ACT GRADUATIONS

Missouri ACT teams are strongly encouraged to formally assess participants’ needs for ACT services at least once every 6 months using the PACT Transition Assessment Scale. An individual may be placed on a graduation track to lesser intensive services if the individual is assessed at a “1” or “2” on all the scaled items. (Graduation may also be considered for individuals assessed at a “3” on Activities of Daily Living scale and “3” or “4” on Community Integration scale.) Teams are encouraged to continually assess the service needs of participants.

Though “graduation” is a process to be celebrated as a step toward recovery, it is recognized that there may be anxiety, sadness and fears experienced by individuals, family members and staff when initiating such a move. ACT team participants may feel rejected, punished and not yet ready to leave the familiarity and support of the ACT team. Family members may worry that their loved one will again experience the intense symptoms that led to the initial ACT referral while ACT team members will face the termination of therapeutic relationships that may span many years. It is therefore imperative that graduation be gradual, thoughtfully planned and individualized with assured continuity of care. More specifically, ACT teams are encouraged to employ the following strategies regarding graduations.

- Introduce the idea of graduation at the very beginning of the consumer’s enrollment (even during the engagement phase) and continue the discussion throughout the individual’s tenure with ACT.
- Involve ACT team members in a discussion of the individual’s potential for graduation and plans necessary to ensure successful transition to lesser level of care.
- Involve the individual in all plan’s related to his/her graduation.
- Be prepared with appropriate interventions should an individual temporarily experience an increase in symptoms or begin to “sabotage” treatment goals in response to graduation plans.
- Involve the individual’s social network – especially family - in developing and reviewing the graduation plan, to the extent approved by the participant.
- Coordinate several meetings with the individual, relevant ACT team members, and the new service provider to introduce the new provider as well as review the participant’s current status, progress in ACT and future goals.
- If possible, temporarily overlap ACT services with those of the new provider.
- Monitor the individual’s status following transition and assist the new provider, as needed.
- Structure “alumni” activities and/or groups that will allow graduated participants to remain appropriately connected to the ACT team (and perhaps serve as mentors for current enrollees).

The ACT team ensures the individual participates in discharge activities, as evidenced by documentation below:

- A transition plan developed with the individual incorporating graduated step down in intensity including a systematic plan to maintain continuity of treatment at appropriate levels of intensive to support the individuals’ continued recovery and have easy access to return to the ACT team if needed.
- Discharge summary to include dates of admission and discharge; reason for admission and referral source; diagnosis or diagnostic impression; description of services provided and outcomes achieved, including any prescribed medication, dosage, and response; medical status and needs that may require ongoing monitoring and support.
- An aftercare plan developed in conjunction with the individual that identifies services, designated provider(s), or other planned activities designed to promote further recovery.

When clinically necessary, the team will make provisions for the expedited re-entry of discharged consumers as rapidly as possible and will prioritize them on the admission or waiting list.