

**Georgia Program Tool Kit  
For  
Assertive Community Treatment  
(ACT) Teams**



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## Georgia Program Tool Kit for ACT Teams

**Assertive Community Treatment (ACT) is identified by the Substance Abuse and Mental Health Services Administration as an evidence-based practice that consistently demonstrates positive outcomes and is recommended by experts as a treatment option for individuals with serious and persistent mental illness (SPMI).**

The *Georgia Program Toolkit for ACT Teams* serves to guide ACT program start-up and implementation by clearly defining the expected minimum program requirements for each Georgia ACT Provider. A successful ACT program model implementation is demonstrated by improvements in consumer outcomes which are accomplished by close adherence to the evidence-based practice of ACT operations (Herinchx et al., 1997; McHugo et al., 1999).

DBHDD is invested in keeping the public informed of the efforts for improving the quality of care and services provided to this particular adult population. The Department is committed to a clearly articulated philosophy (assertive outreach, integrated mental health and substance abuse treatment, stage-wise interventions, comprehensive services and a long-term perspective of recovery) consistent with the ACT model.

There are 13 sections of the Georgia Program Tool Kit for ACT Teams. At the beginning of each section, the overall purpose and rationale for that section is explained and an explanation of program components is provided.

If you have questions, please contact the DBHDD Director of Adult Mental Health at (404) 232-1644.

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## **I. Introduction**

Assertive Community Treatment (ACT) is an evidence-based practice that is consumer-centered, recovery-oriented and a highly intensive community-based service for individuals who have serious and persistent mental illness.

Core Customer:

- The individual's mental illness has significantly impaired his/her functioning in the community.
- The individual has been unsuccessfully treated in the traditional mental health service system because of his/her high level of mental health acuity.
- The use of the traditional clinic-based services for the individual in the past or present have usually been greater than 8 hours of service per month.
- The recipient may be chronically homeless and/or involved with the criminal justice system, and may have had multiple or extended stays in state psychiatric/public hospitals.

ACT provides access to a variety of interventions twenty-four hours, seven days a week. The service utilizes a multidisciplinary mental health team from the fields of psychiatry, nursing, psychology, social work, substance abuse and vocational rehabilitation; additionally, a certified peer specialist is an active member of the ACT Team, providing assistance with the development of natural supports, promoting socialization and the strengthening of community living skills (DBHDD, 2011).

The ACT Team works as one organizational unit, providing community-based interventions that are rehabilitative, intensive, integrated and stage-specific. Services emphasize social inclusiveness through relationship building and active involvement in assisting individuals to achieve a stable and organized life style. The service providers must develop programmatic goals that clearly articulate the use of best/evidence-based practices for ACT consumers using co-occurring and trauma-informed service delivery and support. Practitioners of this service are expected to maintain knowledge and skills according to the current research trends in best/evidence-based practices. ACT is a unique treatment model in which the majority of mental health services are directly provided by the ACT program in the consumer's natural environment. ACT services are individually tailored with each consumer to address his/her preferences and identified goals, which are the basis of the Individualized Recovery Plan (DBHDD, 2011).

### **The Essential Characteristics of Assertive Community Treatment Programs**

- ACT is identified for individuals who have been diagnosed with a serious and persistent mental illness in which the mental illness has interrupted his/her ability to live in the community successfully. Due to the person's mental health conditions, he/she is a higher user of acute psychiatric hospitals and/or emergency/crisis services and/or incarcerations (Allness & Knoedler, 2003; Phillips et al., 2001).

- The process of recovery is embraced because each person with a mental illness is believed to have the ability to live a healthy and productive life when proper guidance, skills, and supports are provided.
- ACT services are delivered by utilizing a multidisciplinary mental health team from the fields of psychiatry, nursing, psychology, social work, substance abuse and vocational rehabilitation. The team is directed by a team leader, who is an integrated part of the multidisciplinary team and provides face-to-face, community-based services to ACT consumers (Allness & Knoedler, 2003).
- ACT support staff work in shifts to provide 24/7 intensive community-based services. The ACT model addresses frequent contacts with consumers as needed. In accordance with DACTS best practice and based on individual need, the average length of services per consumer, per week is two or more hours.
- Multiple contacts may be as frequent as two to three times per day, seven days per week, and are based on consumer need and a mutually agreed upon plan between the consumer and ACT staff. Many, if not all, staff share responsibility for addressing the needs of all consumers requiring frequent contact. The expected total number of contacts per consumer, per month is a median of 12 face-to-face contacts (DBHDD, 2013).
- ACT services are individually tailored by addressing the preferences and identified goals of each consumer. Services and supports are individually tailored emphasizing social inclusiveness through relationship building and the active involvement in assisting individuals to achieve a stable and structured life style. The approach with each consumer emphasizes relationship-building and active consumer involvement to improve functioning, better manage symptoms, achieve individual goals and maintain optimism (Allness & Knoedler, 2003).
- Georgia's ACT programs include a comprehensive and integrated set of medical and psychosocial services provided in non-office settings 80% of the time by a mobile multidisciplinary team. The ACT team provides elements necessary to a person's recovery (Teague, Bond, & Drake, 1998; SAMSHA).
- It is expected that 90% or more of consumers served have face-to-face contact with more than one staff member in a 2 week period (Teague, Bond, & Drake, 1998; SAMSHA; DBHDD 2011).
- ACT consumers will receive and be linked to an array of services in order to meet individualized treatment goals. Individuals with SPMI (Serious Persistent Mental Illness) have a wide range of needs, such as developing the ability to live independently; obtaining employment or other meaningful activity; improving the quality of their family and social relationships; and managing anxiety and other difficult moods (Allness & Knoedler, 2003).

- ACT services are delivered in an ongoing, rather than time-limited, framework to aid the process of recovery and ensure continuity of caregiver. Serious mental illnesses are episodic disorders, and many consumers benefit from the availability of a longer-term treatment/service approach and continuity of care. This allows consumers opportunities to take the next steps forward towards achieving recovery (McHugo et al., 1999; Herinckx et al., 1997).
- The ACT team will be involved in 95% or more of hospital admissions and hospital discharges. The ACT team will be fully engaged in hospitalizations and discharges by collaborating with hospital personnel. The consumer's ACT treatment plan should address recommendations made by hospital personnel (DBHDD, 2011; SAMHSA).
- It is expected that individuals participating in ACT will achieve housing stability and experience a decrease in the debilitating effects of mental illness. Also, individuals will be assisted by the ACT team in defining their recovery plans, social integration and functioning in order to increase community tenure (Allness & Knoedler, 2003; SAMSHA).
- The ACT team is expected to work with informal support systems, dependent upon consents, at least four times a month with or without the consumer being present to provide support and skill training as necessary to assist the consumer in his/her recovery (i.e., family, landlord, employers, support systems, probation officers) (DBHDD, FY 2011; (McHugo et al., 1999; Teague et al., 1998; SAMSHA).

ACT consumers are expected to experience a decrease in frequency and/or duration of hospitalizations, crisis services, and/or incarcerations (Lamberti, Weisman, & Faden, 2004; Herinckx, et al., 1997). The agency will be monitored by the State ACT and CST Services Unit from DBHDD by participation in an annual Fidelity Review along with submission of a monthly programmatic report inclusive of various data indicators including; the number of individuals hospitalized and admitted to ERs; medical and psychiatric admissions; number incarcerated; number of legal contacts; number of consumers who participated in competitive employment; number of consumers who are housed and who are homeless; and number of consumers enrolled and discharged. If the agency appears to have a pattern of consumers being hospitalized and/or incarcerated, low census, poor APS audit scores, poor Fidelity Review outcomes, the agency will receive technical assistance in order to coordinate an action plan (DBHDD, 2011). The ACT provider will receive an ACT Fidelity Review minimally once a year to evaluate if the ACT agency is operating at full Fidelity to the DACT model.

- An external review organization will conduct audits utilizing an authorization process that verifies a proper match between consumer need and the services provided. This involves identification of over-utilization *and* under-utilization of services through careful analysis of consumer functional and behavioral status, resources and participation in the recovery process. It also ensures the services provided as defined in the DBHDD Provider Manual address consumers' therapeutic needs as demonstrated by individual recovery and resiliency plans, provider documentation in the areas of assessment and progress notes.

## II. Intake Process, Admission, and Discharge Criteria

### Intake Process

Georgia's ACT teams are expected to develop collaborative intake processes with relevant community and institutional referral sources to determine an individual's eligibility for admission and to effectively prioritize and engage new consumers. Georgia ACT teams must have clearly written admission criteria that are consistent with the DBHDD guidelines. The ACT program is expected to respond to any referral resource within a 24 hour period and enroll eligible consumers within three days of receipt of the completed referral information.

