

# National Program Standards for ACT Teams

Deborah Allness, M.S.S.W. and William Knoedler, M.D.  
Revised June 2003 by D. Allness

A number of second and third generation studies have shown that ACT programs have not achieved a similar degree of positive outcomes as the original PACT research. Typically lack of strong fidelity to the ACT model is the demonstrated contributor to poorer results. Therefore, this new version of the *National Program Standards for ACT Teams* not only provides minimum standards for program operation but it also provides brief descriptions of the rationale for many of the ACT requirements which have been difficult for providers and administrators to understand and implement. In addition, the ACT Standards have been modified to emphasize that ACT is a client-centered, recovery-oriented service delivery model. Client empowerment, involvement, and choice are fundamental to the principles and operation of individualized, collaborative, and effective ACT service delivery.

## Background: Program Standards

The *National Program Standards for ACT Teams* is written to provide an archetype for departments of mental health to use in writing and promulgating their own Assertive Community Treatment (ACT) program standards. These standards can be customized to address a particular client group and to meet individual state mental health laws and policies.

Known also as administrative rules, program standards have the force of law. From the court's or an administrative law judge's standpoint, a (state) agency has no policy if the policy is not in rule form. "Promulgation" is the term commonly used to mean the sequential process program standards go through to become law. This process ensures that legislators, the public, and people who will be affected have the opportunity to influence the content of the regulation. (The Rules Guide: Developing and Promulgating Rules for the Wisconsin Department of Health and Family Services, 9/15/00)

The purpose of standards is to precisely define: 1) for whom a program is intended; 2) the required services; 3) the type of staff/numbers needed to competently provide the services; and 4) the intended benefits/outcomes for the clients receiving the services. Program standards are used to establish costs and reimbursement methodology (e.g., contracting, Medicaid) and are used for program monitoring and certification purposes. In addition, standards must adhere to related federal laws and regulations (e.g., client rights, Medicaid) and must either coincide with or replace other state standards and policies.

Program standards are structured in one of two ways or in a combination of these ways: 1) in the *prescriptive approach*, the rules are drafted to specify the minimal structures or processes that must be main-

---

tained; 2) in the *outcome based approach*, the rules are drafted to specify the desired client outcomes that must be achieved. ACT Standards are written in the prescriptive approach. However, ACT implementation includes program evaluation to assess client outcome (e.g., symptom reduction and recovery, good quality market housing, education and/or employment, and satisfaction with services).

### ***ACT Program Standards***

The *National Program Standards for ACT Teams* serves to guide ACT program start-up and implementation by clearly defining what are the minimal program requirements. Successful ACT model implementation and demonstrated improvements in client outcome are best accomplished by close adherence to the ACT Standards: serving persons with the most severe and persistent mental illnesses; multidisciplinary staffing with a least one peer specialist; low staff-to-client ratios and intensive services; staff who work weekday, evening, and weekend/holiday shifts and provide 24-hour on-call services; team organizational and communication structure; client-centered individualized assessment and treatment planning; and up-to-date individually-tailored treatment, rehabilitation, and support services based on the original Madison, Wisconsin PACT research project.

The ACT Program Standards follow the format typically used in most states to write standards. The language used must be clear, concise, and precise, communicating the same meaning to anyone who reads it and intends to implement ACT.

There are fourteen sections of the ACT Program Standards. At the beginning of each section, the overall purpose and rationale for that section is explained. In addition, throughout the standards, text boxes will provide further explanation regarding program components. The sections are:

- I. Introduction
- II. Definitions
- III. Admission and Discharge Criteria
- IV. Service Intensity and Capacity
- V. Staff Requirements
- VI. Program Organization and Communication
- VII. Client-Centered Assessment and Individualized Treatment Planning
- VIII. Required Services
- IX. Client Medical Record
- X. Client Rights and Grievance Procedures
- XI. Culturally and Linguistically Appropriate Services (CLAS)
- XII. Performance Improvement and Program Evaluation
- XIII. Stakeholder Advisory Groups
- XIV. Waiver of Provisions

## I. Introduction

*[The introduction section of the program standards provides information regarding why the rule is needed, what the rule will accomplish, and what the general contents of the rule will be.]*

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

The important characteristics of assertive community treatment programs are:

- ACT serves clients with severe and persistent mental illnesses that are complex, have devastating effects on functioning, and, because of the limitations of traditional mental health services, may have gone without appropriate services. Consequently, the client group is often over represented among the homeless and in jails and prisons, and has been unfairly thought to resist or avoid involvement in treatment.
- ACT services are delivered by a group of multidisciplinary mental health staff who work as a team and provide the majority of the treatment, rehabilitation, and support services clients need to achieve their goals. The team is directed by a team leader and a psychiatrist and includes a sufficient number of staff from the core mental health disciplines, at least one peer specialist, and a program/administrative support staff who work in shifts to cover 24 hours per day, seven days a week to provide intensive services (multiple contacts may be as frequent as two to three times per day, seven days per week, which are based on client need and a mutually agreed upon plan between the client and ACT staff). Many, if not all, staff share responsibility for addressing the needs of all clients requiring frequent contact.
- ACT services are individually tailored with each client and address the preferences and identified goals of each client. The approach with each client emphasizes relationship building and active involvement in assisting individuals with severe and persistent mental illness to make improvements in functioning, to better manage symptoms, to achieve individual goals, and to maintain optimism.
- The ACT team is mobile and delivers services in community locations to enable each client to find and live in their own residence and find and maintain work in community jobs rather than expecting the client to come to the program. Seventy-five percent or more of the services are provided outside of the program offices in locations that are comfortable and convenient for clients.
- ACT services are delivered in an ongoing rather than time-limited framework to aid the process of recovery and ensure continuity of caregiver. Severe and persistent mental illnesses are episodic disorders and many clients benefit from the availability of a longer-term treatment approach and continuity of care. This allows clients opportunity to recompensate, consolidate gains, sometimes slip back, and then take the next steps forward until they achieve recovery.

## II. Definitions

*[Program standards define words or phrases that are critical to correctly interpreting the standard. The definitions section identifies words and phrases that are unique to ACT or have different meanings in ACT than in traditional mental health programs.]*

**Assertive Community Treatment (ACT)** is a self-contained mental health program made up of a multidisciplinary mental health staff, including a peer specialist, who work as a team to provide the majority of treatment, rehabilitation, and support services clients need to achieve their goals. ACT

---

services are individually tailored with each client through relationship building, individualized assessment and planning, and active involvement with clients to enable each to find and live in their own residence, to find and maintain work in community jobs, to better manage symptoms, to achieve individual goals, and to maintain optimism and recover. The ACT team is mobile and delivers services in community locations rather than expecting the client to come to the program. Seventy-five percent or more of the services are provided outside of program offices in locations that are comfortable and convenient for clients. The clients served have severe and persistent mental illnesses that are complex, have devastating effects on functioning, and, because of the limitations of traditional mental health services, may have gone without appropriate services. There should be no more than 8-10 clients to one staff member.

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

**ACT Service Coordinator (Case Manager)** is the team member who has primary responsibility for establishing and maintaining a therapeutic relationship with a client on a continuing basis, whether the client is in the hospital, in the community, or involved with other agencies. In addition, the service coordinator leads and coordinates the activities of the individual treatment team (ITT). He or she is the responsible team member to be knowledgeable about the client's life, circumstances, and goals and desires. The service coordinator collaborates with the client to develop and write the treatment plan, offers options and choices in the treatment plan, ensures that immediate changes are made as the client's needs change, and advocates for the client's wishes, rights, and preferences. The service coordinator also works with community resources, including consumer-run services, to coordinate and integrate these activities into the client's overall service plan. The service coordinator provides individual supportive therapy and is the first ITT member available to the client in crisis. The service coordinator provides primary support and education to the family, support system, and/or other significant people. The service coordinator shares these tasks with other ITT members who are responsible to perform them when the service coordinator is not working.

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

**Client-Centered Individualized Treatment Plan** is the culmination of a continuing process involving each client, his or her family, and the ACT team, which individualizes service activity and intensity to meet client-specific treatment, rehabilitation, and support needs. The written treatment plan documents the client's self-determined goals and the services necessary to help the client achieve them. The plan also delineates the roles and responsibilities of the team members who will carry out the services.

