

# Ontario Program Standards for ACT Teams

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Ontario's first edition of the ACT Program Standards was published in 1998. This updated edition builds upon the work of Deborah Allness, M.S.S.W. and William Knoedler, M.D. who have written *The National Program Standards for ACT Teams*, published in 2003. They have kindly granted us permission to use their work in customizing Program Standards for Ontario. The Ministry of Health and Long-Term Care, Province of Ontario would like to thank the authors for the use of their material.

The Standards for this program are largely based on those developed for the Program of Assertive Community Treatment (PACT) in the United States. The original PACT Standards were developed after almost 20 years of field testing in various jurisdictions. A number of second and third generation studies of ACT programs in the U.S. have shown that ACT programs have not always achieved a similar degree of positive outcomes as the original PACT research. Typically, lack of strong fidelity to the ACT model is the demonstrated contributor to poorer results. Therefore, this new version of the *Ontario Program Standards for ACT Teams* not only provides minimum Standards for program operations, but it also provides brief descriptions of the rationale for many of the ACT requirements which have been difficult for providers and administrators to understand and implement. These ACT Standards highlight that ACT is a client-centred, recovery-oriented service delivery model. Client empowerment, involvement, and choice are fundamental to the principles and operation of individualized, collaborative and effective ACT service delivery.

The purpose of Standards is to define precisely: 1) for whom a program is intended; 2) the required services; 3) the type of staff/numbers needed to competently provide the services; and 4) the intended benefits/outcomes for the clients receiving the services. Program Standards are used to establish costs and are used for program monitoring and compliance purposes. In addition, Standards must adhere to related federal and provincial legislation.

## ACT Program Standards

*The Ontario Program Standards for ACT Teams* serves to guide ACT program start-up and implementation by clearly defining what are the minimum program requirements. Successful ACT model implementation and demonstrated improvements in client outcomes are best accomplished by close adherence to the ACT Standards: i.e., serving persons with the most serious mental illnesses; multidisciplinary staffing with at least one peer specialist; low staff-to-client ratios and intensive services; staff who work weekday, evening, and weekend/holiday shifts and provide 24-hour on-call services; team organizational and communication structure; client-centred individualized assessment and treatment/service planning\*; and up-to-date individually-tailored treatment, rehabilitation, and support services based on the original Madison, Wisconsin PACT research project.

There are fourteen sections of the ACT Program Standards. At the beginning of each section, the overall purpose and rationale for that section is explained. In addition, throughout the Standards, text boxes will provide further explanation regarding program components. Please see the Appendix for definitions of terms used in the document.

\* The use of the term "treatment/service planning" reinforces that ACT teams provide treatment, rehabilitation and support services. Some teams may use different terminology such as "recovery" planning or "care" planning.

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# I. Introduction

Assertive Community Treatment (ACT) is a client-centered, recovery-oriented mental health service delivery model that has received substantial empirical support for facilitating community living, psychosocial rehabilitation, and recovery for persons who have the most serious mental illnesses, have severe symptoms and impairments, and have not benefited from traditional out-patient programs.

The important characteristics of assertive community treatment programs are:

- ACT serves clients with serious mental illnesses that are complex and who have very significant functional impairments, and who, because of the limitations of traditional mental health services, may have gone without appropriate services. Consequently, the client group is often over-represented among the homeless and in jails and correctional facilities, and has been unfairly thought to resist or avoid involvement in treatment.
- ACT services are delivered by a group of multidisciplinary mental health staff who work as a team and provide the majority of the treatment, rehabilitation, and support services clients need to achieve their goals. The team is directed by a team coordinator and a psychiatrist and includes a sufficient number of staff from the core mental health disciplines, at least one peer specialist, and a program/administrative support staff who work in shifts to cover 24 hours per day, seven days a week to provide intensive services (multiple contacts may be as frequent as two to three times per day, seven days per week, and are based on client need and a mutually agreed upon plan between the client and ACT staff). Many, if not all, staff share responsibility for addressing the needs of all clients requiring frequent contact.
- ACT services are individually tailored with each client and address the preferences and identified goals of each client. The approach with each client emphasizes relationship-building and active involvement in assisting individuals with serious mental illness to make improvements in functioning, to better manage symptoms, to achieve individual goals, and to maintain optimism.
- The ACT team is mobile and delivers services in community locations to enable each client to find and live in their own residence and find and maintain work in community jobs rather than expecting the client to come to the program. Seventy-five per cent or more of the services are provided outside of the program offices in locations that are comfortable and convenient for clients.
- ACT services are delivered in an ongoing rather than time-limited framework to aid the process of recovery and ensure continuity of caregiver. Serious mental illnesses are episodic disorders and many clients benefit from the availability of a longer-term treatment/service approach and continuity of care. This allows clients opportunity to re-compensate, consolidate gains, sometimes slip back, and then take the next steps forward until they achieve recovery.
- ACT teams are required to have policies and procedures for each of the areas identified in the Standards. Once policies and procedures are in place, they maintain the organizational and service structure that supports the work and are useful in orienting and training new staff.

ACT Standards require “ACT Policies and Procedures.” Typically, the larger agency operating ACT has written policies and procedures, but because ACT programs are freestanding programs, because they are complex to operate, because staff work as a team, and because services are integrated, agency standards alone are not sufficient. Therefore, the team coordinator has the responsibility to write policies and procedures for each of the areas identified in the Standards.

## II. Intake, Admission and Discharge Criteria

*Admission decisions are based on considerations that include admission criteria, current caseload status, staff capacity, ability to manage risk in the community and overall team and organizational functioning. The ACT Program Standards establish written expectations for intake as well as admission and discharge criteria. The reasons for this are: 1) to ensure that clients with the most serious mental illnesses have top priority for ACT services; and 2) to prohibit people with severe mental illness from being inappropriately discharged or dropped from ACT services because of the complexity involved in engaging and finding effective interventions to achieve recovery.*

### A. Intake

It is important that ACT teams find ways to expedite the entire intake and admission process. ACT teams are expected to take the initiative to develop collaborative intake processes with their relevant community and institutional referral sources to determine eligibility for admission, and to effectively prioritize and engage new clients.

ACT teams must have clearly written and easily accessible, published admission criteria, consistent with these standards and readily available to the community at large.

Each ACT team shall stagger client admissions (e.g., 4-6 clients per month) to gradually build up to full capacity. The rate of intake may be more gradual for reasons such as relatively inexperienced staff, where there are significant staffing gaps on the team or where teams are approaching full capacity. Intake occurs monthly until the team has reached capacity. Mature teams will continue to admit new clients if they are not at capacity due to discharges.

Staff resources, organizational structures and processes must be adequate to safely admit clients with specialized needs. The rate of intake and proportion of caseload consisting of highly specialized populations (i.e., individuals with complex comorbid disorders) should be carefully monitored.

The ACT team follows a systematic process in beginning to work with individual clients which includes screening clients referred for admission; arranging and having an admission meeting to begin to establish a relationship with each client and their family; conducting an initial assessment and establishing an initial treatment/service plan in collaboration with each client and their family; providing immediate treatment, rehabilitation and support services; and conducting the comprehensive assessment and establishing the first individualized treatment/service plan with each client, all of which takes time to do well. Therefore, the clients must be admitted gradually (e.g., 4-6 clients per month) rather than starting out at full capacity. Due to smaller team size and geographical distances, rural/smaller size teams in particular may need to admit fewer clients per month.

**Please note:** While the team is building up to the number of clients the team will eventually serve, it still takes full staffing to cover the hours, provide the intensity of services, and do the labor intensive engagement and thorough assessment/treatment planning that clients with the most serious mental illness and their families deserve in order to develop a plan for recovery.

## B. Admission Criteria

The following criteria are to be used by an ACT team in selecting clients “in the greatest need” of ACT services:

1. Clients with serious mental illnesses listed in the diagnostic nomenclature (currently the Diagnostic and Statistical Manual, Fourth Edition, or DSM IV, of the American Psychiatric Association) that seriously impair their functioning in community living. Priority is given to people with schizophrenia, other psychotic disorders (e.g., schizoaffective disorder), and bipolar disorder because these illnesses more often cause long-term psychiatric disability and because of ACT’s proven effectiveness with this population. Clients with other psychiatric illnesses are eligible depending on the level of the long-term disability. (Individuals with a primary diagnosis such as a substance abuse disorder, developmental disability and organic disorders are not the intended client group.)

**and**

2. Clients with significant functional impairments as demonstrated by at least one of the following conditions:
  - a. Inability to consistently perform the range of activities of daily living required for basic adult functioning in the community (e.g., caring for personal business affairs; obtaining medical, legal, and housing services; recognizing and avoiding common dangers or hazards to self and possessions; meeting nutritional needs; maintaining personal hygiene) or persistent or recurrent difficulty performing daily living tasks except with significant support or assistance from others such as friends, family, or relatives.
  - b. Inability to maintain consistent employment at a self-sustaining level or inability to consistently carry out the homemaker role (e.g., household meal preparation, washing clothes, budgeting, or child-care tasks and responsibilities).
  - c. Inability to consistently maintain a safe living situation (e.g., repeated evictions or loss of housing).

**and**

3. Clients with one or more of the following problems, which are indicators of continuous high-service needs (i.e., greater than eight hours per month):
  - a. High use of Schedule 1 hospital services or specialty hospital services, tertiary level services, or psychiatric emergency services such as mental health crisis response services.
  - b. Intractable (i.e., persistent or very recurrent) severe major symptoms (e.g., affective, psychotic, suicidal).
  - c. Coexisting substance abuse disorder of greater than six months.
  - d. Involvement with the criminal justice system due to mental disorder, assessed at low to moderate risk in the community, and the ACT team has determined that it is able to manage the current level of risk in the community.
  - e. Inability to consistently meet basic survival needs, residing in substandard housing, homeless, or at imminent risk of becoming homeless.
  - f. Residing in an in-patient or supervised community residence, but clinically assessed as being able to live in a more independent living situation if intensive services are provided, or requiring a residential or institutional placement if more intensive services are not available.
  - g. Difficulty effectively utilizing traditional office-based out-patient services.

All ACT teams are encouraged to admit clients who meet ACT admission criteria and have had involvement with the criminal justice system at all levels (e.g., clients who have been diverted, clients on probation or parole, or clients of the Ontario Review Board).
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#### 4. Assertive Engagement, Admission and Consent

Clients who are accepted for service by the ACT team may require an assertive engagement process in order to establish a relationship with the ACT team and provide informed consent to receive treatment/service. In the case of clients who repeatedly decline the attempts at engagement by the ACT team over time and indicate that these interventions are unwelcome, ACT teams must reassess the engagement process and establish a time frame for terminating the interventions.

