two years of administrative/supervisory experience and shall be a certified peer specialist supervisor. Individuals who are not certified peer specialist supervisors at the time of hire shall obtain the certification within six months of hire. Also, if a team leader in an existing ACT team is not a certified peer specialist

supervisor, he/she shall obtain the certification within six months from the effective date of this bulletin. In addition to providing administrative oversight to the team, the team leader will also serve the following functions:

- a) Provide direct services at least 10 hours weekly;
- b) Provide formal group supervision at least once every two weeks and provide formal individual supervision at least once every two weeks to each team member who provides direct services to consumers (other than the psychiatrist).

Psychiatrist: A licensed psychiatrist, who works on a full-time basis for a minimum of 32 hours (0.8 FTE) for a 100-consumer full-size team, or on part-time basis for a minimum of 16 hours (0.4 FTE) per week for a 50-consumer modified team. It is recommended that the psychiatrist has one year of experience in providing treatment to consumers diagnosed with a co-occurring substance use disorder. For modified teams, one person shall fill the psychiatrist FTE; and for full-size teams, it is preferred that the FTE be filled by one single individual. If two individuals share the FTE in a full-size team, a mechanism to ensure adequate communication between the psychiatrists shall be in place. The full-size team may also be rated as not fully meeting the psychiatrist fidelity requirement if more than one individual fills the FTE (the fidelity evaluation will consider the extent to which the psychiatrists work together to ensure compliance with the requirements listed below).

The psychiatrist will provide the following treatment services:

- a) Clinical services to all ACT consumers;
- b) Work with the team leader to monitor each consumer's clinical status and response to treatment;
- c) Provide at least monthly assessment of consumer's symptoms and response to medications, including side effects;
- d) Supervise staff delivery of services;
- e) Monitor all consumers' non-psychiatric medical conditions and non-psychiatric medications;
- f) Provide medication education;
- g) Conduct home visits;
- h) Communicate directly with consumers' inpatient psychiatric prescriber when consumers are hospitalized (to ensure continuity of care);
- i) Direct psychopharmacologic and medical services.

Additionally, as a team member, the psychiatrist will perform the following functions:

- a) Supervise the psychiatric treatment of consumers on the team;
- b) Regularly participate in daily staff organizational meetings and treatment planning meetings;
- c) Direct the operation of the medication and medical services by actively collaborating with the registered nurses on the team;
- d) Educate non-medical staff on medications and their side effects;
- e) Provide psychiatric backup during program after-hours and weekends.

Even though the psychiatrist may work part-time, it is very important that the psychiatrist have designated hours when he or she is working on the team. The psychiatrist's hours should be sufficient blocks of time on consistent days in order to carry out his or her clinical, supervisory, and administrative responsibilities. It is also necessary to arrange for and provide psychiatric backup all hours the psychiatrist is not regularly scheduled to work. If availability of the psychiatrist during all hours is not feasible, alternative psychiatric backup shall be arranged (e.g., mental health center psychiatrist, emergency room psychiatrist).

Registered Nurses: On a full-size team, at least 3 FTE registered nurses and on a modified team, 2 FTE registered nurses. A team leader with a nursing degree cannot replace one of the FTE nurses. The registered nurses shall have experience working with persons with mental illness and shall perform the following functions in collaboration with the psychiatrist:

- a. Manage the medication system, administer and document medication treatment;

- b. Screen consumers for medical problems/side effects;
- c. Communicate and coordinate services with other medical providers;
- d. Engage in health promotion, prevention, and education activities;
- e. Provide training to other team members to help them monitor psychiatric symptoms, and; medication side effects;
- f. When consumers are in agreement, develop strategies to maximize the taking of medications as prescribed (medication drops, behavioral tailoring, etc.).

Master's Level Mental Health Professionals: On a full-size team, a minimum of 4 FTE master's level or above mental health professionals in addition to the team leader. Please see Attachment A of this bulletin for the definition of Mental Health Professional. On a modified team, there shall be a minimum of 2 FTE master's level or above mental health professionals in addition to the team leader. It is recommended that at least one of the Master's level mental health professionals (in full-size as well as modified teams) have a graduate degree in social work.

Substance Abuse Specialist: One or more Substance Abuse Specialists having full certification as an addictions counselor or a co-occurring disorders professional by a statewide certification body which is a member of a National Certification Body, or certified by another state government's certification board, shall be designated the role of substance abuse specialist(s).

The ACT team shall provide most of the substance abuse treatment services for consumers with serious mental illness and co-existing substance abuse disorders. The most effective assessment and treatment approaches employ an integrated treatment model in which mental health and substance abuse treatment are provided simultaneously. The Substance Abuse Specialist provides integrated, stage-wise treatment as the lead clinician for assessing, planning, and treating substance use disorders. Core treatment services provided by the Substance Abuse Specialist include, but are not limited to:

- a) Systematic and integrated screening and assessment;
- b) Interventions that are tailored to those in early stages of change readiness (e.g., outreach, motivational interviewing);
- c) Interventions tailored to those in later stages of change readiness (e.g., cognitive behavioral therapy, relapse prevention).

