Table of Contents

I. Introduction

The following Assertive Community Treatment (ACT) Interim Program Standards guide ACT program implementation and define minimum requirements for an ACT team in the State of Alaska. ACT implementation in Alaska will emphasize intensive supported housing and community integration. ACT teams will focus and prioritize services to high utilizers of public resources (e.g., API, Psych ER, emergency responders, DOC), the chronic homeless, those precariously housed, and those living in, or at risk of living in unnecessarily restrictive and segregated environments (i.e., Olmstead class population).

Assertive Community Treatment (ACT) is a client-centered, recovery-oriented behavioral health service delivery model that has received substantial empirical support for reducing psychiatric hospitalizations, facilitating community living, and enhancing recovery for persons with serious mental illnesses. ACT is designed specifically for persons who have the most severe and persistent mental illnesses, have severe symptoms and impairments, and who historically have not benefited from traditional outpatient programs.

An Assertive Community Treatment team consists of a transdisciplinary team of medical, behavioral health, and rehabilitation professionals who work together to meet the intensive needs of recipients with severe and persistent mental illness. ACT teams provide person-centered services addressing the breadth of a recipient's needs, helping him or her achieve their personal goals. Thus, a fundamental charge of ACT is to be the first-line (and generally sole provider) of all the services that ACT recipients need. Being the single point of responsibility necessitates a higher frequency and intensity of community-based contacts, and a very low recipient-to-staff ratio. Services are flexible; teams offer varying levels of care across all recipients, and appropriately adjust service levels given an individual recipient's changing needs across time. For example, a recipient advancing in recovery and preparing to transfer off of the team may be seen by the team less than once per week as part of his or her transition plan. Another may need to be seen more than once a day for several months to help improve his or her stability following a recent hospital discharge, medication change, or move to an independent living setting.

ACT teams assist recipients in advancing toward personal goals with a focus on enhancing community integration and regaining valued roles (e.g., worker, daughter, resident, spouse, tenant, friend). Because ACT teams often work with recipients who may passively or actively resist services, ACT teams are expected to thoughtfully carry out planned assertive engagement techniques which largely consist of rapport-building strategies, facilitating meeting basic needs, and motivational interviewing techniques. These techniques are used to identify and focus on the recipient's life goals and what he or she is motivated to change. Likewise, it is the team's responsibility to monitor the recipient's mental status in a respectful manner that is congruent with the recipient's level of need and functioning. The ACT team delivers all services according to a recovery-based philosophy of care, where the team promotes self-determination, respects the recipient as expert in his or her own right, and engages peers in the process of promoting hope that the recipient can recover from mental illness and regain meaningful roles and relationships in the community.

The important characteristics of ACT programs are:

- ACT serves individuals with severe and persistent mental illness who also experience difficulties with daily living activities. Because of the limitations of traditional mental health services, these individuals often have gone without appropriate services. Consequently, this recipient group is often over represented among individuals who are homeless or are in jails and prisons, and have been unfairly thought to resist or avoid involvement in treatment.
- ACT services are delivered by a group of transdisciplinary mental health staff who work as a team and provide the majority of the treatment, rehabilitation, and support services recipients need to achieve their goals. The team is directed by a team leader and a psychiatric prescriber and includes a sufficient number of staff from the core behavioral health disciplines, at least one peer specialist, and a program or administrative support staff who work in shifts 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 recipient need and a mutually agreed upon plan between the recipient and ACT staff). Many, if not all, staff share responsibility for addressing the needs of all recipients requiring frequent contact. On-call crisis services (including face-to-face crisis assessment and intervention, when necessary) are also available 24 hours a day.
- ACT services are individually tailored with each recipient and address the preferences and identified goals of each recipient. The approach with each recipient 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 recipient to find and live in their own residence and find and maintain work in community jobs rather than expecting the recipient 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 recipients.
- 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 recipients benefit from the availability of a longer-term treatment approach and continuity of care. This allows recipients the opportunity to recompensate, consolidate gains, and when relapses occur, take the next steps forward until they achieve recovery.

II. Definitions

Assertive Community Treatment (ACT) is a self-contained behavioral health program made up of transdisciplinary behavioral health staff, including peer specialists, who work as a team to provide the majority of treatment, rehabilitation, and support services recipients need to achieve their goals. ACT services are individually tailored with each recipient through relationship building, individualized assessment and planning, and active involvement with recipients 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 recipient 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 recipients. The recipients served have severe and persistent mental illness 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 recipients to one staff member.

Activities of Daily Living Services include approaches to support and build skills in a range of activities of daily living (ADLs), including but not limited to, performing household activities, carrying out personal hygiene and grooming tasks, money management, accessing and using transportation resources, and accessing services from a physician and dentist.

Clinical Supervision is a systematic process to review each recipient's clinical status and to ensure that the individualized services and interventions that the team members (including the peer specialist) provide are planned with, purposeful for, effective, and satisfactory to the recipient. The team leader and the psychiatric prescriber have the responsibility to provide clinical supervision which may include: 1) meeting as a group (separately from the daily team meeting) or individually to discuss specific clinical cases; 2) field mentoring (e.g., helping staff by going out in the field with them to teach, role model skills, and providing feedback on skills); 3) reviewing and providing feedback on the specific tools (e.g., the quality of assessments, treatment plans, progress notes); 4) didactic teaching and/or training; and 5) formal in-office individual supervision.

Comprehensive Assessment is the organized process of gathering and analyzing current and past information with each recipient and the family and/or support system and other significant people to evaluate: 1) mental and functional status; 2) effectiveness of past treatment; 3) current treatment, rehabilitation and support needs to achieve individual goals and support recovery; and 4) the range of individual strengths (e.g., knowledge gained from dealing with adversity or personal/professional roles, talents, personal traits) that can act as resources to the recipient and his/her recovery planning team in pursuing goals. The results of the information gathering and analysis are used to: 1) establish immediate and longer-term service needs with each recipient; 2) set goals and develop the initial person-centered treatment plan with each recipient; and 3) optimize benefit that can be derived from existing strengths and resources of the recipient and his/her family and/or natural support network in the community. The comprehensive assessment must meet the standards outlined in this document, in addition to those outlined in 7 AAC 135.110.

Crisis Assessment and Intervention includes coverage offered 24 hours per day, seven days per week for recipients when recipients experience a crisis.

Daily Log is a notebook, cardex, or computerized form which the ACT team maintains on a daily basis to provide: 1) a roster of recipients served in the program; and 2) for each recipient, a brief documentation of any treatment or service contacts which have occurred

within the past 24 hours and a concise behavioral description of the recipient's clinical status and any additional needs.

