Assertive Community Treatment

Assertive Community Treatment (ACT) services are therapeutic interventions that address the functional problems of individuals who have the most complex and/or pervasive conditions associated with a major mental illness or co-occurring addictions disorder. These interventions are strength-based and focused on promoting symptom stability, increasing the individual's ability to cope and relate to others and enhancing the highest level of functioning in the community.

Interventions may address adaptive and recovery skill areas, such as supportive or other types of housing, school and training opportunities, daily activities, health and safety, medication support, harm reduction, money management and entitlements and service planning and coordination.

The primary goals of the ACT program and treatment regimen are:

- To lessen or eliminate the debilitating symptoms of mental illness each individual consumer experiences and to minimize or prevent recurrent acute episodes of the illness.
- To meet basic needs and enhance quality of life.
- To improve functioning in adult social and employment roles and activities.
- To increase community tenure.
- To lessen the family's burden of providing care.

The fundamental principles of this program are that:

- The ACT team is the primary provider of services and, as such, functions as the fixed point of responsibility for the consumer.
- Services are provided in the community.
- The services are person-centered and individualized to each particular person.

Target population

ACT serves persons who have a severe and persistent mental illness (SPMI) listed in the diagnostic nomenclature (current diagnosis per DSM 5) that seriously impairs their functioning in the community.

The individual must have one of the following diagnoses:

- Schizophrenia;
- Other psychotic disorder;
- Bipolar disorder; and/or
- Major depressive disorder.

These may also be accompanied by any of the following:

- Substance use disorder; or
- Developmental disability.

Include one or more of the following service needs:

- Two or more acute psychiatric hospitalization and/or four or more emergency room visits in the last six months.
- Persistent and severe symptoms of a psychiatric disability that interferes with the ability to function in daily life.
- Two or more interactions with law enforcement in the past year for emergency services due to mental illness or substance use (this includes involuntary commitment, ACT/forensic assertive community treatment (FACT)).
- Currently residing in an inpatient bed, but clinically assessed to be able to live in a more independent situation if intensive services were provided.
- One or more incarcerations in the past year related to mental illness and/or substance use (FACT).
- Psychiatric and judicial determination that FACT services are necessary to facilitate release from a forensic hospitalization or pre-trial to a lesser restrictive setting (FACT).

- Recommendations by probation and parole, or a judge with a FACT screening interview, indicating services are necessary to prevent probation/parole violation (FACT).

Must have one of the following:

- Inability to participate or remain engaged or respond to traditional community-based services;
- Inability to meet basic survival needs, or residing in substandard housing, homeless or at imminent risk of becoming homeless; or
- Services are necessary for diversion from forensic hospitalization, pretrial release or as a condition of probation to a lesser restrictive setting (FACT).

Must have three of the following:

- Evidence of co-existing mental illness and substance use disorder;
- Significant suicidal ideation, with a plan and ability to carry out within the last two years;
- Suicide attempt in the last two years;
- History of violence due to untreated mental illness/substance use within the last two years;
- Lack of support systems;
- History of inadequate follow-through with treatment plan, resulting in psychiatric or medical instability;
- Threats of harm to others in the past two years;
- History of significant psychotic symptomatology, such as command hallucinations to harm others;
- Minimum LOCUS score of 3.

Exception criteria:

- The individual does not meet medical necessity criteria I or II, but is recommended as appropriate to receive ACT services by the funding agency or designee, the ACT team leader, clinical director and psychiatrist, in order to protect public safety and promote recovery from acute symptoms related to mental illness.

Program requirements

ACT services must be provided by an interdisciplinary team. Individuals on this team shall have sufficient individual competence, professional qualifications and experience to provide service coordination; crisis assessment and intervention; symptom assessment and management; individual counseling and psychotherapy; medication prescription, administration, monitoring and documentation; substance use treatment; work-related services; activities of daily living services; social, interpersonal relationship and leisure-time activity services; support services or direct assistance to ensure that individuals obtain the basic necessities of daily life; direct assistance to ensure that individuals obtain supportive housing, as needed; and education, support, and consultation to individuals' families and other major supports. ACT is a medical, comprehensive case management and psychosocial intervention program provided on the basis of the following principles:

- The service is available 24 hours a day, seven days a week.
- An individualized service plan and supports are developed.
- At least 90 percent of services are delivered as community-based outreach services.
- An array of services are provided based on individual patient medical need.
- The service is consumer-directed.
- The service is recovery-oriented.

The ACT team must:

- Operate a continuous after-hours on-call system with staff that is experienced in the program and skilled in crisis intervention (CI) procedures. The ACT team must have the capacity to respond rapidly to emergencies, both in person and by telephone.

- Provide mobilized CI in various environments, such as the recipient's home, schools, jails, homeless shelters, streets and other locations.

- Arrange or assist consumers to make a housing application, meet their housing obligations and gain the skills necessary to maintain their home.