Additionally, the Substance Abuse Specialist will perform the following functions within the team:

- a. Modeling skills and individual consultation;
- b. Cross-training other staff to help them identify substance use issues, monitor progress in treatment, and provide stage-wise treatment for dual disorders;
- c. Attending all daily organizational staff meetings; and
- d. Attending all treatment planning meetings for consumers with dual disorders.

Peer Specialist: A minimum of one FTE certified peer specialist with full professional status on either a full-size team or a modified team. No more than two peer specialists shall fill this FTE. Any uncertified peer specialists currently employed by any existing ACT team shall obtain the peer specialist certification within six months from the effective date of this bulletin. A person who is or has been a recipient of mental health services for serious mental illness holds this position. Because of life experience with mental illness and mental health services, the peer specialist provides expertise that professional training cannot replicate. Peer specialists are fully integrated team members who provide highly individualized services in the community and promote consumer self-determination and decision-making. Peer specialists also provide essential expertise and consultation to the entire team to promote a culture in which each consumer's point of view and preferences are recognized, understood, respected and integrated into treatment, rehabilitation, and community self-help activities. The peer specialists shall be provided the required support they need to maintain their prescribed specialized roles. The peer specialist will perform the following functions:

- a. Coaching and consultation to consumers to promote recovery and self-direction;
- b. Training consumers in the use of WRAP and/or other wellness management strategies;

c. Modeling and cross-training of other team members in recovery principles and strategies.

Vocational Specialist: At least one clinical staff (either Master's or other clinical staff, preferably with a degree in rehabilitation counseling) shall be designated for the role of vocational specialist for full-size as well as modified teams. The services provided by the vocational specialist to consumers include the following core aspects of the Supported Employment model:

- a) Engagement;
- b) Vocational assessment;
- c) Job development;
- d) Job placement;
- e) Job coaching and follow-along supports.

Additionally, the vocational specialist will also serve the following functions as a team member:

- a) Modeling skills and consultation;
- b) Cross-training to other staff on the team to help them to develop supported employment approaches with consumers;
- c) Attending all daily organizational meetings;
- d) Attending all treatment plan meetings for consumers with employment goals.

Other Clinical Staff: The remaining clinical staff may be bachelor's level and paraprofessional mental health workers who carry out rehabilitation and support functions. A bachelor's level mental health worker has a bachelor's degree in social work or a behavioral science, and work experience with adults with serious mental illness. A paraprofessional mental health worker may have a bachelor's degree in a field other than behavioral sciences or have a high school degree and work experience with adults with serious mental illness or with individuals with similar human-services needs. These paraprofessionals may have related training (e.g., certified occupational therapy assistant, home health care aide) or work experience (e.g., teaching) and life experience.

Other Recommendations/Requirements on Clinical Staffing

It is recommended that at least one of the clinical staff (either Master's level or other clinical staff) have experience working with the homeless population and be designated as the Housing Specialist. It is also recommended that at least one clinical staff (either Master's or other clinical staff) be a Certified Psychiatric Rehabilitation Practitioner (CPRP) certified by United States Psychiatric Rehabilitation Association (USPRA).

ACT teams serving special populations (example: forensics, older adults) should adjust the staff composition to meet the special needs of the group. As an example, ACT team for older adults should include staff with psychogeriatric training as well as additional medical personnel to better attend to the significant physical health problems that accompany aging.

Program/Administrative Assistant: The program/administrative assistant (1-1.5 FTE in a full-size setting or 1 FTE in a modified setting) is responsible for the following functions:

- a) Organizing, coordinating, and monitoring all non-clinical operations of ACT, including managing medical records;
- b) Management & coordination to daily team schedules; provision of support & assistance to staff in the field;
- c) Operating and coordinating the management information system; maintaining accounting and budget records for consumer and program expenditures; and
- d) Providing receptionist activities, including triaging calls and coordinating communication between the team and consumers/natural supports, and attending to the needs of office walk-ins.

Persons with training as Licensed Practical Nurses (LPN) or who have worked as hospital unit program assistants or administrative support staff in mental health or health care settings are recommended for this position.

Other Training Requirements: All ACT staff, with the exception of the program/administrative assistant, shall complete 12 hours of co-occurring disorder (mental health/substance abuse)-specific training, recovery/resiliency training, and training on trauma within six months of hire unless they have already had this training within the past 2 years. All ACT staff, with the exception of the program/administrative assistant, shall also complete 12 hours of annual training that includes training conducted by consumers and family members. The training should include instruction in the areas most relevant to the needs of the individuals served by the team. Although not mandated, it is recommended that the program/administrative assistant also complete 12 hours of annual training. Additionally, the ACT team should schedule on-going training and consultation, which may include visits to shadow an experienced ACT team, to effectively administer the ACT program and support fidelity to the model. Examples of areas of focus for such training/consultation may include team building, supervision, program protocols, data collection, fidelity issues and any other relevant areas.

The ACT team shall: 1) maintain written personnel policies and procedures for hiring; 2) establish core staff competencies, orientation, and training; and 3) maintain personnel files for each team member containing the job application, copies of credentials or licenses, position description, annual performance appraisals, and individual orientation and training plan.

