ACT Program Standards - Version 4.1

Developed through an extensive consultation and iterative process with Ontario's community of practice in cooperation with the Ontario Association for ACT & FACT - OAAF

Version 3.0: Oct 21, 2016
Version 3.1: Sept 27, 2019 (revisions in green)
Version 3.2: Dec 1, 2021 (revisions in blue)
Version 4.0: Jan 21, 2023 (revisions in red)
Version 4.1: March 8, 2024 (revisions in purple)

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EXECUTIVE SUMMARY

I. ACT Program Standards

The Ontario Program Standards for ACT teams serve to guide ACT program start-up and implementation by clearly defining the minimum expectations for program requirements. Successful ACT model implementation and demonstrated improvements in client outcomes are best accomplished by close adherence to the ACT standards. ACT Teams serve individuals with the most serious mental illnesses who are using the most services, using multidisciplinary staffing, low staff–to-client ratios and proven intensive intervention strategies; they provide 365 day a year coverage, and 24 hour crisis on-call services.

II. Background

Ontario's first edition of the Assertive Community Treatment (ACT) Program Standards was published in 1998. The document was released at Ontario's first ever Assertive Community Treatment Conference in October of 1998 in Toronto, Ontario. Dr. Ian Musgrave, Henry DeSousa, and Margaret Gallow presented the standards to the ACT teams. The first set of standards were taken from the work of Deborah Allness, M.S.W. and William Knoedler, M.D, who developed the National Program Standards for ACT teams in the United States. The Ontario ACT Association would like to thank the authors for the use of their material.

The original standards for ACT teams were developed after field-testing in various jurisdictions. We are still very aware that the closer teams follow the ACT standards, the stronger the fidelity to the ACT program model, therefore, the better the clinical outcomes. The research literature states that those ACT teams with lower fidelity cost much more than those high fidelity programs. It is found that teams with low fidelity ratings are usually more reliant on additional services, which become costly, rather than the all-inclusive team approach to service provision. Fidelity measures tend to assess elements of the ACT program such as the population served, staffing complement, staff roles, specific program processes and interventions.

The second edition of the ACT Standards was released in January 2005 and was presented at the Team Leader/Psychiatrist conference that same month. Brian Davidson, former Manager of Mental Health Programs Branch of the Ministry of Health and Long-Term Care (MOHLTC) took the lead in the distribution of standards. His passion and expertise in ACT services was instrumental in increasing Ontario's capacity to having 80 teams in the province today. Amy Herskowitz was the point person in the Ministry who organized and handled many ACT issues. The second edition of Standards was developed with the assistance of the Technical Advisory Panel and the Standards Sub-committee. These Standards have now been in place for over a decade. There has been extensive consultation and feedback reported from teams in Ontario as to what works well.

Changes in assessment tools over the years, increasing technology advances and other physical/material pieces have been constantly changing. The client population that ACT is targeted to service, for the most part remains the same, but the mental health system has changed.

The original ACT teams in Ontario were developed with the divestment of Ontario's ten former Provincial Psychiatric hospitals to general hospitals. In light of these transitional and evolutionary factors, it is our hope that this third set of Standards reflect today's needs from a practitioner, program and systems perspective.

The MOHLTC is no longer the direct funder of the teams. The 14 Local Health Integration Networks (LHINs) in Ontario now provide oversight of ACT teams with sometimes differing interpretations of model fidelity and varying capacity and flow through expectations.

It is the intent with these newly released standards that the Ontario ACT Association (OAA) will be able to support low/moderate fidelity teams with technical assistance to become high fidelity teams. More ACT teams are needed in Ontario, as the majority of teams are presently at capacity, serving over 6000 individuals. In order to expand the number of teams, we need to ensure that the 80 active teams we have in the province are performing to the best of their ability and producing positive outcomes for clients.

After years of consultation, an improved set of standards is needed for Ontario. We have done extensive research to determine what domains work well and what still needs improvement. The Standards were revised by the Standards Sub Committee and the Technical Advisory Committee before being reviewed by the MOHLTC. The MOHLTC committed to bringing the new standards into force province-wide by April 2019. We continue to await their formal declaration, although the Ministry was informed in writing by the OAAF that all teams were being advised to follow the new standards as of that date, and no objection to their promulgation or recognition as best standard of care has ever been provided to the OAAF. The OAAF explicitly asked the MOHLTC to inform us of any objection to advising teams to adopt the new standards and no objection was ever provided, hence the OAAF interprets this as de facto approval.

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. Standards must also adhere to federal and provincial legislation.

In summary, the standards need revising to clarify grey areas, to reflect current best practices, to prevent model erosion and fidelity drift, to clarify discharge protocols and improve flow through, to highlight adjunctive stepped care service approaches, and to support teams facing untoward service pressures from oversight organizations that do not understand the importance of model fidelity for successful service efficacy.

III. Highlights & Changes Version 3.0 (Oct 21, 2016)

a) *Clients must be 18 or older, with no upper age limit.*
b) *Individuals with a primary diagnosis of borderline personality disorder, substance abuse disorder, or dementia are not appropriate client groups.*

c) *ACT Teams should not accept clients with a high risk for dangerousness who are not safely manageable in the community.*
d) *There must be a clear protocol in place to manage and triage a team's waiting list.*
e) *An ACT team must persistently, repeatedly and assertively attempt to engage with a new client for a minimum period of six months before terminating their referral.*
f) *Special efforts should be made to engage homeless persons with mental illness.*
g) *Regular consideration of transition/discharge readiness is a critical activity to support appropriate "flow through" and foster continuing availability of spaces for new ACT clients [six month ATR (ACT Transition Readiness scale) reviews suggested].*
h) *Teams are encouraged to develop an internal stepped care service level where client need supports it, and/or where local discharge service options are limited.*
i) *It is critical to have at least three months of unsuccessful engagement before discharging an active client from service and to document each attempt at engagement, as well as each service refusal.*
j) *When a client leaves abruptly or does not cooperate in a coordinated and seamless transfer of care to another region, the ACT team should end all involvement with the client a maximum of three months after their departure.*
k) *An ACT team that is fully funded and staffed to current standards is expected to serve a catchment area of 80,000-100,000 people and have a maximum of 85 clients.*
l) *It is clearly recognized that some teams have had to limit their capacity to 65+ clients for justifiable reasons. Given the pressure that teams face from oversight sources and regional health authorities to constantly increase their capacity, a review mechanism is established whereby a team may request an external fidelity review in order to establish/explain a particular capacity level. The results of the review process shall be binding upon the team, sponsoring agency and LHIN.*
m) *An ACT team must be available to directly provide (or through appropriate partnerships) treatment, rehabilitation, support and crisis services seven days per week, 24 hours a day (24/7). This means regularly operating and scheduling ACT staff to work shifts, thus providing direct ACT services at least 8 hours of every day, seven days a week. Additional daily/evening hours of ACT service are determined by clinical need. After-hours crisis service may be provided by ACT staff or through appropriate partnerships.*
n) *There is no set maximum or minimum number of client contacts; staff are encouraged to do what works best to support optimal outcomes for their clients. It is up to each ACT team, using its best clinical judgement, to make this determination and it is considered inappropriate for sponsoring agencies or hospitals to provide external direction to the team on this issue.*
o) *An ACT Team needs to employ a minimum of 11 FTE multidisciplinary clinical staff persons, including the team coordinator, plus 1 FTE program assistant, and a minimum 0.8 FTE psychiatrist. (total: 12.8 FTE)*
p) *Every person on an ACT team should only work for the ACT team. For example: the team coordinator has full time responsibility with his/her team and must not manage other hospital or agency programs; the program assistant must work full time with the ACT Team and not be assigned work responsibilities outside of ACT work.*
q) *It is not acceptable for funding provided to an ACT team to be used for other non-ACT services or non-ACT staff. Money not spent on that for which it was given will have to be returned.*

r) *ACT teams that have been unable to fill a mandatory position must continuously advertise the vacancy and may not hire another clinician to fill the vacancy for longer than twelve month contracts to allow for the filling of the mandatory position, should a skilled clinician become available.*
s) *All job vacancies on all ACT Teams in Ontario must be advertised on the central OAA website bulletin board. Each team is responsible for keeping listings current.*
t) *It is now optional for the team coordinator to determine whether or not they take on direct clinical care for clients. There is no longer a requirement for the team coordinator to carry a small caseload.*
u) *The Team coordinator develops and administers the ACT program budget. It is critical for the team coordinator to be aware of the team's financial resources at all times and to be a meaningful participant in all allocation decisions.*
v) *Each team must have a total of at least 3 Registered Nurses or Registered Practical Nurses (at least one of whom must be a Registered Nurse).*
w) *It is now necessary to have a peer specialist in a 1.0 FTE capacity. Each peer specialist must carry a full caseload (sponsoring agencies or hospitals may not override this requirement). Peer specialists will be required to receive role-specific training as per guidelines published from time to time by the OAA.*
x) *OCAN reviews (as part of treatment planning) are recommended annually (rather than at six month intervals).*
y) *There will be a formal fidelity review of each ACT Team in Ontario at least once every 5 years. At all other times, any staff member on an ACT Team in Ontario may also request a partial or full fidelity review.*
z) *Given current wait times and service demands it is clear that an existing ACT team in Ontario must never be converted to a FACT Team. Separate standards and operational parameters are being developed for FACT Teams in Ontario.*

Highlights & Changes Version 3.1 (Sept 27, 2019)

a) In 2018 the Ontario government announced the elimination of the provincial LHIN network and the ACT standards have been modified to reflect this transition.
b) A formal fidelity review of each ACT Team in Ontario should occur at least once every 5 years. In the absence of direction from the Ministry of Health, the OAAF (Ontario Association for ACT & FACT) has implemented a voluntary accreditation program for ACT teams in Ontario who wish to benefit from collegial support, and who wish to ensure ACT model fidelity and demonstrate that they are operating in accord with the highest operational standards.