- Be involved in psychiatric hospital admissions and discharges and actively collaborate with inpatient treatment staff.

- Ensure provision of culturally competent services.

- ACT team must conduct ongoing monitoring and evaluation of program implementation through the collection of process and outcome measures. Process measures should be obtained through utilization of the EBP Fidelity Scale and General Organizational Index as found within the SAMHSA ACT Toolkit. Outcome measures such as homelessness, hospitalizations, incarcerations, employment and educational status should be collected in addition to the EBP fidelity measures.

The ACT program provides three levels of interaction with the participating individuals:

- Face-to-face encounter – At least 60 percent of all ACT team activities must be face-to-face, with approximately 90 percent of these encounters occurring outside of the office.

- Collateral encounter – Collateral refers to members of the recipient's family or household or significant others (e.g., landlord or property manager, criminal justice staff and employer) 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

(e.g., meeting with a shelter staff person who is assisting an ACT recipient in locating housing).

- Assertive outreach – Refers to the ACT team being 'assertive' about knowing what is going on with an individual and acting quickly and decisively when action is called for, while increasing member independence. The team must closely monitor the relationships that the individual has within the community and intervene early if difficulty arises.

ACT staff must provide a minimum of six encounters with the service recipient or collateral contacts monthly and must document clinically appropriate reasons if this minimum number of encounters cannot be made monthly. At least 50 percent of the encounters shall be with the service recipient. Efforts shall be made to ensure services are provided throughout the month.

The teams will provide comprehensive, individualized services, in an integrated, continuous fashion, through a collaborative relationship with persons with SPMI.

The ACT program utilizes a treatment model that is non-confrontational, follows behavioral principles, considers interactions of mental illness and substance use and has gradual expectations for abstinence.

The teams will provide the following supports and services to consumers:

- Needs assessment and individualized care plan development: This will include items relevant for any specialized interventions, such as linkages with the forensic system for consumers involved in the judicial system. In particular, the assessment will include items related to court orders, identified within 30 days of admission and updated every 90 days or as new court orders are received.

- Crisis assessment and intervention.

- Symptom management and mediation.

- Individual counseling.

- Medication administration, monitoring, education and documentation.

- Skills training in activities related to self-care and daily life management, including utilization of public transportation, maintenance of living environment, money

management, meal preparation, locating and maintaining a home, skills in landlord/tenant negotiations and renter's rights and responsibilities.

- Social skills training necessary for functioning in a work, educational, leisure or other community environment.
- Peer support.
- Addiction treatment and education, including counseling, relapse prevention, harm reduction, anger and stress management.
- Referral and linkage or direct assistance to ensure that individuals obtain the basic necessities of daily life, including medical, social and financial supports.
- Education, support and consultation to individuals' families and other major supports.
- Monitoring and follow-up to help determine if psychiatric, substance use, mental health support and health related services are being delivered, as set forth in the care plan, adequacy of services in the plan and changes, needs or status of consumer.
- The team will assist the consumer in applying for benefits. This includes Social Security Income, Medicaid and Patient Assistance Program enrollment.
- For those members with forensic involvement, the team will liaise with the forensic coordinators, providing advocacy, education and linkage with the criminal justice system to ensure the consumer's needs are met in regards to their judicial involvement, and that they are compliant with the court orders.
- Service provision for ACT will be based on comprehensive history and ongoing assessment of:
    - Psychiatric history, status and diagnosis.
    - Level of Care Utilization System (LOCUS).
    - Telesage Outcomes Measurement System, as appropriate.
    - Psychiatric evaluation.
    - Housing and living situation.
    - Vocational, educational and social interests and capacities.
    - Self-care abilities.

- Family and social relationships.
- Family education and support needs.
- Physical health.
- Alcohol and drug use.
- Legal situation.
- Personal and environmental resources.

Each of these assessments will be completed within 30 days of admission. The LOCUS, psychiatric evaluation and treatment plan will be updated every six months, with an additional LOCUS score being completed prior to discharge.

Provider Qualifications and Responsibilities

The MCO may contract with ACT teams meeting national fidelity standards as evidenced by the SAMHSA Assertive Community Treatment (ACT) Evidence-Based Practices (EBP) Toolkit.

ACT agencies must be licensed pursuant to La. R.S. 40:2151, et. seq. for behavioral health service providers and accredited by an LDH approved national accrediting body: Commission on Accreditation of Rehabilitation Facilities (CARF), Council on Accreditation (COA) or The Joint Commission (TJC). Denial, loss of, or any negative change in accreditation status must be reported in writing immediately upon notification by the accrediting body of such denial, loss of, or any negative change in accreditation status to the managed care entities with which the ACT agency contracts or is reimbursed.

NOTE: Effective March 14, 2017, ACT agencies must apply for accreditation and pay accreditation fees prior to being contracted with or reimbursed by a Medicaid managed care entity, and must maintain proof of accreditation application and fee payment. ACT agencies must attain full accreditation within 18 months of the initial accreditation application date. ACT Agencies contracted with a managed care entity prior to March 14, 2017, must attain full accreditation by September 14, 2018, i.e. 18 months from the initial effective date of the requirement for ACT agencies.