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

**Comprehensive Assessment** is the organized process of gathering and analyzing current and past information with each client and the family, support system, and/or other significant people to

evaluate: 1) mental and functional status; 2) effectiveness of past treatment; and 3) current treatment, rehabilitation and support needs to achieve individual goals and support recovery. The results of the information gathering and analysis are used with each client to establish immediate and longer-term service needs, to set goals, and to develop the first individualized treatment plan with each client.

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

**Daily Organizational Staff Meeting** is a daily staff meeting held at regularly scheduled times under the direction of the team leader (or designee) to: 1) briefly review the service contacts which occurred the previous day and the status of all program clients; 2) review the service contacts which are scheduled to be completed during the current day and revise as needed; 3) assign staff to carry out the day's service activities; and 4) revise treatment plans and plan for emergency and crisis situations as needed. The daily log and the daily staff assignment schedule are used during the meeting to facilitate completion of these tasks.

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

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

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

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

---

**Medication Distribution** is the physical act of giving medication to ACT program clients by the prescribed route which is consistent with state law and the licenses of the professionals qualified to prescribe and/or administer medication (e.g., psychiatrists, registered nurses, and pharmacists).

**Medication Error** is any error in prescribing or administering a specific medication, including errors in writing or transcribing the prescription, in obtaining and administering the correct medication, in the correct dosage, in the correct form, and at the correct time.

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

**Peer Counseling** is counseling and support provided by team members who have experience as recipients of mental health services for severe and persistent mental illness. Drawing on common experiences as well as using and sharing his/her own practical experiences and knowledge gained as a recipient, peer counseling is supportive counseling that validates clients' experiences and provides guidance and encouragement to clients to take responsibility and actively participate in their own recovery.

**Program of Assertive Community Treatment (PACT)** is the name of the original assertive community treatment program, Mendota Mental Health Institute, Madison, Wisconsin, that developed the ACT model and conducted two controlled research studies which substantiated ACT model effectiveness for adults with severe and persistent mental illnesses compared to traditional mental health service delivery. PACT continues to operate and is currently using the ACT model with adolescents with severe and persistent mental illness.

**Psychiatric and Social Functioning History Time Line** is a format or system which helps ACT staff to chronologically organize information about significant events in a client's life, their experience with mental illness, and their treatment history. This format allows staff to more systematically analyze and evaluate the information with the client, to formulate hypotheses for treatment with the client, and to determine appropriate treatment and rehabilitation approaches and interventions with the client.

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

**Recovery** does not have a single agreed-upon definition, "the overarching message is that hope and restoration of a meaningful life are possible, despite serious mental illness. Instead of focusing primarily on symptom relief, as the medical model dictates, recovery casts a much wider spotlight on restoration of self-esteem and identity and on attaining meaningful roles in society." (*Mental Health: A Report of the Surgeon General, 1999, p 97*)

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

**Stakeholder Advisory Groups** support and guide individual ACT team implementation and operation. Each ACT team shall have a Stakeholder Advisory Group whose membership consists of 51 percent mental health consumers and family members. It shall also include community stakeholders that

interact with persons with severe and persistent mental illness (e.g., homeless services, food-shelf agencies, faith-based entities, criminal justice system, the housing authority, landlords, employers, and community colleges). In addition, group membership shall represent the local cultural populations. The group's primary function is to promote quality ACT programs; monitor fidelity to the ACT Standards; guide and assist the administering agency's oversight of the ACT program; problem-solve and advocate to reduce barriers to ACT implementation; and monitor/review/mediate client and family grievances or complaints. The Stakeholder Advisory Group promotes and ensures clients' empowerment and recovery values in assertive community treatment programs.

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

**Treatment Planning Meeting** is a regularly scheduled meeting conducted under the supervision of the team leader and the psychiatrist. The purpose of these meetings is for the staff, as a team, to thoroughly prepare for their work with each client. The team meets together to present and integrate the information collected through assessment in order to learn as much as possible about the client's life, their experience with mental illness, and the type and effectiveness of the past treatment they have received. The presentations and discussions at these meetings make it possible for all staff to be familiar with each client and their goals and aspirations; to participate in the ongoing assessment and reformulation of issues/problems; to problem-solve treatment strategies and rehabilitation options; and to fully understand the treatment plan rationale in order to carry out the plan for each client.

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

### III. Admission and Discharge Criteria

*[The ACT program standards establish written admission and discharge criteria. The reasons for this are: 1) to ensure that clients with the most severe and persistent mental illnesses have top priority for ACT services; and 2) to prohibit people with severe mental illness from being inappropriately discharged or dropped from ACT services because of the complexity involved in engaging and finding effective interventions to achieve recovery.]*

#### A. Admission Criteria

The following criteria are offered to be used by an ACT team in selecting clients "in the greatest need" of ACT services:

1. Clients with severe and persistent mental illness listed in the diagnostic nomenclature (currently the Diagnostic and Statistical Manual, Fourth Edition, or DSM IV, of the American Psychiatric Association) that seriously impair their functioning in community living. Priority is given to people with schizophrenia, other psychotic disorders (e.g., schizoaffective disorder), and bipolar disorder because these illnesses more often cause long-term psychiatric disability. Clients with other psychiatric illnesses are eligible dependent on the level of the long-term disability. (Individuals with a primary diagnosis of a substance abuse disorder or mental retardation are not the intended client group.)
2. Clients with significant functional impairments as demonstrated by at least one of the following conditions:

- 
- 
- a. Significant difficulty consistently performing the range of practical daily living tasks required for basic adult functioning in the community (e.g., caring for personal business affairs; obtaining medical, legal, and housing services; recognizing and avoiding common dangers or hazards to self and possessions; meeting nutritional needs; maintaining personal hygiene) or persistent or recurrent difficulty performing daily living tasks except with significant support or assistance from others such as friends, family, or relatives.
  - b. Significant difficulty maintaining consistent employment at a self-sustaining level or significant difficulty consistently carrying out the homemaker role (e.g., household meal preparation, washing clothes, budgeting, or child-care tasks and responsibilities).
  - c. Significant difficulty maintaining a safe living situation (e.g., repeated evictions or loss of housing).
3. Clients with one or more of the following problems, which are indicators of continuous high-service needs (i.e., greater than eight hours per month):
- a. High use of acute psychiatric hospitals (e.g., two or more admissions per year) or psychiatric emergency services.
  - b. Intractable (i.e., persistent or very recurrent) severe major symptoms (e.g., affective, psychotic, suicidal).
  - c. Coexisting substance abuse disorder of significant duration (e.g., greater than 6 months).
  - d. High risk or recent history of criminal justice involvement (e.g., arrest, incarceration).
  - e. Significant difficulty meeting basic survival needs, residing in substandard housing, homelessness, or imminent risk of becoming homeless.
  - f. Residing in an inpatient or supervised community residence, but clinically assessed to be able to live in a more independent living situation if intensive services are provided, or requiring a residential or institutional placement if more intensive services are not available.
  - g. Difficulty effectively utilizing traditional office-based outpatient services.
4. Documentation of admission shall include:
- a. The reasons for admission as stated by both the client and the ACT team.
  - b. The signature of the psychiatrist.

*The ACT model has demonstrated effectiveness for "clients in the greatest need," who are estimated to make up 20 percent to 40 percent of the total group of persons with severe and persistent mental illnesses. These clients have not received adequate assessment and appropriate services and are typically not even being served in traditional mental health settings. Therefore, admission criteria ensure that the ACT program serves the intended client group. ACT was once considered the service of last resort when, in fact, research has shown that clients benefit from*

*earlier access to ACT. For example, high use of acute psychiatric care should indicate need for more intensive and continuous services in the community, just as intractable and severe major symptoms should indicate need for high-quality individualized assessment, intervention, and support. Both indicators of problems meriting ACT services should bring about appropriate assessment and interventions as well as compassionate and immediate support for the client and his or her family and support system.*

## B. Discharge Criteria

1. Discharges from the ACT team occur when clients and program staff mutually agree to the termination of services. This shall occur when clients:
  - a. Have successfully reached individually established goals for discharge, and when the client and program staff mutually agree to the termination of services.
  - b. Have successfully demonstrated an ability to function in all major role areas (i.e., work, social, self-care) without ongoing assistance from the program, without significant relapse when services are withdrawn, and when the client requests discharge, and the program staff mutually agree to the termination of services.
  - c. Move outside the geographic area of ACT's responsibility. In such cases, the ACT team shall arrange for transfer of mental health service responsibility to an ACT program or another provider wherever the client is moving. The ACT team shall maintain contact with the client until this service transfer is implemented.
  - d. Decline or refuse services and request discharge, despite the team's best efforts to develop an acceptable treatment plan with the client.
2. Documentation of discharge shall include:
  - a. The reasons for discharge as stated by both the client and the ACT team.
  - b. The client's biopsychosocial status at discharge.
  - c. A written final evaluation summary of the client's progress toward the goals set forth in the treatment plan.
  - d. A plan developed in conjunction with the client for follow-up treatment after discharge.
  - e. The signature of the client, the client's service coordinator, the team leader, and the psychiatrist.

