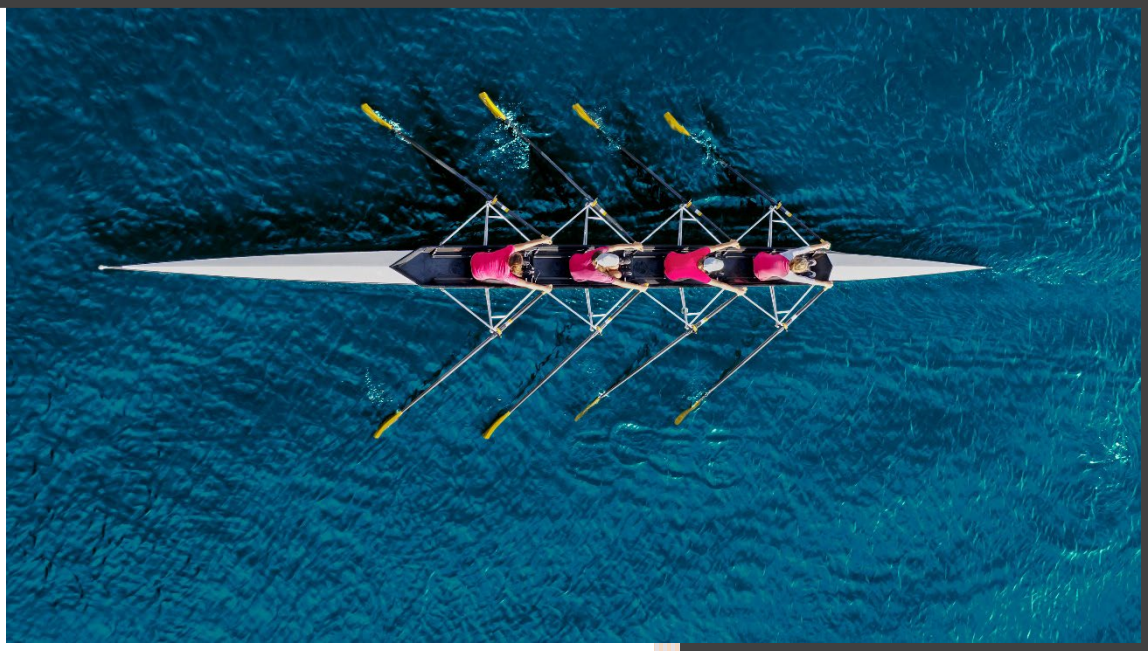
DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES

Montana Program for Assertive Community Treatment and the Role of Relationship in Sustaining Fidelity



WICHE BEHAVIORAL HEALTH PROGRAM

July 2025

Western Interstate Commission for Higher Education Behavioral Health Program 2025 authors:

Annette Robertson, LMSW

Antonia Airozo, MA

Completed in collaboration with Montana Department of Public Health and Human Services, Behavioral Health and Developmental Disabilities Division.

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Goals

- Establish why PACT fidelity standards are vital to improving member lives.
- Set the expectation of reaching and maintaining PACT standards.
- Provide information that will support staff in reaching PACT standards.
- Ultimately, reach fidelity to the Program for Assertive Community Treatment model across all Montana Teams.

Objectives

- Understand why PACT matters
- Review PACT outcomes
- Highlight Montana Rule changes
- Identify PACT fidelity standards

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Program for Assertive Community Treatment

The Role of Relationship in Achieving and Sustaining Fidelity to the Model

1

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Montana Behavioral Health and Developmental Disabilities Division

in partnership with the Western Interstate Commission for Higher Education Behavioral Health Program

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Purpose

- Why
- Expectations
- Intentions

3

Objectives

- **Understand why PACT matters**
- **Review PACT outcomes**
- **Highlight Montana Rule changes**
- **Identify PACT standards**

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Expectations

- **Access**
  - Course saved on MT BHDD website along with the presentation slides
  - Participant guide for personal use
- **Best Practice**
  - Within 1st month of hire
  - Recurring yearly thereafter
- **Supervisors**
  - Reference components regularly
  - Review fidelity standards with new hires and the team on recurring basis
  - Integrate case scenarios and course discussion points into team meetings for expanded learning opportunities

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Why

- **The 'Why' facilitates the 'How' of PACT**
  - Passion
  - Personal experience
  - Belief in Recovery

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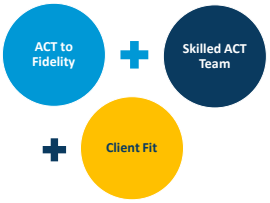
EBPs- ACT Outcomes



ACT Outcomes = Recovery

- Less hospitalizations
- Improved functioning
- Fidelity = Outcomes

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Montana Assertive Community Treatment (MT-ACT) Fidelity and Standards Scale

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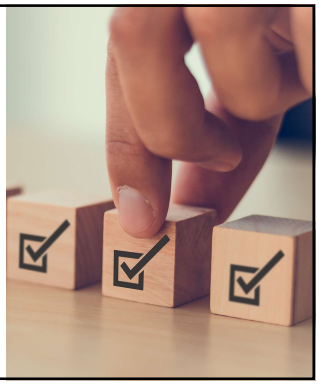
Placeholder

Instructions for TOM

- **Display Fidelity Standards Scale**
- **Flip each page one at a time**



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Fidelity and Standards Scale

- **Key Reminders**
  - It is not about the score, it is about serving members
  - Focus on what is achievable
  - Aim for 4's
  - Reference standards regularly
  - Balance is necessary
  - You are the experts!
- **Policy 460 differs slightly**

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Barriers and Facilitators

As standards are reviewed, consider

- **Barriers – anything that impedes or gets in the way of quality service delivery**
- **Facilitators – anything that helps move closer to fidelity of the model**

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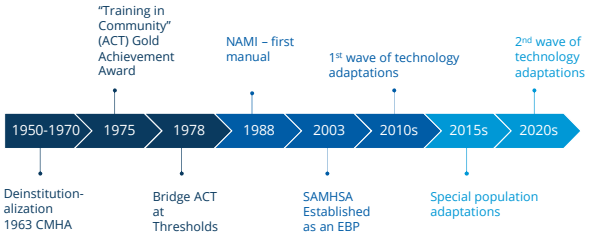
ACT HISTORY



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What and Why of MT Rule

Policy 460

Program for Assertive Community Treatment (PACT)

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MT Rule - Policy 460

- **Getting Closer to PACT Fidelity**
  - Team size and staffing tiered
  - Telehealth allowed up to 40% each week
  - LPN option for larger teams
  - Credit for coordination of care for Team Lead – must document
  - Comprehensive PACT training upon hire and annually
  - Training for Vocational and Clinical staff
- **PACT model is the priority!**

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Who

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The Members

- **Explicit Admission Criteria**
  - SDMI
  - High service needs
  - All services transferred to team, i.e., psychiatric care
- **Small Caseload**
  - 10:1 member to staff ratio - fill in with additional staff to achieve ratio, e.g., PACT Specialist
  - Team staff are generalists

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The Team

- **Staffing**
  - Low turnover
  - Positions fully staffed
  - 6.5-10 FTE depending on team size
- **Natural Supports**
  - Rebuilding/maintaining natural supports
  - Non-clinical
  - Build members' support network

Roles of team staff

- Psychiatric Prescriber
- Team Lead
- Nursing Staff
- Clinical Staff:
  - Co-occurring disorders (COD) tx
  - Therapeutic counseling
- Peer Support Specialist with lived/living psychiatric experience
- Vocational Specialist
- PACT Generalist/Specialist

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The Team

- **The Team Approach**
  - Share entire caseload
- **Shared responsibilities**
  - Assessment
  - Treatment plan goals
  - Service planning & decisions
  - Service delivery
  - Engagement
- **Client driven**

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Program Meetings

4	24	100%
Weekly Meetings	Hour Review	Member Coverage
Every member is discussed at each meeting. All staff attend. Psych 1 time weekly.	Team reports on last 24 hours of member contact.	All member needs and changes are addressed.

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Effective Teams

- **Team health**
  - Psychological safety, goal alignment, constructive controversy, learning
- **Building team alignment to serve members with continuity**
- **Conflict and 'Constructive Controversy'**
  - Goal and strategy conflict is expected and can result in better care
  - Requires effective conflict resolution methods
  - Helps team balance productivity, quality, and safety

(Wholey, et. Al., 2012; Zhu, et. Al., 2017)

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Effective Teams

- **We need to get good at…**
  - Admitting errors, asking for help, and discussing complex problems
  - Learning: New skills in balance with implementation and continuous improvement
  - Information management
    - "The right information available, to the right person at the right time."
    - Help teammates prepare for the visit *and* develop situational awareness

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What and How of Delivering ACT Services

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Assertive Community Treatment Services

- **Services**
  - Case management
  - Illness Management and Recovery skills
  - Help with daily living
  - Building natural supports
  - Crisis Management
  - Psychoeducation
  - Care Coordination
  - Family/group therapy
- **Services**
  - Peer support
  - Employment Counseling
  - Help applying for benefits
  - Medication support
  - Housing support
  - Financial management
  - Counseling
  - Integrated Treatment for Co-occurring disorders
    - 1:1 and groups

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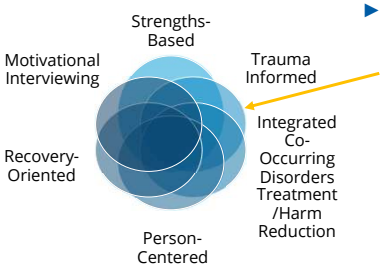
EBP Crosswalk



- **24 Shared Practices across 6 Evidence-Based Practices**
  - Top 10 practices shared across 4 or more EBPs
  - 17 practices shared across 3 or more EBPs

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Active Engagement

- **Intensity**
  - On average, 2, or more, hours per week per member
- **Frequency**
  - On average, 4, or more, visits in person/week per member
  - MT Policy differs from fidelity
    - 40% Telehealth (video) service delivery acceptable

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Assertive Community Treatment: A Client-Centered Approach

- Assertive Engagement
  - PACT policy for outreach & engagement
  - Legal mechanisms
  - Leverage Natural Supports
- No dropout policy
  - 95% + caseload retained/12-months

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Assertive Engagement Best Practices

- **Motivational Interviewing!**
- **Strengths-based**
- **Client Centered**
- **Matching staff to members**
- **Discuss safety and crisis regularly**
- **Persistent and consistent outreach**
  - Checking known hangouts, hospitals, shelters, etc.

