Dear Colleagues:

Enclosed you will find the draft OMHSAS bulletin on Assertive Community Treatment (ACT) for your review and recommendations. The standards outlined in the bulletin are derived from the National Assertive Community Treatment standards. This initiative is part of OMHSAS' efforts to actively promote the inclusion of more Evidence-Based Practices in our behavioral health service delivery system.

Once published in its final form, this bulletin will stipulate the standards and procedures for developing, administering, and monitoring Assertive Community Treatment programs in the Commonwealth. All programs that identify themselves as Assertive Community Treatment (ACT) or Program(s) for Assertive Community Treatment (PACT) shall be required to adhere to the standards and directions outlined in the bulletin. The publication of this bulletin will not have any immediate effect on the programs that are identified as Community Treatment Teams (CTT). However, OMHSAS intends to revisit the guidelines for the provision of CTT services in the coming future.

Subsequent to the publication of the ACT bulletin, OMHSAS will issue a Request for Proposals (RFP) for developing ACT teams in the state. The plan is to develop four such teams in fiscal year 2007/2008. Two of those four teams will be built by phasing out select, existing Community Treatment Teams to form ACT teams that conform to the standards delineated in the bulletin. The remaining two teams will be entirely new ACT entities. Training and technical assistance supported by OMHSAS will assist these teams to conform to the ACT fidelity.

Please provide your comments and feedback on this draft bulletin to Benny Varghese at bvxrghese@state.pa.us by June 18, 2007.

We look forward to continuing the development of viable treatment options for individuals with mental illness/co-occurring disorders. Your partnership in this endeavor is critical to this effort. Thank you.

Sincerely,

[Signature]

Joan L. Erney, J.D.

Enclosure
SCOPE:

County MH/MR Administrators
Behavioral Health Managed Care Organizations

PURPOSE:

The purpose of this bulletin is to stipulate the standards for Assertive Community Treatment (ACT) programs. The publication of this bulletin transmits the information necessary for the provision of ACT services in the Commonwealth. All County MH/MR offices and ACT service providers shall use the guidelines, standards, and procedures outlined in this bulletin for developing, administering, and monitoring ACT programs until final regulations are published and codified.

BACKGROUND:

A Call for Change: Toward a Recovery - Oriented Mental Health Service System for Adults
issued in November 2005 by Pennsylvania Office of Mental Health and Substance Abuse Services (OMHSAS) recognized the importance of Evidence-Based Practices in a recovery oriented mental health service system. This recognition was reinforced in the White Paper "Strategies for Promoting Recovery and Resilience and Implementing Evidence Based Practices" released in October 2006. This document is the OMHSAS follow-up to "A Call for Change" to continue the work in developing recovery-oriented services and supports. One of the Evidence-Based Practices that could play a vital role in our efforts to transform the mental health service system is ACT.

Pennsylvania already has some programs that identify themselves as ACT. Studies have shown that in order to achieve the outcome objectives of the ACT program, it is important that the programs adhere to the fidelity to the ACT model. This bulletin provides directions, and prescribes standards to be followed by all programs that would like to be identified as ACT programs. The program standards delineated in this bulletin are based on the “National Program Standards for ACT Teams” contained in “A Manual for ACT Start-UP” by Deborah J. Allness and William H. Knoedler.

DISCUSSION:

Assertive Community Treatment (ACT) is a consumer-centered, recovery-oriented mental health service delivery model that has received substantial empirical support for facilitating community living, psychosocial rehabilitation, and recovery for persons with the most severe and persistent mental illnesses and impairments who have not benefited from traditional outpatient programs.

The important characteristics of Assertive Community Treatment programs are:
ACT serves individuals with severe and persistent mental illnesses that are complex and have devastating effects on functioning. Because of the limitations of traditional mental health services, many of these individuals may not have received appropriate services. This consumer group is often over represented among the homeless, and in jails and prisons, and has been unfairly thought to resist or avoid involvement in treatment.

ACT services are delivered by a group of multidisciplinary mental health staff who work as a team and provide the majority of the treatment, rehabilitation, and support services the consumers need to achieve their goals.

ACT services are individually tailored for each consumer, and address the preferences and identified goals of each consumer. The approach with each consumer emphasizes relationship building and active involvement in assisting individuals with severe and persistent mental illness to make improvements in functioning, to better manage symptoms, to achieve individual goals, and to maintain optimism.

The ACT team is mobile and delivers services in community locations to enable each consumer to find and live in their own residence, and find and maintain work in community jobs rather than expecting the consumer to come to the program.

