Assertive Community Treatment (ACT)

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What is Assertive Community Treatment (ACT)?
ACT is a service-delivery model that provides comprehensive, locally based treatment to people with serious and persistent mental illnesses. Unlike other community-based programs, ACT is not a linkage or brokerage case-management program that connects individuals to mental health, housing, or rehabilitation agencies or services. Rather, it provides highly individualized services directly to consumers. ACT recipients receive the multidisciplinary, round-the-clock staffing of a psychiatric unit, but within the comfort of their own home and community. To have the competencies and skills to meet a client's multiple treatment, rehabilitation, and support needs, ACT team members are trained in the areas of psychiatry, social work, nursing, substance abuse, and vocational rehabilitation. The ACT team provides these necessary services 24 hours a day, seven days a week, 365 days a year.

How did ACT begin?
Now in its 26th year, the ACT model evolved out of work led by Arnold Marx, M.D., Leonard Stein, M.D., and Mary Ann Test, Ph.D., on an inpatient research unit of Mendota State Hospital, Madison, Wisconsin, in the late 1960s. Noting that the gains made by clients in the hospital were often lost when they moved back into the community, they hypothesized that the hospital's round-the-clock care helped alleviate clients' symptoms and that this ongoing support and treatment was just as important - if not more so - following discharge. In 1972, the researchers moved hospital-ward treatment staff into the community to test their assumption and, thus, launched ACT.

What are the primary goals of ACT?
ACT strives to lessen or eliminate the debilitating symptoms of mental illness each individual client experiences and to minimize or prevent recurrent acute episodes of the illness, to meet basic needs and enhance quality of life, to improve functioning in adult social and employment roles, to enhance an individual's ability to live independently in his or her own community, and to lessen the family's burden of providing care.

What are the key features of ACT?
Treatment:
- Psychopharmacologic treatment, including new atypical antipsychotic and antidepressant medications
- Individual supportive therapy
- Mobile crisis intervention
- Hospitalization
- Substance abuse treatment, including group therapy (for clients with a dual diagnosis of substance abuse and mental illness)

Rehabilitation:
- Behaviorally oriented skill teaching (supportive and cognitive-behavioral therapy), including structuring time and handling activities of daily living
- Supported employment, both paid and volunteer work
- Support for resuming education

Support services:
- Support, education, and skill-teaching to family members
- Collaboration with families and assistance to clients with children
- Direct support to help clients obtain legal and advocacy services, financial support, supported housing, money-management services, and transportation

Who benefits from the ACT model?
The ACT model is indicated for individuals in their late teens to their elderly years who have a severe and persistent mental illness causing symptoms and impairments that produce distress and major disability in adult functioning (e.g., employment, self-care, and social and interpersonal relationships). ACT participants usually are people with schizophrenia, other psychotic disorders (e.g., schizoaffective disorder), and bipolar disorder (manic-depressive illness); those who experience significant disability from other mental illnesses and are not helped by traditional outpatient models; those who have difficulty getting to appointments on their own as in the traditional model of case management; those who have had bad experiences in the traditional system; or those who have limited understanding of their need for help.

What is the difference between ACT and traditional care?
Most individuals with severe mental illnesses who are in treatment are involved in a linkage or brokerage case-management program that connects them to services provided by multiple mental health, housing, or rehabilitation agencies or programs in the community. Under this traditional system of care, a person with a mental illness is treated by a group of individual case managers who operate in the context of a case-management program and have primary responsibility only for their own caseloads. In contrast, the ACT multidisciplinary staff work as a team. The ACT team works collaboratively to deliver the majority of treatment, rehabilitation, and support services required by each client to live in the community. A psychiatrist is a member of, not a consultant to, the team. The consumer is a client of the team, not of an individual staff member. Individuals with the most severe mental illnesses are typically not served well by the traditional outpatient model that directs patients to various services that they then must navigate on their own. ACT goes to the consumer whenever and wherever needed. The consumer is not required to adapt to or follow prescriptive rules of a treatment program.

Is there a difference between ACT and PACT?
There is no difference between the PACT (Program of Assertive Community Treatment) model and the ACT (Assertive Community Treatment) model. Not only does NAMI use ACT and PACT interchangeably, but ACT or PACT is also known by other names across the country. For example, in Wisconsin, ACT programs are called Community Support Programs, or CSP. In Florida, ACT programs are called FACT (Florida Assertive Community Treatment); in Rhode Island and Delaware ACT programs are called Mobile Treatment Teams (MTT), while Virginia uses PACT for its assertive community treatment teams. While the official name that a state, county, or locality uses for ACT varies widely, there is only one set of standards that NAMI sets forth for all programs of assertive community treatment.

How do ACT clients compare with those receiving hospital treatment?
ACT clients spend significantly less time in hospitals and more time in independent living situations, have less time unemployed, earn more income from competitive employment, experience more positive social relationships, express greater satisfaction with life, and are less symptomatic. In one study, only 18 percent of ACT clients were hospitalized the first year compared to 89 percent of the non-ACT treatment group. For those ACT clients that were re-hospitalized, stays were significantly shorter than stays of the non-ACT group. ACT clients also spend more time in the community, resulting in less burden on family. Additionally, the ACT model has shown a small economic advantage over institutional care. However, this finding does not factor in the significant societal costs of lack of access to adequate treatment (i.e., hospitalizations, suicide, unemployment, incarceration, homelessness, etc.).

How available are ACT programs?
Despite the documented treatment success of ACT, only a fraction of those with the greatest needs have access to this uniquely effective program. Only six states (DE, ID, MI, RI, TX, WI) currently have statewide ACT programs. Nineteen states have at least one or more ACT pilot programs in their state. In the United States, adults with severe and persistent mental illnesses constitute one-half to one percent of the adult population. It is estimated that 20 percent to 40 percent of this group could be helped by the ACT model if it were available.

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