"ACT Teams show up no matter how difficult the client may be to serve."

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When and Where

- **24/7 coverage**
  - Phone de-escalation
  - Safety
- **Community-based**
  - When we meet people where they want, we are more likely to see them more often and for longer periods of time.
  - Fidelity = 80%
  - MT = 60%
- **Really cool community visits we heard about**
  - River Walk
  - Fishing
  - Team BBQs!

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Assessment and Treatment Planning

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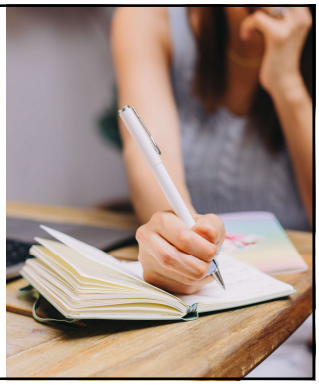
Assessment

- **Intake rate – O2**
  - Intake at a low rate less than or equal to 6 clients per month
  - Smaller roster, less intakes 3/mo.
- **Standard intake and onboarding**
  - Informed consent
  - Clarity of services
  - Confirmed interest



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Crisis Assessment and Stabilization

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Crisis Intervention

Prevention
PACT is crisis intervention. Teams provide mobile response.

24/7 Availability
Assessment, de-escalation, and stabilization services always available.

Hospital Coordination
95%+ responsibility for admissions and discharge planning.

Community Stabilization
Prioritize keeping clients in community when safe and appropriate.

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Hospitalization Best Practice

- **Prevention through frequent contact**
- **Prioritize**
  - Coordination in and out of hospitals
    - RN to RN; Doc to Doc
  - Warm handoffs by transporting
  - Include Natural Supports

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Documentation Standards

- **BIRP Format:**
  - Behavior: Observations and quotes demonstrating medical necessity
  - Intervention: Specific actions and approaches used
  - Response: Client reaction to interventions
  - Plan: Next steps and follow-up actions
- **Documentation Requirements:**
  - Document all services offered (even when declined)
  - Avoid jargon and use clear, professional language
  - Essential for care coordination, fidelity demonstration, and self-care!

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Specialty Roles

Vocational, peer support, co-occurring disorders clinical staff, general counseling, psychiatric nurses, and psychiatrists

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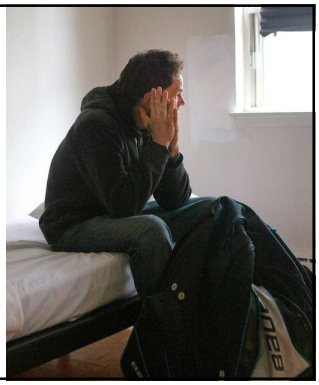
Housing Support

- **Full responsibility for treatment services**
- **The role of the team**
  - Secure leases and pay rent
  - Purchase and repair household items
  - Develop relationships with landlords
  - Moving members
  - Apply to low-income housing waitlists
  - Homecare
- **HEART Waiver**
  - Rental support for members



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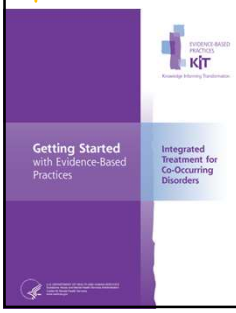
Co-Occurring Disorders Model



- **The approach -**
  - Recovery focused language
  - Non-confrontational approach
  - Stage-based interventions
  - Harm reduction approach
  - Motivational interviewing
  - Shared team responsibility for engagement
  - Treatments plans include substance use treatment services

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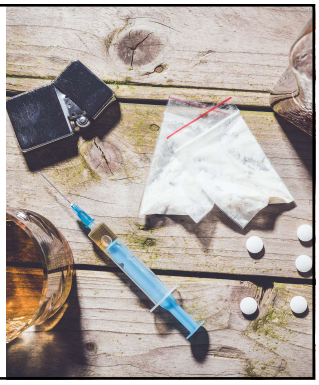
Co-Occurring Disorders Clinical Staff

- **Individualized Substance Use Treatment**
  - Integrated Treatment for Co-Occurring Disorders approach
  - Community-based
  - Generalist
  - 24 minutes +/week per member
  - 50% of members attend one group per month
  - 4 hours of training annually in COD



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Employment Support

- **Vocational Specialists**
  - 2+ staff for large teams
  - 1+/Year training and experience
  - 8+ hours IPS training annually
- **Roles**
  - Assessment and support for a preferred job/career path
  - Community-based
  - Job development in integrated settings – no sheltered workshops
  - Job searching, application, interviewing, job coaching, and follow-along support

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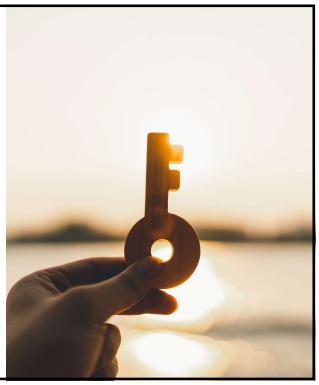
Team Experts

- **Peers**
  - SMI past/current lived psychiatric experience
  - Full time
  - Full professional status
- **Professional Clinician**
  - Provides clinical support to members
    - keep all services within the integrated treatment team approach of PACT



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Practicing PACT Leader

Supervisor of frontline PACT team provides services to members

- Research - among the 5 most strongly related items that impact member outcomes
- When Team Leads have direct clinical contact, better able to model appropriate clinical interventions and remain in touch with the members served by the team
- Coordination of care counts when measuring fidelity

****If it wasn't documented, it didn't happen*

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Medically Trained PACT Staff

H7. Psychiatrist on Staff

For 100 members, at least 1 full-time Psychiatrist is assigned to work with the program. **1:100**

- Serves as medical director for the team
- In addition to medication monitoring, the psychiatrist functions as a fully integrated team member, participating in treatment planning and rehabilitation efforts.
- Telehealth via video is okay in MT!

H8. Nurse on staff

At least 2 full-time Registered Nurses assigned to work with a 100-member program. **2:100**

Large teams with 1 RN, second an LPN in MT

- Critical ingredient in successful PACT programs
- Full member of the team
  - Home visits
  - Treatment planning
  - Daily team meetings
- Educates the team about important medication/medical issues

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Closure for members graduating from PACT

- **Time-unlimited services**
  - Low and slow closure rate
  - <5% graduation annually

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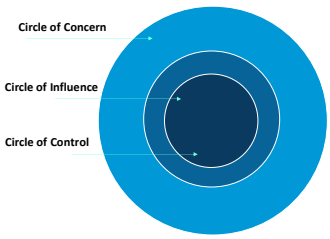
Closing

- Commitment
  - Model
  - Members
- Willingness
  - Balance
  - Teamwork
  - Continuous development
- Remember to stay focused
  - What is within your control
  - What you can influence
  - Know the difference



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THANK YOU!

Toni Airozo

Annette Robertson

Email

www.wiche.edu

arobertson@wiche.edu

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Montana Assertive Community Treatment (MT-ACT) Fidelity and Standards Scale

Description		Rating				
		1	2	3	4	5
Human Resources: Structure and Composition (11 items)						
H1:	**Small caseload**: Consumer/provider ratio = 10:1	50 consumers/team member or more	35 – 49	21 – 34	11 – 20	10 consumers/team member or fewer
H2:	**Team approach:** Provider group functions as team rather than as individual MT-ACT team members; MT-ACT team members know and work with all consumers	Less than 10% consumers with multiple team face-to face contacts in reporting 2-week period	10 – 36%	37 – 63%	64 – 89%	90% or more consumers have in-person contact with >1 staff member in 2 weeks
H3:	**Program meeting:** Meets often to plan and review services for each consumer (prescriber must attend at least one meeting in duration per week)	Service-planning for each consumer usually 1x/month or less	At least 2x/month but less often than 1x/week	At least 1x/week but less than 2x/week	At least 2x/week but less than 4x/ week	Meets at least 4 days/ week and reviews each consumer each time, even if only briefly
H4:	**Practicing MT-ACT leader:** Supervisor of front-line MT-ACT team members provides direct services, including phone and activities with or on behalf of client.	Supervisor provides no services	Supervisor provides services on rare occasions as backup	Supervisor provides services routinely as backup or less than 25% of the time	Supervisor normally provides services between 25% and 50% time	Supervisor provides services at least 50% of time that is expected of other MT-ACT staff
H5:	**Continuity of staffing:** Keeps same staffing over time	Greater than 80% turnover in 2 years	60 – 80% turnover in 2 years	40 – 59% turnover in 2 years	20 – 39% turnover in 2 years	Less than 20% turnover in 2 years
H6:	**Staff capacity:** Operates at full staffing	Operated at less than 50% staffing in past 12 months	50 – 64%	65 – 79%	80 – 94%	Operated at 95% or more of full staffing in past 12 months
H7:	**Psychiatrist on team:** At least 1 full-time psychiatrist/psychiatric prescriber for 100 consumers works with program (Credit for Telehealth)	Less than .10 FTE regular psychiatrist for 100 consumers	.10 – .39 FTE for 100 consumers	.40 – .69 FTE for 100 consumers	.70 – .99 FTE for 100 consumers	At least 1 full-time psychiatrist assigned directly to 100- consumer program