SECTION VI: CONSUMER-CENTERED ASSESSMENT AND INDIVIDUALIZED TREATMENT PLANNING

The purpose of the entire ACT consumer-centered assessment and individualized treatment planning process is to “put the story together” side-by-side with the consumer. Mutually reviewing and learning exactly what has happened to the consumer leads to a consumer-centered plan. The consumer and the Individual Treatment Team (ITT) work together to formulate and prioritize the issues, set goals, research approaches and interventions, and establish the plan. The plan is individually tailored so that the treatment/rehabilitation/support approaches and interventions achieve optimum symptom reduction, help fulfill the personal needs and aspirations of the consumer, take into account the cultural beliefs and realities of the individual, and improve all the aspects of psychosocial functioning that are important to the consumer.

Initial Assessment

An initial assessment and treatment plan shall be done the day of the consumer’s admission to ACT by the team leader or the psychiatrist, with participation by designated team members. The initial assessment shall be based upon all available information, including self reports, reports of family members and other significant parties, and written summaries from other agencies, including police, courts, and outpatient and inpatient facilities, where applicable. The assessment should be a review of all aspects of individual’s life, including physical health, and should not be limited to mental health information only.

At a minimum, the initial assessment shall contain the following information, with strengths listed for each appropriate item:

- A. Consumer Name and date of birth
- B. Consumer telephone number
- C. Next of kin
- D. Emergency contact
- E. Date of Admission to the ACT program
- F. Social Security Number
- G. Presenting problem/consumer self-assessment of problem
- H. Reason for treatment
- I. Availability of social supports and resources
- J. History of psychiatric illness and previous services
- K. Developmental and social history
- L. Current functioning
- M. Mental Health Diagnosis (DSM IV-R or revisions thereafter)
- N. Primary Care Physician information

- O. Physical Health Diagnosis
- P. Current Med list
- Q. Justification for admission
- R. Name of the primary case manager

The initial treatment plan also known as the initial community support plan is completed on the day of admission and guides team services until the comprehensive assessment and comprehensive treatment plan are completed. Interventions from the initial treatment plan should be reported on the consumer weekly schedule. At a minimum, the initial treatment plan should contain the following information:

- A. Consumer Name
- B. Date
- C. Short Term Goals
- D. Problems to be addressed
- E. Objectives
- F. Consumer or guardian participation
- G. Consumer's signature
- H. Team leader's signature

It is recommended that service coordinator and ITT members be assigned by the team leader in collaboration with the psychiatrist at the initial treatment plan meeting. Under no circumstances shall the time frame to assign the service coordinator and ITT members exceed six weeks from the date of admission.

Comprehensive Assessment

Each part of the assessment area shall be completed by an ACT team member with skill and knowledge in the area being assessed. A team member with training and interest in the area does each part and becomes the specialist in that particular area with the consumer. The assessment is based upon all available information, including that from consumer interview/self-report, family members and other significant parties, and written summaries from other agencies, including police, courts, and outpatient/inpatient facilities, where applicable. A comprehensive assessment shall be initiated and completed within six weeks after a consumer's admission according to the following requirements:

- A. In collaboration with the consumer, the (Individual Treatment Team) ITT will complete a psychiatric and social functioning history time line. This is a format or system that helps ACT staff to organize chronologically information about significant events in a consumer's life, their experience with mental illness, and treatment history. This format helps analyze and evaluate information more systematically and formulate hypotheses for treatment, and to determine appropriate treatment and rehabilitation approaches and interventions with the consumer. Please refer to ***the 2003 edition (or any editions/revisions thereafter) of "A Manual for ACT Start-UP" by Deborah Allness and William Knodler for more information on this.***
- B. In collaboration with the consumer, the comprehensive assessment shall include an evaluation in the following areas:

Psychiatric History, Mental Status, and Diagnosis: The psychiatrist is responsible for completing the psychiatric history, mental status, and diagnosis assessment. (Using information derived from the evaluation, a psychiatrist or a clinical or counseling psychologist shall make an accurate diagnosis from those listed in the American Psychiatric Association's DSM IV-R or any later version thereof.) The psychiatrist presents the assessment findings at the first treatment planning meeting.

The psychiatric history, mental status, and diagnosis assessment is to carefully and systematically collect and assess information from the consumer, the family, and past treatment records regarding the onset, precipitating events, course and effect of illness,

including past treatment and treatment responses, risk behaviors, and current mental status. The purpose is to effectively plan with the consumer and his/her family the best treatment approach in order to ensure accuracy of the diagnosis, to eliminate or reduce symptomatology, and to improve social, vocational, and avocational functioning. The psychiatrist, in carrying out the psychiatric history, mental status, and diagnosis assessment, writes a psychiatric history narrative for the consumer's medical record.

Physical Health: A registered nurse is responsible for completing the physical health assessment. The registered nurse presents the assessment findings at the first treatment planning meeting.

Because physical health is extremely important in the management of serious mental illness, the purpose of the physical assessment is to thoroughly assess health status and any medical conditions present to ensure that appropriate treatment, follow-up, and support are provided to the consumer. The first interview to begin this assessment should take place within 72 hours of admission.

Use of Drugs and Alcohol: A team member with experience and training in dual diagnosis substance abuse assessment and treatment is responsible for completing the use of drugs and alcohol assessment. The substance abuse specialist presents the assessment findings at the first treatment planning meeting.

