#	Category	Standard	Provisional Standard	Notes/Comments
1	Service Definition/ Required Components	Assertive Community Treatment (ACT) is an evidence-based psychiatric rehabilitation practice which provides a comprehensive approach to service delivery to consumers with serious mental illness. Services are provided by a multidisciplinary team of providers whose backgrounds and training include social work, rehabilitation, counseling, nursing and psychiatry. The entire team share responsibility for each client, with each team member contributing expertise as appropriate. The team approach ensures continuity of care for clients and creates a supportive environment for providers.		
2	Provider Requirements / Qualifications	Providers of ACT services consist of a multidisciplinary staff organized as a team in which members function interchangeably to provide treatment, rehabilitation, and support. The ACT team shall have sufficient staffing to meet the varying needs of the consumer. As an all-inclusive treatment program, a variety of expertise should be represented on the team. ACT team includes at a minimum, access to part time prescriber (psychiatrist or ARNP) plus 4.0 FTEs including at least .50 FTE nurse, 1.0 FTE QMHP/therapist, 1.0 FTE case manager, .50 FTE peer specialist. The remaining 1.0 FTE may be filled at the agency's discretion as indicated by team and consumer needs.		
3	Staffing Requirements	Caseload size will be no greater than 10 participants per team member, not including the prescriber or administrative support. Each team member must maintain licensure, certification, or credential for each individual profession with regards to required continuing education units. (e.g. Peer Specialists must receive and maintain documentation of at least 6 CEU hours per year.)		

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		All new team members receive training to become familiar with the concept of ACT as an Evidence Based Practice for adults with SMI within 2 months of hiring. All existing team members receive annual ACT refresher training.		
4	Supervision Requirements	The ACT team leader divides his/her time in approximately equal portions between supervisory/administrative and direct service roles. Team leader supervises the staff in their team functions. In addition to having ACT services supervised by the team leader, all team members must adhere to individual supervisory requirements related to their individual disciplines. (e.g. case manager must follow rules for case management supervision; peer support specialist must follow rules for peer support specialist supervision). Sometimes that role can be fulfilled by the team leader, sometimes not.	Each team member must be licensed or certified or credentialed based on each specific discipline. (e.g. QMHP must follow specific Board requirements for licensure/certification; Case managers must be Certified as a Case Manager; Peer Support Specialists must be Certified as peer specialists.)	
5	Admission Criteria	Individuals age 18 or over with serious mental illness (SMI) or a co-occurring SMI and substance use disorder. (The individual must have a primary diagnosis of SMI) ACT is an evidence-based practice for adults with SMI, specifically for individuals with schizophrenia and other major mental disorders. ACT is contraindicated for individuals with primary diagnoses of personality disorders.	Operationalizing of criteria for SMI, based on KRS 210.005. Definition based on diagnosis, disability and duration. Diagnosis: Schizophrenia and Other Psychotic Disorders, Mood Disorders, Personality Disorders (when information and history depict persistent disability and significant impairment in areas of community living). AND Clear evidence of functional impairment in two or more of the following Domains: **Societal/Role Functioning**:	

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			Functioning in the role most relevant to his/her contribution to society, and , in making that contribution, how well the individual maintains conduct within societal limits prescribed by laws, rules and strong social mores**; Interpersonal Functioning:** How well the individual establishes and maintains personal relationships including those made at work and in the family settings as well as those that exist in other settings; **Daily Living/Personal Care Functioning:** How well the individual is able to care for him/herself and provide for his/her own needs such as personal hygiene, food, clothing, shelter and transportation. The capabilities covered are mostly those of making reliable arrangements appropriate to the individual's age, gender and culture; **Physical Functioning**: Individual's general physical health, nutrition, strength, abilities/disabilities and illnesses/injuries; **Cognitive/Intellectual**	

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			Functioning: Individual's overall thought processes, capacity, style and memory in relation to what is common for the individual's age, sex and culture. An individual's response to emotional and interpersonal pressures on judgments, beliefs and logical thinking should all be considered in making this rating; AND one or more of these conditions of duration: Clinically significant symptoms of mental illness have persisted in the individual for a **continuous period of at least two years;** The individual has **been hospitalized for mental illness more than once in the last two years**; There is a history of one or more episodes with marked disability and the illness is **expected to continue for a two year period of time.**	
6	Service Planning / Documentation	ACT services must be coordinated within the context of a comprehensive individualized treatment plan which is developed through a person centered planning process. Each treatment plan will include the services and supports that will be provided, responsible party or provider, outcome/goal and target dates, and will be amended as the participant's needs change. Each service provided shall be documented in the client record. Each		