During initial program implementation, each ACT team will stagger consumer admissions gradually building up to full capacity. DBHDD expects the ACT agency to admit 10 consumers in each of the first four months of start-up until the agency has 40 consumers enrolled. After 40 consumers are admitted into ACT, the tapering of admissions will be no more than 8 per month in order to meet fidelity requirements. This admission expectation is based on the necessity to maintain a stable service environment for existing consumers while meeting the needs of newly admitted consumers who are usually in need of higher intensity of services from the team. Each team will gradually build up capacity and maintain an average daily census of 75 consumers, with the expectation that this will yield provision of service up to 100 consumers over the course of a year (SAMSHA; Teague et al., 1998). In the event that a provider seeks to enroll more than 8 persons in a given month, post start-up, a waiver from DBHDD for over-enrollment must be requested.

### Admission Criteria

Admission decisions are based on eligibility criteria included in the Provider Manual for Community Mental Health, Developmental Disabilities, and Addictive Diseases Providers for DBHDD. The admission criteria (2011) define five domains that a consumer must meet to qualify for ACT (Taube, Morlock, Burns, & Santos, 1990). DBHDD defines targeted ACT consumers as:

1. Individuals with serious and persistent mental illness that significantly impairs the ability to live in the community. **Priority** is given to people recently discharged from an institutional setting with schizophrenia, other psychotic disorders (e.g., schizoaffective disorder) or bipolar disorder because these illnesses often cause long-term psychiatric disability; **AND**
2. Individuals with significant functional impairments as demonstrated by the need for assistance in three or more of the following areas, for which successful completion continues to be difficult despite support from a care giver or behavioral health staff:
  - a) Maintaining personal hygiene;
  - b) Meeting nutritional needs;
  - c) Caring for personal business affairs;
  - d) Obtaining medical, legal, and housing services;



- e) Recognizing and avoiding common dangers or hazards to self and possessions;
  - f) Persistent or recurrent failure to perform daily living tasks except with significant support or assistance from others such as friends and family;
  - g) Employment at a self-sustaining level or inability to consistently carry out homemaker roles (e.g., household meal preparation, washing clothes, budgeting, or childcare tasks and responsibilities);
  - h) Maintaining a safe and stable living situation; **AND**
3. Individuals for whom past (within 180 days of admission) or current response to other community-based intensive behavioral health treatment has shown minimal effectiveness (i.e. Psychosocial Rehabilitation, CSI, etc.). Admission documentation must include evidence of this criterion; **AND**
4. Individuals with **two or more of the following issues** that are indicators of continuous high-service needs (i.e., greater than 8 hours of service per month):
- a) High use of acute psychiatric hospitals or crisis/emergency services including mobile, in-clinic or crisis residential (e.g., three or more admissions per year) or extended hospital stay (60 days within the past year) or psychiatric emergency services.
  - b) Persistent, recurrent, severe or major symptoms that place the individual at risk of harm to self or others (e.g. command hallucinations, suicidal ideation or gestures, homicidal ideation or gestures, self-harm).
  - c) Coexisting substance use disorder of significant duration (e.g., greater than 6 months) or co-diagnosis of substance abuse
  - d) High risk for or a recent history of criminal activity due to mental illness (e.g., arrest and incarceration).
  - e) Chronically homeless (e.g., one extended episode of homelessness for a year or four episodes of homelessness within three years.
  - f) Residing in an inpatient bed (e.g., state hospital, community hospital, CSU) or in a 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 [NOTE: Medicaid may not be billed for services provided while in an inpatient facility. See Community Transition Planning service],
  - g) Inability to participate in traditional clinic-based services; **AND**

If the individual meets one of more of the criteria below, criteria #3 above is waived. All other requirements (criterion 1, 2, & 4) must be met:

- a) Individual is transitioning from a state forensic unit or group home on a Conditional Release order; OR
- b) Within the last 180 days, the individual has been incarcerated two or more times related to a behavioral health condition; OR
- c) Within the last 180 days, individual has been admitted to a psychiatric hospital of crisis stabilization unit two or more times.

## Continued Stay/Discharge/Transitioning Criteria

ACT delivers services in a continuous, rather than time-limited, framework for persons with long-term episodic disorders. This time-unlimited structure allows the ACT team to address relapse possibilities that might occur for consumers beginning the transition process to less intensive services. The ACT team will provide up to a four week period of transition for the consumer. However, even if a consumer and the ACT team recognize current treatment accomplishments, the consumer may begin to show signs of decompensation during this transitioning period, requiring a readjustment to the transition plan. If the consumer needs to stay for an additional authorization period, the ACT team should request such and provide documentation to meet continuing stay criteria. The ACT team will incorporate discharge/transition planning with activities that prepare the consumer for a greater sense of self-reliance when the consumer perceives self-readiness.

ACT consumers will not be prematurely discharged from services. In appropriate circumstances, consumers may transition to less intensive services. Arrangements must be made to maintain contact with the consumer throughout the transition process and until the transfer is complete. Some consumers may be at risk of being discharged due to challenges with engagement. All ACT providers are expected to demonstrate assertive engagement strategies in order to develop a connection and/or reconnect with difficult to engage consumers.

If a consumer wants to terminate his/her ACT services, the ACT team will listen to and accommodate the consumer's preferences regarding services. If the consumer still requests discharge after a team meeting to discuss concerns, the request must be honored.

### **The discharge and transitioning criteria as described for Best Practices and/or from the Provider Manual for Community Behavioral Health Providers:**

1. Individual no longer meets admission criteria (DBHDD, 2011); **OR**
2. Goals of the Individualized Recovery Plan have been substantially met (DBHDD, 2015); **OR**
3. Individual requests discharge and is not in imminent danger of harm to self or others (DBHDD, 2015); **OR**
4. Transfer to another service/level of care is warranted by a change in individual's condition (DBHDD, 2015); **OR**

5. Individual requires services not available in this level of care (DBHDD, 2011).
6. No individual should be considered for discharge prior to 45 days of consecutive outreach and documentation of attempted contacts (telephone calls, visits to various locations, collateral/informal contacts etc.).

**Note:** During discharge/transition, the ACT Team will provide at least three face-to-face contacts per week for most individuals on an ongoing basis. All individuals participating in ACT transitioning must receive a minimum of four face-to-face contacts per month. The Team must see each individual at least once a month for symptom assessment and medication management. A transition plan must be adequately documented in the Individualized Recovery Plan and clinical record (DBHDD, 2011). The ACT team can provide these transitioning services for up to four weeks:

- Psychosocial Rehabilitation Individual / Group
- Case Management/Intensive Case Management
- AD Support Services
- Behavioral Health Assessment
- Service Plan Development
- Diagnostic Assessment
- Physician Assessment (specific to engagement only)
- Individual Counseling (engagement only)

**Documentation of Discharge/Transitioning shall include:**

- The reasons for discharge as stated by both the consumer and the ACT team
- The discharge bridging services in which the consumer will be engaged
- A written final evaluation summary of the consumer’s progress toward the goals set forth in the treatment plan
- Discharge diagnoses, both medical and psychiatric
- Living arrangement
- Summary of consumer’s progress for all areas of his/her life
- Written description of how the consumer defines how he/she has met recovery goals
- A plan developed in conjunction with the consumer for follow-up treatment after discharge
- The signature of the consumer, the team leader, and the psychiatrist

### **III. Service Intensity and Capacity**

#### **Frequency of Client Contact**

ACT Teams must be designed to deliver services in various environments, such as homes, schools, transitional shelters and street locations. Providers should keep in mind that individuals may prefer to meet staff at a community location other than in their homes or other conspicuous locations (e.g., their place of employment or school). Staff should be sensitive to and respectful of individuals’ privacy/confidentiality rights and preferences in this regard to the greatest extent possible.

- Service delivery by ACT teams must highly regard confidentiality. ACT staff members

will address with the consumer the privacy and confidentiality issues regarding his/her treatment in the community. ACT staff members need to remember that wearing visible name tags, wearing stethoscope in to consumers building or desired location, driving agency car/van, wearing nursing scrubs, and any other identifiable items compromises a consumer's confidentiality.

- At least 80% of all service units must involve face-to-face contact with consumers outside of the program office locations that are comfortable and convenient for consumers (including the individual's home, based on individual need, preference and clinical appropriateness) (Teague et al., 1998; SAMSHA).
- Some individuals may need at least five face-to-face contacts per week due to mental health acuity. Other consumers need fewer contacts in a week, but all individuals participating in ACT must minimally receive a median of three face-to-face contacts per week. It is expected that 90% or more of consumers have face-to-face contact with more than one staff member and from multiple disciplines including licensed team members, in a two-week period (DBHDD, 2015; Teague et al., 1998; SAMSHA).
- In addition to a minimum median of 3 face-to-face contacts per week, one of the contacts each month must be for symptom assessment and management of medications (McGrew et al., 1994; Teague et al., 1998; DBHDD, 2011).
- The use of telemedicine/telepsychiatry will not be utilized as the primary method of delivering psychiatric assessment, treatment or intervention in ACT services.

## Frequency of Collateral Contacts

Upon consent from the consumer, the ACT team is expected to work with informal supports (i.e., family, landlord, employers, support network, probation officers) at least two- to-four times a month, with or without the consumer present, to provide support and skill training necessary to assist the identified resource and/or consumer in establishing needed supports/services. Both formal and informal support persons and the ACT team can work together to meet the wide range of needs the consumer may have, such as developing the ability to live independently; obtaining employment or other meaningful activity, improving the quality of family and social relationships; and managing anxiety and other difficult moods.