Education and Employment: A team member with experience and training in vocational assessment and services is responsible for completing the education and employment assessment. The vocational specialist presents the assessment findings at the first treatment planning.

Employment is very important to people with mental illness and is a normalizing structure that is helpful in symptom management. ACT excludes no one because of a poor work history or because of ongoing symptoms or impairments related to mental illness. The purpose of the education and employment assessment is to determine with the consumer, current school or employment status, interests and preferences regarding school and employment, and how symptomatology has affected previous and current school and employment performance.

Social Development and Functioning: A team member who is interested and skillful in attainment and restoration of social/interpersonal skills and relationships and who is knowledgeable about human development is responsible for completing the social development and functioning assessment. The team member who does the assessment presents the assessment findings at the first treatment planning meeting.

The purpose of the social development and functional assessment is to obtain information from the consumer about his or her childhood, early attachments, role in family of origin, adolescent and young adult development, culture, religious beliefs, leisure activities, interests, and social skills. This enables the ACT team to evaluate how symptomatology has interrupted or affected personal and social development. It also collects information regarding the consumer's involvement with the criminal justice system. In addition, it identifies social and interpersonal issues appropriate for supportive therapy.

Activities of Daily Living (ADL): Occupational therapists and nurses are responsible to complete the ADL assessment because team members in these professions have training to conduct ADL assessments. Other staff members with training to do the assessment and who have interest in and compassion for consumers in this area may complete the ADL assessment. The team member who does the assessment presents the assessment findings at the first treatment planning meeting.

The purpose of the activities of daily living assessment is to evaluate the individual's current ability to meet basic needs (e.g., personal hygiene, adequate nutrition, medical care); the quality and safety of the consumer's current living situation; the adequacy of the consumer's

financial resources; the effect that symptoms and impairments of mental illness have had on self-care; the consumer's ability to maintain an independent living situation, and the consumer's desires and individual preferences. This enables the ACT team to determine the level of assistance, support, and resources the consumer needs to reestablish and maintain activities of daily living. Good activities of daily living (ADL) functioning are basic to successful community adjustment for persons with serious mental illness. Consistent assistance to meet ADL needs helps consumers to feel better and less vulnerable living in the community.

Family Structure and Relationships: Members of the consumer's individual treatment team (ITT) are responsible for carrying out the family structure and relationships assessment. The staff members working with the family present the assessment findings at the first treatment planning meeting.

The best way to engage families from diverse communities is to respect and work within their beliefs and values. Many consumers have children, and the consumers' ability to parent may be compromised by their mental illness. The purpose of the family structure and relationships assessment is to obtain information from the consumer's family and other significant people about their perspective of the consumer's mental illness and to determine their level of understanding about mental illness as well as their expectations of ACT services. This information allows the team to define, with the consumer, the contact or relationship ACT will have with the family in regard to the consumer's goals, treatment, and rehabilitation. This assessment is begun during the admission meeting with the consumer and the family members or significant others who are participating in the admission.

- C. While the assessment process shall involve the input of most, if not all, team members, the consumer's psychiatrist, service coordinator, and ITT members will assume responsibility for preparing the written narrative of the results and formulation of the psychiatric and social functioning history time line and the comprehensive assessment. The psychiatric and social functioning history time line and comprehensive assessment shall be completed within six weeks of the consumer's admission to the program.

Individualized Community Support Planning (Individualized Treatment Planning)

Treatment plans shall be developed within 8 weeks of admission through the following treatment planning process. ACT team shall use recovery planning tools such as the Wellness Recovery Action Plan (WRAP) process and shall incorporate the individual's recovery planning into all aspects of treatment and service planning. The ACT team shall also develop Advance Mental Health Directives with each consumer, unless the consumer declines.

- A. The community support/treatment plan shall be developed in collaboration with the consumer and the family or guardian, if any, when feasible and appropriate. The consumer's participation in the development of the treatment plan shall be documented. Together the ACT team and the consumer shall assess the consumer's needs, strengths, and preferences and develop an individualized community support/treatment plan. The community support/treatment plan shall be guided primarily by the consumer's self-selected goals and it shall 1) identify individual strengths/issues/problems; 2) set specific measurable long and short-term goals for each issue/problem; 3) establish the specific approaches and interventions necessary for the consumer to meet his or her goals, improve his or her capacity to function as independently as possible in the community, and achieve the maximum level of recovery possible (i.e., a meaningful, satisfying, and productive life).
- B. As described in Section IV, ACT team staff shall meet at regularly scheduled times for community support/treatment planning meetings. At each meeting, the following staff should attend: the team leader, the psychiatrist, the service coordinator, individual treatment team members, the peer specialist and all other ACT team members involved in regular tasks with the consumer.
- C. Individual treatment team members are responsible to ensure the consumer is actively involved in the development of recovery and service goals. With the permission of the consumer, ACT team

staff shall also involve pertinent agencies and members of the consumer's social network in the formulation of treatment plans.

