Assertive Community Treatment (ACT)

What is the practice?

Assertive Community Treatment (ACT) was developed to meet the complex needs of individuals with serious mental illness (SMI) who also experience continuous high service needs (e.g., repeated or long-term hospitalizations or crisis service use) and challenges with role functioning (e.g., maintaining housing or employment). This outreach-oriented team provides a range of clinical treatment, psychiatric rehabilitation, and case management services and, where possible, diverts escalation to higher levels of care (e.g., inpatient hospital, emergency department) or involvement with the justice system. Services are typically delivered in person at a high intensity and frequency, while also delivered flexibly based on each individual's needs and preferences. Most services are provided in individuals' homes and communities, and in locations that maximize skills generalization (e.g., in the kitchen to learn to cook, at their place of employment to learn specific job skills).

ACT teams typically consist of the following multidisciplinary team roles: (1) a psychiatric care provider who prescribes medication and supports integrated healthcare; (2) nurses who administer medications and promote health and wellness; (3) a co-occurring disorders specialist who provides integrated, stagewise substance use disorder treatment; (4) an employment specialist who utilizes the individual placement and support (IPS) model of supported employment to help individuals pursue employment goals and supported education; (5) a peer support specialist who partners with service recipients on identifying and promoting their own recovery journey and using wellness management strategies to pursue their self-identified goals; (6) mental health clinicians who deliver evidence-based psychotherapy and skills coaching; (7) case managers who facilitate access to services and supports in the community; (8) an in-office program assistant who supports team operations and facilitates communication and support between service recipients, natural supports, and team members; and (9) a team leader who leads the management and supervision of the team, while also dedicating a portion of time to direct practice. More details on staffing are included in the following sections below: ***What infrastructure or readiness is needed to implement this practice? What specific training or certification is required to implement the practice?***

What is the evidence for this practice?

ACT is one of the most well-studied service programs for people with SMI, with more than 50 published empirical studies and several reviews and meta-analyses (Baronet & Gerber, 1998; Bedell et al., 2000; Bond et al., 2001; Burns et al., 2007; Coldwell & Bender, 2007; Gorey et al., 1998; Herdelin & Scott, 1999; Marshall & Lockwood, 2000; McDonagh et al., 2022; Morrissey et al., 2013; Mueser et al., 1998; Ziguras & Stuart, 2000).

What outcomes does this practice produce?

Across studies, nearly all have found positive outcomes related to improved community integration for people served by ACT teams. The most robust findings have been in four outcome domains:

- *Decreased hospital utilization*
- *Increased independent living and housing stability*

- *Retention in treatment, and*
- *Individual and family satisfaction*

Research findings have been weaker in the areas of improving employment, community integration and participation (also referred to as psychosocial functioning), substance use, and justice system involvement. Possible reasons for weaker findings for the first three outcome domains include the need to focus on training and fidelity assessment that reinforce direct service provision using interventions that directly target those outcomes. For example, in order for employment outcomes to improve, the employment specialist should provide the evidence-based model of supported employment, called Individual Placement and Support (IPS), versus spending most of their time delivering generalist services that do not directly address employment outcomes or approaches to employment that have little to no evidence base for individuals experiencing SMI (e.g., referring out to sheltered workshop).

The lack of evidence in improving justice system outcomes suggests the need to utilize the adapted model of ACT – called Forensic ACT or FACT – which typically integrates justice system roles and coordination within the team and has been found to be more effective than standard ACT alone for those with repeated justice system involvement (Lamberti et al., 2017).

How is this practice implemented?

In what contexts is this practice implemented (e.g., schools, clinical)?

Given its target population and core mission, ACT is typically implemented within community behavioral health care agency settings. Most services are delivered outside the office; ACT team members support individuals they serve at health and social service appointments and provide skills training and support in other community settings such as in individuals' homes, school, work, and other community settings (e.g., helping with grocery shopping). ACT team members often liaise with acute inpatient and state hospitals, emergency departments and crisis services, jails, services for unhoused, and other community agencies for the purposes of both identifying eligible participants and coordinating care.