ACT services are delivered in an ongoing rather than time-limited framework to aid the process of recovery and ensure continuity of caregiver. Severe and persistent mental illnesses are episodic disorders and many consumers benefit from the availability of a longer-term treatment approach and continuity of care.

The following attachments to this bulletin establish the standards and guidelines for Assertive Community Treatment services:

- Attachment A: Definitions
- Attachment B: Standards and Guidelines

COMMENTS AND QUESTIONS REGARDING THIS BULLETIN SHOULD BE DIRECTED TO:

Bureau of Policy and Program Development
Office of Mental Health and Substance Abuse Services
P.O. Box 2675
Harrisburg, PA 17105
Telephone (171) 772-7900
ATTACHMENT A

DEFINITIONS

ACT Service Coordination (Case Management) 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 (Case Manager) 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). He or she is the responsible team member to be knowledgeable about the consumer’s life, circumstances, and goals and desires. 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 individual supportive therapy and is the first ITT member available to the consumer in crisis. 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.

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 Individualized Treatment Plan is the culmination of a continuing process involving each consumer, his or her family, and the ACT team, which individualizes service activity and intensity to meet consumer-specific treatment, rehabilitation, and support needs. The written 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.

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).

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.

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.

**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.

**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 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 (case manager), 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. 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 (e.g., psychiatrists, registered nurses, and pharmacists).

**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-medicating management.

**Mental Health Professional** is a person trained in a generally recognized clinical discipline including, but not limited to, psychiatry, social work, psychology, nursing, rehabilitation 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 severe and persistent 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 Groups** support and guide individual ACT team implementation and operation. Each ACT team shall have a Stakeholder Advisory Group whose membership consists of 51 percent mental health consumers and family members. It shall also include community stakeholders that interact with persons with severe and persistent mental illness (e.g., homeless services, food-shelf agencies, faith-based entities, criminal justice system, the housing authority, landlords, employers, and community colleges). In addition, group membership shall represent the local cultural populations. The group’s primary function is to promote quality ACT programs, monitor fidelity to the ACT Standards, guide and assist the administering agency’s oversight of the ACT program, problem-solve and advocate to reduce barriers to ACT implementation, and monitor/review/mediate consumer and family grievances or complaints. The Stakeholder Advisory Group promotes and ensures consumers’ empowerment and recovery values in assertive community treatment programs.

**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.
**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 must be encouraged to attend these meetings.

**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.
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 severe and persistent 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. ACT services are targeted to individuals with severe and persistent 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.

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

This bulletin, in line with the concept of urban and rural teams in the National ACT Standards, 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
- Modified team

Modified teams may be set up in areas where there may be fewer numbers of consumers with severe and persistent mental illness who can benefit from the program, and therefore is not practical to have a full size team. The size of a modified team will depend on staff coverage availability.

Organizational and staff requirements are different for full-size and modified teams as outlined below:

The full-size team shall employ a minimum of 10 to 12 Full Time Equivalent (FTE) multidisciplinary clinical staff persons including the team leader, 1 FTE peer specialist, one to 1.5 FTE program assistants, 16 hours of psychiatrist time for every 50 consumers on the team, and other required staff.

The modified team shall employ a minimum of 6 to 8 FTE multidisciplinary clinical staff persons, including one team leader, one FTE peer specialist, one FTE program assistant, 16 hours of psychiatrist time for every 50 consumers on the team, and other required staff.

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 following table contains the description of the minimum staff requirements:
The staff-to-consumer ratio of ACT teams shall not exceed 1:10, excluding the psychiatrist and the program assistant. New teams that are building their caseloads must still have enough staff to cover all the shifts. The maximum number of consumers in a full-size team shall not exceed 120, for modified teams the maximum number of consumers admitted shall not exceed 8 consumers for each staff member excluding the psychiatrist and the program assistant.

SECTION II: ELIGIBILITY

Provider Participation: All ACT programs will be licensed by the Office of Mental Health and Substance Abuse Services (OMHSAS). Additionally, the ACT provider must 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: Schizophrenia or chronic major mood disorder (diagnostic codes 295 or 296 in the DSV IV-R or any subsequent revisions thereafter). Individuals with a primary diagnosis of a substance abuse disorder or mental retardation 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