*Each discharge is carefully evaluated because clients with the most severe and persistent mental illness frequently have been inappropriately discharged. Monitoring discharges is a critical program evaluation activity. Discharges from ACT should not occur for traditional reasons like transitioning to another program because the person needs less care or utilization review where service outcomes are determined to be achieved. ACT is a service model that has demonstrated that when services for persons with longer-term episodic disorders are delivered in a continuous rather than time-limited framework, relapse can be addressed and treatment gains maintained and improved upon. In addition, clients should not be forced out of the program prematurely. Discharges may occur when clients and program staff mutually agree to the termination of services. All too often clients*

*are not discharged for reasons of recovery or goal achievement but are dropped due to conflicts with staff or because the complexity of the problems and issues require too much staff time. In circumstances when a client wants to "fire" the ACT team, it is important that the ACT team be willing to listen and to accommodate the client's wishes/preferences regarding services. If the client still requests discharge, their request must be honored. The client should be given all necessary help to arrange alternative services and should be given priority for readmission to ACT if they so chose.*

**Please note:** Some new ACT programs stop working with people whom the program failed to effectively engage and admit to the program. Problems with engagement should not be confused with reasons for discharge.

---

**Policy and Procedure Requirements:** The ACT team shall maintain written admission and discharge policies and procedures.

*ACT standards require "ACT Policies and Procedures." Typically, the larger agency operating ACT has written policies and procedures, but because ACT programs are free-standing programs, because they are complex to operate, because staff work as a team, and because services are integrated, agency standards alone are*

*not sufficient. Therefore, the team leader has the responsibility to write policies and procedures for each of the areas identified in the standards. Once policies and procedures are in place, they maintain the organizational and services structure that supports the work and are useful in orienting and training new staff.*

#### **IV. Service Intensity and Capacity**

*[The ACT programs provide intensive services to clients in community settings. The ACT Standards not only establish a minimum staff-to-client ratio but also establish the minimum number of staff required to cover the shifts, set the frequency of staff services contacts with clients, and require gradual admission of clients to the team.]*

##### **A. Staff-to-Client Ratio**

Each ACT team shall have the organizational capacity to provide a minimum staff-to-client ratio of at least one full-time equivalent (FTE) staff person for every 10 clients (not including the psychiatrist and the program assistant) for an urban team. Rural teams shall have the organizational capacity to provide a minimum staff-to-client ratio of at least one full-time equivalent (FTE) staff person for every 8 clients (not including the psychiatrist and the program assistant).

*The staff-to-client ratio may need to be adjusted to a lower ratio in settings where the clients are consistently acutely ill, have spent long periods of time in institutional settings, are being released from correctional settings, or have complicating medical conditions that require more service contacts. Staff-to-client ratios may also need to be adjusted in urban settings where safety is an issue and staff must pair up to work in a particular neighborhood, or in rural areas where staff must travel great geographical distances.*

**Please Note:** The ACT Standards define two sizes of ACT teams: 1) an urban/full size team and 2) a rural/smaller size team. Teams are not designated as urban or rural because one team is located in an urban area and the other is in a rural area. The distinguishing factor is that in a rural area there may be fewer numbers of clients with severe and persistent mental illness who can benefit from the program. Therefore, it is not practical to have a full size team. However, if there are sufficient numbers of clients in a rural area, the ACT program should be full size.

##### **B. Staff Coverage**

Each ACT team shall have sufficient numbers of staff to provide treatment, rehabilitation, and support services 24 hours a day, seven days per week.

Staff coverage is a different measurement of service intensity than staff-to-client ratio and is probably more important to successful ACT implementation. Staff coverage gets at the critical mass of ACT staff needed to cover the 24 hours. Establishing staffing patterns (e.g., shifts, staff rotations) to regularly deliver services 24 hours a day, seven days a week ensures that clients have regular staff help when they need it; reduces client crisis; and helps avoid staff burnout. Having sufficient numbers of staff is necessary to: 1) staff two shifts weekdays; 2) staff one shift each weekend day and holidays; 3) schedule mental health professionals to on-call duty the hours when staff are not working; and 4) have psychiatric backup available all hours the psychiatrist is not regularly scheduled to work. It takes a minimum of 10 staff (taking into account vacation time, sick time and staff attrition) just to cover two 8-hour shifts weekdays with a minimum of two people on the evening shift, one 8-hour shift with a minimum of two people on weekend days and holidays, and mental health professionals to be assigned on-call duty the hours staff are not working. It takes 5 FTE registered nurses to be able to have one nurse on every shift.

When a rural team does not have sufficient staff numbers to operate weekday, weekend, and holiday shifts, staff are regularly scheduled to

provide the necessary services on a client-by-client basis (per the client-centered comprehensive assessment and the individualized treatment plan) in the evenings and on weekends. In addition, the staff should provide crisis services at least during regular work hours. During all other hours, the team may arrange coverage through a reliable crisis-intervention service. In this case, the rural team communicates routinely with the crisis-intervention service (i.e., at the beginning of the workday to obtain information from the previous evening and at the end of the workday to alert the crisis-intervention service to clients who may need assistance and provide effective ways for helping them). The crisis-intervention service should be expected to go out and personally see clients who need face-to-face contact. In locations where there is no crisis-intervention service, appropriate steps will have to be taken for the ACT team to implement their own system.

The staff size may need to be adjusted to a larger number in settings where the clients are consistently acutely ill, have spent long periods of time in institutional settings, are being released from correctional settings, or have complicating medical conditions. In urban settings, where safety is a factor, the staff size may need to be larger to allow for 3-4 staff to work evenings, weekends, and holidays.

### C. Frequency of Client Contact

1. The ACT team shall have the capacity to provide multiple contacts a week with clients experiencing severe symptoms, trying a new medication, experiencing a health problem or serious life event, trying to go back to school or starting a new job, making changes in living situation or employment, or having significant ongoing problems in daily living. These multiple contacts may be as frequent as two to three times per day, seven days per week and depend on client need and a mutually agreed upon plan between clients and program staff. Many, if not all, staff shall share responsibility for addressing the needs of all clients requiring frequent contact.
2. The ACT team shall have the capacity to rapidly increase service intensity to a client when his or her status requires it or a client requests it.
3. The ACT team shall provide a mean (i.e., average) of three contacts per week for all clients. Data regarding the frequency of client contacts shall be collected and reviewed as part of the program's Continuous Quality Improvement (CQI) plan.

*ACT varies intensity to meet the changing needs of clients with severe and persistent mental illness, to support clients in normal community settings, and to provide a sufficient level of service as an alternative to the client needing to be hospitalized to receive that level of care. This is a radical departure from how traditional services are organized. ACT services are delivered continuously and "titrated," meaning that when a client needs more services, the team provides*

*them. Conversely, when the client needs less services, the team lessens service intensity. However, staff who have worked in traditional mental health programs often are so used to scheduling appointments with clients one time a week or thinking that all clients see the psychiatrist at the same interval (e.g., medication check for fifteen minutes every 3 months) that understanding and implementing intensive service delivery is problematic.*

#### **D. Gradual Admission of Team Clients**

Each new ACT team shall stagger client admissions (e.g., 4-6 clients per month) to gradually build up capacity to serve no more than 100-120 clients (with 10-12 staff) on any given urban team and no more than 42-50 clients (with 6-8 staff) on any given rural team.

