St. Clair County Community Mental Health
Providing Opportunities for Health, Wellness, & Connection

# Administrative Policy

## Policy Title: Assertive Community Treatment (ACT)

## Policy #: 03-001-0110

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| **Effective Date:** | 01/29/2025 |
| **Approved by:** | Telly Delor, Chief Operating Officer |
| **Functional Area:** | Program Services |
| **Responsible Leader:** | Kathleen Gallagher, Chief Clinical Officer |
| **Policy Owner:** | Jason Marocco, Adult Services Director |
| **Applies to:** | SCCCMH Staff, Directly Operated Programs, Contracted Network Providers, Community Agency Contractors |

**Purpose:** To establish a framework for the implementation, management, and evaluation of an *Assertive Community Treatment (ACT)* program within St. Clair County Community Mental Health (SCCCMH).

## I. Policy Statement

It is the policy of SCCCMH to provide an Assertive Community Treatment (ACT) program that conforms to evidence-based practice guidelines of the State and other accrediting bodies, and provides a comprehensive, flexible, and individualized array of intensive community-based rehabilitative mental health services to support individuals with serious and persistent mental illness, or co-occurring disorder, through a specialized model of treatment and services delivered by a multi-disciplinary team.

## II. Standards

**A.** The ACT team is a multidisciplinary team made up of professionals who have training and experience in psychiatry, nursing, social work, substance abuse treatment, and peer support. The ACT team members share responsibility for the individuals served by the team and meet together daily to review the status of each individual.

**B.** The ACT team provides supports to individuals to help them maintain their independence in the community; function in social, educational, and vocational settings; reduce hospitalizations; and improve outcomes so they can live a life not dominated by mental illness. The ratio between team members and individuals being served by the team should be no more than 1:10 (for each member of the team, a maximum of 10 beneficiaries, excluding the physician, peers who do not meet paraprofessional or professional criteria,

and clerical support staff).

**C.** The ACT team remains the fixed point of responsibility for the development of the Individual Plan of Service (IPOS) and coordinates all services and supports to be provided to or obtained for the individual, including consultation with other disciplines and coordination of other supportive services as appropriate. Care continuity is maintained with pre-admission screening, team contact during inpatient psychiatric hospitalizations, and team participation in transition and discharge planning. The ACT team facilitates contacts between individuals and various providers who offer a tailored combination of services and supports and works closely with those providers to give individuals a highly integrated array of services that best meet their needs.

**D.** The ACT team provides services and supports to individuals for as long as they are needed and has the capacity to provide rapid response, including the ability to provide multiple contacts and/or visits daily, as needed.

**E.** As individuals progress toward their recovery goals, their needs may vary or progress into less intensive services over time, but services will continue to be available if a need for additional support arises. The ACT team is designed to quickly respond to changes in treatment intensity to avoid negative consequences such as incarceration, loss of relationships, loss of housing, or hospitalization.

**F.** The ACT team provides basic services and supports related to socialization opportunities, employment assistance, family psychoeducation, health care, support groups, locating housing, substance abuse treatment, grocery shopping, legal assistance, transportation, education, meal planning, problem solving, medication monitoring, and money management. The majority of the services (at least 80% of all services) are provided in the individual's home or other community locations.

**G.** Crisis response services are provided directly by ACT team members 24 hours a day, 7 days a week.

**H.** ACT Program Eligibility Criteria. An individual eligible for ACT services Is experiencing current acute or severe psychiatric symptoms that are seriously impairing their ability to function independently, and whose symptoms impede the return of normal functioning as a result of the diagnosis of a serious mental illness and may have a co-existing developmental disability or substance use disorder. Areas of difficulty may include:

- maintaining or having interpersonal relationships with family and friends
- accessing needed mental health and physical health care
- addressing issues relating to aging, especially where symptoms of serious mental illness may be exacerbated or confused by complex medical conditions or complex medication regimens
- performing activities of daily living or other life skills
- managing medications without ongoing support
- maintaining housing
- avoiding arrest and incarceration, navigating the legal system, and transitioning back to the community from jail or prison

