SANILAC COUNTY COMMUNITY MENTAL HEALTH AUTHORITY

CLINICAL POLICY

NUMBER: BC001

NAME: ACT PROGRAM GUIDELINES

INITIAL APPROVAL DATE:	12/19/1995	BY: SCCMHA Board
STAKEHOLDER REVIEW:	12/04/2012	BY: Consumer Advisory Board
(LAST) REVISION DATE:	09/16/2021	BY: Policy Committee
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DISCONTINUED DATE:	N/A	REPLACED BY: NA

I. PURPOSE

To provide an overview of the principles and organizational structure of the ACT Program and determine eligibility for admission, transition, discharge, and case coordinator assignment to the ACT Program.

II. APPLICATION

Populations: **MI Adult**
Programs: **Direct – All MI Adult Programs**

III. POLICY

The Assertive Community Treatment Team (ACT) at Sanilac CMH will conform to the best practice guidelines for ACT ensuring fidelity to the model, effectiveness of the treatment, and compliance with standards of the State and other accrediting bodies.

The purpose of the ACT team is to provide intensive community treatment as well as the development and coordination of natural supports for persons with serious and persistent mental illness, and/or co-occurring substance use disorder, who require a multi-disciplinary team approach and frequent community contacts to achieve movement towards recovery and an improved quality of life.

A. Principles of ACT

- Assertive Community Treatment is a team treatment approach designed to provide comprehensive community based psychiatric treatment, rehabilitation and supports. The Team is comprised of the Psychiatrist, Care Managers, Peer, Nurse, and Supervisor. The Team is the fixed point of responsibility for all services and supports, either provided directly by the team or coordinated by them including consultation with other disciplines and/or referrals to other supportive services. Considering the individual's preferences, clinical appropriateness, and medical necessity, most services are provided in the community.
- ACT services are reserved for persons who have a serious mental illness and require intensive services and supports, and without such services and interventions, could need more restrictive services or settings.
- The team provides basic services and supports essential to improving the person's ability to function in community settings, including assistance with accessing basic needs through available community resources such as food, housing, transportation, and medical care. Supports are given to encourage individuals to function in social, educational, and vocational settings.

- ACT services are based on the principles of recovery and person-centered practice and are individually tailored to meet the needs of the person served. ACT services may vary in intensity over time based on the needs and condition of the persons served. Services may include daily contacts. Crisis services are available 24-hours per day seven days per week by the ACT Team.
- Individuals receiving ACT services are encouraged to actively participate in the medication management plan. Participation includes dialogue and education about medication effects and potential side effects and learning to be as independent as possible in obtaining, taking, and communicating with the psychiatrist about their medication. Level of Team support is tailored to individual need.
- Individuals with co-occurring substance use disorders must have both behavioral health and substance use disorders addressed in the IPOS.
- Individuals with co-occurring substance use disorders, who are in the active stage of change, are encouraged to participate in the IDDT program.
- ACT services are provided for as long as needed by the person served. When the person served is transitioned to less intensive services, careful planning and support enhances the potential for a positive outcome.
- The staff to person served ratio is no more than 1:10 to ensure that there are sufficient staff to meet the needs of the persons served. Staff travel and caseload acuity may require a lower staff to person served ratio.
- ACT services may be offered to individuals ordered to engage in Assisted Outpatient Treatment or NGRI.

B. Team Composition

The ACT Team consists of a Supervisor who is a mental health professional who has specialized knowledge and competencies to lead and supervise the team and is experienced in working with persons who have severe and persistent mental illnesses as well as substance use problems. Additionally, there are qualified behavioral health practitioners, a Psychiatrist, a Registered Nurse, and Certified Peer Support Specialist.

C. Individual / Program Outcomes

ACT will track movement of persons to less restrictive services as well as community tenure, employment, education, community integration, and living situations. The LOCUS is done quarterly and at hospital discharge and when an individual is ready for less or more intensive services.

D. Team Meetings

Team meetings are held daily and documented. Team meeting logs are kept in a secure location and document team members in attendance. The psychiatrist meets with the Team at least weekly and signs the log. Meetings include the following: Review of the clinical status of all persons served by the Team; an update for staff members on treatment contacts that occurred during the previous day; Identification of service needs for the current day and finalizing the day's schedule; review of IPOS and Periodic Reviews; Problem solving, adjusting service intensity and planning for potential emergencies and crisis situations; transition planning to prepare and ready persons served for less intensive services.

E. Clinical Supervision (Documented)

The Team Supervisor routinely provides clinical supervision with additional clinical supervision provided by the Team Psychiatrist and COO. Supervision is to occur in a variety of ways: Team is supervised by the Team Supervisor at the daily Team meetings; individual supervision of Team members bi-monthly or as needed; shared community contacts with the supervisor and other members of the Team; participation in Team meetings by the Team Psychiatrist; Organizational staff meetings (Divisional).

Certified Peer Support Specialists are valuable to the ACT Team and receive supervision along with other members of the Team. Additionally, the Team Supervisor is responsible for professional treatment monitoring of the CPSS.