ACT clients are admitted when the team assumes responsibility for providing the treatment/service. Consent to treatment by the ACT team shall be obtained from the client personally if he or she is capable, or from an incapable client's substitute decision-maker, in accordance with applicable legislation.

Note: The term "treatment" is defined quite broadly in applicable legislation governing consent and would encompass many of the types of services provided by an ACT team.

#### 5. Documentation of admission shall include:

- a. The reasons for admission as stated by both the client and the ACT team.
- b. Signature of psychiatrist or indication of agreement to accept responsibility for the client by the psychiatrist (electronic).

#### 6. Documentation of Service Refusal

When a referral is refused by an ACT team, the team shall provide written documentation of the reasons for refusing service to the referral source.

The ACT model has demonstrated effectiveness for "clients in the greatest need," who are estimated to make up 20 per cent to 40 per cent of the total group of persons with serious mental illnesses. Historically these clients have not received adequate assessment and appropriate services and are typically not even being served in traditional mental health settings. Therefore, admission criteria ensure that the ACT program serves the intended client group. ACT was once considered the service of last resort when, in fact, research has shown that clients benefit from earlier access to ACT.

For example, high use of acute psychiatric care should indicate need for more intensive and continuous services in the community, just as intractable and severe major symptoms should indicate need for high-quality individualized assessment, intervention, and support. Both indicators of problems meriting ACT services should bring about appropriate assessment and interventions as well as compassionate and immediate support for the client and his or her family and support system.

## C. Discharge Criteria

#### 1. Discharges from the ACT team occur when clients and program staff mutually agree to the termination of services. This shall occur when clients:

- a. Have successfully reached individually established goals for discharge. Program staff will arrange for transfer to a less intensive service and maintain contact with the client until transfer is complete.

**or**

- b. Have successfully demonstrated an ability to function in all major role areas (i.e., work, social, self-care) without ongoing assistance from the program, without significant relapse when services are withdrawn (over approximately a two-year period).



**or**

- c. Move outside the geographic area of ACT's responsibility. In such cases, the ACT team shall partner with the client to arrange for transfer of mental health service responsibility to an ACT program or another provider wherever the client is moving. The ACT team shall maintain contact with the client until this service transfer is implemented.

**or**

- d. Decline or refuse services and request discharge, despite the team's intensive and persistent efforts to develop an acceptable treatment/service plan with the client.

2. Documentation of discharge shall include:

- a. The reasons for discharge as stated by both the client and the ACT team.
- b. The client's biopsychosocial status at discharge.
- c. A written final evaluation summary of the client's progress toward the goals set forth in the treatment/service plan.
- d. A plan developed in conjunction with the client for follow-up treatment/service after discharge.
- e. The signature of the client (when possible), the client's service coordinator, the team coordinator, and the psychiatrist.

3. The ACT team must facilitate readmission as a priority when required. In view of ACT's long-term commitment to its clients, the readmission process should be timely and uncomplicated.

Each discharge is carefully evaluated because clients with the most serious mental illness frequently have been inappropriately discharged. Monitoring discharges is a critical program evaluation activity. ACT is a service model that has demonstrated that when services for persons with longer-term episodic disorders are delivered in a continuous rather than time-limited framework, relapse can be addressed and treatment gains maintained and improved upon. In addition, clients should not be forced out of the program prematurely. In appropriate circumstances, clients may transition to less intensive services, but arrangements must be made to maintain contact with the client until the transfer is complete. Discharges may occur when clients and program staff mutually agree to the termination of services. All too often clients are not discharged for reasons of recovery or goal achievement but are dropped due to conflicts with staff or because the complexity of the problems and issues require too much staff time. In circumstances when a client wants to "fire" the ACT team, it is important that the ACT team be willing to listen and to accommodate the client's wishes/preferences regarding services. If the client still requests discharge, their request must be honoured. The client should be given all necessary help to arrange alternative services and should be given priority for readmission to ACT if they so choose.

**Please Note:** Some new ACT programs stop working with people whom the program fails to effectively engage and admit to the program. Problems with engagement should not be confused with reasons for discharge.

***Policy and Procedure Requirements:*** The ACT team shall maintain written admission and discharge policies and procedures.

### III. Service Intensity and Capacity

*The ACT programs provide intensive services to clients in community settings. The ACT Standards not only establish staff-to-client ratios but also establish the minimum number of staff required to cover the shifts, and set the frequency of staff service contacts with clients.*

#### A. Staff-to-Client Ratio

Each urban/full size ACT team shall have the organizational capacity to provide a minimum of 1 full-time equivalent (FTE) staff person for every 10 clients (not including the psychiatrist and the program assistant) when at full capacity. The staff-to-client ratio may need to be adjusted in settings where the clients are consistently acutely ill, have spent long periods of time in institutional settings, are being released from correctional settings, or have complicating medical conditions that require more service contacts. Staff-to-client ratios may also need to be adjusted in settings where safety is an issue and staff must pair up to work in a particular neighborhood. However, the staff-to-client ratio should be no less than 1 FTE for every 7 clients.

Rural/smaller size teams shall have the organizational capacity to provide a minimum of 1 full-time equivalent (FTE) staff person for every 8 clients (not including the psychiatrist and the program assistant) when at full capacity. In addition to the above factors that may warrant a lower staff-to-client ratio is a setting where staff must travel great geographical distances. For rural teams, the staff-to-client ratio should be no less than 1 FTE for every 5.5 clients.

Teams are accountable to the ministry for the number of clients served and must be able to explain the reasons for their staff-to-client ratios in terms of the above factors.

**Please Note:** The ACT Standards define two sizes of ACT teams: 1) an urban/full size team and 2) a rural/smaller size team. Teams are not designated as urban or rural because one team is located in an urban area and the other is in a rural area. The distinguishing factor is that in a rural area there may be fewer individuals with serious mental illness who can benefit from the program. Therefore, it is not practical to have a full size team. However, if there are sufficient numbers in a rural area, the ACT program should be full size. Some Ontario teams with rural catchment areas indicate they have sufficient numbers to warrant a full caseload.

## B. Staff Coverage

Each ACT team shall have a sufficient number of staff to provide treatment, rehabilitation, and support services 24 hours a day, seven days per week.

Staff coverage is a different measurement of service intensity than staff-to-client ratio and probably more important to successful ACT implementation. Staff coverage gets at the critical mass of ACT staff needed to cover the 24 hours. Establishing staffing patterns (e.g., shifts, staff rotations) to regularly deliver services 24 hours a day, seven days a week (24/7) ensures that clients have regular staff help when they need it; reduces client crisis; and helps reduce staff turnover. Having sufficient numbers of staff is necessary to: 1) staff two 8-hour shifts weekdays; 2) staff one shift with a minimum of two people each weekend day and holidays; 3) schedule mental health professionals to on-call duty the hours when staff are not working; and 4) have psychiatric back-up available all hours the psychiatrist is not regularly scheduled to work. It takes a minimum of 11 clinical staff for a fully funded team to provide 24/7 coverage, excluding the psychiatrist and program assistant (taking into account vacation time, sick time and staff attrition). It takes 5 FTE registered nurses to be able to have one nurse on every shift.

When a rural/smaller size team does not have sufficient staff numbers to operate weekday, weekend, and holiday shifts, staff are regularly scheduled to provide the necessary services on a client-by-client basis (per the client-centred comprehensive assessment and the individualized treatment/service plan) in the evenings and on weekends. The ACT team must make arrangements for crisis coverage 24/7. When a rural/smaller size team does not have sufficient staff numbers to operate an after-hours on-call system, staff should provide crisis services at least during regular work hours. During all hours staff are not working, the team must arrange coverage through a reliable crisis intervention service. In this case, the rural/smaller size team communicates routinely with the crisis intervention service (i.e., at the beginning of the workday to obtain information from the previous evening and at the end of the workday to alert the crisis intervention service to clients who may need assistance and provide effective ways of helping them). It is important that clients who need face-to-face contact are seen personally. It is up to the ACT team to make appropriate arrangements. In locations where there is no crisis intervention service or where the service is unable to provide face-to-face contact during the hours covered, appropriate steps will have to be taken for the ACT team to implement their own system.

## C. Frequency of Client Contact

1. The ACT team shall have the capacity to provide multiple contacts a week with clients experiencing severe symptoms, trying a new medication, experiencing a health problem or serious life event, trying to go back to school or starting a new job, making changes in living situation or employment, or having significant ongoing problems in daily living. These multiple contacts may be as frequent as two to three times per day, seven days per week and depend on client need and a mutually agreed upon plan between clients and program staff. Many, if not all, staff shall share responsibility for addressing the needs of all clients requiring frequent contact.
2. The ACT team shall have the capacity to rapidly increase service intensity to a client when his or her status requires it or a client requests it.
3. The ACT team shall provide an average of three contacts per week for all clients. A contact is a meaningful occurrence that ideally takes place face-to-face. There may be instances where telephone support is appropriate. Data regarding the frequency of client contacts shall be collected and reviewed as part of the program's Continuous Quality Improvement (CQI) plan.

ACT varies intensity to meet the changing needs of clients with serious mental illness, to support clients in normal community settings, and to provide a sufficient level of service as an alternative to the client needing to be hospitalized to receive that level of care. This is a radical departure from how traditional services are organized. ACT services are delivered continuously and “titrated”, meaning that when a client needs more services, the team provides them. Conversely, when the client needs less services, the team lessens service intensity.

## IV. Staff Requirements

*ACT teams require adequate numbers of staff members with sufficient individual competence to carry out the array of services and to establish quality supportive relationships with clients. In addition, ACT staff must have attitudes and values that are compatible with ACT philosophy: compassion and respect for persons with severe mental illness and their experiences; understanding and belief in recovery concepts and clients determining their own goals; and client and family involvement in all activities that shape the quality of ACT services.*

### A. Qualifications

The ACT team shall have among its staff persons with sufficient individual competence and professional qualifications and experience to provide the services described in Section VII. It is important to ensure that the team can provide a balance of treatment, rehabilitation and support services. Services include service coordination; crisis assessment and intervention; symptom assessment and management; individual counselling and psychotherapy; medication prescription, administration, monitoring and documentation; substance abuse 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 clients obtain the basic necessities of daily life; and education, support, and consultation to clients’ families and other major supports.

It is also important to have staff who sufficiently reflect the diversity of the local population that the team serves.

### B. Team Size

1. The urban/full size program shall employ a **minimum** of 11 FTE multidisciplinary clinical staff persons including the team coordinator and 1 FTE peer specialist, plus 1 FTE program assistant, and a 0.8 FTE psychiatrist.
2. The rural/smaller size program shall employ a **minimum** of 8 FTE multidisciplinary clinical staff persons, including the team coordinator and 1 FTE peer specialist, plus 1 FTE program assistant, and a 0.5 FTE psychiatrist.

The psychiatrist and the program assistant positions are not counted in the minimum number of multidisciplinary clinical staff positions.