Daily Team 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 within the past 24 hours and the status of all program recipients; 2) review the service contacts which are scheduled to be completed during the current day and revise as needed; 3) when not already assigned within the weekly recipient schedule, assign staff to carry out the day's service activities; and 4) 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 recipient treatment and service contacts to be divided and shared by staff working on that day. The daily staff assignment schedule is developed from a central file of all weekly recipient 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 by the team leader to work collaboratively with a recipient and his/her family and/or natural support members in the community by the time of the initial person-centered treatment planning meeting or thirty days after admission. The core members are the primary practitioner, the psychiatric prescriber, and at least one clinical or rehabilitation staff person who shares case coordination and service provision tasks for each recipient. The ITT has continuous responsibility to be knowledgeable about the recipient's life, circumstances, goals and desires; to collaborate with the recipient to develop and write the treatment plan; to offer options and choices in the treatment plan; to ensure that immediate changes are made as a recipient's needs change; and to advocate for the recipient's wishes, rights, and preferences. The ITT is responsible to provide much of the recipient's treatment, rehabilitation, and support services. ITT members are assigned to take specific service roles with the recipient as stated by the recipient and the ITT in the treatment plan.

Individual Supportive Therapy and Psychotherapy includes verbal therapies that help people address their emotions, thoughts, and behaviors in order to progress toward their own personal recovery goals. Individual psychotherapy may also help recipients understand and identify symptoms in order to find strategies to lessen distress and symptomatology, improve individual role functioning, and evaluate treatment and rehabilitative services. Approaches could include supportive therapy, cognitive behavioral therapy, personal therapy, and psycho-educational therapy. Any service billed to Medicaid as Psychotherapy must meet standards outlined in 7 AAC 135.150.

Initial Assessment and Person-centered Individualized Treatment Plan is the *initial* evaluation of: 1) the recipient's mental and functional status; 2) the effectiveness of past treatment; 3) the current treatment, and rehabilitation and support service needs, and 4) the range of individual strengths that can act as resources to the person and his/her ITT in pursuing goals. The results of the information gathering and analysis are used to establish the

initial treatment plan to achieve individual goals and support recovery. *Completed the day of admission*, the recipient's initial assessment and treatment plan guides team services until the comprehensive assessment and a full person-centered treatment plan is completed.

Integrated Dual Disorders Treatment for Substance Abuse includes integrated and stage-wise assessment and treatment for recipients who have a co-occurring mental health and substance use disorder. This type of treatment is based on the short-term goal of risk reduction and the long-term goal of abstinence.

Medication Distribution is the physical act of giving medication to recipients in an ACT program by the prescribed route which is consistent with state law and the licenses of the professionals privileged to prescribe and/or administer medication (e.g., psychiatric prescribers, 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 recipient and the psychiatric prescriber with the participation of the ITT to carefully evaluate the recipient's previous experience with psychotropic medications and side-effects; to identify and discuss the benefits and risks of psychotropic and other medication; to choose a medication treatment; and to establish a method to prescribe and evaluate medication according to evidence-based practice standards.

Primary Practitioner leads and coordinates the activities of the individual treatment team (ITT) and is the ITT member who has primary responsibility for establishing and maintaining a therapeutic relationship with a recipient on a continuing basis, whether the recipient is in the hospital, in the community, or involved with other agencies; he or she is the lead team member to be knowledgeable about the recipient's life, circumstances, goals and desires. The primary practitioner develops and collaborates with the recipient to write the person-centered treatment plan, offers options and choices in the treatment plan, ensures that immediate changes are made as the recipient's needs change, and advocates for the recipient's wishes, rights, and preferences. While the primary practitioner is the administrative and clinical lead for a particular recipient, he or she shares all other service activities with other members of the ITT.

Peer Support Services include coaching and consultation services which serve to validate recipients' experiences, provide guidance and encouragement to recipients to take responsibility for and actively participate in their own recovery, and help recipients identify, understand, and combat stigma and discrimination against mental illness and develop strategies to reduce recipients' self-imposed stigma. Peer Support Services may be inclusive of Wellness Management Services, such as facilitation of Wellness Recovery Action Plans (WRAP) and Illness Management and Recovery (IMR) services.

Person-Centered Individualized Treatment Plan is the culmination of a continuing process involving each recipient, his/her family and/or natural supports in the community, and the ACT team, which individualizes service activity and intensity to meet the recipient's specific treatment, rehabilitation, and support needs. The written treatment plan documents the recipient's strengths, resources, self-determined goals, and the services necessary to help the recipient achieve them. The plan also delineates the roles and responsibilities of the team members who will work collaboratively with each recipient in carrying out the services. The person-centered individualized treatment plan must meet the standards outlined in this document, in addition to those outlined in 7 AAC 135.120.

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 antianxiety agents.

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

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)

Service Coordination is a process of organization and coordination within the transdisciplinary team to carry out the range of treatment, rehabilitation, and support services each recipient expects to receive per his or her written person-centered treatment plan and that are respectful of the recipient's wishes. Service coordination also includes coordination with community resources, including recipient self-help and advocacy organizations that promote recovery.

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, in consultation with the team leader and the psychiatric prescriber.

Social and Community Integration Skills Training includes services to support social and interpersonal relationships and leisure time activities, with an emphasis on skills acquisition and generalization in integrated community-based settings.

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 state and local government, the criminal justice and courts system, and local consumer and emergency response groups. The group's primary function is to serve as a referral committee; 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 reducing barriers to ACT implementation; and monitor/review types of and trends in recipient and family grievances and complaints. The Stakeholder Advisory Group promotes and ensures recipients' empowerment and recovery values in ACT programs.

Supported Education provides the opportunities, resources, and supports to individuals with mental illness so that they may gain admission to and succeed in the pursuit of post-secondary education, including high school, GED, and vocational school.

Tenancy Support Services include pre-tenancy supports, move-in supports, and on-going housing stability services with the goal of recipients achieving long term tenancy.

Transdisciplinary Approach specifies that team members share roles and systematically cross discipline boundaries. The primary purpose of this approach is to pool and integrate the expertise of team members so that more efficient and comprehensive assessment and intervention services may be provided. The communication style in this type of team involves continuous give-and-take among all members (inclusive of the recipient and, if desired, his/her family/other natural supports) on a regular, planned basis. The role differentiation between disciplines is defined by the needs of the situation rather than by discipline-specific characteristics. The transdisciplinary approach can be contrasted with the transdisciplinary approach in which team members independently carry out assessments and implement their own section of the treatment plan, rather than in a cross-disciplinary, integrated fashion, which also serves to actively involve the recipient in their own assessment and treatment.

Treatment Plan Review is a thorough, written summary describing the recipient's and the ITT's evaluation of the recipient's progress/goal attainment, the effectiveness of the interventions, and satisfaction with services since the last person-centered treatment plan.

Treatment Planning Meeting is a regularly scheduled meeting conducted under the supervision of the team leader and the psychiatric prescriber. The purpose of these meetings is for the staff, as a team, and the recipient and his/her family/natural supports, to thoroughly prepare for their work together. The group meets together to present and integrate the information collected through assessment in order to learn as much as possible about the recipient's life, his/her 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 recipient and his/her goals and aspirations and for each recipient to become familiar with each ITT staff person; to participate in the ongoing assessment and reformulation of strengths, resources, and service needs/issues; 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.

