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Substance Abuse and Mental Health Services Administration

Maintaining Fidelity to ACT: Current Issues and Innovations in Implementation

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Acknowledgments

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Abstract

Assertive Community Treatment (ACT) is an evidence-based service delivery model that provides time-unlimited, community-based services for individuals with serious mental illness who are at particular risk for hospitalization, homelessness, criminal justice system involvement, and psychiatric crises. In 2008, the Substance Abuse and Mental Health Services Administration (SAMHSA) published the ACT Evidence-Based Practices (EBP) KIT (Knowledge Informing Transformation), a toolkit intended to help mental health agencies and teams implement ACT.

Both the toolkit and fidelity tools have received widespread use throughout the United States; however, concerns remain regarding the appropriateness of ACT application and fidelity to the model, both of which potentially dampen achievement of desired outcomes.

This follow-up and companion product reviews the principles of ACT; summarizes contemporary issues impacting ACT teams; and critically examines aspects of ACT implementation and outcomes when teams extend the model to specific target populations and settings. The goal of this guide is to ensure continued efficacy of ACT by reaffirming its fundamentals and promoting awareness of new developments that may be relevant to consider in implementation of the model.

MESSAGE FROM THE ASSISTANT SECRETARY FOR MENTAL HEALTH AND SUBSTANCE USE, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

As the Assistant Secretary for Mental Health and Substance Use in the United States Department of Health and Human Services and the leader of the Substance Abuse and Mental Health Services Administration (SAMHSA), I am pleased to present this new resource: *Maintaining Fidelity to ACT: Current Issues and Innovations in Implementation.*

SAMHSA is committed to improving prevention, treatment, and recovery support services for individuals with mental illnesses and substance use disorders. SAMHSA's National Mental Health and Substance Use Policy Lab developed the Evidence-Based Resource Guide Series to provide communities, clinicians, policymakers, and others with the information and tools to incorporate evidence-based practices in their communities or clinical settings. As part of the series, this guide reviews Assertive Community Treatment (ACT), sharing new developments to support effective implementation.

This guide and others in the series address SAMHSA's commitment to behavioral health equity, including providing equal access for all people to evidence-based prevention, treatment, and recovery services regardless of race, ethnicity, religion, income, geography, gender identity, sexual orientation, or disability. Each guide recognizes that substance use disorders and mental illnesses are often rooted in structural inequities and influenced by the social determinants of health. Behavioral health providers and community partners must give attention to health equity to improve individual and population health.

I encourage you to use this guide to implement ACT programs supporting individuals living with serious mental illness.

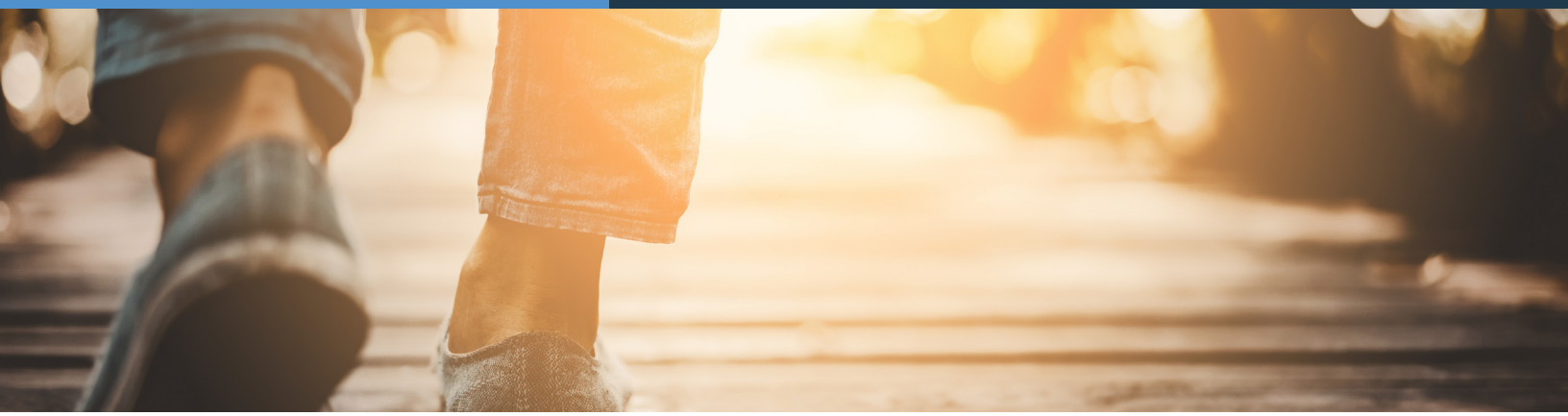
Miriam E. Delphin-Rittmon, PhD
Assistant Secretary for Mental Health and Substance Use
U.S. Department of Health and Human Services

Content of the Guide

Key Terms

Key terms included in the guide are listed below. Key terms are bolded the first time they appear in the text.

Term	Definition
988	The telephone number for the 988 Suicide & Crisis Lifeline (formerly known as the National Suicide Prevention Lifeline). The Lifeline offers 24/7 call, text, and chat access to trained crisis counselors who can help people experiencing a suicidal, substance use, and/or other mental health crisis or any emotional distress. People can also dial 988 if they are worried about a loved one who may need crisis care.
Adaptation	A process of making changes to an evidence-based program to better fit the needs of the population being served without negatively affecting, removing, or changing key or core implementation elements.
Burnout	An occupational condition resulting from chronic workplace stress that has not been successfully managed and is typically characterized by three dimensions: sustained feelings of exhaustion, depersonalization, and professional inefficacy.
Crisis care	A range of services for individuals experiencing an acute mental and/or substance use disorder crisis.
Cultural competence	A set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enable that system, agency, or those professions to work effectively in cross-cultural situations.
Empathetic engagement	A therapeutic technique in which the therapist actively listens to and engages with the client from a place of deep understanding of the client's perspectives and circumstances.
Evidence-based practices (EBPs)	Evidence-based practices are interventions that are guided by the best research evidence with practice-based expertise, cultural competence, and the values of the persons receiving the services, that promote individual-level or population-level outcomes.
Fidelity	The extent to which an intervention is delivered as conceived and planned.
Recovery	A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.
Serious mental illness (SMI)	A mental illness that interferes with a person's life and ability to function. Common SMIs include bipolar disorder, major depressive disorder, and schizophrenia.
Substance misuse	The use of any substance in a manner, situation, amount, or frequency that can cause harm to users or those around them. For some substances or individuals, any use would constitute misuse (e.g., underage drinking, injection drug use).



Chapter 1.

Fundamentals of ACT

Assertive Community Treatment (ACT) is one of the oldest and most researched evidence-based practices (EBPs) for treating people with serious mental illness (SMI).[1] It is used widely across the United States and internationally.[2] ACT is a multidisciplinary, team-based service delivery model that provides time-unlimited, community-based services for individuals with SMI who experience or are at particular risk for concurrent substance use, frequent hospitalization, homelessness, involvement with the criminal legal system, and psychiatric crises. The primary goal of ACT is to help individuals achieve recovery through community treatment, rehabilitation, and support.

ACT seeks to eliminate disparities for individuals diagnosed with SMI whose needs have not been well met by other more traditional delivery approaches. This includes services for individuals who have faced barriers to mental health care due to issues such as discrimination, stigma, limited access, and poverty. Principles of equity are fundamental to ACT. Teams provide services that are person-centered, culturally responsive, trans-disciplinary, and recovery-oriented, and which involve the individual's family and other natural community supports (e.g., faith organizations, friends, community groups).

CHAPTER OVERVIEW

This chapter reviews key aspects of ACT implementation.

Fundamentals of ACT

- ACT principles
- Recovery orientation in ACT

Contemporary Considerations

- Cultural considerations
- Role of peers
- Natural supports
- Wellness management approaches
- Community resources

Evaluating Your Program

- DACTS
- TMACT
- SAMHSA Fidelity Tool

In 2008, the Substance Abuse and Mental Health Services Administration (SAMHSA) published the ACT Evidence-Based Practices KIT (hereinafter referred to as SAMHSA's 2008 ACT Toolkit), a toolkit to help mental health agencies and teams implement ACT. The toolkit also includes information on ***fidelity***, the extent to which an intervention is delivered as conceived. Both the toolkit and fidelity tools have received widespread use throughout the United States,[2] and ACT principles remain consistent with the 2008 publication. However, there is growing interest in extending ACT to certain populations and settings,

including youth, justice-involved clients, immigrants and refugees, and rural communities.[2] Driven by a need to deliver contextually responsive and culturally relevant services, these extensions often necessitate modifications making it especially important to monitor fidelity. Research consistently demonstrates that higher fidelity to the ACT model produces better outcomes.[3-5]

This follow-up and companion product reviews ACT principles, summarizes contemporary issues impacting ACT teams, and examines aspects of ACT implementation when extending the model to specific populations and settings. The goal of this guide is to ensure continued efficacy of ACT by reaffirming its principles while promoting awareness of new developments that providers may want to consider when implementing the model.

1.1 Revisiting the Fundamentals

The primary goal of ACT is **recovery** through community treatment, rehabilitation, and support.[6] To achieve this goal, providers must implement the model with fidelity (see Chapter 3 of this guide for more discussion of fidelity when adapting ACT for new populations). ACT is intended for clients diagnosed with SMI, including but not limited to persistent psychosis and treatment-resistant mood disorders. These individuals may experience significant difficulty with basic functions (e.g., employment, home upkeep) and self-care (e.g., hygiene, medication management). The typical population for ACT has difficulty living independently and integrating within the community without support. Multiple or prolonged hospitalizations, crisis service utilization, and/or legal system involvement are common.

To ensure sufficient staff coverage for clients who may need a high level of intensity and frequency of service, an ACT team might include:

Position	FTE for Full Team serving 80-100 clients
Team Leader	1 FTE
Program Assistant	1 FTE
Psychiatrist/ Psychiatric Nurse Practitioner	32 hours per week, per 100 clients
Registered Nurse(s)	3 FTEs
Co-occurring Disorders Specialist(s)	1—2 FTEs
Employment Specialist(s)	1—2 FTEs
Peer Specialist	1 FTE
Additional MA-level Clinicians	2—3 FTEs
Additional BA-level Staff/ Case managers	1—2 FTEs

Note: Adapted from the Northwest MHTTC. Final team composition may vary based on community context and the needs of the local client population being served. Program assistant and team psychiatrist positions are not included in calculation of staff-to-client ratios.

For reasons related to their mental illness, some clients may also dislike or avoid involvement with traditional mental health services and struggle to engage in standard community support or case management. As an effective service model for individuals meeting these criteria,[3-5] it is critical to assure access to ACT in all communities for all populations. This includes underserved racial, ethnic, and sexual and gender minorities who often experience disproportionate incidence of barriers to accessing behavioral health resources,[7] and rural populations which also struggle with access.[8] Outreach to these populations to engage them in ACT may be necessary.

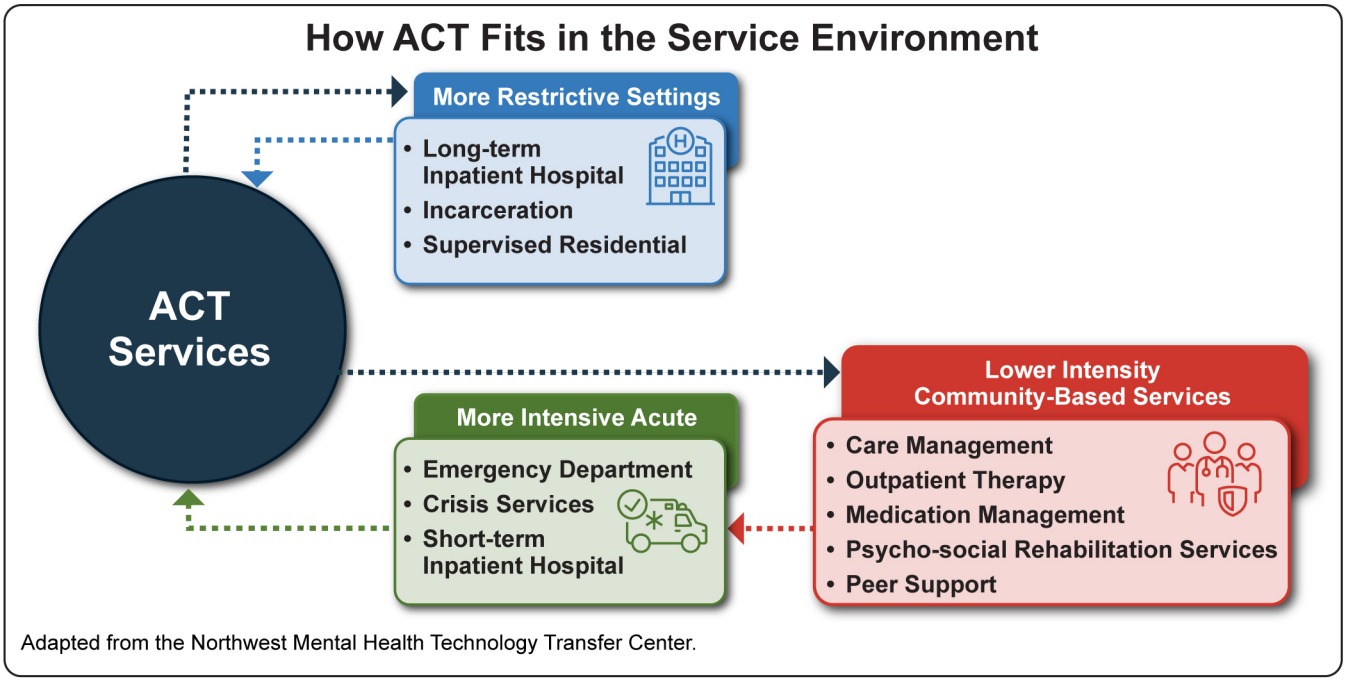
ACT is a self-contained, team-based service delivery system, effectively acting as a hospital without walls. Rather than referring clients to different providers for separate mental health services as case management programs often do, ACT team members provide the majority of needed services. The ACT team is multidisciplinary and includes staff with the broad range of expertise clients likely need. Each team maintains a staff-to-client ratio of no greater than 1 to 10. Depending on the funding source, a team may serve between 80 and 100 clients.

ACT implementation is further characterized by offering a centralized place for clients to receive services, the delivery of whole-person care, and consideration of clients' social determinants of health when providing care. This approach results in services that are both coordinated and integrated. The team can quickly add or remove services to support clients' needs and preferences.

Source: Substance Abuse and Mental Health Services Administration

Importantly, other EBPs may also be delivered within the ACT framework,[9] such as Housing First,[10,11] Supported Employment,[12] and cognitive behavioral therapy for psychosis (CBTp) or cognitive behavioral social skills training for schizophrenia (CBSST).[13] ACT serves as the least restrictive option for eligible clients, meeting their needs in the community rather than in a hospital or residential setting, while providing more intensive care than traditional outpatient services. ACT is time-unlimited and designed to provide services *without* the goal of transitioning clients out of ACT if it remains the level of care needed. Still, some ACT clients may transition to

lower intensity community-based services as they progress with their recovery. Supported Employment,[12] and cognitive behavioral therapy for psychosis (CBTp) or cognitive behavioral social skills training for schizophrenia (CBSST).[13] ACT serves as the least restrictive option for eligible clients, meeting their needs in the community rather than in a hospital or residential setting, while providing more intensive care than traditional outpatient services. ACT is time-unlimited and designed to provide services *without* the goal of transitioning clients out of ACT if it remains the level of care needed. Still, some ACT clients may transition to lower intensity community-based services as they progress with their recovery.



Adapted from the Northwest Mental Health Technology Transfer Center.