H8:	**Nurse on team:** At least 2 full-time nurses assigned for a 100-consumer program (LPN under RN = .5 FTE)	Less than .20 FTE regular nurse for 100 consumers	.20 – .79 FTE for 100 consumers	.80 – 1.39 FTE for 100 consumers	1.40 – 1.99 FTE for 100 consumers	2 full-time nurses or more are members for 100-consumer program
H9:	**Co-Occurring Disorders Specialist on team:** A 100-consumer program with at least 2 staff members with 1 year of training and clinical experience in substance use disorder treatment, and 4 hours of training in co-occurring disorders annually	Less than .20 FTE S/U expertise for 100 consumers	.20 – .79 FTE for 100 consumers	.80 – 1.39 FTE for 100 consumers	1.40 – 1.99 FTE for 100 consumers	2 FTEs or more with 1 year S/U training or supervised S/U experience
H10:	**Vocational Specialist on team:** At least 2 team members with 1 year of training/experience in vocational rehabilitation and support, and 8 hours of Supported Employment training annually	Less than .20 FTE vocational expertise for 100 consumers	.20 – .79 FTE for 100 consumers	.80 – 1.39 FTE for 100 consumers	1.40 – 1.99 FTE for 100 consumers	2 FTEs or more with 1 year voc. rehab. training or supervised VR experience
H11:	**Program size:** Of sufficient absolute size to consistently provide necessary staffing diversity and coverage	Less than 2.5 FTE staff	2.5 – 4.9 FTE	5.0 – 7.4 FTE	7.5 – 9.9	At least 10 FTE staff
	Program Size (State Standard): 50 Consumer Team, or less	Fewer than 5.5 FTE direct clinical staff	5.5 - 5.9 FTE	6.0 - 6.4 FTE	6.5 - 6.9 FTE	Team includes at least 7.0 FTE direct clinical staff

Organizational Boundaries (7 items)

Description		Rating				
		1	2	3	4	5
O1:	**Explicit admission criteria:** Has clearly identified mission to serve a particular population. Has and uses measurable and operationally defined criteria to screen out inappropriate referrals.	Has no set criteria and takes all types of cases as determined outside the program	Has a generally defined mission but admission process dominated by organizational convenience	Tries to seek and select a defined set of consumers but accepts most referrals	Typically, actively seeks and screens referrals carefully but occasionally bows to organizational pressure	Actively recruits a defined population and all cases comply with explicit admission criteria
O2:	**Intake rate:** Takes consumers in at a low rate to maintain a stable service environment	Highest monthly intake rate in the last 6 months = greater than 15 consumers/ month	13 – 15	10 – 12	7 – 9	Highest monthly intake rate in the last 6 months no greater than 6 consumers/ month
	Intake rate (State Standard): 50 consumer, or less, team	Highest monthly rate greater than 7.5	6.5 - 7.5	6 - 6.4	5.9 - 3.1	Highest monthly intake rate in the last 6 months no greater than 3 consumers/ month
O3:	**Full responsibility for treatment services:** In addition to case management, directly provides psychiatric services, counseling/ psychotherapy, housing support, substance use treatment, employment and rehabilitative services.	Provides no more than case management services	Provides 1 of 5 additional services and refers externally for others	Provides 2 of 5 additional services and refers externally for others	Provides 3 or 4 of 5 additional services and refers externally for others	Provides all 5 services to consumers
O4:	**Responsibility for crisis services**: Has 24-hour responsibility for covering psychiatric crises	Has no responsibility for handling crises	Emergency service has after-hours program-generated protocol for program consumers	Is available by phone, mostly in consulting role	Provides emergency service backup, e.g., program is called, makes decision about need for direct program involvement	Provides 24-hour coverage

O5:	**Responsibility for hospital admissions:** Is involved in hospital admissions	Is involved in fewer than 5% decisions to hospitalize	MT-ACT team is involved in 5%– 34% of admissions	MT-ACT team is involved in 35%– 64% of admissions	MT-ACT team is involved in 65%– 94% of admissions	MT-ACT team is involved in 95% or more admissions
O6:	**Responsibility for hospital discharge planning:** Is involved in planning for hospital discharges	Is involved in fewer than 5% of hospital discharges	5% – 34% of program consumer discharges planned jointly with program	35% – 64% of program consumer discharges planned jointly with program	65% – 94% of program consumer discharges planned jointly with program	95% or more program consumer discharges
O7:	**Time-unlimited services (graduation rate):** Rarely closes cases but remains the point of contact for all consumers as needed	More than 90% of consumers are expected to be discharged within 1 year	From 38 – 90% of consumers expected to be discharged within 1 year	From 18 – 37% of consumers expected to be discharged within 1 year	From 5 – 17% of consumers expected to be discharged within 1 year	All consumers served on a time-unlimited basis, with fewer than 5% expected to graduate annually

Nature of Services (10 items)

Description		Rating				
		1	2	3	4	5
S1:	**Community-based services:** Works to monitor status, develop community living skills in community rather than in office	Less than 20% of face-to-face contacts in community	20 – 39%	40 – 59%	60 – 79%	80% of total in-person contacts in community
S2:	**No dropout policy:** Retains high percentage of consumers	Less than 50% of caseload retained over 12-month period	50 – 64%	65 – 79%	80 – 94%	95% or more of caseload is retained over a 12-month period
S3:	**Assertive engagement mechanisms:** As part of ensuring engagement, uses street outreach and legal mechanisms (probation/ parole, OP commitment) as indicated and as available	Passive in recruitment and re-engagement; almost never uses street outreach legal mechanisms	Makes initial attempts to engage but generally focuses on most motivated consumers	Tries outreach and uses legal mechanisms only as convenient - if NO POLICY cannot score more than a 3	Usually has plan for engagement and uses most mechanisms available	Demonstrates consistently well-thought-out strategies and uses street outreach and legal mechanisms whenever appropriate
S4:	**STATE STANDARD: Intensity of service:** High total amount of service time, as needed	Average 15 minutes/ week or less of \in-person contact for each consumer	15 – 49 minutes/ week	50 – 84 minutes/week	85 – 119 minutes/week	Average 2 hours/week or more of in-person contact for each consumer
S5:	**STATE STANDARD: Frequency of contact:** High number of service contacts, as needed **	Average less than 1 in-person contact/ week or fewer for each consumer	1 – 2x/week	2 – 3x/week	3 – 4x/week	Average 4 or more in-person contacts/week for each consumer
S6:	**Work with informal support system:** With or without consumer present, provides support and skills for consumer's support network: family, landlords, employers	Less than .5 contact/ month for each consumer with support system	.5 – 1 contact/ month for each consumer with support system in the community	1 – 2 contact/month for each consumer with support system in the community	2 – 3 contacts/month for consumer with support system in the community	4 or more contacts/ month for each consumer with support system in the community

S7:	**Individualized substance use treatment:** 1 or more team members provides direct treatment and substance use treatment for consumers with substance-use disorders	No direct, individualized substance use treatment provided	Team variably addresses SU concerns with consumers; provides no formal, individualized SU treatment	While team integrates some substance use treatment into regular consumer contact, no formal, individualized SU treatment	Some formal individualized SUD treatment offered; consumers with substance- use disorders spend less than 24 minutes/ week in such treatment	Consumers with substance-use disorders average 24 minutes/ week or more in formal substance use treatment
S8:	**Co-Occurring Disorders treatment groups:** Uses group modalities as treatment strategy for consumers with substance-use disorders	Fewer than 5% of consumers with substance- use disorders attend at least 1 substance use treatment group meeting a month	5 – 19%	20 – 34%	35 – 49%	50% or more of consumers with substance-use disorders attend at least 1 substance use treatment group meeting/month
S9:	**Co-Occurring Disorders Model:** Uses a non-confrontational, stage-wise treatment model, follows behavioral principles, considers interactions of mental illness and substance use disorder, and has gradual expectations of abstinence	Fully based on traditional model: confrontation; mandated abstinence; higher power, etc.	Uses primarily traditional model: e.g., refers to AA; uses inpatient detox & rehab; recognizes need to persuade consumers in denial or who don't fit AA	Uses mixed model: e.g., COD principles in treatment plans; refers consumers to persuasion groups; uses hospitalization for rehab.; refers to AA, NA	Uses primarily COD model: e.g., COD principles in treatment plans; persuasion and active treatment groups; rarely hospitalizes for rehab. or detox except for medical necessity; refers out some SA treatment	Fully based in COD treatment principles, with treatment provided by MT ACT staff members (program mtg, team engagement, documentation language, treatment plans, etc.)
S10:	**Role of consumers on team:** Consumers, i.e., lived/living psychiatric experience, involved as team members providing direct services	Consumers not involved in providing service	Consumers fill consumer-specific service roles (e.g., self-help)	Consumers work part-time in case-management roles with reduced responsibilities	Consumers work full-time in case management roles with reduced responsibilities	Consumers employed full-time as MT-ACT team members (e.g., case managers) with full professional status

** MT BHDD has made an adjustment to allow the use of telehealth. See current state policy for details.

Barriers and Facilitators Worksheet

Barriers: anything that impedes or gets in the way of providing quality services to members while working toward meeting fidelity to the model.