All identified partners must have a release of confidentiality signed by the consumer.

## Staff Coverage

- ACT teams maintain a small consumer-to-clinician ratio, of no more than 10 consumers per staff member. This does not include the psychiatrist, program assistant, transportation staff or administrative personnel. Staff-to-consumer ratio takes into consideration evening and weekend hours, needs of special populations and geographical areas to be served.

- Staff-to-client ratios may also need to be adjusted in settings where safety is an issue, and staff must pair up to work in a particular setting. However, the overall staff-to-client ratio should be no less than one fulltime employee (FTE) for every ten consumers.
- Services must be available by ACT Team staff skilled in crisis intervention 24 hours a day, 7 days a week with emergency response coverage, including psychiatric services (SAMSHA; DBHDD, 2011).
- Answering device, services, referring or forwarding lines to the Georgia Crisis and Access Line do not meet the expectation of “emergency response.” Crisis services are available to ACT consumers and provided by ACT staff (SAMSHA; DBHDD, 2011).
- The team must be able to rapidly respond to early signs of relapse and de-compensation and must be capable of providing multiple contacts daily to individuals in acute need. Best practice recommends that a limited geographic area be served by each ACT team, so that ACT team members can typically respond to a potential crisis within 30-60 minutes.

The ACT team shall provide treatment, rehabilitation, and support activities 24/7. The ACT agency should consider scheduling staff to work two eight-hour shifts with a minimum of two staff on the second shift (afternoon/evening), thus providing services at least 12 hours per day on weekdays. The ACT agency should schedule ACT staff for rotating on-call duty to provide crisis and other services the hours when staff members are not working assigned shifts. Additionally, it may not be feasible for the ACT psychiatrist to be on call 24/7. Therefore, an alternate psychiatric should be available.

## Continuity of Care

ACT teams shall establish mechanisms to provide continuity of care and ensure collaboration with other service providers (e.g., to facilitate transition to other services, inpatient admissions when necessary, and access to other community and institutional services). Of particular importance is transition in and out of psychiatric inpatient, crisis stabilization programs, crisis residential care and correctional/detention facilities.

The major premise of ACT is that consumers are capable of fulfilling a vital role in the management of their illnesses and in making progress towards achieving their goals. Providers accept the responsibility of getting information to the consumers so that they can become more effective in guiding their treatment process. All consumers receiving ACT services are offered choices, and the team will abide by the consumers preferences when offering and providing services.

**Note:** ACT participants who also receive a DBHDD Residential Service may not receive ACT- provided skills training which is a part of the “residential” service. The ACT provider shall be in close coordination with the residential provider such that there is no duplication of services supports/efforts (DBHDD, 2011).

## IV. Staff Requirements

### ACT Staffing Plan per maximum 100 Consumers served

\* **ACT teams are expected to maintain an average daily census of 75**

\*At least 2/3 staff must be Agency Employees (not contracted/1099).

**The following practitioners can provide Assertive Community Treatment:**

- Practitioner Level 1: Physician/Psychiatrist
- Practitioner Level 2: Psychologist, APRN, PA
- Practitioner Level 3: LCSW, LPC, LMFT, RN
- Practitioner Level 4: LMSW; LAPC; LAMFT; Psychologist/LCSW/LPC/LMFT's Supervisee/trainee with at least a Bachelor's degree in social work, community counseling, counseling, psychology, criminology or similar, functioning within the scope of the practice acts of the state; MAC, CAC-I, CAC-II, CADC, CCADC, GCADC (II, III); PP, CPRP, CPS or Addiction Counselor Trainees with Master's or Bachelor's degree in social work, community counseling, counseling, psychology, criminology or similar (addictions counselors may only perform counseling functions related to treatment of addictive diseases).
- Practitioner Level 5: CPS, PP, CPRP, CAC-I, RADT (I, II, or III), Addiction Counselor Trainees with high school diploma/equivalent under supervision of one of the licensed/credentialed professionals above.

**Assertive Community Treatment Team Members Composition must include:**

• *Team Leader* (1.0 FTE required): A fulltime team leader who is the clinical and administrative supervisor of the team and also functions as a practicing clinician on the team; this individual must have at least 2 years of documented experience working with adults with a SPMI and one of following qualifications to be a licensed associated practitioner: It is expected that the practicing ACT team leader provides services in the community at least ten hours per week. The team leader must be dedicated only to the ACT team (DBHDD, 2011; SAMSHA) and can be licensed as one of the following:

- Physician
- Psychologist
- Physician's Assistant
- APRN
- RN with a 4-year BSN
- LCSW
- LPC
- LMFT
- One of the following as long as the practitioner below is under supervision in accordance with O.C.G.A. 43-10A-11:
  - LMSW\*
  - APC\*
  - AMFT\*

\*If the team lead is not independently licensed, then clinical supervision duties

should be delegated appropriately in accordance with expectations set forth in O.C.G.A. Practice Acts.

- *Psychiatrist* (0.40-1.0 FTE required): A full or part time psychiatrist who provides clinical and crisis services to all ACT team consumers; works with the team leader to monitor each individual's clinical/medical status and response to treatment; and directs psychopharmacologic and medical treatment. The psychiatrist to ACT consumer ratio must not be greater than 1:100, and the psychiatrist must provide a minimum of 16 hours per week of direct support to the ACT team/ACT consumers. The psychiatrist must participate at least one time/week in the ACT team meetings (DBHDD, 2011; SAMSHA). The ACT psychiatrist may use telemedicine to provide this service, however, telemedicine is not to be utilized as the primary means of delivery of psychiatric services for ACT consumers.
- *Registered Nurse* (1.0-2.0 FTE required): A registered nurse who provides nursing services in the community and on location for all ACT team consumers and works with the team to monitor each individual's physical health, clinical status and response to treatment. The nurse is responsible for conducting psychiatric assessments; assessing physical health; providing a range of medical treatment, education to consumers on adherence to treatment and prevention of medical issues; nutrition; and a range of rehabilitation and support services. The nurse should be dedicated to the ACT Team and participate in overall treatment goals, and plans in collaboration with consumer and ACT team. The nurse is to be included with the on-call staff rotation providing crisis intervention. The ACT team nurse is expected to consult with community agencies and families for coordination of care. At least one ACT RN must be dedicated to a single ACT team. "Dedicated" means that the RN works with only one team at least 32-40 hours/week and is a full-time employee of the agency (not a subcontractor/1099 employee) (DBHDD, 2011; SAMSHA).
- *Certified Peer Specialist* (1.0 FTE required): One FTE who is fully integrated into the team and promotes consumer self-determination and decision-making and provides 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 certified peer specialist (CPS) will conduct a Wellness and Recovery Action Plan (WRAP) with each consumer on an ongoing basis. The WRAP is an ongoing collaboration between the consumer and the CPS. Each CPS has the ability to serve as an advocate, life coach, or mentor; develop community support; assist in the development of rehabilitation goals; facilitate resolution of issues; or provide education on the importance of maintaining personal wellness and recovery.

**Key elements of WRAP consist of:**

- Wellness Toolbox
- Daily Maintenance Plan
- Identify Triggers and an Action Plan
- Identify Early Warning Signs and an Action Plan
- Identify When Things Are Breaking Down and an Action Plan
- Crisis Plan
- Post Crisis Plan

The WRAP is designed and managed by the consumer and the CPS. The goal of developing a WRAP is to help the consumer acknowledge personal strengths and steps to recovery. The WRAP guides the consumer in exploring behaviors and supports that have been or would be useful in decreasing and preventing intrusive or troubling feelings and behaviors (Copeland; 2009).

- *Substance Abuse Specialist* (1.0 FTE required): A fulltime equivalent substance abuse practitioner who holds a CACI (or an equally recognized SA certification equivalent or higher) and assesses the need for and provides and/or accesses substance abuse treatment and supports for team consumers. If any single team serves more than 50 individuals then there must be more than 1FTE on the team. The ACT team provides 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 must be knowledgeable regarding evidence-based practices for dually diagnosed individuals. The use of Motivational Interviewing, stage-wise treatments, and Integrated Dual Diagnosed Treatment are all interventions that can be implemented. The substance abuse specialist is expected to see each dually diagnosed consumer one time a week for an average of 24 minutes per consumer and to ensure that 50% of the total dually diagnosed consumers receive one monthly dual diagnosis treatment-based group (SAMSHA; DBHDD, 2011).
- *Vocational Specialist* (1.0 FTE required): A vocational specialist has a minimum of one year verifiable vocational rehabilitation experience or training in vocational rehabilitation. Vocational Specialists primarily participate in core principles of individual placement and support (IPS). The vocational specialist's roles are:
  - To integrate supported employment in the ACT Treatment Plan once consumer has a desire to work
  - To assist individuals in identifying vocational interests and skills and in obtaining and maintaining employment. To focus on community jobs that pay at least minimum wage and are of interest to the consumer. The vocational specialist provides outreach, education and support to employers who may be interested in hiring people with mental illness
  - To maintain continuous follow-along supports for the consumer even after employment and as long as the consumer desires assistance from the vocational specialist
  - To help consumers develop a vocational or employment plan that leads to entry into the labor market. Vocational plans should be developed after an assessment of aptitudes, abilities and interests
  - To provide support to ensure that consumers can keep their jobs or remain in their chosen educational programs. The support needed may involve education or problem solving for consumers, employers and co-workers. Supports can also involve coordination and advocacy to ensure consumers have access to necessary community supports, such as income, housing, medical benefits and counseling. (SAMSHA; Allness & Knoedler, 2003)