ACT Principles

The ACT model is guided by multiple essential practices,[6] including:

- **Multidisciplinary team:** Providers with various professional training and backgrounds work together to blend their knowledge and skills. A typical ACT team consists of a team leader, psychiatrist/psychiatric nurse practitioner, registered nurses, a co-occurring disorders specialist, an employment specialist, a peer specialist, clinicians and case managers, and a program assistant. Some teams may include additional specialist positions to provide support in areas such as forensics, housing, psychiatric rehabilitation, and family support or specific roles to assure culturally responsive and equitable care such as interpreter(s) or formal inclusion of natural community supports, (e.g., faith organizations, resettlement agency advocates).
- **Small caseload:** An ACT team that is practicing with fidelity has a staff-to-client ratio of no more than 1 to 10. A team gives each client individualized care.
- **Shared caseload:** Providers do not have individual caseloads; rather, the team as a whole is responsible for ensuring clients receive needed services.
- **Fixed point of responsibility:** The ACT team is responsible for helping a client develop their person-centered plan and collectively provides the services each client needs and wants to support achieving their expressed goals. If using another provider is optimal (e.g., to provide medical care), the ACT team ensures clients receive those services. The team also ensures effective communication about ongoing care needs and goals.

- **Flexible service delivery:** The ACT team meets daily to discuss how each client is doing. Team members quickly adjust their services to respond to changes in client needs.
- **Community-based and community-focused services:** ACT is not an office-based service. ACT teams provide assertive outreach and deliver services in the places where clients spend their time (e.g., homes, shelters, encampments). Services focus on full community integration. A hallmark of ACT is skills training within the community, such as helping people work, shop, bank, use the library, use recreation centers, and engage in other community-based activities. ACT includes community-based and community-focused services that reflect the needs of diverse communities, specifically culturally appropriate spaces.
- **Time-unlimited services:** The ACT team provides services for as long as needed.
- **24/7 crisis availability:** Services are available 24 hours a day, 7 days a week.

Prioritizing Recovery Orientation in ACT: The Importance of a Person-Centered Approach and Shared Decision-Making

SAMHSA defines recovery as "a process of change through which individuals improve their health and wellness, live self-directed lives, and strive to reach their full potential." Recovery is a common theme in all aspects of ACT. It is an ongoing process that is usually measured through both objective indicators of community integration (e.g., community functioning) and subjective indicators of psychological well-being (e.g., hope, positive identity, sense of purpose).[14] The process of recovery is personal and can be supported through multiple means and pathways. Recovery-oriented services are person-centered and non-coercive. They focus on personal goals and strengths, client choice, and individually tailored services.[15]

Recovery is a primary goal of ACT. Services are accessible and person-centered, and clients define their own pathway to recovery without coercion. SAMHSA's 2008 ACT Toolkit described why coercive practices are harmful and how to ensure assertive rather than coercive practices.[6] Early in its history, ACT was criticized for being inappropriately coercive,[16,17] but clients generally do not perceive ACT in this way.[18] Assuring the absence of coercive practices remains an important implementation issue, one that can be specified, measured, and reduced.[19] Centering ACT implementation on recovery-oriented elements—

Person-Centered Care and Shared Decision-Making

Person-centered care ensures mental health care is centered on a client's needs, desires, and strengths. Clients set recovery goals and have choices in the services they receive. For mental health providers, person-centered care means assisting clients in achieving personally meaningful goals. For ACT, this means:

- Engaging the whole person
- Identifying and prioritizing a client's hopes and dreams and embedding them in all services
- Determining a client's preferences, values, and culture to provide more responsive care
- Understanding a client's unique strengths, challenges, concerns, and needs and providing guidance at an appropriate level

Shared decision-making (SDM) is of particular importance to ACT.[21] SDM aims to improve communication, understanding, and decision-making. Providers uphold a client's autonomy by actively engaging them in shaping treatment. ACT team members serve as consultants, providing culturally responsive information and support for clients to consider and decide on treatment options that match their individual values. SDM ensures treatment and recovery decisions are appropriate, leading to increased satisfaction and better health outcomes.[22] SDM promotes client engagement in and responsibility for their care.[23]

person-centered care and shared decision-making—is critical to avoid any perceptions of coercion. As a recovery-oriented and evidence-based practice,[20] ACT is well-positioned to meet growing demand for mental health services. The text box above describes two recovery-oriented elements that should be at the core of ACT practice.

1.2 Contemporary Considerations in Building Your Program

SAMHSA's 2008 ACT Toolkit provides the fundamentals for any mental health organization wanting to establish an ACT program. Since then, mental health organizations and ACT programs have responded to emerging priorities related to ensuring culturally competent and equitable practices; increasing the role of peers; using natural supports, wellness management approaches, and recovery plans; and increasing connections to community resources. This section discusses these priorities and their relevance for building an effective ACT team and training staff.

Peer Support Resources

SAMHSA offers a number of general resources on peer support services, including through the Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS).

A directory of Parent Peer Support Training and Certification Programs provides a state-by-state program description and information about other key areas, such as certification status, training, and the state reimbursement model for peer support services.

Cultural Considerations and Equity

SAMHSA's 2008 ACT Toolkit defines **"cultural competence"** as the assumption that services are more effective when they are delivered in relevant and authentic cultural, age-appropriate, and gender-sensitive contexts.[6,24] Cultural competence remains a significant priority for ACT teams today, particularly as it relates to equity in behavioral health. An equitable behavioral health system is one that provides high-quality, affordable care to all individuals and populations and acknowledges and addresses the extreme disparities in health outcomes for people with SMI.[7]

Compared to those without SMI, individuals diagnosed with SMI are more likely to die prematurely from preventable physical diseases,[25] be involved in the criminal legal system,[26] experience poverty,[27] and be American Indian/Alaska Native or of two or more races.[28] Because ACT is an evidence-based treatment for people with SMI, teams need to be acutely aware of the likelihood that their clients experience inequity in their everyday lives, including racism, classism, and ableism. ACT teams can assure provision of equitable care by hiring and retaining staff of similar ethnicity and/or those from similar cultural and ethnic backgrounds as clients, incorporating interpreters or multilingual staff members into treatment as needed,[29] and ensuring staff understand cultural norms around mental health[29,30] and stigma.

ACT's prescriptive nature and intentional recruitment practice—led by a culturally responsive, multi-disciplinary team—may help mitigate some equity concerns related to accessing services, as eligibility is based on objective diagnostic criteria. However, team members should remain cognizant of implicit bias and actively work to eliminate the pervasive, systemic role it can play across recruitment, referral, and intake systems. Formal steps like engaging in careful examination of screening tools for bias, reviewing referral patterns across race and ethnicity, and participating in individual level data reviews examining recruitment and referral decisions can all help promote equity. Additionally, team members should remain aware of the disproportionate impact workforce shortages and funding challenges can have on access for historically underserved groups.

The Role of Peers

The 2008 toolkit explicitly identifies peer specialists as part of the ACT team, performing roles such as leveraging lived experience to benefit the team and clients, providing expertise about symptom management and the recovery process, and promoting a culture that emphasizes client choice and self-determination.[6] Additional advantages of including peers in treatment for individuals with SMI include their role in promoting a recovery orientation among other ACT team members,[20] enhancing outreach,[31] improving access to supports in the community,[31] and increasing client engagement.[32]

SAMHSA's Model Standards for Peer Support Certification

To support universal adoption, recognition, and integration of the peer mental health workforce, SAMHSA collaborated with federal, state, tribal, and local partners to develop the National Model Standards for Peer Support Certification. Inclusive of mental health, substance use, and family/youth peer certifications, these standards have been developed as guidance for states, territories, tribes, and others, to promote quality and encourage alignment and reciprocity.

In recent years, the use of peers has greatly expanded throughout the behavioral health workforce. Formalization of the role at both the state and national levels has also increased. Data from state mental health agencies (SMHAs) indicate that all 50 states and Washington, D.C., are using peers to support the mental health needs of adult clients,[33] and at least 32 states and Washington, D.C., have initiatives to recruit a greater number of peers into the workforce.[34] Peer certification programs also are available, though they are not standardized across states with respect to whether the SMHA follows internal processes for certification or relies on private certification boards, other organizations, or Medicaid. SAMHSA recently released Model Standards for Peer Support Certification to improve standardization and quality of peer specialist services. Given the limited diversity of the peer workforce, intentional efforts should be made to recruit and train more peers from under-represented communities, assuring client access to peer specialists of similar background(s).

Consistent with ACT fidelity tools, most states have requirements in place that specify inclusion of a peer role. However, states are increasingly integrating peers using a more systematic approach. For example, in 2014, Michigan became the first state to require inclusion of a *certified* peer support specialist on all ACT teams.[35] Certification and credentialing processes have provided both clearer definitions and clearer use cases for teams to follow. Reinforced by research on peer involvement efficacy, formalization of the peer role on ACT teams should become easier as qualified candidates and the funds to hire them become more available.

Engaging Natural Supports

Natural supports include family members, friends, community groups, environmental assets, and other informal supports. When engaged appropriately, natural supports serve a critical role in providing connections for ACT clients and can greatly assist with their recovery at multiple stages. The 2008 ACT Toolkit, for example, notes the importance of engaging family members—with the client's consent—during the assessment phase, to obtain information about the client's illness, ascertain family members' understanding of mental illness, and learn about their expectations of ACT services.[6] To support a client's community living skills, the 2008 toolkit highlights the importance of restoring interpersonal relationships, which may involve team members working with friends and family members in an intermediary role. Team members should be able to recommend family support and education resources locally, nationally, and through reputable online resources. Natural supports can even help clients transition from ACT to less-intensive services.

One of the challenges ACT teams face is maximizing natural supports when the client does not already have them. For an ACT team serving individuals experiencing homelessness, for example, this may be especially problematic. While many people experiencing homelessness are local to the communities where they receive ACT services, others may be transplants either via city busing programs that provide one-way tickets out of communities[36] or through other circumstances. Providing behavioral health support to transient populations, particularly those with SMI, requires a multi-faceted approach.

ACT teams have used different strategies to engage natural supports. These include having families come to treatment planning meetings with client consent, conducting crisis planning with family members, addressing isolation, and encouraging celebration of their successes and strengths.[37,38] Teams should be aware of peer resources in their communities and recommend that clients spend time with peers. Leaders should also emphasize the value of building supportive relationships with trusted individuals outside of one's family, including friends, landlords, and employers.[37] In instances when ACT participants are socially isolated, ACT staff help individuals build new social relationships in their community.

Natural supports are critical in supporting clients' transitions to lower levels of care and sustaining their recovery. ACT teams can facilitate client transitions by educating and supporting family members, friends, and others in this process. This includes engaging natural supports in transition planning, explaining the

progress a client made during their participation in ACT and opportunities for continued growth, and discussing the availability of ongoing support from community-based mental health services and other community resources. Family members may also benefit from working with the ACT team to build skills they need to support their loved one during and after transition.[37]

The Use of Wellness Management Approaches and Recovery Plans

"Wellness" grew as a concept in behavioral health during the 1990s.[39,40] Soon after, SAMHSA put forth a broad approach to pursuing wellness through eight dimensions, based on Swarbrick's work: emotional, spiritual, intellectual, physical, environmental, financial, occupational, and social.[40] Mental health is linked with each dimension and each affects overall quality of life (see SAMHSA's Step-by-Step Guide To Wellness). These dimensions overlap with many of the services ACT provides. They are also reflected in various wellness management approaches and recovery plans aimed at helping people manage their mental illness while pursuing recovery goals. These approaches and programs are potentially useful as part of implementing ACT.

One prominent example is a manualized, self-management intervention program called the Wellness Recovery Action Plan (WRAP®). WRAP® principles are deeply intertwined with the concepts of self-determination and shared decision-making. WRAP® is a facilitated, group-based, and peer-led process. It requires peer facilitators to complete their own plans and participate in training before they lead the process for others.[41] Clients achieve their wellness and recovery goals through help identifying and understanding resources they can use to enhance their personal wellness.[42]

Achieving Whole Health: An Adaptation of WRAP for Asian Americans, Native Hawaiians, and Pacific Islander Communities

Achieving Whole Health is a whole health, wellness program developed by the National Asian American Pacific Islander Mental Health Association (NAAPIMHA). Based on SAMHSA's Whole Health Action Management Program, it is a peer and community-led wellness program designed for use with Asian American, Native Hawaiian, and Pacific Islander (AANHPI) communities.

WRAP® is a proprietary product, so some ACT teams may consider using other wellness management approaches and programs, such as Illness Management and Recovery (IMR) or Enhanced IMR (E-IMR) (combines Integrated Dual Disorders Treatment with IMR to treat co-occurring disorders). Teams may also facilitate psychiatric advanced directives and use the My Mental Health Crisis Plan app to help clients create wellness management plans in case of crisis.

Connection to Community Resources

ACT team members often manage clinical issues, such as medication management, as well as practical, social issues related to an individual's community adjustment (e.g., housing, finances, transportation, shopping).[21] ACT's holistic approach and deliberate integration of services highlight the importance of developing equity-focused partnerships with a range of community services and supports that can meet clients' diverse needs. ACT teams may partner with libraries, school liaisons, faith-based organizations, food pantries, federally qualified health centers, trusted stable support resources like barbers and beauty salons, and other community-based organizations to support the success of clients in the community.

Linkages with other community programs are also vital when working toward the goal of transitioning clients to less intensive services. Connections with community resources serve several purposes related to clients' long-term recovery. They build awareness of resources available to support ACT clients and facilitate clients' participation in needed services during and after ACT. They also help reduce stigma against ACT clients present in the community mental health setting.[37] Finally, connections to community resources can enhance continuity of care when clients transition to less-intensive services.

Building connections within the community to facilitate client care remains a key function of the ACT team leader. These activities, which include acquiring knowledge of available resources, identifying key navigation supports, and doing required outreach, take time. However, a multitude of competing challenges, especially at program start-up, means the task of building and engaging community connections often receives lower priority—to the detriment of the client. It is essential for team leaders to have protected time, formally articulated in their job description, to build the relationships and networks necessary to support clients during care and transition.

1.3 Evaluating Your Program

Fidelity is the extent to which an intervention is faithful to the original model and delivered as intended. For ACT, a fidelity assessment rates the program's performance on the model's core components. A fidelity review identifies strengths and weaknesses in program implementation, supports the development of action plans for program improvement, and enables ACT teams to make needed adjustments. This ensures delivery of services that are likely to reproduce the original model's positive results. ACT fidelity reviews are typically designed to facilitate program improvement. In some service areas, the results of a fidelity review may also factor into decisions about program funding.

Fidelity to the core ACT model is associated with positive client outcomes.[3,43] However, implementing ACT with fidelity can be challenging,[5] especially when on-the-ground realities such as limited funding and staffing lead to program adaptations. The degree to which self-designated "ACT" programs adhere to the original design can often vary,[44,45] and **adaptation** may in fact be the norm,[5] underscoring the need to verify program fidelity.[5,46]

Fidelity assessments can inform program improvement and identify opportunities to enhance program quality.[47] Three fidelity tools are commonly used to assess fidelity in the United States. Each tool, discussed below, reflects the core principles of ACT, with slightly different protocols. Differences and selection criteria are also discussed for circumstances where a particular tool is not mandated. While not described below, some states also use their own versions of these fidelity tools, adding state-specific criteria.

DACTS

First developed in 1998,[48] the Dartmouth Assertive Community Treatment Scale (DACTS) measures the adequacy of ACT implementation. The tool authors and the Center for Evidence-Based Practices at Case Western Reserve University edited specific item anchors and scoring instructions in 2016 to resolve confusion that end-users reported. This new content, synthesized from SAMHSA's 2008 Toolkit, was intended to provide greater consistency and clarity.

The revised DACTS contains 28 items, each rated on a 5-point scale ranging from 1 ("not implemented") to 5 ("fully implemented"). Empirical research and expert feedback form the basis for implementation ratings. Items inform one of three categories: human resources (team structure and composition), organizational boundaries, and nature of services. Ratings are based on the program's current state. Future or planned activities and behaviors are not considered.

An item-level protocol provides definitions, guidance regarding required data and data collection methods, follow-up questions (or probes), and decision rules. Assessment using DACTS is typically done in-person by an external review group or internally by an agency or ACT team. Assessment includes chart reviews, team meeting observations, home visits, and a semi-structured interview with the team leader. Clinicians working on the team are also a valued source of data, as are supervisors and clients, as appropriate.

TMACT

The Tool for Measurement of ACT (TMACT), created in 2011, was developed to be a more sensitive assessment of ACT structures and processes.[47] TMACT reviews the team's:

- Flexible and individualized application of resources to address clients' goals, including appropriate timing and intensity of their delivery
- Approach to treatment and service delivery for meeting clients' complex service needs
- Provision of recovery-oriented services as the focus of care

TMACT assesses current ACT team structure, staffing, and practices and compares them with the principles and core components of the ACT model (i.e., program fidelity). This comparison yields both guided recommendations for quality improvement and quantitative indicators for potential research, evaluation, and policy decisions.

