Assertive Community Treatment (ACT) Program Guidelines Adult and Young Adult

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1. Program Definitions

ACT Team Direct Care Staff: Staff that provide treatment, rehabilitation, and case management. They are counted in the staff-to-individual ratio, this includes professional staff, peers, and paraprofessional staff. Students and trainees may qualify if they are participating in a program leading to a degree or certificate appropriate to the goals, objectives, and services of the outpatient program. Students and trainees must be supervised in accordance with the policies governing the internship/training program and are approved as part of the staffing plan by the New York State (NYS) Office of Mental Health (OMH).

Collateral Persons: Members of the individual's family or household, family of choice, or others who regularly interact with the individual (e.g., landlord, criminal justice staff, employer), are directly affected by or can affect the individual's condition, and who are identified in the service plan as having a role in the individual's treatment. Contacts made with a defined collateral person are provided for the direct benefit of the individual receiving services. Collateral contacts are conducted in accordance with, and for the purpose of, advancing the individual's service plan and for coordination of services with other community mental health and medical providers.

Contact: A face-to-face interaction (duration of at least 15 minutes) between a member of an ACT team and an individual or collateral during which at least one (1) ACT service is provided.

Discharge Planning: The process of planning for successful discharge from a program. Discharge planning includes identifying the resources and supports needed for the transition of an individual to another program and making the necessary referrals. This also includes linkages for treatment, rehabilitation, and supportive services as needed. Discharge planning should be done collaboratively with staff, the individual, and significant others involved with the individual's recovery, and should align with the goals, needs, and desires of the individual.

Employment: Employment at prevailing wages in regular, integrated work settings with the same supervision, responsibilities, and wages as non-disabled workers.

Family/natural support psychoeducation: A strengths-based model rooted in ecological systems theory, trauma theory, social learning and cognitive behavioral theory, narrative models and models of resiliency and social support. A structured curriculum helps participants identify and surmount barriers to learning about emotional response and other psychological processes associated with ongoing and cumulative stress, discrimination, racism, and stigma. Attention to reciprocity and multiple perspectives as well as cultural awareness and humility are integral to the process. Psychoeducation can take place individually, within a group format. The group format allows facilitators and participants to listen and learn from each other, identify, and differentiate the range of stress reactions to traumatic events, share stories and ideas, and develop proactive strategies that build resilience and foster recovery.

Licensed Practitioner of Healing Arts: An individual identified as a professional staff that is licensed by the New York State Education Department (NYSED).

LPHA' s include:

i. Physician: An individual currently licensed to practice medicine issued by NYSED;

ii. Physician Assistant: An individual currently registered to practice as a physician assistant issued by NYSED;

iii. Nurse Practitioner: An individual currently certified to practice as a nurse practitioner issued by NYSED;

iv. Registered Nurse (RN): An individual currently licensed to practice as a registered professional nurse issued by NYSED;

v. Psychologist: An individual currently licensed to practice as a psychologist issued by NYSED;

vi. Social Worker: An individual who is either currently a licensed clinical social worker (LCSW) issued by NYSED or a licensed Master of Social Work (LMSW) practicing under the supervision of a psychiatrist, psychologist, or LCSW employed by the agency;

vii. Mental Health Counselor: An individual currently licensed to practice as a mental health counselor issued by NYSED;

viii. Marriage and Family Therapist: An individual currently licensed to practice as a marriage and family therapist issued by NYSED;

ix. Psychoanalyst: An individual currently licensed to practice as a psychoanalyst issued by NYSED; and

x. Creative Arts Therapist: An individual currently licensed to practice as a creative arts therapist issued by NYSED.

Paraprofessional Staff: Paraprofessional staff must have attained a bachelor's degree or be at least 18 years of age, attained a high-school diploma or equivalent, and have at least six (6) months of direct care experience with individuals with serious mental illness (SMI).

Peer Specialists: Peer specialists are adults who are individuals who have themselves experienced mental illness, substance use, or trauma conditions. The Peer Specialist provides the ACT services from a lived-experience and non-clinical perspective.

Adult ACT teams are highly encouraged to employ peer specialists. Young Adult ACT teams are required to employ peer specialists. The Adult ACT Team Peer Specialist is not required to be a Certified Peer. However, only Certified Peer Specialists, Provisionally Certified Peer Specialists, or Credentialed youth peer advocates can bill for Peer Support Services.

Young Adult ACT teams are required to employ a Certified Peer or Credentialed Youth Peer Advocate.

Teams are encouraged to work with Peer Specialists who are interested in becoming certified or credentialed.

NYS OMH Certified Peer Specialists:

i. Identify as being actively in recovery from a mental health condition and intentionally self-disclose one's mental health recovery journey.

ii. Possess a certification from, or are provisionally certified as, a certified peer specialist by an NYS OMH-approved certified peer specialist certification program.

iii. Supervised by any professional staff.

NYS OMH Credentialed Youth Peer Advocate:

a. An individual 18 to 30 years old who has self-identified as a person who has first-hand experience with emotional (mental health) challenges, behavioral challenges, and/or co-occurring disorders.

b. Uses lived experience with a disability, mental illness, involvement with juvenile justice, special education, substance use disorder (SUD), and/or foster care to assist in supporting youth in their resiliency, recovery and wellness.

c. Possess a credential, or are provisionally credentialed as a Family Advocate, from an NYS OMH-approved credentialing program.

d. Supervised by any professional staff.

Person-Centered Planning: The process of developing a relationship between the ACT team and the individual such that the individual and the team are partners in planning for the individual's recovery. The planning includes; developing goals related to life roles, identifying choices and options, determining action steps, and identifying and securing the services needed to achieve the goals.

Professional Staff: Staff qualified by credentials, education and/or experience to provide clinical supervision and/or direct services related to the treatment of SMI.

Professional staff include:

i. Creative Arts Therapist: An individual who has a master's degree in a mental health field from a program approved by NYSED and is licensed as a creative arts therapist by NYSED or registration or certification by the American Art Therapy Association, American Dance Therapy Association, National Association of Music Therapy or American Association for Music Therapy.

ii. Nurse Practitioner: An individual currently certified as a nurse practitioner by NYSED.

iii. Nurse Practitioner in Psychiatry (NPP): An individual currently certified as a nurse practitioner with an approved specialty area of psychiatry by NYSED or possesses a permit from NYSED.

iv. Occupational Therapist: An individual currently licensed as an occupational therapist by NYSED.

v. Pastoral Counselor: An individual who has a master's degree or equivalent in pastoral counseling or is a Fellow of the American Association of Pastoral Counselors.

vi. Physician: An individual currently licensed as a physician by NYSED.

vii. Psychiatric Rehabilitation Practitioners: An individual certified by the Certification Commission of the Psychiatric Rehabilitation Association.

viii. Psychiatrist: An individual currently licensed as a physician by NYSED.

ix. Psychoanalyst: An individual currently licensed as a psychoanalyst by NYSED.

x. Psychologist: An individual currently licensed as a psychologist by NYSED. Individuals who have obtained at least a master's degree in psychology may be considered professional staff for the purposes of calculating professional staff and full time equivalent professional staff.

xi. RN: An individual currently licensed as a registered professional nurse by NYSED.

xii. Licensed Practical Nurse (LPN): An individual currently licensed as a LPN by NSYED or possesses a LPN permit from NYSED.

xiii. Rehabilitation Counselor: An individual who has either a master's degree in rehabilitation counseling from a program approved by NYSED or current certification by the Commission on Rehabilitation Counselor Certification.

xiv. Social Worker: Licensed Clinical Social Workers; Licensed Master Social Workers or Social Workers who have attained a master's degree in Social Work, who are each supervised by a Licensed Clinical Social Worker, Licensed Psychologist, or Psychiatrist

xv. Therapeutic Recreation Specialist: An individual who has either a master's degree in therapeutic recreation from a program approved by NYSED or registration as a therapeutic recreation specialist by the National Therapeutic Recreation Society.

xvi. Mental Health Counselor: Licensed Mental Health Counselors; Mental Health Counselors who have attained a master's degree and are supervised by a Physician, Physician's Assistant, Licensed Clinical Social Worker, Licensed Master Social Worker, or a Licensed Mental Health Counselor.

xvii. Marriage and Family Therapist: An individual currently licensed as a Marriage and Family therapist by NYSED.

xviii. Other practitioners licensed or permitted by NYSED who have specified training or experience in the treatment of individuals diagnosed with mental illness may be included as professional staff.

Utilization Review Authority: A person or persons designated by an outpatient program to perform the function of Utilization Review.

Warm Handoff: A transfer of care between two (2) members of the health care team, where the handoff occurs directly with the individual who will receive services, or who is receiving services. This transparent handoff of care allows individuals to hear what is said and engages them in communication, giving them the opportunity to clarify or correct information or ask questions about their care.

Wellness Self-Management: Is a set of services designed to improve community functioning and prevent relapse, including:

i. Person-centered recovery-oriented practices that provide knowledge and skills to help individuals diagnosed with SMI enhance personal wellness and develop resiliency;

ii. Skills training through multiple education and skills training sessions over time (between three (3) months and one (1) year), individual and group formats, and

"in vivo" training to facilitate generalization of skills to, among other things, help individuals make informed decisions and improve their quality of life; and

iii. Cognitive behavioral therapy for psychosis.

Forensic ACT teams, see the Forensic ACT Program Guidelines Addendum for additional definitions.

Young Adult ACT

Real World Skills: Skills that a young adult needs to develop/learn and or strengthen on the path to independence. Development of these skills may involve the use of groups and/or community settings to provide opportunities for learning and give individuals a chance to teach each other, when appropriate. Real World Skills include, but are not limited to well-being, financial literacy, decision-making, and maintaining a living situation.

2. Overview

The purpose of Assertive Community Treatment (ACT) is to deliver comprehensive and effective services to individuals who are diagnosed with SMI and whose needs have not been well met by more traditional service delivery approaches.

ACT is grounded in a recovery-oriented practice and provides an integrated set of evidence-based treatment, rehabilitation, case management, and support services delivered by a mobile, multidisciplinary behavioral health treatment team. ACT supports individual recovery through a highly individualized approach that provides individuals with the tools to obtain and maintain housing, employment, relationships, and relief from symptoms and medication side effects. The nature and intensity of ACT services are developed through the person-centered service planning process and adjusted through the process of daily team meetings.

ACT integrates the principles of person-centered, culturally responsive, trauma-informed care, addressing the impact of discrimination/stigma, and cross-system collaboration into its service philosophy. ACT provides services with consideration of cultural/linguistic preference through the use of the cultural formulation interview process and cultural assessment. An essential aspect of ACT is recognizing the importance of family, community-based, and faith-based supports.

ACT individuals often have a treatment history that has been characterized by frequent use of psychiatric hospitalization and emergency rooms, involvement with the criminal justice system, alcohol/substance use, homelessness, and lack of engagement in traditional site-based services. The population served by ACT is a small subset of the overall population with SMI and requires the highest level of services. ACT serves individuals who require frequent and community-based contacts. The individual-to-staff ratio for ACT cannot exceed 10:1. Most individuals with SMI will not need the intense level of service an ACT program offers.

