



ACT Program Guidelines 2007

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1 Overview

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

Assertive Community Treatment is an evidence-based practice. ACT provides an integrated set of other evidence-based treatment, rehabilitation, case management, and support services delivered by a mobile, multi-disciplinary mental health treatment team. ACT supports recipient recovery through a highly individualized approach that provides recipients 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 cultural competence, addressing the impact of discrimination/stigma, and inter-system collaboration into its service philosophy. ACT will provide services with consideration of linguistic preference. An essential aspect of ACT is recognizing the importance of family, community-based, and faith-based supports.

Typically, recipients served by ACT have a serious and persistent psychiatric disorder and a treatment history that has been characterized by frequent use of psychiatric hospitalization and emergency rooms, involvement with the criminal justice system, alcohol/substance abuse, and lack of engagement in traditional outpatient services. The population served by ACT comprises a small subset of persons with serious mental illness. Most people will not need the intense service an ACT program offers.

Persons are usually referred to ACT through a single point of access process within a county and are designated by that process as a high priority candidate for an intensive level of service. These referrals could include persons under a court order for Assisted Outpatient Treatment.

In recognition of New York State's geographic (rural and urban) variations, two sizes of ACT teams have been developed as follows; a 40-48 recipient model and a 60-68 recipient model. Reimbursement is based on team size.

There are two billing rates for ACT; a full rate for those recipients who receive at least 6 contacts in a month (up to three of these contacts may be with collaterals) and a partial rate for those recipients who are seen less than 6 but more than 1 time per month. ACT serves recipients who require frequent and mobile contacts. The recipient-to-staff ratio for ACT cannot exceed 9.9:1.

ACT has a service dollar allotment of approximately \$500 per recipient.

2 Outcomes

The role of ACT in facilitating independence and recovery is organized into three major ongoing and interacting service processes. The first, person-centered service planning and coordination, is accomplished with the active participation of the recipient, and whenever possible, friends and family members. The second, reintegration into community life, focuses on stability, particularly in the areas of housing, symptom management and reduction of harmful behaviors and adverse effects. The third, active participation in normal developmental life roles is evidenced by a return to school, competitive employment, long periods of sobriety with steps towards full recovery, spiritual and recreational pursuits, and participation in social groups in natural settings. The outcomes expected within these processes are as follows:

- Housing that is safe, affordable, and based on the choices and preferences of the individual is attained and maintained.
- Symptoms are controlled, side effects are managed and medication is used as prescribed.
- Substance abuse is reduced.
- A medical provider is chosen and appropriately utilized by the recipient.
- There is a reduction of inpatient admissions, emergency room use, involvement in the criminal justice system, and in dangerous behaviors.
- Employment and /or educational goals chosen by the recipient are attained and maintained.

- Personal stability and well-being are maintained.
- Effective skills are developed to reduce the long term impact of mental illness on an individual's vulnerability to stress, difficulty with interpersonal relationships, deficiency in basic coping skills, marked dependency on hospitals or family and /or poor transfer of learned skills/abilities to new situations.
- The recipient is integrated with and participates in his/her natural community.

3 Services

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

- Supportive of hope and recovery;
- Comprehensive, highly individualized, flexible and focused on learning skills related to life roles;
- Easily accessible, available 24 hours/day, 7 days/week, via the resources of an integrated multi-disciplinary mental health team;
- Respectful of the importance of cultural considerations in service delivery and design;
- Provided in the recipient's language at all points of contact, as needed;
- Committed to building and strengthening therapeutic and family relationships across all interactions;
- Focused on recipient choice, goals and achievable outcomes, including harm reduction;
- Provided in the community in places and situations where problems arise;
- Proactive in terms of continuous monitoring and engagement efforts; and
- Available as long as needed throughout transitions.

The services provided by ACT include a full range of clinical treatment, psychosocial rehabilitation, and community support services designed to promote recovery by improving psychiatric symptoms, preventing relapse, teaching skills, providing direct assistance and securing community resources necessary for successful functioning in work, school, home and social relationships. Services should be culturally relevant 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 recipient. The team has the capacity to tailor contacts based on clinical or rehabilitative need. Scheduled contacts should be purposeful and designed to carry out interventions in the service plan or to address critical needs or situations. For programmatic and licensing purposes, the minimum number of required face-to-face contacts per month is six (6), three (3) of which may be a collateral contacts.

Engaging and retaining recipients in treatment is a high priority in the ACT model. The program adopts the philosophy that recipients are never considered to have "dropped out" of treatment. The team seeks to engage recipients in the manner that is comfortable to them and employs a range of outreach strategies tailored to individual recipient needs and preferences. The team is expected to be persistent in engaging and building trust with recipients who initially refuse services. The team uses a variety of methods to promote engagement with the most reluctant recipients, including street outreach, visiting the recipient's home, and legal mechanisms (probation/parole, Assisted Outpatient Treatment) when appropriate. Court ordered restrictions imposed on a recipient would be monitored regularly during daily meetings and interventions would be planned to help the recipient comply with the court order.

As part of the engagement process, the team will fully explain to recipients the array of available services. Recipient choice with regard to participation in services will be respected.

Developing and working with the recipient's support system can be an important part of treatment that furthers the recipient's integration into the community and provides skills and supports for that

network. The ACT team should persistently attempt to engage with the recipient’s family and support network and include them in the treatment and rehabilitative process, with the recipient’s consent.

The services provided by ACT will be continuously measured to ensure that individualized outcomes in the service plans are achieved. As appropriate and consistent with current research, ACT teams are expected to broaden or refine the services to include current evidence-based practices.

The array of services to be provided by the ACT program is described in Section 3.1.