- coping with relapses or return of symptoms given an increase in psychosocial stressors or changes in the environment resulting in frequent use of hospital services, emergency departments, crisis services, crisis residential programs or homeless shelters
- maintaining recovery to meet challenges of a co-occurring substance use disorder
- encountering difficulty in past or present progress toward recovery despite participation in long-term and/or intensive services

**I.** Discharge from the ACT program. Cessation or control of symptoms alone is not sufficient for discharge from ACT. When individuals have progressed towards recovery and are ready for a less intensive service, the IPOS should document the transition from ACT to less intensive service, such as case management.

1. Recovery must be sufficient to maintain functioning without the support of ACT as identified through the person-centered planning process as described below:
   - the individual no longer meets severity of illness criteria combined with the individual's demonstrated ability to meet all major role functions for a period of time sufficient to show clinical stability
   - the individual has requested transition to other services because they believe they have received the maximum benefit from ACT, and clinical evidence reviewed during the person-centered planning process supports the individual's desire to transition; the IPOS must contain a detailed transition plan that identifies the supports and services that will be made available and a provision for re-certification into ACT services, if needed
2. Other reasons for discharge exist when:
   - An individual is not engaging in ACT services; even though deliberate, persistent, and frequent assertive team outreach has occurred, including documented face-to-face engagement attempts and legal mechanisms, when necessary, which have been consistent but unsuccessful and an appropriate alternative plan has been established with the individual
   - An individual has moved outside of the geographic service area; however, contact continues until service has been established in the new location.

## III. Procedures, Definitions, and Other Resources

### A. Procedures

#### Responsibilities

The ACT Program is unique in the sense that the ACT team collectively shares the responsibility of providing the full spectrum of services to each individual served.

| Position | Responsibilities |
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| Clinician | 1. Conduct assessments and makes diagnostic evaluation.<br>2. Provide treatment services delineated within the Individual Plan of |

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| | Service (IPOS).<br>3. Keep case record updated: BPS, IPOS, Periodic Review and Amendments.<br>4. Provide linking, monitoring, planning, advocacy, coordination and assessing as needed within the agency and/or with community agencies.<br>5. Develop Group interventions<br>6. Develop and train staff on interventions to address and promote recovery<br>7. Follow evidenced based practice i.e. Recovery, IDDT, DBT, FPE, and Supported Employment as required.<br>8. Provide individual and group therapy.<br>9. Provide crisis intervention.<br>10. Completes any necessary forms for the file and/or to meet the needs of the individual.<br>11. Coordinates with health care providers and advocates as necessary.<br>12. Assist with life skill development.<br>13. Instruct and direct self-care.<br>14. Assist with social interaction, gross and fine motor coordination. |
| Case Manager | 15. Provide linking, monitoring, planning, advocacy, coordination and assessing as needed within the agency and/or with community agencies.<br>16. Provide treatment services delineated within the Individual Plan of Service (IPOS).<br>17. Keep case record updated: BPS, IPOS, Periodic Review and Amendments.<br>18. Follow evidenced based practice i.e. Recovery, IDDT, DBT, FPE, and Supported Employment as required.<br>19. Provide crisis intervention.<br>20. Facilitate Groups<br>21. Complete any necessary forms for the file and/or to meet the needs of the individual.<br>22. Coordinate with health care providers and advocate as necessary.<br>23. Assist with life skill development.<br>24. Instruct and direct self-care.<br>25. Assist with social interaction, gross and fine motor coordination. |
| Nurse | 26. Meet with individual for nursing interventions as needed, including injections of prescribed psychotropic medication.<br>27. Coordinate with health care providers and advocates as necessary.<br>28. Coordinate with the pharmacy to ensure refills are received in a timely manner.<br>29. Check in prescription and fill medication boxes as necessary.<br>30. Provide crisis intervention.<br>31. Provide treatment services delineated within the Individual Plan of Service (IPOS).<br>32. Provide linking, monitoring, planning, advocacy, coordination and assessing as needed within the agency and/or with community agencies.<br>33. Follow evidenced based practice i.e. Recovery, IDDT, DBT, FPE, and Supported Employment as required.<br>34. Complete any necessary forms for the file and/or to meet the needs |