Individuals are referred to ACT through a Single Point of Access (SPOA) process within a county. The Local Government Unit (LGU)/SPOA has oversight responsibilities for high-need populations and facilitates access to behavioral health services, including ACT. These referrals may include individuals under a court order for Assisted Outpatient Treatment (AOT). In New York City (NYC), individuals are referred to the Young Adult ACT team by SPOA, in addition to a number of other referral sources.

In recognition of NYS's geographic (rural and urban) variations, two (2) sizes of ACT teams have been developed as follows; a 48-capacity model and a 68-capacity model. Reimbursement is based on team size and geographical location within the State.

2.1 Principles of ACT[1]

An ACT team's primary goal is to provide recovery through community treatment and rehabilitation. ACT core principles include:

- A multidisciplinary team approach with various professional training and background;
- In vivo services and care provided in the community;
- A small caseload, 10:1 caseload ratio;
- Services and care provided as long as needed (see Section 5.5 Transition and Discharge Process);
- A shared caseload, the team as a whole is responsible for working with the individual;
- Flexible service delivery, via daily meetings and other communication to allow teams to quickly adjust schedules and respond to needs;
- A fixed point of responsibility to meet a person's full range of needs within a centralized place; and
- 24/7 crisis availability.

3. Outcomes

The role of ACT in facilitating hope, independence, self-efficacy, wellness, and recovery is organized into three (3) major ongoing and interacting service processes. These services/care processes include Engagement, Self-management, and Integration with the community. ACT teams support individuals as they participate in life roles by exploring and engaging in one (1) or more of the following dimensions: occupational, spiritual, intellectual, physical, environmental, financial, recreational, and/or participation in social groups.

The expected outcomes include:

- Improved engagement as evidenced by participation in treatment/care, community, supports, and/or life role goals;
- Housing that is safe, affordable, and based on the choices and preferences of the individual;
- Improvement in psychiatric symptoms;

[1] Substance Abuse and Mental Health Services Administration. Assertive Community Treatment: Building Your Program. HHS Pub. No. SMA-08-4344, Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, 2008.

- Side effects of medication are managed, medication is used as prescribed, and there is satisfaction with the medication regimen;
- Substance use is reduced, harm reduction is practiced, or substance use services are utilized, including Medication Assisted Treatment (MAT);
- Improved physical health, a medical provider is chosen and utilized by the individual;
- Reduction of inpatient admissions, emergency room/ Comprehensive Psychiatric Emergency Program (CPEP) use, and/or involvement in the criminal justice system;
- Vocational/educational goals chosen by the individual are developed, attained, and maintained;
- Personal stability, wellness and well-being are improved and/or maintained;
- Healthy coping skills are developed to reduce the long-term impact of emotional and psychological stressors on an individual by addressing interpersonal relations, high-risk behaviors leading to hospitalizations, family dynamics, and encountering new situations; and
- The individual is integrated with and participates in their natural community.

The expected outcomes of Young Adult ACT also include:

- Development of and engagement in the implementation of a vocation or education plan;
- Real-world skills needed to live and work independently are identified, developed, and practiced (with support) with the intention of fading that support as the skill is mastered; and
- Family, family of choice, and social support network needed to live and work independently are strengthened and/or identified.

4. Services and Core Operating Principles

The ACT approach is based on core operating principles and values designed to deliver behavioral health services that are:

- Supportive of hope and recovery;
- Comprehensive, individualized, flexible and focused on developing skills related to life roles;
- Easily accessible, available 24 hours/day, seven (7) days/week, via the resources of an integrated multi-disciplinary mental health team;
- Cultural humility inservice design and delivery, provided in the individual's language at all points of contact, as needed;
- Committed to building and strengthening therapeutic and family relationships across all interactions;

- Focused on shared decision making and person-centered planning;
- Provided in the community in an individual's preferred environment;
- Proactive in terms of continuous monitoring, engagement, and support; and
- Available throughout transitions.

The services provided by ACT include a full range of clinical treatment and care, psychosocial rehabilitation, care coordination, and community support services designed to promote recovery by improving psychiatric symptoms, preventing relapse, reducing substance use, teaching skills, providing direct assistance, and securing community resources necessary for successful overall functioning in work, school, community, home, and social relationships. Services should be culturally competent and recovery-based.

The team provides as much service time and as many contacts as needed. Frequent contacts are associated with better outcomes for the individual. The team has the capacity to tailor contacts based on clinical or rehabilitative needs. On a daily basis, ACT teams review each individual's status so the ACT team can quickly adjust the nature and intensity of services as needs change. Scheduled contacts should be designed to carry out interventions in the service plan or to address critical needs or situations.

Engaging and retaining individuals in treatment is a high priority in the ACT model. A lack of engagement should not be seen as a failure on the part of the individual. The team seeks to effectively engage individuals and employs a range of outreach strategies tailored to individual needs and preferences. The team is expected to be persistent in engaging and building trust with individuals who initially are less engaged. The team uses a variety of methods to promote engagement with the least engaged individuals, including street outreach, offering to meet in a more casual setting, or visiting the individual in their home. As part of the engagement process, the team will fully explain to individuals the array of available services. Individual choice with regard to participation in services will be respected.

At times, teams may be required to navigate an individual's legal status, including probation, parole, or AOT order when appropriate. Individuals who are court-ordered AOT will be monitored during daily meetings and interventions would be planned to help the individual adhere to court orders or legal requirements. Teams should work with individuals on the consequences of non-adherence to their court order. Staff will balance advocacy for the individual in collaboration with other service providers for individuals court-ordered to ACT.

Developing and working with the individual's support system is an important part of treatment and recovery that furthers the individual's connection with and inclusion in the community and provides skills and support for that network. Natural supports are important resources through both treatment and transition from ACT for community inclusion. The ACT team should persistently attempt to engage with the individual's family and support network and include them in the treatment and rehabilitative process, according to both the individual and the natural support's preferences.

The services provided by ACT will be continuously measured to ensure that individualized outcomes in the person-centered service plan are achieved. As appropriate and consistent with current research, ACT teams are expected to incorporate evidence-based practices.

4.1 ACT Service Definitions

Medically necessary ACT Services include:

i. Assessment: A multi-disciplinary, continuous process of identifying an individual's behavioral strengths, barriers to achieving goals, and service needs, through the observation and evaluation of the individual's current mental, physical and behavioral health condition and history. Assessment services are provided by professional staff and paraprofessional staff under the supervision of professional staff.

ii. Person-Centered Planning: A continuous process that engages each individual as an active partner in developing, reviewing, and modifying a course of care that supports the individual's progress toward recovery and accomplishing the individual's rehabilitation goals. Person-centered planning services are provided by professional staff or paraprofessional staff under the supervision of professional staff.

iii. Crisis Intervention Services: Remedial activities and interventions, such as medication or verbal counseling/therapy, which specifically address acute distress and associated behaviors when the individual's condition requires immediate attention or could lead to hospitalization. Crisis intervention services are provided by professional staff or paraprofessional staff under the supervision of professional staff. Medication therapy services delivered during a crisis visit are provided by a physician, psychiatrist, physician assistant, nurse practitioner, or registered professional nurse.

iv. Community Integration and Re-integration: A rehabilitative service that engages and assists individuals in the restoration of social, interpersonal, and basic living skills impacted by or lost as a result of mental illness that hinders an individual's ability to live in an integrated community setting of choice. It is an active process that includes coordination of services and supports, assisting in transition from a hospital setting, identification or modification of supports, promoting community tenure, and managing behavioral and physical health needs. Community integration services are provided by professional staff or paraprofessional staff under the supervision of professional staff.

v. Health Services: The gathering of data concerning the individual's physical health history and any current signs and symptoms, and the assessment of the information to determine the individual's physical health status and need for referral to appropriate medical services and continued measuring of specific health indicators associated with increased risk of medical illness and early death. For adults, these indicators include, but are not limited to, checking lab work, taking vitals, recording weight, waist circumference, and body mass index. Health services are provided by a physician, psychiatrist, physician assistant, nurse practitioner, or registered professional nurse.

vi. Medication Management: A full range of medication services including: prescribing and administering medication; reviewing the appropriateness of the individual's existing medication regimen; medication education; monitoring the effects of medication on the individual's mental and physical health; rehabilitative counseling and skill-development to restore an individual's functionality to obtain and self-administer medications, which have been lost due to the onset of mental illness; and recognizing and coping with the side-effects of the individual's medications. Medication evaluation, prescription, administration, and education services are provided by a physician or nurse practitioner. Medication administration and education services are also provided by a physician assistant,

registered professional nurse, or licensed practical nurse. Rehabilitative counseling and skill development regarding medications are provided by professional or paraprofessional staff under the supervision of professional staff.

vii. Psychoeducation: A service to assist individuals and their family, family of choice or supportive collaterals recognize the onset of psychiatric symptoms and prevent, manage, or reduce such symptoms. Psychoeducation services are provided by professional staff or paraprofessional staff under the supervision of professional staff.

viii. Integrated Dual Disorder Treatment: A counseling service and evidence-based practice using an integrated care model providing motivational interviewing, stage-wise interventions, cognitive-behavioral therapy, harm reduction techniques, and linkage to community support groups, to restore functionality and promote recovery for individuals with dual recovery SUD and mental illness. Integrated Dual Disorder Treatment services are provided by professional staff.

ix. Individual, Group, and Family Counseling/Therapy: Problem-specific and goal-oriented behavior therapy using evidence-based practices, such as cognitive-behavioral therapy, as appropriate. Therapy emphasizes social/interpersonal competence, addresses self-defeating beliefs, expectations, and behaviors that disrupt the recovery process, and considers an individual's strengths, needs, and cultural values. Individual, group, and/or family counseling/therapy services are provided by professional staff.

x. Wellness Self-management: Psychosocial rehabilitation and rehabilitative skills training services to restore and maximize an individual's independence in personal health care and wellness. This is done by increasing the individual's awareness of their physical and mental health status and the resources required to maintain physical health and effectively manage serious mental health conditions, including coping skills training, disability education, and relapse prevention training. Wellness self-management services are provided by professional staff or paraprofessional staff under the supervision of professional staff.

xi. Psychosocial Rehabilitation: Develop and enhance an individual's psychiatric stability and promote the capacity and functionality for basic living, including activities of daily living, communication, social and financial management skills, maintaining housing status and familial or educational relationships for children/youth. Psychosocial rehabilitation services are provided by professional staff or paraprofessional staff under the supervision of professional staff.

xii. Vocational/Educational Support Services: Psychosocial rehabilitation services to assist individuals manage and resolve symptoms of mental illness in school or workplace settings, and maintain functional skills necessary to maintain employment or attain educational goals. Services do not include vocational or educational placement or job training services. Vocational/educational support services are provided by professional staff or paraprofessional staff under the supervision of professional staff.

xiii. Peer Support Services: Peer Support Services for adults, young adults, and children/youth include age-appropriate psychoeducation, counseling, person-centered goal planning, modeling effective coping skills, and facilitating

community connections and crisis support to reduce symptomology and restore functionality. Peer support services also include engagement, bridging support, parent skill development, and crisis support for families caring for a child who is experiencing social, emotional, medical, developmental, substance use, or behavioral challenges in their home, school, placement, or community. Services are provided in individual or group settings to promote recovery, self-advocacy, and the development of natural supports and community living skills. Individuals or family members actively participate in decision-making and the delivery of services. Services are directed toward the achievement of the specific, individualized, and result-oriented goals contained in an individual's treatment plan developed under the supervision of a competent mental health professional. Peer support services are provided by certified, provisionally certified, or credentialed peers.