3.1 ACT Services

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

<p><i>Service Planning & Coordination</i> Developing, in partnership with the recipient, 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.</p>	
<p><i>Family Life & Social Relationships</i> 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 support in recovery of recipient.</p>	<p><i>Integrated Treatment for Substance Abuse</i> 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.</p>
<p><i>Housing</i> Finding safe, affordable housing. Negotiating leases and paying rent. Purchasing and repairing household items. Developing relationships with landlords.</p>	<p><i>School & Training Opportunities</i> Identifying interests and skills. Finding and enrolling in school/training programs. Supporting participation in school/training programs.</p>
<p><i>Wellness Self-Management & Relapse Prevention</i> Educating about mental illness,</p>	<p><i>Problem Solving</i> Individual, group, family and behavior therapy that is problem-</p>

<p>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.</p>	<p>specific and goal oriented; uses a therapeutic approach which is 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; and considers a recipient's strengths, needs, and cultural values.</p>
<p>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.</p>	<p>Work Opportunities Identifying interests and skills. Preparing for finding employment. Job coaching and social skills training. Developing and strengthening relationships with employers and other vocational support agencies. Educating employers about serious mental illness.</p>
<p>Health< Education to prevent health problems. Medical screening and follow up. Scheduling routine and acute medical and dental care visits. Sex education and counseling.</p>	<p>Medication Support Prescribing and administering medication. Carefully monitoring response and side effects. Ordering medications from pharmacies. Delivering medications. Educating consumers about medications. Reminding individuals to take medications.</p>
<p>Money Management & Entitlements Completing entitlement applications. Accompanying consumers to entitlement offices. Re-determination of benefits. Budgeting skills. Financial crisis management. Managing food stamps.</p>	<p>Empowerment & Self Help Encouraging and assisting recipients recipients 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 recipients.</p>

4 Program Organization

4.1 Hours of Operation

The ACT team is available seven days a week, 24 hours a day by direct phone link and is regularly accessible to recipients 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.

4.2 Crisis Intervention (Rapid Access)

ACT programs have primary responsibility for crisis response and are the first contact for after-hours crisis calls. The ACT team must operate a continuous and direct after-hours on-call system with staff that are experienced in the program and skilled in crisis intervention procedures. The ACT team must have the capacity to respond rapidly to emergencies, both in person and by telephone. To ensure direct access to the ACT program, recipients must be given a phone list with the responsible ACT staff to contact after hours.

4.3 Eligibility

1. ACT serves persons who have a severe and persistent mental illness listed in the diagnostic nomenclature (current diagnosis per DSM IV) that seriously impairs their functioning in the community. Priority is given to people with schizophrenia, other psychotic disorders (e.g., schizoaffective disorder), bipolar disorder and/or major or chronic depression, because these illnesses more often cause long-term psychiatric disability. Priority is also given to individuals with continuous high service needs that are not being met in more traditional service settings. Individuals with a primary diagnosis of a personality disorder(s), substance abuse disorder or mental retardation are not appropriate for ACT.
 - a. Recipients with serious functional impairments demonstrate at least one of the following conditions:
 - Inability to consistently perform practical daily living tasks required for basic adult functioning in the community without significant support or assistance from others such as friends, family or relatives.
 - Inability to be consistently employed at a self-sustaining level or inability to consistently carry out the homemaker role.
 - Inability to maintain a safe living situation (e.g., repeated evictions or loss of housing).
 - b. Recipients with continuous high service needs demonstrate one or more of the following conditions:
 - Inability to participate or succeed in traditional, office-based services or case management.
 - High use of acute psychiatric hospitals (two hospitalizations within one year, or one hospitalization of 60 days or more within one year).
 - High use of psychiatric emergency or crisis services.
 - Persistent severe major symptoms (e.g., affective, psychotic, suicidal or significant impulse control issues).
 - Co-existing substance abuse disorder (duration greater than 6 months).
 - Current high risk or recent history of criminal justice involvement.
 - Court ordered pursuant to MHL §9.60 to participate in Assisted Outpatient Treatment.
 - Inability to meet basic survival needs or homeless or at imminent risk of becoming homeless.
 - Residing in an inpatient bed or in a supervised community residence, but clinically assessed to be able to live in a more independent setting if intensive community services are provided.

- 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.

4.4 Admission Process

1. Admission to ACT is managed through a local single point of access process (SPOA). Inpatient psychiatric units, mental health outpatient programs, families and/or recipients, and other referral sources submit referrals for ACT services to the single point of access in their county or primary service area.
2. The number of admissions per month should not exceed the range of 4-6, 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, recipients will need the most intense services and that significant initial effort will be required to complete the assessment and to begin to address many unmet needs e.g. housing, entitlements, medical care and stabilizing psychiatric symptoms.
3. An admission decision must be made within seven consecutive days of the receipt of the initial referral, unless indicated by the local municipality to be different due to the needs of that community.
4. Upon the decision to admit an individual to the ACT program, a screening and admission note shall be written, to include:
 - a. The reason(s) for referral;
 - b. Immediate clinical and other service needs for the recipient to attain or maintain stability (see Section 4.11 #4); and
 - c. Admission diagnoses (Axis I and Axis II).
5. When an admission is not indicated, notation shall be made of the following:
 - a. The reason(s) for not admitting;
 - b. The disposition of the case; and
 - c. Any referrals or recommendations made to the referring agency, as appropriate.
6. The recipient's decision not to take medication is not a sufficient reason for denying admission to an ACT program.

4.5 Discharge Process

1. ACT recipients are served with a person-centered approach with no artificial time constraints. Discharge is based on the achievement of recovery goals.
2. ACT recipients meeting any of the following criteria may be discharged:
 - a. Individuals who demonstrate, over a period of time, an ability to function in major life roles (i.e., work, social, self-care) and can continue to succeed with less intensive service.
 - b. 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 recipient until the provider and the recipient are engaged in this new service arrangement.
 - c. Individuals who need a medical nursing home placement, as determined by a physician.
 - d. Individuals who are hospitalized or locally incarcerated for three months or longer. However, an appropriate provision must be made for these individuals to return to the ACT program upon their release from the hospital or jail.
 - e. 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 alternative treatment when the recipient has a history of suicide, assault or forensic involvement.
 - f. 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. For all persons discharged from ACT to another service provider within the team's primary service area or county, there is a three-month transfer period during which recipients who do not adjust well to their new program may voluntarily return to the ACT program. During this period, the ACT team is expected to maintain contact with the new provider, to support the new provider's role in the recipient's recovery and illness management goals.
4. Notification must be made to the local single point of access process coordinator for persons being discharged to other programs managed through the SPOA process.
5. If a recipient of ACT services is under a court order to receive Assisted Outpatient Treatment, any discharge must be planned in coordination with the County's AOT program administrator.
6. The decision not to take medication is not a sufficient reason for discharging an individual from an ACT program.