Highlights & Changes Version 3.2 (Dec1, 2021)

a) Following a careful review of fidelity review practices in other countries and jurisdictions it became clear that formal mandated fidelity reviews at 5 year intervals were not sufficient to maintain model fidelity and prevent the fidelity drift that we have seen occur with some ACT teams in Ontario. Changes in leadership, pressure from management, inadequate funding, and misinterpretation of the provincial operational standards can have a significant impact on the quality and fidelity of service delivery.
b) Accordingly, these standards have been modified in Version 3.2 to reflect the best practices requirement that a formal fidelity review by an external authority with recognized ACT expertise be completed every 2 years.

c) Each fidelity review includes key outcome measures and affords each team the opportunity to compare its functioning across multiple domains and indicators with all other teams in Ontario.

Highlights & Changes Version 4 (Jan 21, 2023)

a) New ACT teams will have staged fidelity reviews after years 1, 2, and 3 and then, like all other established teams, at 2 year intervals thereafter.

IV. ACT Cost Effectiveness

Cost avoidance for 1 ACT Team with 85 clients through a reduction in hospital admissions:*

Pre ACT costs:	*$4.8 million per year*
Year 1 savings:	*$3.2 million per year*
Year 4 savings:	*$3.9 million per year*

1 ACT team at a cost of $1.3 million per year produces cost avoidance of $4 million per year**.

(based on Ontario 2002-2006 data, corrected from $632/bed day to $650/bed day)

This figure is very conservative and excludes ER visits, quality of life and productivity measures, and the reduction in community violence and court/jail costs.

Ontario ACT Program Standards - Version 3.1

1. Introduction

Assertive Community Treatment (ACT) is a client-centred, recovery-oriented, specialized 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 outpatient programs.

ACT services clients with serious mental illness who have significant functional impairments. ACT is delivered by a group of multidisciplinary mental health practitioners who work as a team and provide the majority of the treatment, rehabilitation, and support services to achieve their goals directly in the client's environment of choice. At least 75% of the practitioner's time is spent outside of their program offices.

The team is directed by a Team Coordinator. The team works in shifts to provide coverage 365 days a year and be available 24 hours a day for their clients. ACT services are individually tailored to each client and address the preferences and identified goals of clients.

2. Intake, Admission and Discharge Criteria

Admission decisions are based on considerations that include servicing those individuals who have previously failed cycling through the mental health system without positive clinical or psychosocial outcomes. This means that traditional case management services or other attempts at treatment have been unsuccessful. The research on ACT clearly states that the clinical practices perpetuated through the services are best for those with schizophrenia or an affective disorder such as bipolar illness. 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 research also demonstrates that individuals with a primary diagnosis of psychotic disorder do best on ACT teams due to the highly intensive service they receive. Individuals with a primary diagnosis of borderline personality disorder are not appropriate for ACT teams and should receive treatment in other programs specifically proven to help them (e.g. Dialectical Behaviour Therapy, or DBT).

3. Intake

It is important that ACT teams find ways to develop a collaborative intake process with community partners, hospitals and other social service organizations involved with their client. ACT teams must have clearly written and easily accessible, published admission criteria that are available to the public on their respective agencies' websites.

When ACT teams are in their developmental stages, client intakes should be staggered to between four and six client screenings per month. There is a notable difference between

the intake process and admission: A thorough screening process is required prior to the intake process taking place. It is important to ensure all of the client's relevant medical, clinical and historical information is received and understood before beginning the process of admission. If a client is being referred by a psychiatric specialist or psychiatric agencies/institution, it is imperative that the referral documentation includes a description of the patient's treatment-decision incapability status regarding the medications being prescribed.

Intaking four to six clients per month allows teams to enroll between 45 and 48 clients in their first year of operation. Thereafter, intake may be reduced to a rate of two to four clients per month. The majority of ACT teams in Ontario are currently at, over capacity, or close to capacity, so the rate of admission should be according to the ability of the team to take on and give the newly admitted client the appropriate time and resources that are required. It is imperative that the appropriate resources are in place, particularly with regard to organizational structures that safely admit new clients when teams are near capacity.

Where admission is limited by a lack of flow-through options (e.g., when ACT clients are ready for transition/discharge), each team is encouraged to work with their LHIN and local agencies to develop a stepped-care service level and timely case management options.

4. Admission Criteria

In selecting clients to admit, the ACT team should use the following criteria:

Clients must be 18 or older, with no upper age limit. (As geriatric clients age and have increasingly complex health care demands, and depending on services available in a given region, care may eventually be shared with, or transferred to, a community psychogeriatric service and/or nursing home.)

Clients with serious mental illnesses listed in the Diagnostic and Statistic Manual diagnostic nomenclature (currently the Diagnostic and Statistical Manual, Fifth Edition, or DSM 5, 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.

Some other sub populations are considered appropriate if they have been referred subsequent to unsuccessful treatment from a lesser intensive community mental health service.

- *i) Individuals with a primary psychotic disorder and a secondary diagnosis of personality disorder,*
- *ii) individuals with a concurrent disorder with intractable psychotic symptoms,*
- *iii) individuals with a dual diagnosis with a primary psychotic disorder,*
- *iv) individuals with organic disorders (i.e. brain injury) with intractable psychotic symptoms*

Individuals with a primary diagnosis of borderline personality disorder,

substance abuse disorder, or dementia are not the intended or appropriate client groups.

Clients admitted onto an ACT team should also have significant functional impairments as demonstrated by **at least one** *of the following conditions:*

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 others.

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).

Inability to consistently maintain a safe living situation (e.g., repeated evictions or loss of housing).

And

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):*

1. *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.*
2. *Intractable (i.e., persistent or very recurrent) severe major symptoms (e.g., affective, psychotic, suicidal).*
3. *Coexisting substance abuse disorder of greater than six months.*
4. *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.*
5. *Inability to consistently meet basic survival needs, residing in substandard housing, homeless, or at imminent risk of becoming homeless.*
6. *Residing in an inpatient 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.*

5. Assertive Engagement, Admission and Consent

An assertive outreach approach is a very important component and expectation of community mental health with both Support Coordination and ACT level of care. Making the right to treatment more attractive than the right to refuse treatment is an important challenge within this field. Conventional approaches to engagement should be attempted first. If these attempts do not establish rapport, more unconventional approaches should be attempted. People being referred to ACT should be some of the hardest to serve in the

community. These referrals may be very time consuming and successful engagement over a several month period will demonstrate ACT's worth to the community it serves. A person's capacity to consent to treatment needs to be thoroughly assessed. If the person is not capable of consenting, creative engagement strategies (with the support of the Substitute Decision Maker) should be tried. Individualized methods of outreach and engagement must be utilized in order to meet the unique needs of each person referred.

Homeless clients may be referred to ACT by homelessness outreach program staff in a given community, but where these specific outreach services do not exist, the ACT team itself should assertively attempt to engage any homeless person with suspected mental illness who comes to their attention.

Clients who are accepted for service by the ACT team may require an assertive engagement process in order to establish a relationship with the team and provide informed consent to receive treatment/service. In the case of clients who repeatedly decline attempts at engagement by an ACT team over time, and indicate that these interventions are unwelcome, the team must reassess the engagement process and establish a timeframe for terminating their interventions. The team must persistently, repeatedly and assertively attempt to engage with a new client for a minimum period of six months before terminating their referral. It is important to ensure that each attempt is documented. This information will then be transferred to the discharge document that accompanies each client the team discharges from service.

ACT clients are admitted when the team assumes responsibility for providing the treatment/ service. ACT is a voluntary service program with the following exceptions: when court-ordered, Ontario Review Board (ORB) ordered, or as the result of substitute decision-maker consent. Consent to treatment by the ACT team must 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.

6. Documentation of admission must include:

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

7. Documentation of Service Refusal by a Team

One of the biggest struggles ACT teams are subjected to is their referral sources misunderstanding the reason(s) why a client is refused ACT services. Education about ACT is an ongoing need for community partners, hospitals, correctional institutions and the criminal justice system, for them to have an appreciation of how the program model produces the best outcomes for appropriate clients. Across Canada, there is ***pressure*** *placed on ACT teams to take on clients who are clearly inappropriate for the service and could be better served by other types of treatment programs. It is important for ACT teams to provide clear documentation to the referral source, with the reasons they have when they refuse a referral (e.g., the individual has a primary diagnosis of borderline personality disorder and would be better served in a specialized day program for individuals with that diagnosis. Or, clients with primary substance abuse issues without a psychotic disorder need intervention through a residential facility, intensive counselling and harm reduction*

programs. Or clients with a high risk for dangerousness who are not safely manageable by a community ACT Team.

The ACT model has demonstrated effectiveness for "clients in the greatest need." Some of these clients have not received adequate assessment and appropriate services and are not being served in traditional mental health settings.

Many of the clients that teams have seen over the last decade have not had the historic experiences of long-term hospitalization in provincial psychiatric systems, due to the mental health reform process, which divested the former provincial psychiatric hospitals, and many of their tertiary-level services, to community hospitals and agencies. Newer ACT clients have not been involved in traditional mental health services like case management or crisis response, so early engagement with these individuals is imperative to begin the recovery process. Many of these individuals are at risk of being homeless or are already homeless due to an inability to maintain a secure living environment as a result of their illness.

