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GACTA Global Assertive Community Treatment Association

GACTA Symposium

Advancing knowledge, connection, and better outcomes for people supported by ACT and FACT teams worldwide

Join this virtual event April 28–29, 2026 from 10 AM- 6 PM Eastern

Target Audience: All Providers, Family members, Researchers, and Individuals with lived experience

Cost (includes both days):
€60 & $70 US & $90 CAD
Registration: GACTA.net
Once you register you will receive a conference link in the week prior.
INQUIRIES: jmaher@cmhastarttalking.ca

Tuesday April 28, 2026

Schedule

10 AM	**Welcome** Welcome & Introduction The History of GACTA ***John Maher, MD, FRCPC, GACTA President***
10:30 AM	**GACTA Expert Panel** Updates on the different challenges in practice and service delivery throughout different regions of the world.
11:45 AM	**Denmark** Update from Denmark ***Anne Rosenquist,*** ***Bodil Lundsgaard Josephsen, Lone Tonsgaard***
12:45 PM	**Norway** ACT and FACT in Norway Results from a National Research based evaluations ***Hanne Clausen, MD, PhD Anne Landheim, PhD***
1:45 PM	**Break**
2 PM	**USA** Responding to Resistance and Repairing the Working Alliance ***Jeremy Evenden, MSSA, MBA, LISW-S***
4 PM	**USA** Family and Community Matter! ***Luis Lopez, MA, MS*** ***Helle Thorning, PhD, MS, LCSW***
5 PM	**Australia** Case Management and Assertive Community Treatment ***Alan Rosen, MD***

Wednesday April 29, 2026

Schedule

10 AM	**Welcome**
10:05 AM	**Canada** Ethics in ACT: Three Do or Die Questions ***John Maher, MD, FRCPC***
11:45 AM	**Canada** Medically Indicated Involuntary Addictions Care **Daniel Vigo, MD, Lic Psych, DrPH**
12:45 PM	**USA** NYS Peer Specialists: How Lived Experience Informs Fidelity **Mya Haley & Keiamesha (Kiki) Wilson, BA**
2 PM	**USA** Understanding and Preventing Criminal Legal Involvement Among Adults with Severe Mental Illness ***J. Steven Lamberti, MD***
3 PM	**Canada** ACT as Spiritual Practice ***Nigel Haggan, MA, MSc, PhD*** ***Cantor Michael Zoosman, MSM, BCC***
4 PM	**USA** ACT Daily Team Meeting as Core Hub for Essential Communication and Collaboration ***Lorna Moser, PhD***
5 PM	**USA** Stagewise Treatment -Tailoring Interventions to Readiness for Change ***Deana Leber-George, M.Ed., LPCC-S***
6 PM	**Closing Remarks** ***John Maher, MD, FRCPC, GACTA President***

Welcome Introduction

The History of GACTA

John Maher, MD, FRCPC

President, GACTA

Canada

Bio

Dr. Maher did his medical training at McMaster University, psychiatry residency at the University of Ottawa, and is a Fellow of the Royal College of Physicians and Surgeons of Canada. He has a BA in philosophy and MA in medical ethics.

He has been an Assertive Community Treatment (ACT) Team consulting psychiatrist for 20 years. He previously did adult and emergency psychiatry, was director of a personality disorders program, and provided consultations to transitional youth services, a mental health support court, and a college mental health service.

He was founder and Executive Director of the Trillium Childhood Cancer Support Centre, founding board member of the Canadian Candlelighters Childhood Cancer Foundation, Assistant Director of the National Cancer Control Task Force, Executive Director of Cancer Canada, and founder and Executive Director of Families and Children Experiencing AIDS (FACE AIDS).

He is currently Editor-in-Chief of the Journal of Ethics in Mental Health, President of the Ontario Association for ACT & FACT (OAAF), and President of the Global Assertive Community Treatment Association (GACTA).

GACTA Expert Panel

Moderators:

Luis Lopez, MA, MS

Helle Thorning, PhD, MS, LCSW

Speakers

John Maher, MD, FRCPC (Canada)

Lorna Moser, PhD (USA)

Niels Mulder, MD (Netherlands)

Juanjo Martínez Jambrina, MD (Spain),

Nora Miller, MD (Austria),

Sally Davidson, MD (New Zealand)

Description

- The GACTA Expert Panel will provide updates about the different challenges in practice and service delivery throughout different regions of the world. Join The Conversation!