4.6 Service Intensity

1. The ACT team has the capacity to provide the frequency and duration of staff-to-recipient contact required by each recipient's individualized service plan and their immediate needs.
2. The ACT team must provide a minimum of six (6) visits per month, three (3) of which may be collateral.) The ACT team has the capacity to increase and decrease contacts based upon daily assessment of the recipient's clinical need, with a goal of maximizing independence. The team has the capacity to provide multiple contacts to persons in high need and a rapid response to early signs of relapse. The ACT team has the capacity to provide support and skills development services to recipients' significant others/collaterals. Collateral contacts may include family, friends, landlords, or employers, consistent with the service plan.
3. The team Psychiatrist and/or the Psychiatric Nurse Practitioner (PNP) have scheduling flexibility and, when needed, can see recipients on a weekly basis. The psychiatrist and/or PNP must provide community based services as per the following: the psychiatrist must complete an initial assessment visit to the recipient in the community and quarterly community visits thereafter. The PNP must complete an initial assessment visit in the community and visits in the community at least 80% of the time, including the required quarterly visits thereafter. If the recipient will not come to meet the psychiatrist and/or the PNP at the ACT office, the psychiatrist and/or PNP must provide at least monthly services or as clinically indicated for that individual in the community.
4. The ACT team has the capacity to provide services via group modalities as clinically appropriate; e.g. for recipients with substance abuse disorders, and for family psychoeducation and wellness self-management services.

4.7 Human Resources

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

4.7.1 Staffing Requirements for ACT

1. ACT recipient to clinical staff ratio cannot exceed 9.9:1.
2. The 40-48 recipient model calls for approximately 5 clinical staff (counted in the staff to recipient ratio) and 1.5 support staff; the 60-68 recipient model calls for approximately 7 clinical staff (counted in the staff to recipient ratio) and 1.5 support staff. The program makes every effort to be fully staffed.
3. Team staffing is multi-disciplinary.
4. At least 60% of the total clinical staff is professional.
5. At least 60% of the clinical staff is full-time.
6. The core minimum staffing for an ACT team includes:
 - a. 1 full-time team leader (50% counted in the clinical staff ratio).
 - b. 68 FTE psychiatry for a 60-68 recipient team (may employ a psychiatric nurse practitioner to offset some of the psychiatrist FTE, however, the psychiatrist must work a minimum of 14 hours/week with the PNP fulfilling the balance of the requirements).

.48 FTE psychiatry for a 40-48 recipient team (may employ a psychiatric nurse practitioner to offset some of the psychiatrist FTE, however, the psychiatrist must work a minimum of 10 hours/week with the PNP fulfilling the balance of the requirements).

- c. 1 FTE nurse for every 50 recipients, including at least 1 FTE registered nurse.
 - d. 1 FTE program assistant (support staff - not counted in the clinical staff ratio).
 - e. Other clinical staff to achieve minimum staffing per ACT team model.
7. The minimum staffing must include clinical staff with the following specialized competencies – competency means one year of experience or training in the specialty area and demonstration of the specific skills or knowledge:
- a. 1 FTE substance abuse specialist per team*.
 - i. Substance abuse assessment and substance abuse diagnosis
 - ii. Principles and practices of harm reduction
 - iii. Knowledge and application of stage-wise treatment
 - iv. Knowledge and application of motivational interviewing strategies
 - b. 1 FTE employment specialist per team*.
 - i. Knowledge of models of supported employment
 - ii. Vocational assessment
 - iii. Job exploration and matching to recipient's interest and strengths
 - iv. Skills development related to choosing, securing, and maintaining employment
 - c. 1 FTE family specialist per team*.
 - i. Family needs assessment
 - ii. Family intervention strategies
 - iii. Cognitive behavioral techniques

If an individual is hired on the ACT team to fill a specialty position and does not have the required competency, 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 and supervision must begin within six months of hire and continue for one year. The trainer and/or supervisor must provide written documentation that the individual has attained competency in the required areas.

The ACT team should also designate a staff member to be the wellness self-management specialist; the Wellness Self-management specialist will be responsible for developing interventions based on the Illness Management and Recovery (IMR) Toolkit, OMH's Wellness Self-Management curriculum, and other wellness resources.

4.7.2 Core Competencies

1. At hire, all clinical staff on an ACT team must have experience in providing direct services related to the treatment and recovery of persons with a serious mental illness. Staff should be selected consistent with the ACT core operating principles and values. (See Section 3). Clinical staff should have demonstrated competencies in clinical documentation, stage-wise treatment, and motivational interviewing.
2. All staff will demonstrate basic core competencies in designated areas of practice, including the Assertive Community Treatment core processes, integrated mental health and substance abuse treatment, supported employment, family psycho-education and wellness self-management.
3. All staff must complete ACT core training, consistent with a curriculum guide provided by OMH, during the first 6 months following licensing. The ACT CORE training consists of the following: 1) ACT Core Training Modules 1-6; 2) Recovery 201; 3) Recovery 301 Relapse Prevention and Wellness Recovery Action Plan; and 4) Person Centered Treatment Planning.

4.7.3 Staff Roles & Qualifications

All of the following staff roles and qualifications are required, except for the psychiatric nurse practitioner, paraprofessional staff and the peer specialist, which are optional:

1. Clinical Staff – Direct care staff that provide treatment, rehabilitation and support services and are counted in the staff-to-recipient ratio.
2. Professional Staff – Staff who are qualified by credentials, education and/or experience to provide clinical supervision and/or direct services related to the treatment of serious mental illness (See Section 5.2 Staffing Definitions for an expanded description).
3. Paraprofessional Staff (Optional) – Staff who are qualified by experience and under the clinical supervision of professional staff may carry out rehabilitation and support functions; assist in treatment; provide substance abuse services; provide education, support, and consultation to families; and provide crisis intervention services. Licensed Practical Nurses are encouraged, particularly for teams requiring additional nursing coverage.
4. Team Leader – A full-time staff member, who directs and supervises staff activities, leads team organizational and service planning meetings, provides clinical direction to staff regarding individual cases, conducts side-by-side contacts with staff and regularly conducts individual supervision meetings. The team leader is responsible for direct patient services as a member of the clinical staff, clinical supervision for staff, and administration and leadership of the team, on an ongoing basis. Minimum qualifications are:
 - a. A masters degree or higher in social work, psychology, rehabilitation counseling, or a related field, OR licensure/registration as a registered nurse (RNs are encouraged to be masters level or nurse practitioner), or physician.
 - b. Preference should be given to persons with experience on a multi-disciplinary mobile team.
5. Psychiatrist – Must be currently licensed as a physician by the NYS Education Department and certified by, or be eligible to be certified by, the American Board of Psychiatry and Neurology. The psychiatrist, in conjunction with the team leader, has overall clinical responsibility for monitoring recipient treatment and staff delivery of clinical services. The psychiatrist provides psychiatric and medical assessment and treatment; clinical supervision, education, and training of the team; and development, maintenance, and supervision of medication administration and psychiatric and medical treatment and procedures.
6. Psychiatric Nurse Practitioner (optional) must be currently licensed as a Psychiatric Nurse Practitioner by the NYS Education Department. The Psychiatric Nurse Practitioner (PNP), under the supervision of the psychiatrist and in conjunction with the team leader, has clinical responsibility for monitoring recipient treatment and staff delivery of clinical services. The PNP (when functioning to offset the psychiatrist hours) provides psychiatric and medical assessment and treatment; education and training of the team; and development, maintenance, and supervision of medication administration and psychiatric and medical treatment and procedures. The PNP may also fulfill the duties of a registered nurse (as described below) when not fulfilling the requirement for psychiatry FTE.
7. Registered Nurse – The registered nurse is responsible for conducting psychiatric assessments; assessing physical health needs; making appropriate referrals to community physicians; providing management and administration of medication in conjunction with the psychiatrist; providing a range of treatment, rehabilitation, and support services.
8. Program Assistant – Typically, a non-clinical staff member who is responsible for managing medical records; operating and coordinating the management information system; maintaining accounting and budget records for recipient and program expenditures; and performing reception activities (e.g., triaging calls and coordinating communication between the program and recipients).
9. Substance Abuse Specialist – A clinical staff member, who in addition to performing routine team duties, has lead responsibility for integrating dual-recovery treatment with the tasks of other team members. Competency must be demonstrated by at least 1 year of training and/or experience in integrated mental health and substance abuse assessment and treatment, motivational interviewing techniques and stage-wise treatment.
10. Employment Specialist – A clinical staff member who, in addition to performing routine team duties, has lead responsibility for integrating vocational goals and services with the tasks of all