*The ACT team follows a systematic process in beginning to work with individual clients which includes screening clients referred for admission; arranging and having an admission meeting to begin to establish a relationship with each client and their family; conducting an initial assessment and establishing an initial treatment plan in collaboration with each client and their family; providing immediate treatment, rehabilitation and support services; and conducting the comprehensive assessment and establishing the first individualized treatment plan with each client, all of which takes time to do well. Therefore, the clients must be admitted*

*gradually (4-6 client per month) rather than starting out at full capacity. Due to smaller team size and geographical distances, rural teams in particular may need to admit fewer clients per month.*

*Please Note: While the team is building up to the number of clients the team will eventually serve, it still takes full staffing to cover the hours, provide the intensity of services, and do the labor intensive engagement and thorough assessment/treatment planning that clients with the most severe and persistent mental illnesses and their families deserve in order to develop a plan for recovery.*

#### **V. Staff Requirements**

*[ACT teams require adequate numbers of staff members with sufficient individual competence to carry out the array of services and to establish quality supportive relationships with clients. In addition, ACT staff must have attitudes and values that are compatible with ACT philosophy: compassion and respect for persons with severe mental illness and their experiences; understanding and belief in recovery concepts and clients determining their own goals; and client and family involvement in all activities that shape the quality of ACT services.]*

##### **A. Qualifications**

The ACT team shall have among its staff persons with sufficient individual competence and professional qualifications and experience to provide the services described in Section VIII, including service coordination; crisis assessment and intervention; symptom assessment and man-

agement; individual counseling and psychotherapy; medication prescription, administration, monitoring and documentation; substance abuse treatment; work-related services; activities of daily living services; social, interpersonal relationship and leisure-time activity services; support services or direct assistance to ensure that clients obtain the basic necessities of daily life; and education, support, and consultation to clients' families and other major supports.

*It is also important to have staff that sufficiently represents the local cultural population that the team serves.*

#### B. Team size

1. The **urban program** shall employ a minimum of 10 to 12 FTE multidisciplinary clinical staff persons including the team leader, 1 FTE peer specialist, one to 1.5 FTE program assistants, and 16 hours of psychiatrist time for every 50 clients on the team.
2. The **rural program** shall employ a minimum of 6 to 8 FTE multidisciplinary clinical staff persons, including one team leader, one FTE peer specialist, one FTE program assistant, and 16 hours of psychiatrist time for every 50 clients on the team.

*The psychiatrist and the program assistant positions are not counted in the minimum number of multidisciplinary clinical staff positions.*

#### C. Mental Health Professional

On an urban team of the 10 to 12 FTE multidisciplinary clinical staff positions, there are a minimum of 8 FTE mental health professionals (including one FTE team leader). On a rural team of 6 to 8 FTE multidisciplinary clinical staff, there are a minimum of 5 FTE mental health professionals. Mental health professionals have: 1) professional degrees in one of the core mental health disciplines; 2) clinical training including internships and other supervised practical experiences in a clinical or rehabilitation setting; and 3) clinical work experience with persons with severe and persistent mental illness. They are licensed or certified per the regulations of the state where the team is located and operate under the code of ethics of their professions. Mental health professionals include persons with master's or doctoral degrees in nursing, social work, rehabilitation counseling, or psychology; diploma, associate, and bachelor's degree nurses (i.e., registered nurse); and registered occupational therapists.

1. Required among the mental health professionals are: 1) on an urban team, 5 FTE or at least 3 FTE registered nurses and 2) on a rural team, 2 FTE registered nurses (for either team, a team leader with a nursing degree cannot replace one of these FTE nurses).
2. Also required among the mental health professionals are: 1) on an urban team, a minimum of 4 FTE master's level or above mental health professionals (in addition to the team leader) with at least one designated for the role of vocational specialist, preferably with a master's degree in rehabilitation counseling; and 2) on a rural team, a minimum of 2 FTE master's level or above mental health professionals (in addition to the team leader) with designated responsibility for the role of vocational specialist, preferably with a master's degree in rehabilitation counseling.

- One or more mental health professionals with training and experience in substance abuse assessment and treatment shall be designated the role of substance abuse specialist.

The chart below shows the required minimum staff on urban and rural teams.

Position	Urban	Rural
Team leader	1 FTE	1 FTE
Psychiatrist	16 Hours for 50 Clients	16 Hours for 50 Clients
Registered Nurse	5 FTE or at least 3 FTE	2 FTE
Peer Specialist	1 FTE	1 FTE
Master's level	4 FTE	2 FTE
Other level	1-3 FTE	1.5 - 2.5 FTE
Program/Administrative Assistant	1-1.5 FTE	1 FTE

#### D. Required staff

- Team Leader:** A full-time team leader/supervisor who is the clinical and administrative supervisor of the team and who also functions as a practicing clinician on the ACT team. The team leader has at least a master's degree in nursing, social work, psychiatric rehabilitation or psychology, or is a psychiatrist.

*Practicing clinician means that the team leader is a competent clinician, who leads client-centered assessment and individualized treatment planning by working side-by-side with the client and team members. It is very difficult to*

*direct service delivery without having first-hand knowledge of each client and their family. In addition, first-hand knowledge of clients makes clinical supervision by far more effective and credible.*

- Psychiatrist:** A psychiatrist, who works on a full-time or part-time basis for a minimum of 16 hours per week for every 50 clients. The psychiatrist provides clinical services to all ACT clients; works with the team leader to monitor each client's clinical status and response to treatment; supervises staff delivery of services; and directs psychopharmacologic and medical services.

*The ACT psychiatrist functions as a team member, not just as a consultant to the team. The team psychiatrist sees clients and has clinical supervisory responsibilities for clients and staff, regularly participates in daily staff organizational meetings and treatment planning meetings, and directs operation of the medication and medical services. Even though the psychiatrist may work part-time, it is very important that the psychiatrist have designated hours when he or she is working on the team. The psychiatrist's*

*hours should be sufficient blocks of time on consistent days in order to carry out his or her clinical, supervisory, and administrative responsibilities. It is also necessary to arrange for and provide psychiatric backup all hours the psychiatrist is not regularly scheduled to work. If availability of the psychiatrist during all hours is not feasible, alternative psychiatric backup must be arranged (e.g., mental health center psychiatrist, emergency room psychiatrist).*

3. **Registered Nurses:** On an urban team, five FTE registered nurses (or at least 3 FTE registered nurses) and on a rural team, 2 FTE registered nurses. A team leader with a nursing degree cannot replace one of the FTE nurses.

*Registered nurses are invaluable on ACT teams because they provide medical assessment and services as well as treatment and rehabilitation services. It is important to have sufficient numbers in order to have nurses to work the majority of shifts. It takes 5 FTE registered nurses to have one nurse on every urban team shift. On a rural team it is impossible to staff*

*with only one nurse. Providers starting ACT teams are often hesitant to hire the number of nurses needed because they believe they cost too much. In fact, the failure to pay adequate salaries highly correlates to poor quality staff and high staff turnover in public mental health systems.*

4. **Master's Level Mental Health Professionals:** On an urban team, a minimum of 4 FTE master's level or above mental health professionals (in addition to the team leader), with at least one designated for the role of vocational specialist, preferably with a master's degree in rehabilitation counseling. On a rural team, a minimum of 2 FTE master's level or above mental health professionals (in addition to the team leader) with at least one FTE who has designated responsibility for the role of vocational specialist, preferably with a master's degree in rehabilitation counseling.

*Many rural teams are staffing with the majority of the staff being master's level mental health professionals. Because of the small staff size, there is a greater need for the majority of the*

*staff to have clinical training and credentials to independently carry out treatment and rehabilitation services.*

5. **Substance Abuse Specialist:** One or more mental health professionals with training and experience in substance abuse assessment and treatment shall be designated the role of substance abuse specialist.

*The ACT team provides most of the substance abuse treatment services for clients with severe and persistent mental illness and co-existing substance abuse disorders. The most effective*

*assessment and treatment approaches employ an integrated treatment model in which mental health and substance abuse treatment are provided simultaneously.*

6. **Peer Specialist:** A minimum of one FTE peer specialist on either an urban team or a rural team. A person who is or has been a recipient of mental health services for severe and persistent mental illness holds this position. Because of life experience with mental illness and mental health services, the peer specialist provides expertise that professional training cannot replicate. Peer specialists are fully integrated team members who provide highly individualized services in the community and promote client self-determination and decision-making. Peer specialists also provide essential expertise and consultation to the entire team to promote a culture in which each client's point of view and preferences are recognized, understood, respected and integrated into treatment, rehabilitation, and community self-help activities.

