Assertive Community Treatment

Program Description

Team Wellness Center (TWC) offers Assertive Community Treatment (ACT) program to persons served population who are diagnosed with severe and persistent mental illness/co-occurring disorders and has experienced many hospitalizations. This evidence-based treatment program uses a mobile multidisciplinary treatment team who provides acute, active, ongoing community-based psychiatric, assertive treatment, outreach, and support; 80% of which occurs in the community of the member's choice, which is the least restrictive environment for the persons served. ACT services provided are psychiatric, nurse services, therapeutic and case management services, substance abuse treatment; rehabilitation with a recovery-based approach and peer support.

ACT is the central point for delivering services, as based on the needs of the persons served.

ACT delivers the majority of the treatment, rehabilitation, and recovery support services needed by the persons served, including:

- Symptom assessment and management
- Individual supportive therapy

ACT also addresses persons served basic needs by providing community resources (such as food, housing, medical care, employment and housing support, social activities, transportation, and education assistance), with the understanding that these services decrease hospitalizations, crisis situations, and promotes a better quality of life for persons served.

Program Philosophy

Team Wellness Center is dedicated to enhancing the well-being of individuals by providing an array of comprehensive behavioral and physical services in an environment that promotes quality of life, continuous improvement, and social awareness. ACT brings an array of services to the individual in their own settings to increase the likelihood of continuous participation in programming.

Program Goals

- Assist persons with maximizing recovery by controlling symptoms of mental illness with pharmacology, therapy and supportive services to reduce inpatient hospitalization, emergency room visits, involvement in the criminal justice system and reduction of harm to self and/or others.
- Empower persons with skills to become stable and reduce the long-term effects of severe mental illness and co-occurring disorders by teaching coping skills to enhance positive community participation and ability to manage their own healthcare.
- Develop resources and opportunity for each person to build and maintain hope, self-directed goal setting, family relationships and strengthening the support system available to them.
- Improvement in subjective well-being, quality of life, independent living and satisfaction.

Specific Services Offered

Specific services afforded to each person served in the ACT program is based on preferences and desires of the persons served. The multi-disciplinary team serves as the single point of contact and multiple members of the team are familiar with each member to ensure timely and continuous provision of services; including case management, psychiatric services, counseling/psychotherapy, nursing services, housing and educational support, substance abuse treatment and rehabilitative services, employment services and peer support. All of these services are provided in the individual's home or community to decrease hospital recidivism and crisis situations.

The ACT team develops an initial crisis intervention plan upon contact for each person served and ensures the following:

- Screening for medical or emergency psychiatric services when indicated
- Making referrals to emergency medical or psychiatric services when indicated
- Identifying personnel trained in emergency procedures
- Handling standing orders when appropriate
- Involving significant others with the consent of the persons served
- Obtaining information on advance directives of the persons served, when available
- Collaboration with other community organizations that provide emergency services to ensure continuity of care of the persons served

The ACT team directly provides services to support activities of daily living in community-based settings through:

- Individualized assessment
- Problem Solving
- Side-by-side assistance and support
- Skill training
- Ongoing supervision
- Securing of environmental adaptations, if needed
- Maintaining personal hygiene and grooming
- Performing household activities
- Developing or improve money-management skills
- Accessing means of transportation
- Telephone interventions
- Face-to-face assessments
- Providing mobile services
- Maintaining good physical health and nutrition
- Improving medication management and adherence
- Developing motivation for decreasing substance use
- Developing coping skills and alternatives to substance use
- Achieving periods of abstinence and stability
- Accessing/utilizing self-help or support groups

- Education about the illness/disorder of the persons served
- Education about the strengths and abilities of the persons served
- When applicable, education about the role of the family in the therapeutic process
- Intervention to prevent or resolve conflict
- Ongoing communication and collaboration between the team and the family
- Increases service intensity to the persons served when their needs require additional contacts
- Providing ongoing support and liaison services for persons who are hospitalized or in criminal justice or other restrictive settings

- Providing outreach and follow-up to persons who have been admitted to its program, are in active status, and become isolated in the community or are admitted to more intensive levels of treatment but are likely to return to the program
- The team interacts with community organizations, agencies, and groups to facilitate community adjustment and access to resources for the persons served.