team members. This staff member provides needed assistance through all phases of the vocational service. Competency must be demonstrated by at least 1 year of training and/or experience in vocational assessment, job exploration, and skills development in choosing, getting, and maintaining employment, employment counseling or vocational rehabilitation.

11. Family Specialist – A clinical 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 for providing family psycho-education individually and in groups. Competency must be demonstrated by at least 1 year of training and/or experience in family assessment and intervention, psycho-education and/or other family support services, including cognitive-behavioral strategies.
12. Peer Specialist (Optional) – An ACT team is encouraged to employ a peer specialist. Because of their experiences as service recipients, peer specialists are in a unique position to serve as role models, educate recipients about self-help techniques and self-help group processes, teach effective coping strategies based on personal experience, teach symptom management skills, assist in clarifying rehabilitation and recovery goals, and assist in the development of community support systems and networks.

4.8 Team Treatment

ACT teams use a team approach to treatment, not an individual treatment model. To the greatest extent possible, ACT recipients are the responsibility of the collective team, and not one or two individuals on the team. Although recipients can and will form a special bond with some individual team member, all members of the team should see all of the ACT recipients. It is expected that a majority of recipients will be seen by a minimum of three (3) or more staff members in a given month.

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

4.9 Team Communication

1. Organizational staff meetings are held a minimum of four times a week. The team meeting is critical to facilitate frequent communication among team members about recipient progress and to help teams make rapid adjustments to meet recipient needs. If programs choose to meet the minimum of 4 times weekly, they need to develop mechanisms to share information on the non-meeting day about recipients' behavior and interventions, and to insure that all team members are familiar with the recipients' current status.
2. The organizational meetings should be short (about one hour) and include:
 - a. Review of every recipient on the caseload.
 - b. Review of the status of each recipient to be seen on the day of the meeting.
 - c. Updates on contacts that occurred the day before.
 - d. Updates and revisions to the daily staff assignment schedule.
 - e. Service plan reviews and revisions, as needed.
3. ACT teams maintain and utilize documentation processes to further communications among team members. Examples include:
 - a. A weekly or monthly schedule of contacts and activities for each recipient, organized in a notebook or Cardex, and maintained in a central file.
 - b. A daily team schedule containing a list of recipients to be contacted and the interventions planned for each contact, scheduled paper work time, supervision meetings and other rehabilitation and service activities scheduled to occur that day, to be maintained on a log board.
 - c. A daily communication system, tools for organization of the daily meeting and scheduling of recipient/staff contacts, and a significant event log or other intra-team communication system to make the team aware of high risk situations or other safety issues which may need to be addressed in providing services. Significant recipient 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 work day and discussed at the next team meeting.

- d. A recipient goal board, on which is listed the name of each recipient in the program and the goals of that individual.
- e. A recipient monthly contact log, in which is individually listed all the contacts and attempted contacts, phone contacts, collateral contacts, location, duration, a brief description of the contact and plan for the next contact.
- f. A hospitalization log, in which is listed hospitalization information for each recipient.
- g. A recipient monthly schedule board, on which is recorded future appointments and other important dates, that are not included on the current month scheduling board.
- h. A staff monthly schedule board, on which is recorded staff appointments, training dates that impact scheduling for recipient contacts.

4.10 Assessment & Service Planning

1. The Core of ACT is a multi-disciplinary team process for ongoing assessment and person-centered service planning, conducted under the supervision of the team leader and the psychiatrist and/or the psychiatric nurse practitioner.
2. The team develops a person-centered plan in partnership with the recipient to address all recipient needs and preferences for services and supports. This includes services provided directly by the ACT team as well as services and/or activities that are naturally occurring in the community and provided by other community agencies.
3. An immediate needs assessment and documentation of a plan to address these immediate needs is completed within 7 days of receipt of a referral; immediate needs are defined as: 1) safety/dangerousness; 2) food; 3) clothing; 4) shelter; and 5) medical needs.
4. A Comprehensive Assessment is completed within 30 days of admission, and must include the following information:
 - A. The recipient's psychiatric history, including:
 - i. Illness history (historical time line from age of onset of mental illness);
 - ii. Past and current medication treatments and doses;
 - iii. Rationale for prescriptions and side effects;
 - iv. Contact information of previous prescribers;
 - v. Hospitalizations and other treatments.
 - B. The recipient's problems and strengths, including:
 - i. Service use within the last 12 months;
 - ii. Current functioning;
 - iii. Symptoms and severity;
 - iv. Diagnoses;
 - v. Dangerous behavior/suicidality;
 - vi. Living arrangements;
 - vii. Medical conditions;
 - viii. Community living skills (e.g., managing finances, household tasks, transportation, shopping for household goods and accessing resources);
 - ix. Education and employment history;
 - x. Legal status; and
 - xi. Trauma/abuse history.
 - C. Substance abuse assessment, including:
 - i. Systematic screening method for identifying dual diagnosis recipients;
 - ii. History of substance use and abuse;
 - iii. treatment history;
 - iv. Current/recent use of alcohol and specific drugs (including patterns and amounts of use);
 - v. Social context of substance use;
 - vi. Motives for substance use;
 - vii. Consequences of substance use;