ACT provides direct services, assists with task completion, and teaches skills in the following areas:

Service Planning & Coordination	**Wellness Self-Management & Relapse Prevention**	**Family Life & Social Relationships**
Developing, in partnership with the individual, a comprehensive, individualized and culturally sensitive, goal-oriented service plan, including coordination with other formal and informal providers Identifying primary psychiatric and co-occurring psychiatric disorders, symptoms, and related functional problems Identifying individualized strengths, preferences, needs and goals Identifying risk factors regarding harm to self or others Monitoring response to treatment, rehabilitation, and support services	Educating about mental health, treatment, and recovery Teaching skills for coping with specific symptoms and stress management, including development of a crisis management plan Developing a relapse prevention plan, including identification/ recognition of early warning signs and rapid intervention strategies Developing a willingness to engage in services	Restoring and strengthening the individual's unique social and family relationships. Psycho-educational services (providing accurate information on mental illness & treatment to families and facilitating communication skills and problem solving) Coordinating with child welfare and family agencies Support in carrying out parent role Teaching coping skills to families Enlisting family/family of choice support in recovery of individual

Medication Support Prescribing and administering medication Carefully monitoring response and side effects Ordering medications from pharmacies Delivering medications Educating individuals about medications Reminding individuals to take medications	**Peer Support Services**[2] Advocacy on behalf of the individual and supporting self-advocacy Engagement Assisting with utilizing self-help tools Peer recovery supports and peer counseling Transitional Supports Pre-crisis and crisis support services	**Problem Solving** Individual, group, family, and behavior therapy that is problem-specific and goal oriented Therapeutic approach consistent with evidence-based practices for a particular problem Emphasizes social/interpersonal competence Addresses self-defeating beliefs, expectations, and behaviors that disrupt the recovery process Considers an individual's strengths, needs, and cultural values
Daily Activities Basic personal care and safety skills Grocery shopping and cooking Purchasing and caring for clothing Household chores Using transportation Using other community resources	**Housing** Finding safe, affordable housing Negotiating leases and paying rent Purchasing and repairing household items Developing relationships with landlords	**Money Management & Entitlements** Completing entitlement applications Accompanying individuals to entitlement offices Re-determination of benefits Budgeting skills Financial crisis management Managing food stamps Education about entitlements Wage Reporting
Work Opportunities Identifying interests and skills Preparing for finding employment Social skills training Developing and strengthening relationships with employers and other vocational support agencies Educating employers about SMI Education on information on work incentives	**Empowerment & Self Help** Encouraging and assisting individuals to participate in self-help, advocacy, social clubs, and culturally preferred and supportive community organizations Educating in self-help and recovery-oriented literature organizations, and related resources Educating in rights of individuals	**Integrated Treatment for Substance Abuse** Individual & group modalities for dual disorders treatment Education on substance abuse & interaction with mental illness Non-Confrontational support and support for harm reduction Reflective listening, motivational interviewing & behavioral principles Relapse prevention

[2] ONLY certified or provisionally certified peers can provide reimbursable Peer Support Services.

Health Education to prevent health problems Medical screening and follow up Scheduling routine and acute medical and dental care visits Sex education and counseling Provide education and support for reproductive and sexual health, including linkages, when necessary/appropriate. **Required for Young Adult ACT**	**School & Training Opportunities** Identifying interests and skills Finding and enrolling in school/training programs Supporting participation in school/training programs Internships Apprenticeships	**Real World Skills** (Young Adult ACT) Financial literacy (budgeting, banking, taxes, etc.), and navigating benefits Time management Decision-making and recovery from decisions that do not work out as intended Belonging and advocacy Disclosure issues, boundaries, and healthy relationships Goal setting Transportation Obtaining vital documents

5. Program Organization

5.1 Hours of Operation

The ACT team is available seven (7) days a week, twenty-four hours a day by direct phone and is regularly accessible to individuals who work or who are involved in other scheduled vocational or rehabilitative services during the daytime hours. Teams may utilize a split staff assignment schedule to achieve this coverage. Service provision must be available outside of the standard Monday to Friday, 9:00 am - 5:00 pm hours. NYS OMH requires teams to have flexible work hours allowing for better engagement and accommodation of schedules, (e.g., 10:00 am - 6:00 pm, 11:00 am - 7:00 pm, weekends, etc.). Additionally, the ACT team shall operate a continuous and direct after-hours on-call system.

5.2 Crisis Intervention (Rapid Access)

ACT teams have primary responsibility for crisis response and are the first contact for after-hours crisis. The ACT team must operate a continuous and direct after-hours on-call system, with staff members who are experienced in behavioral health crisis intervention procedures. Teams shall have the capacity to respond rapidly to emergencies, both in person and by telephone. The ACT team will respond in a trauma-informed, recovery-based approach and will resolve the crisis in the shortest amount of time possible and in the least restrictive environment. A crisis may require more than a telephone call. An in-person response may be needed as an intervention to evaluate the situation and to promote crisis stabilization. Individuals must be given an emergency contact list for after-hours that includes the ACT on-call number and other emergency resources.

When individuals served by ACT teams experience emergency situations, an immediate response from the ACT team is required. Timely and appropriate crisis intervention is a fundamental component of the ACT model and helps decrease unnecessary hospitalizations.

Crisis situations often arise with some amount of forewarning and planned interventions should be discussed through ACT daily team meetings. The team should intervene before

the crisis escalates or at the very least, closely monitor the situation until an intervention is feasible.

Some crisis situations cannot be anticipated and require ACT teams to deploy staff to handle them. The crisis-management approaches or interventions provided in the ACT model include but are not limited to the following:

- Medication assessment and treatment in a community setting.
- Safety assessment and crisis planning.
- Increased team contact by staff with various levels of expertise. Increased contact is designed for problem-solving, emotional support and encouragement, supportive therapy, medication administration, and monitoring or obtaining practical resources.
- Securing emergency resources when an individual is faced with a housing crisis.

In some circumstances, hospitalizations will be needed, but a crisis response should first attempt to divert hospitalizations, while taking safety into consideration. When the individual's condition is severe to the point where hospitalization is necessary, an ACT team member will provide clinical information to hospital staff and coordinate follow-up care. Teams should develop linkages and relationships with local emergency rooms, CPEPs, and emergency responders (i.e., Police, EMTs) to improve communication, diversion from inpatient when possible, involvement in sharing clinical knowledge, and warm handoff at discharge.

5.3 Eligibility

Adult ACT serves individuals over the age of 18 who have a mental illness listed in the most current DSM that seriously impairs their functioning in community living. Priority is given to individuals with schizophrenia, other psychotic disorders (e.g., schizoaffective disorder), bipolar disorder, or major/chronic depression, as these illnesses more frequently cause long-term psychiatric disability. Priority is also given to individuals with continuous high service needs that are not being met in more traditional site-based service settings. Individuals without active Medicaid should not be excluded from eligibility. Individuals with a primary diagnosis of a personality disorder(s), SUD, or intellectual/developmental disabilities are not appropriate for ACT.

High Need and Functional Indicators:

1. The individual should have one (1) or more of the following that are indicators of a need for continuous high level of services:
    i. Inability to participate in traditional office-based treatment services and multiple service needs requiring intensive assertive efforts to ensure coordination among systems, services, and providers;
    ii. Two (2) or more psychiatric inpatient admissions over a 12-month period or one (1) long-term hospitalization of 60 calendar days or more;
    i. Excessive use of crisis/emergency service;
    ii. Persistent severe major symptoms (e.g., affective, psychotic, suicidal or significant impulse control issues);

iii. Inability to meet basic survival needs or homeless or at imminent risk of becoming homeless;

iv. Repeat arrests, incarceration, or recent prison release for offenses directly related to mental illness;

v. Coexisting substance-use disorder of significant severity and duration (duration of greater than six (6) months);

vi. Residing in an inpatient bed or in a supervised community residence, but clinically assessed to be able to live more independently if intensive services are provided;

vii. Currently living independently but clinically assessed to be at immediate risk of requiring a more restrictive living situation (e.g., community residence or psychiatric hospital) without intensive community services;

viii. Court-ordered pursuant to Mental Hygiene Law (MHL) §9.60 to participate in AOT.

AND

2. Indicators of significant functional impairments:

   i. Difficulty consistently performing the range of practical daily living and self-care tasks needed to function in the community (e.g., navigating medical, legal, financial, and housing services; recognizing and avoiding common dangers or hazards to self and possessions; achieving good 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;

   ii. Difficulty maintaining consistent employment or achieving consistent educational placement; or

   iii. Significant difficulty maintaining a safe and affordable living situation (e.g., repeated evictions or loss of housing).

Forensic ACT teams and Older Adult ACT teams, see applicable ACT Addendums for additional eligibility criteria.

Flexible ACT Providers, see the Flexible ACT Program Guidelines Addendum for additional considerations for Flexible ACT referrals.

Young Adult ACT Eligibility

Young Adult ACT serves only individuals age 18 to 25 with SMI that impairs functioning in the community, have continuous high service needs, who lack engagement in and whose needs have not been met in traditional outpatient services. The individuals may work or need assistance developing a productive vocational or educational plan. Many of these young adults have very limited family or social support networks, or networks that may be insufficient to meet their needs. Moreover, these individuals often lack many of the real-world skills needed to be successful, independent adults, such as financial literacy, self-care/well-being, time management and decision-making.

Individuals with a primary diagnosis of a personality disorder(s), a SUD, intellectual/developmental disabilities, an IQ below 70, or also being served by the Office for

People with Development Disabilities (OPWDD) are not appropriate for Young Adult ACT. An individual who meets the criteria for OnTrackNY, first episode psychosis, will be referred to that program to receive services if one is available.

Continuous high service needs, which include:

i. Two (2) or more psychiatric hospitalizations or one (1) hospitalization of 60+ days in a 12-month period

ii. Four (4) or more psychiatric emergency room visits in the last 12 months

iii. Co-occurring SUD for six (6) months or more

iv. High risk of justice involvement

v. Residing in inpatient bed, residential program or CR and assessed to be able to live independently with intensive community services

vi. At risk of requiring more restrictive living situation without increased community services

Young Adult ACT is a program that will use assertive and intentional engagement strategies to work with individuals who may have had unsatisfactory experiences with previous mental health systems. Willingness to participate in this specialized Young Adult ACT program is also a requirement. The following real-world skills are necessary to help individuals achieve the goal of becoming an independent adult: Treatment participation, productive vocational or educational plan, social/family/family of choice support system and real-world skills.

5.4 Admission Process

The admission process for ACT is unique and distinct from other mental health programs. It is designed to be more assertive and recognizes that continuous engagement is a key component in this process.

1. Admission to ACT is managed through a local SPOA process. Referral sources may include inpatient psychiatric units, mental health outpatient programs, families and/or individuals, and Health Home Care Management Agencies. *Older Adult ACT Teams, see the Older Adult ACT Program Guidelines Addendum for additional referral sources.* Referrals are submitted to SPOA in the individual's county or primary service area.