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<thead>
<tr>
<th>Position</th>
<th>Full-size</th>
<th>Modified</th>
</tr>
</thead>
<tbody>
<tr>
<td>Team leader</td>
<td>1 FTE</td>
<td>1 FTE</td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>16 Hours for 50 Consumers</td>
<td>16 Hours for 50 Consumers</td>
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<tr>
<td>Registered Nurse</td>
<td>3 FTE</td>
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<tr>
<td>Peer Specialist</td>
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<td>Master’s level</td>
<td>4 FTE</td>
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<td>Other level</td>
<td>1-3 FTE</td>
<td>1.5 – 2.5 FTE</td>
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<tr>
<td>Program/Administrative Assistant</td>
<td>1-1.5 FTE</td>
<td>1 FTE</td>
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(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.

g. Difficulty effectively utilizing traditional office-based outpatient services or evidence that they require a more assertive and frequent non-office based services 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 review and recommendation by the County Administrator and written approval by OMHSAS Field Office. Individuals with the primary diagnosis of substance abuse, brain injury, or Axis 2 disorders are not suitable for ACT.

**Discharge:** Discharges from the ACT team 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.

C. Move outside the geographic area of ACT’s responsibility. In such cases, the ACT team shall arrange for transfer of mental health service responsibility to an ACT program or another provider wherever the consumer is moving. The ACT team shall maintain contact with the consumer until this service transfer is implemented.

D. Decline or refuse services and request discharge, despite the team’s best efforts to develop an acceptable treatment plan with the consumer.

**SECTION III: RESPONSIBILITIES**

**Responsibilities of County Administrators:** County Mental Health Administrators 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 are required to work closely with OMHSAS field office staff to monitor the compliance of ACT providers under their jurisdiction with provisions of these guidelines and standards. The County Administrators are also responsible for providing fiscal and program reports to OMHSAS.

**Responsibilities of Providers:** Providers must 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 have a system in place to collect and analyze data pertaining to the ACT program. This system must 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 8 hour shifts weekdays; 2) staff one 8 day shift each weekend day and holidays; 3) schedule mental health professionals to on-call duty the hours when staff are not working; 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 weekday, weekend, and holiday shifts, 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. In locations where there is no crisis intervention service, 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 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 a consumer requests it.

F. The ACT team shall provide an average of three contacts per week for all consumers.

G. ACT varies intensity to meet the changing needs of consumers with severe and persistent 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. Each new ACT team shall stagger consumer admissions- a full-size team shall admit no more than 5 consumers per month, and a modified team no more than 3 consumers per month. The teams should gradually build up capacity to serve no more than 100-120 consumers (with 10-12 staff) on any given full-size team, and no more than 42-50 consumers (with 6-8 staff) on any given 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 must be admitted rather than starting out at full capacity. Due to smaller team size and geographical distances, admission rates of modified teams need to be lower than a full-size team.

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 on the second shift.

   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 mental health professionals 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. The modified team shall provide 8 hours of coverage per day, with a minimum of one clinical staff on weekends and holidays.
A modified team shall regularly schedule mental health professionals 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 new full-size team shall set a goal of providing 75 percent of service contacts in the community in non-office-based or non-facility-based settings, while each new modified team shall set a goal of providing 85 percent of service contacts 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 must 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 and psychiatrist 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, 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

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 has at least a master’s degree in nursing, social work, psychiatric rehabilitation or psychology, or is a psychiatrist. It is recommended that team leader complete 12 hours of co-occurring specific training.

Psychiatrist: A psychiatrist, who works on a full-time or part-time basis for a minimum of 16 hours per week for every 50 consumers. The psychiatrist provides clinical services to all ACT consumers; works with the team leader to monitor each consumer’s clinical status and response to treatment; supervises staff delivery of services; and directs psychopharmacologic and medical services. It is recommended that the psychiatrist has one year of experience in providing treatment to consumers diagnosed with a co-occurring substance use disorder.

The ACT psychiatrist functions as a team member, not just as a consultant to the team. The team psychiatrist sees consumers and has clinical supervisory responsibilities for consumers and staff, regularly participates in daily staff organizational meetings and treatment planning meetings, and directs operation of the medication and medical services. 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 must 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.

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), with at least one designated for the role of vocational specialist, preferably with a master’s degree in rehabilitation counseling. Please see Attachment A for the definition of Mental Health Professional. On a modified team, a minimum of 2 FTE master’s level or above mental health professionals (in addition to the team leader) with at least one FTE who has designated responsibility for the role of vocational specialist, preferably with a master’s degree in rehabilitation counseling. It is recommended that at least one of the Master’s level mental health professional (in full-size as well as modified teams) has a graduate degree in social work.

Substance Abuse Specialist: One or more mental health professionals having full certification as addictions counselor or 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 must provide most of the substance abuse treatment services for consumers with severe and persistent 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.

Peer Specialist: A minimum of one FTE certified peer specialist on either a full-size team or a modified team. A person who is or has been a recipient of mental health services for severe and persistent 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.