- D. Each consumer's community support/treatment plan shall identify his or her issues/problems, strengths/ weaknesses, and specific measurable short term and long term recovery goals. The plan shall clearly specify the approaches and interventions necessary for the consumer to achieve the individual goals and identify who will carry out the approaches and interventions. The treatment plans shall incorporate two or more strengths/resources as identified in the comprehensive assessment.
- E. The following key areas should be addressed in every consumer's community support/treatment plan: 1) psychiatric illness or symptom reduction; 2) housing; 3) activities of daily living (ADL); 4) daily structure and employment; 5) family and social relationships; 6) trauma assessment; and 7) violence assessment. Please refer to the "Resources" Section of this bulletin for more information on trauma and violence assessments. The service coordinator and the individual treatment team, together with the consumer, will be responsible for reviewing and rewriting the treatment goals and plan whenever there is a major decision point in the consumer's course of treatment (e.g., significant change in consumer's condition or goals) or at least every six months. Additionally, the service coordinator shall prepare a summary (i.e., community support plan review/treatment plan review) which thoroughly describes in writing the consumer's and the ITT's evaluation of his or her progress/goal attainment, the effectiveness of the interventions, and the consumer's satisfaction with services since the last treatment plan. The plan and review will be signed or verbally approved by the consumer, the service coordinator, individual treatment team members, the team leader, the psychiatrist, and all ACT team members.

The ACT team shall maintain written assessment and treatment planning policies and procedures incorporating the requirements outlined in this section.

SECTION VII: REQUIRED SERVICES

Operating as a continuous treatment service, the ACT team shall have the capability to provide comprehensive treatment, rehabilitation, and support services as a self-contained service unit. Services shall minimally include the following:

Service Coordination

Each consumer will have a service coordinator who directs and monitors the activities of the consumer's individual treatment team and the greater ACT team. The primary responsibility of the service coordinator is to work with the consumer to write the treatment plan, to provide individual supportive counseling, to offer options and choices in the treatment plan, to ensure that immediate changes are made as the consumer's needs change, and to advocate for the consumer's wishes, rights, and preferences. The service coordinator may be the first staff person called upon when the consumer is in crisis and is the primary support person and educator to the individual consumer's family. Members of the consumer's individual treatment team share these tasks with the service coordinator and are responsible to perform the tasks when the service coordinator is not working. Service coordination also includes coordination with community resources, including consumer self-help and advocacy organizations that promote recovery.

Crisis Assessment and Intervention

Crisis assessment and intervention shall be provided 24 hours per day, seven days per week that will include telephone and face-to-face contact.

Symptom Assessment and Management

This shall include but is not limited to the following:

- A. Ongoing comprehensive assessment of the consumer's mental illness symptoms, accurate diagnosis, and the consumer's response to treatment;

- B. Psychoeducation regarding mental illness and the effects and side effects of prescribed medications;
- C. Symptom-management efforts directed to help each consumer identify/target the symptoms and occurrence patterns of his or her mental illness and develop methods (internal, behavioral, or adaptive) to help lessen the effects;
- D. Individual Supportive Therapy;
- E. Psychotherapy;
- F. Generous psychological support to consumers, both on a planned and as-needed basis, to help them accomplish their personal goals, to cope with the stressors of day-to-day living, and to recover.

Medication Prescription, Administration, Monitoring and Documentation

- A. The ACT team psychiatrist shall:
 - a. Establish an individual clinical relationship with each consumer;
 - b. Assess each consumer's mental illness symptoms and determine how these symptoms affect the consumer's ability to function in a productive and /or self-satisfying life style as well as provide verbal and written information about mental illness to the ACT team, to the consumer, and to the consumer's family or significant others (with consumer's consent);
 - c. Make an accurate diagnosis based on the comprehensive assessment which dictates an evidence-based medication pathway that the psychiatrist will follow;
 - d. Provide education about medication, benefits and risks, and obtain informed consent;
 - e. Assess and document the consumer's mental illness symptoms, behavior and social/community involvement in response to medication and shall monitor and document medication side effects;
 - f. Provide psychotherapy.
- B. All ACT team members shall assess and document the consumer's mental illness symptoms and behavior in response to medication and shall monitor for medication side effects.
- C. The ACT team program shall establish medication policies and procedures consistent with the applicable federal and state laws to identify processes to:
 - a. Record physician orders;
 - b. Order medication;
 - c. Arrange for all consumer medications to be organized by the team and integrated into consumers' weekly schedules and daily staff assignment schedules;
 - d. Provide security for medications (e.g., daily and longer-term supplies, long-term injectable, and longer term supplies) and set aside a private designated area for set up of medications by the team's nursing staff;
 - e. Administer medications per state law.

Dual Diagnosis Substance Abuse Services

Provision of a stage-based treatment model that: is non-confrontational; considers interactions of mental illness and substance abuse; follows cognitive-behavioral principles; does not have absolute expectations of abstinence and supports harm reduction; understands and applies stages of change readiness in treatment; incorporates skillful use of motivational interviewing interventions; and has consumer-determined goals. This shall include but is not limited to individual and group interventions in:

- A. Engagement (e.g., empathy, reflective listening, avoiding argumentation);
- B. Assessment (e.g., stage of readiness to change, consumer-determined problem identification);
- C. Motivational enhancement (e.g., developing discrepancies, psycho-education);
- D. Active treatment (e.g., cognitive skills training, community reinforcement);
- E. Continuous relapse prevention (e.g., trigger identification, building relapse prevention action plans).