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 clients, their families, and their support system.

8. Service Level Transitions and Discharges

Service level transitions and discharges from the ACT team ideally occur when clients and program staff mutually agree to the transition or termination of services. The ATR (ACT Transition Readiness Scale) can be a helpful tool in this regard, and many teams do an ATR review on clients every 6 months. The Level of Care Utilization System (LOCUS) is not recommended as it is too blunt an instrument for the nuanced considerations required for discharge planning in ACT.

Regular consideration of client transition/discharge readiness is a critical activity to support appropriate "flow through" and foster continuing availability of spaces for new ACT clients. In regions that lack an adequate number of ACT teams or spaces, or where transition or discharge options are limited or backlogged, teams are encouraged to develop internal stepped care service levels and/or push for the development and provision of more, and timely, external discharge opportunities. ACT teams should not have to keep clients who are ready to move on to next levels in their recovery process. This is not a cost effective use of ACT resources, and is a profound disservice to the broader community and new clients in critical need of ACT level care.

Transition/Discharge

a. Transition/Discharge occurs when clients have successfully demonstrated an ability to function in all major areas (i.e., work, social, self-care) with less ongoing assistance from the program, and without significant relapse when services are reduced (over

approximately a two-year period). They have also successfully reached individually-established goals for discharge.

ACT staff will arrange for transition or discharge to:

i) a less intensive internal "stepped care" service level (e.g. Central East LHIN Model);*

**Note: With this model, teams can have 25 of their most stable clients assigned to one prime care coordinator (Stepped Care Nurse) who is hired as an additional ACT Team member. This position requires extra LHIN funding over and above the standard ACT funding envelope. If ACT stepped care clients need intensive services again, they can then transition from a stepped-care service level back to a full service level for as long as needed. This model makes room for 25 new ACT level clients, is cost effective, and provides important continuity of care benefits for existing clients who would not do well if discharged to case management.*

ii) or a regional ACT step down team that 4-5 ACT teams within an urban region can feed into (Ottawa model);

iii) or to an affiliated/external service (community mental health service or hospital with outpatient case management) and maintain contact with the client until transfer is complete.

b. Discharge occurs when clients move outside the geographic area of ACT responsibility. When clients move, the ACT team will ensure that supports are in place for the client by partnering with the designated transfer community outpatient program. If clients are still in need of ACT services, then priority for an ACT-to-ACT team transfer should be automatic and the client should receive service from the ACT team in the community where they are moving. Priority is expected to be given to these transferred clients by the receiving ACT team so there is no disruption in service. A move to a different geographic area can occur abruptly but in the majority of cases, there is usually sufficient time to ensure a seamless transition.

When a move occurs abruptly best efforts should be made to arrange for a transfer of care. If a client leaves abruptly or does not cooperate in a coordinated and seamless transfer of care to another region, the ACT team should end all involvement with the client a maximum of three months after their departure. Psychiatrists will not prescribe medications for longer than the three months after departure, and will only do so during that three-month period if adequate distance contact and monitoring is satisfactory to the psychiatrist.

9. Refusal of ACT Service

Documentation of the reason(s) for discharging a client is very important. There are times where numerous attempts at engagement have been unsuccessful and this should be clearly documented. It is critical to have at least three months of unsuccessful engagement before discharging an active client from service and to document each attempt at engagement, as well as each service refusal.

10. Triage Protocol

There must be a clear protocol in place to manage and triage a team's waiting list. Following an intake assessment, the suggested triage ranking protocol is:

1) *readmission of your own previous ACT clients,*

2) *client transfers from other ACT teams,*

3) *forensics clients requiring ACT level community monitoring (ORB, low-moderate risk),*

4) *clients currently on an inpatient unit with a history of lengthy or frequent admissions who are ready for discharge (and are not being discharged prematurely because of a mistaken belief that ACT level care is comparable to custodial hospital care), and*

5) *clients assessed chronologically by date of referral.*

11. Readmission to ACT Services

ACT clients that have been discharged but need to be readmitted are to be given priority so there is no delay. This is crucial, given the philosophy that ACT has a long-term commitment to its clients.

12. Catchment Area

An ACT team that is fully funded and staffed to current standards is expected to serve a catchment area of 80,000-100,000 people.

It is understood that in some smaller catchment areas in Ontario (e.g. Kingston, St Thomas) more than one ACT Team has been deployed because of the extreme concentration of ACT level clients in some population centres around the former Provincial Psychiatric Hospitals.

13. Maximum Capacity

As a result of 25 years of Assertive Community Treatment service in the province of Ontario we have learned a great deal about how ACT operates within our particular Ontario service system (with its limited case management resources, limited inpatient beds, forensic monitoring expectations, and responses to homelessness). Research and experience make it clear that a fully staffed team (12.8 FTE) should service no more than 85 ACT level clients.

Research and experience also show that some of the intensive services, crisis response capabilities, and rehabilitation programming that ACT must provide become ineffective and unsustainable once a caseload goes over 85 clients.

Cost effectiveness and superior clinical outcomes are inextricably tied to fidelity.

14. Minimum Capacity

Decades of ACT experience across Ontario's expansive geography and various urban configurations has also taught us a great deal about practical limitations to service provision in some circumstances. Some teams have large geographic areas and wide population dispersal with which to contend. Others face dense urban traffic congestion. Some have higher concentrations of forensic clients and attendant intensive monitoring responsibilities. Others operate in areas with an insufficient number of regional ACT teams and have ended up with a concentrated client group marked by extreme complexity and exponential service demands.

These standards direct that all teams should, whenever possible, reach a capacity of 85 clients. It is also clearly recognized that some teams have had to limit their capacity to 65+ clients for the aforementioned reasons. Given the pressure that teams face from oversight sources and regional health authorities to constantly increase their capacity, a review mechanism is established whereby a team may request an external fidelity review (see fidelity review process below) in order to establish/explain a particular capacity level above 65 and below 85. The results of the review process shall be binding upon the team, sponsoring agency and LHIN.

15. Hours of Operation and Staff Coverage

The ACT team must be available to directly provide (or through appropriate partnerships) treatment, rehabilitation, and support activities seven days per week, 24 hours a day (24/7). This means regularly operating and scheduling ACT staff to work shifts, thus providing direct ACT services at least 8 hours of every day, seven days a week.

Additional daily hours of ACT service are determined by clinical need. A hallmark of ACT care is flexibility and accommodation, and putting the needs of the client first, day or night.

However a team's evening scheduling is organized, services and hours must be commensurate with essential clinical needs.

Examples of essential needs that may arise in the evenings are:

1) *Bedtime medication observations for non-compliant clients whose medication causes extreme drowsiness if taken earlier in the day;*
2) *Any exclusively evening or bedtime medications for which a client needs medication observation or reminders;*
3) *Clients who are working and for whom clinical contact is only possible in the evening;*
4) *Family meetings when family members are only available in the evening;*
5) *Social or recreational programs that are only available in the evening;*
6) *ACT supported child visits that are only possible in the evening.*

Note: Some teams have successfully modified their evening practices and scheduling by incorporating pharmacy deliveries, family involvement, and flex hours for ACT staff.

16. Crisis Assessment and Intervention

Crisis assessment and intervention must be provided 24 hours a day, seven days per week. These services include telephone and electronic media support and face-to-face contact. This is a vital part of the ACT service; it is one of the core components that make ACT an intensive treatment model.

Many teams over the past decade have coordinated their after-hours service with their local community crisis service, and have arranged for timely reports from the crisis service on the morning after it was used by a client. This model has worked well with the implementation of crisis services throughout the province. Many teams also still conduct their own on–call service directly within the team. Both models have proven to be very effective and work well, as long as a thorough orientation is completed with clients upon admission, to explain the availability of staff/resources when they are experiencing times of crisis.

17. Frequency of Client Contact

Frequency of client contact is a primary component of the ACT model that needs a more detailed explanation in this edition of the program standards. When clients are first admitted onto a team, there needs to be an intensive engagement that may include one or two daily contacts, as long as it is mutually agreed upon with the capable client (or the treatment plan is supported by the SDM). Sometimes, when a client is admitted to an ACT team, engagement can be problematic or difficult. The number of contacts should be at the high end upon initial admission and titrated down accordingly, once a thorough treatment/recovery plan is initiated. The philosophy and literature on ACT clients has the majority of enrolled clients receiving multiple team contacts per week.

Once clients have stabilized, many on the team's caseload (perhaps up to 25%) may be clients who are only seeing their clinicians once a week. Many questions have been asked around the number of client contacts by staff. It is important to realize that the quantity of contacts per se is not the primary concern; rather, the quality and necessity of the contacts for maintaining and promoting wellness in partnership with the client is the overarching focus. There is no set maximum or minimum; staff are encouraged to do what works best to support optimal outcomes for their clients. It is up to each ACT team, using its best clinical judgement, to make this determination and it is considered inappropriate for sponsoring agencies or hospitals to provide external direction to the team on this issue.

The ACT team must have the capacity to rapidly increase service intensity to clients when their status requires it or as the clients' request it. The average ACT team will likely provide an average of two to three contacts per week for at least 50 of their clients on the team's roster. A contact is defined as "a meaningful occurrence" or interaction between client and clinician that ideally takes place face-to-face. There may be instances where telephone and/or electronic media support are appropriate.