Denmark: Three critical issues Large-Scale Implementation of Manualized Psychotherapy, IPS, and Integrated Dual-Diagnosis Treatment in Community Mental Health Services

Anne Rosenquist
Bodil Lundsgaard Josephsen
Lone Tonsgaard
Mental Health Care, Capital Region in Denmark
Denmark

Bio

The presenters hold overall responsibility for implementing F-ACT, IPS, and integrated dual-diagnosis treatment across Mental Health Services in the Capital Region of Denmark.

Learning Objectives

- Participants will gain insight into how manualized psychotherapy, IPS, and integrated dual-diagnosis treatment are being implemented across community psychiatric services.
- Participants will understand key clinical and organizational impacts of these large-scale reforms in the Capital Region of Denmark

Abstract

Community psychiatric services in the Capital Region of Denmark are undergoing substantial transformation through the implementation of three major initiatives aimed at improving access, coherence, and clinical outcomes for a diverse patient population. First, Flexible Assertive Community Treatment (F-ACT) teams increasingly serve patients with complex non-psychotic disorders who struggle to benefit from the region's existing psychotherapeutic programs. Approximately half of all F-ACT patients present with such profiles, prompting the development of two manualized, transdiagnostic treatment pathways based on Cognitive Behavioral Therapy (CBT) and Dialectical Behavior Therapy (DBT). These structured interventions are primarily offered in groups but can be flexibly adapted for individual treatment, while patients continue to receive assertive outreach and multidisciplinary support within the F-ACT model. Second, Individual Placement and Support (IPS) is being scaled nationally across Denmark. In the Capital Region, IPS specialists are embedded in outpatient psychiatric clinics organized as F-ACT teams, OPUS early-intervention services, and—currently in preparation—child and adolescent psychiatry and psychotherapeutic outpatient clinics. This expansion strengthens vocational recovery efforts across diagnostic groups and service settings. Third, major system changes are underway in the treatment of dual-diagnosis patients. Traditionally managed by municipalities, treatment of substance use disorders has now largely been transferred to hospital psychiatry (from 2025). This shift enables the provision of coordinated treatment for patients who can engage in services across sectors, and fully integrated treatment for those receiving both mental illness and substance use care within hospital psychiatry. The reform has required extensive competency development for staff across Danish mental health services. Together, these initiatives represent a comprehensive modernization of community-based psychiatric care in Denmark.

ACT & FACT in Norway
Results from National Research Based Evaluations

Hanne Clausen, MD, PhD
Anne Landheim, PhD

Norway

Research Center for Substance Use Disorders and Mental Illness, Innlandet Hospital Trust

Bio

Hanne Clausen and Anne Landheim are Norwegian researchers in health services research, specializing in mental health. From 2009, they have conducted comprehensive evaluations of ACT and FACT teams across the country, examining implementation, fidelity, and outcomes. Their work combines quantitative and qualitative approaches to inform mental health policy and clinical practice.

Learning Objectives

- Demonstrate that ACT and FACT can be successfully implemented across different contexts, including rural areas
- Describe the value of Norway's unique model of formalized collaboration between municipalities and specialist health services
- Highlighting how combining quantitative outcomes with qualitative data provides a comprehensive perspective on the impact of FACT for service users

Abstract

ACT was established in Norway in 2009, and FACT in 2013. In connection with the implementation of the two models in different Norwegian contexts, the health authorities initiated a research-based evaluation of the first 12 ACT teams and the first seven FACT teams in Norway. ACT teams were implemented in Norway from 2009 as part of a national initiative by the health authorities, with a structured, top-down implementation process supporting the establishment of the first 12 teams. FACT teams were implemented from 2013 through a similar national strategy. Both models represent a formalized collaboration between specialist health services and municipalities, a structure unique to Norway. In this presentation, we will describe the implementation of the two models in Norway, the collaboration between specialist health services and municipalities, and highlight key findings from our research. The presentation will summarize results from a research-based evaluation of the first 12 ACT teams and seven FACT teams. We will address target groups, the feasibility of implementation across different Norwegian contexts, and fidelity assessments (TMACT and FACT Fidelity Measurement 2010). Two-year outcomes at the individual level will also be presented, including income, activity, employment, housing, substance use, functioning, symptom severity, and quality of life, based on standardized measures. Changes in hospitalization rates, both voluntary and involuntary, between the two-year periods before and after enrolment into the teams are reported. Experiences from service users, relatives, and collaborating partners will also be presented. Finally, we discuss the implications of the research for policy development and clinical practice