Vocational Services include work-related services to help recipients value and understand the implications of, as well as find and maintain meaningful competitive employment in, community-based job sites. Vocational services also include job development

and coordination with employers, as well as follow-along job supports provided to the employer (at the recipient's request) and recipient.

Weekly Recipient 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 recipient's person-centered treatment plan. The ITT shall maintain an up-to-date weekly recipient schedule for each recipient per the person-centered treatment plan.

Wellness Management and Recovery Services are a combination of psychosocial approaches to working with the recipient to build and apply skills related to his or her recovery, including development of recovery strategies, psychoeducation about mental illness and the stress-vulnerability model, building social support, reducing relapses, using medication effectively, coping with stress, symptom management, and getting needs met within the mental health system and community. Examples of such services include Wellness Recovery Action Planning (WRAP) and Illness Management and Recovery (IMR).

III. Provider Requirements

A. Qualifications

The ACT team is administered by a Community Behavioral Health Services Provider that meets all of the following requirements:

1. Meets the qualifications of Community Behavioral Health Services Provider receiving money from the Department as defined in 7 AAC 70.100.;

2. Has a current Department Approval to provide behavioral health services, or be eligible for a Department Approval under 7 AAC 70.030.;

3. Demonstrates adherence to all applicable regulations and grant requirements by remaining in good standing with integrated Departmental Site Reviews, Grant Agreements, and national accreditation;

4. Is established as a legally constituted entity capable of meeting all of the requirements of the Department Approval, Medicaid Regulations, Medicaid Enrollment Agreement, and ACT Interim Program Standards; and

5. Shall comply with all applicable federal and state requirements. This includes but is not limited to State of Alaska Department of Health and Social Services (DHSS) statutes, rules, policies, and regulations; Medicaid Regulations; and other published instruction.

B. Medicaid Enrollment

1. ACT team provider organizations must be an enrolled State of Alaska Medicaid provider.

2. Provider organization is responsible for ensuring that all services are medically necessary and all services are in full compliance with all applicable Medicaid service regulations, including but not limited to Chapters 70, 105, and 135.

C. ACT Program Fidelity Monitoring

1. Provider organizations operating ACT teams will be evaluated according to a standardized fidelity measure to evaluate the extent to which defining elements of the program model are being implemented.

2. The Tool for Measurement of ACT (TMACT; Monroe-DeVita, Moser, & Teague, 2011), or its successor as approved by DBH, will be used to evaluate teams.

3. The aim of these evaluations is not only to ensure the model is being implemented as intended, but also to provide a mechanism for quality improvement feedback, guided consultation, and strategic plans for improvement of practice as necessary.

4. DBH shall track adherence to the ACT model and determine annual ACT performance outcomes for ACT teams through their participation in the administration of the most current ACT fidelity assessment.

5. Provider organizations operating ACT teams must meet all minimum requirements for an ACT team as outlined in the ACT Interim Program Standards.

The provider organization is responsible for all ACT service delivery, and understands that *not all* ACT required activities are eligible for Medicaid billing. It is the provider's responsibility to adhere to all applicable Medicaid regulations, while simultaneously adhering to ACT program standards.

IV. Admission and Discharge Criteria

A. Admission Criteria

Recipients must meet the following admission criteria:

1. Severe and persistent mental illness listed in the diagnostic nomenclature (currently the Diagnostic and Statistical Manual, Fifth Edition, or DSM V, of the American Psychiatric Association) that seriously impair their functioning in community living. Recipients must have a primary mental health diagnosis and a

major Axis I disorder. 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 and because of research supporting the effectiveness of ACT for persons with these disorders. The appropriateness of ACT services for persons without these primary diagnoses is not supported by research and is of questionable appropriateness. Persons with a sole diagnosis of a substance use disorder, mental retardation, brain injury or Axis II disorders are not the intended recipient group for ACT services. Persons with severe mental illnesses who have not been able to remain abstinent from drugs or alcohol will not be excluded from ACT services.

2. 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. Continuous high-service needs as demonstrated by at least one of the following:

    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. Co-occurring substance use disorder of significant duration (e.g., greater than six months).
    d. High risk or recent history of criminal justice involvement (e.g., arrest and incarceration).
    e. Significant difficulty meeting basic survival needs or residing in substandard housing, homelessness, or at 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 or benefiting from traditional office-based outpatient services or other less-intensive community-based programs (e.g., recipient fails to progress, drops out of service).

4. Documentation of admission shall include:

   a. The reasons for admission as stated by both the recipient and the ACT team.
   b. The signature of the psychiatric prescriber.

B. Discharge Criteria

1. Discharges from the ACT team occur when recipients and ACT staff mutually agree to the termination of services. This shall occur when recipients:

   a. Have successfully reached individually established goals for discharge and when the recipient and program staff mutually agrees to graduation from ACT services.
   b. Move outside the geographic area of ACT's responsibility. In such cases, the ACT team shall arrange for transfer of behavioral health service responsibility to an ACT program or another provider wherever the recipient is moving. The ACT team shall maintain contact with the recipient until this service transfer is completed.
   c. Demonstrate an ability to function in all major role areas (i.e., work, social, self-care) without requiring ongoing assistance from the program for six to nine months without significant relapse when services are withdrawn.
   d. Decline or refuse services and request discharge, despite the team's best efforts to develop an acceptable person-centered treatment plan with the recipient.

2. In addition to the discharge criteria listed above based on mutual agreement between the recipient and ACT staff, a recipient discharge may also be facilitated due to any one of the following circumstances:

   a. Death.
   b. Inability to locate the recipient for a prolonged period of time.
   c. Long-term incarceration.
   d. Long-term hospitalization where it has been determined based on mutual agreement by the hospital treatment team and the ACT team that the recipient will not be appropriate for discharge for a prolonged period of time.

3. If the recipient is accessible at the time of discharge (i.e., according to circumstances listed under III.B.1 above), the team shall ensure recipient participation in all discharge activities, as evidenced by documentation as described below:

    a. The reasons for discharge as stated by both the recipient and the ACT team.
    b. The recipient's bio-psychosocial status at discharge.
    c. A written final evaluation summary of the recipient's progress toward the goals set forth in the person-centered treatment plan.
    d. A plan developed in conjunction with the recipient for follow-up treatment after discharge.
    e. The signature of the recipient, the recipient's primary practitioner, the team leader, and the psychiatric prescriber.

4. When clinically necessary, the team will make provisions for expedited re-entry of discharged recipients as rapidly as possible and will prioritize them on the admission and/or waiting list.

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

V. Service Intensity and Capacity

A. Staff-to-Recipient Ratio

Each ACT team shall have the organizational capacity to provide a minimum staff-to-recipient ratio of at least one full-time equivalent (FTE) staff person for every 10 recipients (not including the psychiatric prescriber and the program assistant) for a full team. Half teams shall have the organizational capacity to provide a minimum staff-to-recipient ratio of at least one full-time equivalent (FTE) staff person for every 8 recipients (not including the psychiatric prescriber and the program assistant).