## C. Required Staff

On an ACT team, there is a psychiatrist, a program/administrative assistant, a team coordinator, registered nurses, and, at a minimum, a social worker, an occupational therapist, a substance abuse specialist, a vocational specialist, a peer specialist and other clinical staff.

**The chart below shows the required minimum staff on urban/full size and rural/smaller size teams. Please note that the minimum number is not necessarily optimum for any particular team. Teams may require additional staff for reasons such as caseload size and complexity (see also section on staff-to-client ratios).**

Position	Urban/Full Size	Rural/Smaller Size
Team Coordinator	1 FTE	1 FTE
Registered Nurse	3 FTE	2 FTE
Social Worker	1 FTE	3 FTE* * On a rural team, 1 of these staff may serve a dual role.
Occupational Therapist	1 FTE	
Substance Abuse Specialist	1 FTE	
Vocational Specialist	1 FTE	
Peer Specialist	1 FTE	1 FTE
Other Clinical Staff	2 FTE	1 FTE
Total Multidisciplinary Clinical Staff (excluding psychiatrist and program assistant)	11 FTE	8 FTE
Psychiatrist	0.8 FTE	0.5 FTE
Program/Administrative Assistant	1 FTE	1 FTE
<b>Total</b>	<b>12.8 FTE</b>	<b>9.5 FTE</b>

**Mental Health Professionals:** Mental health professionals have: 1) professional degrees in one of the core mental health disciplines; 2) clinical training including internships and other supervised practical experiences in a clinical or rehabilitation setting; and 3) clinical work experience with persons with serious mental illness. They are licensed or certified to practice in Ontario, are regulated under provincial legislation and/or their professional colleges and operate under the code of ethics of their profession. Mental health professionals include persons with master's or doctoral degrees in nursing, social work, rehabilitation counselling, or psychology; diploma and bachelor's degree/level nurses (i.e., registered nurse); registered occupational therapists; and registered/bachelor's level social workers.

Among the clinical staff on an urban/full size team, there is a **minimum** requirement of 8 FTE mental health professionals. On a rural/smaller size team, there is a **minimum** requirement of 6 FTE mental health professionals. The team coordinator, registered nurses, social worker, occupational therapist, and vocational specialist must be mental health professionals as defined above.

**Other Clinical Staff:** The other clinical staff may be bachelor's level and paraprofessional mental health workers who carry out rehabilitation and clinical support functions. A bachelor's level mental health worker has a bachelor's degree in a behavioural science (other than social work) and work experience with adults with serious mental illness. A paraprofessional mental health worker may have a bachelor's degree in a field other than behavioural science, have a community college or high school diploma and work experience with adults with serious mental illness or with individuals with similar human services needs. These paraprofessionals may have related training (e.g., substance abuse worker, social services worker, certified occupational therapy assistant, home health care aide) or work experience (e.g., teaching) and life experience.

Because it is challenging to provide on-the-job training, staff must be hired with education and experience in working with persons with serious mental illness. Therefore, recruitment and hiring are extremely important when filling all positions but particularly when filling positions with persons without professional degrees and training. On a rural/smaller size team, because of the small staff size, there is a greater need for the majority of the staff to have clinical training and credentials to independently carry out treatment and rehabilitation services.

## Roles

1. **Team Coordinator:** A full-time team coordinator/supervisor is the clinical and administrative supervisor of the team and also functions as a practicing clinician on the ACT team. The team coordinator has a master's or bachelor's degree and is a professional regulated under the Regulated Health Professions Act (e.g., nursing, psychology or occupational therapy) or is a registered social worker. The team coordinator is a dedicated position and shall not substitute for any other position.

The team coordinator is the senior clinician on the team. "Practicing clinician" means that the team coordinator is a competent clinician, who leads client-centred assessment and individualized treatment planning by working side-by-side with the client and team members, provides in vivo supervision and frequently carries a small caseload. It is very difficult to direct service delivery without having first hand knowledge of each client and their family. In addition, first-hand knowledge of clients makes clinical supervision far more effective and credible.

2. **Psychiatrist:** A psychiatrist is a minimum of 0.8 FTE on an urban/full size team and 0.5 FTE on a rural/smaller size team. The psychiatrist provides: clinical services to all ACT clients; works with the team coordinator to monitor each client's clinical status and response to treatment; supervises staff delivery of services; and directs psychopharmacologic, medical services and other clinical care.

The ACT psychiatrist functions as a team member, not just as a consultant to the team. The team psychiatrist sees clients and has clinical supervisory responsibilities for clients and staff, regularly participates in daily staff organizational meetings and treatment planning meetings, and directs operation of the medication and medical services. Even though the psychiatrist may work part-time, it is very important that the psychiatrist have designated hours when he or she is working on the team. The psychiatrist's hours should be sufficient blocks of time on consistent days in order to carry out his or her clinical, supervisory and administrative responsibilities.

It is also necessary to arrange for and provide psychiatrist back-up all hours the psychiatrist is not regularly scheduled to work. If availability of the psychiatrist during all hours is not feasible, alternative psychiatric back-up must be arranged (e.g., mental health centre psychiatrist, emergency room psychiatrist).

When ACT clients are admitted to hospital, it is important that there be good collaboration between the ACT team psychiatrist and the in-patient psychiatrist. Some teams have service agreements with the admitting hospital. In some cases, ACT psychiatrists follow clients when they are admitted.

3. **Registered Nurses:** On an urban/full size team, a minimum of 3 FTE mental health professional registered nurses and on a rural/smaller size team, a minimum of 2 FTE mental health professional registered nurses are required.

Registered nurses are invaluable on ACT teams because they provide medical assessment and services as well as treatment and rehabilitation services. It is important to have sufficient numbers in order to have nurses to work the majority of shifts. It takes 5 FTE registered nurses to have a nurse on every urban/full size team shift. On a rural/smaller size team it is impossible to staff with only one nurse. Providers starting ACT teams are often hesitant to hire the number of nurses needed because of the cost. In fact, the failure to pay adequate salaries highly correlates to poor quality staff and high staff turnover in the mental health system. This is also true for other mental health workers.

4. **Social Worker:** One or more mental health professionals with training and experience in social work are required.

Social workers lead the team in the engagement and partnership with family members of clients and/or their natural supports in the treatment/service planning process and in individual and/or multiple family support and therapy.

Social workers may also provide leadership to the team with respect to entitlements, (e.g., financial, housing), advocacy and “working the system”.

5. **Occupational Therapist:** One or more mental health professionals with training and experience in occupational therapy are required. Occupational therapists act as fully integrated team members functioning in the team’s generalist role, and also provide discipline-specific client-centred rehabilitative expertise.

Occupational therapists address health and well-being through enabling client occupation in a balance of meaningful self-care, leisure and productivity. Occupational therapists draw from a professional body of knowledge on the interdependent aspects of function including personal dimensions (i.e., physical, mental and social), spiritual dimensions (i.e., those enabling a sense of meaning, choice and purpose), occupational roles and activities, and environmental factors. Occupational therapists contribute to the team expertise in assessment (e.g., functional assessments, evaluation of daily time use, environmental assessments, cognitive or physical assessment) and intervention (e.g., remediating impairments, developing strategies for adaptation, facilitating skill development, strengthening client’s resources, matching client strengths, values and activity).

The inclusion of occupational therapy as an essential rehabilitation profession contributes to the full range of treatment, rehabilitation and support.

6. **Vocational Specialist:** One or more mental health professionals with specific training and experience in vocational rehabilitation are required. This may include occupational therapy or other specific vocational rehabilitation certification. Vocational specialists contribute leadership and expertise to the ACT team in providing vocational program elements within the team and/or in collaboration with other community resources.

There are eight key vocational program elements defined in the Ministry of Health and Long-Term Care's policy framework for employment supports for person with serious mental illness, "Making It Work":

1. Job Development/Creation/Employer Outreach
2. Skills Development/Training for Job/Education
3. Skills Training on the Job
4. Job Search Skills/Job Placement
5. Employment Planning/Career Counselling
6. Supported Education
7. Supports to Sustaining Education/Employment
8. Leadership Training

7. **Substance Abuse Specialist:** One or more staff with training and experience in substance abuse assessment and treatment shall be designated the role of substance abuse specialist. Staff performing this role may be mental health professionals, or graduates of substance abuse programs at community colleges who are registered social services workers.

The ACT team provides most of the substance abuse treatment services for clients with serious mental illness and co-existing substance abuse disorders. The most effective assessment and treatment approaches employ an integrated treatment model in which mental health and substance abuse treatment are provided simultaneously.

8. **Peer Specialist:** A minimum of 1 FTE peer specialist on either an urban/full size team or a rural/smaller size team is required. A person with relevant skills and experience who is, or has been, a recipient of mental health services for serious mental illness holds this position. Because of life experience with mental illness and mental health services, the peer specialist provides expertise that professional training cannot replicate. Peer specialists are fully integrated team members functioning in the team's generalist role, who also provide highly individualized services and promote client self-determination and decision-making. Peer specialists also provide essential expertise and consultation to the entire team to promote a culture in which each client's point of view and preferences are recognized, understood, respected and integrated into treatment, rehabilitation, and community self-help activities.

The peer specialist must be paid a salary commensurate with other staff members. In addition, consumers who have the credentials can be employed in any of the other required positions and should be paid at the professional rate.

9. **Program/Administrative Assistant:** The program/administrative assistant (minimum 1 FTE) is responsible for organizing, coordinating, and monitoring all non-clinical operations of ACT, including: managing medical records; operating and coordinating the management information system; maintaining accounting and budget records for client and program expenditures; and providing receptionist activities, including triaging calls and coordinating communication between the team and clients.

Persons with training as Registered Practical Nurses (RPN), or who have worked as hospital unit program assistants or administrative support staff in mental health or health care settings, are ideal for this position.

**Policy and Procedure Requirements:** The ACT team shall: 1) maintain written personnel policies and procedures for hiring; 2) establish core staff competencies, orientation, and training; and 3) maintain personnel files for each team member containing the job application, copies of credentials or licenses, position description, annual performance appraisals, and individual orientation and training plan.