TMACT has 47 program-specific items rated on a 5-point scale ranging from 1 ("not implemented") to 5 ("fully implemented"). As with DACTS, a combination of expert opinion and empirical literature determined rating anchors. The average rating across the 47 items becomes the final TMACT score and an index of overall performance. TMACT items fall into six subscales.

TMACT Subscales

1. Operations and Structure (OS)
2. Core Team (CT)
3. Specialist Team (ST)
4. Core Practices (CP)
5. Evidence-Based Practices (EP)
6. Person-Centered Planning and Practices (PP)

A TMACT fidelity review is typically conducted by two trained evaluators, who are ideally independent from the reviewed program. Evaluators should have experience and training in interviewing and data collection procedures (including chart reviews), a strong understanding of ACT, and familiarity with how to use TMACT. After evaluators gather initial information from the team prior to the onsite review, trained evaluators spend two days with the team to obtain needed data. Data sources include team surveys, team member interviews, service recipient interviews, chart reviews, team meeting observations, treatment plans, and team tools. Following a TMACT review, a final report is encouraged to document findings and recommendations. TMACT developers have also released a product called electronic TMACT (eTMACT), an online platform that supports TMACT data collection, management, analysis, and reporting.

SAMHSA Fidelity Tool

SAMHSA's 2008 ACT Toolkit discusses the importance of process and outcome measures and building a quality assurance system that can support a program from start-up through the life of the program. The toolkit includes two process measures—a readiness assessment and fidelity tool—to help ACT programs understand whether they are providing services faithful to the evidence-based practice model or with high fidelity. The SAMHSA Fidelity Tool is included in SAMHSA's 2008 ACT Toolkit under "Getting Started with EBPs."

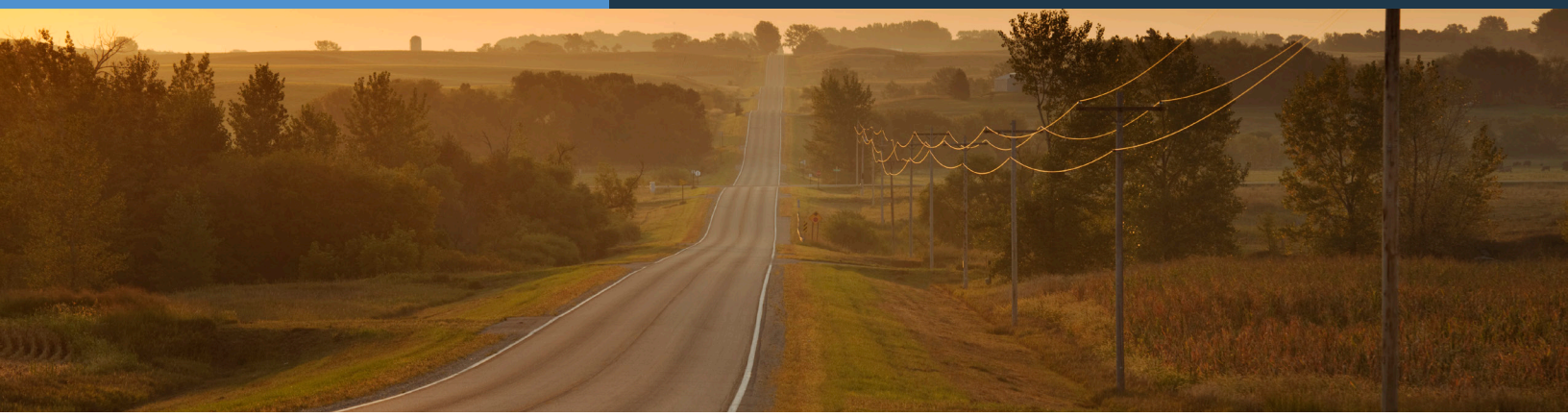
The readiness assessment helps programs track the processes and administrative tasks required to develop an ACT program, generating an ongoing "to-do" list (or implementation plan) to guide ACT implementation. It also documents the components of ACT services that are in place, and those that are not yet implemented. The readiness assessment is a particularly relevant tool for programs that are in start-up mode and want to build a new program with fidelity in mind.

The fidelity tool gives new programs an opportunity to conduct their first process assessment before providing any ACT services and to determine if ACT's core components are in place. Programs will likely be subject to formal fidelity systems and procedures once in operation. However, using the SAMHSA fidelity tool, which closely mirrors DACTS, can provide an informal (i.e., non-punitive) opportunity to ensure the team is on track for strong implementation prior to more formal fidelity assessments. Like the DACTS tool, the SAMHSA fidelity tool contains 28 ACT team-specific items, each rated on a 5-point scale ranging from 1 ("not implemented") to 5 ("fully implemented"). The scale items fall into three categories: human resources (structure and composition), organizational boundaries, and nature of services.

1.4 Summary

This chapter reviewed ACT fundamentals. It reiterated key concepts, such as taking a person-centered recovery orientation that is based on shared decision-making between team members and clients. It also noted changes since the 2008 ACT toolkit, such as advances in certification for peers and the increased use of wellness management approaches and recovery plans within ACT teams. The chapter provided teams with a foundation for implementing the model with fidelity and helping clients with severe and persistent mental illness achieve long-term recovery. However, teams encounter many practical issues and real-world challenges when implementing ACT that can threaten fidelity. Many teams have had to tailor the model to circumstances within their communities (e.g., workforce shortages) and to public health realities (e.g., COVID-19 public health emergency). Chapter 2 of this guide discusses the contemporary issues teams face when implementing ACT and strategies they have used successfully to maintain high fidelity.

Given significant demand for ACT services, ACT adaptations have emerged to address the needs of specific populations, including individuals with criminal justice involvement, people in rural areas, youth, older adults, and immigrants. Chapter 3 describes examples of ACT implementation among these populations, with the goal of promoting awareness and learning of on-the-ground experiences. These examples also offer potential areas for future research.



Chapter 2.

Contemporary Issues in ACT Implementation

While the fundamental components of Assertive Community Treatment (ACT) implementation remain consistent with SAMHSA's 2008 ACT Toolkit,[5] important and emerging challenges have developed over the past 15 years. This chapter introduces the reader to these issues with the goal of increased awareness and understanding of how each issue may impact an ACT team.

CHAPTER OVERVIEW

This chapter discusses contemporary issues and challenges that have emerged in the 15 years since the release of the 2008 ACT Evidence-Based Practices KIT.

The purpose of the chapter is to increase awareness and understanding of potential impacts on ACT teams.

Current Issues:

- COVID-19 PHE
- Substance Use
- Supported Employment
- Medical Health Needs
- Housing Crisis
- 988 & Crisis Services

Sustainability Considerations:

- Step Down
- Workforce Shortages
- Funding

2.1. Current Issues

Responding to Challenges During the COVID-19 Public Health Emergency

The COVID-19 public health emergency (PHE) presented unique challenges for ACT programs in the United States and their delivery of services. These challenges highlighted barriers ACT programs faced even before the pandemic. However, despite pandemic-related difficulties, ACT teams displayed great resilience and maintained essential services.[49,50] Many prioritized the needs of their clients while shifting service delivery to protect the health and safety of themselves and clients.[49-52] Lessons learned from having to make alterations to the model during the PHE may be useful for ongoing ACT implementation as well as future disruptive events that could occur.

Despite positive reports regarding their overall ability to make needed adjustments, some ACT staff and clients experienced challenges as a result of the PHE and the necessary changes in implementation.[53,54] For example, staff found that telehealth was not appropriate for all clients for several reasons: some did not have access to phones and others were reluctant to meet by phone, had difficulty using the technology, or were not always able to read and understand the telehealth privacy policy.[50,52,55]

For some teams, staff shortages worsened as staff fell ill or quarantined.[51] In addition, staff were at increased risk of stress and **burnout**, which can manifest as exhaustion, depersonalization (e.g., being detached from oneself and emotionally distant from one's clients and work), and feelings of inefficacy (e.g., having a reduced sense of professional accomplishment).[50,56] Staff experienced challenges with work-life balance, emotional distress, and organizational communication, highlighting the importance of supportive communication across team and organizational levels. Coordinating with other services, like obtaining government documents and community resources, also posed new challenges and required more staff time.[50,51] Housing was less available for some clients,[53] which made quarantining more difficult. For example, one team had to coordinate with multiple partners (e.g., community health centers and emergency rooms) to quarantine ACT clients who were COVID-positive.[52]

To address these and other challenges, ACT teams made a variety of adaptations during the PHE to ensure continuity of care and fidelity to the ACT model:

- **Minimized in-person client contact**. Teams quickly switched from home visits to meeting with clients by phone and video.[49-51,53] In-person visits were limited to clients needing injections, urgent psychiatric evaluations, or help stabilizing after hospitalization.[50]
- **Took protective measures**. Staff wore masks, maintained distance from clients during in-person meetings, and saw clients outside when the weather permitted.[50,53]
- **Conducted staff meetings remotely**. Some teams initially suspended daily clinical meetings until mechanisms were established to meet remotely.[51] Teams then held staff meetings using virtual meeting platforms or found larger meeting rooms where social distancing among staff was possible.
- **Adjusted work schedules**. Team schedules often rotated week to week between working from home and in-person.[50,51]
- **Limited transportation assistance**. Some teams reduced client transportation to protect clients and staff.[50,57] Others prioritized transporting only clients who were uncomfortable with public transportation due to higher risk for infection.[53]
- **Altered medications**. When clinically appropriate, teams switched clients to long-acting injection medications or gave clients pills to last for a week to minimize personal contact.[50,51] This occurred more during the early months of the PHE, when accessing personal protective equipment was difficult.[50]

The PHE and related adaptations sparked some positive changes for ACT programs, most notably in telehealth. Expanded telehealth capacities may benefit ACT over the long term by giving teams another set of tools to use with some clients. For example, one team noted that meeting with clients via telehealth enabled them to maintain their pre-pandemic average number of client contacts.[49] Another team reported that they were able to increase their number of contacts with some clients compared to pre-pandemic levels.[53] Most programs gained new telehealth capabilities and formed closer connections to community partners.[52]

However, the quality of services provided via telehealth compared to in-person has not been

well studied to determine if virtual contacts and telehealth are effective treatment modalities for individuals with serious mental illness (SMI).[58] Many ACT clients may lack the resources to use telehealth. Following the PHE, ACT teams will likely continue to provide services primarily in-person and mostly in the community to meet the complex needs of the people they serve, including teaching daily living skills to clients where they live, work, and engage with fellow community members.

Other positive changes include increased care for clients' health hygiene and staff well-being. ACT teams used the pandemic to educate clients about COVID-19, personal protective equipment, and overall health hygiene, knowing that individuals with SMI may not understand or have access to new and evolving guidance around the PHE and may be vulnerable to misinformation.[50,51] ACT teams were sensitive to the potential for staff burnout, and took special care to support staff resiliency, mental health, and morale through team building activities before meetings, open discussion about needed improvements, empathetic and supportive communication, and staff recognition.[50-52] These activities may have long-term payoff for staff morale.[56]

Overall, teams found ways to maintain continuity of care for clients despite ongoing challenges and have tried to deliver ACT services in a way that ensures adherence to the model's fundamental principles and high fidelity. SAMHSA's Mental Health Technology Transfer Center Network provides virtual consultation meetings for teams on COVID-19 and other topics. Recordings of past meetings are available on their website.

ACT and Co-Occurring Substance Use

Historically, about a quarter of people with SMI have a co-occurring substance use disorder (SUD).[61] The high association between individuals with SMI and SUDs has necessitated the integration of mental health and substance use treatment services for ACT clients. All ACT teams must have the capacity to address substance use, inclusive of consistent and emerging challenges.

The Challenge of Substance Use

While the trends in substance use vary regionally and over time, alcohol is the most commonly used substance throughout the United States,[59] and opioid misuse has been a persistent challenge nationally since the 1990s.[60]

ACT team members involved in integrating care for substance use and mental health include a psychiatrist and/or psychiatric nurse practitioner, peer specialists who have lived experience with mental illness and possibly co-occurring disorders, and other clinicians, perhaps including someone with expertise in treating individuals with a co-occurring disorder.[6,62] When possible, SUD services are best delivered through the integrated dual disorder treatment model, in which both mental health disorders and SUDs are treated concurrently.[63,64] Implementation of the integrated dual disorder treatment model should include harm reduction services and the use of evidence-based substance use treatment approaches.

Pharmacotherapy is a core part of treatment for co-occurring disorders. Teams must be able to provide or connect individuals to evidence-based, pharmacological treatment services, which include prescribing appropriate medications (e.g., anti-craving medication like naltrexone, and medication for opioid use disorders like buprenorphine) to treat their SUD. For some medications (e.g., methadone), ACT teams will refer clients to other treatment centers or clinics licensed to provide methadone. The ACT team may then provide medication management.

ACT teams should be acquainted with harm reduction practices and services and incorporate them in ACT programs as part of the dual disorder treatment model. Harm reduction practices reduce the negative consequences of illicit drug use and thus save lives.[65] Client education is a vital component of prevention and harm reduction services and may include education on the use of naloxone, prevention of human immunodeficiency virus (HIV) and viral hepatitis, and safer methods of drug administration. Teams must also become aware of the illicit substances available to clients in the community and educate them about their dangers, as well as the side effects of using substances in combination with prescribed medications. ACT clients who consume heroin, cocaine, or methamphetamine, for example, may unknowingly consume fentanyl[66] or xylazine,[67] as these are often combined with the other drugs. Teams can help prevent overdoses from potentially lethal drug combinations by participating in additional naloxone training and connecting clients to necessary services.

Access to and distribution of naloxone to ACT teams, emergency responders, and the family members and friends of individuals who use drugs are critical. ACT clients experiencing homelessness, for example, experience better health outcomes when they participate in harm reduction programs, including fewer drug-related risks, hospital visits and admissions, and overdoses.[68] ACT teams should encourage clients who use opioids to engage in harm reduction practices, such as using opioids in the presence of others and having naloxone on hand in the case of an overdose. ACT teams should also be aware of the need to administer naloxone more frequently or in greater amounts when clients use more potent opioids. They should receive training to administer naloxone appropriately in all situations.[69] In some cases, naloxone distribution programs can serve as an initial entry point for substance use treatment. Other harm reduction practices like fentanyl test strip distribution and syringe services (laws vary by state) may also be valuable for people who use drugs.

ACT and Supported Employment

For individuals with SMI, employment and the pursuit of a productive life plays a meaningful role in supporting recovery. However, many ACT clients experience discrimination in the workplace as well as internalized stigma that reduces their confidence in being able to work or makes working difficult.[70,71] Employment support therefore remains a core ACT service.

Seven Principles of the Supported Employment (SE) Model

- Eligibility is based on consumer choice
- SE services are integrated with comprehensive mental health treatment
- Competitive employment is the goal
- Benefits counseling is personalized
- Job search starts soon after consumers express interest in working
- Follow-along supports are continuous and time-unlimited
- Consumer preferences are important

An employment specialist on an ACT team focuses their efforts on supporting a client's productivity, helping clients engage in meaningful activities like community projects, school, or paid employment. Serving as a primary advocate for the client, they identify needs; support readiness; and strategize ways to help clients manage problems they experience while volunteering, in school, or in the workplace.

As noted in SAMHSA's 2008 ACT Toolkit, ACT employment services are based on Supported Employment (SE).[72] SE is an evidence-based practice that helps clients with disabilities quickly secure a competitive job in the community. SE is more effective than traditional vocational services at helping people with SMI obtain competitive work, achieve employment quickly, work more hours and weeks per year, and earn higher wages.[73,74]

In 2010, SAMHSA released a comprehensive Supported Employment Toolkit. SE and ACT pair well and share common principles and practices (see box), including assertive outreach, integration with multidisciplinary care teams, and time-unlimited services. Both are also person-centered. Selected sections of SAMHSA's SE Toolkit, and research since then, can guide teams in making SE a part of ACT's integrated package of available programs and services.