- *A second licensed or licensed associate team member* (1.0 FTE required): A fulltime practitioner licensed to provide psychotherapy/counseling under the practice acts, or a person with an associate license who is supervised by a fully licensed clinician and provides individual and group support to consumers. This position is in addition to the team leader.
- *Para-Professional* (1.0 FTE required): Paraprofessional mental health worker provide rehabilitation and support services under the supervision of a licensed clinician. For example:
- *Program/Administrative Assistant* : The program assistant or administrative assistant 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. This position is recommended based on best practices but **not a requirement** (Allness & Knoedler, 2003).
- *Primary Practitioner*: **This is not an added position** but a title given to a consumer's primary ACT staff member who leads and coordinates the activities of the Individual Treatment Team (ITT) and is the ITT member primarily responsible for establishing and maintaining a therapeutic relationship with a consumer on a continuing basis, whether the consumer is in the hospital, in the community or involved with other agencies. In addition, he/she is the responsible team member to be knowledgeable about the consumer's life, circumstances, goals and desires. The primary practitioner develops and collaborates with the consumer to write the person-centered treatment plan; ensures that changes are made as the consumer's needs change; and advocates for the consumer. The primary practitioner works with other community resources to coordinate activities and to integrate other agencies or service activities into the overall service plan with the consumer. The primary practitioner provides individual supportive therapy and provides primary support and education to the family and/or support system and other significant people. The primary practitioner shares these service activities with other members of the ITT who are responsible to perform them when the primary practitioner is not working (Allness & Knoedler, 2003).

## Staff Supervision

The licensed clinician shall assume responsibility for supervising and directing all team and staff activities. This supervision and direction shall consist of:

- 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/service approaches,
- 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,
- Regular meetings with individual staff to review their work with consumers, assess clinical performance and give feedback,

- Regular reviews, critiques and feedback of staff documentation (i.e., progress notes, assessments, treatment/service plans, treatment/service plan reviews).
- Written documentation of all clinical supervision provided to ACT team staff.

## Staff Training

The DBHDD requires ACT Providers and ACT Teams to receive technical assistance from the D B H D D central and/or field offices on ACT implementation, the organizational structure of ACT, team roles, and achieving full fidelity. The central office offers separate mandated training for ACT providers.

### Paraprofessional Required Training

DBHDD has specified a minimum standard training requirement for staff who are not licensed/certified practitioners and/or do not have one of a number of recognized credentials but who provide reimbursable services for an approved provider agency. **The [Provider Manual for Community Behavioral Health Providers](#) contains all details about the training requirement for paraprofessionals.**

ACT team members share responsibility for all consumers. Staff who may be providing services outside of their area of specialty or beyond their score of credential must complete the paraprofessional training requirements.

## V. Staff Meetings and Planning Service

The ACT team shall conduct treatment team meetings, individual treatment team meetings, treatment planning meetings, and treatment planning review meetings at regularly scheduled times per a schedule established by the team leader. These meetings will be conducted in accordance with the following procedures:

- *Treatment Team Meeting (referred to as the Daily Organization/Morning Meeting in the NAMI start-up manual)* is a **daily** staff meeting held at regularly scheduled times under the direction of the team leader or an appointed designee. The meetings are conducted at least four times a week to meet full fidelity. Each consumer is discussed and documentation is made for review of the service contacts that occurred the previous day and the status/needs of the consumer. The meetings will review the service contacts which are scheduled to be completed during the current day and revised as necessary based on consumer needs. The daily staff assignment is discussed in order to carry out the day's service activities. Also, the meeting will be used to address general service needs, and crisis/emergency situations as needed. The daily log and the daily staff assignment schedule are used during the meeting to facilitate completion of these tasks. All consumers within ACT receive care from a multidisciplinary team and providers of ancillary services who work collaboratively on the mental health team. Multidisciplinary collaboration requires that all team members regularly communicate the consumer's progress and are not merely component parts.

It is expected that all ACT programs coordinate all elements of treatment and

rehabilitation to ensure collaboration (Allness & Knoedler, 2003).

- *Daily Staff Assignment Schedule* is a daily timeline summarizing all consumer treatment and service contacts. Based on the consumers individualized needs, determination will be made of which team member will provide face-to-face services. This daily staff schedule for all consumer's activities details for the day, what will be conducted by specific team members, where colleagues are, and how to reach them if issues or situations arise. Because consumers needs often change, the daily staff schedule addresses personalized care which is not based on a team member seeing the same consumer each week at the same time. An example of this maybe a situation where on Monday a consumer admitted to the CPS that she is using substances and in the Tuesday morning meeting, the daily schedule would incorporate the CAC to begin services treatment with the consumer.
  - *Individual Treatment Team (ITT)* is a group of three to five ACT staff members comprised of both clinical and rehabilitation experts. According to best practices, the team is organized **at least thirty days after admission**. The ITT members are assigned by the team leader and the psychiatrist to work collaboratively with a consumer and his/her family and/or natural supports in the community. The ITT team is considered the primary team at that time based on the consumer's needs and goals. For example, the consumer verbalized during the comprehensive assessment that he desires to obtain employment, wants to address his substance abuse and feels ashamed about his mental illness. The primary ITT would consist of vocational specialist, substance abuse specialist, and the certified peer specialist. All teams must include the primary practitioner, psychiatrist, and at least one clinical or rehabilitation staff person who shares case coordination and service provision tasks for each consumer.
  - The ITT has continuous responsibility to be knowledgeable about the consumer's life, circumstances, goals and desires. The team will collaborate with the consumer to develop and write the treatment plan; to offer options and choices in the treatment plan; to ensure that immediate changes are made as a consumer's needs change; and to advocate for the consumer. The ITT is responsible to provide much of the consumer's treatment, rehabilitation, and support services. ITT members are assigned to take separate service roles with the consumer as specified by the consumer and the ITT in the treatment plan. Please review NAMI Start-up Manual by Allness and Knoedler (2003) for further discussion about ITT.
  - *Treatment Planning Meeting* is a regularly scheduled meeting conducted under the supervision of the team leader and the psychiatrist. The purpose of this meeting is for the entire ACT team and the consumer and his/her designated family/natural supports, to thoroughly prepare to work together. The meeting is conducted **after the Comprehensive Assessment is completed** and the team will meet together to present and integrate the information collected through the assessment in order to learn as much as possible about the consumer's life, his/her experience with mental illness, and the type and

effectiveness of the past treatment he/she has received. The presentations and discussions at this meeting make it possible for all staff to be familiar with each consumer and his/her goals and aspirations, and for each consumer to become familiar with each ITT staff person.

- *Treatment Plan Review* is a thorough, written summary describing the consumer's and the ITT's evaluation of the consumer's progress/goal attainment, the effectiveness of the interventions and satisfaction with services since the last person-centered treatment plan. DBHDD requires treatment plan review to occur at **least every three months, or more frequently as needed.** This will allow for the treatment plan to be reviewed and revised as indicated. The treatment plan review is utilized to capture the consumer's progress toward goals for problems that they are currently being treated for. The review assists in addressing the justification for continued stay at the current level of care or justification for a transfer to different level of care.

### ACT Meeting Grid

Type of Meeting	Tasks/Description/Purpose	Who is Present	How often
<p><b>Treatment Team Meeting</b> Usually conducted in the morning</p>	<ul style="list-style-type: none"> <li>▪ Discussion of every consumer; even if briefly</li> <li>▪ Lasts 1 hour Meeting covers: medical, medication, SA, crisis or relapse signs for SA/MH issues, supports, upcoming appointments, progress, needs, &amp; vocational.</li> <li>▪ Daily Staff Assignments</li> <li>▪ Daily Log</li> <li>▪ Weekly consumer schedules and schedule changes: based on consumer needs</li> <li>▪ Building team cohesiveness, brainstorming and supporting each other.</li> </ul>	<ul style="list-style-type: none"> <li>▪ The Entire Team and Psychiatrist at least once a week</li> </ul>	<ul style="list-style-type: none"> <li>▪ Minimum 3 times a week</li> <li>▪ DACTS gives an agency a score of a 5 when the team meets 4 to 5 times a week.</li> </ul>
<p><b>Treatment Planning Meeting</b></p>	<ul style="list-style-type: none"> <li>▪ Discuss comprehensive assessment.</li> <li>▪ Orient consumer to ACT services.</li> <li>▪ Review what consumer wants out of treatment assist in goal identification</li> <li>▪ Introduce consumer to his/her ITT members.</li> <li>▪ Answer consumer questions.</li> <li>▪ Make recommendations for the treatment plan.</li> <li>▪ Discuss resources, barriers, goals, needs and deficiencies.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Newly enrolled Consumer</li> <li>▪ The entire team and Psychiatrist</li> </ul>	<p>Upon completion of comprehensive assessment and prior to the ITT meeting</p>