## V. Program Organization and Communication

***Working as a multidisciplinary team, staff organization and communication are critical when delivering highly individualized services in community settings. Unless the ACT program organization and communication structure is solidly in place, it is impossible for teams to provide intense, well-organized, multiple services to clients while ensuring coordination of care.***

### A. Hours of Operation and Staff Coverage

#### 1. Urban/Full Size Teams

- a. The ACT team shall be available to provide treatment, rehabilitation, and support activities seven days per week, 24 hours a day (24/7). This means:
  - i. Regularly operating and scheduling staff to work two 8-hour shifts with a minimum of 2 staff on the second shift, thus providing services at least 12 hours per day weekdays.
  - ii. Regularly operating and scheduling staff to work one 8-hour shift with a minimum of 2 staff each weekend day and every holiday.
  - iii. Regularly scheduling ACT staff for on-call duty to provide crisis and other services the hours when staff are not working.
  - iv. ACT team staff who are experienced in the program and skilled in crisis intervention procedures shall be on-call and available to respond to clients by telephone or in person.
  - v. Regularly arranging for and providing psychiatric back-up all hours the psychiatrist is not regularly scheduled to work. If availability of the ACT psychiatrist during all hours is not feasible, alternative psychiatric back-up should be arranged (e.g., mental health centre psychiatrist, emergency room psychiatrist).

#### 2. Rural/Smaller Size Teams

- a. The ACT team shall be available to provide treatment, rehabilitation, and support activities seven days per week. Crisis services must be available to ACT clients 24 hours a day. When a rural/smaller size team does not have sufficient staff numbers to operate two 8-hour shifts weekdays and one 8-hour shift weekend days and holidays, staff are regularly scheduled to provide the necessary services on a client-by-client basis (per the client-centred comprehensive assessment and individualized treatment/service plan) in the evenings and on weekends. This means:
  - i. Regularly scheduling staff to cover client contacts in the evenings and on weekends.
  - ii. Regularly scheduling ACT staff for on-call duty to provide crisis and other services the hours when staff are not working. ACT team staff who are experienced in the program and skilled in crisis intervention procedures shall be on-call and available to respond to clients by telephone or in person.
  - iii. The ACT team must make arrangements for crisis coverage 24/7. When a rural/smaller size team does not have sufficient staff numbers to operate an after-hours on-call system, the staff should at least provide crisis services during regular work hours. During all hours staff are not working, the team must arrange coverage through a reliable crisis intervention service. The rural/smaller size team communicates routinely with the crisis intervention service (i.e., at the beginning of the workday to obtain information from the previous evening and at the end of the workday to alert the crisis intervention service to clients who may need assistance and to provide effective ways of helping them). It is important that clients who need face-to-face contact are seen personally. It is up to the ACT team to make appropriate arrangements. In locations where there is no crisis intervention service or where the service is unable to provide face-to-face contact during the hours covered, appropriate steps will have to be taken for the ACT team to implement their own system.

- iv. Regularly arranging for and providing psychiatric back-up all hours the psychiatrist is not regularly scheduled to work. If availability of the ACT psychiatrist during all hours is not feasible, alternative psychiatrist back-up should be arranged (e.g., mental health centre psychiatrist, emergency room psychiatrist).

Many mental health programs claim to provide 24/7 services, when in fact, the staff only work Monday through Friday eight-to-five with telephone crisis or emergency room coverage the rest of the hours. While ACT teams rotate staff to cover 8-hour shifts, they provide their own on-call and will go out to see clients face-to-face as necessary. In rural/smaller size ACT programs where crisis intervention services are limited, it is very important for ACT to develop a system for face-to-face crisis response. It is not acceptable to leave crisis work to hospital emergency rooms or law enforcement alone.

## B. Place of Treatment/Service

Each team shall provide a minimum of 75 per cent of client service contacts in the community, in non-office-based or non-facility-based settings.

An essential ingredient in the way that services are delivered in the ACT program is “assertive outreach.” The majority of treatment and rehabilitation interventions take place “in the community,” that is, in the client’s own place of residence and neighborhood, at employment sites in the community, and in the same sites of recreation and leisure activities that all citizens use (e.g., parks, movie theatres and restaurants).

The rationale for use of assertive outreach is to allow the provision of psychosocial services “in vivo,” where clients need to use them. The latter factor eliminates the need for transfer of learning, which may be difficult to achieve for many persons with serious mental illnesses.

## C. Staff Communication and Planning

1. The ACT team shall conduct **daily organizational staff meetings** at regularly scheduled times per a schedule established by the team coordinator. These meetings will be conducted in accordance with the following procedures:
  - a. The ACT team shall maintain a **daily log** which provides:
    - A roster of the clients served in the program; and
    - For each client, a brief documentation of services that have been provided during the last 24 hours and a concise, behavioural description of the client’s status that day.
  - b. **The daily organizational staff meeting** shall commence with a review of the daily log to update staff on the client contacts which occurred the day before and to provide a systematic means for the team to assess the day-to-day progress and status of all clients.
  - c. The ACT team, under the direction of the team coordinator, shall maintain a weekly client schedule for each client. The **weekly client schedule** is a written schedule of all client contacts that staff must carry out to fulfill the goals and objectives in the client’s treatment/service plan. The team will maintain a central file of all weekly client schedules.
  - d. The ACT team, under the direction of the team coordinator, shall develop a daily staff assignment schedule from the central file of all weekly client schedules. The **daily staff assignment schedule** is a written timetable for all the client contacts and all indirect client work (e.g., medical record review, meeting with collaterals such as employers and social assistance), job development, treatment/service planning, and documentation to be done on a given day, to be divided and shared by the staff working on that day.

- e. The daily organizational staff meeting will include a review by the shift organizer of all the work to be done that day as recorded on the **daily staff assignment** schedule. During the meeting, the **shift organizer** will assign staff to carry out the service activities scheduled to occur that day, and the shift organizer will be responsible for ensuring that all tasks are completed or rescheduled.
  - f. During the **daily organizational staff meeting**, the ACT team shall also revise treatment/service plans as needed, plan for emergency and crisis situations, and add client contacts to the daily staff assignment schedule per the revised treatment/service plans.
2. The ACT team shall conduct treatment/service planning meetings under the supervision of the team coordinator and the psychiatrist. These treatment/service planning meetings shall:
- a. Convene at regularly scheduled times per a written schedule set by the team coordinator;
  - b. Occur and be scheduled when the majority of the team members can attend, including the psychiatrist, team coordinator, and all members of the Individual Treatment/Service Team (IT/ST);
  - c. Require individual staff members to present and systematically review and integrate client information into a holistic analysis and prioritize issues; and
  - d. Occur with sufficient frequency and duration to make it possible for all staff:
    - 1) To be familiar with each client and their goals and aspirations;
    - 2) To participate in the ongoing assessment and reformulation of issues/problems;
    - 3) To problem-solve treatment strategies and rehabilitation options;
    - 4) To participate with the client and the IT/ST in the development and the revision of the treatment/service plan; and
    - 5) To fully understand the treatment/service plan rationale in order to carry out each client's plan.

Staff communication and scheduling (i.e., daily organizational staff meetings and treatment/service planning meetings) are critical to overall operation and teamwork.

Understanding and implementation of this section of the ACT Standards is essential to team operation and to ensure effective and efficient service delivery.

## D. Continuity Mechanisms

ACT teams shall establish mechanisms to provide continuity of care and ensure collaboration with other service-providers (e.g., to facilitate transition to other services, in-patient admissions when necessary, and access to other community and institutional services).

## E. Staff Supervision

The team coordinator and psychiatrist shall assume responsibility for supervising and directing all staff activities. This supervision and direction shall consist of:

1. Individual, side-by-side sessions in which the supervisor accompanies an individual staff member to meet with clients in regularly scheduled or crisis meetings to assess staff performance, give feedback, and model alternative treatment/service approaches;
2. Participation with team members in daily organizational staff meetings and regularly scheduled treatment/service planning meetings to review and assess staff performance and provide staff direction regarding individual cases;
3. Regular meetings with individual staff to review their work with clients, assess clinical performance, and give feedback;

4. Regular reviews, critiques, and feedback of staff documentation (i.e., progress notes, assessments, treatment/service plans, treatment/service plan reviews); and
5. Written documentation of all clinical supervision provided to ACT team staff.

**Policy and Procedure Requirements:** The ACT team shall:

- 1) Maintain written program organization policies and procedures, including required hours of operation and coverage, staff communication and planning, emphasis on team approach, and staff supervision, as outlined in this section; and
- 2) Have policies and procedures for risk management.

## VI. Client-Centred Assessment and Individualized Treatment/Service Planning

***The purpose of the entire ACT client-centred assessment and individualized treatment/service planning process is to “put the story together” side-by-side with the client. Mutually reviewing and learning the client’s psychosocial history leads to a client-centred plan. The client and the IT/ST work together to formulate and prioritize the issues, set goals, research approaches and interventions, and establish the plan. The plan is individually tailored so that the treatment/rehabilitation/support approaches and interventions achieve optimum symptom reduction, help fulfill the personal needs and aspirations of the client, take into account the cultural beliefs and realities of the individual, and improve all the aspects of psychosocial functioning that are important to the client.***

### A. Initial Assessment

An initial assessment and treatment/service plan shall be done the day of the client’s admission to ACT by the team coordinator or the psychiatrist, with participation by designated team members.

### B. Comprehensive Assessment

Each part of the assessment shall be completed by the ACT team member most skilled and knowledgeable in the area being assessed. A team member with training and interest in the area does each part and becomes the specialist in that particular area with the client. The assessment is based upon all available information, including that from client interview/self-report, family members and other significant parties, and written summaries from other agencies, including police, courts, and out-patient/in-patient facilities, where applicable. Consent to the collection, use and disclosure of this information must be obtained, if consent is required in accordance with any legislation that applies in these circumstances. The team member who has conducted the assessment presents the findings at the first treatment/service planning meeting. A comprehensive assessment shall be initiated and completed as soon as possible, ideally within one month after a client’s admission according to the following requirements:

1. In collaboration with the client, the Individual Treatment/Service Team (IT/ST) will complete a psychiatric and social functioning history time line.
2. In collaboration with the client, the comprehensive assessment shall include an evaluation in the following areas:
  - a. ***Psychiatric History, Mental Status, and Diagnosis:*** The psychiatrist is responsible for completing the psychiatric history, mental status, and diagnosis assessment. The psychiatrist presents the assessment findings at the first treatment/service planning meeting.

The psychiatric history, mental status, and diagnosis assessment involves careful and systematic collection of information from the client, the family, and past treatment records regarding the onset, precipitating events, course and effect of illness, including past treatment and treatment responses, risk behaviours, recent life events and current mental status.

The purpose is to effectively plan with the client and family the best treatment approach to eliminate or reduce symptomatology and to ensure accuracy of the diagnosis. The psychiatrist, in carrying out the psychiatric history, mental status, and diagnosis assessment writes a psychiatric history narrative of the client's medical record.

- b. **Physical Health:** A registered nurse is responsible for completing the physical health assessment. The registered nurse presents the assessment findings at the first treatment/service planning meeting.

Because physical health has been ignored for many people with serious mental illness, the purpose of the physical assessment is to thoroughly assess health status and any medical conditions present to ensure that appropriate treatment, follow-up and support are provided to the client. The first interview to begin this assessment should take place within 72 hours of admission.