Work-Related Services

Work-related services are those services that help consumers value, find, and maintain meaningful employment in community-based job sites. Work-related services include, but are not limited to:

- A. Assessment of job-related interests and abilities through a complete education and work history assessment as well as on-the-job assessments in community-based jobs;
- B. Assessment of the effect of the consumer's mental illness on employment with identification of specific behaviors that interfere with the consumer's work performance and development of interventions to reduce or eliminate those behaviors and find effective job accommodations;
- C. Development of an ongoing employment rehabilitation plan to help each consumer establish the skills necessary to find and maintain a job;
- D. Individual supportive therapy to assist consumers to identify and cope with mental illness symptoms that may interfere with their work performance;
- E. On-the-job or work-related crisis intervention;
- F. Work-related supportive services, such as assistance with grooming and personal hygiene, securing of appropriate clothing, wake-up calls, and transportation, if needed;
- G. Maintaining ongoing relationships with employers to facilitate the creation of work environments that would be conducive to the hiring of ACT consumers who want to seek employment;
- H. Assisting consumers in locating jobs that they are interested in, and making the initial contact with the employer to arrange for any accommodations as necessary or if requested by consumers.

Activities of Daily Living

Services to support activities of daily living in community-based settings include individualized assessment, problem solving, sufficient side-by-side assistance and support, skill training, ongoing

supervision (e.g. prompts, assignments, monitoring, encouragement), and environmental adaptations to assist consumers to gain or use the skills required to:

- A. Find housing which is safe, of good quality, and affordable (e.g., apartment hunting); finding a roommate; landlord negotiations; furnishing, and decorating; and procuring necessities (such as telephones, furnishings, linens);
- B. Perform household activities, including house cleaning, cooking, grocery shopping, and laundry, carry out personal hygiene and grooming tasks, as needed;
- C. Develop or improve money-management skills;
- D. Use available transportation;
- E. Have and effectively use a personal physician and dentist.

Social/Interpersonal Relationship and Leisure-Time Skill Training

Services to support social/interpersonal relationships and leisure-time skill training include supportive individual therapy (e.g., problem solving, role-playing, modeling, and support); social skills teaching and assertiveness training; planning, structuring, and prompting of social and leisure-time activities; side-by-side support and coaching; and organizing individual and group social and recreational activities to structure consumers' time, increase their social experiences, and provide them with opportunities to practice social skills and receive feedback and support required to:

- A. Improve communication skills, develop assertiveness, and increase self-esteem;
- B. Develop social skills, increase social experiences, and develop meaningful personal relationships;
- C. Plan appropriate and productive use of leisure time;
- D. Relate to landlords, neighbors, and others effectively;
- E. Familiarize themselves with available social and recreational opportunities and increase their use of such opportunities.

Peer Support Services

These services validate consumers' experiences and guide and encourage them to take responsibility for and actively participate in their own recovery. In addition, these services help consumers identify, understand, and combat stigma and discrimination against mental illness and develop strategies to reduce self-imposed stigma. Peer Support Services are multifaceted, and include, but not limited to:

- A. Individual advocacy, crisis management support, and skills training;
- B. Introduction and referral to consumer self-help programs and advocacy organizations that promote recovery;
- C. Access and utilization of natural resources within the community;
- D. Cultivation of self worth and a sense of wellness;
- E. Modeling recovery-oriented attitudes and behaviors.

Support Services

Support services or direct assistance to ensure that consumers obtain the basic necessities of daily life, including but not necessarily limited to:

- A. Medical and Dental services;
- B. Safe, clean, affordable housing. Stable housing and housing choice are critical components of recovery. ACT team shall partner with consumers in individual housing assessment and planning. Consumers have a right to choose housing in the most integrated setting possible;
- C. Financial support and/or benefits counseling (e.g., SSI, SSDI, TANF, General Assistance, Food Stamps, Section 8, Vocational Rehabilitation, Home Energy Assistance);
- D. Social service;
- E. Transportation;
- F. Legal advocacy and representation.

Education, Support, and Consultation to Consumers' Families and Other Major Supports

Services provided regularly under this category to consumers' families and other major supports, with consumer agreement or consent shall include:

- A. Individualized psychoeducation about the consumer's illness and the role of the family and other significant people in the therapeutic process;
- B. Intervention to restore contact, resolve conflict, and maintain relationships with family and or other significant people;
- C. Ongoing communication and collaboration, face-to-face and by telephone (at least 2 times per month for each consumer), between the ACT team and the family/natural supports;
- D. Introduction and referral to family self-help programs and advocacy organizations that promote recovery;
- E. Assistance to consumers with children (including individual supportive counseling, parenting training, and service coordination) including but not limited to:
 - a. Services to help consumers throughout pregnancy and the birth of a child;
 - b. Services to help consumers fulfill parenting responsibilities and coordinate services for the child/children;
 - c. Services to help consumers restore relationships with children who are not in the consumer's custody.

The ACT team shall maintain written policies and procedures for all services outlined in this section. If a consumer requires services which are beyond the realm of the direct services that an ACT team is mandated to provide, the team will coordinate those services with providers outside of the ACT team or bring in outside consultation to assist the team in meeting the comprehensive needs of the individual.