2. The number of admissions per month should not exceed the range of four (4) to six (6), unless otherwise approved by the State, particularly for newly licensed teams that are attempting to fill up to full capacity. Consideration should be given to the fact that, during the weeks following admission, individuals will need highly intensive services that requires significant initial effort to complete the assessment and begin addressing many unmet needs (e.g., housing, entitlements, medical care and stabilizing psychiatric symptoms).

3. Assertive engagement must begin immediately upon receipt of the referral from LGU/SPOA. Assertive engagement entails well-thought-out strategies to locate and keep individuals connected with the team. If individuals are referred to ACT while in institutional settings (e.g., Jail, Inpatient, etc.) the ACT Team should make every effort to initiate engagement prior to discharge.

4. An admission decision must be made no later than seven (7) business days of initial contact with the individual. Documentation in the record should be made for delays related to incarceration with the understanding that the individuals may not complete their admission until a later time due to an unknown release date.
    i. Teams should have an ongoing dialogue with SPOA if there are difficulties locating an individual. If the individual is not able to be located within two (2) weeks of receipt of the referral, SPOA will be notified and determine the next steps based on the needs of that individual.
    i. Any reasons for delay must be documented.
5. Upon the decision to admit an individual to ACT, a screening and admission note shall be written to include:
    i. The reason(s) for referral;
    ii. Immediate clinical and other service needs for the individual to attain or maintain stability;
    iii. Admission diagnoses; and
    iv. The admission note is approved and signed by the team leader or other LPHA.
6. When an admission is not indicated, notation shall be made of the following:
    i. The reason(s) for not admitting (an individual's decision to not take medication is not a sufficient reason to deny admission to an ACT team);
    ii. The disposition of the case; and
    iii. Any recommendations for alternative services, as appropriate.
7. SPOA must be notified of the decision to admit or not admit.

Forensic ACT teams, see the Forensic ACT Program Guidelines Addendum for additional eligibility requirements.

5.4.1 Young Adult ACT Referrals and Admissions

The admission process for Young Adult ACT is unique and distinct from other mental health programs. It is more assertive and intentional, recognizing that continuous engagement is a key component in the admission process.

1. In NYC, referrals to Young Adult ACT are made to the provider from various sources including, but not limited to:
    - NYC SPOA, acute care psychiatric Hospitals, state psychiatric hospitals, CPEP, mental health outpatient clinics, federally qualified health centers, residential treatment programs, children’s mental health services, Managed Care Organizations (MCO), OnTrackNY, or families.
2. For Rest of State, admission to Young Adult ACT is managed through a local SPOA process. Referrals are submitted to SPOA in the individual’s county or primary service area.

- Referral sources may include inpatient psychiatric units, mental health outpatient programs, families and/or individuals, and Health Home Care Management Agencies.

3. All admissions to Young Adult ACT will be made in consultation with representative(s) of NYS OMH.

4. Individuals ages 18 to 25 who meet admissions criteria are eligible to be served by Young Adult ACT. If the team census is below 75% for three months, after one year of operation, OMH may, at its discretion, on a case-by case basis, permit the admission of individuals up to age 27.

5.5 Transition and Discharge Process

5.5.1 Transition

In NYS, ACT is delivered using the Transitional Care Framework, which has three (3) overlapping dimensions: engaging and envisioning life goals; engaging in wellness self-management; and integration and meaningful inclusion in the community. Implicit in this framework is the notion that an individual's needs change as they move through life, and as such, the treatment approach should have flexibility and adaptability to meet the individual where they are in their recovery. The ACT team uses a variety of core evidence-based practices and services, including person-centered planning, case management, community integration, wellness self-management, and supportive skills training, to facilitate and support growth as the individual moves toward less intensive services.

The following guidelines should be used to support the transition process:

1. Individuals are served with a person-centered approach. The focus is on facilitating engagement around life goals. Participation in ACT is one step on the road to recovery. As such, the Transitional Care Framework should support the work of the team. The service plan's goals and objectives should focus on recovery, community integration and inclusion, and a planned transition to less intensive services. Dimension three (3) of the framework (transition of care toward recovery and community integration and inclusion) is an active process of linkage, tryouts, and transfer of care with an emphasis on warm handoffs. See Resources: Transition Manual for ACT Providers (TMAP).

2. The team must identify existing and new supports that will be firmly in place to support the individual during the transition and beyond. These supports should include a mix of natural supports, community resources, rehabilitative supports, and clinical services.

5.5.2 Discharge

1. Individuals meeting the following criteria may be transitioned to less intensive services in the community:

    i. Individuals who demonstrate, over a period of time, an ability to function in major life roles (i.e., vocational activities, social, self-care) and can continue to succeed with less intensive services.

2. Individuals may also be transferred or discharged for the following reasons:

    i. Transferred to another ACT team (team closure, or other reason) or similar level of care (such as Integrated Mobile Treatment).

ii. Individuals who move outside the geographic area of the ACT team's responsibility. The ACT team must arrange for transfer of mental health service responsibility to an appropriate provider and maintain contact with the individual until the provider and the individual are engaged in this new service arrangement.

iii. Transferred to other outpatient treatment services. Outpatient treatment services include clinic, Personalized Recovery Oriented Services (PROS), private psychiatrist or other provider, outpatient substance use treatment, care management, primary care doctor, Continuing Day Treatment, Certified Community Behavioral Health Clinic (CCBHC), Home and Community Based Care/Community Oriented Recovery and Empowerment (CORE) services.

iv. Individuals who are hospitalized or locally incarcerated for three (3) months or longer. An appropriate provision must be made for these individuals to return to the ACT program upon their release from the hospital or jail.

v. Individuals who need a medical nursing home placement, as determined by a physician.

vi. Individuals who request discharge, despite the team's best, repeated efforts to engage them in service planning. Special care must be taken in this situation to arrange for alternative treatment when the individual has a history of suicide attempts, assault, or forensic involvement.

vii. Individuals who are lost to follow-up for a period of greater than 3 months after persistent efforts to locate them, including following all local policies and procedures related to reporting individuals as "missing persons."

3. When an individual is discharged from ACT to another service provider within the team's primary service area or county, there is a three (3) month transfer period during which the individual may voluntarily return to the ACT program if they do not adjust well to their new program or level of service. It is important during this transition time that there is a warm handoff to new services. The ACT team is expected to maintain contact with the new provider to support the new provider's role in the individual's recovery and goals.
4. Notification must be made to the local SPOA coordinator for all individuals being discharged. If the individual is enrolled in a MCO, the MCO must also be notified.
5. If an individual is under court order to receive AOT, any discharge must be planned in coordination with the County's AOT program administrator.
6. A number of tools are available to support the transition process and should be utilized by the Team, including the Transition Manual for ACT Providers (T-MAP).
7. The decision not to take medication is not a sufficient reason for discharging an individual from ACT.
8. Discharge summary documentation should include:

    i. The reasons for discharge (using the discharge categories outlined above).

    ii. The individual's status and condition at discharge.

    iii. A written final evaluation or summary of the individual's progress toward the goals set forth in the service plan.

iv. A plan developed in conjunction with the individual for treatment after discharge and for follow-up. Specialty Mental Health Care Management, when possible, should participate in discharge planning to support continuity of care and warm handoff.

v. The discharge summary must be signed by the staff completing the document.

vi. The signature of the individual on the discharge summary is encouraged, but not required.

9. The discharge summary is transmitted to the receiving program prior to the arrival of the individual. When circumstances interfere with a timely transmittal of the discharge summary, notation shall be made in the record of the reason for delay. In such circumstances, a copy of all clinical documentation is forwarded to the receiving program, as appropriate, prior to the arrival of the individual.

The agency shall develop and maintain a procedure regarding discharge, transmitting discharge summaries with appropriate content to receiving program(s), and to facilitate warm hand-offs to providers, including Specialty Mental Health Care Management for Health Home Plus (HH+), where applicable.

Young Adult ACT Discharge in addition to the above:

1. Individuals who are no longer within the eligible age range for Young Adult ACT, which serves young adults ages 18 to 25, must be transferred to an appropriate provider. The Young Adult ACT team must maintain contact with the individual until the provider and individual are engaged in this new service arrangement.
2. Individuals who move outside the geographic area of the Young Adult ACT team's responsibility. The Young Adult ACT team must arrange for transfer of mental health service responsibility to an appropriate provider and maintain contact with the individual until the provider and the individual are engaged in this new service arrangement.
3. Young adults are expected to be served by Young Adult ACT for two (2) to three (3) years depending upon their needs, goals, and progress. In order to accommodate the needs of individuals admitted up to age 25, transfer or discharge must take place no later than the individual's 28th birthday.
4. If OMH agreed to allow one or more individuals to be admitted up to age 27, those individuals must be transferred or discharged by their 30th birthday.

5.6 Service Intensity

1. The ACT team has the capacity to provide the frequency and duration of staff-to-individual contact required by each individual's immediate needs and their person-centered service plan.
2. The ACT team has the capacity to increase and decrease contacts based upon daily assessment of the individual's clinical need, with a goal of maximizing independence.
3. The team has the capacity to provide multiple contacts to individuals in high need and rapid response to early signs of relapse.
4. The team, with the exception of the psychiatrist/NPP, conducts a minimum of 80% of contacts in the community.

5. The team psychiatrist/NPP has scheduling flexibility and, when clinically necessary, can see individuals as frequently as needed. The majority of individuals should be seen by a psychiatrist/NPP approximately monthly (i.e., every one to six weeks). No individuals should be seen less frequently than every three months. Frequency of service provision should be titrated depending on client need and treatment plan specifications. The psychiatrist/NPP completes the initial assessment in the community. Visits by the psychiatrist/NPP should be completed in the community at least quarterly thereafter, or more if clinically indicated.
6. The ACT team has the capacity to provide services via group modalities as clinically appropriate; e.g., for individuals with SUD, for family psychoeducation, and wellness self-management services.

Forensic ACT teams and Flexible ACT teams, see applicable ACT Addendums for additional service intensity requirements.

5.7 Staffing and Team Operations

The following sections detail the guidelines for staffing an ACT team.

5.7.1 Staffing Requirements for ACT

Forensic ACT teams, Older Adult ACT teams, Rural ACT teams, and Flexible ACT teams, Section 5.7.1 does not apply. See applicable ACT Addendums for all staffing requirements.