- c. **Use of Drugs and Alcohol:** The substance abuse specialist is responsible for completing the use of drugs and alcohol assessment and presents the assessment findings at the first treatment/service planning meeting.

Substance use is typically not well enough assessed with persons with serious mental illness. It requires a lot of time to accurately assess substances. The purpose of the use of drugs or alcohol assessment is to collect information to assess and diagnose if the client has a substance abuse disorder and to develop appropriate treatment interventions to be integrated into the comprehensive treatment plan. Team members who are concurrent disorder specialists join with the individual treatment/service teams and take primary responsibility for assessment, planning and treatment for clients with substance use problems. Standardized assessment tools for substance abuse should be used.

- d. **Education and Employment:** The vocational specialist (who may be an occupational therapist) is responsible for completing the education and employment assessment and presents the assessment findings at the first treatment/service planning meeting.

Employment is very important to people with mental illness and is a normalizing structure that is helpful in symptom management. ACT excludes no one because of a poor work history or because of ongoing symptoms or impairments related to mental illness. The purpose of the education and employment assessment is to determine with the client: how he or she is currently structuring time; current school or employment status; interests and preferences regarding school and employment; and how symptomatology has affected previous and current school and employment performance. This assessment begins the working relationship between the client and the vocational specialist to establish educational and vocational goals.

- e. **Social Development and Functioning:** The social worker is responsible for completing the social development and functioning assessment and presents the assessment findings at the first treatment/service planning meeting.

The purpose of the social development and functional assessment is to obtain information from the client about his or her childhood, early attachments, role in family of origin, adolescent and young adult development, culture, religious beliefs, leisure activities, interests, and social skills. This allows the ACT team to evaluate how symptomatology has interrupted or affected personal and social development. It also includes information regarding any client involvement with the criminal justice system. In addition, it identifies social and interpersonal issues appropriate for supportive therapy.

- f. **Activities of Daily Living (ADL):** The occupational therapist or nurse is responsible for completing the ADL assessment and presents the assessment findings at the first treatment/service planning meeting.

The purpose of the activities of daily living assessment is to evaluate: the individual's current ability to meet basic needs (e.g., personal hygiene, adequate nutrition, medical care); the quality and safety of the client's financial resources; the effect that symptoms and impairments of mental illness have had on self-care; the client's ability to maintain an independent living situation; and the client's desires and individual preferences. This allows the ACT team to determine the level of assistance, support, and resources the client needs to reestablish and maintain activities of daily living. Good activities of daily living (ADL) functioning is basic to successful community adjustment for persons with serious mental illness. Consistent assistance to meet ADL needs helps clients to feel better and less vulnerable living in the community. Occupational therapists and nurses have the training to complete the ADL assessment. Other staff with an interest in this area can be trained to do the assessment.

- g. **Family Structure and Relationships:** The social worker is responsible for carrying out the family structure and relationships assessment and presents the assessment findings at the first treatment/service planning meeting.

Historically, people with serious mental illness have received most of their support and care from their families. The best way to engage families from diverse communities is to respect and work within their beliefs and values. Many clients have children, and clients' ability to parent may be compromised by their mental illness. Unfortunately, it has also been the case that mental health providers have not always included or welcomed the participation of families or other significant people. The purpose of the family structure and relationships assessment is to obtain information from the client's family and other significant people about their perspective on the client's mental illness, to determine their level of understanding about mental illness and their expectations of ACT services. This information allows the team to define, with the client, the contact or relationship ACT will have with the family in regard to the client's goals, treatment, and rehabilitation. This assessment is begun during the admission meeting with the client and the family members or significant others who are participating in the admission.

3. While the assessment process shall involve the input of most, if not all, team members, the client's psychiatrist, service coordinator and IT/ST members will assume responsibility for preparing the written narrative of the results, formulating the psychiatric and social functioning history time line and completing the comprehensive assessment, ideally, within one month of the client's admission to the program.
4. The service coordinator and IT/ST members will be assigned by the team coordinator in collaboration with the psychiatrist by the time of the first treatment/service planning meeting or within thirty days after admission.

## C. Individualized Treatment/Service Planning

Treatment/service plans will be developed through the following treatment/service planning process:

1. The treatment/service plan shall be developed in collaboration with the client and the family or substitute decision-maker, if any, when feasible and appropriate. The client's participation in the development of the treatment/service plan shall be documented. Together the ACT team and the client shall assess the client's needs, strengths, and preferences and develop an individualized treatment/service plan. The treatment/service plan shall: 1) identify individual issues/problems; 2) set specific measurable long- and short-term goals for each issue/problem; and 3) establish the specific approaches and interventions necessary for the client to meet his or her goals, improve his or her capacity to function as independently as possible in the community, and achieve the maximum level of recovery possible (i.e., a meaningful, satisfying, and productive life). The plan shall identify who will carry out the approaches and interventions.
2. As described in Section V, ACT team staff shall meet at regularly scheduled times for treatment/service planning meetings. At each treatment/service planning meeting the following staff should attend: the team coordinator, the psychiatrist, the service coordinator, individual treatment/service team members, the peer specialist and all other ACT team members involved in regular tasks with the client.
3. Individual treatment/service team members are responsible to ensure the client is actively involved in the development of treatment/service (recovery) goals. With the consent of the client, ACT team staff shall also involve pertinent agencies and members of the client's social network in the formulation of treatment/service plans.
4. The following key areas should be considered for every client's treatment/service plan, including but not limited to: 1) psychiatric illness or symptom reduction; 2) housing; 3) activities of daily living (ADL); 4) daily structure and employment; and 5) family and social relationships. The service coordinator and the individual treatment/service team, together with the client, will be responsible for reviewing and rewriting the treatment/service goals and plan whenever there is a major decision point in the client's course of treatment/service (e.g., significant change in client's condition or goals) or at least every six months. Additionally, the service coordinator shall prepare a summary (i.e., treatment/service plan review) which thoroughly describes in writing the client's and the IT/ST's evaluation of his or her progress/goal attainment, the effectiveness of the interventions, and the client's satisfaction with services since the last treatment/service plan. The plan and review will be signed or verbally approved by the client, the service coordinator, individual treatment/service team members, the team coordinator, the psychiatrist, and all ACT team members.

The ACT client-centred approach to individualized services may be easy for mental health professionals to accept philosophically, but it is often harder for them to grasp conceptually and put into practice. All clinical and rehabilitation services begin with comprehensive assessment and individualized treatment/service planning. There is probably no better process to build a working relationship with clients and their families and to strategize more effective interventions than ACT comprehensive assessment and individualized treatment/service planning.

**Policy and Procedure Requirement:** The ACT team shall maintain written assessment and treatment/service planning policies and procedures incorporating the requirements outlined in this section.

## VII. Required Services

***Mental disorders are treatable, contrary to what many think. A complete range of efficacious treatments is available to ameliorate symptoms. In fact, for most mental disorders, there is generally a range of treatments of proven efficacy. Assertive community treatment is not only an evidence-based practice, but is also an effective service delivery model to provide persons with more disabling schizophrenia, other psychotic disorders, and bipolar disorders a range of the most effective treatment, rehabilitation, and support services. The ACT multidisciplinary staff individually plan and deliver services targeted to help clients: 1) address the complex interaction between symptoms and psychosocial functioning; and 2) achieve personal goals. Accepted current practice interventions which are provided in assertive community treatment include: supportive counselling and psychotherapy, including cognitive behavioural therapy, personal therapy, and psychoeducation; integrated substance abuse and mental health treatment, including motivational enhancement therapy; evidence-based pharmacological treatment using practice guidelines (algorithms); supported employment; peer counselling and consultation; collaboration with families and family psychoeducation; and treatment of trauma and post-traumatic disorders.***

Operating as a continuous treatment service, the ACT team shall have the capability to provide comprehensive treatment, rehabilitation, and support services as a self-contained service unit.

Services shall minimally include the following:

### A. Service Coordination

Each client will be assigned a service coordinator who coordinates and monitors the activities of the client's individual treatment/service team and the greater ACT team. The primary responsibility of the service coordinator is to work with the client to write the treatment/service plan, to provide individual supportive counselling, to offer options and choices in the treatment/service plan, to ensure that immediate changes are made as the client's needs change, and to advocate for the client's wishes, rights, and preferences. The service coordinator is typically also the first staff person called on when the client is in crisis and is the primary support person and educator to the individual client's family. Members of the client's individual treatment/service team share these tasks with the service coordinator and are responsible to perform the tasks when the service coordinator is not working. Service coordination also includes coordination with community resources, including consumer self-help and advocacy organizations that promote recovery.

### B. Crisis Assessment and Intervention

Crisis assessment and intervention shall be provided 24 hours per day, seven days per week. These services will include telephone and face-to-face contact and will be provided in conjunction with the local mental health system's crisis services program as appropriate.



## C. Psychiatric Treatment

Psychiatric treatment provides tools to clients to enable them to manage their own illness. This shall include, but is not limited to, the following:

1. Ongoing comprehensive assessment of the client's mental illness symptoms, accurate diagnosis, and the client's response to treatment with the purpose of optimizing symptom reduction;
2. Psychoeducation regarding mental illness and the effects and side effects of prescribed medications;
3. Symptom-management efforts directed to help each client identify/target the symptoms and occurrence patterns of his or her mental illness and develop methods (internal, behavioural, or adaptive) to help lessen the effects;
4. Individual supportive therapy;
5. Psychotherapeutic interventions such as Cognitive Behavioural Therapy and individual psychotherapy; and
6. Generous psychological support to clients, both on a planned and as-needed basis, to help them accomplish their personal goals, to cope with the stressors of day-to-day living, and to recover.

### **Medication Prescription, Administration, Monitoring and Documentation**

1. The ACT team psychiatrist shall:
  - a. Establish an individual clinical relationship with each client;
  - b. Assess each client's mental illness symptoms and provide verbal and written information about mental illness;
  - c. Make an accurate diagnosis based on the comprehensive assessment which dictates an evidence-based medication pathway that the psychiatrist will follow;
  - d. Provide education about medication, benefits and risks, and obtain informed consent for treatment; and
  - e. Assess and document the client's mental illness symptoms and behaviour in response to medication and shall monitor and document medication side effects.
2. All ACT team members shall assess and document the client's mental illness symptoms and behaviour in response to medication and shall monitor for medication side effects.
3. The ACT team shall establish medication policies and procedures which identify processes to:
  - a. Record physician orders;
  - b. Order medication;
  - c. Arrange for client medications, as required, to be organized by the team and integrated into clients' weekly schedules and daily staff assignment schedules;
  - d. Provide security for medications (e.g., daily and longer-term supplies) and set aside a private designated area for set up of medications by the team's nursing staff; and
  - e. Administer medications per regulations in Ontario to team clients.<sup>1</sup>

<sup>1</sup> See *Oral Medication Administration: Practice Guidelines for ACT Teams in Ontario, An Information Guide* by T. Holz and M. Gehrs, 2002, prepared for ACT Technical Advisory Panel.