SECTION VIII: RECORDKEEPING

Records shall be maintained to verify compliance with the requirements of these guidelines, and shall be retained for a minimum of seven years. Site survey reports, employee schedules, payroll records, consumer case records, medication records, job descriptions, documents verifying employee qualifications and training, policies and protocols, fees or charges, records of Supervision and training, letters of agreements with referral sources and service agencies, and a grievance and appeals process are examples of records that shall be kept to verify compliance with these guidelines.

Consumer Case Record

- A. The ACT team shall maintain a treatment record for each consumer.
- B. Intake information should have documentation that identifies the reason for referral and consumer's eligibility for ACT services.
- C. The case record shall be confidential, complete, accurate, and contain up-to-date information relevant to the consumer's care and treatment.
- D. The case record shall contain written assessments, treatment plans, psychiatric & social functioning history time line, and the nature and extent of services provided, such that a person unfamiliar with the ACT team can easily identify the consumer's treatment needs and services received.
- E. Progress notes shall contain at least the following information:
 - a. Consumer's identifying information (name and any other identifying number);
 - b. Date and time of service;
 - c. Staff travel times;
 - d. Services provided as they relate to the goals and objectives of the treatment plan;
 - e. Detailed description of the service;
 - f. Consumer's response to intervention services, changes in behavior and mood, and outcome of intervention services;
 - g. Plans for continuing treatment;
 - h. Clinician's signature with credentials.
- F. The consumer record shall contain a medication record with information on all medications ordered or prescribed by physician staff and shall minimally include the following:
 - a. Name of medication;
 - b. Date, time, and dosage;
 - c. Frequency of administration or prescribed change;
 - d. Route of administration;
 - e. Name of prescribing physician;
 - f. Name of the staff member who dispensed/administered each dose;
 - g. A record of pertinent information regarding adverse reactions to drugs, drug allergies, or sensitivities shall be maintained, and should be updated when any new information is available.
- G. Other record contents shall include, but not be limited to:
 - a. Copies of all consultation reports concerning the consumer;
 - b. When psychometric or psychological testing is done, record shall contain a copy of a written report describing the test results and implications, and recommendations for treatment;
 - c. Any additional information relating to the consumer that has been secured from sources outside the PACT program;
 - d. A signed consent for treatment for all voluntary admissions.
- H. The team leader and the program assistant shall be responsible for the maintenance and security of the consumer records.
- I. The consumer records shall be located at ACT team headquarters and, for confidentiality and security, are to be kept in a locked file.
- J. For purposes of confidentiality, disclosure of treatment records by the ACT team is subject to all the provisions of applicable state and federal laws.

- K. Consumers shall be informed by staff of their right to review their own records and the steps required to request to do so.
- L. Each consumer's clinical record shall be available for review and to be copied by the consumer and/or the guardian, if any, in conformance with all legal requirements.

The ACT team shall maintain written medical records management policies and procedures. Detailed description of the content and format for the case records is contained in "A Manual for ACT Start-UP" by Deborah J. Allness and William H. Knoedler.

SECTION IX: CONSUMER RIGHTS AND GRIEVANCE PROCEDURES

ACT teams shall have policies and procedures for consumer rights and grievance procedures that ensure compliance with federal and state laws and also ensure that all team members fully understand, inform, and respect a consumer's right to appropriate treatment in a setting and under conditions that are the most supportive of each person's personal liberty and restrict such liberty only to the extent necessary consistent with each consumer's treatment needs, applicable requirements of law, and applicable judicial orders. (Bill of Rights for Mental Health Patients, PAIMI Act of 1991 42 U.S.C. 1080 et seq.)

- A. ACT teams shall be knowledgeable about and familiar with consumer rights including the right to:
 - a. Confidentiality;
 - b. Informed consent to medication and treatment;
 - c. Treatment with respect and dignity;
 - d. Prompt, adequate, and appropriate treatment;
 - e. Treatment which is under the least restrictive conditions;
 - f. Nondiscrimination;
 - g. Control of own money;
 - h. File grievances or complaints;
 - i. Mental Health Advance Directives.
- B. ACT teams shall be knowledgeable about and familiar with the mechanisms to implement and enforce consumer rights with regard to:
 - a. Grievance or complaint procedures under state law;
 - b. Medicaid;
 - c. Americans with Disabilities Act;
 - d. Protection and Advocacy for Individuals with Mental Illness;
 - e. Mental Health Advance Directives.

The ACT team shall maintain written consumer rights policies and procedures.

SECTION X: CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES (CLAS)

ACT teams shall ensure that consumers receive from all staff members effective, understandable, and respectful care that is provided in a manner compatible with consumers' cultural health beliefs and practices and written and spoken language preferences including American Sign Language (ASL) and Braille.

- A. ACT teams should implement strategies to recruit, retain, and promote a diverse staff that are representative of the demographic characteristics of the service area.
- B. ACT teams should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.
- C. ACT teams shall offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each consumer with limited English-proficiency at all points of contact, in a timely manner during all hours of operation.