<p><b>Individual Treatment Team (ITT) Meeting</b></p>	<ul style="list-style-type: none"> <li>▪ Discussion of identified consumers.</li> <li>▪ Explore how ITT team will reach recovery goals and treatment needs.</li> <li>▪ Develop Treatment Plan</li> <li>▪ Write a progress note that includes meeting attendees, outcome and ITT roster.</li> </ul>	<p>3 to 5 people who best fit the consumers' needs</p>	<p>Meeting occurs after the comprehensive assessment is completed and the Treatment Planning Meeting has already occurred.</p> <p>Meet as needed</p> <p>ITT team may change every 3 months depending on consumer's needs.</p> <p>Prior to Discharge and transitioning consumer</p> <p>Team may need to meet with consumer if issues arise.</p>
<p><b>Treatment Plan Review</b></p>	<ul style="list-style-type: none"> <li>▪ Update treatment plan—the primary case manager will update treatment plan in this meeting.</li> <li>▪ A written summary describing the consumer's and the ITT's evaluation of the consumer's progress/goal attainment, the effectiveness of the interventions, and satisfaction with services since the last person-centered treatment plan was written.</li> </ul>	<ul style="list-style-type: none"> <li>▪ Entire Team</li> <li>▪ Psychiatrist</li> <li>▪ Consumer</li> </ul>	<p>Quarterly and at reauthorization; on-going.</p>

Non-attendance exception can be decided and documented by the team leader.

## Documentation of Meetings

The ACT team must have documentation (e.g., notebook, binder, file, etc.) which contains all staffing interactions (which shall become a document for audit purposes, and by which claims/encounters may be revoked-even though there are no funds attached). In addition to the requirements in Section G.2 in the DBHDD Provider Manual, a log of staff meetings is required to document staff meetings as outlined in Section A.2 of the DBHDD Provider Manual.

The ACT programs will maintain a daily log during the first meetings of the day and provide a roster of individuals served. For each individual served, there will be brief documentation of any treatment or service contacts that have occurred during the day and the behavioral description of the individual's clinical status. Team members who do not attend the morning meeting can review the daily log. The log is a good source of communication between the morning shift and the evening shift. It is similar to a brief shift report in hospital settings (Allness & Knoedler, 2003).

## **VI. Client-Centered Assessment and Individualized Recovery Treatment Planning**

The consumer and the ACT team work together to formulate and prioritize consumers issues, set goals, research approaches and interventions and establish the individualized recovery treatment plan (IRP). Goals are expected to be developed and written in accordance with S.M.A.R.T. (specific, measureable, attainable, realistic and timely) methodology. ACT consumers may present engagement challenges requiring a more generic initial recovery treatment plan at the onset of treatment/support. It is expected that the treatment plan be individualized and recovery-oriented after the team becomes engaged with the individual. The allowance for “generic” content of the IRP shall not extend beyond one initial authorization period.

The individualized recovery plan is 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 completed upon enrollment by the ACT team lead and the psychiatrist. The initial assessment evaluates the consumer’s appropriateness for ACT’ documents his/her initial diagnosis; reviews the immediate needs for the consumer; informs the consumer about ACT; develops a generic individualized recovery plan/service plan; and serves as authorization for the service.

### **ACT Comprehensive Assessment**

*ACT Comprehensive Assessment* is the organized process of gathering and analyzing current and past information with each consumer and the family and/or support system and other significant people in the individual’s social network. The multidisciplinary team gathers data pertaining to its specialty on the ACT team. For example, the substance abuse section will be completed by the certified addictions counselor. According to best practices and the DACTS model, the comprehensive assessment is used to establish immediate and longer-term service needs with each consumer and to set goals and develop the first individualized treatment plan. Because of the complexity of the mental illness and the need to build trust with the consumer, the comprehensive mental health, addiction and functional assessments may take up to 60 days. When a person identifies and allows his/her natural supports to be partners in his/her recovery, the ACT team documentation will demonstrate this participation and in accordance with confidentiality. Review NAMI Start-up Manual by Allness and Knoedler (2003) for copy of a comprehensive assessment.

**The ACT Comprehensive Assessment will cover the following areas** (Allness & Knoedler, 2003):

- Reasons for admission
- History of present mental illness

- Treatment goals and individual strengths
- Evaluation of mental and functional status; along with a proper diagnosis
- Prior treatment and rehabilitating services used and the outcomes of these services
- Physical health
- Use of alcohol or drugs and SA treatment
- Education and employment
- Assets, limitations, preferences for future education and employment
- Social development and functioning
- Social skills and legal involvement
- Activities of daily living skills
- Family structure and relationships
- Recommendations for initial plan
- Recommendations for treatment plan goals and individual strengths/weaknesses

**Goals of the comprehensive assessment are:**

- To reconstruct and evaluate the individual’s history and experiences in his/her life while living with a mental illness
- To form a therapeutic alliance with each ACT consumer
- To work with the individual on his/her own terms by not rushing to complete the comprehensive assessment but to view the assessment as an ongoing practice
- To help the individual identify personal needs and aspirations and instilling hope for recovery
- To understand the individual on various individual and social levels in order to develop an individualized treatment plan
- For the nurse and psychiatrist to evaluate medical needs and interventions that are to be addressed in treatment

**ACT Six-month Re-Assessment:**

ACT consumers will be re-assessed at 6 month intervals from date of completion of the initial assessment. This is in accordance with NAMI best practice for ACT, and will support the process of re-evaluating the consumer’s needs and efficacy of interventions. Sources of information may be different from those included in the initial/ comprehensive assessment. The 6-month re-assessment will offer an opportunity for integration of information that is gathered as part of the multiple visits from all service providers, and allows the team to revisit needs in preparation for submitting the 6-month re-authorization as well as adjustment/updating of the treatment plan. This 6-month reassessment should be an integral component of the 6-month re-authorization process.

**Additional Requirements: A psychiatric and social functioning timeline**

*Psychiatric and Social Functioning TimeLine* is a form which assists ACT team staff to organize chronological information about significant events in the consumer’s life. The timeline can reveal how one’s mental illness has impacted his/her ability to live productively in the community. The timeline can reveal developmental milestones that were not reached because of the person’s mental illness. The timeline will also provide a treatment history of possible anniversary dates or triggers that have contributed or may contribute to hospitalization. This

format allows staff to systematically analyze and evaluate information with the consumer, to formulate hypotheses for treatment, and to determine appropriate treatment and rehabilitation approaches and interventions with the consumer. One person on the team is responsible for gathering the data and completing the form. The individual chosen to complete the timeline will work in the ACT office gathering data. Please review the NAMI Start-up Manual by Allness & Knoedler (2003) for a copy of a timeline.

## **Individualized Recovery Treatment Planning**

The Individualized Treatment Plan shall be developed utilizing a client-centered approach in collaboration with the consumer and consumer-designated family or substitute decision maker. The consumer's participation in directing the development of the treatment plan shall be documented. Together the ACT team and consumer shall assess the consumer's needs, strengths, and preferences, and develop an individualized treatment service plan. The ITT members are responsible for ensuring that the consumer is actively involved in the development of treatment recovery goals. With the consent of the consumer, the ACT team shall also involve relevant agencies and members of the consumer's social network in the formulation of treatment/service plan.

### **The treatment/service plan shall:**

- Identify individual issues/problems.
- Set S.M.A.R.T. short-term and mid-term goals for each issue/problem.
- Establish the specific approaches and interventions necessary for the consumer to meet his/her goals, improve his/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).
- Document in the plan who will carry out the approaches and interventions.

### **Possible components of the treatment/service plan may include:**

- Symptom management
- Physical health issues
- Substance abuse (if needed)
- Education and employment
- Social development and functioning
- Activities of daily living
- Family structure and relationship
- Psychiatric illness or symptom reduction
- Housing
- Daily structure and employment
- Family and social relationships
- Co-occurring illnesses (if needed)

## **VII. Required Services**

The multidisciplinary ACT team will individually plan and deliver services that are targeted to



help consumers address the complex interaction between symptoms and psychosocial functioning in order for the consumer to achieve personal goals.

**Best Practices and Full Fidelity for ACT include the following services:**

- Service coordination
- Crisis assessment and intervention
- Symptom assessment and management
- Cognitive-Behavioral Therapy
- Motivational Interviewing
- Self-management skills
- Medication prescription, administration, monitoring and documentation
- Substance abuse treatment, dual disorder treatment
- Work/education-related services
- Activities of daily living services and family supports
- Social, interpersonal relationship and leisure-time activity services
- Support services or direct assistance to ensure that consumers obtain the basic necessities of daily life

### **Crisis Assessment and Intervention**

A crisis is a period of disequilibrium and decreased functioning. A crisis is not an event but the individual's perception of and response to an event or situation. Consumers' acute responses include helplessness, confusion, anxiety, shock, and anger (Golan, 1978). ACT teams are expected to provide services 24/7. One of the significant goals of ACT is to prevent hospitalization. Each ACT consumer should have a WRAP to assist him or her in recognizing signs and triggers that might predict a crisis episode, thereby allowing for a coordinated response and prevention of re-hospitalization.