## D. Concurrent Disorder Services

Provision of a stage-based integrated treatment/service model that is non-confrontational, considers interactions of mental illness and substance abuse, and has client-determined goals.<sup>2</sup> This shall include, but is not limited to, individual and group interventions in:

1. Assessment using standardized assessment tools for substance abuse and ongoing reassessment;
2. Motivational interviewing/counselling (e.g., stages of change, developing discrepancies, decisional matrix);
3. Active treatment/service (e.g., counselling, cognitive skills training, community reinforcement);
4. Relapse prevention (e.g., trigger identification, building relapse prevention action plans); and
5. Referral to withdrawal management services as needed.

## E. Work-Related Services

Work-related services to help clients value, find and maintain meaningful employment in the community. Services in this category are identified in the Ministry of Health and Long-Term Care's policy framework for employment supports, *Making It Work*. Services are provided within the team and/or in collaboration with other community resources. Services include:

### 1. Job Development/Creation/Employer Outreach

The goal of this core element is to increase the overall number of employment opportunities available, and improve consumers' access to those opportunities. Employment opportunities include paid temporary employment and permanent jobs. Delivering this element may result in the creation of jobs, through the development of a consumer-operated alternative business, an agency-sponsored business or another enterprise. An essential component of this element includes providing outreach, education and support to employers who may be interested in hiring people with mental illness and this may result in an increased number of individuals in competitive employment.

### 2. Skills Development/Training for Job/Education

This core element aims to develop the general and/or technical skills that consumers need to succeed in their chosen job search, or to pursue their chosen educational goals. Delivery could involve teaching generic skills, such as getting organized for work or getting along with colleagues. It could also mean teaching specific technical skills, such as operating a cash register or a computer software program.

This core element can be delivered through volunteering, job coaching in unpaid or paid temporary placements with employers, or through educational programs or apprenticeships.

### 3. Skills Training on the Job

This program element involves developing general and/or technical job skills during paid permanent employment. The support can be delivered by a job coach, a supervisor or colleagues at a local business, consumer-operated alternative business or agency-sponsored business.

### 4. Job Search Skills/Job Placement

Local agencies and programs may provide one or both components of this core support element. Job Search Skills programs teach people how to prepare resumes, and how to conduct themselves during job interviews. Job Placement programs approach prospective employers, attempt to match consumers to jobs, and help consumers prepare for employment interviews.

<sup>2</sup> Refer to *Best Practices: Concurrent Mental Health and Substance Use Disorders*, Health Canada, 2001.

## **5. Employment Planning/Career Counselling**

This element involves assisting people to develop a vocational or employment plan that leads either to further education, or to entry into the labour market. Vocational plans should be developed after a thorough assessment of aptitudes, abilities and interests, and after considering the local employment market.

## **6. Supported Education**

The goal of supported education is to help consumers develop a vocational goal. This may involve finding employment or pursuing further education. Delivering the support can be accomplished through a range of activities, such as providing instruction in English as a Second Language, academic upgrading and/or remediation, and sessions on career planning.

## **7. Supports to Sustaining Education/Employment**

The goal of this core element is to provide support, as required, to ensure that mental health consumers can keep their jobs or remain in their chosen educational programs.

The support needed may involve education or problem solving for consumers, employers and co-workers alike. Supports can also involve coordination and advocacy to ensure consumers have access to necessary community supports, such as income, housing, medical benefits and counselling. The services themselves may be provided by an external resource person, or by someone at the job site.

## **8. Leadership Training**

The goal of leadership training is to teach mental health consumers the skills they need to take on a leadership role in creating and running a consumer-operated alternative business, or an agency-sponsored business. This may involve mentoring and job shadowing, or training consumer/survivors in community development techniques. The expertise of local employers represents a vital resource for leadership training.

# **F. Activities of Daily Living**

Activities of daily living services support clients to: find housing which is safe, of good quality, and affordable (e.g., apartment hunting; finding a roommate; landlord negotiations; cleaning, furnishing, and decorating; and procuring necessities such as telephones, furnishings, linens); perform household activities, including house cleaning, cooking, grocery shopping, and laundry; develop healthy eating habits; carry out personal hygiene and grooming tasks, as needed; develop or improve money-management skills; use available transportation; and have and effectively use a personal physician and dentist.

Services include:

1. Individualized assessment;
2. Problem solving;
3. Sufficient side-by-side assistance and support;
4. Skill training;
5. Ongoing supervision (e.g., prompts, assignments, monitoring, encouragement); and
6. Environmental adaptations to assist clients to gain or use the skills to perform the above activities.

## G. Social/Interpersonal Relationship and Leisure-Time Skill Training

These services support clients to improve their social/interpersonal relationships and use leisure-time effectively, including: improving communication skills, developing assertiveness, and increasing self-esteem; developing social skills, increasing social experiences, and developing meaningful personal relationships; planning appropriate and productive use of leisure time; relating to landlords, neighbors, and others effectively; and familiarizing themselves with available social and recreational opportunities and increasing their use of such opportunities.

Services include:

1. Supportive individual therapy (e.g., problem solving, role-playing, modeling, and support);
2. Social-skill teaching and assertiveness training;
3. Planning, structuring, and prompting of social and leisure-time activities;
4. Side-by-side support and coaching; and
5. Organizing individual and group social and recreational activities to structure clients' time, increase their social experiences, and provide them with opportunities to practice social skills and receive feedback and support to develop the above skills.

## H. Peer Support Services

ACT teams are expected to promote client-centred practices by the deployment of a peer specialist, the active participation of clients in service planning and development, and the creation of opportunities for clients to be able to bring forth complaints and suggestions to a third party without fear of adverse impact on the services rendered. Peer support services serve to validate clients' experiences and to guide and encourage clients to take responsibility for and actively participate in their own recovery. In addition, services help clients identify, understand, and combat stigma and discrimination against mental illness and develop strategies to reduce self-imposed stigma.

Services include:

1. Judicious utilization of self-disclosure and sharing of life experience to serve as mentor and role model;
2. Assisting clients to recognize and develop coping mechanisms to deal with symptoms and social stigma;
3. Educating staff within the team regarding the consumer perspective on the mental health system and assisting the team to maintain a client-centred approach that maximizes client participation and empowerment;
4. Advocating for development of consumer initiatives within the community and identifying opportunities for client empowerment; and
5. Introducing and referring clients to consumer self-help programs and advocacy organizations that promote recovery.

## I. Support Services

Support services or direct assistance to ensure that clients obtain the basic necessities of daily life, including but not necessarily limited to:

1. Medical and dental services;
2. Safe, clean, affordable housing;
3. Financial support and/or benefits counselling (e.g., social assistance, ODSP, CPP, federal disability tax credit);
4. Social services;
5. Transportation; and
6. Legal advocacy and representation.

## J. Family-Centred Services

ACT teams are expected to demonstrate a strong family orientation. The provision of family support and therapy specific to ACT clients' families is a cornerstone of ACT services. The active inclusion of family members in service planning and revisions where appropriate, the creation of opportunity for family members to provide feedback and suggestions for improvement to the ACT team as a whole, and any relevant projects or goals are all examples of promoting family involvement that bring clients, their care providers and families together. Services provided regularly under this category to clients' families and other major supports, with client agreement or consent, include:

1. Individualized psychoeducation about the client's illness and the role of the family and other significant people in the therapeutic process\*;
2. Intervention to restore contact, resolve conflict, and maintain relationships with family and/or other significant people;
3. Ongoing communication and collaboration, face-to-face and by telephone, between the ACT team and the family;
4. Introduction and referral to family self-help programs and advocacy organizations that promote recovery\*; and
5. Assistance to clients with children (including individual supportive counselling, parenting training, and service coordination) including but not limited to:
  - a. Services to help clients throughout pregnancy and the birth of a child;
  - b. Services to help clients fulfill parenting responsibilities and coordinate services for the child/children; and
  - c. Services to help clients restore relationships with children who are not in the client's custody.

\* These are general services that do not require client consent.

**Policy and Procedure Requirement:** The ACT team shall maintain written policies and procedures for all services outlined in this section.

## VIII. Client Record

***Since ACT records often require more documentation than is required by many mental health agencies, the team coordinator and the psychiatrist need to work with/obtain approval from mental health agency administrators and medical records personnel to set up an ACT client record which will satisfy the agency policies and federal and provincial legislation. In addition, the ACT client record should be located physically with the ACT program. The ACT client record may be governed by legislation in respect of the collection, use and disclosure of personal health information and the requirements of any applicable legislation must be met. The requirements below are minimum requirements and are not intended to summarize or replace legislative requirements which may be in place at the time of issuing these Standards or in the future.***

- A. The ACT team shall maintain a treatment/service record for each client.
- B. The treatment/service record is confidential, complete, accurate, and contains up-to-date information relevant to the client's care and treatment.
- C. The record shall accurately document assessments, treatment/service plans, and the nature and extent of services provided, such that a person unfamiliar with the ACT team can easily identify the client's treatment needs and services received.
- D. The team coordinator and the program assistant shall be responsible for the maintenance and security of the client treatment/service records in accordance with all applicable legislation.
- E. The client records are to be kept in a locked file, for confidentiality and security reasons.
- F. Access to client records by clients, service-providers and third parties is subject to all the provisions of applicable federal and provincial legislation.

***Policy and Procedure Requirement:*** The ACT team shall:

- 1) Maintain written clinical records, management policies and procedures; and
- 2) As of November 1, 2004: maintain health information confidentiality policies in accordance with the *Personal Health Information Protection Act*.

## IX. Client Rights and Complaint Resolution Procedures

ACT teams' policies and procedures that ensure protection of client rights must be consistent with provincial legislation and include a transparent mechanism to redress complaints. All team members must fully understand a client's right: to have his or her capable decisions about autonomy and self-determination respected; to make decisions that may not be in his or her best interests; and to give or refuse consent to services or treatment, where the client is capable with respect to such decisions. Where the client is not capable, all team members must respect the need to comply with legislation and professional standards that govern consent to treatment and services for incapable persons. These principles are intrinsic to the basic tenets of client-centred care. The team must facilitate the fair, simple, speedy and efficient resolution of complaints.

Education is the cornerstone of client empowerment. It is critical that teams provide ongoing and updated information regarding rights in order for clients to fully exercise the options available to them. This includes ensuring that access to a complaint mechanism is explained and readily available.

**A. ACT teams shall be knowledgeable about and familiar with client rights including the right to:**

1. Confidentiality;
2. Informed consent to medication and treatment;
3. Individualized treatment with respect and dignity;
4. Withdraw consent or refuse service;
5. Control finances;
6. Nondiscrimination;
7. Be supported in decision-making; and
8. File complaints and be assisted with the process.