Data regarding the frequency of client contacts should be collected and reviewed as part of the program's Continuous Quality Improvement (CQI) plan.

18. Place of Treatment/Service

Each team should provide a minimum of 75% 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 neighbourhood, 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 illness.

19. Staff Requirements

Staff coverage gets at the critical mass of ACT staff needed to cover the 24 hours of service availability. Establishing staffing patterns such as shifts or staff rotations to deliver services 24 hours a day, seven days a week (24/7/365), guarantees regular staff assistance for clients when they need it, reduces client crisis, and helps reduce staff turnover.

A minimum of 11 full-time clinical staff are required 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).

ACT teams require adequate numbers of staff with sufficient individual competence to carry out the array of services and to establish quality supportive relationships with clients. This distinguishes ACT teams from other mental health programs. The multifaceted expertise of clinicians from various mental health disciplines that comprise an ACT team make it unique.

Aside from their clinical expertise, one thing that is essential for all clinicians working on an ACT team, is a thorough understanding of Psychosocial Rehabilitation (PSR) principles and practices and an understanding of the recovery model. In addition, clinical staff must embrace attitudes and embody values that are compatible with the ACT philosophy of compassion and respect for persons with severe mental illness and their experiences; understanding and believing in recovery concepts and clients' rights to determine their own goals, as well as client and family involvement in all activities that shape the quality of ACT services.

20. Qualifications

The ACT team is expected to have staff with sufficient individual competence, professional qualifications and experience to provide and balance the range of diverse services required by clients, such as treatment, rehabilitation and support. Core services of a team include, but are not limited to: 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 assistance, support and skill-building with activities of daily living; help with social, interpersonal relationships, and leisure-time activities; navigating support services or providing direct assistance to ensure clients obtain the basic necessities of daily life; and psychoeducational support and consultation to clients' families.

21. Required Staff

An ACT Team needs to employ a minimum of 11 FTE multidisciplinary clinical staff persons, including the team coordinator plus 1 FTE program assistant, and a 0.8 FTE psychiatrist.

All ACT teams require a psychiatrist, a program/administrative assistant, a team coordinator, registered nurses, registered practical nurses, and, at a minimum, a social worker, an occupational therapist, an addictions specialist, a vocational specialist, a peer specialist and other clinical staff.

The chart below shows the required minimum staff for a team. Please note that the minimum number is not necessarily optimal for any particular team. Teams may require additional staff for reasons such as caseload size and complexity.

Position	***ACT Requirement***
Team Coordinator Registered Nurse/Registered Practical Nurse Social Worker Occupational Therapist Substance Abuse Specialist Vocational Specialist Peer Specialist Other Clinical Staffs	1 FTE 3 FTE 1 FTE 1 FTE 1 FTE 1 FTE 1 FTE 2 FTE
Psychiatrist Program/Administrative Assistant	0.8 FTE 1 FTE ***12.8 FTE total***

Every person on an ACT team should only work for the ACT team. For example: the team coordinator has full time responsibility with his/her team and must not manage other hospital or agency programs; the program assistant must work full time with the ACT Team and not be assigned work responsibilities outside of ACT work. It is not acceptable for funding provided to an ACT team to be used for other non-ACT services or non-ACT staff [meaning other than the 12.8 FTE positions or as advised in the draft ACT Team budget (see appendix)]. Money not spent on that for which it was given will have to be returned.

Note: ACT teams that have been unable to fill a mandatory position must continuously advertise the vacancy and may not hire another clinician to fill the vacancy for longer than

twelve month contracts to allow for the filling of the mandatory position, should a skilled clinician become available.

All job vacancies on all ACT Teams in Ontario must be advertised on the central OAA website bulletin board. Each team is responsible for keeping listings current.

22. Roles

One of the most frequently asked questions from any ACT team member is how to assist individuals with a more defined description of what their role should be on a team.

This new set of standards will hopefully assist teams in understanding what each practitioner is responsible for as it pertains to the care of individual clients admitted into ACT.

These responsibilities are listed in general terms below…

23. Team Coordinator

A full-time team coordinator/supervisor is the clinical and administrative supervisor for the team. It is optional for the team coordinator to determine whether or not they take on direct clinical care for clients. This is something that is up to an individual's comfort level with being able to make the time commitment to having a clinical caseload. The indirect clinical work (from managing the daily morning team meetings and making constant clinical decisions that occur day to day) can be sufficient. There is no longer a requirement for the team coordinator to carry a small caseload.

The team coordinator is a health professional with substantial experience in the care and treatment of individuals with serious mental illness, with a diploma or degree in a relevant discipline, and who is committed to the philosophy and operating fidelity of ACT services. The coordinator's education can be from a variety of disciplines: nursing, social work, occupational therapy, counselling, or a combination of experiences and academics.

Leadership skills are imperative for the team coordinator position, and someone with a very affable and patient personality who is able to think quickly on their feet is critical.

The team coordinator is the senior clinician on the team. The role requires a competent clinician who leads client-centred assessments and individualized treatment planning by working side-by-side with clients and team members, and provides in vivo supervision. It is very difficult to direct service delivery without having firsthand knowledge of each client and their family. In point of fact, firsthand knowledge of clients makes clinical supervision far more effective and credible.

Examples of the Team Coordinator's responsibilities are listed below:

Directs the day to day clinical operations of the ACT team, including scheduling staff work hours to assure appropriate coverage for the day, evening, weekend and holiday shifts and on-call hours.

Leads the daily organizational staff meetings and treatment planning meetings.

Continually evaluates the status of clients and does appropriate planning and coordination of treatment activities to ensure immediate attention to their changing needs.

Directs and coordinates the client admission process. The ideal situation is where the team coordinator meets the potential client (with the psychiatrist if they feel this would be helpful) after receiving a referral and determines suitability for the ACT program.

Participates in staff recruitment, interviewing, hiring, termination, work assignments, orientation and performance supervision.

Develops and administers the ACT program budget. It is important for the team coordinator to have a thorough understanding of the available financial resources at all times in order to manage the program accordingly. Many teams have higher level administration oversee their budgets; this is not an adequate approach because it is critical for the team coordinator to be aware of the team's financial resources at all times and to be a meaningful participant in all allocation decisions. The team coordinator ensures ACT funding is allocated appropriately, according to the Standards, and according to team needs. Team coordinators should also have responsibility to apportion resources for travel and staff education.

Develops and maintains program policies, and reviews and revises as necessary.

Providing a thorough orientation of the expectations for this position when an individual is hired reinforces the required skill set for directing an ACT team. Team coordinators are the individuals who ultimately have to make quick and sometimes, very difficult decisions. Flexibility is highly valued and having the ability to collaborate regularly with the team psychiatrist works best for success in this position.

Team Coordinator and Staff Supervision:

The team coordinator assumes the responsibility for supervising and directing all staff activities. Supervision and direction consists of:

Individual, side-by-side sessions, in which the coordinator 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;

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;

Regular meetings with individual staff to review their work with clients, assess clinical performance, and give feedback;

Regular reviews, critiques, and feedback of staff documentation (i.e., progress notes, assessments, treatment/service plans, treatment/service plan reviews).

Note: It is recommended that the team coordinator position not be part of a Bargaining Unit, where possible.

24. Program/Administrative Assistant

The program/administrative assistant 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. The program/administrative assistant is a proactive, problem solving team member who works in close collaboration with all team members and receives guidance and support from the Team Coordinator.

It is the role of the program/administrative assistant on an ACT team to:

Skillfully support clients with severe mental illness when they are seeking services.

Greet people at the ACT offices and answer telephone calls.

Triage and coordinate communication between team and clients.

Liaise with the CTO coordinator.

Obtain answers to questions for clients, families, community resources and agencies.

Work with callers to relieve urgent situations or to temporarily manage them until other staff are available.

Assess and report behaviours that are out of the ordinary for that particular client.

Prepare the staff work schedule, recommend and revise policies and procedures pertaining to these schedules.

Maintain records of staff time worked and leave.

Order and maintain unit supplies, equipment, and furniture, and arrange for repairs when necessary.

Record important statistical requirements such as client admissions and discharges.

Inform and consult with ACT team members for the proper maintenance of the clinical client records.

Prepare letters, memos and reports using word processing equipment.

Collect necessary data and prepare reports.

25. Psychiatrist

The psychiatrist position is a minimum of 0.8 FTE. It is recognized that some teams may wish this, at their discretion, to be a 1.0 FTE depending on the particular team's client mix (e.g., more forensic clients, higher concentration of acuity/risk, extraordinary illness complexity, geographic dispersal, etc.).

ACT teams must never intentionally keep the psychiatrist position partially or fully vacant in order to direct psychiatrist dollars to other ACT services or positions.

Some ACT teams have more than one psychiatrist sharing the 0.8 FTE position, which can work adequately as long as it doesn't devolve into an external consultation model. An ACT psychiatrist working and participating as a full team member is critical to team function and client success.

A model in which clients are taken to an outpatient department to see a psychiatrist is not preferred. While this may, from time to time, be all that is available locally, it should only be used when clinically essential and a return to standard ACT operating practices should occur as soon as possible. An ACT psychiatrist and a psychiatrist consulting to an ACT team have very different skill sets and levels of participation in ACT services and team function. An ACT psychiatrist has a unique and sophisticated community psychiatry skillset akin to specializations in forensic, geriatric, pediatric, consultation-liaison, addiction, or dual diagnosis psychiatry.