| Position | Responsibilities |
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| | of the individual.<br>35. Facilitate Groups<br>36. Assist with life skill development.<br>37. Instruct and direct self-care.<br>38. Assist with social interaction, gross and fine motor coordination. |
| Mental Health Assistant | 39. Provide treatment services delineated within the Individual Plan of Service (IPOS).<br>40. Assist with life skill development.<br>41. Instruct and direct self-care.<br>42. Assist with social interaction, gross and fine motor coordination.<br>43. Link with community supports.<br>44. Provide crisis intervention.<br>45. Follow evidenced based practice i.e. Recovery, IDDT, DBT, FPE, and Supported Employment as required.<br>46. Facilitate groups<br>47. Complete any necessary forms for the file and/or to meet the needs of the individual.<br>48. Coordinate with health care providers and advocates as necessary. |
| Peer Support Specialist | 49. Assist with life skill development.<br>50. Instruct and direct self-care.<br>51. Assist with social interaction, gross and fine motor coordination.<br>52. Link with community supports.<br>53. Educate about available resources.<br>54. Provide treatment services delineated within the Individual Plan of Service (IPOS).<br>55. Follow evidenced based practice i.e., Recovery, IDDT, DBT, FPE, and Supported Employment as required.<br>56. Facilitate groups<br>57. Complete any necessary forms for the file and/or to meet the needs of the individual.<br>58. Coordinate with health care providers and advocate as necessary. |

## B. Related Policies

Administrative Policy #01-002-0015, Clinical Service Protocols & Practice Guidelines

Administrative Policy #02-002-0005, Customer Services and Access to Customer Service Department

Board Policy #03-001-0005, Person Centered Planning Process

Administrative Policy #03-001-0045, Court Ordered Treatment (Including Involuntary Hospitalization)

Administrative Policy #03-002-0075, Referrals for Collaborative Treatment

Administrative Policy #03-003-0050, Outreach & Discharge

Administrative Policy #03-003-0080, Zero Suicide: Suicide Prevention Program

Administrative Policy #04-003-0090, Medication Review and Psychiatric Evaluation Appointment Preparation

### C. Definitions

1. *Assertive Community Treatment (ACT):* An evidence-based practice that improves outcomes for people with severe mental illness who are most at-risk of psychiatric crisis and hospitalization and involvement in the criminal justice system. ACT services are based on the principles of recovery and person-centered practice and are individually tailored to meet the needs of the individual receiving services. ACT is a multidisciplinary team-based service whose team members share responsibility for service delivery.
2. *Individual Plan of Service (IPOS):* A written plan of service that specifies goal-oriented treatment or training and support services, directed by the individual as required by the Mental Health Code. The IPOS identifies the needs and goals of the individual receiving services; and the amount, duration and scope of the services and supports to be provided. For persons receiving mental health services, the individual plan of service must be developed through a person-centered planning process. In case of minors, the child and his family are the focus of service planning, and family members are an integral part of the treatment planning process. This document may be referred to as a treatment plan or a support plan.

### D. Forms

#0916 ACT Outcomes Report with Instructions

### E. Other Resources (i.e., training, secondary contact information, exhibits, etc.)

N/A

### F. References

1. MDHHS Medicaid Provider Manual, Behavioral Health and Intellectual and Developmental Disability Support and Services, Section 4 – Assertive Community Treatment Program
2. Medicaid State Plan 1915 (B)

## IV. History

- Adopted: 01/ /2025
- Last Revised: n/a
- Last Reviewed: 01/ /2025 BY: Jason Marocco, Joy Vittone
- Non-Substantive Revisions: n/a
- Key Words: evidence-based practice, client-centered, integrated services, crisis intervention, community-based, recovery-orientated, stabilization