**B. ACT teams shall have a policy for addressing and resolving client complaints with established procedures based on principles of fairness<sup>3</sup>, including:**

1. Transparency;
2. Accessibility;
3. Measures to accommodate client and reduce barriers;
4. Client's right to be represented, supported and assisted through the process;
5. Informed options for resolution that include the client;
6. Confidentiality;
7. Established timelines that include continuous feedback to the client;
8. The maintenance of all ACT services without consequence;
9. An investigative process that is independent from direct service provision, where possible;
10. Written reasons for the decision and options for appeal should the client disagree;
11. A mechanism of appeal to an adjudicator independent of the ACT team, where possible (e.g., sponsoring agency, advisory body, board of directors, etc.); and
12. A system of record-keeping and complaints documentation that is independent of a clinical record and shall not be filed as part of the record.

<sup>3</sup> Also see *Operating Manual for Mental Health and Addiction Treatment Services (Substance Abuse and Gambling Services)* Funded by the Ministry of Health and Long-Term Care, December 2003, page 27.

**C. ACT teams shall provide clients appropriate information and assistance in accessing other complaint mechanisms or advocacy groups, including but not limited to:**

1. Legal Clinics or lawyer referral services;
2. Psychiatric Patient Advocate Office (PPAO);
3. Legal Aid Ontario;
4. Ontario Human Rights Commission (OHRC);
5. Professional regulating bodies;
6. Community mental health agencies;
7. Consent and Capacity Board;
8. Ombudsman (if ACT team is part of a provincial psychiatric hospital);
9. Ontario Review Board; and
10. Social Benefits Tribunal.

**Policy and Procedure Requirement:** The ACT team shall maintain client rights policies and procedures.

How ACT teams understand and implement client rights and complaint procedures is basic to what the ACT client-centred approach is all about. Client-centred means each client is listened to, respected, encouraged, and supported to direct his or her own treatment/service plan. Therefore, ACT teams need to: 1) understand and comply with legislative requirements to ensure that ACT clients know their rights and that their rights are respected; and 2) implement a client and family “friendly” complaint system which effectively hears and resolves client complaints about ACT services and ACT staff.

## X. Barrier-Free Services

***Mental illnesses are prevalent in people across all cultures, races and abilities. However, members of ethnic and racial minorities, and persons with disabilities (e.g., physical, sensory, learning, developmental) face additional barriers to receiving quality mental health treatment/service. ACT staff should reflect the diversity of the communities the team serves. During the initial and comprehensive assessments, the staff must be aware of and take into account the client’s culture and background, such as traditions, customs, helping networks, language/dialects and disability. Staff must understand how differences such as culture, language and disability affect clients’ abilities to access and benefit from services. All ACT staff must adhere to the Ontario Human Rights Code and provide accommodation to remove barriers to service. Hospital-sponsored programs also have obligations under the Ontarians with Disabilities Act, 2001.***

- A. ACT should ensure that clients receive from all staff members effective, understandable, and respectful care that is provided in a manner compatible with clients’ cultural beliefs and practices, preferred language and disability. Accommodation for disability in accordance with *the Ontario Human Rights Code* must be provided.
- B. ACT teams should implement strategies to recruit, retain, and promote a diverse staff who reflect the demographic characteristics of the service area.



- C. ACT teams should ensure that staff at all levels and across all disciplines receive training in human rights, the duty to accommodate (e.g., Braille, large print, American Sign Language, etc.) and culturally appropriate service delivery.
- D. ACT teams must offer and provide competent services in the client's preferred language, including bilingual staff and interpreter services, at no cost to each client with limited English-proficiency at all points of contact, in a timely manner during all hours of operation. Family and friends should not be used to provide interpretation services (except by request of the client).
- E. ACT teams must make available easily understood client-related materials and post signage in the languages of the commonly encountered groups and/or groups represented in the service area.

**Policy and Procedure Requirement:** The ACT team shall maintain written policies and procedures incorporating the requirements outlined in this section.

## XI. Performance Improvement and Program Evaluation

***Program evaluation is critical in order to know if clients are realizing the expected and desired outcomes from ACT. It is also important to know if the program is adhering to the ACT model. Each program is expected to evaluate: 1) client outcomes; 2) client and family satisfaction with the services; and 3) fidelity to the ACT model. Program evaluation should be used by the ACT team, the Ministry of Health and Long-Term Care and community advisory bodies to evaluate program performance and to establish program improvement/performance goals.***

The ACT team shall have a performance improvement and program evaluation plan, which shall include the following:

- A. A statement of the program's objectives. The objectives shall relate directly to the program's clients or target population.
- B. Measurable criteria that shall be applied in determining whether or not the stated objectives are achieved.
- C. Methods for documenting achievements related to the program's stated objectives.
- D. Methods for assessing the effective use of staff and resources toward the attainment of the objectives.
- E. In addition to the performance improvement and program evaluation plan, the ACT team shall have a system for regular review that is designed to evaluate the appropriateness of admissions to the program, treatment or service plans, discharge practices, and other factors that may contribute to the effective use of the program's resources.
- F. The ACT team shall be subject to central monitoring and evaluation procedures established by the Ministry of Health and Long-Term Care. Continuation of funding for the team shall be contingent upon compliance with the Transfer Payment Agreement.

**Policy and Procedure Requirement:** The ACT team shall maintain performance improvement and program evaluation policies and procedures.

## XII. Community Advisory Bodies

***Each ACT program relates to a community advisory body which plays a role in guiding and supporting local ACT team start-up, implementation, and on-going operation. This body may support other mental health services as well as ACT teams. This group performs a key role in promoting high quality and recovery-oriented services for ACT clients.***

- A. The ACT team shall relate to a community advisory body which supports and guides ACT team implementation and operation. This body may support other mental health services as well as ACT teams. The community advisory body is accountable and reports directly to the Board of Directors of the sponsoring agency. Members are chosen for their expertise in mental health or addiction services, their links with other relevant community services, their ability to represent the interests of clients and their families and the community, and any other expertise required to direct a mental health service. Members should include mental health consumers and community stakeholders that interact with persons with serious mental illness (e.g., homeless services, food banks, faith-based entities, criminal justice system, supportive housing providers, landlords, employers, and community colleges). If a member has a conflict of interest, that person should declare the conflict, abstain from discussion and voting where there is a direct conflict of interest or remove himself/herself from the advisory body. If the advisory body supports other mental health services as well as ACT, at least some members must be knowledgeable about the ACT model. Membership on the advisory body shall also reflect the diversity of the local population.
- B. The role of advisory bodies<sup>4</sup> as described in the *Operating Manual for Mental Health and Addiction Treatment Services (Substance Abuse and Gambling Services) Funded by the Ministry of Health and Long-Term Care* is to:
1. Advise the Board of Directors on policies/directions for mental health and/or addiction services;
  2. Represent the interests of clients and their families, referring agencies and the local community;
  3. Develop and maintain good communication with the community, and provide opportunities for community representatives to have input into planning local mental health and/or addiction services;
  4. Promote partnerships, community awareness and understanding of mental health and addiction issues; and
  5. Review and make recommendations on the agency's annual operating plan and budget, identify any opportunities to increase cost-effectiveness by collaborating with other agencies, and bring to the Board's attention any significant deviations from the plan and budget during the year.

In addition to the above role with respect to all the community mental health/addiction services addressed by the community advisory body, the body shall:

1. Promote fidelity to the ACT Program Standards; and
2. Problem-solve and advocate to reduce system barriers to ACT implementation.

***Policy and Procedure Requirement:*** The community advisory body shall have written terms of reference incorporating the requirements outlined in this section.

<sup>4</sup> Also see *Operating Manual for Mental Health and Addiction Treatment Services (Substance Abuse and Gambling Services) Funded by the Ministry of Health and Long-Term Care*, December 2003, pp. 8-10.

## XIII. Accountability

***The Ministry of Health and Long-Term Care establishes accountability requirements for Ontario ACT teams. ACT teams are required to adhere to these Standards. Sponsoring agencies of ACT teams are required to sign Transfer Payment Agreements with the ministry and submit annual Operating Plans and Budgets as well as annual data reports which include ACT demographic, clinical and outcome data. The Ministry of Health and Long-Term Care may grant ACT teams waivers of requirements in the ACT team Program Standards under certain circumstances.***

- A. Sponsoring agencies of ACT teams are required to sign Transfer Payment Agreements with the Ministry of Health and Long-Term Care and submit annual operating plans and budgets, in accordance with ministry requirements for community mental health programs. ACT teams which experience challenges in implementing these Standards should document these in the annual Operating Plan.
- B. The ACT team may request of the Ministry of Health and Long-Term Care a waiver of any required Standard that would not diminish the effectiveness of the ACT model, violate the purposes of the program, or adversely affect clients' health and welfare. Waivers cannot be granted which are inconsistent with client rights or provincial, federal, or local laws and regulations. Waivers must be provided in writing.
- C. ACT teams are required to submit annual data reports in accordance with ministry requirements.

# Appendix

## Definitions

***Program Standards define words or phrases that are critical to correctly interpreting the Standard. The definitions section identifies words and phrases that are unique to ACT or have different meanings in ACT than in traditional mental health programs.***

***Assertive Community Treatment (ACT)*** is a self-contained mental health program made up of a multidisciplinary mental health staff, including a peer specialist, who work as a team to provide the majority of treatment, rehabilitation, and support services that clients need to achieve their goals. ACT services are individually tailored with each client through relationship building, individualized assessment and planning, and active involvement with clients to enable each to find and live in their own residence, to find and maintain work in community jobs, to better manage symptoms, to achieve individual goals, and to maintain optimism and recover. The ACT team is mobile and delivers services in community locations rather than expecting the client to come to the program. Seventy-five per cent or more of the services are provided outside of program offices in locations that are comfortable and convenient for clients. The clients served have serious mental illnesses that are complex, have significant functional impairments, and, because of the limitations of traditional mental health services, may have gone without appropriate services.

***ACT Service Coordination*** is a process of organization and coordination within the multidisciplinary team to carry out the range of treatment, rehabilitation, and support services each client expects to receive per his or her written individualized treatment/service plan and is respectful of the client's wishes. Service coordination also includes coordination with community resources, including consumer self-help and advocacy organizations that promote recovery.