Facilitators: anything that helps us support members in their recovery and to reach fidelity to the model.

Instructions

- Review the standards
- Identify and record questions, team strengths, and challenges
- Discuss with your supervisor

1. **Question(s):**

2. **Strengths**

3. **Challenges**

Assertive Community Treatment Services[1]

O3-Fidelity standard: ACT providers are fully responsible for treatment services. In addition to case management, ACT directly provides psychiatric services, counseling/ psychotherapy, housing support, substance use treatment, employment and rehabilitative services.

Abstracted Table: Moving ACT Treatment into Standard Practice

1. Rehabilitative approach to daily living *skills*
    a. Grocery shopping and cooking
    b. Purchase and care of clothing
    c. Use of transportation
    d. Help with social and family relationships
2. Family involvement
    a. Crisis management
    b. Counseling and psychoeducation with family and extended family
    c. Coordination with family service agencies
3. Work opportunities
    a. Help to find volunteer and vocational opportunities
    b. Provide liaison with and educate employers
    c. Serve as job coach for consumers
4. Entitlements
    a. Assist with documentation, e.g. state ID
    b. Accompany consumers to entitlement office
    c. Manage food stamps
    d. Assist with determination of benefits
5. Health promotion
    a. Provide preventive health education
    b. Conduct medical screening
    c. Schedule maintenance visits
    d. Provide liaison for acute medical care
    e. Provide reproductive counseling and sex education
6. Medication support
    a. Order medications from pharmacy
    b. Deliver medications to consumers
    c. Provide education about medication

[1] Phillips, S. D., Burns, B. J., Edgar, E. R., Mueser, K. T., Linkins, K. W., Rosenheck, R. A., Drake, R. E., & McDonel Herr, E. C. (2001). Moving assertive community treatment into standard practice. Psychiatric Services (Washington, D.C.), 52(6), 771-779. https://doi.org/10.1176/appi.ps.52.6.771

    d. Monitor medication compliance and side effects
7. Housing assistance
    a. Find suitable shelter
    b. Secure leases and pay rent
    c. Purchase and repair household items
    d. Develop relationships with landlords
    e. Improve housekeeping skills
8. Financial management
    a. Plan budget
    b. Troubleshot financial problems (for example, disability payments)
    c. Assist with bills
    d. Increase independence in money management
9. Counseling
    a. Use problem-oriented approach
    b. Integrate counseling into continuous work
    c. Ensure that goals are addressed by all team members
    d. Promote communication skills development
    e. Provide counseling as part of comprehensive rehabilitative approach

EBP Self Evaluation

Evidence Based Practice	New & Developing	Proficient & Developing	Advanced & Developing
Cross-practice skills, values, and approaches			
Client driven	☐	☐	☐
Strengths-based	☐	☐	☐
Person-centered and collaborative	☐	☐	☐
Autonomy and choice	☐	☐	☐
Community-based	☐	☐	☐
Relationship-based and focused on trust and communication	☐	☐	☐
Recovery and resilience oriented	☐	☐	☐
Engaging	☐	☐	☐
Continually improves *(Awareness and acceptance of growth areas; efforts to grow and develop)*	☐	☐	☐
Empowering	☐	☐	☐
Culturally responsive and committed to equity	☐	☐	☐
Committed to safety *(Both client and staff, physical and emotional. Includes mindfulness of safer behaviors, settings, and client transitions)*	☐	☐	☐
Trauma-Informed	☐	☐	☐
Committed to reducing barriers and increasing accessibility	☐	☐	☐
Peer support *(Either as a practitioner or as a team member. If you are a team member, you are aware of the essential nature and effectiveness of the role. You are competent at raising visibility of the role to clients. You are knowledgeable and supportive of the strengths, challenges, and needs of the role.)*	☐	☐	☐
Natural supports and settings *(Elicits client natural supports and preferred settings. Effective at supporting connections and activities with natural supports and settings.)*	☐	☐	☐
Holistic approach	☐	☐	☐

(Aware of and addressing all aspects of health; 8 domains of wellness)			
Integrated, multi-disciplinary approach *(Use of teammates, ability to pass on client needs and carry forward what another team member started. Communication and coordination with other key supports like primary care and family.)*	☐	☐	☐
Acceptance and compassion	☐	☐	☐
Active listening *(Open questions, reflections, Affirmations, and Summaries (OARS))*	☐	☐	☐
Empathic	☐	☐	☐
Planning *(Development of client-identified goals and breaking them down into small actionable steps.)*	☐	☐	☐
Focusing *(working with clients to identify a target behavior; Maintained focus on identified goals)*	☐	☐	☐

Assertive Engagement Best Practices

Essential characteristics of active engagement identified by ACT providers

- Persistence
- Consistency
- The foundation for a therapeutic relationship
- Empathy
- Holism
- Advocacy
- Respect
- Dignity
- Humanity
- Validation
- Empowerment
- Team communication

Table abstracted from Understanding Engagement in PACT[2]

Meaning of assertive engagement	**Formal engagement strategies**
Shared understanding, holistic, therapeutic relationship, consistency and persistent, empathetic, yet assertive, prevention **Informal engagement strategies**	Treatment plan development, team decision making process, pharmacotherapy, utilization of social support, linking with physical health provider **Engagement strategies for difficult to engage clients**
Accepting clients as they are, flexibility in care, humanizing experiences, empowerment, communication, reward system*****	Altering team expectations, different meanings of engagement, intense outreach, client rights, involuntary admission

***Consideration:** Be mindful of the difference between bribing people to do what is desired by us as providers versus reinforcing tactics that align with a client's own goals. Rewards can set up a punitive system and may well remind clients of institutional settings where rights were removed. These reminders can elicit

[2] George, M., Manuel, J.I., Gandy-Guedes, M.E. et al. "Sometimes What They Think is Helpful is Not Really Helpful": Understanding Engagement in the Program of Assertive Community Treatment (PACT). Community Ment Health J 52, 882–890 (2016). https://doi-org.aurarialibrary.idm.oclc.org/10.1007/s10597-015-9934-9

distrust with the team. Consider instead the natural reinforcement of aligning around a client's need or enjoying time together by talking over a meal. There is a difference.

- "If you calm down, I will take you to coffee." (Punitive, infantilizing, and coercive)
- "I really enjoyed our talk the other day. You had some great insights about what you want to do in the future. That coffee shop gets great sunlight, are you up for walking with me to get a cup today to finish our conversation?" (Affirming, naturally reinforcing, and aligned with the client's goals.)

Assertive Engagement Protocol[3]

An Assertive Engagement Protocol is a critical mechanism for ensuring an ACT team has considered and attempted all avenues of engaging a client in services prior to considering discharge from the team. The protocol can be completed by hand, electronically or be incorporated into an electronic medical record. The intent of this template is to offer ACT teams some key considerations for this process. Unique qualities of the client, community, agency, and team might require modification of this document. Ideally, an ACT team would document their efforts on the protocol during multiple team meeting discussions concerning any person who is not yet engaged or have disengaged from services. The team would complete the section that best matches the situation (i.e. difficulty developing a working relationship and/or difficulty locating the person). The length of the assertive engagement process and frequency of outreach attempts will vary considerably based on the person's need. Typically, individual agencies have already developed a discharge policy and procedure that would follow utilization of this document.

Client: **Client ID:** **Date of Last Contact:**

Date	Steps Taken	Responsible Team Member	Outcome
	Updated team regarding person's current status (i.e. identify explicit reasons for non-engagement).		
	The team has discussed, planned and utilized motivational approaches to build relationship and trust.		
	Considered whether team has different priorities than the person (i.e. What does the person want? Are their basic needs met? Are we ahead of the person?)		
	Three or more different ACT team members have attempted to engage the person (with consideration of relevant specialty roles).		
	Team leader attempted to engage the person.		
	Consulted with the person's supports. Document name and contact information below ("N/A" if not applicable).		
	Emergency Contact:		
	Support #1:		
	Support #2:		
	Support #3:		

[3] Center for Evidence-Based Practices at Case Western University | www.centerforebp.case.edu | ver.11/17/17

	Landlord:		
	Previous Provider:		
	Probation/Parole Officer:		
	Payee:		
	Guardian:		
	Prescriber has attempted engagement at locations known to be frequented in the community.		
	The team has enlisted the previous provider to encourage engagement in ACT services.		
	If applicable, the team has attempted a crisis intervention.		
	Utilized larger agency and local board process for discussing risk management concerns.		
	Sent person a letter regarding request for contact. (Mailed to last known address, emergency contact address, and other known addresses. Could occur simultaneously with other steps.)		
	Assessed need for and initiated additional legal mechanisms (as a last resort – see DACTS protocol):		
	Outpatient commitment process		
	Payee ship		
	Guardianship		
	Other steps taken based on team discussion process:		