Team members on duty have daily staff meetings to:

- Review the clinical status of the persons served
- Review the current needs of the persons served
- Update staff members on treatment contacts that occurred during the previous day(s)
- Identify contacts with the persons served that need to occur
- Develop the daily work schedule for the team
- Review treatment plans, when appropriate
- Adjust service intensity for persons served as needed
- Plan for potential emergency and crisis situations
- Ensure information shared at organizational staff meetings is documented

The ACT team is coordinated by a team leader who:

- Has specialized knowledge and competencies that meet the needs of the persons served
- Provides clinical supervision to ACT team staff
- Provides direct services to persons served by the ACT team

The majority of the ACT team members are qualified behavioral health practitioners

Each ACT team has one or more nursing staff members who:

- Participate(s) in treatment planning meetings based on the needs of the persons served
- Provides sufficient nursing coverage to meet the needs of the persons served
- Directly provide(s) services

Each ACT team has a psychiatrist or a physician specialist in addiction medicine who:

- Is a member of the team
- Directly provides services
- Is available to participate in treatment planning meetings based on the needs of the persons served
- Provides clinical consultation and supervision to the team

TWC commits its efforts to recruit staff, who are peers, to become team members and to provide peer support or consultation to persons served by the ACT team

Population Served

ACT provides evidence-based and promising practices services to individuals at least 18 years of age, with severe and persistent mental health conditions who often have co-occurring issues which result in multiple hospitalizations; such as substance abuse, homelessness, crisis episodes, and interaction with the judicial system.

Admissions Criteria

Admission criteria for ACT participation is based on the persons extensive history of hospital and crisis episodes resulting in continuous decomposition of mental illness. The administration of the Integrated Biopsychosocial is the face-to-face assessment used to determine if the persons served is eligible for the ACT program. The Level of Care (LOCUS), American Society of Addiction Medicine (ASAM), medical necessity and persons served diagnosis are used to determine if the persons serve meets the medical necessity criteria for the ACT program. Self-/referring and/or legal guardian request may also be basis for admission to ACT.

Referral Source

Persons are referred to ACT by TWC Care Coordinators, Therapist, Psychiatrist, Primary Care Physicians, Courts, probation officers, self-referral and/or other Community Mental Health (CMH) agencies. Referrals to ACT is based on continuous hospitalizations and crisis episodes which exceed standard care practices at TWC.

Setting

80% of ACT services are provided in the persons' served home or community.

Hours of Operation/Frequency

ACT is a mobile services multi-disciplinary treatment team that provides Clinical Therapy, Case Management, Primary Care, Peer Support, Crisis Intervention services, and supportive services 24-hours/7-days per-week.

ACT has its own crisis phone manned by the ACT team 24/7 year-round.

Location(s)

ACT services are provided in persons' homes and community settings. Other ACT services may be provided at specific TWC locations i.e. psychiatric services.

ACT office location:

Eastern Market
2925 Russell St.
Detroit, MI 48207

Transition Criteria

Transition criteria is based on Quarterly and Annual review of the persons served case records. The ACT team along with the persons served determines whether or not the member is ready for transition. This would be evident by the persons served meeting targeted goals/objectives in the treatment plan and persons served stability. ACT team offers members referrals and supplemental services to support persons served during their transition and afterwards.

Discharge/Exit Criteria

Discharge/Exit criteria from ACT program is based on the persons served exhibiting improvement in all major functioning in mental health challenges, moving outside of the geographical area, mutual agreement of persons served and ACT team, completion of treatment goals and objectives, transition into other programs and member's desire to no longer participate in the ACT program.

Discharge from the program occurs:

- When the persons served and program staff members mutually agree to the termination of services
- When the person served moves outside the geographic area of the team's responsibility. In such cases, the ACT team:
    - Arranges for transfer of mental health service responsibility to a provider in the location to which the person served is moving
    - When feasible, maintains contact with the person served until service transfer is arranged
- When the person served demonstrates an ability to function in all major role areas (i.e., work, social, self-care), with only minimal assistance from the program for a period of one year or more as agreed to by the ACT Team
- When the person served is not court ordered and requests termination of services
- When the team, despite repeated efforts, cannot locate the person served
- Documentation of discharge is completed by identified member(s) of the treatment team
- Discharge documentation includes the signature of:
    - The primary case manager for the person served
    - The team leader
    - The psychiatrist, when possible
    - The person served, when possible

Payer/Funding Source

Funding is provided by Detroit Wayne Mental Health Authority (DWMHA), Michigan Department of Health and Human Services (MDHHS), and private insurances.

Fee for Service

No

Bundled Service (H0039)