*The peer specialist must be paid a salary commensurate with other staff members. In addition, consumers who have the credentials can be*

*employed in any of the other required positions and should be paid at the professional rate.*

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

*Because it is impossible to provide on-the-job-training, staff must be hired with education and experience in working with persons with severe and persistent mental illness. Therefore, recruit-*

*ment and hiring are extremely important when filling all positions but particularly when filling positions with persons without professional degrees and training.*

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

*Persons with training as Licensed Practical Nurses (LPN) or who have worked as hospital unit program assistants or administrative*

*support staff in mental health or health care settings are ideal for this position.*

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

## VI. Program Organization and Communication

*[Working as a multidisciplinary team, staff organization and communication are critical when delivering highly individualized services in community settings. Unless the ACT program organization and communication structure is solidly in place, it is impossible for*

*teams to provide intense, well-organized, multiple services to clients while ensuring coordination of care. Therefore, the hours of operation, staff coverage, place of treatment, staff communication and planning, and staff supervision are the required structure of ACT operation and support all service delivery.]*

**A. Hours of Operation and Staff Coverage**

**1. Urban Teams**

- a. The ACT team shall be available to provide treatment, rehabilitation, and support activities seven days per week. This means:
  - i. Regularly operating and scheduling staff to work two 8-hour shifts with a minimum of 2 staff on the second shift, thus providing services at least 12 hours per day week-days.
  - ii. Regularly operating and scheduling staff to work one 8-hour shift with a minimum of 2 staff each weekend day and every holiday.
  - iii. Regularly scheduling mental health professionals for on-call duty to provide crisis and other services the hours when staff are not working. ACT team staff who are experienced in the program and skilled in crisis-intervention procedures shall be on call and available to respond to clients by telephone or in person.
  - iv. Regularly arranging for and providing psychiatric backup all hours the psychiatrist is not regularly scheduled to work. If availability of the ACT psychiatrist during all hours is not feasible, alternative psychiatric backup should be arranged (e.g., mental health center psychiatrist, emergency room psychiatrist).

**2. Rural Teams**

- a. The ACT team shall be available to provide treatment, rehabilitation, and support activities seven days per week. When a rural team does not have sufficient staff numbers to operate two 8-hour shifts weekdays and one 8-hour shift weekend days and holidays, staff are regularly scheduled to provide the necessary services on a client-by-client basis (per the client-centered comprehensive assessment and individualized treatment plan) in the evenings and on weekends. This means:
  - i. Regularly scheduling staff to cover client contacts in the evenings and on weekends.
  - ii. Regularly scheduling mental health professionals for on-call duty to provide crisis and other services the hours when staff are not working. ACT team staff who are experienced in the program and skilled in crisis-intervention procedures shall be on call and available to respond to clients by telephone or in person.
  - iii. When a rural team does not have sufficient staff numbers to operate an after-hours on-call system, the staff should provide crisis services during regular work hours. During all other hours, the team may arrange coverage through a reliable crisis-intervention service. The rural team communicates routinely with the crisis-intervention service (i.e., at the beginning of the workday to obtain information from the previous evening and at the end of the workday to alert the crisis-intervention service to clients who may need assistance and to provide effective ways for helping them). The crisis-intervention service should be expected to go out and see clients who need face-to-face contact.

- iv. Regularly arranging for and providing psychiatric backup all hours the psychiatrist is not regularly scheduled to work. If availability of the ACT psychiatrist during all hours is not feasible, alternative psychiatrist backup should be arranged (e.g., mental health center psychiatrist, emergency room psychiatrist).

*Many mental health programs espouse to provide 24-7 services, when in fact, the staff only works Monday through Friday eight-to-five with telephone crisis or emergency room coverage the rest of the hours. While ACT teams rotate staff to cover 8-hour shifts, they provide their own on-call and will go out to see clients face-to-face as necessary. In rural ACT programs where crisis intervention services are limited, it is very important for ACT to develop a system for face-to-face crisis response. It is not acceptable to leave crisis work to law enforcement alone because that is traumatizing to clients and unfair to law enforcement.*

*Please Note: The ACT Standards define two sizes of ACT teams: 1) an urban/full size team and 2) a rural/smaller size team. Teams are not designated as urban or rural because one team is located in an urban area and the other is in a rural area. The distinguishing factor is that in a rural area there may be fewer numbers of clients with severe and persistent mental illness who can benefit from the program. Therefore, it is not practical to have a full size team. However, if there are sufficient numbers of clients in a rural area, the ACT program should be full size.*

## **B. Place of Treatment**

Each new urban team shall set a goal of providing 75 percent of service contacts in the community in nonoffice-based or nonfacility-based settings, while each new rural team shall set a goal of providing 85 percent of service contacts in the community in nonoffice-based or nonfacility-based settings. Data regarding the percentage of client contacts in the community will be collected and reviewed to verify that goals are being met as part of the program's Continuous Quality Improvement (CQI) plan.

*An essential ingredient in the way that services are delivered in the ACT program is "assertive outreach." The majority of treatment and rehabilitation interventions take place "in the community," that is, in the client's own place of residence and neighborhood, at employment sites in the community, and in the same sites of recreation and leisure activities that all citizens*

*use (e.g., parks, movie houses, and restaurants). The rationales for use of assertive outreach is to enable the provision of psychosocial services "in vivo," where clients need to use them. The latter factor eliminates the need for transfer of learning, which has been difficult to achieve for many persons with serious mental illnesses.*

## **C. Staff Communication and Planning**

1. The ACT team shall conduct **daily organizational staff meetings** at regularly scheduled times per a schedule established by the team leader. These meetings will be conducted in accordance with the following procedures:
  - a. The ACT team shall maintain a written **daily log**, using either a notebook or a cardex. The daily log provides:

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

*Staff communication and scheduling (i.e., daily organizational staff meetings and treatment planning meetings) are critical to overall operation and teamwork. This level of detailed organization is foreign to traditional mental health services but is fundamental to evidence-based*

*treatment and necessary to achieve effectiveness and efficiency in mental health service delivery. Understanding and implementation of this section of the ACT Standards is essential to team operation.*

#### **D. Staff Supervision**

Each ACT team shall develop a written policy for clinical supervision of all staff providing treatment, rehabilitation, and support services. The team leader and psychiatrist shall assume responsibility for supervising and directing all staff activities. This supervision and direction shall consist of:

1. Individual, side-by-side sessions in which the supervisor accompanies an individual staff member to meet with clients in regularly scheduled or crisis meetings to assess staff performance, give feedback, and model alternative treatment approaches;
2. 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;
3. Regular meetings with individual staff to review their work with clients, assess clinical performance, and give feedback;
4. Regular reviews, critiques, and feedback of staff documentation (i.e., progress notes, assessments, treatment plans, treatment plan reviews); and
5. Written documentation of all clinical supervision provided to ACT team staff.

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

### **VII. Client-Centered Assessment and Individualized Treatment Planning**

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

#### **A. Initial Assessment**

An initial assessment and treatment plan shall be done the day of the client's admission to ACT by the team leader or the psychiatrist, with participation by designated team members.

## B. Comprehensive Assessment

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

1. In collaboration with the client, the ITT will complete a psychiatric and social functioning history time line.
2. In collaboration with the client, the comprehensive assessment shall include an evaluation in the following areas:
  - a. **Psychiatric History, Mental Status, and Diagnosis:** The psychiatrist is responsible for completing the psychiatric history, mental status, and diagnosis assessment. (Using information derived from the evaluation, a psychiatrist or a clinical or counseling psychologist shall make an accurate diagnosis from those listed in the American Psychiatric Association's DSM IV.) The psychiatrist presents the assessment findings at the first treatment planning meeting.