What is the dosage of this practice (e.g., short-term sessions, six-week curriculum)?

ACT services are delivered flexibly and are personalized to individuals' needs and preferences as specified in their person-centered treatment plan. There is no specific service dosage; however, given the population served, most individuals receive an average of three face-to-face and approximately two hours of service contact per week. The multidisciplinary staffing and comprehensive range of services offered also means that often multiple team members (typically at least three) provide those individualized services in the community during the week and that clients have access to someone on the team anytime of the day or night to help address emerging needs.

While there is no time limit on someone's enrollment in ACT, the team works collaboratively with service recipients toward transition to less intensive services. ACT clients identify what is important to them in their life and the team offers clinical services and skills teaching that help them reach those goals. Graduation from the program is discussed early and transparently with clients. As clients gain independence, accomplish goals, and learn to manage mental health symptoms, ACT clinicians facilitate their transition to a less intensive level of care.

How is the practice delivered (e.g., online, in-person)?

ACT services are primarily delivered in person, with the vast majority of services delivered in the community. Because of this, the team is able to outreach and engage individuals where they are, as well

as ensure that clinical services and skills training are tailored to the situations in which they will be applied. Depending on client preference or staff availability, some services such as groups may also be offered in an office setting.

Since ACT is a team-based service program it is intended that all team members work together to support each other's work. Teams meet daily to review the status of all clients served by the team, discuss previous and planned service contacts, address emerging clinical needs and need for proactive contacts, and coordinate scheduling and service coverage. While a subset of the team may work more closely with a certain client depending on that client's needs and preferences, it is expected that all team members be familiar with the entire caseload of people served so that they can step in to support them as needed. Similarly, delivering ACT services with high fidelity to the model involves regular cross-training between roles on the team to facilitate collaboration and ensure a uniform, team-wide approach to supporting client recovery.

What infrastructure or readiness is needed to implement this practice (e.g., capacity for data analysis, individual full-time equivalent [FTE])?

Before implementing ACT, it is recommended that agencies demonstrate readiness to implement evidence-based practices, including aligning agency resources to implement the model with high fidelity. Start-up funding (including training costs) is essential for initially implementing ACT as the team begins to serve clients. A bundled payment model that accounts for the level of non-billable time needed in team-based care models is preferable to fee-for-service financing models. Ongoing training, consultation, and fidelity reviews are essential for facilitating ACT sustainability.

ACT teams typically serve up to 100 individuals and no fewer than 40-50 clients. Teams should not exceed a ratio of 10 clients per staff member. The table below includes typical ACT staffing pattern.

Typical ACT Team Staffing

Position	Full Team (serves 80-100)	Half Team (serves 40-50)
Team Leader	1 FTE	1 FTE
Psychiatric Care Provider/Prescriber	16 hours per 50 clients	16 hours per 50 clients
Registered Nurses	3 FTE	1.5 - 2 FTE
Peer Specialist	1 FTE	1 FTE
MA-level Clinicians*	4 FTE	2 FTE
BA-level CMs*	1 – 3 FTE	1.5 – 2.5 FTE
***may include Co-Occurring Disorders Specialist**	*1 FTE*	*1 FTE*
***may include Employment Specialist**	*1 FTE*	*1 FTE*
Program Assistant	1 – 1.5 FTE	1 FTE

For which population(s) can this practice be implemented?

For which population(s) is this best or promising practice (BPP) intended? Has it been adapted for diverse groups? If so, which ones?

The population for whom ACT is intended and has been found most effective is individuals with SMI, who also experience continuous high-service needs (e.g., multiple or long-term inpatient, crisis service, or justice system admissions) and challenges with role functioning (i.e., maintaining housing, employment, personal needs). Many of these individuals also meet criteria for a co-occurring substance use disorder.