1. ACT team composition should include 10 or fewer individuals per team member (10:1), this ratio excludes psychiatric practitioners and program assistants.
2. The 48-capacity model calls for five (5) staff (counted in the staff to individual ratio) and one (1) full time employee (FTE) program assistant and 0.48 psychiatrist/ 0.7FTE NPP; the 68-capacity model calls for seven (7) staff (counted in the staff to individual ratio) and one (1) FTE program assistant and 0.68 psychiatrist/ one (1) FTE NPP. The program must make every effort to be fully staffed.
3. Team staffing is multi-disciplinary.
4. At least 60% of the staff included in the 10:1 ratio is professional.
5. At least 60% of the staff included in the 10:1 ratio is full-time.
6. Teams who are experiencing high staff turnover, or low staffing numbers affecting the 10:1 ratio should follow up with their regional NYS OMH Field Office to notify them of these challenges and plans to meet the needs of the individuals.
7. The minimum staffing for an ACT team includes the following core positions:
    i. 1 FTE team leader (time is approximately spent 50% on direct care and 50% on administrative tasks). This split is important for this role as sharing in the clinical work keeps the team leader in touch with the everyday challenges carried by the staff.[3] Clinical work includes but is not limited to: the coordination of individual appointments outside of ACT; phone calls with family, housing, jail, etc.; referral

[3] Allness, D. J., & Knoedler, W. H. (2003). A manual for act start-up: Based on the pact model of community treatment for persons with severe and persistent mental illnesses. NAMI.

follow up; intakes; discharge planning; safety visits or “double-teaming”; staff coverage for time off and sick time; visits with individuals; etc.

ii. Psychiatrist/NPP (excluded from the 10:1 ratio)

For a 48 capacity team:
Psychiatric Coverage by:
0.48 FTE Psychiatrist; OR
0.48 FTE Psychiatrist and NPP combined, working in collaboration; OR
0.70 FTE Nurse Practitioner of Psychiatry

For a 68 capacity team:
Psychiatric Coverage by:
0.68 FTE Psychiatrist; OR
0.68 FTE Psychiatrist and NPP combined, working in collaboration; OR
1 FTE Nurse Practitioner of Psychiatry

iii. 1 FTE RN for the first 50 individuals:

48 Model: 1 FTE RN

68 Model: 1 FTE RN and a minimum of a .36 RN or LPN

iv. 1 FTE Program Assistant (excluded from the 10:1 ratio)

8. In addition to the above listed core positions, the below specialty roles must be included in the 10:1 ratio.

i. 1 FTE Substance Use Specialist;

ii. 1 FTE Vocational Specialist;

iii. 1 FTE Family Specialist;

9. 0.5 FTE or 1 FTE Peer Specialist is highly encouraged.

Young Adult ACT Staffing Requirements

The Young Adult ACT teams in NYC and rest of State will generally reflect the ACT staffing model for a 48-person team.

The minimum staffing for a Young Adult ACT team includes the following core positions:

i. 1 FTE Team Leader (time is approximately spent 50% on direct care and 50% on administrative tasks)

ii. Psychiatric Coverage by Psychiatric Coverage by:
0.48FTE Psychiatrist; OR
0.48 FTE Psychiatrist and NPP combined, working in collaboration; OR
0.70 FTE Nurse Practitioner of Psychiatry

iii. 1 FTE RN

iv. 1 FTE Program Assistant

In addition to the above listed core positions, the below specialty roles are required in the 10:1 staffing ratio.

v. 1 FTE Substance Use Specialist (MSW or Licensed Mental Health Counselor)

vi. 1 FTE Vocational Specialist

vii. 1 FTE Peer Specialist (Certified Peer Specialist or Credentialed Youth Peer Advocate)

A 68 capacity team will require two (2) additional staff:

viii. 1 FTE Licensed Clinician (Psychologist, Social Worker (LCSW or LMSW), or LMHC)

ix. 1 FTE Psychiatric Rehabilitation Practitioner

5.7.2 Core Competencies/Staff Training Requirements

1. At hire, all staff, with the exception of the program assistant, on an ACT team must have experience in providing direct services related to the treatment and recovery of individuals with Mental Illness. Staff should be selected consistent with the ACT core operating principles and values.
2. Staff should have demonstrated competencies in harm reduction, trauma-informed care, stage-wise treatment, motivational interviewing, and other evidence-based practices. All staff will demonstrate basic core competencies in designated areas of practice, including the ACT core operating principles, integrated physical health and behavioral health, vocational services, family psychoeducation, and wellness self-management.
3. Each specialty role shall possess competency in the following specialized areas. If an individual is hired on the ACT team to fill a specialty position and does not have the required competencies, the agency must provide a written plan detailing the training and supervision that will be provided to enable the individual to obtain competency. The training should begin immediately upon hire. The agency must be able to provide written documentation that the individual has attained competency in the required areas. Competency means one (1) year of experience or training in the specialty area and demonstration of the specific skills or knowledge.

    i. Substance Use Specialist

    - Substance use assessment and identification of SUD, including tobacco, alcohol, and opioid use disorders
    - Principles and practices of harm reduction
    - Knowledge and application of stage-wise treatment
    - Knowledge and application of motivational interviewing strategies and stage-matched treatments for all SUD
    - Training and/or experience in integrated mental health and substance use services

    ii. Vocational Specialist

    - Knowledge of models of supported employment/Individual Placement and Support (IPS)
    - Knowledge of psychosocial rehabilitative services

- Ability to complete a vocational assessment to determine mental health needs in the workplace or education (e.g., career profile)
- Skills development related to choosing, securing, and maintaining employment and educational goals

iii. Family Specialist

- Family needs assessment
- Family intervention strategies
- Cognitive behavioral techniques
- Training and/or experience in psychoeducation and/or other family support services

4. Although the above positions are required as a part of the 10:1 ratio, the ACT team should consider other areas that staff should have competencies in, such as wellness self-management, housing, and/or criminal justice. For example, a staff person with an added specialty in wellness self-management would be responsible for developing interventions based on the Wellness Management and Recovery Toolkit and other wellness resources, and would share this expertise with the team. ACT Institute provides training to develop skills in these areas.
5. See Appendix A for training requirements for NYS ACT teams. *For Forensic ACT teams, Older Adult ACT teams, and Flexible ACT teams, see appropriate ACT Addendums for additional core competencies and training requirements for staff.*

Young Adult ACT:

1. Substance use training (Focus on Integrated Treatment modules and NYS Office of Addiction Services and Support modules) will be required for all Young Adult ACT team staff, as indicated in the list of training requirements.
2. LGBTQIA+ modules will be required for all Young Adult ACT team staff.
3. Sexual health training will be required for all Young Adult ACT team staff.
4. Employment 101 training will be required for all Young Adult ACT team staff.
5. Substance use specialist must have a master's degree in social work or be a Licensed Behavioral Health Counselor. In addition to ACT role training, the substance use specialist must complete the Integrated Mental Health and Addictions Treatment Training Certificate.
6. The vocational specialist will be required to complete the ACT role training and IPS training within 60 days of being hired.
7. Peer specialist must be appropriate to meet the needs of the population and be a certified peer specialist or credentialed youth peer advocate.
8. Family specialist training will be required for all Young Adult ACT team staff
9. Cognitive health (CPI modules) will be required for all Young Adult ACT team staff

10. Executive functioning training and supervision provided by CPI – two (2) staff should be designated to receive training necessary to run an Executive Functioning Group
11. Additional trainings may be proposed, such as Cannabis, Alcohol, and Harm Redction

5.7.3 Staff Roles and Qualifications

Staff Supervision:

Staff supervision for all staff occurs both formally, through direct supervision and clinical consultation availability, as well as informally, through regular organizational and service planning meetings, which are a hallmark of the ACT evidence-based practice model.

The following staff roles and qualifications are required:

1. Team leader - A full-time staff member whose role is three-fold: providing direct services as a clinician on the team; providing supervision to each specialty role based on evidence-based practice, trauma-informed care, cultural humility, and person-centered language; and providing administrative oversight to the team. The Team leader regularly conducts individual supervision, which may include direction to staff regarding individual cases or side-by-side contact with staff. Minimum qualifications are:
    i. A master's degree or higher in social work, psychology, rehabilitation counseling, or a related field, OR licensure/registration as a RN (RNs are encouraged to be master's level or nurse practitioner), or physician.
    ii. Preference should be given to individuals with experience on a multi-disciplinary mobile team.
2. Psychiatrist/NPP – The psychiatrist/NPP, in conjunction with the team leader, has overall clinical responsibility for monitoring individual treatment and staff delivery of clinical services. The psychiatrist/NPP provide both psychiatric and medical assessment, along with treatment. The psychiatrist/NPP provide clinical supervision, education, and training to the team. The psychiatrist/NPP provides psychopharmacology services related to the development, maintenance, and supervision of medications for psychiatric and medical purposes, including medications for opioid, alcohol, and tabacco use disorders, clozapine and Long-acting injectables. It is highly recommended that the psychiatrist/NPP be trained and experienced in prescribing buprenorphine. In Young Adult ACT, the psychiatrists/NPP also provide pre-exposure prophylaxis (PrEP) for clients at risk for HIV.

    The NPP must practice in accordance with NYS practice requirements. Any supporting documentation must be available for review.
3. RN – Responsible for conducting assessments, assessing basic health and medical needs, coordinating health care with community medical providers (e.g., primary care physicians, specialists, etc.), providing management and administration of medication in conjunction with the psychiatrist/NPP, providing a range of treatment, rehabilitation, education, and support services.
4. Program Assistant – Responsible for managing medical records, supporting daily staff communication by assisting in maintaining documentation processes in a central location for access and visualization by all team members, maintaining CAIRS documentation, maintaining accounting and budget records for individual and program expenditures, utilizing resources to help inform team members (PSYCKES, Regional Health

Information Organization (RHIO) and performing reception activities (e.g., triaging calls and coordinating communication between the program and individuals).

5. Substance Use Specialist – A staff member, who in addition to performing routine team duties, has lead responsibility for integrating dual-recovery treatment with the tasks and services of other team members. The substance use specialist provides and coordinates assessment, treatment, planning, and services for substance use based on the needs of the individual.
6. Vocational Specialist – A staff member who, in addition to performing routine team duties, has lead responsibility for sharing knowledge and expertise, and integrating employment goals with services and tasks of team members. Vocational specialists assess the effect of the individual's mental health on employment and implement an employment strategy to enable individuals to get and keep a job. Vocational specialists help individuals seeking employment, to find the best match for their work interests and skills and preferred work environment.
7. Family Specialist – A staff member who, in addition to performing routine team duties, has lead responsibility for integrating family goals and services with the tasks of all team members and providing family psychoeducation individually and in groups.
8. Peer Specialist (Recommended) – A staff member with lived experience. Peer specialists are in a unique position to serve as role models, educate individuals about self-help techniques and self-help group processes, teach effective coping strategies based on personal experience, teach wellness management skills, assist in clarifying rehabilitation and recovery goals, and assist in the development of community support systems and networks. ACT providers are highly encouraged to employ peer specialists.

Forensic ACT teams, Older Adult ACT teams, and Flexible ACT teams, see applicable ACT Addendums for changes to staff qualifications.

5.8 Team Treatment

ACT uses a team approach to treatment, not an individual treatment model. To the greatest extent possible, ACT individuals benefit from working with the collective team, and not one (1) or two (2) individuals on the team. Although individuals can and will be more engaged with certain team members, all members of the team should see all of the ACT individuals. It is expected that a majority of individuals will be seen by a minimum of three (3) or more staff members in a given month.

Flexible ACT teams, see the Flexible ACT Program Guidelines Addendum for changes to team treatment.

Within the scope of ACT, the team provides all needed and preferred services for the individual. Except at points of transition, the ACT team does not refer out for clinical, rehabilitative or support services.

5.9 Team Communication

1. Organizational staff meetings, often scheduled in the morning, are held a minimum of four (4) times a week. The team meeting is critical to facilitate frequent communication among team members about individual progress and to help teams make rapid adjustments to best meet individual needs. ACT teams should develop protocols to share pertinent individual information (e.g., significant events, behaviors, interventions,

etc.) to ensure that all team members are informed of an individual's current status. The organizational meetings should be short and spend no more than approximately one (1) minute per individual on the team (no more than an hour, depending on team size) and include:

i. A brief and clinically relevant review of every individual on the team.

ii. Updates on contacts that occurred most recently and have not yet been reviewed in prior staff meetings.