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		service note shall substantiate each individual service provided. Each service note shall include the type of service provided, the date of service, the time of service, place of service and the person providing the service. Each service note shall be signed by the person providing the service. Each ACT team member will document services he or she provides and the type of service he or she provides relative to at least one goal/objective on each client's treatment plan. Each individual ACT service shall directly relate to each client's treatment plan and each service note will reflect that. Treatment plans will be updated at least once every six months. **ASSESSMENT** The Level of Care Utilization System (LOCUS), published by the American Association of Community Psychiatrists, must be used along with an initial assessment, to determine appropriateness for an ACT level of care. Each individual must be described as consistent with a Level Four – Medically Monitored Non-Residential Services, on the LOCUS instrument to be accepted into an ACT level of care. An initial assessment must include some type of tool, such as a biopsychosocial assessment form, and must include diagnostic information and identify immediate clinical and other necessary service needs. Biopsychosocial assessments generally include information related to current suicidal/homicidal risk, past trauma or current risk of trauma, current symptoms, past symptoms, past history of treatment successes and failures, relevant medical information and current living arrangements. (assessments can include many more		

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		areas) This initial assessment will lead to an initial treatment plan with a diagnosis (can be provisional) and a set of initial goals and objectives, which may include continued assessment. A complete comprehensive assessment must be completed within 30 days of admission into ACT services. This assessment must include a description of the individual's symptoms of mental illness and their impact on deficits or barriers in the major areas of adult functioning (functional assessment), as well as a description of the individual's strengths and resources for recovery (strengths assessment). All team members are responsible for gathering information related to this assessment, but the QMHP or other appropriately qualified staff is responsible for documenting the findings and signing necessary forms. This comprehensive assessment will lead to the development of the individualized treatment plan. This process must include a person centered process and individuals must be involved in developing their own goals and objectives. The comprehensive assessment, including the functional assessment, must be updated at least every six months. **ASSERTIVE OUTREACH AND ENGAGEMENT** ACT team members must be persistent in its efforts to reach out to consumers and help them actively engage in rehabilitation and recovery. At least 60% of the team's contacts with consumers must occur in the community.		

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		The minimum number of face to face contacts per client is 10 per month. **WORK WITH NATURAL SUPPORT SYSTEM** With the consumer's permission, the ACT team provides consultation and support to natural support system of the consumer including family, friends, landlords, employers, etc., in order to reduce conflict and increase consumer autonomy and independent functioning. **CRISIS SERVICES** The ACT team must provide crisis assessment, crisis intervention and nonresidential crisis stabilization for the consumers it serves. The ACT team must have a method for responding to emergencies and crises 24 hours a day, 365 days per year. If the consumer needs access to residential crisis stabilization programs, there must be a formal agreement between the ACT team and the residential crisis program, with the consumer's permission, to share and support the individual's crisis plan.		
7	Continued Stay Criteria	Priority for continuing ACT services is given to individuals who have a substantial disability and functional impairment in 3 or more major areas of adult role functioning and/or who require intensive community services consistent with those described at a Level Four-Medically Monitored Non-Residential Services on the Level of Care Utilization System (LOCUS) Adult Version 2000. (published by the American Association of Community Psychiatrists).		

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		Other continued service criteria include: the desired outcome or level of functioning has not been restored, improved or sustained over the timeframe outlined in the individual person centered treatment plan; **OR** the individual continues to be at risk for relapse based on comprehensive assessment, history or the tenuous nature of the functional gains; **AND** at least one of the following applies: 1) the individual has achieved current goals/objectives and additional goals/objectives are indicated as evidenced by documented symptoms. 2) the individual is making satisfactory progress toward meeting goals and there is documentation that supports continuation of services to address the goals in the individual treatment plan. 3) the individual is making some progress, but the specific interventions in the individual treatment plan need to be modified so that greater gains, which are consistent with the individual's premorbid or potential level of functioning, are possible. 4) the individual fails to make progress or demonstrates regression in meeting goals/objectives through the interventions outlined in the individual treatment plan. (in this case the individual diagnosis should be reassessed to identify any unrecognized additional disorders, and goals/objectives should be revised based on the findings.) If the individual is functioning effectively with ACT services and discontinuation of services would otherwise be indicated, the ACT team services should be maintained **if it can be reasonably anticipated that regression is likely to occur if ACT services are withdrawn.** This decision should be based on either of the following: 1) the individual has a documented		