B. Staff Coverage

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

C. Frequency of Recipient Contact

1. The ACT team shall have the capacity to provide multiple contacts per week with recipients 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 recipient need and a mutually agreed upon plan between recipient and program staff. Many, if not all, staff shall share responsibility for addressing the needs of all recipients requiring frequent contact.

2. The ACT team shall have the capacity to rapidly increase service intensity to a recipient when his or her status requires it or a recipient requests it.

3. The ACT team shall provide an average of 1.5 face-to-face contacts per week for all recipients. Data regarding the frequency of recipient contacts shall be collected and reviewed as part of the program's performance improvement plan.

4. The ACT team shall deliver services based on the individual needs of the recipient. Service delivery should demonstrate flexibility and is expected to change over time, with the frequency and intensity of services determined by recipient need.

D. Gradual Admission of Team Recipients

Each new ACT team shall stagger recipient admissions (i.e., no more than 4-6 recipients per month) to gradually build up capacity to serve no more than 80-100 recipients on any given full team and no more than 42-50 recipients on any given half team.

Policy and Procedure Requirements: The ACT team shall maintain service capacity and intensity policies and procedures.

VI. Staff Requirements

A. Qualifications

The ACT team shall have among its staff, persons with sufficient individual competence and professional qualifications and experience to provide services, including service coordination; crisis assessment and intervention; recovery and symptom management; individual counseling and psychotherapy; medication prescription, administration, monitoring and documentation; substance abuse treatment; intensive supported housing services; work-related services; activities of daily living services; social, interpersonal relationship and leisure-time activity services; support services or direct assistance to ensure that recipients obtain the basic necessities of daily life; and education, support, and consultation to recipients' families and other major supports. The staff should have sufficient representation of the local cultural population that the team serves.

B. Team Size

1. The **full ACT program** shall employ a minimum of 10 to 12 FTE transdisciplinary clinical staff persons, including 1 FTE team leader and 1 FTE peer specialist on the team.

2. The **half ACT program** shall employ a minimum of 7 to 8 FTE transdisciplinary clinical staff persons, including 1 FTE team leader and 1 FTE peer specialist on the team.

C. Mental Health Professionals on Staff

Of the minimum 10 to 12 FTE transdisciplinary clinical staff positions on a full team, there are a minimum of 8 FTE mental health professionals (including one FTE team leader). Of the minimum 7 to 8 FTE transdisciplinary clinical staff positions on a half team, there are a minimum of 4.5 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. Mental health professionals also include persons with master's or doctoral degrees in nursing, social work, rehabilitation counseling, or psychology; diploma, associate, and bachelor's nurses (i.e., registered nurse); and registered occupational therapists.

1. Required among the mental health professionals are: 1) on a full team, 3 FTE registered nurses and 2) on a half team, 1.5 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 a full team, a minimum of 4 FTE master's level or above mental health professionals (in addition to the team leader); and 2) on a half team, a minimum of 2 FTE master's level or above mental health professionals (in addition to the team leader).

D. Required Staff

The chart below shows the required staff on full and half teams.

Position	Full	Half
Team leader	1 FTE	1 FTE
Psychiatric prescriber	16 Hours for 50 Recipients	16 Hours for 50 Recipients
Registered Nurse	3 FTE	1.5 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

(1 FTE Vocational Specialist, 1 FTE Substance Abuse Specialist, and 1 FTE housing specialist may be included within either the "Master's level" or "Other level" staffing categories above. These are not necessarily *additional* positions, see position descriptions below.)

The following provides a description of and qualifications for required staff on all ACT teams.

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 psychiatric prescriber, but is dedicated full-time to the role of team leader. The team leader must hold an active State of Alaska license in their respective discipline.

Psychiatric Prescriber: A psychiatric prescriber may include a psychiatrist licensed under 7 AAC 110.400, an advanced nurse practitioner licensed and certified as required under 7 AAC 110.100, if the provider is working within the scope of the provider's education, training, and experience, if the provider has prescriptive authority, and if the provider is enrolled under 7 AAC 120.100(c) as a dispensing provider. The psychiatric prescriber works on a full-time or part-time basis for a minimum of 16 hours per week for every 50 recipients. The psychiatric prescriber provides clinical services to all ACT recipients; works with the team leader to monitor each recipient's clinical status and response to treatment; supervises staff delivery of services; and directs psychopharmacologic and medical services.

Registered Nurses: All registered nurses shall have an active license to practice nursing in the State of Alaska under AS 08.68 and be working in the individual's field of expertise. On a full team, 3 FTE registered nurses are required. On a half team, 1.5 FTE registered nurses are required. A team leader with a nursing degree cannot replace one of the FTE nurses.

Master's Level Mental Health Professionals: On a full team, a minimum of 4 FTE master's level or above mental health professionals (in addition to the team leader) are required. On a half team, a minimum of 2 FTE master's level or above mental health professionals (in addition to the team leader) are required.

Substance Abuse Specialist: One or more team members with 1) at least one year of training in substance abuse assessment and treatment, or 2) at least one

year of supervised experience and 40 hours of training in substance abuse assessment and treatment shall be designated the role of substance abuse specialist. Forty hours of training shall include but not be limited to:

i. Introduction to substance use and the interaction between substance use and mental illness;
ii. Integrated screening and assessment for substance use, abuse, and dependence;
iii. Stages of change readiness and corresponding stage wise approaches to treatment; and
iv. Knowledge of other community resources for substance abuse treatment and support.

Preference will be given to people who have training or experience in working with individuals with mental illness and have training or experience in integrated dual disorder treatment.

Vocational Specialist: One or more team members with at least one year of training and experience in employment services (e.g., job development, job placement, supported employment) shall be designated the role of vocational specialist. Preference will be given to people who have training and experience in working with individuals with mental illness within the supported employment (i.e., Individual Placement and Support [IPS] model.

***Housing Specialist*:** One or more team members with at least one year of training and experience in providing tenancy support services shall be designated the role of housing specialist. This does not have to be an *additional* position on the team, but there does need to be at least one person identified on the team that has the training and experience to assume this role.

Peer Specialist: A minimum of one FTE peer specialist is required on either a full team or a half 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 their 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 recipient self-determination and decision-making. Peer specialists also provide essential expertise and consultation to the entire team to promote an organizational culture in which each recipient's point of view and preferences are recognized, understood, respected and integrated into treatment, rehabilitation, and community self-help activities.

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-service needs. Those paraprofessionals may have related training (e.g., certified occupational therapy assistant, home health care aide) or work experience (e.g., teaching) and life experience.

Program/Administrative Assistant: The program/administrative assistant (1-1.5 FTE in a full setting or 1 FTE in a half setting) 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 recipient and program expenditures; and providing receptionist activities, including triaging calls and coordinating communication between the team and recipients.

Optional: If it is determined that legal resources are needed and available through partnership agreements, the ACT team can include a part-time civil attorney employed by a statewide legal advocacy organization to provide legal care to ACT team recipients. The attorney will provide a full spectrum of interventions that address the legal needs for individuals to include: training of ACT team members to recognize legal needs and triage, consultations, and legal representation to ACT participants. The attorney will attend daily ACT team meetings and be available for other consultations as needed.