Responding to Resistance and Repairing the Working Alliance

Jeremy Evenden, MSSA, MBA, LISW-S
The Center for Evidence-Based Practices, Case Western Reserve University **OH, USA**

Jeremy Evenden, MSSA, MBA, LISW-S, is the Manager of CEBP Accounts and Senior Consultant and Trainer at the Center for Evidence-Based Practices (CEBP) at Case Western Reserve University. He provides technical assistance (consulting, training, and evaluation) to organizations that are implementing evidence-based practices, emerging best practices, and other strategies that improve services and outcomes for people diagnosed with severe mental illness and co-occurring substance use disorders. He has consulted with organizations serving a variety of populations, including mental health, substance abuse, criminal justice, primary healthcare, children, adolescents, and families, developmental disabilities, housing, and employment. He is an adjunct instructor at the Mandel School of Applied Social Sciences, where he teaches Motivational Interviewing. Mr. Evenden is a member of the Motivational Interviewing Network of Trainers (MINT), an international association of trainers in MI. He received his undergraduate degree in Social Work from Ohio University in Athens, OH, and his Master of Science in Social Administration from the Mandel School of Applied Social Sciences and Master of Business Administration from Weatherhead School of Management at Case Western Reserve University in Cleveland, OH.

Learning Objectives

- Explain and recognize resistance (discord and sustained talk) within the change process.
- Identify staff behaviors to avoid that are likely to increase the frequency and intensity of discord and sustain talk.
- Understand how to respond effectively to discord and sustain talk to repair the working alliance.

Abstract

Motivational interviewing is an approach that promotes self-awareness and intrinsic motivation in a person. Resistance arises as a normal, expected dynamic within conversations exploring any change process.

Resistance can manifest in two forms: either discord (indicating a disconnect between the person and provider) and sustain talk (indicating the person is still not ready for change). The presence of discord or an increase in sustained talk is an indication that the provider needs to adjust their approach because the person may not feel understood and may feel pushed into a change they are not yet ready to pursue. When internal motivation still needs to be identified and developed, effective responses involve accepting and validating the person's perspective rather than challenging it. Responding to resistance avoids judgment, confrontation, and/or persuasion, which reduces defensiveness, builds rapport, and can increase the potential for the person to talk about change. Once resistance has been appropriately responded to and decreased, finding options to help the person become clearer and more achievable. Participants will learn to distinguish the types of resistance (discord from sustain talk) and strategic responses to skillfully respond without increasing resistance.

Family and Community Matter!

Helle Thorning, PhD, MS, LCSW
Luis Lopez, MA, MS
Columbia University, New York State Psychiatric Insitute & The Center for Practice Innovations **USA**

Helle Thorning, PhD, MS, LCSW-R, is a Clinical Professor of Psychiatric Social Work (in Psychiatry) at the Columbia University Vagelos College of Physicians and Surgeons.
Dr. Thorning is a clinician, educator, consultant, and researcher. Her work focuses on the development and implementation of educational and psychoeducational interventions aimed at improving quality of life and outcomes for individuals and families affected by trauma, behavioral health challenges, parenting under stress, and life transitions. She is a recognized trainer in Assertive Community Treatment (ACT) and Critical Time Intervention (CTI) and has published widely on interventions and the experiences of families and siblings in behavioral health contexts.

Luis O. Lopez, MA, MS, is the Director of I CONECT at CPI. He has an MA in Counseling from NJCU and an MS in Administration from Metropolitan College in NYC. He also studied philosophy and politics for 3 years at the New School for Social Research.
He is a counselor, a trainer, a consultant, and a coach. He has been in the field of Behavioral Health since 1987. He worked with NYC probation and NYC foster care services for a few years. He has over 15 years of experience working in housing services as a provider and as a trainer. He has been involved in the implementation and sometimes, unique application, of Evidence-Based Practices since 2003. He has been at the New York State Psychiatric Institute since 2013. He has expertise in the areas of Trauma Responsive Care, Motivational Interviewing, Dual Recovery, Group Dynamics, Cultural Humility, Stages of Change, Harm Reduction, WRAP, CBT, Wellness Self-Management, recovery-based language, Social Justice Advocacy and the ACT Model.
He has facilitated workshops in over 150 conferences nationally, in Canada, and in Europe. He has conducted consultations in Puerto Rico and the US Virgin Islands. In 2023, he presented in Leuven, Belgium, on the topic of Integrating Recovery in ACT Teams. In June 2024, he was asked to keynote on the topic of Supervising ACT Teams in Aviles, Spain. In June 2025, he presented in Denmark on topics of Recovery, team dynamics, and ACT fidelity. Additionally, he co-facilitated an international ACT expert panel.
He is the lead consultant of his LLC, LOL Connections. He is a member of the American Counseling Association and ACA-NY. He is a chess player, a Jiu-Jitsu practitioner, and a DJ at TWITCH TV and MIXCLOUD. He is also a founding member of GACTA (the Global ACT Association) and a board member of the ALLIANCE for Rights and Recovery.
Luis and Helle co-direct the GACTA curriculum workgroup, and they serve on the conference committee with Dr. John Maher.