- viii. Insight;
 - ix. Motivation to address substance use; and
 - x. Specific behavioral information on both substance abuse and mental health disorders and how they influence each other.
- D. The recipient's choices, including:
- i. Treatment and rehabilitative goals that are consistent with the purpose and intent of the ACT program;
 - ii. Life goals, including educational, vocational, residential, social or recreational pursuits;
 - iii. Skills and resources needed to achieve goals;
 - iv. Interest in self-help, advocacy, and empowerment activities.
- E. The Comprehensive Assessment is updated at least every six (6) months at the Service Plan review; as well as whenever there are significant events or changes in life circumstances.
- F. If requires assessment information is not obtainable, evidence of efforts to secure the information required for the completion of the Comprehensive Assessment should be documented on the assessment form and in the progress notes.
- G. The Comprehensive Assessment is approved and signed by the Team Leader or designated clinical supervisor.
5. A comprehensive service plan is prepared within 30 days of admission, with specific objectives and planned services necessary to facilitate achievement of the recovery goals. The service plan is strengths-based, culturally relevant, responsive to recipient preferences and choices, and shall include;
- a. The recipient's designated mental illness diagnosis;
 - b. The approval and signature of the physician and the team leader or designated clinical supervisor involved in the treatment;
 - c. Plans to address all psychiatric conditions and/or documentation of rationale to defer treatment.
 - d. The recipient's treatment goals, objectives (including target dates), preferred treatment approaches, and related services;
 - e. The recipient's educational, vocational, social, wellness management, residential or recreational goals; associated concrete and measurable objectives; and related services.
 - f. When psychopharmacological treatment is used, a specific service plan including identification of target symptoms, medication, doses, and strategies to monitor and promote commitment to medication;
 - g. A crisis/relapse prevention plan including presenting the recipient with the opportunity to complete an advance directive;
 - h. An integrated substance abuse and mental health service plan for recipients with co-occurring disorders, including:
 - i. Interventions that target the interactions between the two disorders (for example, providing coping skills for psychiatric difficulties that may contribute to substance abuse).
 - ii. Any plan for the provision of additional services to support the recipient outside of the ACT program;
 - iii. A crisis plan that targets both substance abuse and mental health concerns.
 - iv. documentation of a rationale to defer treatment.
 - i. Input of all staff involved in treatment of the recipient;
 - j. Involvement of the recipient and others of the recipient's choice, and;
 - k. Planned use of service dollars.
6. The comprehensive service plan is reviewed and updated at least every 6 months, including:
- . Assessment of the progress of the recipient in regard to the mutually agreed upon goals in the service plan;
 - a. Changes in recipient status;
 - b. Adjustment of goals, time periods for achievement, intervention strategies or initiation of discharge planning, as appropriate.

- c. The service plan review is approved and signed by the psychiatrist and team leader or designated clinical supervisor.
- 7. The recipient's participation in service planning and approval of the service plan are evidenced in the planning process and documented by the recipient's signature. Reasons for non-participation shall also be documented in the case record.
- 8. Service contacts and attempted contacts are documented in the progress notes. Such notes shall identify the particular services provided and specify their relationship to a particular goal or objective documented in the service plan. Progress notes must document progress or lack of progress toward goals, significant events and the recipient's response to the service provided. Gaps in services should be documented. The progress note shall contain the date and location of contact and be signed by the person who provided the service.
- 9. Service dollars spent and their related treatment objectives are documented in progress notes.

4.11 Case Records

- 1. A complete case record is maintained for all recipients in accordance with recognized and acceptable principles of record keeping:
 - a. Case record entries shall be made in non-erasable ink or typewriter and shall be legible.
 - b. Case records shall be periodically reviewed for quality and completeness by the agency quality assurance program; and
 - c. All entries in case records shall be dated and signed by appropriate staff.
- 2. The case record shall be available to all staff of the ACT Program who are participating in the treatment of the recipient and shall include the following information:
 - a. Recipient identifying information and history;
 - b. Pre-admission screening notes, as appropriate;
 - c. Diagnoses;
 - d. Assessment of the recipient's psychiatric, physical, social, and/or rehabilitation needs;
 - e. Reports of all mental and physical diagnostic exams, assessments, tests, and consultations;
 - f. The service plan;
 - g. Periodic service plan reviews;
 - h. Record and date of all on-site and off-site face-to-face contacts with the recipient, the type of service provided, the duration and location of contact;
 - i. Dated progress notes which relate to goals and objectives of treatment and significant events and/or untoward incidents;
 - j. Dated and signed records of all medications prescribed;
 - k. Medication interaction/compatibility;
 - l. Level of commitment to taking medications;
 - m. Duration of medication treatment;
 - n. Referrals to other programs and services;
 - o. Consent forms;
 - p. Record of contacts with collaterals;
 - q. Service dollar expenditures documented in service plan and progress notes;
 - r. Recipient preferences and choices;
 - s. Discharge Documentation including:
 - i. The reasons for discharge (using the discharge categories outlined in Section 4.5).
 - ii. The recipient's status and condition at discharge.
 - iii. A written final evaluation or summary of the recipient's progress toward the goals set forth in the services plan.
 - iv. A plan developed in conjunction with the recipient for treatment after discharge and for follow-up.
 - v. The signature of the team leader or designated clinical supervisor and the psychiatrist.

- vi. The signature of the recipient and/or a family member, or justification as to why not, if possible.
- vii. Discharge summary: A discharge summary is transmitted to the receiving program prior to the arrival of the recipient. 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 recipient.

4.12 Organizational Processes

The following sections detail the organizational processes required for ACT program quality assurance and improvement, utilization review, incident management, staff development, staff safety, cultural competence, CAIRS compliance and discharge procedure

4.12.1 Quality Improvement and Leadership

Strong team leadership is critical to improving organizational performance. Clinical leadership on the ACT team is provided through the direction of the physician and/or the psychiatric nurse practitioner and the team leader. Administration and team leadership is the responsibility of the team leader. Leadership will include a daily review of recipient progress in treatment, and barriers to achieving treatment outcomes and recipient choices.

4.12.2 Utilization Review

The Agency shall maintain a systematic utilization review process which is conducted by individuals who are appropriately credentialed and do not provide direct care to the ACT recipients he/she reviews.