Assertive Engagement Protocol
Unable to Locate

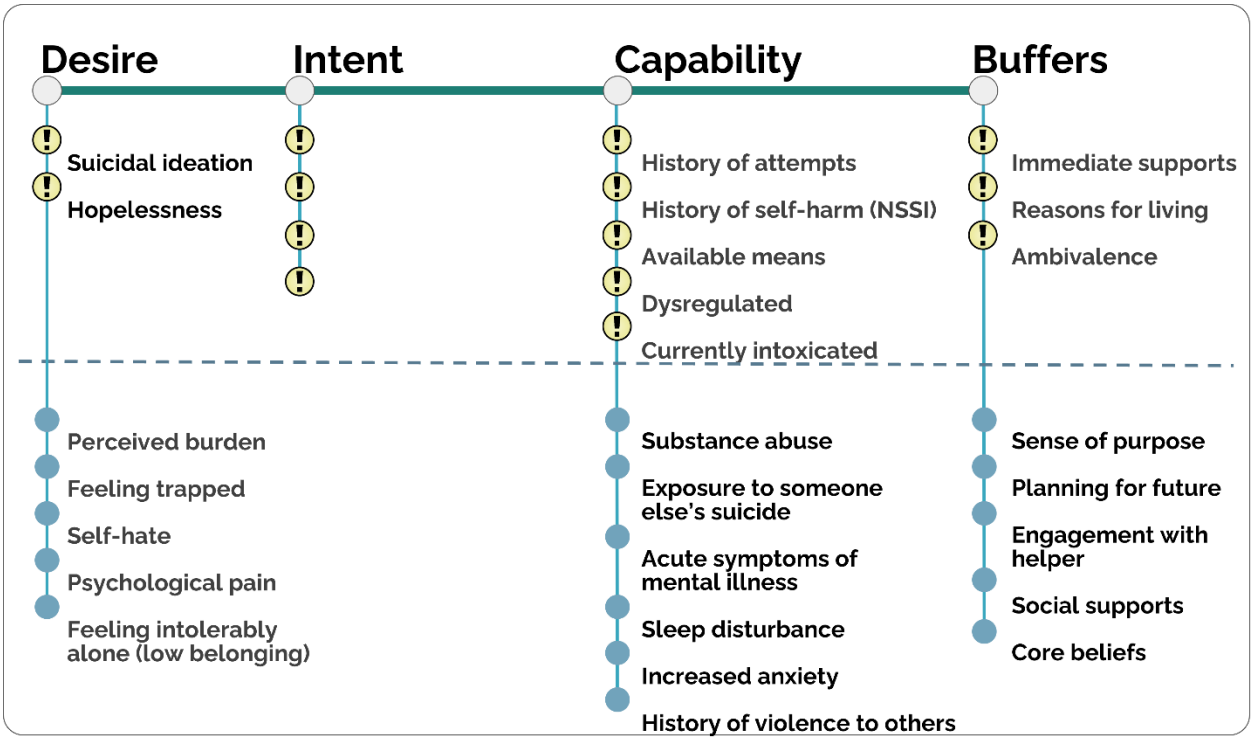
Client: **Client ID:** **Date of Last Contact:**

Date	Steps Taken	Responsible Team Member	Outcome
	Updated team regarding person's current status (i.e. identify explicit reasons for non-engagement).		
	Attempted to call person at least 3-4 times per week.		
	Visited the person's home regularly without verification of person's presence.		
	Consulted with the person's supports. Document name and contact information below ("N/A" if not applicable).		
	Emergency Contact:		
	Support #1:		
	Support #2:		
	Support #3:		
	Landlord:		
	Previous Provider:		
	Probation/Parole Officer:		
	Payee:		
	Guardian:		
	Checked other potential community locations (in person or electronic sources).		
	Local Hospitals:		
	Homeless Shelters:		
	Nursing homes:		
	Jails/Prisons:		
	Other Agency Providers (i.e. primary health, previous provider, pharmacy):		
	Other locations frequented by the person:		

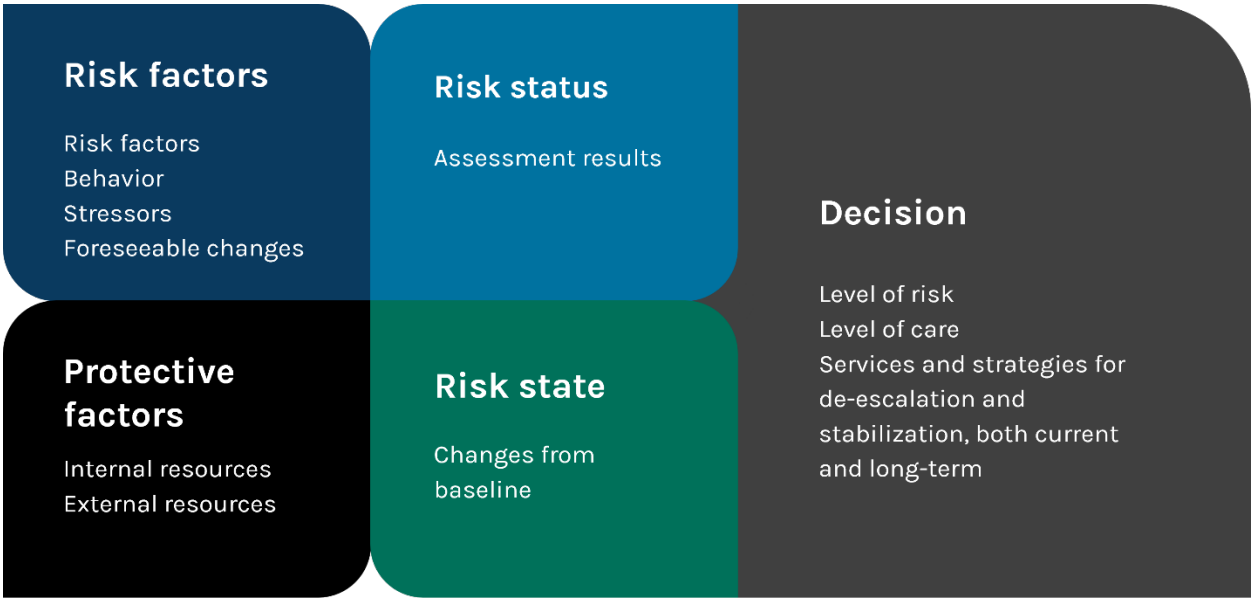
	Sent person a letter regarding request for contact. (Mailed to last known address, emergency contact address, and other known addresses. Could occur simultaneously with other steps.)		
	Conducted a safety check with the landlord and police at the person's last known residence.		
	Contacted local authorities (i.e. CIT officers) to file a missing person's report.		
	Assessed need for and initiated additional legal mechanisms (as a last resort – see DACTS protocol):		
	Outpatient commitment process		
	Payee ship		
	Guardianship		
	Other steps taken based on team discussion process:		

Crisis Assessment and Stabilization

DICB: Desire, Intent, Capability, and Buffers



Gauging Risk



Risk Factors

Enduring (fixed, historical, or constant risk factors)		
Individual	**Relational**	**Community**
• Prior attempts • Lifetime ideation • History of MI depression • Chronic illness and pain • Criminal/legal problems • Impulsive/aggressive habits • Substance use • Adverse childhood experiences	• Bullying • Family/loved one's history of suicide • Loss of relationships • High conflict or violent relationships • Social isolation	• Lack of access to healthcare • Suicide cluster in the community • Stress of acculturation • Community violence • Historical trauma • Discrimination
Societal: Stigma; Access to lethal means; Unsafe media portrayals of suicide		
Dynamic: (changing factors often driven by current context)		
Current thinking, behaviors, stressors, triggers, increased/new symptoms or challenges, lack of engagement/alliance		

Protective Factors

Individual	**Relational**	**Community**

• Physical Health
• Sense of Purpose
  — Reasons for living (family, friends, pets, etc.)
  — Strong sense of cultural identity
• Coping/problem solving
• Healthy Thinking
• Self Esteem
	• Support from partners, friends, and family
	• General feelings of connection to others
		• Feeling connected to school, community, and other social institutions
		• Availability of consistent and high quality physical and behavioral healthcare

Societal: Reduced access to lethal means; Cultural, religious, moral objections to suicide		
Dynamic: Mindset; current level of engagement and feelings about relationships		

Warning Signs

Talking about	Feeling	Changing behavior
• Wanting to die • Great guilt or shame • Being a burden	• Empty, hopeless, trapped, or having no reason to live • Extremely sad, more anxious, agitated, or full of rage • Unbearable emotional or physical pain	• Making a plan • Researching ways to die • Withdrawing from friends • Saying goodbye, giving away important items, or making a will • Taking dangerous risks • Extreme mood swings • Eating or sleeping changes • Increased use of drugs or alcohol

Addenda

In-Team Scenarios and Worksheets

Case Scenario Introductions

Case Summary: Amanda

Background and Trauma History
Amanda is a 34-year-old woman with a complex trauma history stemming from early childhood. She grew up in a household marked by neglect and abuse, where her basic needs were often unmet. Her teenage years were marred by instability and a lack of safe, consistent adult support, leading to periods of homelessness and reliance on survival behaviors. Amanda has shared past experiences of interpersonal violence, including a recent triggering event involving two men she partied with last weekend, which has heightened her distress.