Contemporary issues, such as workforce shortages, funding, and the recent COVID-19 pandemic (all discussed elsewhere in this guide), have impacted how some ACT teams approach employment services. Depending on their state and available funding, employment specialists often collaborate with other programs. For example, vocational rehabilitation and Ticket to Work service providers coordinate to expand their clients' access to employment supports and help them maintain entitlement to benefits such as Medicaid and Social Security.

ACT employment specialists should coordinate SE implementation with the full ACT team, linking employment goals to other goals in a client's treatment plan.[75] Once employed, follow-up is a critical component of SE to ensure clients retain employment and are successful in their positions. An employment specialist on an ACT team can help negotiate work-related problems (e.g., low productivity or inappropriate work behaviors) and provide access to training for career advancement, among other job coaching activities.

Within the widely adopted Individualized Placement and Support (IPS) model of SE, the practice of disclosure (i.e., the process of sharing one's mental health condition with employees and coworkers) is one of the components most strongly associated with employment.[76] The ACT employment specialist can help support clients with this process if clients choose to disclose. After a client has worked in a position for a certain length of time (e.g., a year or more), the client may transition out of the SE program while continuing to receive services from the rest of the ACT team.[77] Conversely, the client might transition out of the ACT program while still receiving SE services. The integration of employment and mental health services improves a client's employment outcomes.[74]

Medical Health Needs of ACT Clients

Adults with SMI have an increased risk for chronic medical conditions, such as diabetes, obesity, and cardiovascular disease.[78-80] These diseases contribute to adverse health events and higher mortality among people with SMI compared to the general population.[57,80] ACT teams should therefore coordinate their clients' care for both mental and physical health conditions.

ACT teams can ensure they are meeting clients' physical health needs by starting with an assessment. Assessment results will inform a client's treatment plan and may expand the plan to include primary care, medication management, physical activity programs, health promotion, illness management and recovery

curricula, and/or other meaningful activities (e.g., activities related to personal interests), which studies have shown to have both physical and psychological benefits.[81-83]

The multidisciplinary nature of ACT teams enables them to provide many of the services in a client's treatment plan; however, a client's physical health needs may require referral to providers outside the ACT team. Teams should expect to provide referrals to primary care clinics and then facilitate integrated care and management of their client's mental health and physical health conditions.[57] This may involve:[57]

- Ensuring clients obtain all prescribed medications
- Encouraging and instructing clients in taking their medications and achieving self-sufficiency in managing their health conditions
- Monitoring and educating clients about potential side effects and contra-indications (e.g., interactions between anti-anxiety and blood pressure medications)
- Providing transportation to follow-up medical appointments

For ACT clients at risk for or living with sexually transmitted and blood-borne viral infections, such as HIV and Hepatitis C, an ACT team's coordination of clients' physical and mental health needs is especially critical. Many people with SMI engage in behaviors (e.g., sex trading, intravenous drug use) or live in conditions (e.g., shared living arrangements and shared use of personal equipment) that increase their risk for HIV and Hepatitis C.[84] It is important that these ACT clients receive preventative care or treatment, such as pre-exposure prophylactic (PrEP) and post-exposure prophylactic (PEP) medications or antiretroviral or antiviral therapy.

ACT teams can connect clients to clinics that provide specialized care for these conditions if they do not have internal capacity. Teams can also educate and monitor their clients' use of medications for their HIV or Hepatitis C and discuss with them how their condition may impact the efficacy of any psychotropic medications they are taking.[85] Teams can also inform clients of the logistics and timing of taking medication, such as how many Hepatitis C medications should be taken all at once, rather than being broken up into many separate administrations.

ACT and the Housing Crisis

The primary goal of ACT is to help clients become independent and integrated into their community. This includes supporting clients to obtain a home and remain stably housed, an outcome many ACT programs have successfully achieved.[86] However, an affordable housing supply crisis in the United States creates significant challenges for ACT teams. Finding safe, appropriate, supportive, and affordable housing placements for clients can be a serious challenge. In 2019, the United States had a shortage of over 7 million affordable and available rental homes for extremely low-income renters; no state in the country had an adequate supply of affordable housing.[87] The COVID-19 pandemic has only exacerbated housing insecurity.[88]

Serving clients who are experiencing homelessness can be challenging for both people experiencing homelessness and service providers. Wait times for rental assistance can range from a few months to several years,[89] during which time people waiting for housing may experience adverse health impacts.[90] During homelessness, clients often build strong relationships with other people experiencing homelessness and may find it difficult to leave their encampments or other communities and move into more stable housing.[91] Policies like encampment clearance, which forcefully removes people from their places of unsheltered homelessness, without proper connection to supportive services may produce negative health outcomes.[92] Assertive outreach and a person-centered approach can be an effective way to connect clients with appropriate services as they move into stable housing.[93]

To address challenges related to identifying, securing, and maintaining housing for ACT clients, some ACT programs in recent years have put increased emphasis on housing services, and some teams have elected to include a housing specialist.[94,95] This is a new development since publication of SAMHSA's 2008 ACT Toolkit, which does not mention this position. The responsibilities of a housing specialist are to gather information about subsidy programs, low-income housing programs, tenancy laws, landlord information, and housing options.[96] A housing specialist may also assess and promote clients' housing readiness, coordinate with shelters and other housing providers to address clients' housing needs, work with clients to develop their skills in obtaining and maintaining independent living, and advocate for clients to receive an appropriate level of housing and supports in their living environments.[97]

The Importance of Housing for ACT

In response to housing challenges, some ACT programs now include a housing specialist, a position not formally referenced in SAMHSA's 2008 ACT Toolkit.

Like other ACT team members, housing specialists are available 24/7 to respond to psychiatric crises, including those that are housing related. A housing specialist may be a full-time position, or another team member (e.g., a case manager) may assume this role part-time in addition to their other responsibilities. Of note, a housing specialist is not a required staff position for implementing an ACT program with high fidelity, although provision of housing services is an expectation of all programs.[98] Another challenge for service providers is that clients, who are usually low income, may not have resources to pay for housing, and ACT programs may be unable to pay for their clients' housing long-term. Although SAMHSA grant funding cannot be used for supplemental housing payments, the Centers for Medicare and Medicaid Services has approved Section 1115 waivers in some states (e.g., Arizona, Arkansas, Massachusetts, Oregon) allowing them to support some non-clinical services, including housing, for specific high-need populations.[99,100]

Teams may consider a Housing First approach, an effective housing strategy that prioritizes connecting clients with permanent housing without requiring them to first address other problems, such as substance use, or engage in other services.[101] In addition, ACT teams may coordinate with a local continuum of care or federal programs like the Projects for Assistance in Transition from Homelessness (PATH) program to provide clients with other opportunities for supported housing. The Homeless and Housing Resource Center (HHRC), a SAMHSA advisory on behavioral health services for people who are homeless, and an evidence-based resource guide on expanding access to and use of behavioral health services for people experiencing homelessness provide more resources for serving people with SMI who are experiencing or at risk of homelessness.

ACT, 988, and Crisis Services

Individuals served by ACT programs may sometimes experience psychiatric crises and need **crisis care**. They may have thoughts of suicide or may have confrontations with law enforcement, resulting in violent altercations with a risk of deadly results. ACT is a strategy for preventing and alleviating crisis situations.[102] Individuals who have frequent contacts with law enforcement due to behavioral health issues may benefit from the ACT model.

An ACT team is intended as the first line of support for clients and their families in crisis and is available 24/7. Their accessibility and support can potentially avoid the need for clients to contact the **988** Suicide and Crisis Lifeline. 988 is now the universal number in the United States for suicide prevention and assistance during a mental health crisis.[103,104] Individuals in distress can call, text, or chat 988 and be connected to their local crisis center. There, a trained crisis counselor provides support and resources.[104] Specialized call, text, and chat supports are available for veterans, Spanish speakers, and LGBTQI+ youth and young adults. In addition, as a result of the Consolidated Appropriations Act of 2021, states must set aside at least 5 percent of their Community Mental Health Services Block Grant (MHBG) to support evidence-based crisis systems.[105] These systems include crisis call centers, mobile crisis response teams, and crisis receiving and stabilization facilities. Once fully implemented, these services are likely to be an important resource for ACT clients.

A crisis hotline does *not* replace ACT crisis programming but can be a supportive and even transformational service prior to a crisis and after crisis stabilization. ACT teams help clients avoid potential crises by being available 24/7, and when crises do occur, work with clients to resolve them. Members of ACT teams have established relationships with their clients and experience with clients' unique needs. Their goal is to provide targeted and individualized crisis response and support, avoiding or minimizing the need for national crisis line (e.g., 988) services. All ACT teams should have an established crisis protocol, including guidelines that explain to clients which team member they should call first in an emergency and how to reach them. An ACT team's implementation of their crisis response protocol lessens the burden for national crisis hotlines, which are often inundated with calls.

Although not a replacement, 988 still has a role in ACT. 988 crisis counselors might connect an individual who has placed multiple calls in distress to behavioral health services, which could then refer individuals to an ACT program if they meet admissions criteria. Additionally, existing ACT clients can be made aware of 988, as needed, especially for support upon discharge from ACT or for when they transition to less intensive services.

2.2 Sustainability Considerations

Step Down From ACT

One of the key principles of ACT since its inception is *time-unlimited services*. It is a criterion measured in DACTS, ACT's earliest fidelity instrument. SAMHSA's 2008 ACT Toolkit defines time-unlimited services as delivery of program services for as long as needed, with fewer than 5 percent of clients expected to graduate annually.[6] However, since 2008, some have raised concerns about clients' indefinite participation.[9,106,107] Concerns focus on whether this practice is contrary to the program's recovery goal, whether it limits access to the program for other community members seeking services, and the program's cost and cost-effectiveness.[53,108-110]

Although research findings are mixed, studies have shown that clinical gains for clients, including considerable rates of recovery, are possible after transition to less intensive care.[37,106,109] With greater frequency, ACT teams are focusing on transitioning clients to less intensive service levels, actively embedding a recovery orientation into the ACT program. The newer TMACT fidelity instrument also now includes *Transition to Less Intensive Services* as a measure of ACT program performance and fidelity, rather than the DACTS criterion, *Time-Unlimited Services.*

Transition looks different for each client, and the type and location of services following transition will differ depending on client need and community setting (e.g., urban, rural). A variety of services may be available: a formal step-down program, outpatient hospital services, intensive case management, services provided by a family physician and/or a community psychiatrist, long-term care, and supportive housing.[107] ACT services and transition services may overlap for a period ranging from a few months to more than a year to ensure that clients are successfully connected with other services.[107] ACT teams should ensure program fidelity during this transition period and be aware of any financing limitations that could restrict reimbursement for multiple services. ACT teams may also re-admit discharged clients within the first year following transition if more intensive services are again needed.[107]

Transition can be a vulnerable time for clients.[37] ACT team members have expressed multiple concerns, including client resistance and fears about transition, service access issues (availability, transportation, and payment), a potential loss or deterioration of clinical gains, and challenges related to maintaining natural supports.[37,107,109] Clients also have worries such as not knowing why they are being transitioned, feelings of abandonment, and loss of relationships and concerns over having to build relationships with new case managers and other providers.[37,107,109]

Lack of services and instability in some communities may also present challenges. Some communities, especially rural ones and those in underserved, ethnic and racial minority communities, may not have formal step-down programs, and providers and programs that

offer lower levels of care may be limited or at capacity.[107] Programs in both urban and rural communities may refuse to accept clients transitioning from ACT because they are unable to serve individuals with complex behavioral health needs. Programs may also abruptly discharge some patients or deny them access to preferred transition services due to insurance or funding issues. Particularly in states that have not implemented Medicaid expansion, clients may lack safety nets, making the prospect of a successful transition more precarious. Some teams mitigate community barriers by continuing to provide some services, such as administering injection drugs, while transitioning clients.[107]

The challenges for ACT teams may seem daunting, but resources to support teams are available. Tools to assess a client's readiness for transition have been developed and tested.[106,111,112] The Transition Readiness Scale, developed by New York's Office of Mental Health, assesses clients on seven domains: treatment engagement, housing stability, medication compliance, psychiatric hospitalization, use of emergency services, high-risk behaviors, incidence of harmful behaviors, and criminal justice involvement.[112] SAMHSA's Mental Health Technology Transfer Center Network provides technical assistance on ACT program implementation. In addition, training and technical assistance resources are available through other organizations (e.g., New York State's ACT Institute for Recovery-Based Practice, SPIRIT Lab Assertive Community Treatment Training, the University of North Carolina's Institute for Best Practices, and Case Western Reserve University's Center for Evidence-Based Practices).

Teams can also glean guidance on how to manage the process of transition from the transition subscale of the TMACT fidelity tool[98] and other teams' and clients' successful experiences,[37,107,109] including:

- Team members should avoid one-size-fits-all approaches; all aspects of the discharge/graduation process, including the timeframe, will vary by client.[98]
- Teams should educate clients about the transition to less intensive services and explain that it demonstrates the success of their recovery process; teams should make clear that the transition process involves shared decision-making and is person-centered.[107]
- Decisions about readiness for transition should be based on team members' understanding of the client's needs, recovery progress, and aspirations (facilitated by recurring assessment and explicit criteria, when possible).[98]
- Teams should engage in careful discharge planning processes, allowing plenty of lead time for making connections to services.[98]
- Teams should plan for an overlap in ACT-provided and transition services,[107] and after transition occurs, follow up with clients, as needed; follow-up may include monitoring client challenges, managing referrals, and monitoring clients' progress.[98]
- Transition planning should involve celebration and encouragement, and team members should use graduation terminology.[37,107]
- The ACT team and particularly peers should provide inspiration and instill confidence in clients who are ready for transition; they can all help manage clients' fears and anxiety related to leaving the ACT program.[37]
- Teams should always maintain a recovery orientation when providing ACT services. The goal of the program is to support clients to become self-sufficient and lead healthy and productive lives. Transition, or graduation, from ACT to less-intensive services is part of the process for reaching this goal.[47]

Managing Workforce Shortages

Workforce shortages in behavioral health are extremely high. The COVID-19 pandemic and the continuing overdose crisis have further increased the demand for behavioral health professionals and mental health and substance use services. Using data from SAMHSA's National Survey on Drug Use and Health on unmet needs for mental health or substance use treatment services, the Health Resources and Services Administration (HRSA) projects a shortage of adult psychiatrists that, by 2035, will meet only 57 percent of the demand in the United States.[113] This number could drop to 50 percent if behavioral healthcare access barriers are removed and populations historically facing these barriers seek services.[113] Behavioral health providers from minority racial and ethnic backgrounds that match ACT clients can be even more difficult to find.[114,115]

These projections, based on 2020 data, may not fully account for the increased demand for behavioral health services or workforce departures due to the pandemic.[113] Workforce shortages for adult psychiatrists may be even higher than HRSA's estimates predict. These workforce shortages pose challenges for ACT. A single ACT team can require a dozen professionals or more when fully staffed, and it is important for new teams to be aware of both the challenges associated with managing workforce shortages and the potential strategies to address them. Certain positions within the team are especially hard to fill. In particular, psychiatrists and other prescribers such as psychiatric nurse practitioners are key members of the team, but as indicated by the data cited above, are often the most difficult to secure.

Rural counties are more likely to have shortages than urban counties, and many counties in the central, northern, and southern parts of the United States have no psychiatrists at all.[116] Recruiting psychiatrists is made even more challenging due to higher paid positions being available in other settings and organizations.

Turnover among ACT team members can also be problematic. Multiple factors contribute to turnover within health professions, including lack of growth opportunities, workload and excessive job demands, perceived low organizational support, and insufficient compensation. Since 2020, fear of COVID-19 exposure and psychological stress due to the COVID-19 pandemic have also influenced turnover among healthcare

workers.[117-119] However, even before the pandemic, turnover on ACT teams averaged 14 percent in a six-month period, with some teams having a much higher turnover.[120] Turnover is often difficult for clients who have formed close interpersonal relationships with team members, and it can result in discontinuity of services and diminished support for clients.[53,120]

Reflecting on existing ACT programs' efforts to mitigate staff hiring and turnover challenges, newly formed and struggling teams may benefit from implementing selected strategies. These include creating part-time positions for roles that are harder to fill, including working with community colleges and other community-based organizations to identify and hire students who are in need of clinical hours to meet their licensure requirements. Organizations may also consider recruiting professionals who have qualifications to fill more than one role (for example, a clinician serving as both a case manager and a substance use specialist), and when necessary, collaborating with external organizations to provide some services.