Some ACT teams have negotiated a combination of part-time and on-call hours with their psychiatrists. The risk with this approach is that some teams and sponsoring agencies may intentionally understaff the psychiatry position for cost saving or funding diversion purposes. The FTE requirements delineated above must guide best practice, and any on-call availability over and above that should be welcomed (but is not mandatory).

Even though psychiatrists work part-time, it is crucial for them to have designated hours when working on the team. The psychiatrist's hours should be sufficient blocks of time on consistent days in order to carry out their clinical, supervisory and administrative responsibilities.

It is necessary to arrange for and provide alternative back-up for all hours the psychiatrist is not regularly scheduled to work. Alternative psychiatric back up may include the local mental health centre's psychiatrist, or an emergency room's psychiatrist.

ACT psychiatrists are paid on a salary/compensation model out of specific ACT funding dollars and are not allowed to bill OHIP for client contact because this would be inappropriate double billing. The salary/compensation model is essential to provide the service flexibility and crisis response time that the variability of ACT client needs demand.

The ACT psychiatrist is not just a consultant to the team. It is imperative that the team psychiatrist functions as a full team member. This requires attending morning meetings and the scheduled weekly treatment/recovery review meetings to offer direction and assistance to the 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.

When ACT clients are admitted to hospital, it is effective to have collaboration between the team psychiatrist and the inpatient psychiatrist. Some teams have service agreements with the admitting hospital. In some cases, ACT psychiatrists follow clients when they are admitted.

Some of the specific responsibilities of the ACT team psychiatrist are listed below:

Conducts psychiatric assessments, including psychiatric history, course of illness and response to treatment(s), mental status examination and DSM 5 diagnoses. Psychiatrists present their assessment results at daily team meetings and treatment/recovery plan meetings.

Collaborate with Registered Nurses/Registered Practical Nurses in assessment of clients' physical health, making appropriate referrals to general practitioners or specialists for further assessment and treatment, when required.

Prescribe psychotropic medications, conduct regular assessments of therapeutic responses and side effects, and educate clients about their prescribed medications.

Provide individual, group, and family therapy, as well as illness education.

Provide on-site crisis assessment and management of clients during regular work hours, and over the phone, during other hours when it has been negotiated.

Be actively involved in inpatient admissions where staff privileges are available for seamless follow-up care.

Submit written reports and documentation in a timely fashion within the standard guidelines for the agency or hospital practice that is in place.

Assist the team coordinator, where appropriate, in the administration of the clinical program.

Provide ongoing training to the ACT team members in the knowledge and skills basic to the treatment of persons with severe and persistent mental illness.

Offer treatment tools to clients, which enable them to manage their own illness. This includes, but is not limited to, the following:

Deliver ongoing, comprehensive assessments of clients' mental illness symptoms, make accurate diagnoses, and monitor and document clients' response to treatment(s) with the purpose of optimizing symptom reduction.

Engage in psychoeducation regarding mental illness, the intended effects and side effects of prescribed medications.

Symptom management efforts directed to help each client identify/target the symptoms and occurrence patterns of their mental illness and developing methods (internal, behavioural, or adaptive) to help lessen the effects.

Individual supportive therapy.

Psychotherapeutic interventions such as Cognitive Behavioural Therapy and individual psychotherapy (or supervision and/or assistance if appropriate when these are delivered by other trained/skilled clinicians).

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.

The ACT team psychiatrist's role is to:

Establish an individual clinical relationship with each client;

Assess each client's mental illness symptoms and provide verbal and written information about mental illness;

Make an accurate diagnosis based on the comprehensive assessment which dictates an evidence-based medication pathway that the psychiatrist will follow;

Provide education about medication, benefits and risks, and obtain informed consent for treatment; and

Assess and document the client's mental illness symptoms and behaviour in response to medication, as well as monitor and document medication side effects.

All ACT team members assess and document the client's mental illness symptoms and behaviour in response to medication and monitor for medication side effects.

The ACT team establishes medication policies and procedures which identify processes to:

a. *Order medication;*

b. *Arrange for client medications, as required, to be organized by the team and integrated into clients' weekly schedules and daily staff assignment schedules;*

c. *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*

d. *Administer medications per regulations in Ontario to team clients.*

Note: Nurse Practitioners (NP) and Physician Assistants (PA) potentially have important and helpful roles to play on ACT Teams (monitoring more stable clients, physical medicine challenges). The scopes of practice for both disciplines are not yet clearly defined or well developed for tertiary psychiatric care in Ontario. What is clear in the present and will remain true in the future is that psychiatrists on ACT Teams cannot be replaced or have reduced working hours because a NP or PA is also working on, or closely with, the team.

To be absolutely clear, the psychiatrist has a specialist skill set (complex medication management, capacity assessment, psychotherapy, rehabilitation expertise, and legal responsibilities) that cannot be supplanted by NP or PA clinicians.

26. Registered Nurses/Registered Practical Nurses

The scope of practice for Registered Practical Nurses has changed immensely, particularly since the last set of standards was released. It is valuable to have at least three Registered Nurses/Registered Practical Nurses on each team. Many ACT teams in Ontario employ a blend of Registered Nurses and Registered Practical Nurses and this staffing complement works extremely well.

Of note, practice guidelines stipulate that Registered Nurses may care for anyone, including complex and unstable patients. Registered Practical Nurses are partially limited insofar as their primary role is in the care of clients who have reached some level of stability in illness presentation. This distinction may be of little practical significance in the day to day work of ACT, but it bears mentioning that each team must have at least one Registered Nurse and that there is a special burden of responsibility that falls to Registered Nurses when dealing with unstable patients.

The Registered Nurses/Registered Practical Nurses on an ACT team are expected to:

Instruct ACT clients and their families in health education and disease prevention, educate, support and advocate for clients and their families about their rights and preferences around treatment and recovery.

Coordinate, schedule, and administer medical assessments of clients' physical health, making appropriate referrals to community physicians for further assessment and treatment, and coordinate psychiatric treatment with medical treatment, in collaboration with the team psychiatrist.

Provide assistance in the maintenance of clients' physical health through collaboration with family physicians or nurse practitioners to ensure that clients' primary care needs are being met. Nurses may conduct home visits to determine the clients' needs, which may result in first aid, treatments such as medication administration, glucometer readings, monitoring of vital signs, and observation for changes in clients' conditions that require physical attention, with an ongoing duty to record information in the client file.

Assume responsibility for developing, writing, implementing and evaluating, and revising overall treatment goals and plans, in collaboration with the client.

Provide individual supportive therapy and symptom management, ensuring that immediate changes are made in the treatment/recovery plans as clients' needs change.

Develop, revise, maintain and supervise team psychopharmacologic and medical treatment and medication policies under the direction of the psychiatrist, by transcribing, administering, evaluating and recording psychotropic medications prescribed.

Evaluate and chart psychotropic medication effectiveness, complications, and side effects, and arrange for required lab work, according to protocol.

Organize with other team members to manage a system of providing medication to clients and integrating medication administration tightly into clients' individual/recovery plans.

Manage pharmaceutical and medical supplies, under the direction of the team psychiatrist and in collaboration with other nurses on the team.

Participate in treatment, rehabilitation, and support services.

27. Social Worker

The social worker may have a BSW or MSW depending on a team's preference or hiring policies. The social worker must be registered (RSW).

The Social Worker is an integral member of the team who provides counselling and guidance to ACT clients. The social worker counsels individuals and family members regarding behavioural modifications, symptom management, rehabilitation, social adjustment, and financial assistance.

The ACT team social worker is responsible for:

Counselling and educating families about severe and persistent mental illness.

Interviewing individuals, families and significant others to assess clients' social, emotional, physical and mental impairments, as well as financial needs.

Assisting clients in obtaining appropriate community resources for financial support, such as ODSP, Ontario Works, supportive housing, etc.

Determining clients' eligibility for financial assistance, where appropriate.

Leads group counselling sessions and plans psychosocial programming for clients in need of specific services, essentially serving as a liaison between social service agencies and clients.

Developing program content, organizing, and leading activities planned to enhance the social development of individual ACT clients.

Investigating and monitoring home conditions to determine safety and avoid harmful living conditions, in partnership with the rest of the clinical team.

Obtaining a thorough social history in a timely manner with each new client and bringing relevant concerns to the attention of all team members.

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 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:

Individualized psychoeducation about the client's illness and the role of the family and other significant people in the therapeutic process.

Intervention to restore contact, resolve conflict, and maintain relationships with family and/or other significant people.

Ongoing communication and collaboration, face-to-face and by telephone or electronic media, between the ACT team and the family.

Introduction and referral to family self-help programs and advocacy organizations that promote recovery.

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.

An essential core activity of ACT is supporting client self-determination in relation to legal matters (charges, diversion, probation, CTOs, SDMs, PGT- guardianship, POA, Mental Health Advance Directives and PHIPA). The social worker should have special knowledge and expertise in these areas and should support team members with knowledge sharing and advice.

28. Peer Specialist

When the first set of Standards was released in 1998, the requirement for a Peer Specialist was to be a 0.5 FTE designated per team. The teams quickly found the valuable role that individuals with lived experience fulfill on teams.

It is now necessary to have a peer specialist in a 1.0 FTE capacity. The peer specialist provides expertise that professional training cannot replicate. Peer specialists can provide essential expertise and consultation to the entire team that assists clients with self-determination and decision-making.

The peer specialist must be paid a salary commensurate with other staff members bearing in mind that lived experience with mental illness is a credential, while the individual who fills this position will also have qualifications that would be required of any mental health clinician on the team (e.g., degree, diploma, relevant prior mental health service delivery experience).