*The psychiatric history, mental status, and diagnosis assessment is to carefully and systematically collect and assess information from the client, the family, and past treatment records regarding the onset, precipitating events, course and effect of illness, including past treatment and treatment responses, risk behaviors, and current mental status. The purpose is to effectively plan*

*with the client and his family the best treatment approach to eliminate or reduce symptomatology and to ensure accuracy of the diagnosis. The psychiatrist, in carrying out the psychiatric history, mental status, and diagnosis assessment, writes a psychiatric history narrative for the client's medical record.*

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

*Because physical health has been ignored for many people with severe and persistent mental illness, the purpose of the physical assessment is to thoroughly assess health status and any medical conditions present to ensure that appro-*

*priate treatment, follow-up, and support are provided to the client. The first interview to begin this assessment should take place within 72 hours of admission.*

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

*Substance use is typically not well enough assessed with persons with severe and persistent mental illness. It requires a lot of time to accurately assess substance use to establish abuse of or dependency on substances. The purpose of the use of drugs or alcohol assessment is to collect information to assess and diagnose if the client has a substance abuse disorder and to develop*

*appropriate treatment interventions to be integrated into the comprehensive treatment plan. Team members who are dual-diagnosis specialists join with the individual treatment teams and take primary responsibility for assessment, planning, and treatment for clients with substance use problems.*

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

*Employment is very important to people with mental illness and is a normalizing structure that is helpful in symptom management. ACT excludes no one because of a poor work history or because of ongoing symptoms or impairments related to mental illness. The purpose of the education and employment assessment is to determine with the client how he or she is currently*

*structuring time; current school or employment status; interests and preferences regarding school and employment; and how symptomatology has affected previous and current school and employment performance. This assessment begins with the working relationship between the client and the vocational specialist to establish educational and vocational goals.*

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

*The purpose of the social development and functional assessment is to obtain information from the client about his or her childhood, early attachments, role in family of origin, adolescent and young adult development, culture, religious beliefs, leisure activities, interests, and social skills. This enables the ACT team to evaluate*

*how symptomatology has interrupted or affected personal and social development. It also collects information regarding the client's involvement with the criminal justice system. In addition, it identifies social and interpersonal issues appropriate for supportive therapy.*

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

*The purpose of the activities of daily living assessment is to evaluate the individual's current ability to meet basic needs (e.g., personal hygiene, adequate nutrition, medical care); the quality and safety of the client's current living situation; the adequacy of the client's financial resources; the effect that symptoms and impairments of mental illness have had on self-care; the client's ability to maintain an independent living situation, and the client's desires and individual preferences. This enables the ACT team to determine the level of assistance, support, and resources the client needs to rees-*

*tablish and maintain activities of daily living. Good activities of daily living (ADL) functioning are basic to successful community adjustment for persons with severe and persistent mental illness. Consistent assistance to meet ADL needs helps clients to feel better and less vulnerable living in the community. Occupational therapists and nurses have the training to complete the ADL assessment. However, other staff members can be trained to do the assessment but they must have interests in and compassion for clients in order to work in this area.*

- g. **Family Structure and Relationships:** Members of the client's individual treatment team (ITT) are responsible to carry out the family structure and relationships assessment. The staff members working with the family present the assessment findings at the first treatment planning meeting.

*Historically, people with severe and persistent mental illness have received most of their support and care from their families. This is especially true for people of color who tend to have strong family ties. The best way to engage families from diverse communities is to respect and work within their beliefs and values. Many clients have children, and clients' ability to parent may be compromised by their mental illness. Unfortunately, it has also been the case that mental health providers have not included or welcomed the participation of families or other significant people. The purpose of the*

*family structure and relationships assessment is to obtain information from the client's family and other significant people about their perspective of the client's mental illness and to determine their level of understanding about mental illness as well as their expectations of ACT services. This information allows the team to define, with the client, the contact or relationship ACT will have with the family in regard to the client's goals, treatment, and rehabilitation. This assessment is begun during the admission meeting with the client and the family members or significant others who are participating in the admission.*

3. While the assessment process shall involve the input of most, if not all, team members, the client's psychiatrist, service coordinator (case manager), and ITT members will assume responsibility for preparing the written narrative of the results and formulation of the psychiatric and social functioning history time line and the comprehensive assessment, ensuring that a psychiatric and social functioning history time line and comprehensive assessment are completed within one month of the client's admission to the program.
4. The service coordinator and ITT members will be assigned by the team leader in collaboration with the psychiatrist by the time of the first treatment planning meeting or within thirty days after admission.

### C. Individualized Treatment Planning

Treatment plans will be developed through the following treatment planning process:

1. The treatment plan shall be developed in collaboration with the client and the family or guardian, if any, when feasible and appropriate. The client's participation in the development of the treatment plan shall be documented. Together the ACT team and the client shall assess the client's needs, strengths, and preferences and develop an individualized treatment plan. The treatment plan shall 1) identify individual issues/problems; 2) set specific measurable long- and short-term goals for each issue/problem; 3) establish the specific approaches and interventions necessary for the client to meet his or her goals, improve his or her capacity to function as independently as possible in the community, and achieve the maximum level of recovery possible (i.e., a meaningful, satisfying, and productive life).
2. As described in Section VI, ACT team staff shall meet at regularly scheduled times for treatment planning meetings. At each treatment planning meeting the following staff should attend: the team leader, the psychiatrist, the service coordinator (case manager), individual treatment team members, the peer specialist and all other ACT team members involved in regular tasks with the client.
3. Individual treatment team members are responsible to ensure the client is actively involved in the development of treatment (recovery) and service goals. With the permission of the client, ACT team staff shall also involve pertinent agencies and members of the client's social network in the formulation of treatment plans.
4. Each client's treatment plan shall identify his or her issues/problems, strengths/ weaknesses, and specific measurable goals. The treatment plan must clearly specify the approaches and interventions necessary for the client to achieve the individual goals (achieve recovery) and identify who will carry out the approaches and interventions.
5. The following key areas should be addressed in every client's treatment plan: 1) psychiatric illness or symptom reduction; 2) housing; 3) activities of daily living (ADL); 4) daily structure and employment; and 5) family and social relationships. The service coordinator (case manager) and the individual treatment team, together with the client, will be responsible for reviewing and rewriting the treatment goals and plan whenever there is a major decision point in the client's course of treatment (e.g., significant change in client's condition or goals) or at least every six months. Additionally, the service coordinator shall prepare a summary (i.e., treatment plan review) which thoroughly describes in writing the client's and the ITT's evaluation of his or her progress/goal attainment, the effectiveness of the interventions, and the client's satisfaction with services since the last treatment plan. The plan and review will be signed or verbally approved by the client, the service coordinator, individual treatment team members, the team leader, the psychiatrist, and all ACT team members.

*The ACT client-centered approach to individualized services may be easy for mental health professionals to accept philosophically but it is often harder for them to grasp conceptually and put into practice. All clinical and rehabilitation services begin with comprehensive assessment and*

*individualized treatment planning. There is probably no better process to build a working relationship with clients and their families and to strategize more effective interventions than ACT comprehensive assessment and individualized treatment planning.*

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

## VIII. Required Services

*[Mental disorders are treatable, contrary to what many think. An armamentarium of efficacious treatments is available to ameliorate symptoms. In fact, for most mental disorders, there is generally a range of treatments of proven efficacy. (Mental Health: A Report of the Surgeon General, 1999, p 65). Assertive community treatment is not only an evidence-based practice but is also an effective service delivery model to provide persons with more disabling schizophrenia, other psychotic disorders, and bipolar disorders a range of the most effective treatment, rehabilitation, and support services. The ACT multidisciplinary staff individually plans and delivers services targeted to help clients 1) address the complex interaction between symptoms and psychosocial functioning, and 2) achieve personal goals. Accepted current practice interventions which are provided in assertive community treatment include: supportive counseling and psychotherapy, including cognitive behavioral therapy, personal therapy, and psychoeducation; integrated substance abuse and mental health treatment, including motivational enhancement therapy; evidence-based pharmacological treatment using practice guidelines (algorithms); supported employment; peer counseling and consultation; collaboration with families and family psychoeducation; and treatment of trauma and posttraumatic disorders.]*

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

Services shall minimally include the following:

### A. Service Coordination

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

### B. Crisis Assessment and Intervention

Crisis assessment and intervention shall be provided 24 hours per day, seven days per week. These services will include telephone and face-to-face contact and will be provided in conjunction with the local mental health system's emergency services program as appropriate.