Organizational strategies can also help to prevent turnover and support team members. Clinical supervision is particularly important for staff development and support. Supervision has shown to have significant effects on staff and end-user outcomes, including retention.[121] These include holding staff retreats to discuss program goals and team challenges, adding team building activities to team meetings, providing opportunities to reflect on "positive moments," and creating a "safe space" for staff to talk about stressful issues.[50,51,122]

Another consideration is for organizations to coordinate with programs focused on addressing racial and ethnic minorities in the behavioral workforce. For example, SAMHSA's Minority Fellowship Program offers specialized training for behavioral health professionals in multiple disciplines. Graduates of this program may be possible recruits for ACT teams in the future.

Funding and Considerations for Fidelity

Funding for ACT comes from a variety of sources, primarily state general revenues and Medicaid reimbursement. Some states may also leverage grants (e.g., SAMHSA's Mental Health Block Grant, ACT grant program, and CCBHC Expansion grants) or use local funds.[123] Financing approaches vary with respect to the types and amounts of allocated resources, as well as reimbursement strategies. Program eligibility, the types and availability of offered services, and the composition of treatment teams influence financing arrangements for ACT programs.

There are multiple ways funding mechanisms can complicate ACT program fidelity. These challenges, described below, are important for agencies to understand when establishing teams and identifying funding sources.

Funding Models and Related Challenges		
Funding Model	**Challenge(s)**	**Potential Threat to ACT Fidelity**
Medicaid Fee for Service	States that finance ACT under Medicaid typically do so under the rehabilitative services and/or targeted case management categories.	Reimbursement for ACT services is constrained within the parameters of what is allowable under each state's plan. It is not mandatory for Medicaid to cover ACT services.[124]
	Some states continue to provide services within a fee-for-service payment model. They establish a payment rate for provided services using a standard methodology that accounts for the time, skill, training, and intensity required for a specific service; expenses associated with providing the service; and associated professional liability costs.	Some components are not covered, including the time it takes to engage a client and provide outreach, as well as transportation costs. This means organizations are not compensated for components critical to ACT success and must find other financing sources, operate at a loss, or risk compromising fidelity of the ACT model.
	Though some states establish a rate based on the team model, others require each team member to bill services separately.	This billing model can interfere with implementing the ACT model (e.g., limiting a team approach to delivering services, having daily meetings, or conducting intensive client outreach), as multiple organizations are not allowed to bill for the same period or encounter. It may also increase administrative burden across the team, requiring team members to engage in administrative activities often not viewed as "productive."
Medicaid Managed Care	Flexibility allowed within this model supports ACT programs. Managed care companies can develop bundled case rates that allow for teaming. In addition, bundled case rates can be negotiated with organizations to include some of the costs or services not allowed within a fee-for-service model.	Bundled rates may disincentivize serving people that are most in need. This is mainly due to more resources being required to serve those most in need, resulting in organizations having a smaller financial margin.
State General Revenue	Many states pair their Medicaid dollars with state general revenue to provide full coverage for ACT services because Medicaid does not cover everyone or everything. State dollars are used to fund services for those who are uninsured, for important infrastructure development (i.e., initial and ongoing training, start-up dollars for new teams, and fidelity monitoring), or for components that are not covered by the Medicaid State Plan. However, the pressures on general revenue funds are significant and have been particularly strained since the COVID-19 pandemic. In addition, most states have balanced budget requirements,[125] which limit states' spending flexibility. Local funds may also be somewhat unpredictable.	The funding amount is not adjusted for actual cost amounts but is carried over from the first round of funding. Uncertainties about funding can put pressures on any program to reduce services, but with regard to ACT, doing so can have a negative impact on fidelity.

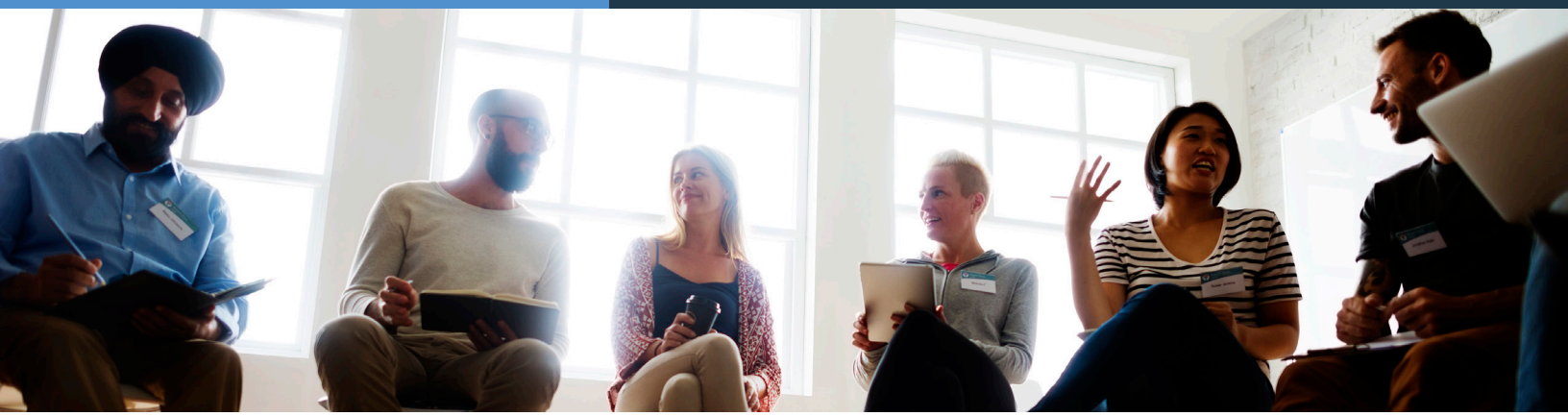
Funding Models and Related Challenges		
Funding Model	**Challenge(s)**	**Potential Threat to ACT Fidelity**
Grants & Local Funds	Some states provide ACT services through grants or local funds. State mental health block grants and other federal grant funds (e.g., SAMHSA's ACT grant program, CCBHC Expansion grants) may support services and program activities not reimbursed by Medicaid and provide services for the uninsured. They may also support establishment or expansion of an ACT program and infrastructure development (e.g., staff training, fidelity monitoring).	Use of these funding streams is risky as they are subject to federal and state budget changes and grant amounts are often not adjusted for rising costs. Almost from the time of grant award, programs should plan for continuation funding to sustain the program and maintain continuity of care and program fidelity once the grant period is over. Maintaining fidelity remains a requirement even as grant funding ends or diminishes.

Note: More information regarding Medicaid and behavioral health services like ACT can be found in Medicaid Handbook: Interface with Behavioral Health Services (samhsa.gov).

States and agencies often spend considerable time obtaining the necessary funding to support ACT teams, often braiding funding from multiple sources to cover delivery of the full array of services to all clients and implement the program in the way it was intended. State mental health agencies have an important role in ensuring sufficient funding for ACT within their states.[123,126] They can assist programs to identify funding gaps and to locate and secure funding from other sources. They can collaborate with their state Medicaid authority to ensure consideration of ACT when developing their state's Medicaid plan and billing mechanisms.[123,127] They also can develop and provide funding support for state technical assistance programs that can assist programs in delivering ACT with high fidelity.[126]

2.3 Summary

Understanding the contemporary issues in ACT program implementation is a first step in enhancing operational efficiencies, overcoming implementation barriers, maintaining fidelity, ensuring program sustainability, and improving client outcomes. Some of the challenges discussed in this chapter are experienced by many evidence-based behavioral health programs (e.g., workforce issues, financing). However, some are unique to ACT due to the intensive nature of the ACT intervention, the involvement of a multidisciplinary team, the broad array of services provided, and the complex needs of the participant population. The implementation strategies discussed in this chapter require concerted efforts from the entire ACT team and from mental health agencies and others in leadership positions. Appropriate responses to these contemporary issues, as with the ACT program itself, will require a team approach.



Chapter 3.

Extending the ACT Model: What the Research Tells Us

As Assertive Community Treatment (ACT) has expanded across the United States and globally over the past 40 years, teams in the field have modified the model to extend its application to specific target populations and settings. In Europe, for example, researchers have developed and tested a model called Flexible ACT. Adaptations also have been developed to serve individuals with criminal justice involvement (called "Forensic ACT"), individuals in rural areas, youth, older adults, and immigrant populations, as well as others. Adaptations involve tailoring care, programs, and services to the cultural, social, gender, and demographic contexts of the people served to yield positive outcomes. SAMHSA's Evidence-Based Resource Guide, Adapting Evidence-Based Practices for Under-Resourced Populations, provides research supporting adaptations of evidence-based practices (EBPs) for under-resourced populations.

However, these adaptations are not fully developed models, and the degree to which there are peer-reviewed studies to describe them varies. While there are more than two dozen studies that have examined Forensic ACT, for example, there are far fewer that have focused on older adults and immigrant populations. Across studies, sample sizes also vary as does rigor of the study design. Many of the studies available for review rely on naturalistic observations of a single program without a representative sample or any controls.

The variability in quantity and quality of research is a primary reason why it is inadvisable to describe outcomes associated with these models. Observational studies do not permit statements about program impacts, and cause

CHAPTER OVERVIEW

This chapter synthesizes implementation descriptions of Flexible ACT and modifications of ACT for five selected populations.

Note that variability in quantity and quality of research hinders the ability to discuss outcomes of reviewed adaptations.

In addition, descriptions of modifications are not systematically documented in literature; therefore, core elements of modifications cannot be thoroughly summarized.

Despite these limitations, available research is informative and should be used to create awareness and to inspire continued learning. Use the links below to advance to the sections of interest.

Selected adaptations:

and effect relationships cannot be established. Similarly, the descriptions of implementation in published literature are generally presented as observations. Each published study that describes how ACT was implemented with a particular population (e.g., among people in rural areas, with youth or older adults) is best thought of as a case study, and usually a systematic description of implementation is not provided.

Without implementation details, it is not feasible to provide a simple description of core program elements across adaptations. Additionally, core elements of a program model implemented in one site may vary in another site—for example, teams in one location may comprise certain staff but in another location team composition may be quite different. Therefore, while it would be helpful to enumerate the core elements of the ACT modifications discussed in this chapter and compare and contrast them to the core elements of the foundational ACT program, it would be misleading to do so. The formative nature of much of the available literature precludes any systematic discussion of core elements of modifications, limiting any high-level discussion of fidelity. It also limits discussion of the relationship between core program elements and the efficacy of these ACT programs. Attribution of core elements to client outcomes cannot be made at this time.

While new research and practice-based evidence will continue to emerge, there is value in identifying modifications designed for specific populations or settings and describing them to the extent possible. It is important to promote awareness of these and inspire a collective commitment to learning more to ensure efficacy. Formal research, while not definitive in its current state, can still be informative. Even for populations where the literature is less robust, these implementation descriptions can offer important guidance for ACT teams as they work with these populations. With the mindset of promoting awareness and learning, this chapter synthesizes implementation descriptions of Flexible ACT and modifications of ACT for five selected populations. It also offers suggestions for additional investigation to further assess appropriateness.

3.1. Methodology and Review Process

This chapter covers published research in English from 2003 through 2023 for each selected population or adaptation of ACT. Studies include randomized controlled trials (RCTs), quasi-experimental designs (QEDs), case studies, single sample pre-post designs, epidemiological studies, descriptive studies, and implementation studies. The intention of this review is to provide a snapshot of implementation on these selected applications of ACT. It excludes studies where implementation was not described.

As detailed in Chapter 1, ACT includes a range of features that are linked to fidelity assessments. In each description of an ACT modification in this chapter, we focus on the team structure (e.g., changes in the type of team members and the target caseload) and service delivery (e.g., modifications in how services are organized and provided). We also include a section on changes in the types of services offered.

ACT Elements Highlighted for Each Program Adaptation	
ACT Element	**Modifications in…**
Team structure	• **Team composition** (team leader, program assistant, psychiatrist/psychiatric nurse practitioner, nurse, peer specialist, MA-level clinicians, BA-level staff/case managers, co-occurring disorder specialist, employment specialist) • **Small caseload** (staff to client ratio of 1:10)
Service delivery	• **Shared caseload** (team as a whole is responsible for services rather than individual caseloads) • **Fixed point of responsibility** (ACT team provides all services with limited referrals out) • **Flexible service delivery** (meeting daily to discuss client progress) • **Community-based services** (delivery of services in locations where clients spend their time) • **Time-unlimited services** • **24/7 crisis availability**
Service types	• **Clinical services** – Case management – Crisis services – Integrated substance use – Psychiatric and medical care – Psychiatric rehabilitation – Psychotherapy • **Community services** – Family psychoeducation – Supportive housing – Vocational services

3.2. Selected Adaptations and Populations

Flexible ACT

Current State of Practice: What We Know About Flexible ACT

- Reported modifications were intended to accommodate different international healthcare models and a broader population of people with SMI.
- Reported modifications and implementation practices include combining individual case management for people with SMI who are more stable and stepping up to ACT on an as-needed basis while clients are at risk of relapse or readmission; larger staff-to-client ratios; and the development of a new fidelity tool.
- Research is needed to 1) provide additional implementation details critical to assessing appropriateness and fidelity; 2) differentiate between localized solutions and more standardized adaptations; and 3) assess efficacy of the modified program.

Flexible Assertive Community Treatment (Flexible ACT) is a variation of ACT developed in the Netherlands.[128,129] Flexible ACT is intended to accommodate different healthcare models, areas with low population density, and a broader SMI population.[129,130] It combines two approaches within a multidisciplinary

recovery-oriented team: 1) individual case management for people with SMI who are mostly stable; and 2) aspects of ACT, such as shared case management and assertive outreach for individuals at risk of relapse or re-admission.[129-132]

Flexible ACT has been used with a variety of groups, including forensic, youth, and rural populations; implementation aspects of Flexible ACT for these populations are included in the respective sections below. Flexible ACT has also supported individuals with combined intellectual disabilities and challenging behavior or mental illness.[133,134] To describe implementation of this adaptation, we draw from 13 peer-reviewed studies. All are from outside the United States and include programs in the Netherlands, Demark, Sweden, Norway, and the United Kingdom (UK).

Team Structure

A primary hallmark of implementation that differs in Flexible ACT is the larger caseloads than in a typical ACT team. In contrast to a 1:10 ratio, these larger caseload sizes include 20 to 30 clients per case manager and approximately 200 clients per treatment team.[128,129,135] In general, the staff composition of Flexible ACT teams is similar to ACT,[128] although some variability may occur (for example, the addition of an occupational therapist or a physiotherapist).[136]

Service Delivery

In Flexible ACT, an individual's level of care can be increased or decreased,[129] which is intended to match intensity of services to current client needs.[129,137] Those who need more intensive services receive services comparable to what is provided in traditional ACT, while those needing less intensive services receive individual case management.[129,132] Daily team meetings, sometimes referred to as "board" meetings, are used to coordinate client care and any changes to service intensity.[136,138,139] Team members can add clients to a Flexible ACT virtual whiteboard when clients experience worsening symptoms, for crisis prevention, or to address treatment avoidance.[129,136]

Once the team adds the client's name to the board to receive assertive outreach from the full team, the team sets in motion the client's personalized crisis plan, and the psychiatrist visits the client within two days. The case manager informs the client and their family, if applicable, that the team will provide more intensive care for a time to prevent re-admission and shorten the crisis.[129] Flexible ACT provides most services in homes, but also provides services like psychologist and psychiatrist appointments in an office setting, which is a departure from ACT.[128,129,135]

In contrast to the other adaptations described in this chapter, Flexible ACT has its own fidelity tool.[140] In 2017, the Flexible ACT Fidelity Tool was updated to be responsive to local variations in implementation based on population profiles and regional variations in services.[141] The new tool includes items related to recovery-oriented practices; emphasizes the safety of the client and team; increases the number of hours for a psychologist; increases the need for expertise related to somatization, substance use, and cognitive impairment; and incorporates a paid peer specialist.[141]

Service Types

In general, the services in Flexible ACT are similar to those provided by a typical ACT team. Occasional modifications may occur, such as the addition of music therapy.[142] Variable service intensity and mode of service delivery (team-based delivery versus individual case management) are the more meaningful departures from the usual array of ACT services.