Peer specialists provide mutual support, including the sharing of experiential knowledge and skills and social learning, which plays an invaluable role in clients' recovery. Individuals with lived experiences encourage and engage other clients in recovery and provide each other with a sense of belonging, supportive relationships, valued roles, and community.

ACT teams are expected to promote client-centred practices by integrating the peer role as a specialized clinician, and by encouraging the active participation of clients in service planning and development.

Peer support services validate clients' experiences and guide and encourage them to take responsibility for and actively participate in their own recovery. In addition, peer support helps clients identify, understand, and combat stigma and discrimination against mental illness and develop strategies to reduce self-imposed stigma.

Some of the practices that the Peer Specialist is responsible for on an ACT team are listed below:

Judicious utilization of self-disclosure and sharing of life experience to serve as a mentor and role model.

Assist clients to recognize and develop coping mechanisms to deal with symptoms of mental illness, and social stigma.

Educate staff within the team regarding the consumer perspective on the mental health system, and assist the team in maintaining a client-centred approach that maximizes client participation and empowerment.

Advocate for the development of consumer initiatives within the community and identify opportunities for client empowerment.

Introduce and refer clients to consumer self-help programs and advocacy organizations that promote recovery.

Each peer specialist must carry a full caseload as per the guidelines above. Sponsoring agencies or hospitals may not override this requirement (and thereby place an undue work burden on other team members).

Peer specialists will be required to receive role-specific training as per guidelines published from time to time by the OAA.

29. Occupational Therapist

The original set of ACT standards did not have a designated occupational therapist required for each team. It was found quickly that an important addition to teams would be provided by an occupational therapist.

The occupational therapist plans, organizes and conducts functional assessments. Their role is particularly important during the first few months of a client's assessment and admission to a team. It is useful to have both an informal, and formal assessments completed to distinguish the level of severity in functional impairments that an ACT client has.

The occupational therapist should assist with individual activities of daily living. It is important that the client is able to have the skills required to live in an environment of their own choosing. Some clients have had the skills prior to the disruption of their lives, to live independently, and may need to be re-taught.

Like all ACT team members, the occupational therapist must work in partnership with the other clinicians to adjust treatment plans that accommodate the clients' needs. It is important for ACT clients to maximize their independence by gaining new skills and adapting existing skillsets required for independent living.

Activities of daily living services support clients to: find housing that 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, linens, food, and cleaning supplies); perform household activities like 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 family physician and dentist.

Occupational therapy services include:

Individualized functional assessments.

Problem solving for tasks associated with activities of daily living (i.e., bill payments).

Individual assistance and support on a face-to-face basis, as needed.

Skills training.

Ongoing functional supervision (e.g., providing prompts, assignments, monitoring, and encouragement).

Environmental adaptations to assist clients in gaining or using existing skills to perform the above activities.

30. Addiction Specialist

The addictions specialist is responsible for completing the use of drugs and alcohol assessment and presenting the assessment findings at the treatment/service-planning

meeting. Substance use is typically not assessed sufficiently with persons with serious mental illness.

Accurate substance use assessments are time-consuming in order to collect information that evaluates and determines whether clients have a substance abuse disorder, and if so, to develop appropriate treatment interventions for integration into the comprehensive treatment plan. Team members with concurrent disorder expertise collaborate with the individual treatment/service teams and take primary responsibility for assessing, planning and developing treatment(s) for clients with substance use problems. Standardized assessment tools for substance abuse should be used.

The addiction specialist on an ACT team is expected to perform the following functions for individuals and/or groups:

Provide a stage-based, integrated treatment/service model that is non- confrontational, considers interactions of mental illness and substance abuse, and has client-determined goals. Assess, using standardized assessment tools for substance abuse and monitor with ongoing reassessment(s);

Engage in motivational interviewing/counselling (e.g., stages of change, developing discrepancies, decisional matrix);

Conduct active treatment/service (e.g. counselling, cognitive skills training, community reinforcement);

Develop and deliver relapse prevention resources (e.g., trigger identification, building relapse prevention action plans); and

Refer to withdrawal management services as needed.

31. Vocational Specialist

Vocational specialists are also referred to as employment counsellors. Their role is important on the team as they help ACT clients to understand their capabilities and develop employment, educational and/or volunteer goals. They work in partnership with the client to link them with workplace options and to direct employers. It is critical that vocational specialists have an awareness of their clients' potential and know what skills would be required in the vocation of their clients' choice.

The role of vocational specialist on an ACT team is expected to:

Sit directly with the client to learn about their personality, education and previous work experience, skills and interests. It is up to the expertise of the vocational specialist to determine what aptitude and occupational preference tests they administer.

Administer any training and skill-building that clients request when pursuing vocational or educational goals for themselves. Other skills such as t, job search, employment planning, supported employment, supported education, and leadership training may also be provided.

The vocational specialist should work within the team with clients and limit brokering of their services to other employment agencies. Ensure that linkages are made for clients to have optimal opportunities for paid and unpaid work experiences, and educational/training options.

Work-related services help clients value, find and maintain meaningful employment in the community. Services in this category are identified in the MOHLTCMOHLTC's 2000 policy framework for employment supports, Making It Work, and are still relevant today. Services are provided within the team and/or in collaboration with other community resources, and may 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 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 interpersonal and social skills for 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 work-related service. Job search skills programs teach people how to prepare résumés, 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.*

5. *Employment Planning/Career Counselling*
    - *This element involves assisting people to develop a vocational or employment plan that either leads 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 existing jobs or remain in their chosen educational programs.*
   - *The support needed may involve education or specific problem-solving skills acquisition for consumers, employers and co-workers alike. Supports can also involve coordination and advocacy to ensure consumers have access to necessary community resources, such as income supports, supports within 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.*

32. Other Clinical Staff

There are two positions where there is flexibility for each team to hire individuals who provide rehabilitation and clinical support functions. These individuals can have a college diploma in a program such as social service worker, spiritual care worker, behavioural science technology, and human services worker. Education and experience are important combinations to recognize in successful ACT workers. Personality is key in these positions, as staff need to be able to face challenging experiences and be extremely flexible, patient, compassionate and empathetic.

Because it is challenging to provide on-the-job training on an ACT team, staff must have previous experience working with persons with serious mental illness. Therefore, recruitment and hiring are extremely important when filling all positions, but particularly when filling the positions for other clinical staff. This gives the team an opportunity to look at the specific needs of the team and what would be best suited to meet the clients' needs. For example, one Ontario team has an Indigenous support worker who has been extremely well-received to provide added cultural expertise to their program. Other teams have hired recreational therapists, who are critical in developing physical and leisure activities. Teams can assess what positions are needed to add additional skillsets that meet their clients' needs.

Other clinical staff may have a variety of responsibilities, which may include, but are not limited to, providing assistance with:

Medical and dental care.

Securing safe, clean and affordable housing.

Financial support and/or benefits counselling (e.g., social assistance, ODSP, CPP, federal disability tax credit).

Accessing social services.

Transportation (e.g., navigating public transportation).

Legal advocacy and representation.

Supportive individual therapy and coaching (e.g., problem-solving, role-playing, modeling).

Social-skill teaching and assertiveness training.

Planning, structuring, and prompting of social and leisure-time activities

Organizing individual and group social and recreational activities to help structure clients' time, increase their opportunities for social experiences, and provide them with opportunities to practice social skills and receive feedback and support to develop those skills.

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, neighbours, and others effectively; and familiarizing themselves with available social and recreational opportunities and increasing their involvement in community living.

33. Orientation for New ACT Personnel

It is imperative that each ACT team have an intensive training program set up for each new staff member who joins the team. Medication management is an important part of the ACT orientation process.

34. Program Organization and Communication

Working as a multidisciplinary team, staff organization and communication are critical to delivering highly individualized services in community settings. Unless the ACT program's organization and communication structure is solidly in place, it is impossible for teams to provide the myriad of intensive services to clients, while ensuring their coordinated care.

35. Staff Communication and Planning

The ACT team conducts daily organizational staff meetings at regularly scheduled times as per a plan established by the team coordinator. These meetings will be conducted in accordance with the following procedures:

Teams maintain a daily log, which provides:

A roster of the clients served in the program; for each client, a brief document of services that have been provided during the last 24 hours and a concise, behavioural description of the client's status that day.

The daily organizational staff meeting shall commence with a review of the daily log to update staff on the client contacts during the day before (reviewing the previous 24 hours) and provide a systematic means for the team to assess the day-to-day status and progress of each client.

Under the direction of the team coordinator, the ACT team maintains a weekly schedule for each client. The weekly client schedule is a record of all client contacts that staff must carry out to fulfill the goals and objectives in the client's treatment/service plan. The team is expected to maintain a central file of all weekly client schedules.

Also under the purview of the team coordinator, the team develops a daily staff assignment schedule from the central file, of all weekly client schedules. The daily staff assignment schedule is a timetable for all the client contacts and all indirect client work (e.g., medical record review, meeting with collateral contacts 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.

The daily organizational staff meeting includes 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 assigns staff to carry out the service activities scheduled to occur that day, and the shift organizer is responsible for ensuring that all tasks are completed or rescheduled.

During the daily organizational staff meeting, the ACT team also revises treatment/ service plans as needed, plan for emergency and crisis situations, and add client contacts to the daily staff assignment schedule, as per the revised treatment/service plans.

The ACT team conducts treatment/service-planning meetings under the supervision of the team coordinator and psychiatrist. These treatment/service planning meetings are expected to:

Convene at regularly planned times per a written schedule set by the team coordinator. This usually means that an hour is set aside during the week to review and update at least four to five treatment/service plans.