While there have been a variety of ACT adaptations, few have been as well-studied as Forensic ACT, or FACT, which serves individuals with psychiatric disabilities with more extensive involvement within the justice system (Lamberti et al., 2017). FACT teams typically include staff who work in the justice system (e.g., a probation officer, specialty court liaison) as part of the team while also maintaining fidelity to standard ACT (Lamberti & Weisman, 2021).
Some states have adapted ACT to meet the needs of transition-age young adults and youth and other populations, but there is not agreement among experts on the extent to which these models are still considered ACT given the great number of adaptations to population, staff competencies and roles, and interventions delivered.

For which populations, if any, is this practice NOT a good fit?

ACT is not the best available service program for all individuals with high mental health service needs and challenges with treatment engagement regardless of diagnosis. Further, people diagnosed with a developmental disorder, an autism spectrum diagnosis, a personality disorder such as Borderline Personality Disorder, or people whose psychotic symptoms are primarily the result of substance use or a medical condition are better served by other specialized services.

Who can implement this practice?

What expertise is needed to implement the practice?

All team members must have a clear understanding and expertise in their specialized role on the team (e.g., nurse, co-occurring disorders specialists), while also recognizing that they will have shared responsibilities across the team in more generalist services such as case management and crisis response. All ACT team members participate in daily team meetings to plan services, review clients' status and goals, and focus on proactively heading off crises and addressing emerging needs. The entire team should be trained in a person-centered, recovery-oriented approach to treatment planning and service delivery (Adams & Grieder, 2014).

What specific training or certification is required to implement the practice?

Required training and certification varies by role on the team:

- ***Team Leader:** requires a clinical license and a master's degree in counseling, social work, or a related human service field;*
- ***Psychiatric Care Provider:** requires a medical degree, psychiatric specialization, and sufficient qualifications to prescribe medications and monitor health conditions. Typically, a board-certified psychiatrist, psychiatric nurse practitioner, or other psychiatric care provider.*
- ***Mental Health Practitioner:** requires a master's degree in counseling, social work, or a related field and a license to practice psychotherapy. Ideally, MHPs should come to this work trained to deliver evidence-based treatments for treating serious mental illness, such as Motivational Interviewing and Cognitive Behavioral Therapy.*
- ***Nurses:** requires registered, licensed nurses (RNs) with at least one year of experience with people with serious mental illness.*
- ***Co-Occurring Disorders (COD) Specialist:** requires at least a bachelor's degree and must meet the local standards for a co-occurring or substance use disorder specialist, which can include*

additional certification courses, supervision, and/or advanced degrees. Should be familiar with integrated stage-wise treatment for co-occurring substance use disorders.

- ***Supported Employment Specialist:*** *requires at least a bachelor's degree and one year of experience in delivering supported employment services in line with the individual placement and support model (IPS).*
- ***Peer Support Specialist****: self-identifies as an individual with a serious mental illness and meets local requirements for peer certification. Ideally, has received training in wellness management and recovery interventions such as Wellness Recovery Action Planning (WRAP) or Illness Management and Recovery (IMR).*

What costs are associated with delivering this practice? *(e.g., developer fee for materials, other program materials, staff travel to clients, incentives for clients)*

Costs associated with delivering this practice vary by state, region, and the healthcare setting in which they are delivered. Most teams are primarily supported by Medicaid, with some by Medicare. Some teams are supported by state-level or regional funding, and many leverage support through Federal Block Grant funding, especially as teams start up and have not yet begun to secure reimbursement through Medicaid or other insurance sources. A bundled payment model is typically a better financing approach than fee-for-service given the amount of nonbillable time ACT teams spend in team-based approaches (e.g., planning services in the daily team meeting, transportation for outreach). A national study of ACT led by the University of North Carolina is currently underway to provide more information about the status of ACT teams nationally, including more information about ACT financing and costs (Moser et al., 2022).

Costs also vary depending on trainers selected. Note that the MHTTC Network can provide some training and consultation on this BPP free of cost.

What costs and commitments are associated with becoming trained in this practice?

What is the cost associated with becoming trained?