Other Implementation Aspects

As noted above, Flexible ACT serves a broader population of individuals with SMI.[129] Some programs report success in pairing Flexible ACT with other interventions to address commonly occurring issues, such as trauma[143,144] and substance use (such as smoking).[145]

Providers who work within the Flexible ACT model report several advantages of the approach:

- Shared caseloads reduce job strain, provide more confidence when handling crises,[146] and improve teamwork.[132] Shared caseloads also enable colleagues to support staff, and staff report having positive feelings about work and clients' quality of care.[146]
- Daily board meetings facilitate communication and alert members when a client's level of need changes, so they can provide more or less support.[132]
- The outreach component of Flexible ACT is an opportunity to identify the type of support the patient needs and connect them to appropriate community resources.[132]

However, larger staff-to-client ratios of 1:20 can be a barrier to engaging with patients, particularly those that initially decline services. Caseloads may also limit the ability to provide assertive outreach and maintain frequent contact with clients.[132] Another caution is that sharing care of a client among team members can threaten the therapeutic alliance if a client who challenges a clinician's skills in **empathetic engagement** prefers working with a particular staff member.[132] If this occurs, a Flexible ACT team can modify the shared caseloads approach to adjust to the needs and preferences of these clients.

Forensic ACT

Current State of Practice: What We Know About Forensic ACT

- Forensic ACT reflects the reality that individuals with SMI are overrepresented in the jail and prison system and are at high risk for recidivism. Reported modifications were intended to address criminogenic risk factors and needs.
- Reported modifications and implementation practices include interfacing with legal representatives, including parole and probation officers, judges, and law enforcement, either outside of the ACT team or by including legal agents on ACT teams, and prioritizing programming that specifically addresses criminogenic factors, like housing and employment.
- Research is needed to 1) provide additional implementation details critical to assessing appropriateness and fidelity; 2) differentiate between localized solutions and more standardized adaptations; and 3) assess efficacy of the modified program.

Individuals with SMI are significantly overrepresented in the jail and prison system,[147] stay longer in jail than people without SMI, and once released, are at higher risk for recidivism. In addition, individuals with mental health and/or substance use disorders who reenter the community from jail and prison often encounter significant barriers to behavioral health treatment, stable and safe housing, meaningful employment, and other recovery support services. As an intensive intervention designed for individuals with complex needs, ACT teams have long served both individuals who have reentered the community from jail and prison as well as individuals who are at high-risk for incarceration.

ACT with individuals involved with the criminal legal system has had mixed success. One systematic review found that ACT decreased rates of arrest and incarceration in only two out of ten studies,[148] suggesting that the model may not meet all the needs of forensic clients. Given the challenges associated with serving the needs of this population, clinicians have identified practices that can improve mental health outcomes and daily functioning while reducing arrests, incarceration, and hospitalization—a model that is now termed Forensic ACT (FACT).

As described by SAMHSA, FACT is differentiated from ACT by:[149]

- Addressing criminogenic risk and needs as part of the treatment plan, including the use of evidence-based cognitive behavioral therapies shown to reduce recidivism
- Having a criminal justice partner and a peer specialist with lived criminal justice experience on the treatment team
- Serving clients with SMI who have prior arrests and incarcerations
- Leveraging sanctions and incentives imposed by the criminal justice agencies providing supervision, when appropriate

FACT can also be defined by the Rochester Forensic ACT Scale (R-FACTS), a 16-item fidelity tool designed for FACT. R-FACTS borrows some elements from TMACT while also measuring implementation of programming that addresses criminogenic needs.[150]

While SAMHSA's definition and R-FACTS identify certain components of FACT, use of the term varies in the field. For example, some FACT programs involve legal leverage, the process of using legal authority to mandate treatment engagement for individuals with SMI or substance use disorders who are involved in the justice system.[151] FACT programs examined over the last 20 years vary in eligibility based on whether they require a certain number of interactions with the justice system, a formal diagnosis such as schizophrenia or bipolar disorder, high utilization of hospital and emergency services, or referral from the justice system.[152-156] Other Forensic ACT programs focus on a specific point (or points) along the criminal justice continuum. A program in California mandated the FACT program as a condition of parole, while another program specifically served individuals who were on conditional release following a ruling of not guilty by reason of insanity.[157]

Assisted Outpatient Treatment

Assisted Outpatient Treatment (AOT) is a program that serves a population similar to ACT clients, but eligibility criteria for AOT differs from ACT in important ways. Most importantly, participation in ACT is typically voluntary, and clients can leave the program at any time for any reason (though in some states, the court can designate ACT as a mandated service program for individuals who receive an order for involuntary outpatient commitment). In contrast, only a court can place individuals in AOT, and clients are required to follow a treatment plan approved by the court.

The implementation description below is drawn from nine studies that specifically refer to their programs as FACT, as well as four that use different terminology but were identified or categorized by experts in the field as FACT. Each of these studies took place in the United States, except one which took place in Belgium.

[b] Formerly called the Comprehensive Opioid, Stimulant, and Substance Abuse Program (COSSAP), and may be referred to as such on some documents and resources.

Team Structure

One way FACT addresses the complex needs of individuals with SMI and criminal justice involvement is by including criminal justice personnel and specialists as part of the FACT team. This may include probation officers,[153,158] parole officers, or a forensic psychiatrist.[159] Based on a survey of FACT teams reporting collaborations with probation departments, more than 60 percent had a full-time probation officer, more than half of the teams had probation officers attend treatment meetings at least once a week, and nearly 90 percent of team leaders viewed the probation officer as a treatment team member.[158] Of note, programs may also make the intentional choice not to include probation or parole officers on the team itself.[155]

If not official members of the team, probation and parole officers[152] and other criminal justice personnel often maintain strong partnerships with FACT teams.[159,160] Partnerships between clinicians and criminal justice personnel can provide legal leverage for clients to engage in and maintain treatment.[151] One FACT program developed a close partnership with a judge, effectively establishing an informal mental health court for its clients. Another FACT program offered judicial monitoring, which included regular meetings between a FACT team member, presiding judge, and public defenders to help problem-solve for the client as issues arose.[161] Cross-training mental health and criminal justice team members can facilitate communication, collaboration, and increase cross-system knowledge.

Involving empathic and patient providers on the FACT team is crucial to program success. While person-centered care is central to ACT, helping FACT clients understand where they have agency over their own pathways to health and recovery is important,[151] particularly if FACT is court-mandated. Techniques to promote engagement between providers and clients include demonstrating empathy about rules and expectations, minimizing control when safe and possible, and offering choices to support a client's sense of agency.[151] In one study, FACT participants connected their willingness to participate in FACT programming to the empathetic and kind natures of clinicians and legal staff on the team.[151] Given the FACT client population may include individuals with personality disorders and those who have committed violent crimes and sexual offenses, staff should receive special training in working with these issues.[162]

ACT team members should also be aware of the impact of racism, prejudice, and inequity existent in the criminal justice system and law enforcement practices. The United States leads the rest of the world in its incarceration rate, and Black and Hispanic or Latino people make up 51 percent of the incarcerated population despite being approximately 30 percent of the U.S. population.[163] Black and African-American people are incarcerated in state prisons at five times the rate of White people, while Hispanic or Latino people are incarcerated at 1.3 times the rate of White people. Almost half the 2.2 million people incarcerated in the United States as of 2020 were non-violent drug offenders, people who could not afford bail, or individuals being held for failure to pay minor debts, suggesting that poverty is also a major risk factor for incarceration.[164] ACT team members must understand how poor non-White individuals are already at heightened risk for arrest and incarceration, and those with SMI are at extreme risk.

Service Delivery

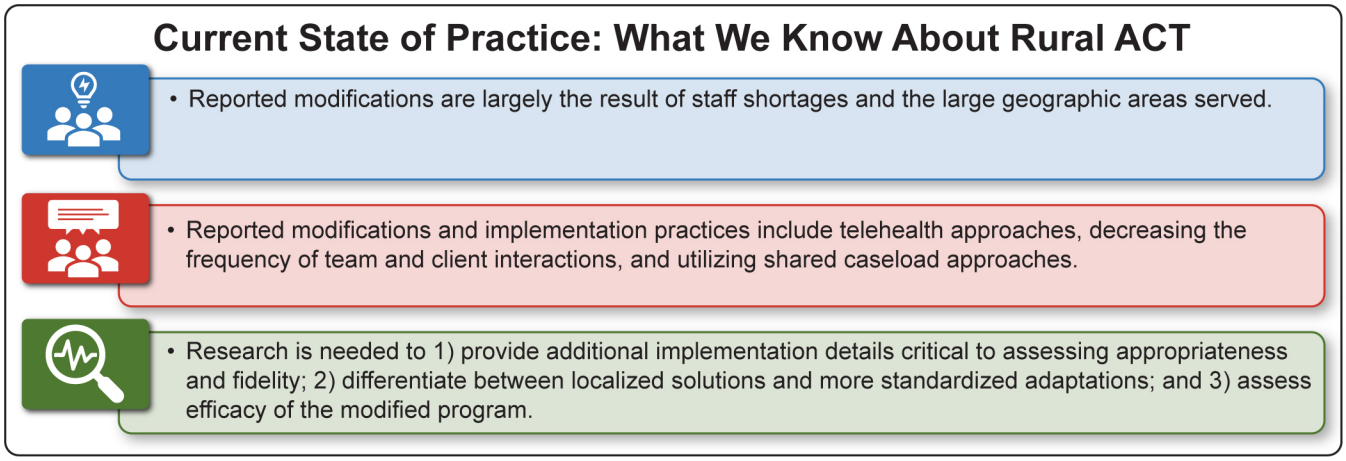
Due to variability in FACT clients and point of intervention, the admissions and discharge criteria for clients may be different from those used by a typical ACT team and should be clearly established.[165] In FACT, the time-unlimited nature of ACT may be interrupted by re-arrest, incarceration or re-incarceration, and other factors of the legal system beyond the FACT team's control, and discharge may be necessary. One caution from existing FACT programs is that creating discharge criteria should *not* be used as a method of discharging clients who are more challenging to work with. The 24/7 availability of ACT and compassionate relationships with clients are especially important for FACT teams, whose clients may have experienced social rejection, including from previous treatment providers.

Service Types

The challenges common to typical ACT populations, such as SMI, poverty, homelessness, substance use, and unemployment, are all relevant to a FACT population and require the same service approaches as ACT. For the FACT population, however, the risk of recidivism and interaction with the criminal legal system is much higher. Thus, FACT programs often focus on these risk factors as part of their comprehensive programming.[166]

This focus is of particular relevance when helping clients find affordable housing, since many housing programs are reluctant to accept clients with histories of crimes such as burglary, assault, and arson. A key factor of success for one FACT program was the use of an existing supervised apartment facility specifically intended for individuals with substance use. The program later developed and maintained connections with other residential options, including single-residency occupancy buildings. With poverty being a high-risk factor for FACT clients, providing assistance to access supplemental security income (SSI) and other benefit programs is also particularly important.

Rural Populations



The experience of a person with SMI in a rural area may be quite different from that of an individual in an urban or suburban locale. Above all, accessing behavioral health care in rural areas includes multiple barriers.[8,167] Rural areas face a well-known shortage of behavioral healthcare services,[8] along with lack of service accessibility, affordability, and acceptability, all of which the National Rural Health Association notes as critical challenges.

Populations in these communities have higher poverty rates,[168-170] fewer employment opportunities,[171,172] and greater transportation challenges[8,173] compared to people living in more densely developed areas, all of which complicate the process of receiving help. Additional stressors are present for those involved with farming or agricultural work,[174] including weather events, interrelated work and family roles, high rates of work-related injuries, debt, intergenerational tensions, and isolation.[175]

Not surprisingly, rural ACT teams have experienced challenges with implementation. Clients are often spread across large distances with limited public transportation and greater transportation costs for clients and ACT teams.[132,169,176] Rural teams have staff shortages,[167] especially related to filling the role of prescribers and other specialists. These constraints have led to several ACT adaptations in rural contexts, as evidenced through anecdotal reports and published literature.

Since 2002, there are more than a dozen published descriptions of ACT implementation in rural areas, either theoretically or empirically. Examples of implementation draw from rural areas of North Carolina and Maine, as well as from Denmark, the Netherlands, Norway, and Canada. In rural Vermont, a Housing First ACT model was adapted to serve clients,[177] and comparisons between rural and urban settings[107,176,178] are also illustrative. The implementation aspects described below draw from nine peer-reviewed studies.

Team Structure

Adaptations to the rural ACT team composition are primarily to accommodate the shortage of mental health staff in rural communities. One team highlighted the difficulty of recruiting staff due to the intensity of ACT services, including the 24/7 on-call responsibilities.[168] Gaps in the team structure and modifications include:

- Other staff playing the role of housing specialist and educational specialist[176]
- Using peer support workers as case managers[176]
- Hiring part-time staff,[139] such as a half-time instead of full-time employment specialist,[168] or a part-time psychiatrist[168,169] or nurse practitioner[168]

Challenges to the Provision of Mental Health Services in Rural Communities

- **Availability:** Staffing or service shortages limit receipt of services
- **Accessibility:** Knowledge of when and where to obtain services, including coordination of services across sectors of the health and social services system, as well as travel issues
- **Affordability:** Costs associated with receiving care and availability of benefits/insurance for services
- **Acceptability:** Persistent issues related to the negative perception and stigma attached to the need for services

From *The Future of Rural Behavioral Health*

Another modification is to require clients to have a community psychiatrist in lieu of including one on the team.[107] While higher client staff ratios have been reported on rural compared to urban ACT teams,[176] staff ratios can still adhere to fidelity standards in a rural setting.[107,176]

Service Delivery

Limitations related to staff availability and geographic distances drive many of the service delivery modifications when ACT is implemented in rural areas. Even prior to the COVID-19 pandemic, rural ACT programs addressed these by delivering some services through telehealth.[169] In one program, telepsychiatry was well accepted by patients and staff and increased productivity and efficiency by reducing travel time and enabling the psychiatrist to participate in crisis response.[169] This program had a half-time psychiatrist position who spent 80 percent of their time meeting with clients in-person for at least monthly appointments, using the remaining 20 percent of their time for telepsychiatry for additional visits per month or as needed for crises.[169]

Telehealth can also facilitate a multidisciplinary approach. One team holds hybrid meetings with clients, where a team member visits the client in-person and brings a device to connect with other staff, allowing multiple staff to meet with the client despite long travel distances that make meeting multiple staff in-person infeasible.[139]

Long travel distances can impact the overall frequency of team meetings and client visits in rural settings. Rural teams may have team meetings once or twice a week rather than daily or may schedule all in-person meetings on the same day to minimize staff driving times. Driving distances can also mean changes for the nature of contact with clients—for example, visiting clients once or twice a week or using a satellite office to serve a portion of clients and having staff visit this site two or three times a week.[168]

A program in rural Vermont took a service approach of assigning geographically based caseloads to service coordinators, with regional specialists who provided care as needed. Telehealth visits supplemented weekly in-person visits.[177] Other teams in Norway took a similar approach, hiring staff in multiple locations and functioning with multiple bases of operation, which they felt enabled faster crisis response, less task delegation, and more intensive services.[139] Another team supplemented weekly client visits with a 24-hour hotline telephone service.[179]

Rural ACT teams may modify service delivery to accommodate the ability to handle client transitions. The lack of formal step-down options in rural communities poses a significant barrier,[107] making it harder to transition clients who are ready for less intensive services. When community services are under one agency, and even in the same building, transitions may be smoother because of the ease of meetings between ACT staff and community program workers.[107]

Additional strategies for coordination with community providers that may facilitate client transitions include co-locating an ACT team with a primary care provider, connecting clients with other services in the community,[107] continuing to provide administration of injectable medications even after termination of services,[107] and provision of overlapping services.[107] Since having 24/7 crisis availability and staffing on-call services are challenging in rural settings one modification is to use other mental health services to cover overnight and weekend phone contact with clients.

