

ACT Commonly Asked Questions

Q: What diagnoses qualify for ACT?

A: A primary diagnosis of Schizophrenia, Schizoaffective Disorder, Bipolar Disorder, or Major Depressive Disorder with psychotic features is required for ACT admission. A primary diagnosis of TBI, Substance Use Disorder, Anxiety Disorder, Borderline Personality Disorder, or Major Depressive Disorder without psychosis does not qualify an individual for ACT. Please refer to the Eligibility Guide for full criteria.

Q: How long does it take to get accepted to an ACT team once a referral is made?

A: The timeframe varies depending on team capacity and the availability of required documentation to establish medical necessity. Submitting complete and accurate documentation with the referral form can greatly decrease the time to intake. Priority is given to individuals who demonstrate the highest level of need, as well as those whose needs align with the services and supports the team is currently able to provide.

Q: Can a person living in a CADI-funded group home or assisted living facility receive ACT services?

A: No. This would be considered a duplication of services. If the individual is transitioning out of a group home or assisted living setting, they may be eligible if they meet all other ACT referral criteria. There *may* be some exceptions made in very rare circumstances upon approval from DHS commissioner.

Q: Can an individual receive CADI services in their own home and still be considered for ACT?

A: No. This would be a duplication of services. On very rare occasions, CADI funding for an extreme medical condition may be allowed in addition to ACT, but the identified service must clearly fall outside the scope of ACT's provided practices.

Q: If a person already has a psychiatrist or therapist, can they continue those services while on ACT?

A: No. This would be considered duplication of services. The ACT team provides both psychiatric and therapeutic services, and the individual must agree to transition to the team psychiatrist and therapist. ACT replaces other community mental health services such as psychiatry, therapy, case management, and ARMHS to ensure integrated, coordinated care.

Q: If the person is working with vocational rehabilitation services, can they continue with that provider?

A: No. This would be a duplication of services. The ACT team provides its own vocational rehabilitation and employment support through the team's vocational specialist.

Q: Can an individual referred to ACT continue formal substance use treatment?

A: The ACT team provides both individual and group treatment for substance use disorders and assists with connecting to self-support programs. Continuing with a separate SUD provider would be duplication of services, and a transition plan would need to be developed.

Q: How often does the ACT team meet with individuals?

A: Frequency varies by need. ACT is available on a 24/7 crisis basis and provides services multiple times per week. Most clients receive interventions from different team members two to three times per week.

A typical schedule includes:

- Individual session with primary staff (chart manager/case manager)
- Individual session with the ACT nurse for medication management
- Attendance at ACT groups (offered four times per week)
- Psychiatry sessions about once per month (or more frequently if needed). Service frequency is flexible and adjusted based on each person's clinical status and recovery needs.

Q: What is the ACT team's role with medications and appointments?

A: ACT nurses provide direct medication support, which may include delivery, monitoring, and education. They also assist clients with physical and mental health appointments, ensuring connection to care and follow-through. Nurses frequently use creative engagement strategies for clients who are ambivalent or anxious about healthcare needs.

Q: What if a person needs ACT but isn't willing or lacks insight?

A: ACT is designed for individuals who are ambivalent, resistant, or lack insight into their illness. Difficulty engaging in traditional services is a qualifying factor, not a barrier. The team uses persistent, compassionate engagement and motivational approaches to build trust. However, ACT is a voluntary service. If a person consistently declines participation

and does not wish to engage, they cannot be forced to remain enrolled unless under civil commitment or court order.

Q: Why won't the ACT team take a person who is in crisis or actively decompensating?

A: ACT is a long-term, rehabilitative treatment program, not a crisis stabilization service. It's designed to provide ongoing, intensive support that helps individuals stay out of crisis. Those in acute crisis (e.g., suicidal, violent, disoriented, or unable to safely function) often need a higher level of care first, such as residential treatment, inpatient hospitalization, or mobile crisis intervention, to stabilize. Once safety is ensured and the individual is stabilized, ACT may be appropriate to provide ongoing support, medication management, and skill-building to prevent future crises. Because ACT is rehabilitative, most individuals cannot effectively engage in its interventions during an active psychiatric crisis.

Q: Why do ACT staff, including nurses or therapists, take clients out to eat or shopping?

A: ACT is a rehabilitative, community-based model that helps individuals practice and generalize skills in real-life settings. What may look like “just going out to eat” or “shopping” is actually a purposeful, in-vivo skill-building and engagement intervention tied to treatment goals. All ACT staff are expected to meet clients where they live and function. Recovery doesn't happen in an office. It happens in the community. Meeting in neutral or enjoyable environments helps build rapport, decrease anxiety, and improve engagement. A simple coffee outing with a nurse may eventually foster trust that leads to acceptance of life-changing medication or greater stability.

Q: Why does it seem like some ACT clients never graduate from the program?

A: ACT serves individuals with severe and persistent mental illness who require long-term, intensive support to remain stable in the community. Some have chronic symptoms, limited supports, or cognitive challenges that make transition to lower levels of care unsafe or unrealistic. Graduation from ACT is based on functional stability, not time. Many individuals reach greater independence, while others may need ACT's ongoing support indefinitely to maintain wellness and prevent hospitalization, homelessness, or incarceration. The goal is always recovery and autonomy, but for some, continued ACT involvement *is* what recovery looks like.