Learning Objectives

- Learn to recognize the concepts underlying the duty to care and the dignity of risk paradigm
- Understand the value of the family lifecycle and mutuality, reciprocity, and resiliency in engagement and enhancement of the community of care in the context of Assertive Community Treatment
- Develop engagement strategies

Abstract

The dominant narrative across cultures presents people with living with behavioural health challenges relying on family for significant assistance and support, rarely engaging in positive adult relationships, unfit to be parents and needing to be protected from themselves. This overriding model of duty to care and risk aversion underlies many treatment approaches while the contributions made by persons with challenges to their families and communities have been largely overlooked.

This presentation will discuss family-based solutions and reciprocity from a life cycle perspective among ACT participants, family members and natural supporters as a critical component to enhance resiliency and recovery to foster communities of care.

Case Management and Assertive Community Treatment

Alan Rosen, MD
University of Sydney, University of Wollongong
Australia

Dr. Rosen is an officer of the Order of Australia, a Fellow of the Royal Australian and New Zealand College of Psychiatrists, is affiliated with the Brain & Mind Centre at the University of Sydney and the Institute of Mental Health at the University of Wollongong (Australia), and is Chair of Transforming Australia's Mental Health Service System (TAMHSS). He has been a psychiatrist serving Aboriginal communities in a remote region of New South Wales for 35+ years.

Learning Objectives

- Describe the evolution of community mental health services, including the shift from hospital-based care to community mental health teams (CMHTs)
- Compare key models of case management, including assertive community treatment (ACT) and other forms of community-based care coordination
- Evaluate the evidence base for case management approaches and explain potential reasons for international differences in reported effectiveness.

Abstract

Recent decades have seen the relocation of psychiatric care from hospital-based settings to community-based services in many countries. The initial phases of deinstitutionalization led to a replication of the general hospital outpatient clinic model for review of community patients by psychiatrists, but gradually, services began to expand the support available to people with more severe mental health problems. Over time, the addition of nurses, psychologists, occupational therapists, and social workers led to the establishment of community mental health teams (CMHTs). As community health and social care provision expanded, it became an increasingly complex system to navigate. Case management was developed to address this by assigning individual staff to assess service users' needs and coordinate their treatment and care.

Contemporary mental health services use a variety of models of case management, of which assertive community treatment (ACT) is the most intensive and clearly defined form. Assertive outreach is another term for ACT used in the UK. In some countries, case managers are referred to as 'care coordinators'. This presentation will explore these models of community mental health care, the evidence for them, and the possible explanations for the discrepancies in their effectiveness reported in the international literature.

Ethics in ACT: Three Do or Die Questions

John Maher, MD, FRCPC
Canadian Mental Health Association
Canada

- Is mandatory locked residential addiction treatment ethically defensible?
- Is paying clients money for medication compliance unethical coercion?
- Should ACT staff support or assist with physician-assisted suicide?

Learning Objectives

- Understand the issues of autonomy and duty to care in addictions survival strategies
- Understand the cost-benefit and moral justification for paying cash for medication compliance
- Understand the role of ACT care in suicide prevention in a rapidly modified moral environment

Abstract

The ethical territory for ACT teams is complicated and fraught with values clashes between protective postures and the fostering of autonomy. Capacity impairment often necessitates the provision of developmental scaffolding over the course of long term relationships. In too many instances ACT staff watch client's tragic slide to death from drug use within this prolonged opioid crisis. We also watch relapses from medication refusal and the subsequent chaos and trauma of hospital readmissions and sometimes heart wrenching suicide. And now in Canada we are being asked to shift our moral base from suicide prevention to indifference or outright support of a state sanctioned suicide pathway. What are our consciences and our professional duties demanding of us?