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		history of regression in the absence of ACT services or attempts to titrate ACT services downward have resulted in regression; 2) there is an epidemiologically sound expectation that symptoms will persist and that ongoing outreach treatment interventions are needed to sustain functional gains.		
8	Discharge Criteria	Each individual participant is assessed regularly, at a minimum, once every six months, to determine continuing need for ACT services. When individuals no longer meet the eligibility criteria for ACT services, they are assisted in making a transition to less intensive or "stepped down" services that better meet their needs. If it becomes evident after discontinuation of ACT services that an individual's community functioning has deteriorated and the individual is in need of ACT services, the ACT team will expedite a shift for that individual to begin receiving ACT services again.		
9	Service Setting	The ACT team provides services in natural settings, where individuals live, work and interact with other people, in the community.		
10	Service Limitations / Exclusion	Personality Disorders as a Primary Diagnosis are NOT appropriate for ACT services. Substance Use Disorders as a Primary Diagnosis are NOT appropriate for ACT services.		
11	Unit of Service	ACT services are billed as a monthly service.		
12	Service Codes	HCPC Code: H0040 DBHDID Code: 256		
13	Program Evaluation / Quality Improvement	ACT teams will meet an acceptable level of fidelity to the ACT model of service as measured by the Dartmouth Assertive Community Treatment Scale (DACT). Fidelity assessments will be provided by DBHDID or its contractors until an acceptable level of fidelity is	ACT fidelity assessments may be self-administered by the team once an acceptable level of fidelity is achieved.	

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		achieved. The ACT team must participate in all program evaluation and quality improvement activities requested by DBHDID. This may include consumer demographic and outcome data, site visits, training and technical assistance activities, fidelity assessments, etc.		
14	Program Principles	ACT services are characterized by low client to staff ratios; providing services in the community rather than in the office; shared caseloads among team members; 24-hour staff availability; direct provision of all services by the team; and time-unlimited services. Except for necessary administrative functions, the staff works as a team and do not have individual caseloads. Teams review the entire roster of consumers and exchange information about the services provided, the consumer response to these services, and the planned next steps. Additional team meetings are scheduled as necessary for assessment, service planning, staff training, and administrative purposes. Team members are expected to be available to work outside of regular office hours, including evenings, weekends and holidays, to meet consumer needs. The following services may be delivered within the program as indicated by consumer need: Intake, medication administration or monitored self-administration, individual and/or group therapy, case management, mobile crisis intervention and resolution, mental health consultation, family support and education, and basic living skills. **Psychiatrist/ARNP/ prescriber**		

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		Must be available 10 hours per week per minimum per 50 consumers. The ACT team must notify DBHDID within 5 business days of a vacancy in this position and must ensure adequate interim coverage until the position is filled. Backup coverage must be arranged when the prescriber is on vacation or is unavailable for any reason. **Licensed Nurse** Must have .50 FTE licensed nurse per 40 consumers. Must have one year of prior mental health experience, preferably in community based settings. The team must notify DBHDID within 5 business days of a vacancy in this position and must ensure adequate interim coverage until the position is filled. The Licensed Nurse collaborates with the prescriber to manage the team's medication system, to administer and document medication treatment, to conduct health assessments, to coordinate care with other health care providers, and to provide training to the team and to the consumers on psychiatric symptoms, medications, and side effects. **Qualified Mental Health Professional** QMHP as defined in KRS 202A, 011 (12). In addition to providing clinical services for ACT participants, the QMHP will provide supervision for the team. *** Please refer to the Supervisory Section of this document for further information. **Case manager** Must meet the criteria for a Certified Targeted Adult Case Manager as defined in 907 KAR 1:515 and 1:550. *** Please refer to the Supervisory Section of this document for further information. **Peer Support Specialist**		

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		Must be certified as peer specialists in accordance with 908 KAR 2:220. *** Please refer to the Supervisory Section of this document for further information.		