The ACT team should have conversations upon admission and maintain continual dialogue with consumers regarding measures that will likely prevent hospitalization/incarceration. Examples of preventive measures include medication compliance; teaching coping and de-escalation skills to consumers; providing consumers with contact information of natural supports; and/or exploring items that may provide a sense of safety/security to consumers.

**The beginning stage of crisis intervention:**

- Engage consumer
- Define and assess the crisis situation
- Identify the emotional and behavioral responses and perceptions of consumer
- Break down the situation into smaller manageable parts to help identify steps leading up to crisis
- Review current behavioral reactions
- Reveal ways consumer could have handled situation differently by emphasizing strengths and choices

**The next phase of crisis intervention:**

- Design an action plan
- Review barriers to action plan

- Write down past resilience behaviors
- Identify triggers
- Identify signs leading up to crisis

**The last stage of a crisis intervention:**

- Review the action taken and evaluate success
- Offer guidance about handling future crisis situations
- Process feelings around ending the crisis-therapeutic relationship
- If crisis intervention did not deescalate thoughts, feelings, or behaviors then hospitalization may be necessary

## Co-Occurring Disorder Services

If a consumer has a co-occurring disorder, the substance abuse specialist will provide at least one weekly session to address co-occurring issues with the use of stage-wise interventions. Evidence-based practices shows positive results for individuals with co-occurring disorders which includes integrated Dual Diagnosis Treatment, Motivational Interviewing, and Cognitive Behavioral Therapy.

The ACT team shall provide a stage-based integrated treatment model that is non-confrontational, considers interactions of mental illness and substance abuse, and has client-determined goals. When promoting behavioral change for a consumer, the change is based on incremental growth. For lasting change to occur, an individual must be educated, prepared, motivated and supported. Stage-wise interventions are suggestions to provide individually adapted health and behavioral changes tailored to the individual’s specific interests, preferences and readiness to change. Evidence-based practice stage-wise interventions teach participants the behavioral skills needed to incorporate healthier habits into their lifestyles. The interventions are based on established behavioral change models.

Consumers in the early stages of readiness to change (pre-contemplation or engagement stage) receive content that is designed to raise their awareness about the benefits of recovery. As their state of readiness evolves, the interventions adapt according to the consumers goals and confidence levels. The interventions are built around weekly themes that encourage sustainable and incremental changes. The goal is to promote action by providing resources, education, and support. Motivational Interviewing incorporates stages of change that are identifiable by the person’s statements and behaviors.

Harm reduction must be addressed with consumers who have a dual diagnosis. Harm reduction is not a model but a set of practical strategies that reduce negative consequences of substance use by incorporating a spectrum of strategies for safer use and to manage ones use to possible abstinence.

**Harm reduction is based on four principles:**

- While absolute abstinence is a goal for many or most substance abusers, few achieve it, and those who do may relapse periodically
- Ordinary medical treatment readily accepts and practices ameliorative therapies, which

preserve health and well-being even when people fail to observe all recommended health behaviors

- Therapists should present accurate information to clients and may express their own beliefs, but they cannot make judgments on clients
- There are many shades of improvement in every kind of therapy, and all improvement should be encouraged (Denning, Little, & Glickman, 2004).

### **Examples of Harm Reduction Techniques**

- Remind consumers who have stopped using drugs/alcohol for a while in order that their tolerance will be lower, and therefore, their bodies will react to the same dosage differently than before.
- Identify goals for decreased levels of usage.
- Encourage consumers to take their first dose later in the day to encourage control and gradual reduction (avoid or reduce the early morning dose).
- Reflect on previous episodes of treatment and relapses.
- Analyze the causes underlying one's previous criminal behavior, triad connection and possible consequences
- Explore costs and benefits of crime

### **Work Related Services**

Work related services are integrated into the ACT model to assist consumers in finding and maintaining competitive employment. Employment, even if part-time, will create social inclusion for the consumer, enhance self-esteem and provide a structured lifestyle.

It is the expectation that the ACT team's Vocational Specialist will assess and address the consumer's vocational skills, interests and desires. The ACT Vocational Specialist holds the responsibility to assist the consumer in job search and obtaining an interview and other job related supports as needed. ACT Vocational Specialists are expected to engage in job development with potential employers on behalf of ACT enrolled consumers. If a consumer is enrolled in both ACT and Supported Employment, a collaborative relationship between the supported employment agency and the ACT vocational specialist should be established. Both professionals may work toward achieving the same goal of helping the consumer to develop the skills necessary to obtain competitive employment.

### **Mental Health benefits of involvement in work**

- Fosters feelings of productivity and usefulness
- Creates a sense of purpose and fulfillment of time
- Creativity and income
- Allows one to perform a variety of tasks and increase skills
- Offers interaction with others
- Creates new experiences
- Teaches responsibility
- Provides opportunities to make friends
- Allows one to contribute to the community

## Activities of Daily Living and Wellness Recovery

Activities of daily living services support consumers enhance and maintain safe and affordable housing. The ACT team supports the acquisition of daily living skills such as performing household activities, cooking, grocery shopping, laundry, developing healthy eating habits, carrying out personal hygiene and grooming tasks, developing or improving money-management skills; using transportation, and correctly visiting a personal physician or other medical professional. The ACT team educates consumers on wellness topics such as nutrition, exercise, diabetes and diabetes prevention, heart disease, relaxation and stress management and smoking cessation.

## Social/Interpersonal Relationship and Leisure-Time Skill Training

The ACT team will help consumers improve their social/interpersonal relationships and their use of leisure-time. Activities may include improving communication skills, developing assertiveness, increasing social skills, enhancing social experiences, family reunification, planning appropriate use of leisure time and relating to landlords, neighbors and others effectively. When ACT participants are also receiving a DBHDD residential service, the consumer may not receive ACT-provided skills training that is a part of the “residential” service. The ACT provider shall be in close coordination with the Residential provider such that there is no duplication of services supports/efforts. A formal MOU is needed to structure and clearly define what services the ACT team will provide and what services the residential provider will provide.

## Peer Support Services

DBHDD promotes client-centered practices with the integration of CPSs throughout our behavioral health services. The peer support specialists serve to validate consumers’ experiences and to guide and encourage consumers to take responsibility for and to actively participate in their own recovery. In addition, peer services help consumers identify, understand, and combat stigma and discrimination against mental illness and develop strategies to reduce self-imposed stigma.

As of benefit of their personal experience with mental illness and mental health services, the CPS provides expertise that professional training cannot replicate. The CPSs are fully integrated ACT 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 and respected.

### **Peer Support services include:**

- Self-disclosing and sharing of appropriate experiences to serve as a mentor and a role model;
- Developing and helping consumers to recognize the need for coping mechanisms to deal with symptoms and social stigma;
- Educating team about the consumer perspective on the mental health system; helping the

- team to maintain a client-centered approach that maximizes consumer participation;
- Advocating for development of consumer initiatives within the community and identifying opportunities for consumer self-sufficiency;
- Introducing and referring consumers to self-help programs and advocacy organizations that promote recovery; and
- Developing a WRAP with consumers.

## Support Services

The ACT team will assist consumers in using transportation and making medical and dental appointments; provide benefits counseling (e.g., Income Assistance, assistance in filing Social Security/Disability); help find affordable housing; and locate other community resources.

## Family-Centered Services

ACT teams are expected to include consumers' family members or others whom the consumers consider to be of significance for participation in the recovery process. Some benefits of active inclusion of significant others are:

- Discussing strengths and experiences of the consumer and how consumers' mental illness impacts their support system
- Promoting reduction in stress and increase coping skills
- Structuring problem-solving approach
- Improving communication skills
- Building support systems and plans
- Providing family psychoeducation
- Addressing family unification

## Groups

Research indicates that better outcomes are achieved when group treatment is integrated as a curriculum-based treatment for individuals with serious and persistent mental illness. Research suggests that modifications in maladaptive behavior occur most effectively when stages of treatment are taken into account (Kanas, 2000).

Clarification for groups (up to twenty units/week): A group may be offered to no more than ten ACT participants at one time. This group contains no fewer than three consumers and no more than ten. This may be offered for no more than five hours in any given week for an individual enrolled in ACT services. Only ACT consumers are permitted to attend these group services. The group practitioner levels are ordered 1-5 when a curriculum-based therapeutic group is offered such as Dialectical Behavioral Therapy skills building, Motivational Interviewing, Cognitive Behavioral groups (DBHDD, 2011).