- D. ACT teams shall provide to consumers, in their preferred language, both verbal offers and written notices informing them of their right to receive language assistance services.
- E. ACT teams shall assure the competence of language assistance provided to limited English proficient consumers by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services except when requested by the consumer.
- F. ACT teams shall make available easily understood consumer-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.
- G. ACT teams should develop, implement and promote a written strategic plan that outlines clear goals, policies, operational plans and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.
- H. ACT teams should conduct initial and ongoing organizational self-assessments of Culturally and Linguistically Appropriate Services (CLAS) related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, consumer satisfaction assessments and outcome-based evaluations.
- I. ACT should ensure that data on the individual consumer's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems, and be periodically updated.
- J. ACT teams should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and consumer involvement in designing and implementing CLAS-related activities.
- K. ACT should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing and resolving cross-cultural conflicts or complaints by consumers.
- L. ACT is encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information.

The ACT team shall maintain written Culturally and Linguistically Appropriate Services (CLAS) policies and procedures incorporating the requirements outlined in this section.

SECTION XI: PERFORMANCE IMPROVEMENT AND PROGRAM EVALUATION

Program evaluation is critical in order to know if consumers are realizing the expected and desired outcomes from ACT. It is also important to know if the program is adhering to the ACT model. Each program is expected to evaluate the following:

- A. Consumer outcome
- B. Consumer and family satisfaction with the services including independent Consumer Family Satisfaction Team (CFST) reviews.
- C. Fidelity to the ACT model using the latest version of the Dartmouth Assertive Community Treatment Scale (DACTS) stipulated by OMHSAS. The DACTS shall be completed annually for each ACT team either by the Managed Care Organization or a consultant familiar with the DACTS fidelity tool. DACTS scores shall be used to determine any corrective actions. OMHSAS will review the results of the DACTS fidelity scale along with the program standards as part of the licensing/approval process.

The ACT team shall have a performance improvement and program evaluation plan, which shall include the following:

- A. A statement of the program's objectives. The objectives shall relate directly to the program's consumers or target population;
- B. Measurable criteria that shall be applied in determining whether or not the stated objectives are achieved;
- C. Methods for documenting achievements related to the program's stated objectives;
- D. Methods for assessing the effective use of staff and resources toward the attainment of the objectives;
- E. In addition to the performance improvement and program evaluation plan, the ACT team shall have a system for regular review that is designed to evaluate the appropriateness of admissions to the program, treatment or service plans, discharge practices, and other factors that may contribute to the effective use of the program's resources.

The ACT team shall maintain performance improvement and program evaluation policies and procedures.

SECTION XII: RATE SETTING/PAYMENT

OMHSAS will issue separate communication(s) to address rate-setting and payments.

SECTION XIII: ACT ADVISORY COMMITTEE

Each ACT program shall have an advisory committee to support and enhance the local ACT team through assistance with start-up, implementation and on-going operations. This committee performs an essential ACT program role: supporting the ACT team as the program delivers each consumer high quality, recovery oriented services. 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 percent of the advisory committee shall be comprised of recipients (or former recipients) of mental health services and family members. Other community stakeholders and representatives from diverse community services such as consumer support organizations, food pantries, homeless shelters, housing authorities, landlords, educational institutions, the criminal justices system, employers and the business community shall constitute the remainder of the advisory committee. The committee membership shall also represent the cultural diversity of the local population. The advisory committee shall meet at least quarterly, with regular attendance by the team leader (or designee), and shall:

- A. Promote the development and continuation of quality ACT model programs;
- B. Review compliance with program audits and ACT program standards;
- C. Inform and support the administering agency's on-going quality improvement process;
- D. Promote and ensure the presence of consumer's empowerment and recovery values Within the assertive community treatment team; and
- E. Examine program outcome measures, including consumer and family satisfaction.

The ACT team shall maintain written advisory committee policies and procedures, incorporating the requirements outlined in this section.

SECTION XIV: WAIVER OF PROVISIONS

ACT programs may request waivers of requirements in program standards. The waiver request shall not diminish the effectiveness of the ACT model. For example, a waiver would not be approved if a program requested to operate without a psychiatrist, because that position is central to program operation and service delivery. The ACT team may request of OMHSAS a waiver of any required standard that would not diminish the effectiveness of the ACT model, violate the purposes of the program, or adversely affect consumers' health and welfare. Waivers cannot be granted which are inconsistent with consumer rights or federal, state, or local laws and regulations. All waiver requests shall be sent through OMHSAS field office for consideration. Requests for admission of individuals who do not meet the eligibility criteria for ACT shall be directed to the Behavioral Health Managed Care Organization or the County MH/MR, as applicable, for approval.

SECTION XV: RESOURCES

1. "A Manual for ACT Start-UP" by Deborah J. Allness and William Knoedler (2003 Edition) published by the National Alliance for the Mentally Ill (NAMI).
2. ACT link on NAMI Website: http://www.nami.org/template.cfm?section=ACT-TA_Center
3. Substance Abuse & Mental Health Services Administration (SAMHSA) website: <http://mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/community/default.asp>
4. Acquired Brain Injury Network of Pennsylvania, Inc website: <http://www.abin-pa.org/>
5. Resources on Trauma Assessment: <http://www.johnbriere.com>
6. Resources on Violence Assessment - Centers for Disease Control and Prevention/National Center for Injury Prevention and Control website: <http://www.cdc.gov/ncipc>.