### **C. Symptom Assessment and Management**

This shall include but is not limited to the following:

1. Ongoing comprehensive assessment of the client's mental illness symptoms, accurate diagnosis, and the client's response to treatment
2. Psychoeducation regarding mental illness and the effects and side effects of prescribed medications
3. Symptom-management efforts directed to help each client identify/target the symptoms and occurrence patterns of his or her mental illness and develop methods (internal, behavioral, or adaptive) to help lessen the effects
4. Individual supportive therapy
5. Psychotherapy
6. Generous psychological support to clients, both on a planned and as-needed basis, to help them accomplish their personal goals, to cope with the stressors of day-to-day living, and to recover

### **D. Medication Prescription, Administration, Monitoring and Documentation**

1. The ACT team psychiatrist shall:
  - a. Establish an individual clinical relationship with each client
  - b. Assess each client's mental illness symptoms and provide verbal and written information about mental illness
  - c. Make an accurate diagnosis based on the comprehensive assessment which dictates an evidence-based medication pathway that the psychiatrist will follow
  - d. Provide education about medication, benefits and risks, and obtain informed consent
  - e. Assess and document the client's mental illness symptoms and behavior in response to medication and shall monitor and document medication side effects
  - f. Provide psychotherapy
2. All ACT team members shall assess and document the client's mental illness symptoms and behavior in response to medication and shall monitor for medication side effects.
3. The ACT team program shall establish medication policies and procedures which identify processes to:
  - a. Record physician orders
  - b. Order medication
  - c. Arrange for all client medications to be organized by the team and integrated into clients' weekly schedules and daily staff assignment schedules
  - d. Provide security for medications (e.g., daily and longer-term supplies, long-term injectable, and longer term supplies) and set aside a private designated area for set up of medications by the team's nursing staff
  - e. Administer medications per state law to team clients

### E. Dual Diagnosis Substance Abuse Services

Provision of a stage-based treatment model that is non-confrontational, considers interactions of mental illness and substance abuse, and has client-determined goals. This shall include but is not limited to individual and group interventions in:

1. Engagement (e.g., empathy, reflective listening, avoiding argumentation)
2. Assessment (e.g., stage of readiness to change, client-determined problem identification)
3. Motivational enhancement (e.g., developing discrepancies, psychoeducation)
4. Active treatment (e.g., cognitive skills training, community reinforcement)
5. Continuous relapse prevention (e.g., trigger identification, building relapse prevention action plans)

Prochaska, J.O. & DiClemente, C. C. *The transtheoretical approach: Crossing traditional boundaries of therapy*. Homewood, IL: Dow Jones/Irwin. 1984.  
Monti, P., Abrams, D., Caden, R., & Cooney, N. *Treating alcohol dependence*. New York: Guilford. 1989.  
Meyers, R. & Smith, J. *Clinical guide to alcohol treatment*. New York: Guilford. 1995.

### F. Work-Related Services

Work-related services to help clients value, find, and maintain meaningful employment in community-based job sites and services to develop jobs and coordinate with employers but also includes but is not necessarily limited to:

1. Assessment of job-related interests and abilities through a complete education and work history assessment as well as on-the-job assessments in community-based jobs
2. Assessment of the effect of the client's mental illness on employment with identification of specific behaviors that interfere with the client's work performance and development of interventions to reduce or eliminate those behaviors and find effective job accommodations
3. Development of an ongoing employment rehabilitation plan to help each client establish the skills necessary to find and maintain a job
4. Individual supportive therapy to assist clients to identify and cope with mental illness symptoms that may interfere with their work performance
5. On-the-job or work-related crisis intervention
6. Work-related supportive services, such as assistance with grooming and personal hygiene, securing of appropriate clothing, wake-up calls, and transportation, if needed.

### G. Activities of Daily Living

Services to support activities of daily living in community-based settings include individualized assessment, problem solving, sufficient side-by-side assistance and support, skill training, ongoing supervision (e.g. prompts, assignments, monitoring, encouragement), and environmental adaptations to assist clients to gain or use the skills required to:

1. Find housing which is safe, of good quality, and affordable (e.g., apartment hunting; finding a roommate; landlord negotiations; cleaning, furnishing, and decorating; and procuring necessities (such as telephones, furnishings, linens)
2. Perform household activities, including house cleaning, cooking, grocery shopping, and laundry

3. Carry out personal hygiene and grooming tasks, as needed
4. Develop or improve money-management skills
5. Use available transportation
6. Have and effectively use a personal physician and dentist

#### **H. Social/Interpersonal Relationship and Leisure-Time Skill Training**

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

1. Improve communication skills, develop assertiveness, and increase self-esteem
2. Develop social skills, increase social experiences, and develop meaningful personal relationships
3. Plan appropriate and productive use of leisure time
4. Relate to landlords, neighbors, and others effectively
5. Familiarize themselves with available social and recreational opportunities and increase their use of such opportunities

#### **I. Peer Support Services**

Services to validate clients' experiences and to guide and encourage clients to take responsibility for and actively participate in their own recovery. In addition, services to help clients identify, understand, and combat stigma and discrimination against mental illness and develop strategies to reduce clients' self-imposed stigma:

1. Peer counseling and support
2. Introduction and referral to consumer self-help programs and advocacy organizations that promote recovery

#### **J. Support Services**

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

1. Medical and dental services
2. Safe, clean, affordable housing
3. Financial support and/or benefits counseling (e.g., SSI, SSDI, Food Stamps, Section 8, Vocational Rehabilitation, Home Energy Assistance)
4. Social service
5. Transportation
6. Legal advocacy and representation

**K. Education, Support, and Consultation to Clients' Families and Other Major Supports**

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

1. Individualized psychoeducation about the client's illness and the role of the family and other significant people in the therapeutic process
2. Intervention to restore contact, resolve conflict, and maintain relationships with family and or other significant people
3. Ongoing communication and collaboration, face-to-face and by telephone, between the ACT team and the family
4. Introduction and referral to family self-help programs and advocacy organizations that promote recovery
5. Assistance to clients with children (including individual supportive counseling, parenting training, and service coordination) including but not limited to:
  - a. Services to help clients throughout pregnancy and the birth of a child
  - b. Services to help clients fulfill parenting responsibilities and coordinate services for the child/children
  - c. Services to help clients restore relationships with children who are not in the client's custody

**Policy and Procedure Requirement:** The ACT team shall maintain written policies and procedures for all services outlined in this section.

**IX. Client Medical Record**

*[Since ACT records often require more documentation than many mental health agencies do, the team leader and the psychiatrist need to work with/get approval from mental health agency administrators and medical records personnel to set up an ACT medical record which will satisfy the agency policies and the federal and state laws. In addition, the ACT client record needs to be located physically with the ACT program.]*

- A. The ACT team shall maintain a treatment record for each client.
- B. The treatment record is confidential, complete, accurate, and contains up-to-date information relevant to the client's care and treatment.
- C. 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 client's treatment needs and services received.
- D. The team leader and the program assistant shall be responsible for the maintenance and security of the client treatment records.
- E. The client records are located at ACT team headquarters and, for confidentiality and security, are to be kept in a locked file.
- F. For purposes of confidentiality, disclosure of treatment records by the ACT team is subject to all the provisions of applicable state and federal laws.

---

G. Clients shall be informed by staff of their right to review their own records and the steps required to request to do so.

H. Each client's clinical record shall be available for review and to be copied by the client and the guardian, if any.

**Policy and Procedure Requirement:** The ACT team shall maintain written medical records management policies and procedures.