Medically Indicated Involuntary Addictions Care

Daniel Vigo, MD, Lic Psych, DrPH **Canada**

Chief Scientific Advisor for Psychiatry, Toxic Drugs, and Concurrent Disorders - Government of British Columbia & Provincial Medical Lead for the Advance Practice of Assertive Community Treatment (ACT-AP BC)

Daniel is a clinical psychologist, a medical doctor, and a university specialist in psychiatry. He obtained a Doctorate in Public Health from Harvard University, as well as Post-Doctoral Research and Clinical Fellowships at Columbia University (NY, US) and the University of British Columbia. He has 20+ years of clinical and supervisory experience, focused on the treatment of the most severely affected clients in various settings, including outpatient and inpatient care, community recovery centres, and specialized concurrent disorders care. He led a collaboration with King's College (UK) and Columbia University (US) to develop practice implementation guidelines for ACT in Argentina, where he was the Founding Director of the first Assertive Community Treatment Department, which he led for several years. He currently heads the Mental Health Systems and Services Lab at UBC, holds faculty appointments at UBC's Department of Psychiatry and School of Population and Public Health (as well as at Harvard Medical School), and is a Scientist at the Centre for Health Evaluation and Outcome Sciences at St. Paul's Hospital. Daniel has worked closely with the BC Ministry of Health and Health Authorities on various strategic health systems initiatives and currently leads Health Canada-funded implementation and evaluation projects at the national level. He is Provincial Medical Lead for the Advance Practice of Assertive Community Treatment (ACT-AP BC). Most recently he was appointed Chief Scientific Advisor for Psychiatry, Toxic Drugs, and Concurrent Disorders - Government of British Columbia, Canada.

Learning Objectives

- Understand who should be considered for involuntary addictions treatment.
- Learn about the operational model implemented in British Columbia.
- Appreciate the clinical complexities and challenges of supporting clients through their concurrent disorder/brain injury recovery pathways.

Abstract

We must take stock of the complexity of concurrent disorders and acquired brain injury in the context of addiction to toxic and new illicit drugs. Health Minister Josie Osborne said the ongoing toxic drug crisis has led to a "small but growing number of people who are living with overlapping mental-health and substance-use challenges, as well as brain injuries from repeated overdoses." Dr. Vigo is overseeing the creation of new, highly secure facilities where people held under the Mental Health Act can receive involuntary treatment, housing and support. He has laid out three specific scenarios under which people with substance-use disorders could be admitted for involuntary care: if they had simultaneous mental disorders; if they had an acute and severe psychiatric condition with unknown causes; or if they had ongoing mental impairment after an acute crisis had passed. All pertain to people with overlapping psychiatric and addiction problems. Crucially, the recommendations do not permit the authorities to hold people solely for addiction. But under Dr. Vigo's guidelines, a physician could point to the patient's history, conclude their drug use meant they'd be back shortly and hold them for longer to treat their mental illness. Involuntary treatment "can be a tool to preserve life and treat the source of impairment" among those with complex needs.

NYS Peer Specialists:
How Lived Experience Informs Fidelity

Mya Haley
Keiamesha (Kiki) Wilson, BA
ACT Institute New York State **USA**

Learning Objectives

- Understand how Peer Specialists function on NYS ACT Teams
- Recognize how the core values of Peer Specialist work are also the foundational EBPs that make the ACT model what it is
- Brainstorm and plan for continued partnership and support of Peer Specialists beyond the conference

(Elizabeth) Mya Haley, is the Coordinator of Best Practices and Fidelity at the ACT Institute in New York State. She is also a former and forever Peer who has spent much of her career working with, for and alongside a community of those who have been serviced by the mental health system. The work that Mya does spans across and impacts ACT teams across New York State. Her ethos is simple: First, ask why are things the way they are? Second, brainstorm ways that things can be better, while ensuring to welcome and truly partner with those impacted in the process. This is what led to her work in fidelity, in understanding the model and being inspired create dynamic, accessible ways of teaching, learning and cross-training betwixt the ACT Institute and providers doing the community work.

Keiamesha, affectionally referred to as "Kiki" has served in numerous capacities within in community mental health programs for more than 10 years. Kiki received her Bachelor of Arts degree from the College of New Rochelle. Kiki has more than four years of ACT experience, having held several roles on New York City teams and has experience with Personalized Recovery Oriented Services (PROS), having served as a recovery specialist. Additionally, Keiamesha served several years working with the undomiciled population in New York City, as a Housing Outreach Specialist, helping a diverse population connect and or reconnect to recovery services and to secure permanent housing.
Kiki's work is guided by her passion for working with marginalized communities, helping those individuals find their voice, and for being an advocate for culturally sensitive, person-centered, recovery-oriented care. Kiki uses her lived experience of mental health challenges (direct and indirect via family members), navigating the criminal justice system, and the impact of systemic challenges to inform her work and be a conduit for change.