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.

VII. Program Organization and Communication

A. Hours of Operation and Staff Coverage

1. Full Teams

a. The ACT team shall be available to provide treatment, rehabilitation, crisis intervention, and support activities seven days per week. For full teams, this means:

i. Regularly operating and scheduling staff to work at least 12 hours per day weekdays. Regularly operating and scheduling ACT staff to work 8 hours a day, with a minimum of 2 staff each weekend day and every holiday.

ii. Regularly scheduling ACT staff on-call duty to provide crisis services and deliver services the hours when staff are not working. MHP's on the ACT staff who are experienced in the program and skilled in crisis-intervention procedures shall be

on call to provide back-up to on-call staff and be available to respond to recipients by telephone or by going out to see recipients who need face-to-face contact.

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

2. Half Teams

a. Half teams with 7 or more clinical full time equivalents: The ACT team shall be available to provide treatment, rehabilitation, crisis intervention, and support activities seven days per week. For half teams with seven or more full time clinical staff, excluding the program assistant and prescriber, this means:

i. Regularly scheduling ACT staff for a minimum of 10-hour shift coverage on weekdays and six- to eight-hour shift coverage on weekends and holidays. In addition to the minimum specifications identified above, staff are regularly scheduled to provide the necessary services on a recipient-by-recipient basis (per the comprehensive assessment and person-centered treatment plan) in the evenings and on weekends. The number of staff per shift may be driven by recipient need.

ii. Regularly scheduling ACT staff on-call duty to provide crisis services and deliver services the hours when staff are not working. MHP's on the ACT team who are experienced in the program and skilled in crisis-intervention procedures shall be on call to provide back-up to on-call staff and be available to respond to recipients by telephone or be available to respond to see recipients who need face-to-face contact

iii. In addition to the use of on-call ACT staff, the team may arrange for coverage through a reliable crisis-intervention service as long as there is a mechanism by which the half 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) and the on-call ACT staff are available to consult and see recipients face-to-face when necessary and/or if requested by the crisis-intervention services provider.

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

b. Half teams with less than 7 clinical full-time equivalents: The ACT team shall be available to provide treatment, rehabilitation, crisis intervention, and support activities seven days per week. For half teams with less than seven full time clinical staff, excluding the program assistant and prescriber, this means:
   i. Regularly scheduling staff for at least 8 hour shift coverage on weekdays;
   ii. Through the use of the *Daily Team Meeting* and the *Daily Staff Assignment Schedule,* adjusting schedules and providing staff to carry out the needed service activities in the evenings or on weekend days when necessary;
   iii. Regularly scheduling staff on-call duty to provide crisis services and deliver 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 recipients by telephone or in person.
   iv. When a half 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 ACT team shall rotate cell phone/pager coverage 24/7 to be available for face-to-face contacts and shall arrange with the crisis-intervention service to be notified when a face-to-face contact is needed. The half 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).

B. Place of Treatment

Ideally and at the discretion of the recipient, service contacts will occur in the recipient's community or home in order to better understand their living environment. Each team shall set a goal of providing 75 percent of service contacts in

the community in non-office-based or non-facility-based settings. Data regarding the percentage of recipient contacts in the community will be collected and reviewed to verify that goals are being met as part of the program's Quality Improvement (QI) plan.

C. Staff Communication and Planning

1. The ACT team shall conduct **daily team 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 or computerized **daily log**. The daily log provides:

      i. A roster of the recipients served in the program, and
      ii. For each recipient, a brief documentation of any treatment or service contacts that have occurred during the last 24 hours and a concise, behavioral description of the recipient's status that day.

   b. The **daily team 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 recipients.

   c. The ACT team, under the direction of the team leader, shall maintain a **weekly recipient schedule** for each recipient. The weekly recipient schedule is a written schedule of all treatment and service contacts that staff must carry out to fulfill the goals and objectives in the recipient's person-centered treatment plan. The team will maintain a central file of all weekly recipient 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 recipient schedules. The daily staff assignment schedule is a written timetable for all the recipient treatment and service contacts and all indirect recipient work (e.g., medical record review, meeting with collaterals, 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 team meeting will include a review by the shift manager or team leader of all the work to be done that day as recorded on the daily staff assignment schedule. During the meeting, the shift manager or team leader 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 team meeting**, the ACT team shall also schedule any additional contacts based on emerging recipient needs and crises, as well as proactive contacts to prevent future crises. This meeting is held on a daily basis in addition to the regularly scheduled treatment planning meetings.

2. The ACT team shall conduct **person-centered treatment planning meetings** under the supervision of the team leader and the psychiatric prescriber. These treatment planning meetings shall:

a. Convene at regularly scheduled times per a written or computerized schedule maintained by the team leader.

b. Occur and be scheduled when the recipient and the majority of the team members can attend, including the psychiatric prescriber, team leader, and all members of the ITT. These meetings may also include the recipient's family and/or natural supports, if desired and available.

c. Require individual staff members to present and systematically review and integrate recipient information into a holistic analysis and work with the recipient and ITT to establish priorities for services.

d. Occur with sufficient frequency and duration to make it possible for all staff to be familiar with each recipient and their goals and aspirations and for each recipient to become familiar with ITT staff; to participate in the ongoing assessment and reformulation of strengths, resources, and service needs/issues; to problem-solve treatment strategies and rehabilitation options; to participate with the recipient and the ITT in the development and the revision of the person-centered treatment plan; and to fully understand the treatment plan rationale in order to carry out the plan with each recipient at least every 90-135 days.

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 psychiatric prescriber shall assume responsibility for supervising and directing all staff activities. This supervision and direction shall consist of:

1. Individual, side-by-side field mentoring sessions in which the supervisor accompanies an individual staff member to meet with recipients in regularly scheduled or crisis meetings to assess their performance, give feedback, and model alternative treatment approaches;

2. Regular individual or group meetings with staff to review their work with recipients, assess clinical performance, and give feedback;

3. Regular reviews, critiques, and feedback on staff documentation (i.e., progress notes, assessments, treatment plans, treatment plan reviews);

4. Didactic teaching and/or training; 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.

VIII. Assessment and Person-Centered Treatment Planning

A. Initial Assessment and Treatment Plan

An initial, brief assessment and treatment plan shall be done the day of the recipient's admission to ACT by the team leader or the psychiatric prescriber. Other designated team members may also conduct the initial assessment/treatment plan, with review and approval by the team leader and psychiatric prescriber.

B. Comprehensive Assessment

Each part of the assessment area shall be completed by the respective team specialist and/or an ACT team member who possesses 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 recipient. The assessment is based upon all available information, including that from recipient interview/self-report, family and/or natural supports, and written summaries from other agencies, including police, courts, and outpatient/inpatient facilities, where applicable. A comprehensive assessment shall be initiated and completed <u>within six weeks of</u> a recipient's admission according to the following requirements:

1. In collaboration with the recipient, the comprehensive assessment shall include an evaluation of the following areas:

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

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.