When possible, it is recommended that states and communities engage with local ACT experts to provide training and implementation support to ACT teams. When there are no local ACT experts, we recommend engaging in a train-the-trainer model where national ACT experts help to develop local capacity for training locally, which will help to sustain implementation and support for the model over time. Several training and technical assistance programs specializing in ACT can be contacted individually about fees associated with their training (see more information below under ***Are there recognized providers of training in this practice?****).*

While itself an evidence-based intervention, ACT is also an avenue for delivering other, role-specific interventions such as Motivational Interviewing, Supported Employment/Education, Cognitive Behavioral Therapy for psychosis, and more. The cost and availability of these trainings also vary.

What is the time commitment associated with completing training?

As mentioned above, training and certification is role-specific and will vary with the required expertise of each specialist. However, it is common for all new team members to undergo a one- to two-day training in the overall model of ACT and receive ongoing training and consultation in the model.

Are there recognized providers of training in this practice?

Several state training and technical assistance centers offer national training on ACT:

ACT Training Based on the TMACT:
UNC Institute for Best Practices: Contact Lorna Moser, lorna_moser@med.unc.edu
University of Washington SPIRIT Lab: Contact Maria Monroe-DeVita, mmdv@uw.edu
Private consultant and trainer, Lynette Studer: lstuder@wisc.edu

ACT Training Based on the DACTS:
Case Western Center for Evidence-Based Practices: Contact Ric Kruszynski: richard.kruszynski@case.edu

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Does the practice have an associated fidelity assessment?

ACT does have well-studied fidelity assessment tools, and much of the detail provided above is derived from the best practice guidelines outlined in those tools. The current ACT fidelity tool is called the Tool for the Measurement of Assertive Community Treatment (TMACT), which builds upon the Dartmouth Assertive Community Treatment Scale (DACTS) in order to more sensitively assess not just the team's structure but also their delivery of specialty services. DACTS is still used in some states and provides a briefer assessment of ACT structure and some areas of service and functioning.

Fidelity assessment of an ACT team is generally conducted every one to two years and involves reviewer visiting the team for approximately 2 days to interview staff, observe delivered services and team functioning, and review clinical records. Qualitative and quantitative data collected from these reviews are then used to generate fidelity scores across a range of domains (in both the DACTS and TMACT, these scores range from 1-5, with 5 representing high fidelity). These scores are incorporated into a longer written report that showcases the team's strengths and primary areas of growth and typically include tangible recommendations for further training. Depending on the policies of the state in question, fidelity scores may be used solely internally for quality improvement purposes or may be tied to funding renewal for ACT teams.

What resources or references are useful for understanding/implementing the practice?

The Northwest MHTTC has a regional focus on ACT and hosts bi-monthly virtual consultation calls to support ACT teams nationally:
Region 10 MHTTC Area of Focus Document | Mental Health Technology Transfer Center (MHTTC) Network (mhttcnetwork.org)

https://mhttcnetwork.org/centers/northwest-mhttc/national-assertive-community-treatment-act-virtual-consultation-meetings

The Northwest MHTTC has developed a preparatory course to serve as a primer in understanding ACT:
Introduction to Assertive Community Treatment (ACT) | Mental Health Technology Transfer Center (MHTTC) Network (mhttcnetwork.org)

Where should you go for more information?

Assertive Community Treatment (ACT) | SPIRIT Lab at the University of Washington (uwspiritlab.org)
Assertive Community Treatment (ACT) - UNC Center for Excellence in Community Mental Health
Assertive Community Treatment (ACT) (ny.gov)

How to Use the Evidence-Based Practices KITs (samhsa.gov)

References

Adams, N., & Grieder, D. (2014). *Treatment planning for person-centered care: Shared decision making for whole health (Practical resources for the mental health professional) (2nd ed).* Amsterdam: Elsevier.