***ACT Service Coordinator (Primary Worker)*** is the team member who has primary responsibility for establishing and maintaining a therapeutic relationship with a client on a continuing basis, whether the client is in the hospital, in the community, or involved with other agencies. In addition, the service coordinator leads and coordinates the activities of the individual treatment/service team (IT/ST). He or she is the responsible team member to be knowledgeable about the client's life, circumstances, and goals and desires. The service coordinator collaborates with the client to develop and write the treatment/service plan, offers options and choices in the treatment/service plan, ensures that immediate changes are made as the client's needs change, and advocates for the client's wishes, rights, and preferences. The service coordinator also works with community resources, including consumer-run services, to coordinate and integrate these activities into the client's overall service plan. The service coordinator provides individual supportive therapy and, if available, is the first IT/ST member available to the client in crisis. The service coordinator provides primary support and education to the family, support system, and/or other significant people. The service coordinator shares these tasks with other IT/ST members who are responsible to perform them when the service coordinator is not working.

***Client*** is a person who has agreed to receive services and is receiving client-centred treatment, rehabilitation, and support services from the ACT team.

***Client-Centred Individualized Treatment/Service Plan*** is the culmination of a continuing process involving each client, his or her family, and the ACT team, which individualizes service activity and intensity to meet client-specific treatment, rehabilitation, and support needs. The written treatment/service plan documents the client's self-determined goals and the services necessary to help the client achieve them. The plan also delineates the roles and responsibilities of the team members who will carry out the services. (Note: The use of "treatment/service planning" reinforces that ACT teams provide treatment, rehabilitation and support services. Some teams may use different terminology such as "recovery" planning or "care" planning.)

**Clinical Supervision** is a systematic process to review each client's clinical status and to ensure that the individualized services and interventions that team members (including the peer specialist) provide are effective and planned with, purposeful for, and satisfactory to the client. The team coordinator and the psychiatrist have the responsibility to provide clinical supervision that occurs during daily organizational staff meetings, treatment/service planning meetings, and in individual meetings with team members. Clinical supervision also includes review of written documentation (e.g., assessments, treatment/service plans, progress notes, correspondence).

**Community Advisory Bodies** support and guide individual ACT team implementation and operation. Each ACT team shall relate to a community advisory body. This body may support other mental health services as well as ACT teams. The community advisory body is accountable and reports directly to the Board of Directors of the sponsoring agency. Members are chosen for their expertise in mental health or addiction services, their links with other relevant community services, their ability to represent the interests of clients and their families and the community, and any other expertise required to direct a mental health service. Members should include mental health consumers and community stakeholders that interact with persons with serious mental illness (e.g., homeless services, food banks, faith-based entities, criminal justice system, supportive housing providers, landlords, employers, and community colleges). If the advisory body supports other mental health services as well as ACT, at least some members must be knowledgeable about the ACT model. Membership on the advisory body shall also reflect the diversity of the local population.

In addition to the role of community advisory bodies outlined in the *Operating Manual for Mental Health Services and Addiction Treatment Services (Substance Abuse and Gambling Services) Funded by the Ministry of Health and Long-Term Care*, the body promotes fidelity to the ACT Program Standards and problem-solves and advocates to reduce system barriers to ACT implementation.

**Comprehensive Assessment** is the organized process of gathering and analyzing current and past information with each client and the family, support system, and/or other significant people to evaluate: 1) mental and functional status; 2) effectiveness of past treatment/service; and 3) current treatment, rehabilitation and support needs to achieve individual goals and support recovery. The results of the information gathering and analysis are used with each client to establish immediate and longer-term service needs, to set goals, and to develop the first individualized treatment/service plan with each client.

**Daily Log** is a record which the ACT team maintains on a daily basis to provide: 1) a roster of clients served in the program; and 2) for each client, a brief documentation of any treatment or service contacts which have occurred during the last 24 hours and a concise behavioural description of the client's clinical status and any additional needs.

**Daily Organizational Staff Meeting** is a daily staff meeting held at regularly scheduled times under the direction of the team coordinator (or designee) to: 1) briefly review the service contacts which occurred the previous day and the status of all program clients; 2) review the service contacts which are scheduled to be completed during the current day and revise as needed; 3) assign staff to carry out the day's service activities; and 4) revise treatment/service plans and plan for emergency and crisis situations as needed. The daily log and the daily staff assignment schedule are used during the meeting to facilitate completion of these tasks.

**Daily Staff Assignment Schedule** is a written, daily timetable summarizing all client treatment and service contacts to be divided and shared by staff working on that day. The daily staff assignment schedule will be developed from a central file of all weekly client schedules.

**Individual Treatment/Service Team (IT/ST)** is a group or combination of three to five ACT staff members who together have a range of clinical and rehabilitation skills and expertise. The IT/ST members are assigned to work with a client by the team coordinator and the psychiatrist by the time of the first treatment/service planning meeting or within thirty days after admission. The core members are the service coordinator, the psychiatrist, and one clinical or rehabilitation staff person who backs up and shares case coordination tasks and substitutes for the service coordinator when he or she is not working. The individual treatment/service team has continuous responsibility to: 1) be knowledgeable about the client's life, circumstances, goals and desires; 2) collaborate with the client to develop and write the treatment/service plan; 3) offer options and choices in the treatment/service plan; 4) ensure that immediate changes are made as a client's needs change; and 5) advocate for the client's wishes, rights, and preferences. The IT/ST is responsible to provide much of the client's treatment, rehabilitation, and support services. Individual treatment/service team members are assigned to take separate service roles with the client as specified by the client and the IT/ST in the treatment/service plan.

**Individual Supportive Therapy and Psychotherapy** are verbal therapies that help people make changes in their feelings, thoughts, and behaviour in order to move toward recovery, clarify goals, and address self stigma. Supportive therapy and psychotherapy also help clients identify and achieve personal goals; understand and identify symptoms in order to find strategies to lessen distress and symptomatology; improve role functioning; and evaluate treatment and rehabilitative services. Current psychotherapy approaches include cognitive behavioural therapy, personal therapy, and psychoeducational therapy.

**Initial Assessment and Service Initiation** is the initial evaluation of: 1) the client's mental and functional status; 2) the effectiveness of past treatment/service; and 3) the current treatment, rehabilitation, and support service needs. The initial assessment is completed the day of admission.

**Initial Treatment/Service Plan** is developed using the results of the information gathering analysis from the initial assessment to help the client achieve individual goals. The initial treatment/service plan is completed the day of admission and guides team services until the comprehensive assessment and treatment/service plan are completed. Service begins on the day of admission. (Note: The use of the term "treatment/service planning" reinforces that ACT teams provide treatment, rehabilitation and support services. Some teams may use different terminology such as "recovery" planning or "care" planning.)

**Medication Error** is any error in prescribing or administering a specific medication, including errors in writing or transcribing the prescription, in obtaining and administering the correct medication, in the correct dosage, in the correct form, and at the correct time.

**Medication Management** is a collaborative effort between the client and the psychiatrist with the participation of the Individual Treatment/Service Team (IT/ST) to: 1) carefully evaluate the client's previous experience with psychotropic medications and side-effects; 2) identify and discuss the benefits and risks of psychotropic and other medication; 3) choose a medication treatment; and 4) establish a method to prescribe and evaluate medication according to evidence-based practice standards. The goal of medication management is client self-medication management.

**Peer Counselling** is counselling and support provided by team members who have experience as recipients of mental health services for serious mental illness. Drawing on common experiences as well as using and sharing his/her own practical experiences and knowledge gained as a recipient, peer counselling is supportive counselling that validates clients' experiences and provides guidance and encouragement to clients to take responsibility and actively participate in their own recovery.

***Program of Assertive Community Treatment (PACT)*** is the name of the original assertive community treatment program, Mendota Mental Health Institute, Madison, Wisconsin, that developed the ACT model and conducted two controlled research studies which substantiated ACT model effectiveness for adults with the most serious mental illnesses compared to traditional mental health service delivery. PACT continues to operate and is currently using the ACT model with adolescents with serious mental illness.

***Psychiatric and Social Functioning History Time Line*** is a format or system which helps ACT staff to chronologically organize information about significant events in a client's life, their experience with mental illness, and their treatment/service history. This format allows staff to more systematically analyze and evaluate the information with the client, to formulate hypotheses for treatment with the client, and to determine appropriate treatment and rehabilitation approaches and interventions with the client.

***Psychotropic Medication*** is any drug used to treat, manage, or control psychiatric symptoms or disordered behaviour, including but not limited to antipsychotic, antidepressant, mood-stabilizing or anti-anxiety agents.

***Recovery*** does not have a single agreed-upon definition, however, "*the overarching message is that hope and restoration of a meaningful life are possible, despite serious mental illness. Instead of focusing primarily on symptom relief, as the medical model dictates, recovery casts a much wider spotlight on restoration of self-esteem and identity and on attaining meaningful roles in society.*" (Mental Health: A Report of the Surgeon General (U.S.), 1999, p. 97)

***Rural/Smaller Size Teams*** serve smaller numbers of clients than urban/full size teams. Teams are not designated as urban or rural because one team is located in an urban area and the other is in a rural area. The distinguishing factor is that in a rural area there may be fewer individuals with serious mental illness who can benefit from the program. Therefore, it is not practical to have a full size team. However, if there are sufficient numbers of clients in a rural area, the ACT program should be full size.

***Shift Organizer*** is the ACT team member in charge of developing and implementing the daily staff assignment schedule; making all daily assignments; ensuring that all daily assignments are completed or rescheduled; and managing all emergencies or crises that arise during the course of the day. This is done in consultation with the team coordinator and the psychiatrist.

***Treatment/Service Plan Review*** is a thorough, written summary describing the client's and the individual treatment/service team's evaluation of the client's progress/goal attainment, the effectiveness of the interventions, and satisfaction with services since the last treatment/service plan.

***Treatment/Service Planning Meeting*** is a regularly scheduled meeting conducted under the supervision of the team coordinator and the psychiatrist. The purpose of these meetings is for the staff, as a team, to thoroughly prepare for their work with each client. The team meets together to present and integrate the information collected through assessment in order to learn as much as possible about the client's life, their experience with mental illness, and the type and effectiveness of the past treatment/service they have received. The presentations and discussions at these meetings make it possible for all staff to be familiar with each client and their goals and aspirations; to participate in the ongoing assessment and reformulation of issues/problems; to problem-solve treatment strategies and rehabilitation options; and to fully understand the treatment/service plan rationale in order to carry out the plan for each client.

**Urban/Full Size Teams** serve sufficient numbers of clients to warrant a full size team. Teams are not designated as urban or rural because one team is located in an urban area and the other is in a rural area. The distinguishing factor is that in a rural area there may be fewer individuals with serious mental illness who can benefit from the program. Therefore, it is not practical to have a full size team. However, if there are sufficient numbers in a rural area, the ACT program should be full size.

**Weekly Client Schedule** is a written schedule of the specific interventions or service contacts (i.e., by whom, when, for what duration, and where) which fulfill the goals and objectives in a given client's treatment/service plan. The individual treatment/service team (IT/ST) shall maintain an up-to-date weekly client contact schedule for each client per the client-centred individualized treatment/service plan.



Aug/05