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 drug and alcohol assessment. The substance abuse specialist presents the assessment findings at the first treatment planning meeting.

d. ***Housing:*** A team member with experience and training in tenancy support services is responsible for completing the housing assessment. Included in this area is the assessment of the recipient's current housing situation, including exploration of their needs and preferences related to housing. The assessment should focus on current barriers to accessing and maintaining good quality, safe, and affordable housing. The housing specialist presents assessment findings at the first treatment planning and updates information in subsequent team meetings.

e. ***Education and Employment:*** A team member with experience and training in vocational assessment and services is responsible for completing the education and employment assessment. Included in this area is the assessment of community inclusion and integration as it relates to education and employment. The assessment emphasizes the recipient's desire and goals related to education and employment rather team member's determination of readiness. Information gathered during ongoing work-based assessments is not to determine employability, but to determine type of job and supports required to help the recipient succeed in work and education including the type of environments that will promote recovery and positive work/education experiences and education and job accommodations to support the recipient's success. A vocational profile should be updated with each new job and education experience. The vocational specialist presents assessment findings at the first treatment planning and updates information in subsequent team meetings.

f. ***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. Included in this area is the assessment of the individual's social and interpersonal inclusion and integration within the community. The team member who does the assessment presents the assessment findings at the first treatment planning meeting.

g. ***Activities of Daily Living (ADL):*** Nurses and other clinical staff with training or experience in this area (e.g., occupational therapists) are responsible to complete the ADL assessment. Other staff members with training to do the assessment and who have interest in and compassion for recipients in this area may complete the ADL assessment. The team member who does the assessment presents assessment findings at the first treatment planning meeting.

h. ***Family Structure and Relationships:*** Members of the recipient's 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.

i. ***Strengths and Resources:*** Members of the recipient's ITT are responsible for engaging the recipient in his or her own narrative in order to identify individual strengths and resources as well as those within the individual's family, natural support network, service system, and community at large. These may include: skills, talents, personal virtues and traits, interpersonal skills, interpersonal and environmental resources, cultural knowledge and lore, family stories and narratives, knowledge gained from struggling with adversity, knowledge gained from occupational and parental roles, spirituality and faith, and hopes, dreams, goals, and aspirations.

2. While the assessment process shall involve the input of most, if not all, team members, the recipient's psychiatric prescriber, primary practitioner, 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 comprehensive assessment is completed within one month of the recipient's admission to the program. After the assessment formulation is complete, the ITT will solicit feedback from the recipient and obtain his/her signature indicating participation in the assessment process. A copy of the signed assessment shall be made available to the recipient.

3. The primary practitioner and ITT members will be assigned by the team leader in collaboration with the psychiatric prescriber by the time of the first treatment planning meeting or thirty days after admission.

4. The comprehensive assessment must meet the standards outlined in this document, in addition to those outlined in 7 AAC 135.110.

C. Person-Centered Treatment Planning

Person-centered treatment plans will be developed through the following treatment planning process **within 30 days** of a recipient's admission to the team:

1. As described in Section VII, 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 psychiatric prescriber, the primary practitioner, ITT members, the peer specialist and all other ACT team members who are assigned to provide treatment, rehabilitation, and support with the recipient. ACT staff shall make every effort to ensure that the recipient and his/her family and/or natural supports (if desired by the recipient) are supported and in attendance at the treatment planning meeting.

2. The person-centered treatment plan shall be developed in collaboration with the recipient and his/her preferred natural supporters, and/or guardian, if any, when feasible and appropriate. The recipient's participation in the development of the treatment plan shall be documented. The ACT team shall evaluate together with each recipient their needs, strengths, and preferences and develop together with each recipient a person-centered treatment plan. The treatment plan shall identify individual service needs; strengths and capacities; set specific and measurable long- and short-term goals for each service need/issue; establish the specific approaches and interventions necessary for the recipient to meet his/her goals, improve his/her capacity to function as independently as possible in the community, and achieve the maximum level of recovery possible (i.e., a meaningful, satisfying, and productive life). The recipient's own words are reflected in the treatment plan.

3. ITT members are responsible to provide the necessary support to ensure the recipient is actively involved in the development of treatment (recovery) and service goals and participation in the treatment plan meetings. This may include offering of peer-based coaching and/or skills training around his/her role in developing their own person-centered treatment plan. With the permission of the recipient, ACT team staff shall also involve pertinent agencies and members of the recipient's social network in the formulation of treatment plans.

4. Each recipient's treatment plan shall identify specific measurable recipient goals, followed by recipient strengths and potential barriers to each goal. The treatment

plan must then clearly specify the approaches and interventions necessary for the recipient to achieve the individual goals (i.e., recovery) and identify who will carry out the approaches and interventions.

5. The following key areas should be addressed in every recipient's person-centered treatment plan unless they are explored and designated as "not of current interest" by the recipient: psychiatric illness or symptom reduction; housing; ADL; daily structure and employment; family and social relationships; physical health; and other life areas, goals and aspirations as identified by the recipient (e.g., community activities, empowerment, decision-making).

6. The primary practitioner and the ITT, together with the recipient, will be responsible for reviewing and rewriting the treatment goals and plan whenever there is a major decision point in the recipient's course of treatment (e.g., significant change in recipient's condition or goals) or at least every 90-135 days. Additionally, the primary practitioner shall prepare a summary (i.e., treatment plan review) which thoroughly describes in writing the recipient's and the ITT's evaluation of his/ her progress/goal attainment, the effectiveness of the interventions, and the satisfaction with services since the last treatment plan. The plan and review will be signed or acknowledged by the recipient, the primary practitioner, ITT members, the team leader, the psychiatric prescriber, and all ACT team members. A copy of the signed person-centered plan is made available to the recipient.

7. The person-centered individualized treatment plan must meet the standards outlined in this document, in addition to those outlined in 7 AAC 135.120.

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 Core ACT Services

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

A. Service Coordination

Each recipient will be assigned a primary practitioner who coordinates and monitors the activities of the recipient's ITT and the greater ACT team. The primary responsibility of the primary practitioner is to work with the recipient to write the person-centered 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 recipient's needs change, and to advocate for the recipient's wishes, rights, and preferences. In most cases, the primary practitioner is also the first staff person called on when the recipient is in crisis and is the primary support person and educator to the individual recipient's family. Members of the recipient's ITT share these tasks with the primary practitioner and are responsible to perform the tasks when the primary practitioner is not working. Service coordination also includes coordination with community resources, including recipient self-help and advocacy organizations that promote recovery.

Optional: If it is determined that legal resources are needed and available through partnership agreements, the ACT team can include a part-time civil attorney employed by a statewide legal advocacy organization to provide legal care to ACT team recipients. The attorney will provide a full spectrum of interventions that address the legal needs for individuals to include: training of ACT team members to recognize legal needs and triage, consultations, and legal representation to ACT participants. The attorney will attend daily ACT team meetings and be available for other consultations as needed.