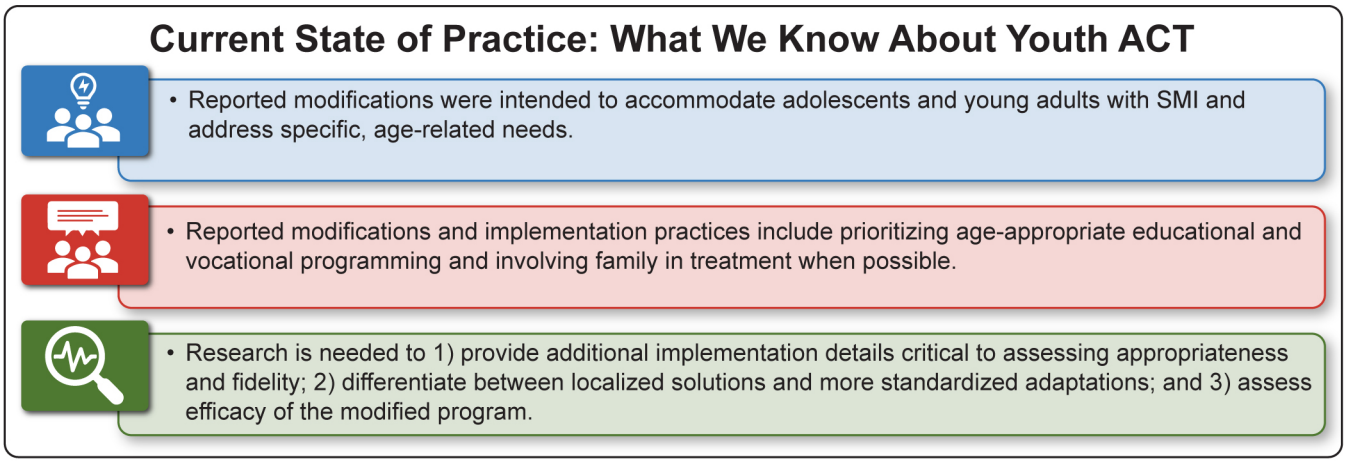
Service Types

As noted above, some services may not be available in rural areas or available with more limited frequency on a team-by-team basis. Some rural teams in especially remote areas may choose *not* to provide all services themselves due to limited resources or large geographic distances between clients.[139] Even some urban Flexible ACT teams do not provide all services themselves.[139] This increases the need for

collaboration with other community providers[180] and perhaps municipalities, which brings challenges for coordinating care.[139] Teams may spend more time coordinating care, which takes time away from serving clients and may ultimately reduce the number of clients that can be served and therefore each team member's caseload.[139] On the other hand, rural ACT teams have implemented ACT with fidelity and no major modifications.[181] Not all rural ACT teams will need to delegate services to other providers.

In a study of Flexible ACT teams in rural Norway, practitioners reported challenges with different aspects of the model, including multidisciplinary shared caseloads, providing intensive outreach, and managing crises. These challenges led to multiple adaptations to practice, including fewer team meetings, part-time staff, use of digital tools, context-adaptive planning, intermunicipal collaboration, and lower caseload sizes to accommodate lower population density. Modifications were viewed as both having the potential to increase relevance of Flexible ACT to rural contexts but also as potential threats to core practice elements.[139]

Youth and Adolescents



At the same time in the early 1980s that ACT gained attention as an intensive program for adults with SMI, the term "wraparound" services emerged to describe a similar approach for youth with complex needs.[182] Over the years, researchers and clinicians continue to use "wraparound" to describe the comprehensive nature of ACT services. Wraparound also has transformed from a philosophy into a formalized approach that includes measures to assess fidelity. Thus, the adaptation of ACT for youth draws from both ACT as implemented with adults as well as from wraparound.

Wraparound Services

SAMHSA describes wraparound as a team-based care approach that builds on strengths as a way to identify both formal and informal support for children and youth and notes that it is the most commonly used approach to provide Intensive Care Coordination (ICC), a key service highlighted in the 2013 Bulletin on Behavioral Health Services for Children, Youth, and Young Adults With Significant Mental Health Conditions.

ACT for youth, sometimes explicitly called "Youth ACT," is increasingly available in the United States. The most extensive application of Youth ACT is in New York State, where the New York State Office of Mental Health has developed program guidelines. Using multiple funding streams, the state is supporting approximately 20 teams to serve children between the ages of 10 and 21 and their families. In Missouri, the model is called Assertive Community Treatment for Transitional Age Youth (ACT-TAY), and as of March 2023, had more than a dozen programs focused on individuals aged 16 to 25.[183] ACT-TAY can differ from other

youth ACT programs because of its inclusion of young adults. Some ACT-TAY programs are integrating roles and interventions specifically to treat individuals for first-episode psychosis.

The Minnesota Department of Human Services supports Youth ACT/Intensive Rehabilitative Mental Health Services (IRMHS) programs to serve individuals who are between 8 and 20 years old and meet other level of care criteria.[184] Programs also exist in California,[185] New York,[186] and North Carolina,[187] among others.

While the research literature is not as extensive as for Forensic and Flexible ACT, there are several publications that have focused on ACT with youth. In 2017, a team from the Netherlands completed a formal review of studies, published between 2002 and 2016, on interventions with youth that they considered to be ACT.[a] They determined that ACT with youth reduced severity of psychiatric symptoms, reduced both the frequency and length of psychiatric hospital admissions, and resulted in significant improvements in general functioning.[188]

The implementation description of Youth ACT below includes a total of 10 studies overall. One of these describes the program as an application of Flexible ACT.[189] Half the examples of implementation come from programs in Switzerland, the Netherlands, Australia, the United Kingdom, and Canada. Participants ranged from 11 to 30 years, with most Youth ACT programs including participants under the age of 25.

Team Structure

Modifications to the team structure primarily include the addition of team members with skills and backgrounds that are relevant for this age, such as educational specialists[189,190] and employment and vocational specialists.[189-192]

Service Delivery

Guided by an awareness that youth and young adults may be less motivated to participate in treatment, programs implementing Youth ACT have made modifications to their service delivery in several ways. In a departure from the typical ACT structure, this can include designating a single team member as the primary staff person to increase trust and bonding between the client and team. In this example, clients continued to work with other staff outside of their primary staff person throughout treatment.

Teams also use engagement strategies tailored to youth and young adults. This includes avoiding language that could dissuade engagement, such as rarely using the word "therapy" despite the use of approaches such as dialectical behavior therapy and cognitive behavior therapy as part of treatment.[193] To reach youth directly, staff use text messaging for appointment reminders, check-ins, and to initiate engagement.[190] And, while ACT

[a] Four of the studies in this review focus on Assertive Continuing Care (ACC), a program that is focused on youth with substance use disorders. Aspects of implementation from ACC are not included in this guide.

typically occurs in the home and familiar places to the client, treatment locations for youth may be purposefully expanded to include other places, such as coffee shops, community centers, parks, and schools.[193-195]

Being youth-guided and including family involvement are considered important aspects of the ACT model because they recognize the critical roles that youth and families can play in the recovery process. For youth in ACT, family involvement is critical, since youth often still live at home with their families. One program incorporated "family-aided" ACT, which included a multi-family therapy group for families that provided psychoeducation around biological, physiological, and social aspects of schizophrenia, as well as education around reducing stressors in the home environment. Another program used systemic family therapy and counseling sessions specifically for parents and caretakers. Teams must be familiar with local and national family supports, such as family peer supports who provide emotional support and educate families about behavioral health systems so they can be effective advocates for their children.

Some Youth ACT programs may modify the timing of services—for example, making participation time-limited in overall length of ACT enrollment.[193,194,196] For at least one Youth ACT program, there was not 24/7 availability of clinicians.[194]

Service Types

In addition to their mental health concerns, youth and young adults are typically navigating issues related to school, social relationships, and developmental milestones. Therefore, Youth ACT may involve more emphasis on supporting academic success, building social skills, and addressing developmental challenges. Youth ACT also encompasses more family interaction due to the client's age. Programs often focus on independent living and forging an autonomous identity.[189,193,197,198] Similar to adult populations, transition-age youth within ACT programs may experience or be at risk of homelessness. To address these needs, programs can work with youth homeless organizations, supportive housing programs, and community organizations with Housing First programming. ACT with youth can also include aspects of services such as:

- Consultation with key individuals, including guidance counselors and teachers[192]
- Focus on age-related health and well-being topics, such as puberty and helping adolescents process body changes[193]
- Financial training and support in managing finances[189]

Older Adults

Current State of Practice: What We Know About ACT for Older Adults

- Reported modifications are largely the result of clients' comorbidities and increased physical health needs.
- Reported modifications and implementation practices include incorporating geriatric specialists, providing additional physical health-related trainings to staff, and decreased emphasis on employment.
- Research is needed to 1) provide additional implementation details critical to assessing appropriateness and fidelity; 2) differentiate between localized solutions and more standardized adaptations; and 3) assess efficacy of the modified program.

The United States is in the midst of a demographic shift in which the number of older adults is anticipated to outnumber children under the age of 18 for the first time in 2034.[199] While older adults with SMI have a shorter life expectancy than the general population,[200] many individuals diagnosed early with SMI now reach older adulthood.[201] Older adults with SMI have substantially higher rates of diabetes, lung disease, cardiovascular disease, and other medical conditions compared to adults without SMI.

They also experience common challenges of aging in general, such as reduced mobility, falls, and dementia.[202] Agencies working with older adults with SMI may encounter individuals who need assistance with issues that are unique to their stage of life, such as making long-term care and end-of-life decisions.[203] Other unique service needs of older adults can include socialization,[204] caregiver respite,[205] suicide prevention,[206] and grief support.[204]

These and other related factors led to some initial efforts to explore the use of ACT specifically with older adult populations. A SAMHSA evidence-based guide, Psychosocial Interventions for Older Adults With Serious Mental Illness, recognized ACT as an evidence-based intervention that has demonstrated positive outcomes for older adults. One of the programs cited in that guide[207] focused on older adults but did not describe modifications in how ACT was provided.

Five other peer-reviewed studies discussed below have described a full-fidelity ACT model for older adults,[208,209] "psychogeriatric ACT,"[210] "Assertive Community Treatment for the Elderly,"[211] and application of ACT among a veteran population that includes individuals over the age of 50.[212] Across these studies, the clinical populations were at least 50 years of age and some included individuals over the age of 75.

Team Structure

To address the specific needs of an older population, an important modification is to incorporate team members with geriatric and psychogeriatric expertise.[210] This may include adding a geriatrician to offer general health expertise for more comprehensive community care or an occupational therapist focused on home safety and mobility assessments who can facilitate access to gait aids, assess fall risk, and help implement fall prevention strategies. Geriatric psychiatrists, who can provide integrative care for dementia and late-life mental and general medical conditions, might also be on an ACT team. However, as of 2018, there are less than 2,000 geriatric psychiatrists country-wide, so while this standard is ideal, it is not commonplace.[116] To reflect the decreased need for employment among older adults, the role of vocational specialists may be less prominent.[210,211]

Service Delivery

Overall, aspects of ACT service delivery with older adults have not been described as purposefully different in significant ways. However, one program observed variability in the nature of contacts that took place with older adults. This includes team members having more frequent contact with family as well as nonfamily caregivers, a greater proportion of visits held face-to-face in the community, and older adults being more likely than younger adults to receive services from a single case manager.[212]

Service Types

Similar to youth, the specific types of services that older adults need may be different than for younger adults. Among older adults who were engaged in ACT through a Veterans Affairs program, older adults were less likely to receive psychotherapy, psychiatric medication management, substance use treatment, and housing or vocational support, and were also involved in fewer recreational activities.[212] More support may be required for physical health-related issues as needs and appointments may be elevated.[209] Given that employment may be less of a primary need for older adults, a program may purposefully reduce focus on vocational support.[210]

Other Implementation Aspects

Interviews with staff members from six ACT teams that work with older adults provide a sense of some of the challenges in working with this population through the ACT model.[209] Four main themes emerged:

- Older adults' **physical health** needs are considerable, including the number of medical issues and appointments, the need for staff to accompany clients, access barriers to primary care, and the risk of falls.
- Older adults' need for **supports and services** differ, including accessing housing and long-term care, need for increasing services with age, and barriers in accessing all services due to wait lists and denial.
- There are questions around **geriatric expertise**, including how to integrate geriatric specialists with the ACT team, challenges in understanding cognitive impairment, and lack of expertise in advance care planning.
- Team members highlighted the issue of **team versatility versus strain**, namely, the increased workload and time required to serve older adults, the need for collaboration, and whether teams can sustain the level of flexibility needed to adequately serve this population.

ACT teams may consider supplementary education to prepare *all* team members for the unique challenges of serving older adults, including the complexities of health issues, availability of resources, and how ageism may affect services.[208] ACT teams must understand the Long-Term Care Ombudsman, Aging and Disability Resources Centers, Area Agencies on Aging, and other age-specific resources in their areas to address elder abuse, advocate for supports, and improve quality of life.

Immigrant and Refugee Populations

Current State of Practice: What We Know About ACT for Immigrant and Refugee Populations

- Reported modifications are largely the result of cultural and linguistic variations between clients.
- Reported modifications and implementation practices include culturally matching staff to clients, extra psychoeducation, addressing other viewpoints on the nature and stigma around mental health, and adjusting outcome measures to reflect cultural context.
- Research is needed to 1) provide additional implementation details critical to assessing appropriateness and fidelity; 2) differentiate between localized solutions and more standardized adaptations; and 3) assess efficacy of the modified program.

Immigrants and refugees are particularly vulnerable to depression, anxiety, and PTSD.[213] In many cases, a refugee is in a new country specifically *because* of trauma experienced in their home country, either through political conflicts or natural disaster. Significant trauma can be a precipitant for SMI or exacerbate existing mental illness.[214] In addition, factors of the post-migration experience, such as language barriers, structural racism, acculturation, loss of social status, and social isolation can have a negative impact on mental health.[215]

Any ACT team may serve an individual who is an immigrant or refugee. In addition to providing culturally competent and trauma-informed care more generally, modifications to ACT delivery and services for individual clients may involve incorporating specific cultural practices. Where a large number of immigrants are served within a service area, some agencies have created ACT programs that cater specifically to recent immigrants or refugees, sometimes for specific ethnic groups.[29,216,217] In one survey of an ACT team intended for immigrants, two thirds of clients could only communicate in languages other than English.[29] Relatively little has been written about ACT for immigrants, refugees, or people who do not speak the majority language and also do not identify as immigrants. The implementation aspects described below draw from four peer-reviewed studies.

Common Postmigration Factors That Impact Mental Health

- Uncertainty about immigration or refugee status
- Unemployment
- Loss of social status
- Loss of family and community social support
- Concern about family members left behind
- Language barriers
- Challenges in acculturation
- Discrimination and racism

Adapted from Kirmayer, et al. (2011)[215]

Team Structure

ACT teams serving immigrant populations generally strive to have staff reflect the cultural identities of the populations they serve, with team members able to communicate in their clients' primary languages.[29,30,217] Besides language and culture, staff might also share a similar refugee status and therefore shared lived experience with the challenges immigrants and refugees face.[30]

Service Delivery

Implementation of several core aspects of ACT conflict with certain best practices in culturally competent care. In particular, assigning staff to clients based on language and ethnic match can be at odds with the ACT practice of a shared team approach. One way to address this is through a "paired" staffing approach, in which one member of the pair reflects the client's background and works alongside other members of the team who may not share the same background.[217]

The optimal style of interaction between staff and clients may differ for certain ethnic groups compared to what would be typical in other ACT populations. Whereas ACT emphasizes shared decision making, one program serving Southeast Asian clients found it more beneficial for staff to present themselves as experts and in an authority-figure role. This facilitated trust with clients and reflects[30] a dynamic that differs from what is typical in ACT.