- It is recommended that individuals who require more detailed conversation are saved for further review at the end of the meeting. This will help maintain the flow of the meeting and help ensure meetings conclude within the desired time. This allows for significant events, high-risk situations, safety concerns, and emerging needs to be addressed to determine service delivery.[4]

iii. Review of current status for hospitalizations and admissions, plan for visiting individuals while hospitalized, communication with inpatient staff, plan for discharges, and follow-up care.

- It is recommended that ACT teams have access to QEs/RHIOs for purposes of receiving hospitalization alerts and for medical documentation. The program assistant should check for any hospitalizations prior to the organization staff meeting for review during the meeting.
- Review of current status for individuals incarcerated or recently arrested for the planning of visits. Plans should include communication with the individual, staff at the jail or prison; plan for release; and any plans for support of legal needs.
- Brief review of prior on-call contacts since the last staff meeting.
- Updates and revisions to the daily staff assignment schedule.
- Service plan reviews and revisions, as needed.

2. To optimize teamwork, communication, and individual services, ACT teams keep pertinent information in a way that can be easily updated and rapidly accessible by all staff. Tools that can be used for this centralized communication system include, but are not limited to, white- or smart-boards or electronic platforms that are easily accessible by all staff. Information to be accessible should include:

i. Weekly or monthly schedule of contacts and activities for each individual.

ii. Individual goal board, on which is listed the name of each individual in the program and the goals of that individual.

[4] Substance Abuse and Mental Health Services Administration. Assertive Community Treatment: Building Your Program. DHHS Pub. No. SMA-08-4344, Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, 2008.

iii. Daily team schedule with a list of individuals to be contacted and by who, the interventions planned for each contact, and other service activities scheduled to occur that day.

iv. Significant event log or other intra-team communication systems to make the team aware of high-risk situations or other safety issues needing to be addressed when providing services. Significant issues and observations made by staff between team meetings can be recorded in the daily log prior to the end of the staff person's workday and discussed at the next team meeting.

v. Monthly contact tracker that individually lists all the contacts and attempted contacts, phone contacts, collateral contacts, location, duration, a brief description of the contact, and a plan for the next contact.

vi. Running record or log of current individuals hospitalized.

vii. Monthly schedule board for individuals with future appointments and other important dates, that are not included in the current month's schedule.

viii. Staff monthly schedule board, on which is recorded staff on-call schedule, staff time off/holiday/vacation, staff supervision, in-office days, training dates, or anything else that might impact staff scheduling for individual contacts.

ix. Other communication log suggestions include, but are not limited to:

- AOT Management
- Chart Captains
- IM Schedule
- MD Board

New information, changes in individual's functioning, and lack of engagement are clearly identified and immediately communicated to team members via progress notes, logs, verbal reports etc.

Forensic ACT teams and Flexible ACT teams, see applicable Guidelines Addendum for additional team communication requirements.

5.10 Assessment and Person-Centered Service Planning

The core of ACT is a multidisciplinary team process for ongoing assessment and person-centered service planning, conducted under the supervision of the team leader and the psychiatrist/NPP.

Forensic ACT teams, see the Forensic ACT Program Guidelines Addendum for additional forensic assessments.

5.10.1 Immediate Needs

An immediate needs assessment and documentation of services planned to address these immediate needs are completed within seven (7) business days of admission; immediate needs are defined as: safety/dangerousness; food; clothing; shelter; and medical needs.

- Any reason for delay should be documented.

5.10.2 Initial Assessment

An initial assessment is completed within 45-60 calendar days of admission allowing flexibility to promote individualized assessment processes and for engagement purposes.

The initial assessment expands the information gathered in the immediate needs assessment to provide the broader base of knowledge needed to address complex, longer-standing psychosocial or health care needs. The 45-60 calendar day completion time permits the initiation of services to meet immediate needs and allows for a more thorough collection of assessment information and shared understanding of the individual.

The initial assessment describes in detail the individual's medical, physical, and psychosocial status and needs. The initial assessment also evaluates the individual's resources and strengths, including family and other supports, which can be utilized during service planning. Information used to complete the clinical picture of the individual may be collected from a variety of sources (e.g., family, and other natural supports, team members' observations, medical records, former providers, PSYCKES) in addition to the direct engagement of the individual.

Elements of an initial assessment may include:

i. Diagnosis and presenting problem;

ii. Individual's strengths;

iii. Psychiatric history (may include timeline from age of onset of mental illness; past and current medication and doses, hospitalizations, and other service use; current functioning, symptoms, and severity; dangerous behavior/suicidality; exploration of Clozapine, if applicable);

iv. Psychosocial areas (may include living arrangements; social stressors and supports; parenting role/plans and goals (pregnant or children under 18); community living skills (e.g., managing finances, financial literacy, household tasks, transportation, shopping for household goods and accessing resources); involvement in legal systems; trauma/abuse history);

v. Sociocultural areas (may include: the individual's lived experience and cultural lens; roles of spirituality/religion; individual's meaningful values and goals; leisure interests and engagement activities; the impact of psychiatric disability on social functioning);

vi. Employment and education (may include current activities; daytime structure; school/employment status; educational history; employment/military history; vocational/educational interests);

vii. Substance use screening (may include: the history of substance use; treatment history; current/recent use of alcohol and specific drugs (including patterns and amounts of use); consequences of substance use; insight/awareness of strengths and challenges; motivation to address substance use);

viii. Physical health (may include current medical conditions; health risk factors; medical history; overlaps between psychiatric and physical ailments; individual perspective on health status; service needs).

Assessment elements that are not immediately available should be added as they become known. Assessment is an ongoing process. Whenever there are significant events or changes in life circumstances, an assessment should be considered based on need (e.g., hospitalization, incarceration, risk, substance use).

Assessment should be reviewed and updated at least every six (6) months when the service plan is updated.

5.10.3 Person-Centered Service Plans

Person-centered services start with a service plan that recognizes each participant as a unique individual. The person-centered planning is strengths-based and consistent with the individual's values, culture, beliefs, and goals. Person-centered planning is a collaborative process where the individual participates in the development of goals and planning for services to the greatest extent possible. Person-centered planning incorporates the direct feedback and input from the individual regarding their perceived barriers and strengths and prioritizes their main goals to align the service plan to the individual.

The ACT staff members take an active role in guiding, reframing, raising discrepancies, and offering compassion and hope by translating direct individual feedback into a person-centered plan of action. ACT staff members are expected to engage the individual in person-centered planning during the intake process and throughout service delivery. Focused attention should be given to understanding and addressing the impact of the social determinants of mental health and wellness, including housing, income/finances, and impact of discrimination. A person-centered service plan is prepared within 45-60 calendar days of admission, with specific objectives and interventions, including planned services necessary to facilitate achievement of recovery goals. The service plan is strengths-based, culturally relevant, and responsive to individual preferences and choices.

The service plan should include:

1. The individual's SMART (specific, measurable, attainable, realistic, time oriented) goals and objectives, preferred treatment approaches, associated concrete and measurable objectives, and planned services; goals may include, but are not limited to:
    i. The individual's educational, vocational, social, wellness management, residential or recreational goals
2. Needs that are identified by staff, but are not identified as goals by the individual, should be documented and addressed with the individual as needed;
3. An integrated substance use and mental health service plan for individuals with co-occurring disorders, including:
    i. Interventions that target the interactions between the two (2) disorders (for example, providing coping skills for psychiatric difficulties that may contribute to substance use);
    ii. Any plan for the provision of additional services, outside of the scope of ACT Team, provided to support the individual outside of the ACT program;
    iii. Documentation of a rationale to defer treatment.
4. A crisis/relapse prevention plan includes presenting the individual with the opportunity to complete an advance directive, if applicable;

5. Reflective of the input of all staff, including the psychiatrist/NPP, involved in services provided to the individual;
6. A list of all collaterals of choice involved in an individual's treatment, if applicable;
7. Involvement of the individual and others of the individual's choice;
8. Identify activities to be carried out from an AOT order, where applicable;
9. Demonstrates future orientation and documentation of specific and individualized discharge criteria; and
10. Planned use of service dollars, if applicable.

The service plan must be signed by LPHA staff. If the person completing the service plan is not an LPHA, both they and an LPHA must sign the service plan.

The individual's participation in service planning and approval of the service plan is evidenced in the person-centered planning process and documented in the case record. Reasons for non-participation shall also be documented in the case record. Additionally, service planning and review occurs with family/supports present, if the person consents.

5.10.4 Service Plan Reviews

1. The person-centered service plan is reviewed at least every six (6) months based on ongoing assessment. Reviews should include a summary in the record which includes progress/lack of progress of the goals and objectives in the service plan, and other needs identified.
2. When applicable, service plan updates to the goals and objectives should involve adjustment of time periods for achievement, intervention strategies, or the initiation of discharge planning.
3. The service plan reviews must be signed by LPHA staff. Either the person completing the service plan or another LPHA staff, in addition to the staff completing the plan, must sign.

5.10.5 Progress Notes

Service contacts and attempted contacts are documented in the record. Progress notes shall identify the particular services provided and specify their relationship to a particular goal or objective documented in the service plan.

ACT teams should ensure that reimbursement is obtained for services identified and provided in accordance with an individual's goals and needs. In practice, the nature and intensity of ACT services and goals are continuously adjusted through the process of daily team meetings and review of individual needs. Based on the individual's current needs and circumstances, services may be altered in order to avoid hospitalization or to increase stability in the community. In these circumstances, the rationale should be clearly documented in the case record as to why the service was provided and is not identified in the service plan.

Progress notes are to include the following:

i. The date of the service; location the service was provided;

ii. Length in minutes of contact;

iii. Documentation of service provided and specify their relationship to a particular goal or objective documented in the service plan or rationale why service was needed that is not identified in the service plan;

iv. Progress or lack of progress toward goals;

v. Address significant events, as applicable;

vi. Contact with collateral, as applicable;

vii. Service dollars spent and their related treatment objectives, as applicable; and

viii. Signature of the person who provided the service.

5.11 Case Records

1. A complete case record is maintained for all individuals in accordance with recognized and accepted principles of record-keeping:
    i. Any paper case record entries shall be made in non-erasable ink and shall be legible;
    ii. Case records shall be periodically reviewed for quality and completeness by the agency quality assurance program; and
    iii. All entries in case records shall be dated and signed by the appropriate staff.
2. The case record shall be available to all ACT team staff and shall include the following information:
    i. Individual demographic information;
    ii. Pre-admission screening notes and referrals, as appropriate;
    iii. Diagnoses;
    iv. Immediate needs;
    v. Assessments and risk assessments, as applicable;
    vi. Any documentation supporting behavioral health or physical health care (e.g., reports of mental and physical diagnostic exams, assessments, tests, or consultations);
    vii. Service plan and service plan reviews;
    viii. Service notes and progress notes;
    ix. Dated and signed records of all medications prescribed;
    x. Referrals to other programs and services;
    xi. Consent forms; and
    xii. Discharge documentation, if applicable.