B. Crisis Assessment and Intervention

1. Crisis assessment and intervention shall be available 24 hours per day, seven days per week. These services will include telephone and face-to-face contact.

2. The ACT team is the first-line crisis evaluator and responder.

3. The local mental health system's emergency services program, as appropriate, will provide adjunctive crisis intervention services as is clinically indicated. Whenever possible, a representative from the ACT team will be present to support the ACT recipient when external crisis responders are involved with the recipient.

4. Each ACT recipient will have an individualized, strengths based crisis plan that will assist the ACT team when responding to a crisis. As with the treatment planning process, the recipient will take the lead role in developing the crisis plan.

C. Assertive Outreach and Engagement

1. The ACT team will engage in active outreach (face-to-face interaction) with people in the streets, shelters, under bridges, and in other non-traditional settings. Active outreach will include identifying individuals in need, screening, developing rapport, offering support while assisting with immediate and basic needs, and referral to appropriate resources.

2. The ACT team will use a variety of techniques to engage recipients, including the use of collaborative and motivational interventions to engage recipients and promote recipients' development of intrinsic motivation to receive services from the ACT team.

3. When necessary, the ACT team will use therapeutic limit-setting interventions to create extrinsic motivation for receiving services deemed necessary to prevent harm to self or others.

4. In addition to being proficient in a range of engagement interventions, the team has a thoughtful process for evaluating and measuring the effectiveness of techniques and modifying approaches when necessary.

D. Assessment and Service Planning

Assessment and Service planning shall include but not be limited to the following:

1. Identify or update primary psychiatric and co-occurring disorders, symptoms, and related functional impairments, particularly as they relate to impediments to recipients' desired life roles, as a part of the comprehensive clinical assessment.

2. Assess transition readiness on an ongoing basis using standardized tools.

3. Update and revise, in partnership with the recipient, an individualized, comprehensive, culturally sensitive, goal-oriented person-centered treatment plan.

4. Identify individualized strengths, resources, preferences, needs, and goals, and include identified strengths in the treatment plan goals and action steps.

5. Create specific and clinically thoughtful interventions to be delivered by the team, which are then cross-walked to a recipient weekly/monthly schedule used to guide day-to-day team planning.

6. Identify risk factors for harm to self or others.

7. Monitor response to treatment, rehabilitation, and support services.

8. Develop person-centered, functional crisis plans.

E. Empirically Supported Interventions and Psychotherapy

1. The ACT team should provide individual and/or group psychotherapy as specified in the recipient's treatment plan.

2. Clinicians should use empirically supported techniques to address specific psychological and behavioral problems (e.g., anxiety, psychotic symptoms, emotional dysregulation, and trauma symptoms).

3. All psychotherapy services should be provided by a trained, licensed therapist; however basic interventions may be carried out by non-licensed staff with appropriate training and supervision.

F. Wellness Self-Management and Relapse Prevention

Wellness Self-Management and Relapse Prevention services shall include but not be limited to the following:

1. Defining and identifying the recipient's recovery goals within the recipient's frame of reference.

2. Developing strategies for implementing and maintaining the identified recovery goals.

3. Education about mental illness, treatment, and recovery.

4. Teaching skills for coping with specific symptoms and stress management.

5. Facilitating the development of a personal crisis management plan, including suicide prevention or psychiatric advance directive.

6. Developing a relapse prevention plan, including identification/recognition of early warning signs and rapid intervention strategies.

7. Delivery of wellness management interventions via group and individual work such as Wellness Recovery Action Plans (WRAP) or Illness/Wellness Management and Recovery (IMR/WMR).

G. Medication Support

Medication Support services shall include but not be limited to the following:

1. Use of a shared decision-making model in identifying medication needs and preferences.

2. Prescription, administration, and ordering of medication by appropriate medical staff.

3. Assisting recipients in accessing medications.

4. Monitoring medication response and side effects.

5. Educating recipients about medications.

6. Helping recipients develop the ability to take medications with greater independence.

H. Integrated Dual Disorders Treatment for Substance Abuse

Services will include but not be limited to the following:

1. Providing support that is non-confrontational and that promotes harm reduction or abstinence, depending on the recipient's stage of change readiness.

2. Assessing stages of change readiness and related stage of treatment.

3. Providing outreach and engagement to those in a pre-contemplation or contemplation stage of change readiness.

4. Using motivational interviewing for those in contemplation and preparation phase of change readiness.

5. Providing active substance abuse counseling and relapse prevention, using cognitive-behavioral interventions, for those in late stages of change readiness.

6. Educating on substance abuse and interaction with mental illness.

7. Providing individual and group modalities for dual disorders treatment.

8. Staff providing substance abuse treatment must be appropriately certified or licensed.

I. Tenancy Support Services (Housing)

Tenancy support services should be consistent with an evidenced-based Supportive Housing Model and include but not be limited to the following:

1. Pre-Tenancy Supports
    a. Assisting recipients to define housing needs and preferences
    b. Assessment of barriers to accessing and maintaining housing
    c. Assisting recipients in finding good quality, safe, and affordable housing that follows the recipient's preferences in level of independence and location (e.g., housing search, finding a roommate,

rental application, assistance with rental interview, facilitation of housing unit inspection)
   d. Assisting with locating housing options with a focus on integrated independent settings
   e. Applying for housing subsidies and housing programs

2. Move-In Supports
   a. Assisting recipients with household set up (e.g., procuring necessities, such as bedding, kitchen supplies, household furniture, telephone, and assistance with security deposit)
   b. Physically assisting with move-in or re-location
   c. Facilitation of meeting property manager, neighbors, and other important contacts
   d. Assisting the recipient in negotiating and understanding the terms of the lease and paying rent and utilities

3. On-going Housing Stability Services
   a. Providing necessary supports and skills training to achieve long term tenancy (e.g., training on tenant expectations and skills (Ready to Rent), maintaining regular contact with and developing amicable relationship with landlord, serving as the ready contact person for landlords in order to avoid and resolve housing issues)
   b. Providing tenancy support and advocacy for the recipient's tenancy rights at the individual's home at least monthly.
   c. Assisting recipient with community and neighborhood integration
   d. Providing tenant rights education and periodic meetings with property manager to proactively address tenancy issues
   e. Emergent visits to recipient for support/resolution of household emergencies (eviction prevention/mediation activities)
   f. Providing tenancy support services to recipients transitioning to the community from institution or congregate settings

J. Education Services

Supported education related services are for ACT recipients whose high school, college or vocational education was interrupted or prevented. Services provide support to enrolling and participating in educational activities.

1. Strengths-based assessment of educational interests, abilities and history.

2. Pre-admission counseling to determine which school and/or type of educational opportunities may be available.

3. If indicated, referral to GED classes and testing.

4. Assistance with completion of applications and financial aid forms.

5. Help with registration.
6. Orientation to campus buildings and school services.
7. Assessment of learning style and study skills.
8. Early identification and intervention with academic difficulties.
9. Linking with academic supports such as tutoring and learning resources.
10. Assistance with time management and schoolwork deadlines.
11. Supportive counseling.
12. Information regarding disclosing mental illness.
13. Advocating with faculty for reasonable accommodations.