Baronet, A.-M., & Gerber, G. J. (1998). Psychiatric rehabilitation: Efficacy of four models. *Clinical Psychology Review, 18*(2), 189–228. https://doi.org/10.1016/S0272-7358(97)00106-2

Bedell, J. R., Cohen, N. L., & Sullivan, A. (2000). Case management: The current best practices and the next generation of innovation. Community Mental Health Journal, 36(2), 179–194. https://doi.org/10.1023/A:1001894311127

Bond, G. R., Drake, R. E., Mueser, K. T., & Latimer, E. (2001). Assertive community treatment for people with severe mental illness: Critical ingredients and impact on patients. *Disease Management & Health Outcomes, 9,* 141-159.

Burns, T., Catty, J., Dash, M., Roberts, C., Lockwood, A., & Marshall, M. (2007). Use of intensive case management to reduce time in hospital in people with severe mental illness: systematic review and meta-regression. *British Medical Journal, 335*, 336-340.

Coldwell, C. M., & Bender, W. S. (2007). The effectiveness of assertive community treatment for homeless populations with severe mental illness: A meta-analysis. *American Journal of Psychiatry, 164*, 393-399.

Gorey, K. M., Leslie, D. R., Morris, T., Carruthers, W. V., John, L., & Chacko, J. (1998). Effectiveness of case management with severely and persistently mentally ill people. *Community Mental Health Journal*, *34*(3), 241–250. https://doi.org/10.1023/A:1018761623212

Herdelin, A. C., & Scott, D. L. (1999). Experimental studies of the Program of Assertive Community Treatment (PACT). *Journal of Disability Policy Studies*, *10*(1), 53–89. https://doi.org/10.1177/104420739901000105

Lamberti, J. S., Weisman, R. L., Cerulli, C., Williams, G. C., Jacobowitz, D. B., Mueser, K. T., Marks, P. D., Strawderman, R. L., Harrington, D., Lamberti, T. A., & Caine, E. D. (2017). A randomized controlled trial of the Rochester forensic assertive community treatment model. *Psychiatric Services*, *68*(10), 1016–1024. https://doi.org/10.1176/appi.ps.201600329

Lamberti, J. S. & Weisman, R. L. (2021). Essential elements of forensic assertive community treatment. *Harvard Review of Psychiatry, 29*, 278-297.

Marshall, M., Lockwood, A., Bradley, C., Adams, C., Joy, C., & Fenton, M. (2000). Unpublished rating scales: A major source of bias in randomised controlled trials of treatments for schizophrenia. *The British Journal of Psychiatry*, *176*, 249–252. https://doi.org/10.1192/bjp.176.3.249

McDonagh, M., Dana, T., Kopelovich, S., Monroe-DeVita, M., Grusing, S., Blazina, I., Bougatsos, C., & Selph, S. (2022). Psychosocial interventions for adults with schizophrenia: An overview and update of systematic reviews. *Psychiatric Services, 73,* 299-312.

Morrissey, J. P., Domino, M. E., & Cuddeback, G. S. (2013). Assessing the effectiveness of recovery-oriented ACT in reducing state psychiatric hospital use. *Psychiatric Services*, *64*(4), 303–311. https://doi.org/10.1176/appi.ps.201200095

Morrissey, J., Meyer, P., & Cuddeback, G. (2007). Extending assertive community treatment to criminal justice settings: Origins, current evidence, and future directions. *Community Mental Health Journal, 43*, 527-544.

Moser, L., Monroe-DeVita, M., Studer, L., & Cuddeback, G. (2022, August 1). *National Assertive Community Treatment (ACT) virtual consultation meetings: August 2022*. YouTube. https://www.youtube.com/watch?v=GIJVeO8Ba1o

Mueser, K. T., Bond, G. R., Drake, R. E., & Resnick, S. G. (1998). Models of community care for severe mental illness: A review of research on case management. *Schizophrenia Bulletin, 24*, 37-74.

Ziguras, S. J., & Stuart, G. W. (2000). A meta-analysis of the effectiveness of mental health case management over 20 years. *Psychiatric Services*, *51*(11), 1410–1421. https://doi.org/10.1176/appi.ps.51.11.1410

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For more information, contact your local MHTTC Regional National or Focus Area Center. Visit https://mhttcnetwork.org/centers/selection to find your center.

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