1. The Agency will develop a process to systematically monitor, analyze and improve the performance of the ACT team in assisting recipients to achieve their treatment outcomes. This will include the development of a quality improvement plan consistent with the mission and values of the ACT program. The plan will include:
 - a. A data collection process that provides information relevant to specific treatment outcomes
 - i. As part of the data collection process, the team will complete forms provided by NYSOMH on the CAIRS System for a baseline assessment (BASf), to be begun within 30 days of admission and completed in a timely manner, and updated assessments (FUAF) at 6-month intervals, to assess recipient outcomes. These forms are to be completed through the CAIRS system. These forms will be part of the team's regular assessment and service planning process.
 - b. An analysis of recipient progress to identify outcome trends,
 - i. Data analysis will be conducted by the team and the agency to identify trends, verify goal achievement and service quality, and identify areas of improvements and the impact of corrective actions:
 1. Programs will analyze core outcomes at 6-month intervals consistent with the required assessment and service planning process.
 2. 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.
 - c. A verification of service provision and quality that supports goal attainment,
 - d. An identification of service provision and treatment which needs improvement,
 - e. Corrective action/process improvement plans specific to the results of the analysis, and
 - f. Self-administration of the DACTS annually to ensure fidelity to the ACT model and transmittal of this information to OMH.

- g. The need for continued stay shall be documented by the agency:
 - i. Documentation should reference back to the reason for admission and goal achievement.
 - ii. Documentation should occur for each client a minimum of every twelve months.
 2. The agency will participate in the development of any state or LGU utilization management process.

4.12.3 Incident Management and Reporting

The Agency and the ACT teams must develop, implement and monitor an incident management program in accordance with New York State Rules and Regulations. When available, ACT programs will utilize the NYS Incident Management and Reporting System (NIMRS).

4.12.4 Staff Development and Core Competencies

The agency ensures that the ACT staff receives appropriate and ongoing professional training. It is required that all staff attends the ACT CORE: Modules 1-6, Recovery 201, Recovery 301, and Person-Centered Service Planning trainings. Ongoing training in specialty practices, clinical skill development, and culturally competent care is the responsibility of the agency.

4.12.5 Safety Plan

The ACT team provides services in the community where recipients live, work, socialize, and recreate. 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 are trained in community safety and routinely follow the safety plan.

4.12.6 Cultural Competence

Cultural Competence is the ongoing practice of gathering and utilizing knowledge, information, and data from and about, individuals, families, communities, and groups. That information is integrated and transformed into specific clinical practices, standards and skills, service approaches, techniques and marketing strategies, and evidence-based initiatives that match the service population; and serves to increase the quality and appropriateness of mental health care. The provision of culturally competent care is a core value of the ACT model. The agency is responsible to develop a Cultural Competence Plan, based on the approved OMH outline. The plan encompasses the demographics of the recipients and the community, and includes the social, recreational, cultural, educational, and spiritual resources and venues of the community that are available to ACT recipients. The plan ensures that language assistance services are available.

The agency/program is expected to have available written information, including flyers, handouts, brochures, pamphlets and newspapers on self-help, community, and cultural resources. This information should be made available to the recipients at the program site and should be brought to them in the community.

4.12.7 CAIRS (Child and Adult Integrated Reporting System)

NYSOMH developed the CAIRS system to collect, analyze, trend, and report recipient data and outcomes. NYSOMH requires that ACT teams complete the Baseline Assessment Form (BASf) and the Follow-up Assessment Form (FUAF) on the CAIRS system at **prescribed time intervals**. The agency is responsible to develop and maintain a procedure that ensures the timely entry of this information by the ACT team.

1. The Baseline Assessment Form must be started within 30 days of recipient's admission to the ACT team and is to be completed as required assessment information is obtained. The Baseline Assessment Form is to be entered using the computerized CAIRS system.
2. The Follow Up Assessment Form must be completed annually, except for individuals on AOT status. For individuals on AOT status, the Follow Up Assessment form must be completed every six (6) months from the date of admission or from the date of a new AOT court order. The Follow Up Assessment Form is to be entered using the computerized CAIRS system.
3. The final Follow Up Assessment Form must be completed at the time of discharge from ACT.

4.12.8 Discharge Procedure

The agency shall develop and maintain a procedure regarding discharge and transmits discharge summaries with appropriate content to receiving program.

4.13 Program Site

1. Persons (recipients, staff, and visitors) shall be safe from undue harm while they are at the program site.
2. Persons (recipients, staff, and visitors) with various disabilities shall have access to appropriate program areas. Programs shall adjust service environments, as needed, for recipients 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.

4.14 Coordination between ACT & Other Systems

1. The ACT program develops agreements for assuring service continuity with other systems of care including:
 - a. Emergency service programs
 - b. State and local psychiatric hospitals
 - c. Rehabilitation services
 - d. Housing agencies
 - e. Social services
 - f. VESID/educational institutions
 - g. Self-help/peer-run services
 - h. Independent living centers
 - i. Clubhouses
 - j. Natural community supports, including parenting programs, churches/spiritual centers and local groups/organizations
 - k. Local correctional facilities and other forensic organization such as parole and probation.
2. ACT programs are expected to fully implement the systems coordination plans, which were submitted as part of the ACT PAR application and were approved by the Office of Mental Health.
3. ACT programs follow the provisions of MHL §9.60 and related local procedures in providing Assisted Outpatient Treatment.

4.14.1 Relationship between ACT & Psychiatric Inpatient Facilities

ACT Teams are closely involved in hospital admissions and hospital discharges in order to ensure continuity and coordination of services, and to be a support and advocate for recipients. It is expected that the team is involved in at least 70% of hospital admissions and at least 70% of hospital discharges.

1. To ensure continuity and coordination of care for ACT recipients, it is recommended that the ACT team work closely with local hospitals to achieve the following goals, where possible:
 - a. The ACT psychiatrist has DCS Authority under M.H.L. 9.37.
 - b. When the host agency for an ACT team also operates an Article 28 hospital, the ACT psychiatrist has hospital admitting privileges.
 - c. The ACT team is consulted on emergency room dispositions and admission/ discharge decisions involving ACT recipients.
2. When a recipient is hospitalized, the ACT team should take the following steps to coordinate with the clinical staff at the hospital:
 - a. Contact the recipient's responsible physician/treatment team to familiarize them with ACT assessment findings and the recipient's community service plan, including medication regimen.
 - b. Provide the recipient with support and hope during the hospitalization period.
 - c. Advocate with landlords and other collaterals in the community to maintain current living arrangement and other appropriate service commitments.
 - d. Work with the discharge staff and recipient to formulate the recipient's discharge plan.
3. The ACT team may receive reimbursement for services to recipients admitted for treatment to an inpatient facility, pursuant to the requirements of Part 508 Medicaid Assistance Rates of Payment for ACT Services.