The provider agency must meet all qualifications as required for other outpatient and rehabilitation agencies and must maintain documentation and verification of licensure, accreditation, staff criminal background checks, TB testing, drug testing, evidence of fidelity to the model (via SAMHSA ACT EBP Toolkit) and required training for staff employed or contracted with the agency.

ACT agencies must adhere to all requirements established in the Provider Responsibilities section located in the Outpatient Services: Rehabilitation Services chapter of this manual. Please refer to that section for specific information on all provider responsibilities.

Each ACT team shall have sufficient numbers of staff to provide treatment, rehabilitation and support services 24 hours a day, seven days per week. Each ACT team shall have the capacity to provide the frequency and duration of staff-to-program member contact required by each recipient's individualized service plan.

Each ACT team shall have the capacity to increase and decrease contacts based upon daily knowledge of the program member's clinical need, with a goal of maximizing independence. The team shall have the capacity to provide multiple contacts to persons in high need and a rapid response to early signs of relapse. The nature and intensity of ACT services are adjusted through the process of daily team meetings.

Each ACT team shall include at least:

- One qualified ACT team leader.
- One board-certified or board-eligible psychiatrist.
- Two nurses, at least one of whom shall be a RN.
- One other licensed mental health professional.
- One substance use service provider.
- One employment specialist.
- One housing specialist.
- One peer specialist.

Each ACT team shall have a staff-to-individual ratio that does not exceed 10:1. Any ACT team vacancies that occur will be filled in a timely manner to ensure that these ratios are maintained. All professional staff must be currently and appropriately licensed by the applicable professional board. Prior to providing the service, each member receives an assessment of initial training needs based on the skills and competencies necessary to provide ACT services. Each staff person must meet the required skills and competencies within six months of their employment on an ACT team. Successful completion of LDH-approved trainings can satisfy this requirement.

Allowed Provider Types and Specialties

- PT AA Assertive Community Treatment Team, PS 8E CSoC/Behavioral Health

Planning and documentation requirements

A comprehensive assessment must be completed within 40 days of admission to the program. A service plan, responsive to the individual's preferences and choices and signed by the individual, must be developed and in place at the time services are rendered.

Each individual service plan must consist of the following:

- The individual's specific mental illness diagnosis.
- Plans to address all psychiatric conditions.
- The individual's treatment goals and objectives (including target dates), preferred treatment approaches and related services.
- The individual's educational, vocational, social, wellness management, residential or recreational goals, associated concrete and measurable objectives and related services.
- The individual's goals and plans, and concrete and measurable objectives necessary for a person to get and keep their housing.
- When psycho-pharmacological treatment is used, a specific service plan, including identification of target symptoms, medication, doses and strategies to monitor and promote commitment to medication, must be used.

- A crisis/relapse prevention plan, including an advance directive.
- An integrated substance use and mental health service plan for individuals with c0-co-occurring disorder (COD).

Documentation shall be consistent with the Dartmouth Assertive Community Treatment Scale (DACTS), which is an ACT Fidelity Scale found in the SAMHSA toolkit for ACT. The individual service plan will include input of all staff involved in treatment of the individual, as well as involvement of the individual's and collateral others' of the individual's choosing. In addition, the plan must contain the signature of the psychiatrist, the team leader involved in the treatment and the individual's signature (refusals must be documented).
The individual service plan is reviewed and updated every six months. A tracking system is expected of each ACT team for services and time rendered for or on behalf of any individual.

Exclusions

ACT services are comprehensive of all other services, with the exception of psychological evaluation or assessment and medication management. These may be provided and billed separately for a recipient receiving ACT services.

ACT shall not be billed in conjunction with the following services:

- Behavioral health (BH) services by licensed and unlicensed individuals, other than medication management and assessment.
- Residential services, including professional resource family care.

Billing

Only direct staff face-to-face time with the member or family may be billed. ACT may be billed for under CPST but must be consistent with the CPST State Plan definition. CPST is a face-to-face intervention with the individual present; however, family or other collaterals may also be involved. Medicaid also does not pay when the vocational supports provided via ACT qualify for vocational rehabilitation funding, even if the vocational rehabilitation services are not available.

Intensive case management (ICM) may be billed using a combination of codes licensed practitioner, PSR and CPST, subject to prior authorization. ICM is not an EBP and use of research based and evidence based practices is preferred over the use of ICM.

NOTE: Individualized substance use treatment will be provided to those consumers for whom this is appropriate; co-occurring disorder treatment groups will also be provided off-site of the ACT administrative offices, though they do not take the place of individualized treatment. Substance use/mental health treatment will also include dialectical behavioral therapy, cognitive behavioral therapy (CBT) and motivational enhancement therapy.