#### **X. Client Rights and Grievance Procedures**

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

**A. ACT teams shall be knowledgeable about and familiar with client rights including the right to:**

1. Confidentiality
2. Informed consent to medication and treatment
3. Treatment with respect and dignity
4. Prompt, adequate, and appropriate treatment
5. Treatment which is under the least restrictive conditions
6. Nondiscrimination
7. Control of own money
8. File grievances or complaints

**B. ACT teams shall be knowledgeable about and familiar with the mechanisms to implement and enforce client rights:**

1. Grievance or complaint procedures under state law
2. Medicaid
3. Americans with Disabilities Act
4. Protection and Advocacy for Individuals with Mental Illness

**C. ACT teams shall be prepared and provide clients appropriate information and referral to the Protection and Advocacy Agency and other advocacy groups.**

**Policy and Procedure Requirement:** The ACT team shall maintain client rights policies and procedures.

*How ACT teams understand and implement client rights and grievance or complaint procedures is basic to what the ACT client-centered approach is all about. Client-centered means each client is listened to, respected, encouraged, and supported to direct his or her own treatment plan and services. Therefore, ACT teams need*

*to: 1) understand and comply with client rights law to ensure that ACT clients know their rights and that their rights are respected, and 2) implement a client and family "friendly" grievance system which effectively hears and resolves client grievances or complaints about ACT services and ACT staff.*

**XI. Culturally and Linguistically Appropriate Services (CLAS) United States.** (Dept. of Health and Human Services. Office of Minority Health. *National Standards for Culturally and Linguistically Appropriate Services in Health Care: Final Report.* [Rockville, MD]: U.S. Dept. of Health and Human Services, 2001.)

*[Mental illnesses are prevalent in people across all cultures. Unfortunately, as the Surgeon General states in his Mental Health: Culture, Race, and Ethnicity report, all Americans do not have equal access to treatment, especially members of ethnic and racial minorities, who face additional barriers to receiving quality mental health treatment. One of the most devastating consequences of the lack of cultural competence is misdiagnosis. The cultural appropriateness of mental health services may be the most important factor in the accessibility of services by people of color. ACT teams must attain cultural competence. At a minimum, ACT staff should sufficiently represent the local diverse populations the team serves. Furthermore, all ACT staff should receive appropriate cultural-competence training. During the initial and comprehensive assessments, the staff must be aware of and take into account the client's culture and background, such as folkways, traditions, customs, formal and informal helping networks, rituals, and dialects. Staff must be knowledgeable about various cultures and how they affect the development of specific skills and attitudes to provide services that meet the individual consumer's needs. ACT staff must ensure that lack of proficiency in English is not a barrier to receiving act services.]*

*[Cultural Competency is a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enable them to work effectively in cross-cultural situations. Cultural competency is the acceptance and respect for difference, a continuous self assessment regarding culture, an attention to the dynamics of difference, the ongoing development of cultural knowledge, and the resources and flexibility within service models to meet the needs of minority populations (Cross T., Bazron, B., Dennis, K., & Isaacs, M. (1989). Towards a culturally competent system of care, volume I. Washington, D.C.: Georgetown University Child Development Center, CASSP Technical Assistance Center.)]*

- A. ACT should ensure that clients receive from all staff members effective, understandable, and respectful care that is provided in a manner compatible with clients' cultural health beliefs and practices and preferred language.
- B. ACT teams should implement strategies to recruit, retain, and promote a diverse staff that are representative of the demographic characteristics of the service area.
- C. ACT teams should ensure that staff at all levels and across all disciplines receive ongoing education and training in culturally and linguistically appropriate service delivery.

- D. ACT teams must offer and provide language assistance services, including bilingual staff and interpreter services, at no cost to each client with limited English-proficiency at all points of contact, in a timely manner during all hours of operation.
- E. ACT teams must provide to clients in their preferred language both verbal offers and written notices informing them of their right to receive language assistance services.
- F. ACT teams must assure the competence of language assistance provided to limited English-proficient clients by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except by request of the client).
- G. ACT teams must make available easily understood client-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.
- H. ACT teams should develop, implement and promote a written strategic plan that outlines clear goals, policies, operational plans and management accountability/oversight mechanisms to provide culturally and linguistically appropriate services.
- I. ACT teams should conduct initial and ongoing organizational self-assessments of CLAS-related activities and are encouraged to integrate cultural and linguistic competence-related measures into their internal audits, performance improvement programs, client satisfaction assessments and outcome-based evaluations.
- J. ACT should ensure that data on the individual client's race, ethnicity, and spoken and written language are collected in health records, integrated into the organization's management information systems, and be periodically updated.
- K. ACT teams should develop participatory, collaborative partnerships with communities and utilize a variety of formal and informal mechanisms to facilitate community and client involvement in designing and implementing CLAS-related activities.
- L. ACT should ensure that conflict and grievance resolution processes are culturally and linguistically sensitive and capable of identifying, preventing and resolving cross-cultural conflicts or complaints by clients.
- M. ACT is encouraged to regularly make available to the public information about their progress and successful innovations in implementing the CLAS standards and to provide public notice in their communities about the availability of this information.

*CLAS standards were developed by a national project advisory panel and are based on analytical review of key laws, regulations, contracts and standards currently in use by federal and state agencies, and other national organizations.*

*These standards are clear and concise and serve as an effective guide to ensure that services for ACT clients are culturally and linguistically appropriate.*

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

## **XII. Performance Improvement and Program Evaluation**

*[Program evaluation is critical in order to know if clients are realizing the expected and desired outcomes from ACT. It is also important to know if the program is adhering to the ACT model. Each program is expected to evaluate: 1) client outcome; 2) client and family satisfaction with the services; and 3) fidelity to the ACT model. Program evaluation should be used by the ACT team, state program monitors, and stakeholder advisory groups to evaluate program performance and to establish program improvement/ performance goals.]*

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

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

**Policy and Procedure Requirement:** The ACT team shall maintain performance improvement and program evaluation policies and procedures.

## **XIII. Stakeholder Advisory Groups**

*[Each ACT program has a stakeholder advisory group to guide and support local ACT team start-up, implementation, and on-going operation. It is this group that performs the most important ACT program role: ensuring that the program provides each client high quality and recovery-oriented services.]*

- A. The ACT team shall have a stakeholder advisory group to support and guide ACT team implementation and operation. The stakeholder advisory group shall be made up of at least 51 percent mental health consumers and family members and include other community stakeholders such as representatives from services for the homeless, consumer-support organizations, food-shelf agencies, faith-based groups, criminal justice system, housing authorities, landlords, employers, and/or community colleges. Group membership shall also represent the cultural diversity of the local population.
- B. The stakeholder advisory group shall:
  - 1. Promote quality ACT model programs
  - 2. Monitor fidelity to the ACT program standards
  - 3. Guide and assist with the administering agency's oversight of the ACT program
  - 4. Problem-solve and advocate to reduce system barriers to ACT implementation
  - 5. Review and monitor client and family grievances and complaints

6. Promote and ensure clients' empowerment and recovery values in assertive community treatment programs.

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

#### XIV. Waiver of Provisions

*[States may grant mental health programs waivers of requirements in program standards. The waiver request must not diminish the effectiveness of the ACT model. For example, a waiver would not be approved if a program requested to operate without a psychiatrist, because that position is central to program operation and service delivery. Therefore, waiver requests must be well thought out and not affect program effectiveness.]*

- A. The ACT team may request of the ACT certification entity a waiver of any required standard that would not diminish the effectiveness of the ACT model, violate the purposes of the program, or adversely affect clients' health and welfare. Waivers cannot be granted which are inconsistent with client rights or federal, state, or local laws and regulations.

*Typically providers submit a request with written justification for a waiver of a particular section of standards. The request is reviewed by the state mental health authority. Waiver requests that diminish the effectiveness of ACT services, compromise positive client outcome, and place clients at risk of their safety in the community must be scrutinized and not approved. Often,*

*political considerations may take priority over fidelity to the ACT model and quality of client care. This should be avoided. It has also been the case that the state staff who approve waivers do not necessarily have sufficient clinical or ACT program knowledge to effectively evaluate the waiver requests.*

*These standards are derived from the State of Wisconsin Department of Health and Social Services, Division of Community Services, (April, 1989), Community Support Programs for the Chronically Mentally Ill Standards, and the State of Rhode Island Department of Mental Health, Retardation and Hospitals, Division of Mental Health and Management Services (February 3, 1992) Mobile Treatment Team Standards.*

*These National Standards for ACT Teams, June 2003, were developed with support from the U.S. Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, Community Support Branch, through grant # SM52579-4.*

*The ACT Standards is a companion document to A Manual for ACT Start-Up: Based on the PACT Model of Community Treatment for Persons with Severe and Persistent Mental Illnesses, written with support from the National Alliance for the Mentally Ill Assertive Community Treatment Technical Assistance Center.*