Current Challenges
Amanda is navigating severe substance use challenges, particularly involving methamphetamine and alcohol, which contribute to erratic behavior and periods of emotional instability. Recently, she has shown signs of crisis, including suicidal ideation, as her struggles with addiction have intensified. Her apartment is frequently in disarray, reflecting her internal chaos, and recent risky behaviors have heightened concerns about her safety. Amanda is ambivalent about seeking help, wavering on whether she wants to engage in detox or crisis stabilization services.

Strengths and Aspirations
Despite her challenges, Amanda is a person of incredible resilience and creativity. She has lived independently for the last two years and has successfully remained out of the hospital for the last six months. She has a sharp sense of humor that often lightens the mood during difficult conversations and allows her to connect with others. Amanda is a talented artist who has created stunning pieces of work, often using her art as a therapeutic outlet for processing emotions. She frequently talks about wanting a better life, expressing a deep desire to find stability, reconnect with family, and move toward a healthier, more fulfilling future.

Case Summary: Jacob

Background and Trauma History

Jacob is a 43-year-old man with a long history of severe paranoid schizophrenia. His symptoms, including pervasive mistrust and delusions that others are out to harm him, have led to years of homelessness and social isolation. Despite his challenges, Jacob comes from a loving and supportive family with deep religious roots, which he holds as a central part of his identity. However, his religious convictions often intersect with his paranoia, making it difficult for him to trust others, including his care team.

Current Challenges

Jacob remains disengaged from services and has been difficult for the team to locate, engage, and house. When found, he typically limits interactions to a few minutes before withdrawing. His untreated symptoms and distrust make it challenging to engage Jacob.

Strengths and Aspirations

Jacob is highly intelligent and has a deep knowledge of religious scripture, often quoting Bible verses during conversations. He cares deeply for others, demonstrated by moments when he shares food or resources with others experiencing homelessness. Jacob has expressed a longing for stability and trust.

Program Team Meeting Scenario

Instructions

- Read scenario
- Highlight indicators
    - Meeting effectiveness
    - Facilitators and detractors of team trust and quality relationships
    - Facilitators and detractors of client trust and quality service

Scene

It's a typical Thursday morning at the ACT program office. The building is alive with activity as the team prepares for the day, moving through their pre-meeting routines. Some check the assignment board to confirm which clients they'll see today. Others gather essential items like medications, client mail, and handouts. Despite the bustle, there's an undertone of anticipation and preparation for the team meeting. Some sit at desks, hurriedly finishing notes from the day before. Others cluster near the coffee pot, exchanging greetings and snippets of conversation.

Scenario

In a corner of the room, a newly hired case manager, *Elizabeth*, fidgets with her notebook, scanning the notes she made from yesterday's client visit. Her thoughts race. *Will they think I missed something obvious? Should I even bring up Amanda's behavior? What if I'm wrong?*

Across the room, *Carlos*, the peer support specialist, notices Elizabeth's unease. After greeting her with a friendly nod, he initiates a conversation.

Carlos:
"Hey, Elizabeth, how's it going? You look like you've got something on your mind."

Elizabeth (hesitating):
"I do. I mean, it's nothing really—just some stuff about Amanda. I'm not sure if I should bring it up in the meeting."

Carlos:
"Why not? That's what the team's for. Amanda's a tough one, but if you're noticing something, it's probably worth sharing."

Elizabeth:
"She's just… really off. Erratic behavior, a trashed apartment, and some pretty

disrespectful comments. I don't know—it makes me wonder if she's okay to live on her own."

Carlos:
"That's fair. It sounds like you're picking up on some important stuff. Maybe the team can brainstorm some ideas. I know the team leader's always open to support, too, if you want to check in after the meeting."

Elizabeth (relaxing a little):
"Thanks, Carlos. I appreciate that."

Meanwhile, *Jamie* glances at her watch, sighing audibly as she grabs her tablet. *I've got three clients to see before lunch. This meeting better not drag,* she thinks. She groans as she takes a seat at the conference table, bouncing her leg and looking at everyone annoyed.

The meeting begins 5 minutes late.

Monica:
"Good morning, everyone. Before we dive into the roster, are there any hot topics we need to tackle today?"

The room is quiet for a moment. Elizabeth hesitates but ultimately stays silent, unsure if her concern qualifies as a "hot topic." Monica moves on.

Monica:
"Okay, let's start with Josiah's clients since he's out today. Can someone read his email update?"

Carlos raises a hand and volunteers, quickly pulling up the email on his phone. As he reads, most of the team listens attentively, but *Jamie* scrolls through her phone. When Monica calls on Jamie for a report on a client she visited the day before, she looks up abruptly.

Jamie:
"Oh, right. I went by yesterday, but the client wasn't home, so I came back early to catch up on notes."

Alex (interjecting):
"Did you check the backyard? I mentioned he sometimes hangs out there, and I scheduled a big doctor's appointment for him yesterday."

Jamie (shrugging):
"I forgot you said that. I didn't check, but really, it's the member's job to stay on top of this. I'm not a babysitter or a taxi service."

The room grows quiet. Monica raises an eyebrow but doesn't address the comment directly, moving on to the next client report. She makes a note to speak with Jaime after the meeting.

Later in the meeting, Elizabeth gathers her courage. She clears her throat and speaks hesitantly.

Elizabeth:
"Um, I wanted to bring up something about Amanda. She's been acting really erratic—like, maybe substance use? Her apartment is trashed, and she made some pretty rude comments yesterday. It just... doesn't seem like she's managing well."

The team looks at Elizabeth. Carlos nods supportively, while Taylor raises an eyebrow.

Taylor:
"Sounds like Amanda. She's always like that. What's new?"

Carlos (jumping in):
"I think Elizabeth's got a good point. Amanda's been struggling more lately. Maybe we should think about adjusting her supports."

Monica:
"Good observation, Elizabeth. After we get through the roster, let's talk more about what we can do to help Amanda during her next team visit. Thanks for bringing that up."

Elizabeth smiles slightly, relieved. The meeting continues, and the exchange leaves her feeling a bit more confident in the team dynamic...

Jamie and Taylor roll their eyes, feeling frustrated that they won't get out early like they had hoped.

A placeholder for noting team effectiveness facilitators and detractors is provided below.

Notes: (Meeting effectiveness, facilitators and detractors of team trust, quality relationships, client trust, and quality service)

Assertive Engagement Scenario

Instructions

- Read scenario
- Identify factors that contribute to or detract from client engagement

Scenario

Friday Morning Team Meeting
The ACT team gathers for their regular Friday morning meeting. The facilitator begins by reviewing the status of clients, eventually turning the focus to Jacob. Jacob, assigned to the team three months ago, remains disengaged, and the assessment and treatment plan are incomplete due to difficulty locating and engaging him. Team members voice their frustration.

Josiah:
"I tried finding him three times this week—no luck. He wasn't at the shelter or the park."

Taylor:
"When I did catch him last week, he only stayed for two minutes before walking off. I couldn't even start the conversation."

Jamie:
"Honestly, maybe it's time to close his case. We're not meeting the frequency or intensity requirements, and he's clearly not interested."

The Team Leader pauses, drawing attention to the **assertive engagement principles** highlighted in their training.

Monica (Team Leader):
"Before we consider discharge, let's explore strengths-based problem-solving. We know Jacob struggles with paranoia and mistrust, but what are his strengths? What might connect with him on a deeper level?"

The room is quiet until Carlos, the peer support specialist, speaks up.

Carlos:
"Jacob's faith seems important to him. I know it is part of his illness too, but he's

always quoting scripture when I see him. What if we used that as a starting point? Maybe his faith can be a strength and a source of connection too."

The facilitator nods and suggests pairing Carlos with Jacob for the day to try this strategy.

Later that day, Carlos spots Jacob near a community garden. Jacob looks wary, his posture tense, and his eyes dart around as if assessing for threats. Carlos approaches slowly, mindful of Jacob's paranoia.

Carlos:
"Hey, Jacob. Nice shirt—Romans 8:28, right? 'In all things, God works for the good of those who love Him.' What do you think that means?"

Jacob hesitates but seems intrigued. He glances at his shirt, then at Carlos.

Jacob:
"It means... God has a plan. Even when things seem bad, He's still working."

Carlos (nodding):
"That's a powerful message. It feels like it fits you — you're working through a lot, but you're still here, still trying. That takes strength."

Jacob visibly relaxes, his arms dropping to his sides. He starts to talk about his beliefs and how they help him make sense of the world.

As the conversation deepens, Carlos discusses a plan for looking into housing options. Jacob suddenly stiffens.

Jacob:
"My last counselor said we'd go shopping for new clothes today. He lied to you and me. Why would I trust any of you with finding a home!"

Carlos:
"I'm really sorry about that, Jacob. It is possible he told me and I forgot to write it down. Sometimes I miss details. Does that ever happen to you?

Jacob:

All the time! Just this morning, I forgot there was a free breakfast at the church. I got there late and didn't get a thing to eat!

Carlos:

"That is the worst. I need my breakfast! If I don't get it, my meds can really mess with my stomach. Sorry again about the clothes. I bet you were looking forward to that. Can you find it in your heart to forgive my mistake? Maybe we could walk down to the coffee shop and make a plan for getting you some clothes tomorrow. You can see me write it in the notes for the next case manager to be sure. I have some flex funds to get us a bite. What do you say?"

Jacob:

Jacob softens.

"Wait, you take meds! I didn't know. You seem so normal. How did you get a job? And yes, I'm starving, let's go. I probably should take my meds anyway. Do you have them?