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);

Require individual staff members to present, systematically review and integrate client information into a holistic analysis that prioritizes issues; and

Occur with sufficient frequency and duration to make it possible for all staff:

To be familiar with each client, their goals and aspirations;

To participate in the ongoing assessment and reformulation of issues/problems;

To problem-solve treatment strategies and rehabilitation options;

To participate with the client and the IT/ST in the development and revision of the treatment/service plan; and

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 functional teamwork.

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

36. Service Coordination

Each client is assigned a "primary coordinator". One of the main responsibilities of the primary coordinator" is to organize and monitor the treatment/recovery plan for the client. This person knows all aspects of the client's care and coordinates meetings to discuss the client's progress.

37. Client-Centred Assessment and Individualized Treatment/Service Planning

The purpose of the 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 individual treatment/service team 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 treatment/rehabilitation/support approaches and interventions achieve 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 aspects of psychosocial functioning that are important to the client.

38. Initial Assessment

The initial assessment takes place once a client has been accepted into the team, and is different than the intake process, which determines eligibility for admission. The initial assessment is conducted within 30 days of the client's admission to the program. The team coordinator determines which practitioners are best suited to meet the client over the first few weeks of engagement. The initial assessment process is developed through mini teams, for example, a nurse, addiction specialist and social worker may be the first individuals to assess the client and establish rapport. Then, a report is made on the client record, describing initial findings and a treatment/recovery plan is developed within 30 days of admission. The client's weekly schedule is established as a joint venture with the client during this time.

39. Individual Treatment/Service Plan/Recovery Plan

To be completed within 30 days of ACT admission.

Treatment/service plans are created through the following process:

The treatment/service plan is developed in collaboration with the client and the family or substitute decision-maker, if feasible and appropriate. The client's participation in the development of the treatment/service plan must be documented. Together, the ACT team and the client assess the client's needs, strengths, and preferences, and flesh out an individualized treatment/service plan, which serves to: 1) identify individual issues/problems; 2) set detailed and measurable long- and short-term goals for each issue/problem; and 3) establish 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). Recovery permeates every aspect of the treatment plan. Plans should include psychosocial rehabilitation components of recovery such as self-direction, allowing clients to lead, exercise choice and determine their own path by optimizing autonomy, independence and control of resources to achieve a self-determined life. By definition, the recovery process must be self-directed by the individual, who defines his or her own life goals and designs a unique path towards those goals. The plan should examine individuals' unique strengths and resiliencies, as well as their needs, preferences, experiences and cultural background in all of its diverse representations. Clients should be empowered to choose from a range of options that they may not have been exposed to before ACT programming. Clients are encouraged to participate fully in all decisions that affect their lives. The treatment plan is a tool that the client should work with and revisit daily, not just review every six months. It is important to look at individual strengths during the treatment planning process, not just at client problems. The ultimate goal for ACT clients is to have personal responsibility for their own journey of recovery. At times, taking steps towards achieving these goals takes an enormous amount of courage and the guidance of a skilled ACT practitioner.

The treatment plan process should be filled with hope that ACT clients can overcome barriers and obstacles that confront them.

Note: It should nevertheless be understood that some clients consistently lack insight into their illness and will be limited in their abilities and desire to be involved in such a plan.

The plan must identify who will carry out specific approaches and interventions.

ACT team staff meet at regularly scheduled times for treatment/service planning. At each treatment/service planning meeting, the following staff should attend: the team coordinator, psychiatrist, primary service coordinator, individual treatment/service team members, peer specialist and any other ACT team members involved in regular tasks with the client.

Individual treatment/service team members are responsible to ensure the client is actively involved in the development of their recovery goals. With the consent of the client, ACT team staff also involve pertinent agencies and members of the client's social network in the formulation of treatment/service plans

The following key areas should be considered for every client's treatment/service plan, including but not limited to: 1) recovery-based language when describing 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, are 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 to a year. This will include psychiatric reassessment of the client's treatment-decision capability as such capability is not necessarily static.

Additionally, the service coordinator prepares a summary (i.e., documented treatment/service plan review) which thoroughly describes the client's and individual treatment/service team's evaluation of their progress/goal attainment, the effectiveness of interventions, and the client's satisfaction with services since the last iteration of the treatment/service plan. The plan and review are signed or verbally approved by the client and/or substitute decision maker, the service coordinator, individual treatment/ service team members, the team coordinator, the psychiatrist, and all ACT team members.

40. Comprehensive Assessment & Ontario Common Assessment of Need (OCAN)

A comprehensive assessment must be completed by an ACT team member in collaboration with the client. Any ACT staff person may be designated to complete the comprehensive assessment, provided they are skilled and knowledgeable in the areas to be assessed. It is acknowledged that further, in-depth assessment can be added to the initial comprehensive assessment at any time. The initial assessment is based upon all available information, including but not limited to, that from client interview/self-report, family members and other significant parties, and written summaries from other agencies, including police, courts, and outpatient/inpatient facilities, where applicable. Consent to the collection, use and disclosure of this information must be obtained, particularly if consent is required to comply with legislation. The team member who conducts the assessment presents the findings at the first treatment/service planning meeting, along with the psychiatrist. A comprehensive assessment is initiated and completed as soon as possible and may be done prior to a client starting service, but ideally, no later than one month after a client's admission. The comprehensive assessment includes an evaluation in the following areas:

a. *Psychiatric History, Social Function History, Mental Status, and Diagnosis: The psychiatrist is responsible for completing the psychiatric history, mental status, and diagnostic assessment. ACT team member(s) supporting the completion of the comprehensive assessment may assist in the collection of information for the psychiatric history. The psychiatrist presents the assessment findings at the first treatment/service planning meeting. The psychiatric history, mental status, diagnosis, assessment, and treatment-decision capability assessment involves careful and systematic collection of information from the client, family, and past treatment records regarding the onset, precipitating events, course and effect of illness, 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 ensure accuracy of the diagnosis. Upon completion and presentation of the psychiatric history, mental status, and diagnostic assessment to the team, the psychiatrist prepares a psychiatric history narrative for the client's medical record.*

b. *Physical Health: Initial physical health information may be obtained by the ACT team member(s) designated to complete the comprehensive assessment. It is recommended that the registered nurse/registered practical nurse assists in obtaining a family physician for the client if they do not have one. The registered nurse/registered practical nurse can then coordinate the treatments needed or prevention methods in conjunction with the family physician. The purpose of the physical assessment is to thoroughly evaluate the client's physical health status and identify any medical conditions present to ensure appropriate treatment, follow-up and support are provided. Due to the potential urgency of some physical conditions, the physical health assessment should be done prior to or immediately at the start of service.*

c. *Use of Substances: Initial substance use information may be obtained by the ACT team member(s) designated to complete the comprehensive assessment. The addiction specialist is responsible for reviewing information (where applicable) and completing (where applicable) the substance use assessment, and presenting these assessment findings at the first treatment/service planning meeting.*

d. *Education and Employment: Initial education and employment information may be obtained by the ACT team member(s) designated to complete the comprehensive assessment. The vocational specialist is responsible for reviewing information and completing (where applicable) the education and employment assessment and presenting their assessment findings at the first treatment/service planning meeting. Employment is of great consequence to people with mental illness and is a normalizing structure that can be 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 identify with clients: how they currently structure their time; current school or employment status; interests and preferences regarding school and employment; and, how symptomatology has affected previous and current school and/or employment performance. This assessment begins the*

working relationship between the client and vocational specialist to establish educational and occupational goals.

e. *Social Development and Functioning: Initial social development and functioning information may be obtained by the ACT team member(s) designated to complete the comprehensive assessment. The social worker is responsible for reviewing the information, completing (where applicable) the social development and functioning assessment, and presenting these assessment findings at the first treatment/service planning meeting. The purpose of the social development and functional assessment is to obtain information from clients about their childhood experiences, early attachments, roles in their 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): Initial ADL information may be obtained by the ACT team member(s) designated to complete the comprehensive assessment. The occupational therapist, social worker, or nurse may be responsible for reviewing the information, completing (where applicable) the ADL assessment and presenting these assessment findings at the first treatment/service planning meeting. The purpose of the ADL 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 ADL function is basic to successful community adjustment for persons with serious mental illness. Consistent assistance to meet ADL needs helps clients feel more confident and less vulnerable about living in the community. While occupational therapists, social workers and nurses have the specific training to complete the ADL assessment, other staff with an interest in this area can be trained accordingly.*

g. *Family Structure and Relationships: Initial family structure and relationship information may be obtained by the ACT team member(s) designated to complete the comprehensive assessment. The social worker is responsible for reviewing the information, carrying out the family structure and relationships assessment and (where applicable) presenting these assessment findings at the first treatment/service planning meeting. Historically, many people with serious mental illness have received the majority 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. Mental health providers have not always included or welcomed the participation of families or other significant people in clients' lives. 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 begins at the initial admission meeting with the client and the family members or significant others who are participating in the admission.

While the assessment process involves input of most, if not all, team members, the client's psychiatrist, primary coordinator and individual treatment/service team members assume responsibility for ensuring completion of the written narrative of the results, formulating the psychiatric and social functioning history timeline (optional) and completing any missing components of the comprehensive assessment, ideally, within six months of the client's admission to the program.

The service coordinator and individual treatment/service team members are assigned by the team coordinator in collaboration with the psychiatrist by the time of the first treatment/service planning meeting or within 30 days of admission.