5.12 Quality Improvement and Leadership

Strong team leadership is critical to improving performance and achieving positive outcomes. Clinical leadership on the ACT team is provided through the direction of the psychiatrist/NPP and the Team Leader. Administration and oversight of the day-to-day operations are the responsibility of the Team Leader. Oversight includes a review of individual progress in treatment and barriers to achieving person-centered outcomes. Additionally, the use of a fidelity tool and aggregated data may be used to assess team performance (i.e., Tableau, ACT Profile, PSYCKES). This will facilitate points of data for continual quality improvement projects.

5.12.1 Child and Adult Integrated Reporting System (CAIRS)

NYS OMH developed the CAIRS system to collect, analyze, trend, and report individual data and outcomes. NYS OMH requires that ACT teams enter baseline data, follow-up data, and discharge data in the CAIRS system as indicated below. The agency is responsible to develop and maintain a procedure that ensures the timely entry of this information by the ACT team.

i. Baseline data must be entered into CAIRS within 30 days of the individual's admission to the ACT team.

ii. Follow-up data must be entered in six (6) month intervals from the date of admission.

iii. Teams should run the "Follow-ups by program unit report" to assist in timely completion. This report provides due dates for data entry.

iv. The discharge data must be completed at the time of discharge from ACT.

5.12.2 Programmatic Policies and Procedures

ACT teams should work with their individual agencies to develop, periodically review and revise as appropriate all programmatic and administrative policies and procedures.

1. The provider shall maintain personnel records for all staff, including sub-contracted/per diem staff, who will be providing services or supervision. These records must minimally include:

    i. Resume or application demonstrating appropriate experience to deliver or supervise services, as necessary to meet minimum staff qualifications;

    ii. Verification of degree, licensure, or other certifications/credentials, as necessary to meet minimum staff qualifications; and,

    iii. Documentation of required training.

2. The Provider shall maintain policies and procedures regarding:

    i. Written criteria for admission and discharge from the program. Admission policies should include a mechanism for screening individuals at the time of referral and assuring that those referred from inpatient, forensic, or emergency settings who are determined to be high risk are admitted to the ACT team timely. Policies around assertive engagement practices should be included as well.

ii. Conducting initial and ongoing risk assessments and developing plans to address identified areas of elevated risk, including procedures to ensure that any health or mental health issues identified are treated appropriately by the ACT team.

iii. Addressing individual engagement and retention in treatment including, at minimum, plans for outreach and re-engagement efforts commensurate with an individual's assessed risk.

iv. Screening for use or dependence on alcohol, tobacco, or other drugs as well as for treatment of alcohol, tobacco, and other drug-related conditions.

v. Data collection, analysis, how it will be used for quality improvement, and procedures around timely CAIRS data entry.

i. Discharge, including the process for transferring an individual to another service provider or level of care, and follow up three (3) months post-discharge.

ii. Person-centered service planning and meeting due dates.

vi. Crisis and emergency response, including crisis intervention, rapid response, and having staff on-call 24/7.

vii. Transportation of individuals receiving services by agency staff.

viii. Provision of clinical supervision for all staff.

ix. Quality improvement and utilization review.

x. Incident management, reporting and review.

xi. Secure record retention specific to the provision of services.

xii. Staff training and workforce development.

xiii. Community safety for staff.

xiv. Confidentiality and disclosure of protected health information in accordance with state and federal laws.

xv. Individual grievance process that ensures the timely review and resolution of individual complaints, and which provides a process enabling individuals to request a review by NYS OMH when resolution is not satisfactory.

xvi. Workforce recruitment and retention, including maintaining ACT fidelity around staffing requirements, addressing how teams will manage if down staff (below 10:1 ratio), efforts to recruit and retain a workforce that is representative of the people they serve, and to develop cultural competency skills in their current and prospective workforce through staff development and training.

xvii. Self-assessment of fidelity to the ACT model.

xviii. Promoting the competency of its workforce by registering in the Center for Practice Innovation (CPI) learning management system (LMS) and ensuring appropriate staff conduct required training as directed by NYS OMH.

Flexible ACT teams, see the Flexible ACT Program Guidelines Addendum for additional programmatic policies and procedures.

5.12.3 Quality Management

The Agency will develop a process to systematically monitor, analyze, and improve the performance of the ACT team in assisting individuals to achieve their treatment outcomes. This includes the development of a quality improvement plan consistent with the mission, principles, and values of the ACT program. The plan will include:

i. A data collection process that provides information relevant to specific treatment outcomes;

ii. Baseline data entry into CAIRS, to be completed within 30 days of admission, and updated follow-up data at six (6) month intervals. Teams should have multiple staff with access to complete data entry;

iii. Monitoring data via outcome reporting platforms shared by NYS OMH, such as Tableau and the ACT Team Profile. Teams should be aware of their data, compared both regionally and statewide, to use for quality management and licensing visits;

iv. An analysis of ACT team performance identifying outcome trends;

v. Data analysis conducted by the team and the agency to identify trends, verify goal achievement, service quality, areas of improvement, and the impact of corrective actions;

vi. An analysis of core outcomes at six (6) month intervals consistent with the required assessment and service planning process. The analysis will be used as a bench measure for teams to review their progress in achieving core outcomes and to make decisions regarding the improvement of organizational performance;

vii. A verification of service provision and quality that supports goal attainment;

viii. Any identification of service provision and treatment which needs improvement;

ix. Corrective action/process improvement plans specific to the results of the analysis; and

x. Self-assessment of fidelity to the ACT model (using the TMACT or available soon the NYS ACT Fidelity Tool).

5.12.4 Utilization Review

The Agency shall maintain a systematic utilization review process conducted by individuals who are appropriately credentialed and do not provide direct care to the ACT individuals whose records are being reviewed.

i. The need for an ACT participants continued stay with the program shall be documented by the agency.

ii. Documentation should reference back to the reason for admission and goal achievement.

iii. Documentation of the review should occur for each client a minimum of every 12 months.

5.12.5 Utilization Management

The agency will participate in any State, Managed Care, or LGU utilization management process.

Utilization Management (UM) Guidelines for NYS Medicaid Managed Care Organizations (MMCO) and Health and Recovery Plans (HARP) regarding ACT should be followed by ACT teams and MCOs.

5.12.6 Incident Management and Reporting

The Agency and the ACT teams must develop, implement, and monitor an incident management program in accordance with NYS Rules and Regulations Part 524. ACT programs will utilize the NYS Incident Management and Reporting System as required by NYS OMH.

5.12.7 Team Safety Planning

The ACT team provides services in the community where individuals live, learn, work, and socialize. Safety of the staff in the community is an important feature of the ACT model. The agency must develop a comprehensive safety plan specific to the ACT team and ensure that all staff members are trained in community safety and routinely follow the safety plan.

5.12.8 Eliminating Disparities and Achieving Health Equity

ACT integrates the principles of person-centered, culturally responsive, trauma-informed care, addressing the impact of discrimination, stigma, and cross-system collaboration into its service philosophy. ACT provides services with consideration of cultural/linguistic preference through the use of the cultural formulation interview process and cultural assessment. An essential aspect of ACT is recognizing the importance of family, community-based, and faith-based supports. To continue the work of eliminating disparities, achieving health equity, and improving treatment outcomes for marginalized populations, the agency should:

1. Have a mission statement that includes information about the intent to serve individuals from marginalized/underrepresented populations.
2. Have an updated diversity, inclusion, equity, or cultural/linguistic competence plan that includes:
    i. Workforce diversity (data-informed recruitment to hire, train and retain staff and supervisors from the most prevalent cultural groups of its ACT individuals);
    ii. Workforce inclusion;
    iii. Reducing disparities in access, quality, and treatment outcomes; and
    iv. Solicit input from diverse community stakeholders and organizations
3. Documented training strategy for topics related to diversity, inclusion, cultural competency, and reduction of disparities in access, quality, and treatment outcomes. Training topics should include implicit bias, diversity recruitment, creating inclusive work environments, and providing language access services.
4. Meet the language access needs of the individual's served by ACT, including:

i. Use of data to identify the most prevalent language access needs;

ii. Availability of staff who speak the most prevalent languages;

iii. Provision of best practice approach to provide language access services (in person, phone, video interpretation);

iv. Having key documents and forms translated into the languages of the most prevalent cultural group of ACT individuals served by the team; and

v. Efforts to address other language accessibility needs, such as Braille and limited reading skills should also be planned for.

5.13 Program Site

1. Persons (individuals, staff members, and visitors) shall make every effort to keep safe from undue harm while they are at the program site.
2. Persons (individual, staff, and visitors) with various disabilities shall have access to appropriate program areas. Programs shall adjust service environments for individuals who are blind, deaf, or otherwise impaired.
3. Programs shall have sufficient furnishings, adequate program space, and appropriate program-related equipment for the population served.
4. Medications and case records shall be stored according to applicable laws to ensure only authorized access.

5.14 Coordination Between ACT and Other Systems

1. As part of the ACT program, teams are charged with care coordination of services and supports and identification or modification of supports to promote community tenure and manage behavioral and physical health needs. ACT teams should work with the individual's community supports to address crises and social determinants of health. ACT teams should develop agreements for assuring service continuity with other systems of care including, but not limited to:

    i. Family Services (Administration for Children's Services, Department of Social Services, Child Protective Services);

    ii. Adult Protective Services;

    iii. Benefit services (Department of Social Services, Social Security Income, etc.);

    iv. Emergency service programs, such as crisis residences;

    v. State and local psychiatric hospitals;

    vi. Rehabilitation services;

    vii. Housing agencies/shelter system;

    viii. Social services;

    ix. ACCESS-VR/educational institutions;

    x. Self-help/peer-run services;

    xi. Independent living centers;

xii. Clubhouses;

xiii. Natural community supports, including parenting programs, churches/spiritual centers, and local groups/organizations; and

xiv. Local correctional facilities, local law enforcement, and other forensic organizations such as parole and probation.

2. ACT teams follow the provisions of MHL §9.60 and related local procedures in providing AOT.

3. ACT and Health Homes: HH+ services will be available for adults with SMI and who meet certain indicators for high need, such as the risk for disengagement from care and/or poor outcomes (e.g., ACT stepdown). Individuals transitioning off ACT to a lower level of service may benefit from the enhanced support of HH+ for up to 12 consecutive months. Go to the following link for details: HH+ High Need SMi Guidance 9/2021 (ny.gov)

4. ACT and HARP:

   i. Behavioral Health Home and Community Based Services (BH HCBS): If an individual is receiving ACT services when enrolled in a HARP, the ACT team will assume responsibility for the BH HCBS eligibility assessment process for as long as the individual is receiving ACT services as described below:

      - If the individual is being discharged and is interested in BH HCBS services, at the point that ACT teams are actively planning for an individual's discharge from ACT, the ACT team will conduct a BH HCBS eligibility assessment. This will determine whether the individual is eligible for BH HCBS post-discharge from ACT and for what services.

      - The ACT team will request the BH HCBS level of service determination and make referrals for BH HCBS as appropriate. The ACT team will initiate the warm hand-off process by making a referral to a Health Home Care Manager (HHCM). The HHCM will complete the BH HCBS plan of care (See Discharge Workflow for ACT Recipients Enrolled in HARP for more detail).

   ii. CORE: If an individual is receiving ACT services when enrolled in a HARP, the ACT team will assume responsibility for reviewing CORE services.