Engagement Best Practices:
Factors that get in the way of engagement:

Crisis Assessment and Stabilization Scenario

Instructions

- Read scenario
- Identify strengths and risk factors
- Explore how your team would address the crisis.

Elizabeth steps into Amanda's apartment and immediately feels a wave of discomfort. The apartment is chaotic—empty beer bottles litter the floor, a fresh hole mars the door, and foils with meth residue are scattered around a trash can. Amanda is pacing rapidly, her movements erratic, and her speech is fast and disjointed. Elizabeth has not been around drugs and her strong values makes it hard for her to see Amanda's state. Elizabeth reminds herself that not everyone got the same upbringing. She takes a steadying breath, reminding herself of the need for calm and empathy.

Amanda glances up and freezes for a moment, then her expression softens into something resembling relief.

Amanda:
"Thank God you're here! I didn't think anyone would show up. It's been... It's been a lot."

Elizabeth (gently):
"I'm here, Amanda. Let's talk about what's been going on. It sounds like things have been really hard lately."

Amanda begins pacing again, her words tumbling out in a torrent.

Amanda:
"I don't know where to start. It's like everything is spinning out of control. Those guys last weekend—they said they were my friends, but they weren't. They scared me, and now I can't stop thinking about it. I haven't even slept since then... three days. I'm just wired and empty, you know?"

Elizabeth nods, maintaining eye contact.

Elizabeth:
"That sounds terrifying, Amanda. I'm so sorry you went through that. No wonder you're feeling so overwhelmed. What else has been on your mind?"

Amanda stops pacing and sinks onto the couch, her hands trembling slightly.

Amanda:
"What's the point? It's like everything I try just falls apart. My place is a mess, my head won't stop spinning, and I don't even know where to start. I think I'd be better off dead. I am so sick of getting to this point. I always get myself mixed up with these scum bags. I can't stop using. I am so terrified, so alone, and I just want it all to stop!"

Elizabeth:
"It's a lot to carry, Amanda. I hear you saying that you wish you weren't here. Are you having any thoughts of killing yourself?"

Amanda:
"It is all I have been thinking about since those bastards left! I just see myself jumping over the railing. It would be so quick and easy…."

"Hey!" (Amanda raises her voice and stands up) I see what you are doing. You can't make me go to the hospital. I know my rights. The cops will beat me, then I'll get strapped in and drugged. I'd rather die. Please don't put in the hospital!"

Elizabeth remembers her teammate share that Amada has a traumatic past with male offenders and some really scary hospitalizations. She is considering her options to help Amanda keep safe.

Identify indicators of desire, intent, capability, and buffers
How would you help Teresa stabilize? What would you ask? Who would you involve?

Assessment Scenario

Instructions

- Read scenario
- Highlight what seems relevant to document and discuss

Scenario Continued: Coffee Shop Conversation Between Carlos and Jacob

Carlos sits across from Jacob at a small coffee shop, the late afternoon sunlight casting long shadows across their table. Jacob has a cup of coffee in front of him but keeps his hands wrapped tightly around the cup, his gaze flickering nervously between the door and the window. His shoulders are hunched, and his posture reflects a mix of weariness and guardedness. Despite his tense demeanor, he has taken the step of meeting with Carlos, suggesting a willingness, however tentative, to engage.

Jacob presents as a thoughtful yet deeply mistrustful individual. His words are deliberate, reflecting his intelligence and introspection, but his responses often hint at underlying paranoia. His clothes are clean but worn, consistent with his history of homelessness. His near appearance despite his difficult circumstances suggests self-pride, independence, and resourcefulness. As Jacob talks, his intelligence and thoughtfulness shows as he articulates historical events and biblical scripture with remarkable insight.

Carlos:
"Jacob, I have to say, that shirt is a good one. Romans 8:28, right? ‘In all things, God works for the good of those who love Him.’ What made you pick that verse?"

Jacob (shrugging, speaking softly):
"It reminds me that... even when things seem bad, there’s still a purpose. Like... maybe all of this means something."

Carlos (nodding):
"That’s such a hopeful perspective. Your faith seems like a really strong anchor for you. Does it help you on the hard days, too?"

Jacob (hesitating):
"Sometimes. But it’s hard when people twist faith to control others. And, I know for certain there are many others that say they walk in the faith that are secretly soldiers of the devil. It makes it tough to trust anyone."

Carlos (reflecting):
"Yeah, I can see how it could be really hard to feel safe. Trust is hard, especially when people misuse something so personal. What helps you feel safe when things get overwhelming?"

Jacob (pausing, lowering his voice):
"I guess... being alone. I stay away from people. It's just safer that way."

Carlos:
"That makes sense. Safety is so important. If you could picture a quiet, safe place just for you, what would it look like?"

Jacob:
"Somewhere no one can find me. No noise, no people judging me."

Carlos:
"That sounds peaceful. If we could help you find a home that was on the quieter side, and we helped you create a peaceful space in one of the rooms, would you be open to talking about it?"

Jacob (nodding slightly):
"Maybe. If it's quiet."

Carlos:
"You've been out here in the cold for a while. How's your health holding up? Are you feeling okay?"

Jacob (shrugging):
"I've been coughing a lot lately and my teeth are killing me. Probably nothing. I'm always clenching my jaw cuz of the cold and everybody coughs out here being in the elements. I don't go to doctors—they ask too many questions."

Carlos:
"I hear you. It can be overwhelming. But that cough sounds like it's been bothering you. Maybe there's a doctor who can meet you on your terms—keep it simple and quick?"

Jacob (hesitant):
"I don't know... maybe if they don't push me."

Carlos:

"You mentioned you mostly stay away from people. Are there any people you feel okay being around—family, friends, or even someone from church?"

Jacob:

"Yeah, I like that church where I get the free breakfast. The Pastor really knows his stuff, and nobody really bothers me. I can just sit in the back and listen....And, well I guess my sister sometimes. She tries to check on me, but I push her away. I don't want her to get dragged into my mess."

Carlos:
"Sounds like she cares about you a lot. What's something she's done recently that meant a lot to you?"

Jacob:
"She brought me a blanket last month. It was cold, and she just showed up. Didn't even say much, just left it for me."

Carlos:
"That's really thoughtful of her. Maybe there's a way to lean on that support without feeling like it's too much—just small steps."

Carlos:
"You've got so much insight, Jacob. I can tell you think deeply about things. What else keeps you grounded, like your faith?"

Jacob:
"Reading history. I like figuring out how things connect. It's... calming, I guess."

Carlos:
"That's an amazing skill. Do you ever draw connections between what you read and what's happening now?"

Jacob:
"Sometimes. But people now... they don't make sense."

Carlos:
"Yeah, people can be unpredictable. What about art? I remember you mentioned sketching before—do you still do that?"

Jacob:
"Sometimes. I draw things I see in my head. It helps clear the noise."

Carlos:
"That's a powerful outlet. You've got so many creative and thoughtful sides to you."

Carlos:
"Jacob, I've really enjoyed this conversation. You've shared a lot, and it helps me understand what's important to you. You look like you could take a break from all this talking. I looks like I still have some extra time. If we swing by the office, I can pick up your weekly funds. Did you want to try and go shopping today or set something up for tomorrow? We can talk more about what a safe place looks like for you and maybe brainstorm how to make it happen."

Jacob (hesitant, then nodding):
"Yeah, I'm pretty tired. Being around people for a while really drains me. Maybe we could just sit in the car quietly while we drive to get some winter clothes?

Carlos:
"Sure Jacob, that sounds perfect. I really appreciate you telling me exactly what you need. That's a good habit to have. Let's head out." As they leave Carlos is already thinking about how he might bring up keeping the clothes nice as a way to explore housing options…

Jacob's needs and strengths:

Treatment Planning Worksheet

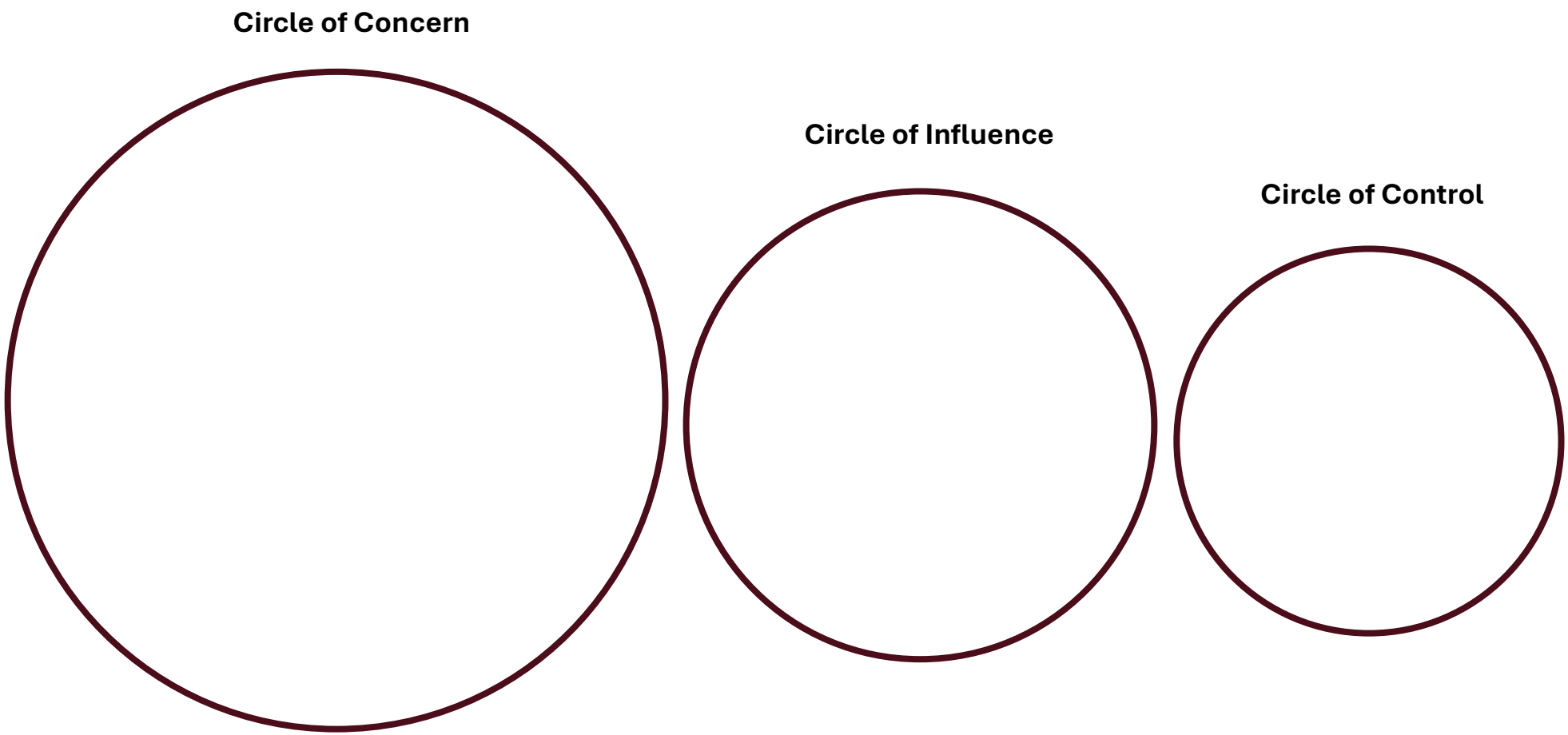
Instructions:

Based on the scenario:

- What are the key items to report back to the team?
- How would you prioritize Jacobs's needs?
- How might you phrase the goals in Jacob’s own words for electronic health record?

Key Items to Report Back to the Team:
Priority Needs:
Goals:

Locus of Control Worksheet



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Definitions

Compassion Satisfaction: positive, altruistic feelings of self-appreciation achieved when caring for and helping others. (Perez-Bret E, Altisent R, Rocafort J. 2016)

Collective trauma—cultural, historical, social, political, and structural traumas (i.e., racism, bias, stigma, oppression, genocide) that impact individuals and communities across generations. (Grossman, et al, 2021)

Crisis: A time of intense difficulty, trouble, or danger. A time when a difficult or important decision must be made. Crisis is self-defined (Oxford English Dictionary)

Fidelity: Fidelity is defined as the degree to which a program or person implementing an evidence-based practice adheres to specific standards defined for that practice model (Bond and Drake, 2020).

Individual trauma—an event, series of events, or set of circumstances, that is experienced by an individual as physically or emotionally harmful or life threatening and has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.[10]

Interpersonal trauma—adverse childhood events, child maltreatment, domestic and sexual violence, human trafficking, elder abuse, etc.

Neuroplasticity: the ability of the nervous system to change its activity in response to intrinsic or extrinsic stimuli by reorganizing its structure, functions, or connections. (Kanorski, 1948; cited by Puderbaugh and Emmady, 2023)

Resilience: the process and outcome of successfully adapting to difficult or challenging life experiences, especially through mental, emotional, and behavioral flexibility and adjustment to external and internal demands. A number of factors contribute to how well people adapt to adversities, predominant among them (a) the ways in which individuals view and engage with the world, (b) the availability and quality of social resources, and (c) specific coping strategies. Psychological research demonstrates that the resources and skills associated with more positive adaptation (i.e., greater resilience) can be cultivated and practiced. (American Psychological Association, 2018)

Resilience Skill Set (U Penn, Positive Psychology Center, accessed, August 2024)

- Self-awareness
- Self-regulation
- Mental agility
- Strengths of character
- Connection
- Optimism

Secondary Trauma Stress: the emotional duress experienced by persons having close contact with a trauma survivor, especially concerned family members, a natural response to a survivor's traumatic material with which helpers may identify and empathize (Figley & Kleber, 1995)

STS symptoms are related to thoughts, emotions, and behaviors resulting from the knowledge about traumatic events experienced by others but also from engagement in helping the trauma victims.

They include the same symptoms which occur in PTSD and are experienced by people directly exposed to trauma (Figley, 1995)

3 domains: (I) reexperiencing of the primary survivor's traumatic event; (2) avoidance of reminders and/or numbing in response to reminders; and (3) persistent arousal.

Therapeutic Relationship: Enola K. Proctor (1982) the relationship that exists between the mental health service provider and client which facilitates the wellbeing of the client and the achievement of his or her goals.

Vicarious Trauma: VT the permanent trans-formation in the inner experience of the provider that comes about as a result of empathic engagement with clients' trauma material" (Pearlman & Saakvitne,1995)

Primary symptoms: disturbances in the provider's cognitive frame of reference, identity, worldview, spirituality, in addition to changes in affect tolerance, fundamental psychological needs, deeply held beliefs about self and others, interpersonal relationships, internal imagery, and physical presence in the world.

Imminent Danger: We have reason to believe based on the information that we've gathered that there is a very short timeframe between the person's current risk status and actions that could lead to self or other harm. It is imminent when we are reasonably sure that if no actions are taken, the individual is likely to seriously harm or kill themselves in the very near future. (SAMHSA 988, 2022)

Note: In the Tarasoff case there were a total of 67 days between the time of threat and when the threat was carried out. Threats should be taken seriously.

Emotion-Regulation refers to the processes by which we influence which emotions we have, when we have them, and how we experience and express them (Gross, 1998)

Emotional Labor: The management of feelings to create a publicly observable facial and bodily display. (Hochschild, 1983, cited by Jeung, Changsoo, and Chang, 2018)

Closely related term that makes the connection between emotional labor and its impacts on health. "**Surface acting:** is more likely to cause emotional exhaustion due to the effort required to fake or suppress negative emotions.[41] Surface acting consistently produces emotional exhaustion that results in diminished well-being.[74] Research suggests that surface acting is likely to deplete energy, as it involves long-lasting internal tension between one's displayed (suppressed) and true feelings, which in turn causes emotional dissonance. According to the person-centered concept of authenticity, conforming to external expectations leads to self-alienation and compromised feelings of authentic living.[75] Empirical research has revealed that accepting external influences and acting against one's internal emotions has a significant association with anxiety, stress, and diminished subjective and psychological wellness.[75] The continuous experience of emotional dissonance is more likely to increase the risk of high levels of psychological effort, thereby leading to loss of resources.[76,77] and finally resulting in burnout."(Changsoo, and Chang, 2018)

Intellectual Humility: the degree to which people recognize that their beliefs might be wrong. (Leary, et al, 2002)

Burnout: a prolonged response to chronic emotional and interpersonal stressors on the job. It is defined by the three dimensions of exhaustion, cynicism, and professional inefficacy. (Maslach & Leiter, 2016)

Mental Agility: The ability to look at situations from multiple perspectives and to think creatively and flexibly. (University of Pennsylvania, Positive Psychology Center, accessed, August 2024)

Moral Distress: The combination of (1) the experience of a moral event, (2) the experience of 'psychological distress' and (3) a direct causal relation between the two. (Morley, Bradbury-Jones, and Irvine, 2019)

Optimism: The ability to notice and expect the positive, to focus on what you can control, and to take purposeful action. (University of Pennsylvania, Positive Psychology Center, accessed, August 2024)

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Resources

1. Dr. Marc Brackett Webcast - Dealing with Feelings Expert on emotional regulation that brings in experts and other famous people to normalize and explore the world of emotions. https://www.youtube.com/@MarcBrackett
2. Case Western: ACT Team Meeting Tools https://case.edu/socialwork/centerforebp/resources/act-team-meeting-tools
3. Crisis Prevention Institute: Library of Accessible Guides (10 tips to de-escalation). Free videos. https://www.crisisprevention.com/library/
4. Crisis Response training (Free): Register with Open Path to get access to a complete catalogue of eLearning courses. https://learninghub.ownpath.co/
5. Documentation Standards Presentation, MT BHDD, November 2024: https://medicaidprovider.mt.gov/docs/training/2024Training/DocumentationfromaReviewerPerspective11.21.2024.pdf
6. Homeless and Housing Resource Center, Understanding and Supporting Residents with Serious Mental Illness, 2024, https://hhrctraining.org/system/files/paragraphs/download-file/file/2024-10/hhrc_-understanding_smi_508.pdf
7. Howard Brown Safety Planning Tool (Free) training and tools: https://suicidesafetyplan.com/training/
8. MHTTC ACT training (recorded): https://www.healtheknowledge.org/
9. Medical Record Documentation MT BHDD (Recorded Training): https://www.youtube.com/watch?v=dgcXVb3LQFM
10. National ACT Website: https://uwspiritcenter.org/assertive-community-treatment-act-3/national-act-consultation-calls/
    1. To obtain access to the listserv, complete the survey: Sign up here: http://www.institutebestpractices.org/sign-up-form/
11. Substance Abuse and Mental Health Services Administration
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