Acceptable group practitioners are those on the ACT team who meet the practitioner levels as follows:

- Practitioner Level 1: Physician/Psychiatrist

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- Practitioner Level 2: Psychologist, CNS-PMH
- Practitioner Level 3: LCSW, LPC, LMFT, RN
- Practitioner Level 4: LMSW; LAPC; LAMFT; Psychologist/LCSW/LPC/LMFT's Supervisee/trainee with at least a Bachelor's degree in social work, community counseling, counseling, psychology, criminology or similar, functioning within the scope of the practice acts of the state; MAC, CAC-I, CAC-II, CADC, CCADC, GCADC (II, III); PP, CPRP, CPS or Addiction Counselor Trainees with Master's or Bachelor's degree in social work, community counseling, counseling, psychology, criminology or similar (addictions counselors may only perform counseling functions related to treatment of addictive diseases).
- Practitioner Level 5: CAC-I, RADT (I, II, or III), Addiction Counselor Trainees with high school diploma/equivalent (practitioners at this level may only perform these functions related to treatment of addictive diseases).

Substance abuse groups should be offered once a month to at least 50% of the total dually diagnosed consumers in ACT (SAMSHA; DBHDD, 2011). This group has to be treatment-oriented and curriculum-based. If needed, an ACT team can refer a consumer to another program (SAMSHA; DBHDD, 2011).

**Examples of self-help groups that are not billable include:**

- Double Trouble
- NA/AA Anonymous
- NAMI family support

*Note:* If an ACT organization provides these self-help groups, the interactions that may occur between a consumer and an ACT team member is not billable.

**ACT is a comprehensive team intervention and most additional services are excluded, with the exceptions of:**

- Peer Supports
- Residential Supports
- Substance Abuse—Intensive Outpatient (SA—IOP)
- Community Transition Planning (to be utilized as a person is transitioning to/from an inpatient setting, CSU or jail)
- Group Training/Counseling (within parameters listed in Section A)
- Supported Employment
- Those services which are identified as a part of the transition plan as noted earlier in this document.

## VIII. Client Record

The ACT team shall maintain a treatment record for each consumer. The treatment record is confidential, complete and accurate and contains up-to-date information relevant to the consumer's care and treatment. The record shall accurately document assessments, treatment plans 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 the services received. The team leader and the program assistant will be responsible for the maintenance and security of the

consumer treatment records. Consumer records are located at the ACT team headquarters and, for confidentiality and security, are to be kept in a locked file. For purposes of confidentiality, disclosure of treatment records by the ACT team is subject to all the provisions of applicable state and federal laws. Consumers shall be informed by staff of their right to review their record and the process involved in requesting to do so. Each consumer's clinical record shall be available for review and may be copied by authorized personnel (DBHDD, 2011).

Detailed expectations for documentation are set forth in the [Provider Manual for Community Behavioral Health Providers](#)

## **IX. Client Rights and Complaint Resolution Procedures**

ACT teams' policies and procedures ensure the protection of consumer rights and must be consistent with state and federal law, the [Provider Manual for Community Behavioral Health Providers](#) and the Medicaid Part I Program and Policy Manual, which includes a mechanism to readdress complaints. All team members must fully understand consumer rights:

- To have autonomy and self-determination
- To be respected; to make decisions that may not be in his/her best interests; and to give or refuse consent to services or treatment, where the consumer is capable with respect to such decisions.
- Where the consumer is not capable, all team members must respect the need to comply with the laws and professional operations that govern consent to treatment and services for incapable persons.
- These principles are intrinsic to the basic tenets of consumer-centered care. The team must facilitate the fair and efficient resolution of complaints.
- Nondiscrimination
- Control of own money
- Voice or file grievances or complaints
- Confidentiality

## **X: ACT Fidelity Review: Program Evaluation**

### **What is an ACT Fidelity Review:**

The ACT Fidelity Scale is the Dartmouth Assertive Community Scale (DACTS) developed by Teague, Bond, and Drake (1998). The DACTS contains 28 program specific items to measure the adequacy of implementation of ACT programs. Each item is scored using a likert scale from 1-5, with 1 meaning not implemented and 5 meaning fully implemented. Items on the scale fall into three categories: human resources (structure and composition); organizational boundaries; and nature of services.

- ACT Fidelity monitoring ascertains a measurement of an ACT team's current practice based upon clinical record reviews, staff interviews and interviews with consumers; along with administrative documents. The fidelity score and composite report can assist in practice improvement areas and assist in providing technical assistance to professional employees.
- The ACT Fidelity Scale has been developed to measure the adequacy of ACT program implementation. A team of two to three representatives will conduct the Fidelity Reviews and will convene to review results. If the team feels a need for further clarification, the

team will be asked to submit additional documents to ensure the most accurate results as possible. It is important for the ratings to be made objectively, based on fidelity evidence.

- At the end of the review, a brief impression of findings will be verbally shared with the ACT program, highlighting significant ratings with an emphasis on the strengths of the program.
- Each agency will receive an ACT Fidelity Monitoring Report which includes a fidelity score and explanation. The report will be informative, factual and constructive.
- Following receipt of the report, the ACT Fidelity Review team will facilitate a fidelity review exit interview, inclusive of the review team, the ACT provider and regional and state office staff.
- The ACT Fidelity Review is conducted at least once a year. The DBHDD ACT and CST Services Unit will contact the agency to schedule a fidelity review.
- To review the ACT Fidelity Tool Kit, please visit [www.samsha.gov](http://www.samsha.gov).

### **The Description of the 3 Categories of the DACTS:**

- **Human resources section:** The Human Resources Domain measures the number and mix of professionals comprising the ACT team and the extent to which the team uses a multi-disciplinary approach to service delivery.
- **Organization boundaries section:** The Organizational Boundaries Domain examines the structure and operations of the ACT team and the extent to which the team coordinates with other organizations involved in delivery of services to ACT recipients.
- **Nature of services:** The Nature of Services Domain evaluates how the ACT team delivers services to ACT recipients.

The fidelity assessment is administered by individuals who have experience and training in interviewing, data collection and auditing. The reviewers have an understanding of the nature of services, operations, and best practices. The maximum achievable DACTS total score is 140. Each ACT provider is expected to achieve a minimum total DACTS score of 112 and a minimum DACTS mean score of 4.0, in order to be considered as operating within fidelity. Individual items receiving a score below a 3.0 on the DACTS require a Corrective Action Plan, and progress toward deficient areas will be monitored.

## **XI. Community Advisory Bodies**

Each ACT program/operating agency is encouraged to establish a local community advisory body that supports and guides the ACT's team implementation and operation. This body may also support other mental health services and performs a key role in promoting high quality and recovery-oriented services for ACT clients.

ACT advisory committee/council/board members are chosen for their specific knowledge about the ACT model; their general knowledge of mental health and addiction services; their links with relevant community resources; and their ability to represent the interests of consumers and the ACT community program. Members selected should include both mental health consumers and community stake holders.

### **Possible Committee Members:**



- State, county and local mental health administrators
- Consumers and family members
- Corrections
- Vocational rehabilitation
- Housing and Medicaid representatives
- NAMI

**The community advisory body should have written terms of reference for incorporating the requirements outlined in this section. The main responsibilities of the advisory body are to:**

- Promote fidelity to the ACT Program Operations.
- Address problems and advocate reducing system barriers to ACT implementation.
- Provide the program with advice on timely resolutions to emerging issues.
- Represent the interests of consumers and their families regarding services received from the ACT team.
- Develop and maintain good communication with the community.
- Promote partnerships, awareness and understanding of the program's target population.
- Review and make recommendations on the ACT agency's annual operating plan and budget; identify any opportunities to increase cost-effectiveness by collaborating with other agencies; and bring to the Board's attention any significant deviations from the plan and budget during the year.

## ACT Coalition

ACT teams are a key community resource to help support consumers in the community who are most at risk of re-hospitalization. ACT can also serve as a bridge to the community for many of our consumers who have had repeated and prolonged hospitalizations.

DBHDD hosts monthly or bimonthly meetings including ACT providers and key members of DBHDD as well as other presenters. The meetings include information directly relevant to providing treatment for ACT consumers and maintaining full fidelity to the model.

ACT team leaders must attend at least 95% of all Coalition meetings. More than one person per ACT provider may attend, and this should include staff from the team as well as other key management who may be involved in development of strategies related to ACT services.

Corrective action will be taken against agencies not meeting DBHDD's expectation of the 95% attendance to the ACT Coalition meetings.

ACT providers will need to provide DBHDD with current ACT team email information in order to receive emails about ACT related items and invitations to the ACT Coalition. Please send the agency's primary contact for the ACT and the CEO to [Kimberly.miller@dbhdd.ga.gov](mailto:Kimberly.miller@dbhdd.ga.gov).

The Benefits of the ACT Coalition Meetings:

A collaborative and objective arrangement that allows ACT providers an opportunity to engage in discussion of matters of importance; receive relevant information; share concerns and

- Receive technical assistance trainings to help ACT providers enhance their program
- An opportunity to network with other agencies
- Support from fellow peers

- Share resources
- To learn about changes in policies and procedures
- To learn from guest speakers
- Share information to and from the state office

## **XII: Outcomes**

Outcomes show the benefits and improvement for individuals during and following participation in ACT services. With the use of outcome data, the patterns of the program and consumers become visible.