      - ACT teams should also look at CORE services to support transition and identify if CORE better meets their goals.

      - The ACT team will complete the LPHA recommendation for services and make referrals.

5. ACT and PROS:

   i. PROS: Integrates treatment, support, and rehabilitation to facilitate individualized recovery. Many individuals can transition from ACT to a PROS program as their community functioning and wellness management skills improve. To facilitate these transitions, NYS regulations allow individuals receiving ACT services to simultaneously enroll in a PROS program with the following stipulations:

- An individual receiving ACT services may enroll in a PROS program for no more than three (3) months within any 12-month period.
- Reimbursement for ACT services provided to individuals who are receiving both ACT and PROS services will be limited to the ACT partial step-down payment rate.

5.14.1 Relationship between ACT and Psychiatric Inpatient Facilities

ACT teams are closely involved in hospital admissions and hospital discharges to ensure continuity and coordination of services and to be a support and advocate for individuals. It is expected that the team, to the best of their ability, is involved in at least 80% of hospital admissions and at least 80% of hospital discharges.

1. To ensure continuity and coordination of care for ACT individuals, it is recommended that the ACT team work closely with local hospitals to achieve the following goals, where possible:
    i. The ACT psychiatrist/NPP has Director of Community Services Authority under MHL §9.37.
    ii. When the host agency for an ACT team also operates an Article 28 hospital, the ACT psychiatrist/NPP has hospital admitting privileges.
    iii. The ACT team is consulted on emergency room dispositions and admission/ discharge decisions involving ACT individuals.
    iv. Utilization of QEs/RHIOs for notifications of hospitalizations.
    v. Communication with MCOs.
2. When an individual is hospitalized, the ACT team should take the following steps to coordinate with the clinical staff at the hospital:
    i. Familiarize the responsible physician/treatment team with the individual's ACT assessment findings and community service plan, including medication regimen.
    ii. Provide the individual with support and hope during the hospitalization period.
    iii. Advocate with landlords and other collaterals in the community to maintain current living arrangements and other appropriate service commitments.
    iv. Work with the discharge staff and individual to formulate the individual's discharge plan.
    v. Communicate with MCOs where applicable.
3. The ACT team may receive reimbursement for services to individuals admitted for treatment to an inpatient facility, pursuant to the requirements of Part 508 Medicaid Assistance Rates of Payment for ACT Services.
4. In advance to discharge, the ACT team should actively participate in discharge planning, when possible, to support continuity of care and successful community integration.
5. When an individual has been discharged, the ACT team should take the following steps to ensure continuity of care in the community and decrease the likelihood of readmission to the hospital:

i. ACT Team Staff should plan to meet with individuals on day of discharge and escort them home or to next level of care. Professional staff should meet with the individual within three (3) to seven (7) days post-discharge.

ii. Complete progress notes regarding the contact and how the individual is doing.

iii. Provide any needed follow-up.

iv. Make every effort to connect with inpatient staff to address any open clinical issues and to obtain a discharge summary if that has not been provided.

5.15 Rights of individuals

1. ACT individuals are entitled to the rights defined in this subdivision. A provider of ACT services shall be responsible for ensuring the protection of these rights.
2. Individuals have the right to an individualized person-centered service plan which they form in partnership with the provider.
3. Individuals have the right to all information about services so they can make choices that fit their recovery.
4. Participation in treatment in an outpatient program is voluntary and individuals are presumed to have the capacity to consent to such treatment. The right to participate voluntarily in and to consent to treatment shall be limited only to the extent that:
    i. §330.20 of the Criminal Procedure Law and Part 541 of Title 14 provide for court-ordered receipt of outpatient services;
    ii. Article 81 of the MHL provides for the surrogate consent of a court-appointed guardian for individual needs;
    iii. §9.60 of the MHL provides AOT for people with mental illness who, in view of their treatment history and present circumstances, are unlikely to survive safely in the community without supervision;
    iv. §33.21 of the MHL provides for the surrogate consent of a parent or guardian of a minor; or
    v. An individual engages in conduct that poses a risk of physical harm to self or others.
5. The central goal of the person-centered service plan is to facilitate the formulation of goals and services that the individual chooses. The individual will not be penalized or terminated from the program for choices with which the provider does not agree.
6. The confidentiality of individuals' clinical records shall be maintained in accordance with §33.13 of the Mental Hygiene Law and Federal Standards (e.g., HIPAA).
7. Individuals shall be assured access to their clinical records consistent with §33.16 of the Mental Hygiene Law.
8. Respect for individuals' dignity and individual integrity is the cornerstone of the provider's care and treatment.
9. Individuals have the right to receive services in such a manner as to assure non-discrimination.

10. Individuals have the right to be treated in a way that acknowledges and respects their cultural environment.
11. Individuals have the right to a maximum amount of privacy consistent with the effective delivery of services.
12. Individuals have the right to freedom from abuse and mistreatment by employees.
13. Individuals have the right to be informed of the provider's grievance policies and procedures and to initiate any question, complaint, or objection accordingly. Grievances and complaints will be addressed fully without reprisal from the provider.
14. A provider of service shall provide a notice of individuals' rights to each individual upon admission to an ACT Program. Whenever possible, the rights will be discussed and explained in the individual's primary language. Such notice shall be provided in writing and posted in a conspicuous location easily accessible to the public. The notice shall include the address and telephone number of the Commission on Quality of Care for the Mentally Disabled, the nearest regional office of the Protection and Advocacy for Mentally Ill Individuals Program, the nearest chapter of the Alliance for the Mentally Ill of New York State and NYS OMH.

5.16 Fiscal Models

1. Geographic variances in population density and service needs can affect the size of the ACT team. To address these potential variances, there are two (2) sizes of ACT programs, 68-capacity teams, and 48-capacity teams. For maximum cost-effectiveness, it is recommended that an existing 48-capacity team first be expanded to a 68-capacity team if service need is indicated.
2. It is expected that ACT teams may go above capacity on occasion. The team should make these decisions based on the clinical determination that the team can support this, and every effort should be made to remain within the 10:1 ratio if this happens. Some examples of reasons a team may go above capacity include, but are not limited to:
    i. For an AOT individual who is in the hospital or incarcerated for an extended period of time but remains court-ordered, a team can decide to take a new admission. When the AOT individual returns after discharge/release, there may be a need to go above capacity;
    ii. During transition where an individual is in the process of being discharged and admission is occurring simultaneously;
    iii. If an individual is in process of being stepped down and being served at a partial rate; or
    iv. If an individual needs to return to a team 90-day post-discharge.
3. NYS OMH may choose to put out a request for proposal (RFP) for new teams in areas where there is a need. Any awardees must complete a prior approval review (PAR) application and any other required documentation before becoming licensed.
4. The ACT teams have been funded to support experienced full-time clinical and administrative staff to support retention and longevity of staff on the team.
5. Refer to the posted Medicaid schedule for current approved and pending ACT rates.

In addition to the billing rates, teams receive funding from the state for service dollars and non-Medicaid net deficit funding.

5.17 Reimbursement and Exclusions

There are three (3) Medicaid Reimbursement Rates for ACT; a full rate for those individuals who receive at least six (6) contacts in a month (up to three (3) of these contacts may be with collaterals), and a partial rate for those individuals who have less than six (6) contacts but at least two (2) contacts per month, and inpatient hospital rate for individuals in the hospital. Six (6) contacts per month for the full rate is the billing minimum, however, individuals receiving services may need additional contacts during the month.

ACT staff provides most of the services required by ACT individuals. Therefore, ACT providers are prohibited from billing the Mental Health Medicaid Program for any costs over and above the ACT case payment, and other providers are excluded from billing for certain services for individuals enrolled in ACT. The non-billable services for ACT individuals are: Intensive Case Management, Supportive Case Management, Blended and Flexible Case Management, NYS OMH Clinic, and NYS OMH Continuing Day Treatment (CDT) Program.

ACT teams are permitted to bill Medicaid for any month in which an individual is receiving only pre-admission or crisis services from a clinic or CDT.

Reimbursement for services provided to an individual who is receiving both ACT and PROS services will be limited to the partial step-down payment rate.

It is expected that ACT programs will provide integrated mental health and substance use treatment, but ACT individuals may need access to other substance use services not rendered in ACT programs (e.g., detoxification). Therefore, ACT individuals can receive services rendered by substance use providers and ACT teams simultaneously and, as appropriate, these providers can bill Medicaid for such services.

5.18 Certification

1. All ACT programs must be certified (licensed) by NYS OMH.
2. Certification as an ACT program requires a comprehensive application for PAR pursuant to The Official Compilation of the Codes, Rules and Regulations of the State of New York, 14 NYCRR Part 551.
3. These guidelines are the NYS OMH standards for licensed ACT programs. The Commissioner of the NYS OMH must approve any waivers to these standards.

Information about licensing, PAR, and relevant laws and regulations can be found on the NYS Office of Mental Health Bureau of Inspection and Certification website.

ACT Addendums

Flexible ACT Program Guidelines Addendum

Forensic ACT Program Guidelines Addendum

Rural ACT Program Guidelines Addendum

Older Adult ACT Program Guidelines Addendum

ACT Resources

ACT Institute

The ACT Institute, part of CPI, provides training, support, and consultation to ACT providers across NYS. The training curriculum is based on national evidence-based practice consortium standards and modifications to these standards as developed by OMH. Training is delivered via in-person and distance-learning modalities. See “ACT Resources” below for more information.

Assertive Community Treatment (ACT) (ny.gov)

ACT 508 Regulations

ACT Institute Learning Management System

ACT Medicaid Billing

ACT Standards of Care

Building Your Program (samhsa.gov)

Service Dollar Guidance

Transition Manual for ACT Providers (TMAP)

Utilization Management Guidelines for New York State Medicaid Managed Care Organizations and Health and Recover Plans Regarding Assertive Community Treatment (ny.gov)

Appendix

Appendix A: Training Requirements

Training memo

Appendix B: Training Curriculum

Training Curriculum Overview

Table 1. Adult ACT Staffing Requirements

ACT Staffing Requirements	
48 Capacity Team	**68 Capacity Team**
Included in 10:1 Ratio	**Included in 10:1 Ratio**
Team Leader (1 FTE)	Team Leader (1 FTE)
Registered Nurse (1 FTE)	Registered Nurse (1 FTE)
Vocational Specialist (1 FTE)	Vocational Specialist (1 FTE)
Substance Use Specialist (1 FTE)	Substance Use Specialist (1 FTE)
Family Specialist (1 FTE)	Family Specialist (1 FTE)
	RN or LPN (0.36 FTE)
	Other roles or specialties (1.64 FTE) • Peer Specialist (**highly encouraged**) • Vocational Specialist, Substance Use Specialist, Family Specialist, Wellness Specialist, Housing Specialist, Criminal Justice Specialist, etc.
Not included in the 10:1 ratio	**Not included in the 10:1 ratio**
Program Assistant (1 FTE)	Program Assistant (1 FTE)
Psychiatrist (0.48 FTE)/ NPP (0.70 FTE)	Psychiatrist (0.68 FTE)/ NPP (1 FTE)