4.15 Rights of Recipients

1. ACT recipients 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. Recipients have the right to a person-centered, individualized service plan which they form in partnership with the provider.
3. Recipients 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 recipients 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:
 - a. Section 330.20 of the Criminal Procedure Law and Part 541 of Title 14 provide for court-ordered receipt of outpatient services;
 - b. Article 81 of the Mental Hygiene Law provides for the surrogate consent of a court-appointed guardian for personal needs;
 - c. Section 9.60 of the Mental Hygiene Law provides assisted outpatient treatment 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;
 - d. Section 33.21 of the Mental Hygiene Law provides for the surrogate consent of a parent or guardian of a minor; or
 - e. A recipient engages in conduct that poses a risk of physical harm to self or others.
5. The central goal of an individual, person-centered service plan is to formulate goals and services that the recipient chooses. The recipient will not be penalized or terminated from the program for choices with which the provider does not agree.
6. The confidentiality of recipients' clinical records shall be maintained in accordance with Section 33.13 of the Mental Hygiene Law and Federal Standards (e.g., HIPAA).
7. Recipients shall be assured access to their clinical records consistent with Section 33.16 of the Mental Hygiene Law.
8. Respect for recipients' dignity and personal integrity is the cornerstone of the provider's care and treatment.
9. Recipients have the right to receive services in such a manner as to assure non-discrimination.
10. Recipients have the right to be treated in a way that acknowledges and respects their cultural environment.
11. Recipients have the right to a maximum amount of privacy consistent with the effective delivery of services.

12. Recipients have the right to freedom from abuse and mistreatment by employees.
13. Recipients 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 recipients' rights to each recipient upon admission to an ACT Program. Whenever possible, the rights will be discussed and explained in the recipient'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 the Office of Mental Health.

4.16 Fiscal Models

1. Geographic variances in population density and service needs can affect the size of ACT teams. To address these potential variances, there are two sizes of ACT programs – a 60-68 capacity team and a 40-48 capacity team. Localities can choose to implement either model. In general the State will not approve proposals for multiple 40-48 capacity teams within a County unless there is a specific justification based on capacity need and primary service area population (For maximum cost-effectiveness, it is recommended that an existing 40-48 capacity team first be expanded to a 60-68 capacity team, before a second 40-48 capacity team is initiated). A PAR application must have County approval of the model size and then receive State OMH approval.
2. The ACT programs have been funded to support experienced fulltime clinical and administrative staff that can commit to remaining with the program for a reasonable period of time.

4.17 Reimbursements & Exclusions

1. ACT staff provides most of the services required by ACT recipients. 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 recipients are: Intensive Case Management, Supportive Case Management, Blended and Flexible Case Management, OMH Clinic, and OMH Continuing Day Treatment Program.
2. ACT programs are permitted to bill Medicaid for any month in which a recipient is receiving only pre-admission or crisis services from a clinic or CDT.
3. It is expected that ACT programs will provide integrated mental health and substance abuse treatment, but ACT recipients may need access to other substance abuse services not rendered in ACT programs (e.g. detoxification). Therefore, ACT recipients can receive services rendered by substance abuse providers and ACT teams simultaneously and, as appropriate, these providers can bill Medicaid for such services.

4.18 Certification

1. All ACT programs must be certified (licensed) by NYSOMH.
2. Certification as an ACT program requires a comprehensive application for Prior Approval Review pursuant to 14 NYCRR Part 551.
3. These guidelines are the NYS Office of Mental Health's standards for licensed Assertive Community Treatment programs. The Commissioner of the NYSOMH must approve any waivers to these standards.

5 Definitions

The following section provides definitions of some of the more frequently-used terms used in this document.

5.1 Program Definitions

Assessment	Is the continuous clinical process of identifying an individual's behavioral strengths and weaknesses, problems and service needs, through the observation and evaluation of the individual's current mental, physical and behavioral condition and history. The assessment shall be the basis for establishing a diagnosis and service plan.
Case Management	Is an active process that connects persons to resources and supports to help them live in the community, manage their mental illness and meet their personal goals.
Collateral Persons	Revised 9/1/19 Are members of the recipient's family or household, or significant others (including, but not limited to, landlord, criminal justice staff, employer, shelter staff) who regularly interact with the recipient and are directly affected by or have the capability of affecting his or her condition and are identified in the service plan as having a role in treatment. A collateral contact does not include contacts with other mental health service providers or individuals who are providing a paid service that would ordinarily be provided by the ACT team. A group composed of collaterals of more than one recipient may be gathered together for purposes of goal-oriented problem solving, assessment of treatment strategies and provision of practical skills for assisting the recipient in the management of his or her illness.
Contact	Is a face-to-face interaction (duration of at least 15 minutes) between a member of an ACT team and a recipient or collateral during which at least one ACT service is provided.
Crisis Intervention Services	Are activities and interventions, including medication and verbal therapy, designed to address acute distress and associated behaviors when the individual's condition requires immediate attention.
Discharge Planning	Is the process of planning for termination of ACT services and/or identifying the resources and supports needed for the transition of an individual to another program. This process includes making the necessary referrals/linkages for treatment, rehabilitation and supportive services based on an assessment of the recipient's current mental status, strengths, weaknesses, problems, service needs, the demands of the recipient's living, working and social environments, and the recipient's own goals, needs and desires.
Engagement	Is the process of obtaining a person's trust, interest and commitment to participate in service planning and services to promote recovery.
Family Psychoeducation	Is a service that is provided by professionals, that is long-term (over 6 months), and that focuses on education, stress reduction,

coping skills and other supports. The service is provided to relatives and families who are in regular contact with the recipient of services. The primary rationale for the service is that many recipients live at home and/or have contact with relatives; thus education and support for these families will reduce stress and increase the chance for recovery.

Health Screening Service Is the gathering of data concerning the recipient's medical history and any current signs and symptoms, and the assessment of the data to determine his or her physical health status and need for referral for noted problems. The data may be provided by the recipient or obtained with his or her participation. The assessment of the data shall be done by a nurse practitioner, physician, physician's assistant, psychiatrist or registered professional nurse.

Health Service Is training to maximize independence in personal health care by increasing the individual's awareness of his or her physical health status and the resources required to maintain physical health, including regular medical and dental appointments, basic first aid skill and basic knowledge of proper nutritional habits and family planning. Also included is training on topics such as AIDS awareness.

Integrated Treatment for Co-Occurring Substance Abuse and Mental Health Disorders Is a service characterized by assertive outreach and stagewise treatment models that emphasize a harm reduction approach. The service is provided to recipients with co-occurring substance abuse disorders. The primary rationale for the service is that substance abuse worsens outcomes and up to 50% of recipients have co-occurring substance abuse disorders.