The DBHDD expects all ACT providers to deliver quality services with the emphasis of operating within fidelity to the ACT Model. If the ACT agency is modeling fidelity, the outcome data is expected to show a decrease in recurrent acute episodes of illness, homelessness, hospitalizations and incarcerations, and an increase in the consumer's quality of life, involvement in social and employment activities.

Outcomes are considered a program evaluation tool that provides the viewer a snap shot of the program implementation to the ACT model. Each ACT program shall evaluate: 1) consumer outcomes; 2) consumer and family satisfaction with the services; and 3) fidelity to the ACT model. Specific outcomes monitored by DBHDD include: 1) census, 2) enrollments within three days of referral, 3) psychiatric re-admission, 4) psychiatric inpatient days, 5) jail days, 6) non-homeless persons and 7) consumer employment. Program evaluation will be used by the ACT team, the Regional Offices, an External Review Organization, the state ACT Coordinator of DBHDD and the community advisory board in order to evaluate program effectiveness and to establish program improvement and performance goals. Each ACT agency is expected to submit outcome data to the state ACT Coordinator once a month. Please review outcome form on pages 43-44.

## **XIII. Recovery**

Recovery is more than the elimination of symptoms from an otherwise unchanged life. It is about regaining wholeness, connection to the community and a purpose-filled life.

Pat Deegan (1987) wrote:

Recovery does not refer to an end product or result. It does not mean that one is "cured" nor does not mean that one is simply stabilized or maintained in the community. Recovery often involves a transformation of the self-wherein one both accepts ones limitation and discovers a new world of possibility. This is the paradox of recovery i.e., that in accepting what we cannot do or be, we begin to discover who we can be and what we can do. Thus, recovery is a process.

It is a way of life. It is an attitude and a way of approaching the day's challenges. It is not a perfectly linear process. Like the sea rose, recovery has its seasons, its time of downward growth into the darkness to secure new roots and then the times of breaking out into the sunlight. But most of all recovery is a slow, deliberate process that occurs by poking through one little grain of sand at a time.

DBHDD expects all ACT providers to create a recovery supportive environment in which

consumers are involved in all aspects of their treatment, individuals define their own recovery, staff value consumers' self-determination, critical thinking and independence.

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## Appendix A - Evidence-based Practices in ACT

### EBP Embedded in ACT:

- Illness Management and Recovery
- Integrative Dual Diagnosis Treatment
- Collaboration with families/Psycho-education
- Motivational Interviewing Techniques
- Supported Employment
- Permanent Supported Housing
- Psycho-educational Multifamily Groups

### Specific evidence-based practices that are within the ACT model can be provided by the ACT team:

- Cognitive Behavioral Therapy for Social Skills Training
- Evidence-based pharmacological treatment using practice guidelines (algorithms) and a collaborative approach with ACT consumers;
- Double Trouble to Recovery (non-billable because self help group)
- Pathways to Housing First Model
- Dialectical Behavioral Therapy
- Trauma Affect Regulation: Guide for Education and Therapy
- Seeking Safety
- Program to Encourage Active, Rewarding Lives for Seniors
- IPS
- Trauma Recovery Empowerment Model
- Collaborative Documentation
- Integrated Dual Disorder Treatment

**Note:** Please review [www.SAMHSA.gov](http://www.SAMHSA.gov) for descriptions of all these evidence-based practices.

## APPENDIX B - ACT MONTHLY PROGRAMMATIC REPORT



Assertive Community Treatment (ACT) Form

ACT Monthly Programmatic Report ANNEX: G

Instructions: Please enter monthly performance data into the ACT Programmatic Report and submit no later than the 10th calendar day of the following month. Data shall reflect the number of consumers who benefit from ACT Services this month. All fields are required. Enter 0 (zero) where there is no data value (no blanks).

Provider Name:

DBHDD Region And Geographic Service Area:

Service Type:

Name of Person Completing Report:

ACT Month/Year of Service:

Email of Person Completing Report:

Date of last ERO Audit :  Score:  %

Date of last Fidelity Review for ACT:  Score:

### A. ACT TEAM CENSUS

Month

**1. ACT Team Consumer Census End of LAST MONTH.**

**2. Number of ACT Team Consumer Discharges this Month**

**0**

**3. Total Number Consumers Received into ACT Services this Month.**

**0**

**a. Consumers Received into Services within 24 hours of Referral Date this Month.**

**b. Consumers Received into Services within 3 days of Referral Date this Month.**

0

**c. Consumers Received into Services within 5 days of Referral Date this Month.**

0

**d. Consumers Received into Services within 7 days of Referral Date this Month.**

0

**e. Consumers Received into Services within more than 7 days of Referral Date this Month.**

0

**4. Total Number Consumer Enrollments (MICP approved) into ACT this Month.**

0

**5. Contracted Capacity Range:**

**Please indicate the number of ACT FTE Non-Administrative Staff at the end of this Month.**

0.0

**Maximum Capacity:**

\_\_\_ Consumers

**6. ACT Team Consumer Census End of THIS MONTH (only include MICP approved)**

0

**B. REFERRAL SOURCES**

Month

**7. Number of Consumer Referrals received this Month:**

**0**

**a. Consumers Referred by DBHDD Core Provider this Month.**

0

**b. Consumers Referred by Inpatient Facility this Month.**

0

**c. Consumers Referred by Jail/Prison this Month.**

0

**d. Consumers Referred by Emergency Room this Month.**

0

**e. Consumers Referred by Homeless Provider this Month.**

0

**f. Consumers Referred by Other Source this Month.**

0

**C. CONSUMER OUTCOME DATA FOR THOSE IN ACT SERVICES MORE THAN 30 DAYS**

Month

**8. Number of EMERGENCY ROOM Visits Due to Behavioral Health Crises**

0

**9. PSYCHIATRIC Inpatient Admissions to Hospitals, CSU's, and/or Inpatient Detox by ACT Consumers:**

**a. Number ACT Consumer Psychiatric Inpatient Admissions this Month (DUPLICATED)**

0

**1. Number of State or Private Hospital admissions this Month (DUPLICATED)**

0

**2. Number of ACT Consumer CSU and/or Inpatient Detox admissions this Month (DUPLICATED)**

0

**b. Number of ACT Consumer Psychiatric Inpatient Admissions this Month (UNDUPLICATED # of consumers)**

0

**c. Number Psychiatric Inpatient Days Utilized this Month.**

0

**d. Number Psychiatric Inpatient Readmissions within 90 days of Discharge this Month.**

0

**10. MEDICAL Inpatient Admissions to Hospitals by ACT Consumers:**

**a. Number ACT Consumer Medical Inpatient Admissions this Month.**

0

**b. Number Medical Inpatient Days Utilized this Month.**

0

**c. Number Medical Inpatient Readmissions within 90 days of Discharge this Month.**

0

**11. Police/Criminal Justice Contacts (excluding mandated contacts for parole or probation)**

**a. Number ACT Consumer Contacts with Police/Criminal Justice this Month.**

0

**b. Number of Incarcerations this Month**

0

**c. Number Jail Days Utilized this Month.**

0

**12. Total Number ACT Consumers Employed or Participating in Work Related Activities this Month:**

0

**a. Number ACT Consumers Competitively Employed 15 Hours or more this Month**

0

**b. Number ACT Consumers Competitively Employed less than 15 Hours this Month**

0

**c. Number ACT Consumers in Non-Competitive Work Related Activities this Month (earning less than minimum wage, volunteer, work training)**

0

**13. Number ACT Consumers w/an Episode of Homelessness this Month(without a residence).**

0



D. LIVING ARRANGEMENTS

Month

**14. Number ACT Consumers by Living Arrangement this Month:**

**0**

**a. Living in Apartment or Home with Full Tenant Rights this Month.**

0

**b. Living in Supported Housing with Full Tenant Rights this Month.**

0

**c. Living in Congregate Housing, Boarding Home, Personal Care Home, Group Home this Month.**

0

**d. Living with Family or Friends with No Tenant Rights this Month.**

0

**e. Living on the Street, Homeless Shelter, Motel this Month.**

0

**f. Living in Other Arrangements this Month.**

0

E. DISCHARGE CRITERIA

Month

**15. Total ACT Consumers Discharged from ACT this Month:**

**0**

**a. Graduated, Referred to Other Provider of Lesser Intensive Services this Month.**

0

**b. Dropped Out, Refused Services, Unable to Locate, Unplanned Relocation this Month.**

0

**c. Terminated, Team decided they would not serve them this Month.**

0

**d. Unable to Obtain Authorization for ACT Services this Month.**

**e. Deaths this Month(Suicide, Other Causes).**

**F. TEAM POSITION STATUS**

**16. Use the drop-down menu to indicate which of the following ACT Team positions are filled or vacant. If the team does not have the position, select "N/A".**

**Position Title**

**Status**

**Psychiatrist #1**

**Psychiatrist #2**

**Team Lead**

**Nurse #1**

**Nurse #2**

**Cert. Addiction Counselor #1**

**Cert. Addiction Counselor #2**

**Vocational Specialist #1**

**Vocational Specialist #2**

**Cert. Peer Specialist #1**

**Cert. Peer Specialist #2**

**OTHER Team Position**

**Position Title Status Option**

Comments 

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