**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 severe and persistent 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 severe and persistent 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.

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

**Program/Administrative Assistant:** The program/administrative assistant (1-1.5 FTE in an full-size
setting or 1 FTE in a modified setting) who is responsible for organizing, coordinating, and monitoring
all non-clinical operations of ACT, including managing medical records; operating and coordinating
the management information system; maintaining accounting and budget records for consumer and
program expenditures; and providing receptionist activities, including triaging calls and coordinating
communication between the team and consumers. 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.

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.

At a minimum, the initial assessment shall contain the following information:

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

The initial treatment 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

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.

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 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 family the best treatment approach to eliminate or reduce symptomatology and to ensure accuracy of the diagnosis. 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 has been ignored for many people with severe and persistent 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. This assessment begins with the working relationship between the consumer and the vocational specialist to establish educational and vocational goals.

**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 severe and persistent 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 to carry 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 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 (case manager), 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, ensuring that a psychiatric and social functioning history time line and comprehensive assessment are completed within six weeks of the consumer’s admission to the program.

D. The service coordinator and ITT members will be assigned by the team leader in collaboration with the psychiatrist within six weeks after admission.

**Individualized Treatment Planning**

Treatment plans shall be developed within 8 weeks of admission through the following treatment planning process:

A. The 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 treatment plan. The treatment plan shall 1) identify individual 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 treatment planning meetings. At each treatment planning meeting the following staff should attend: the team leader, the psychiatrist, the service coordinator (case manager), 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 treatment plan shall identify his or her issues/problems, strengths/weaknesses, and specific measurable goals. The treatment plan must clearly specify the approaches and interventions necessary for the consumer to achieve the individual goals (achieve recovery) and identify who will carry out the approaches and interventions.

E. The following key areas should be addressed in every consumer’s treatment plan: 1) psychiatric illness or symptom reduction; 2) housing; 3) activities of daily living (ADL); 4) daily structure and employment; and 5) family and social relationships. The service coordinator (case manager) 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., 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 be assigned a service coordinator (case manager) who coordinates 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 on 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. These services will include telephone and face-to-face contact and will be provided in conjunction with the local mental health system’s emergency services program as appropriate.

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 provide verbal and written information about mental illness
   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 and behavior 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, 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 to help consumers value, find, and maintain meaningful employment in community-based job sites and services to develop jobs and coordinate with employers but also includes but is not necessarily 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.

**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
C. Carry out personal hygiene and grooming tasks, as needed
D. Develop or improve money-management skills
E. Use available transportation
F. 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. Promoting the utilization of natural resources within the community
D. Facilitating the development of sense of wellness and self worth

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
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, 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, between the ACT team and the family

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.

SECTION VIII: RECORDKEEPING

Records must be maintained which verify compliance with the requirements of these guidelines. Consistent with the regulations in 55 PA Code 1101.51(e) (Medical Assistance General Provisions), records must be kept for a minimum of four 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 must 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 contains up-to-date information relevant to the consumer’s care and treatment.

D. The case record must 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 must 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 must 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 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 the guardian, if any

The ACT team shall maintain written medical records management policies and procedures.

SECTION IX: CONSUMER RIGHTS AND GRIEVANCE PROCEDURES

ACT teams must 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 seg.)

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 must 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 must 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 must 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 must 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 must 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

C. Fidelity to the ACT model

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: STAKEHOLDER ADVISORY GROUPS

Each ACT program should have a stakeholder advisory group to guide and support local ACT team start-up, implementation, and on-going operation. It is this group that performs the most important ACT program role: ensuring that the program provides each consumer high quality and recovery-oriented services. The stakeholder advisory group shall be made up of at least 51 percent mental health consumers and family members and include other community stakeholders such as representatives from services for the homeless, consumer-support organizations, food-shelf agencies, faith-based groups, criminal justice system, housing authorities, landlords, employers,
and/or community colleges. Group membership shall also represent the cultural diversity of the local population. The stakeholder advisory group shall:

A. Promote quality ACT model programs
B. Monitor fidelity to the ACT program standards
C. Guide and assist with the administering agency’s oversight of the ACT program
D. Problem-solve and advocate to reduce system barriers to ACT implementation
E. Review and monitor consumer and family grievances and complaints
F. Promote and ensure consumers’ empowerment and recovery values in assertive community treatment programs.

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

SECTION XIII: WAIVER OF PROVISIONS

ACT programs may request waivers of requirements in program standards. The waiver request must 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 must be sent to OMHSAS field office for consideration.