F. Admission

ACT services are targeted to persons with serious mental illness who require intensive services and supports and who, without ACT, would require more restrictive services and/or settings. ACT is a voluntary program and persons must agree to receive services.

Examples of persons who meet these criteria are as follows:

- Individuals with serious mental illness with difficulty managing medications without ongoing support, or with disabling symptoms despite medication compliance.
- Is 18 years of age or older
- Resides in Sanilac County
- Individuals who also have a co-occurring substance use disorder
- Individuals with a serious mental illness who exhibit socially disruptive behavior that puts them at high risk for arrest and inappropriate incarceration or those exiting a county jail or prison
- Frequent users of inpatient psychiatric hospital services or crisis services
- Older persons with serious mental illness or persons with complex medical conditions or medication needs
- Persons transitioning from a State Hospital or a Supervised Living Placement to Independent Living
- Must require intensive services and supports and who, without ACT, would require more restrictive services and/or settings.

Individuals to be considered for ACT Program generally meet the following criteria:

- The individual has not responded well to more traditional outpatient services.
- Serious and recalcitrant symptoms of mental illness with extensive impairment in functioning.
- Severe difficulties with basic, everyday activities such as, keeping safe, caring for basic physical needs, or maintaining safe and adequate housing.
- Any combination of:
  - Frequent hospitalizations, - unemployment, - substance abuse,
  - Homelessness, - involvement in the criminal justice system.
- History of difficulty complying with medication regime, and needing frequent monitoring and supports at least twice a week.

Persons with the following primary diagnoses are not eligible for ACT Program services:

- Personality Disorders
- Substance Use Disorders
- Intellectual or Developmental Disability

Admission Process:

- Referrals will generally come from Sanilac County Mental Health Outpatient clinic, hospital discharges, or through the intake process.
- Individuals will be referred to ACT for consideration using the Staffing/Transfer/Referral form #226.
- Referrals are forwarded to the ACT Program supervisor. Referring clinician will present the case to the ACT Team.
- Admission to ACT will be a clinical decision by ACT Program supervisor and the Team. Individual need, program services availability and program capacity will be considered in making this determination.

- Individual must agree to participation in ACT after having ACT services explained and clearly defined to the person.
- Current primary case holder and ACT staff will attend a transfer meeting with the individual prior to ACT services beginning and the plan will be reviewed and amended at this transfer meeting unless there are extenuating circumstances.
- The ACT Team determines the primary case holder based upon the current caseloads and the specific needs of the individual.
- Once the primary case holder is assigned, they are responsible to perform the duties/responsibilities of that role.
- As required by the Medicaid Manual, persons served by ACT will have access to ACT crisis services 24 hours a day, 7 days a week. Individuals will be provided the crisis line number. In an event that the number does not get a response from the ACT crisis phone, they will also be given the ACCESS after hours on-call number to use as a back up if needed.

G. Continued Eligibility of ACT Services

It is anticipated that persons who receive ACT services will need intensive services to address the needs identified in the Individual Plan of Service. LOCUS assessments are completed quarterly. The IPOS and progress notes are reviewed quarterly for:

1. Progress made toward achieving goals or objectives
2. Reviewing number of contacts made during the past 90 days and assessing the ongoing need for the current level of intensity. If there is an average of less than 5 face-to-face contacts per month for a 3 consecutive month period, the treatment plan and LOCUS assessment should be reviewed to determine if a less intense service should be provided instead of ACT.

H. Transitioning to Less Intensive Service and Discharge

Individuals who meet medical necessity criteria for ACT services usually require and benefit from long-term participation in ACT. ACT is not a service that is appropriate for short-term stabilization and then transition into another program. If it has been determined that less intensive services could meet an individual's needs, then a transition plan is developed to prepare the individual for less intensive services. This is done when the individual no longer meets severity of illness criteria and has demonstrated the ability to meet all major role functions for a period of time sufficient to demonstrate clinical stability. This is done through the person centered planning process listed below.

1. The individual's progress and strengths are reviewed.
2. A transition plan is developed that includes reducing services to the level that will be provided upon transfer to a less intense service.
3. An Adverse Benefit Determination letter will be sent to the individual reflecting the discharge from ACT.
4. A transition meeting is set with the new service provider.

I. Other Discharges

1. Discharges may occur if engagement of the person in ACT is not possible despite deliberate, persistent and frequent outreach attempts. These attempts may include face to face engagement attempts, contacting natural supports, or legal mechanisms and should be consistent and documented over a course of 30 days. In such situations, an Adverse Benefit Determination letter is sent to the last known address.
2. Discharge is appropriate if the person served has moved outside the geographic service area. An Adverse Benefit Determination letter is sent to the individual at the current address.
3. Discharge is appropriate if the person served no longer wishes to participate and requests discharge from the ACT Program.
4. Discharge is appropriate if the person served requires long term residential care or other dependent care placement.

J. References

- Medicaid Provider Manual
- SAMHSA Toolkit for Assertive Community Treatment Programs
- Improving MI Practices Field Guide to Assertive Community Treatment, June 2020
- CNS Healthsource