Medication Support Means a full range of medication related services including:

- Providing recipients and collaterals with information concerning the effects, benefits, risks and possible side effects of a proposed course of medication;
- Prescribing and/or administering medication;
- Reminding individuals to take medications;
- Reviewing the appropriateness of the recipient's existing medication regimen through review of records and consultation with the recipient and/or family or care-giver;
- Monitoring the effects of medication on the recipient's mental and physical health;
- Storing, monitoring, record keeping and supervision associated with the self-administration of medication;
- Activities that focus on educating recipients about the role and effects of medication in treating symptoms of mental illness;
- Training in the skill of self-medication;

- Ordering medications from pharmacies; and
- Delivering medications, if needed.

Person Centered Planning	Is the process of developing a relationship between the ACT team and the recipient such that the recipient and the team are partners in planning for the recipient'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
Post-Traumatic Stress Disorder (PTSD) Treatment	Is a service provided to recipients who have been exposed to catastrophic events, have had past exposure to trauma, or are trauma victims. Treatment of co-morbid disorders targets symptoms of each disorder simultaneously by providing combination therapy (e.g. individual, medication, global, family, group and social rehabilitation therapies). The primary rationale for the service is that people exposed to similar catastrophic events react differently; some will develop severe psychological distress (e.g. PTSD) while others will not. People treated for PTSD can make a full recovery.
Self-Help & Peer Support Education	Is a service focused on educating recipients about, and supporting participation in, mutual aid fellowships (including starting and running autonomous groups). The service is provided to recipients with limited social networks who are interested in developing a "helper" role, who wish to share and learn about personal coping strategies, and who desire to participate in self-generated structured activities that they find personally meaningful. The primary rationale for the service is that self-help is a complement to treatment and becomes a life-long support that has proven to be beneficial in sustaining management of many disabling health conditions including mental illness. The benefits of this form of mutual aid are empowerment, an increased sense of self-identity, and increased self-esteem.
Socialization	Means activities that are intended to diminish tendencies toward isolation and withdrawal by assisting recipients in the acquisition or development of social and interpersonal skills. "Socialization" is an activity meant to improve or maintain a recipient's capacity for social involvement by providing opportunities for application of social skills. This occurs through the interaction of the recipient and the ACT team staff in the program and through exposure to opportunities in the community. Modalities used in socialization include individual and group counseling and behavior intervention.
Supported Employment	Supported employment is a service characterized by rapid job search and placement (with a de-emphasis on pre-vocational training and assessment) based on recipient preferences and that

provides follow along support. The service is provided to recipients interested in competitive work. The primary rationale for the service is that the rates for competitive work are low although most recipients want competitive work.

Supported employment refers to employment at prevailing wages in regular, integrated work settings with the same supervision, responsibilities, and wages as non-disabled workers.

**Supportive Skills
Training**

Is the development of physical, emotional and intellectual skills needed to cope with mental illness and the performance demands of personal care and community living activities. Such training is provided through direct instruction techniques including explanation, modeling, role playing and social reinforcement interventions.

Symptom Management

Means activities which are intended to achieve a maximum reduction of psychiatric symptoms and increased functioning. This includes the ongoing monitoring of a recipient's mental illness symptoms and response to treatment, interventions designed to help recipients manage their symptoms, and assisting recipients to develop coping strategies to deal with internal and external stressors. Services range from providing guidance in everyday life situations to addressing acute emotional distress through crisis management and behavior intervention techniques.

**Utilization Review
Authority**

Means a person or persons designated by an outpatient program to perform the function of Utilization Review.

**Wellness Self-
Management**

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

- Psychoeducation (counseling and coaching on early warning signs and avoidance of stressors) to minimize the incidence of relapse by enhancing medication adherence through behavioral tailoring, motivational interviewing, and skills training for recipient-doctor interactions;
- Skills training through multiple education and skills training sessions over time (between 3 months and 1 year), individual and group formats, and "in vivo" training to facilitate generalization of skills; and
- Cognitive behavioral therapy for psychosis including education about stress-vulnerability .

Clinical Staff

Are all staff members who provide services directly to recipients. 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 and are supervised in accordance with the policies governing the training program and are approved as part of the staffing plan by the Office of Mental Health.

Professional Staff

Are individuals who are qualified by credentials, training and experience to provide supervision and direct service related to the treatment of mental illness and shall include the following:

1. Credentialed Alcohol and Substance Abuse Counselor (CASAC) is an individual who is credentialed by the New York State Office of Alcoholism and Substance Abuse Services.
2. Creative arts therapist is an individual who has a master's degree in a mental health field from a program approved by the New York State Education Department, and is licensed as a creative arts therapist by the NY State Education Department 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.
3. Nurse practitioner is an individual who is currently certified as a nurse practitioner by the New York State Education Department.
4. Occupational therapist is an individual who is currently licensed as an occupational therapist by the New York State Education Department.
5. Pastoral counselor is an individual who has a master's degree or equivalent in pastoral counseling or is a Fellow of the American Association of Pastoral Counselors.
6. Physician is an individual who is currently licensed as a physician by the New York State Education Department.
7. Psychiatrist is an individual who is currently licensed as a physician by the New York State Education Department and who is certified by or eligible to be certified by, the American Board of Psychiatry and Neurology.
8. Psychologist is an individual who is currently licensed as a psychologist by the New York State Education Department. 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.

9. Registered professional nurse is an individual who is currently licensed as a registered professional nurse by the New York State Education Department.
10. Rehabilitation counselor is an individual who has either a master's degree in rehabilitation counseling from a program approved by the New York State Education Department or current certification by the Commission on Rehabilitation Counselor Certification.
11. Social worker is an individual who is either currently licensed as a licensed master social worker or a licensed clinical social worker by the New York State Education Department or has a master's degree in social work from a program approved by the New York State Education Department.
12. Therapeutic recreation specialist is an individual who has either a master's degree in therapeutic recreation from a program approved by the New York State Education Department or registration as a therapeutic recreation specialist by the National Therapeutic Recreation Society.
13. Mental Health Counselor is an individual who is currently licensed as a Mental Health Counselor by the NY State Education Department.
14. Marriage and Family Therapist is an individual who is currently licensed as a Marriage and Family therapist by the NY State Education Department

Other Professional Disciplines

May be included as professional staff with the prior written approval of the Office of Mental Health, when individuals in such disciplines shall have specified training or experience in the treatment of individuals diagnosed with mental illness.

Licensed Practitioner

Means a person defined as professional staff that is licensed by the New York State Education Department.

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