Modifying outcomes and how they are measured can also be useful. Teams may want to frame treatment goals and processes with consideration of cultural norms. For clients whose cultures are less individualistic and more communal, interdependence as opposed to independence might be a primary goal—for example, a goal may be for a client to return home to live with family rather than seeking independent living.[30]

In consideration of the barriers that some clients might face due to language and low educational levels, it may make sense to use smaller increments of change when measuring a client's progress in vocational and educational goals. For example, teams may use the stages of change model (pre-contemplation, contemplation, preparation, action, maintenance, and termination) rather than quantitative goals sometimes used in other programs.[30]

Lastly, a minor modification could be to dedicate time at all team meetings to discuss the clinical impacts of cultural factors,[29] as well as to address differences in staff's definitions of illness.[217]

Service Types

The addition of an acculturation assessment during intake can be useful to assess language skills and attitudes and beliefs around mental illnesses and treatments.[29,30,217] Programs may also want to consider combining spiritual rituals or interpretations with Western medication and practices to make content more culturally relevant.[30]

Psychoeducation is a specific service with heightened importance in serving immigrants within ACT programs.[30] Psychoeducation can include educating clients on how to navigate the U.S. mental health system, how family life might change after onset of mental illness,[216] common components of the Western model of care,[30,216] and interactions of certain herbal medicines and pharmaceuticals.[30] One ACT program that delivered family psychoeducation for Chinese and Tamil clients found that psychoeducation helped to improve communication and understanding between clients, clinicians, and family members; enabled family members to improve medication adherence; educated family members on how to recognize and report early signs of crisis; and offered a space for clients and family members to build trust and connection.[216,217]

Beyond the usual ACT processes of including family members, selected modifications can be especially important in delivering culturally specific ACT programming. Determining which family members are appropriate to include in the treatment process should be consistent with cultural expectations of the client.[30] Programming for families can be made more accessible by offering transportation, food, and flexible scheduling, including weekends.[216] To alleviate concerns about stigma associated with mental health services, programs can emphasize to families that treatment is confidential.[30,216]

Other Implementation Aspects

If an ACT team is going to serve a specific population, it may be helpful for the team leader to meet regularly with referring agencies to reduce confusion about program inclusion criteria.[217] Team members can interface with community-based organizations and community leaders to address stigma in client communities.[30] Another implementation consideration is that ACT team staff may need education on cultural norms and historical traumas affecting their client communities,[30] as well as historical strengths. Over time, staff can develop expertise in specialized social services for immigrants and refugees within the community.[29,217]

3.3. Gaps and Opportunities

Ensuring Fidelity to the ACT Model

Each of the adaptations discussed in this chapter incorporates core elements of the original ACT model. Each also includes modifications to be responsive to the specific needs of the client population or to address considerations and constraints within the community. The fidelity tools available for ACT—DACTS, TMACT, and SAMHSA's fidelity tool from SAMHSA's 2008 ACT Toolkit—were designed for the original model. While ACT adaptations discussed in this chapter can use these tools to assess fidelity, the tools do not consider program elements that have been modified or the rationale for the modifications. The exceptions to this are Flexible ACT and FACT, which have both developed their own fidelity tool. This raises questions:

- When ACT is adapted for a specific population, should the fidelity process involve assessment of all components except for those that have been modified, and the scoring adjusted accordingly?
- At what stage does a modification become a different model, warranting its own fidelity processes, such as with Flexible ACT?
- How many components must remain intact before it is no longer "ACT"?

Some states (e.g., South Dakota, Colorado) have developed their own fidelity instruments to capture the unique elements of their program (e.g., a team size of at least 3 FTE members in rural areas of Colorado).[218]

As modification of ACT for these populations and others continue to expand, states and agencies will need to address these questions to ensure their program's validity. It also is important to evaluate these modified programs to determine the 1) extent to which they are achieving intended program outcomes (e.g., reduction in hospital admissions, retention in treatment) and 2) necessary, or core, program components that need to be retained to achieve outcomes.

These data would provide information to justify continued program operation and funding. Research findings would also lead to clearer specifications for each specialized program.

Documenting and Sharing ACT Modifications and Innovations

Modifications to the original ACT model are driven by the desire to better meet community needs, provide access to ACT for certain populations, and address equity and program access concerns, as well as by the burdens programs experience related to adhering to fidelity and cost. Each community and population within the community is different, and a rural, forensic, or youth ACT program in one part of the country is likely to differ from

Advancing Equity

The National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care provides detailed action steps to advance equity and quality and eliminate disparities in service delivery. The website, Think Cultural Health, supported by the U.S. Department of Health and Human Services (HHS), has compiled CLAS resources, including a behavioral health implementation guide.

the same somewhere else. Communities may initially model their program on a similar version, but then, by necessity, introduce modifications or innovations that address specific needs, constraints, or conditions within their own area. As discussed in this chapter, modifications may include part-time employment for some staff, inclusion of new specialties on ACT teams, fewer team meetings, higher or lower caseloads, use of telehealth to supplement in-person meetings, and collaboration with other providers for service delivery, among other changes.

The information presented in this chapter only touches the surface of most of the adaptions. The field would benefit from a deeper understanding of the innovations and modifications made for each type of ACT program, and the challenges and opportunities they create. Within each ACT component, these modifications are an opportunity for lessons learned. Documenting and sharing them may motivate other communities who have resisted or experienced barriers to implementing programs for people with SMI to develop their own ACT programs. Learning about the experiences of others can also improve program practices in communities looking for innovative solutions to problems. It is important to note that documentation of programmatic experience with adaptations should be inclusive of client perspectives in addition to the perspectives of administrators and practitioners.

There is also a need for rigorous studies of the ACT modifications discussed in this chapter. As noted previously, many studies of these programs are observational, and conclusions about their efficacy for individuals with SMI are not possible. Service delivery environments also have evolved over time. RCTs comparing efficacy of these ACT modifications to "usual care" in the current healthcare contexts are essential, as are studies of clients' perceptions of services to ensure all needs are met appropriately and acceptably. Well-designed investigations of these programs will help ensure that people experiencing SMI have the most appropriate care.

Workforce Development and Expansion

The mental health crisis in the United States is unprecedented and requires an approach that meets the needs of people of all ages, backgrounds, and living situations. ACT was developed decades ago to help individuals with SMI. It gave individuals with SMI access to a multidisciplinary team of mental health and other professionals who could provide 24/7 services to help them integrate in society. Modifications to the ACT model emerged over time to address the special needs of particular populations. Some of these modifications involved adding other professionals to the ACT team; others required making adjustments to team composition and service delivery to accommodate workforce shortages.

Hiring and maintaining the mental health workforce, including addressing racial and ethnic disparities, has been difficult and may be especially challenging for mental health professionals working in the community compared to those who are clinic-based. Investing in the mental health workforce is critical for the continuation of existing ACT programs, expansion of ACT in other communities, and meeting the demand for mental health services for people with SMI.

Current programs exist to specifically address the ethnic and racial disparities in the workforce, including SAMHSA's Minority Fellowship Program and the National Network to Eliminate Disparities in Behavioral Health. Policy researchers have suggested multiple proposals to expand the mental health workforce. One of these is to widen the scope of the National Health Service Corps' Loan Repayment Program to encompass mental health practitioners who offer services outside of clinical settings, such as in-home or community-based care through ACT.[127] Currently, the program mandates that most professionals provide their services within a clinic.[127]

Policy researchers have also proposed incentivizing states to create loan repayment programs, mandating that private health insurance policies cover team-based treatment models (which would ensure higher compensation), enhancing Medicaid reimbursement rates for ACT, and encouraging states to transition from fee-for-service Medicaid reimbursement to a more adaptable payment system that permits ACT teams to deliver the model with precision and as intended.[127]

Equity Considerations and Opportunities

SAMHSA defines equity as the right of all individuals, regardless of race, age, ethnicity, gender, disability, socioeconomic status, sexual orientation, or geographical location, to access high-quality and affordable healthcare services and support.[7] Equity considerations and opportunities occur at multiple stages of ACT program implementation: planning, recruitment, service delivery, fidelity assessment, and outcome evaluation. A focus on equity at each stage can enhance access to mental health services and overall program outcomes for individuals with SMI who have historically experienced barriers to care, such as systemic and structural racism, isolation, housing instability, stigma, and poverty.

ACT integrates principles of equity. Services are person-centered, culturally responsive, and trauma-informed; involve cross-sector collaboration; and address equity issues like access to care. However, national data on demographic and other background characteristics of ACT clients and program outcomes are currently unavailable. This makes it difficult to analyze equitable implementation at the national level or access issues and challenges for specific populations. Moreover, research on the extent to which ACT programs reduce disparities in service use and mental health outcomes is limited, precluding guidance on specific implementation practices that can improve access and outcomes for different populations.[219,220]

To ensure equitable implementation of ACT, programs should develop strategies related to equity before starting service delivery. How programs recruit participants, advertise for and hire staff, deliver services (e.g., virtually or in-person, with a trauma-informed approach), consider and execute adaptations, and involve clients in decision-making all have equity considerations. Internal reviews of tools, processes, and decisions can identify bias and promote equity. Program evaluation, that programs themselves or independent researchers conduct, can also inform equitable implementation by assessing the extent to which ACT programs have reduced disparities in access and outcomes. Research should examine implementation factors associated with reducing disparities to provide guidance on what works. ACT training and resource guides can then incorporate this to enhance program delivery.

Finally, decades of research have made it clear that interventions like ACT cannot have long-term success at reducing disparities or achieving lasting health outcomes for clients without concurrent fundamental changes in the social determinants of health that adversely affect some communities and populations.[221,222] ACT programs, policymakers, community leaders, mental health consumers, and others from multiple sectors would mutually benefit from collaborating on this issue. They can identify community needs and policy and system changes (e.g., mental health, housing, education, violence prevention) that would improve the social determinants of health and support the effectiveness of ACT programs, the recovery of individuals with SMI, and the overall health of the community. Community change efforts, if planned and implemented alongside consumers and providers involved in interventions like ACT, can help address the larger issue of social and health equity.



Appendices.

List of Appendices

Appendix A.

Acknowledgments

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Appendix B.

Summary of Studies of ACT Adaptations

The table below identifies studies that were the source for examples of implementation included in Chapter 3. Studies in Chapter 3 that were only cited to introduce each ACT adaptation are not included in the table below.

Ref # in list	Authors, Year	Country	Study Design	Sample[a]
Flexible ACT				
143	Albers, et al. (2022)	Netherlands	Mixed methods process evaluation	N=215 Flexible ACT clients and staff completed structured questionnaires; 34 semi-structured interviews with 16 clients and 18 staff
138	Bønes, et al. (2022)	Norway	Literature review	N/A
131	Drukker, et al. (2011)	Netherlands	QED	N=114 Flexible ACT, 333 TAU
145	Küçükaksu, et al. (2022)	Netherlands	Qualitative	N=5 experts in treating tobacco addiction in people with SMI
146	Lexén & Svensson (2016)	Sweden	Qualitative	N=18 Flexible ACT staff interviews
144	Mauritz, et al. (2022)	Netherlands	Mixed methods	N=22 Flexible ACT clients with PTSD and other comorbid SMI
132	Nielsen, et al. (2021)	Denmark	Qualitative	N=17 interviews with FACT staff (8 former ACT staff, 9 former community mental health practitioners); teams were urban and rural
142	Skånland (2022)	Norway	Qualitative	N=6 Flexible ACT clients, 1 staff
135	Sood, et al. (2017)	U.K.	Qualitative	N=475 Flexible ACT clients, 95 of whom were previously on ACT and 380 were on TAU
136	Svensson, et al. (2018)	Sweden	QED	N=84 clients
139	Trane, et al. (2022)*	Norway	Qualitative	N=5 rural Flexible ACT team leaders
129	van Veldhuizen (2007)	Netherlands	N/A (Descriptive)	N/A
141	Westen, et al. (2021)	Netherlands, Denmark, & Sweden	N/A (History)	N/A
Forensic ACT				
165	Cuddeback, et al. (2009)	U.S.	Qualitative	N=28 Forensic ACT teams
111	Cuddeback, et al. (2011)	U.S.	Qualitative	N=14 clients from four Forensic ACT teams
162	Cuddeback & Morrissey (2011)	U.S.	Qualitative	N= 654 ACT-eligible people, 641 Forensic ACT-eligible people
153	Cusack, et al. (2010)	U.S.	RCT	N=72 Forensic ACT and 62 TAU clients
154	Davis, et al. (2008)	U.S.	Pre/post	N=96 clients
166	Erickson, et al. (2009)	U.S	Retrospective design	N=130 clients
155	Kelly, et al. (2017)	U.S.	Pre/post	N=21 clients
158	Lamberti, et al. (2011)	U.S.	Qualitative	N=607 members of the National Association of County Behavioral Health and Developmental Disability Directors
151	Lamberti, et al. (2014)	U.S.	Qualitative	N=31 clients
161	Lamberti, et al. (2017)	U.S	RCT	N=35 Forensic ACT, 35 TAU
160	Marquant, et al. (2018)	Belgium	Retrospective design	N=70 Forensic ACT, 56 TAU
156	McCoy, et al. (2004)	U.S.	Pre/post	N=24 clients
159	Weisman, et al. (2004)	U.S.	N/A (Descriptive)	N=60 clients

Ref # in list	Authors, Year	Country	Study Design	Sample[a]
Rural Populations				
180	Aagaard & Müller-Nielsen (2011)	Denmark	QED	N=86 ACT; 88 controls; Denmark
179	Hastrup & Aagaard (2015)	Denmark	QED	N=81 ACT; 85 controls; Denmark
107	LeFebvre, et al. (2018)	Canada	Qualitative	Staff from five urban and three rural ACT teams; Ontario
181	Pope & Harris (2014)	Canada	Pre/post	N=29; Newfoundland and Labrador
168	Schroeder (2018)	U.S.	N/A (Descriptive)	N= 2 ACT teams, Portland, Maine (80-85 clients) and Brunswick, Maine (30-34 clients)
176	Siskind & Wiley-Exley (2009)	U.S.	Mixed-methods	N=440 rural North Carolina clients; N=62 urban Massachusetts
177	Stefancic, et al. (2013)	U.S.	Pre/post	N=170 clients; Vermont
169	Swanson & Trestman (2018)	U.S.	Qualitative	Ongoing study, sample size not reported; Virginia
139	Trane, et al. (2022)*	Norway	Qualitative	N=5 rural Flexible ACT team leaders; Norway
Youth and Adolescents				
198	Angell & Test (2002)	U.S.	Longitudinal analysis	N=87 clients, ages 20-32
191	Ahrens, et al. (2007)	U.S.	Pre/post	N=15 clients, ages 15-20
193	Baier, et al. (2013)	Switzerland	Pre/post	N=35 clients, ages 13-18
189	Broersen, et al. (2022)	Netherlands	Case study	N=1 client, from age 20 to 23
194	Daubney, et al. (2021)	Australia	Pre/post	N=243 clients, ages 13-19
190	Klodnick, et al. (2021)	U.S.	Longitudinal analysis	N=110 clients, ages 18-28
195	Mantzouranis, et al. (2019)	Switzerland	Pre/post	N=179 clients, ages 8-19
192	McFarlane, et al. (2015)	U.S.	Risk-based allocation design, AKA regression discontinuity	N=337 clients, ages 12-25
196	Urben, et al. (2015)	Switzerland	Pre/post	N=98 clients, ages 13-18
197	Urben, et al. (2016)	Switzerland	Longitudinal analysis	N=47 clients, ages 13-18
Older Adults				
208	Levin & Miya (2008)	U.S.	N/A (Descriptive)	N=42 clients
212	Mohamed, et al. (2009)	U.S.	N/A (Descriptive)	N=5,222 clients
210	Stanley, et al. (2023)	Canada	N/A (Descriptive)	N=68 clients at time of writing, 91 total clients admitted thus far
211	Stobbe, et al. (2014)	Netherlands	RCT	N=32 ACT, 30 TAU
209	Tau & Cohen (2022)	Canada	Qualitative, with descriptive statistics	N=12 ACT staff interviews, statistics on 763 clients
Immigrant Populations				
216	Chow, et al. (2010)	Canada	Mixed methods	N=14 clients, 20 family members, and 5 ACT staff Race/ethnicity of clients: Chinese and Tamil
30	Granias, et al. (2020)	U.S.	N/A (Primarily literature review)	N/A Race/ethnicity of clients: Southeast Asian (Hmong, Karen, Vietnamese, and Cambodian)
217	Law (2007)	Canada	Qualitative	N=90 ACT clients Race/ethnicity of clients: Chinese, Tamil, Vietnamese, Korean, Japanese, Afro-Caribbean, and Indigenous people
29	Yang, et al. (2005)	Canada	Pre/post	N=66 ACT clients Race/ethnicity of clients: Chinese, Tamil, Vietnamese, Caribbean, African, Indigenous people, Jewish, Iranian, and Somali

[a] Unless otherwise specified, N equals number of clients.

* This article is cited under multiple populations.

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