It is recommended that teams complete an initial OCAN assessment within 90 days of admission to the team. The OCAN was chosen as a provincial assessment with one of the important benefits being the client input component. The OCAN assessment is considered an addition to -- not a replacement for -- the comprehensive assessment. Subsequent OCAN reviews as part of treatment planning are recommended to be done annually (rather than at six month intervals) for ACT clients.

The Comprehensive Assessment sub-committee of the Technical Advisory Committee has developed a standardized checklist (see appendix) with assessment topics to guide the initial history and assessment, which when combined with the OCAN will constitute the fidelity requirements for the comprehensive assessment.

41. Client Record

Since ACT records often require more documentation than many other mental health programs, the team coordinator and psychiatrist must work collaborative to obtain approval from mental health agency administrators and medical records personnel to set up an ACT client record, which satisfies the agency's policies, and complies with federal and provincial privacy, and personal health information legislation. The ACT client record should be located physically with the ACT program. Below are minimum requirements that are not intended to summarize or replace legislative direction, and which may be in place at the time of issuing these Standards or in the future:

The ACT team must maintain a treatment/service record for each client.

The treatment/service record is a confidential, complete, accurate, and up-to-date record of information relevant to the client's care and treatment.

The record should 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.

The team coordinator and program assistant are responsible for the maintenance and security of the client treatment/service records, in accordance with all applicable legislation.

Client records must be kept in a locked file for confidentiality and security reasons.

Access to client records by clients, service providers and third parties is subject to all provisions of applicable federal and provincial legislation, particularly with respect to the Personal Health Information Protection and Privacy Act.

42. Client Rights and Complaint Resolution Procedures

ACT teams' policies and procedures ensure protection of clients' rights, must be consistent with provincial legislation, and include a transparent mechanism to redress complaints. All team members must fully understand clients' rights to have their capable decisions about autonomy and self-determination respected; to make decisions that may not be in their best interests; and to give or refuse consent to services or treatment, where clients are deemed capable with respect to such decisions. Where clients are not capable, all team members must comply with legislation and professional standards that govern consent to treatment and services for incapable persons. Team members must be educated as to the ramifications of a client's treatment-decision incapability status, particularly the fact that an incapable client may be required to accept treatment even when preferring not to receive it. 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 access to a complaint mechanism that is explained and readily available. ACT teams should be knowledgeable about and familiar with clients' rights, such as the right to: confidentiality; informed consent to medication and treatment; individualized treatment with respect and dignity; withdraw consent or refuse service; control finances; non-discrimination; be supported in decision-making; and file complaints and be assisted with the complaints process. Client rights must also include the elements of: transparency, accessibility, measures to accommodate and reduce barriers; rights to legal representation, supported and assisted through any legal process; informed options for resolution that include the client;;established timelines that include continuous feedback to the client; maintenance of ACT services without consequence; an investigative process for complaints independent from direct service provision, where possible; written reasons for decisions and options for appeal, should the client disagree; mechanisms for appeal to an adjudicator independent of the ACT team, where possible (e.g., sponsoring agency, advisory body, board of directors, etc.); and a system of record-keeping and complaints documentation that is independent of a clinical record and, is not filed as part of the record.

43. Barrier-Free Services

Mental illnesses are prevalent across all cultures nationalities, and, abilities; however, members of ethnic and racial minorities, and persons with disabilities (e.g., physical, sensory, learning, developmental, etc.) face additional barriers to receiving quality mental

health treatment and service. ACT staff should reflect the diversity of the communities they serve. During the initial and comprehensive assessments, 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 need to understand how differences in 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 accommodations to remove barriers to service. Hospital-sponsored programs also have obligations under the Ontarians with Disabilities Act, 2001.

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

ACT teams must offer and provide competent services in the client's preferred language, which includes having bilingual staff and access to interpreter services at no cost to clients with limited English proficiency, and at all points of contact. Language accessibility must be provided 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).

ACT teams must make available easily understood, client-related materials and post signage in the languages of the most common population groups represented in the service area.

44. Fidelity Reviews

It is anticipated that every ACT team will be subject to central monitoring and evaluation procedures established by the Ministry of Health. As of Dec 2021, no such monitoring protocol is in place. Accordingly, as an interim (and possibly long-term) measure, the OAAF has developed a voluntary accreditation process for Ontario ACT teams.

Each ACT Team in Ontario should undergo a formal accreditation process every 2 years. The OAAF Fidelity Reviewer(s) shall conduct in-person team fidelity reviews (as per the established protocol) at the voluntary request of each team. Deficiencies should be remedied within 6 months of the completed review if a team wishes to receive a full fidelity endorsement. The Fidelity Reviewer will follow up at the six month mark as necessary.

New ACT teams will have staged fidelity reviews after years 1, 2, and 3 and then, like all other established teams, at 2 year intervals thereafter.

The review shall also include an assessment of how ACT dollars are being spent, and whether all is in accord with established funding guidelines.

Each team name will be listed on the OAAF website along with one of the following descriptors:

(ACT Team name): Accreditation requested & scheduled for (year)
(ACT Team name): Fully accredited by the OAAF (year). Valid for two years.

In the intervals between full accreditation reviews, each ACT Team may ask the OAAF to complete a partial review in order to address an issue which has arisen, or to seek advice on how to interpret and apply a particular element of the Standards.

In addition to the above, the 20 member OAAF-TAC (Technical Advisory Committee) will, upon request, provide ongoing practical assistance and guidance to each team, or to individual team members. Additionally, The TAC will, from time to time, release interpretive bulletins.

45. Program Evaluation and Performance Improvement

Performance improvement and program evaluation standards are critical components within the ACT model. Years of research from program evaluation has demonstrated ACT is one of the most effective treatment models in mental health for its target population. Program evaluation is essential to know concretely, by using reliable and tested methods, if clients are realizing the expected and desired outcomes, based on the team's adherence to the ACT model.

Each program is expected to evaluate: 1) client outcomes; 2) client and family satisfaction with services rendered; and 3) fidelity to the ACT model.

Each ACT team is expected to have a performance improvement and program evaluation plan, which includes:

A statement of the program's objectives. The objectives relate directly to the program's clients and target population.

Measurable criteria that shall be applied in determining whether or not the stated objectives are achieved.

Methods for documenting achievements related to the program's stated objectives.

Methods for assessing the effective use of staff and resources toward the attainment of program objectives.

In addition to the performance improvement and program evaluation plan, the ACT team must 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.

Brief reviews should occur with a minimum frequency of every six months. One method to implement this is to develop a yearly project plan timeline. Team members can be

responsible for taking ownership in meeting each of the standards. The design of this timeline empowers specific team members to take an educational opportunity to invest in the standards, develop expertise in a minimum of three standards each, and build capacity for training, orienting and correcting their own team practices.

46. Accountability

The MOHLTC establishes broad accountability directives for funded programs in agencies and hospitals that are under the responsibility and oversight of the ministry. ACT teams are required to adhere to their program standards; sponsoring agencies of ACT teams are required to adhere to the performance indicators and targets outlined in their Hospital Service Accountability Agreements (HSAA) and Multi-Sector Service Accountability Agreements (MSSAA). These agreements mandate reporting on ACT demographic, clinical and outcome data.

An ACT team may request a waiver from the Ministry of Health with respect to an element of these Standards only if such a waiver 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 will be provided in writing. The MOHLTC/LHINS/OAA may grant ACT teams waivers of requirements in the ACT team program standards only under certain exceptional circumstances.

ACT teams are required to submit annual data reports in accordance with MOHLTC requirements.

It is recommended that each ACT team in Ontario has a best practice guideline for each of the domains in the provincial standards.

47. FACT (Flexible ACT) in Ontario: Some Clarification

FACT teams have 10-20% ACT level clients and 80-90% case management level clients and carry a caseload of 200. Unfortunately, well meaning but mistaken information has been promulgated about the appropriateness of the European FACT model for large urban settings in Ontario.

FACT Teams operate in the Netherlands (where the model was developed) against a backdrop of 150 inpatient psychiatric beds per 100,000 people. This means that many of the sickest people in the Netherlands are in hospital, while in Ontario, with a bed ratio of 35 per 100,000, these same people live in the community and need ACT level service to be maintained in the community. It is a misunderstanding for LHINs to believe that the FACT Team model is directly transferable to the Ontario setting, or that FACT Teams have ACT level capacity advantages, or are more cost effective than ACT level services.

An Ontario specific FACT Team model may be appropriate in a smaller urban/rural area with a catchment of 50,000-80,000 people, or in a large urban area that has been properly saturated with ACT level service first, or where a dual diagnosis sub-specialty service is

required. They have a potentially important place in our service system, but not before ACT level services are properly implemented and appropriately distributed.

Given current wait times and service demands it is clear that an existing ACT team in Ontario must never be converted to a FACT Team.

Separate OAAF standards and operational parameters have been developed for Ontario FACT Teams.

48. Acknowledgements (Version 3.0)

The Ontario ACT Association would like to acknowledge and warmly thank Ruth Woodman for preparing the first draft of these revised standards; her years of experience, wisdom, and passionate commitment to ACT have been invaluable. Additionally, we thank John Maher for helping guide the revision process and for his work on the many earlier drafts. We also wish to thank the members of the Standards Sub-committee and the ACT Technical Advisory Committee for their excellent contributions. A special thank you goes to Dave Guthrie, Jason Halliday, Terry Landry, Roger Renaud, Amanda Ye and to all of the ACT Team members across the province who have provided such helpful feedback.

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