K. Vocational Services

Vocational Services will be in alignment with evidenced-based Supported Employment models and will include but not be limited to the following:

1. Encouraging, motivating, and assistance with identifying and developing interests and skills.
2. Direct assistance with job development that includes locating preferred jobs, assisting with the application process, and involvement with employers.
3. Providing ongoing supports, such as job coaching.
4. Developing and strengthening relationships with local employers and other vocational support agencies.
5. Educating employers about available vocational supports and working with individuals with disabilities, such as serious mental illness.
6. Surveying local employers to identify various work settings and job roles.
7. Exploring and proposing job carving options with employers (e.g., breaking down a job role into multiple job roles with a more limited list of tasks and responsibilities, and full-time equivalent requirements.
8. Finding, enrolling, and supportive participation in school/training programs.
9. Providing benefits counseling and linkage to SSA work incentives.

L. Psychiatric Rehabilitation and Assistance with Activities of Daily Living

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

1. Perform household activities, including household maintenance and cleaning, cooking, grocery shopping, and laundry.

2. Carry out personal hygiene and grooming tasks, as needed.

3. Develop or improve money-management skills.

4. Maintain safety in home and community.

5. Dress appropriately for the weather, including the purchase and care of appropriate clothing.

6. Develop healthy, appropriate, and satisfying social relationships.

7. Use available transportation.

8. Have and effectively use a personal physician and dentist.

9. Access legal advocacy and representation, if needed.

M. Social and Community Integration Skills Training

Social and community integration skills training serve to support social/interpersonal relationships and leisure-time skill training. Specific interventions include supportive individual therapy, 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 help structure recipients' 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, as necessary

2. Develop social skills, increase social experiences, and where appropriate, 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

N. Peer Support Services

These include services to validate recipients' experiences and to guide and encourage recipients to take responsibility for and actively participate in their own recovery, as well as services to help recipients identify, understand, and combat stigma and discrimination against mental illness and develop strategies to reduce recipients' self-imposed stigma. Peer Support Services include:

1. Services which promote self-determination and encourage/reinforce choice and decision making.

2. Introduction and referral to recipient self-help programs and advocacy organizations that promote recovery.

3. Facilitation of wellness management and recovery strategies (WRAP, IMR)

4. The Peer Specialist will serve as a consultant to the ACT team to support a culture of recovery in which each recipient's point of view and preferences are recognized, understood, respected and integrated into treatment, rehabilitation, support, and community activities.

O. Family Life and Social Relationships

Services provided under this category include:

1. Restoration and strengthening the recipient's unique social and family relationships.

2. Providing psycho-educational services (e.g., providing accurate information on mental illness and treatment to families and facilitating communication skills and problem solving).

3. Coordinating with child welfare and family agencies.

4. Support in carrying out parent role.

5. Teaching coping skills to families in order to support recipient's recovery.

6. Enlisting family support in recovery of the recipient.

7. Facilitating the recipient's natural supports through access to local support networks and trainings, such as NAMI's Family-to-Family.

8. Helping recipients expand network of natural supports.

P. Health

Services provided under this category include:

1. Educating recipients to prevent health problems.

2. Providing and coordinating medical screening and follow up.

3. Scheduling routine and acute medical and dental care visits, and assisting recipient in attending these visits.

4. Sex education and counseling.

5. Health and nutrition counseling.

Q. Money Management and Entitlements

Services provided under this category include:

1. Assisting recipient in gathering documents and completing entitlement and other benefit applications.
2. Accompanying recipients to entitlement offices.

3. Assisting with re-determination of benefits.

4. Providing financial crisis management.

5. Teaching budgeting skills and asset development.

6. Teaching skills in managing food stamps.

7. Assisting with representative payee, if needed.

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

IX. Recipient Medical Record

A. The ACT team shall maintain a treatment record for each recipient.

B. The treatment record is confidential, complete, accurate, and contains up-to-date information relevant to the recipient's care and treatment.

C. The record shall accurately document assessments, treatment plans, and the nature and extent of services provided, such as a person unfamiliar with the ACT team can easily identify the recipient's treatment needs and services received.

D. The team leader and the program assistant shall be responsible for the maintenance and security of the recipient treatment records.

E. The recipient 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. Recipients shall be informed by staff of their right to review their record and the process involved to request to do so.

H. Each recipient's clinical record shall be available for review and may be copied by authorized personnel.

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

X. Recipient Rights and Grievance Procedures

A. ACT teams shall be knowledgeable about and familiar with recipient rights including the rights 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. Voice or file grievances or complaints

B. ACT teams shall be knowledgeable about and familiar with the mechanisms to implement and enforce recipient rights. These include:

Grievance or complaint procedures under:

1. Alaska Administrative Code and Statute

2. Medicaid

3. Americans with Disabilities Act

4. Protection and Advocacy for Mentally Ill Individuals

5. Local and State Tenant Rights Laws

C. ACT teams shall provide recipients with information regarding their rights and grievance procedures.

D. ACT teams shall be prepared and provide recipients with appropriate information and referral to the Protection and Advocacy agency and other advocacy groups.

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

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.

A. ACT teams should ensure that recipients receive from all staff members, effective, understandable and respectful care that is provided in a manner compatible with their cultural health beliefs and practices. ACT teams will also make every attempt to ensure that recipients receive services in their preferred language and will make arrangements for interpreter services, if available.

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 receives 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 recipient with limited English-proficiency at all points of contact, in a timely manner during all hours of operation.

E. ACT teams must provide to recipients 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 recipients by interpreters and bilingual staff. Family and friends should not be used to provide interpretation services (except by request of the recipient).

G. ACT teams must make available easily understood recipient-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, recipient satisfaction assessments and outcome-based evaluations.

J. ACT should ensure that data on the individual recipient'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 recipient 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 recipient.

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.

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

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 recipients or target population.

B. Measurable criteria 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

A. The ACT team shall have a stakeholder advisory group to support and guide ACT team implementation and operation. The stakeholder advisory group will serve as a referral committee and will include representation from state and local government, the criminal justice and courts system, and local consumer and emergency response groups. The Stakeholder Advisory Group shall not have access to individually-identifiable recipient information without written recipient consent.

The stakeholder advisory group shall:

1. Prioritize services to high risk individuals identified as frequent users of the emergency services system (and meet eligibility criteria for ACT)

2. Promote quality ACT model programs

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. Promote and ensure recipients' empowerment and recovery values in ACT 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

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

Summary of Policy and Procedure Requirements

- Admission and Discharge
- Service Intensity and Capacity
- Staff Requirements
- Program Organization and Communication
- Assessment and Person-Centered Treatment Planning
- Required Core ICM Services
- Recipient Medical Record
- Recipient Rights and Grievance Procedures
- Culturally and Linguistically Appropriate Services
- Performance Improvement and Program Evaluation
- Stakeholder Advisory Groups