Understanding and Preventing Criminal Legal Involvement Among Adults with Serious Mental Illnesses (SMI)

J. Steven Lamberti, MD **USA**

Professor of Psychiatry, University of Rochester Medical Center

Dr. Lamberti is Professor of Psychiatry at the University of Rochester Medical Center (URMC), where he divides his time between teaching, conducting research, and providing clinical care. He received his medical degree from the University of Missouri and completed his psychiatry residency and a neuropsychiatry fellowship at URMC. Dr. Lamberti's career is dedicated to promoting recovery among adults with schizophrenia spectrum disorders, with a focus on preventing hospitalization, arrest, and incarceration through collaboration between families, clinicians, and criminal justice professionals. Dr. Lamberti and his research team have conducted numerous clinical trials evaluating novel medications for treating psychosis and accompanying symptoms. He has also received funding from the National Institute of Mental Health, the Robert Wood Johnson Foundation, and Arnold Ventures to lead development of the Rochester forensic assertive community treatment (FACT) model. For their pioneering work in developing FACT, Dr. Lamberti and his colleagues received the 1999 American Psychiatric Association (APA) Services Achievement Gold Award, the 2002 New York State Community Health Improvement Award, and the 2009 NAMI New York Program Award. Dr. Lamberti is also a recipient of the 2004 APA Van Ameringen Award for Psychiatric Rehabilitation and the 2018 CIT Appreciation Award from Crisis Intervention Team International.

Learning Objectives

- Discuss why adults with SMIs are overrepresented across the criminal legal system.
- Describe a unified framework for understanding and preventing arrest and incarceration of adults with SMIs.
- List current best practice approaches for preventing criminal legal involvement among adults with SMIs.

The prevalence of adults with serious mental illnesses (SMIs) is approximately three to four times higher within jail, prison, probation, and parole populations than in the general public. Understanding of this complex problem requires examination from sociological, criminological, and clinical perspectives. Sociological analysis demonstrates how stigma, poverty, racial inequities, and punitive enforcement and sentencing practices channel vulnerable individuals into arrest and detention. Criminological science demonstrates that the presence and accumulation of empirically validated criminogenic risk factors increase the likelihood of recidivism. Clinical research, in turn, demonstrates that untreated symptoms and limited access to evidence-based treatments increase the likelihood of crisis and subsequent arrest and incarceration.

Informed by these perspectives, a unified framework is presented for understanding and preventing criminal legal involvement among adults with SMIs. This framework points not to mental illness as the primary driver of arrest and incarceration but to a mismatch between the needs of people with SMIs and institutions ill-equipped to respond to them. Using this framework as a springboard, this presentation will discuss current best practice approaches to preventing criminal legal system involvement among adults with SMIs. These approaches include assisted outpatient treatment, forensic assertive community treatment, crisis intervention teams, critical time intervention, mental health courts, and specialty (mental health) probation and parole.

ACT as Spiritual Practice

Nigel Haggan
Family Advisory Committee, BC ACT
Cantor Michael Zoosman,
Spiritual Health Practitioner, Vancouver Coastal Health
BC, Canada

Bio

Nigel Haggan grew up between the polite streets of middleclass protestant Belfast, the tidepools of Belfast Lough and the predominantly Roman Catholic borderlands between the N and South of Ireland. Exposure to diverse cultures and work with Aboriginal people, opened his eyes to different ways of understanding and being in the world. His recent work explored the harm caused by exclusion of the spiritual dimensions of knowledge from higher education. He is a passionate advocate for the inclusion of spirituality as vital to the immediate care and long-term flourishing of ACT clients, carers and their families.

Learning Objectives

- Understand spirituality as an integral dimension of existence, vital for flourishing of clients, their families, and ACT Team Members
- Understand the concept of 'Spiritual Attending' or 'Deep Listening' that starts from a place of 'not knowing' as opposed to a diagnosis
- Understand the rationale for a Spiritual Health Practitioner on every ACT team

Abstract

We contrast the centrality of spirituality in Indigenous science and medicine with marginalization in mainstream practice. We review past and present causes of exclusion and the consequent burden on Indigenous people as perceived leaders in spirituality. We suggest that religion, philosophy and science are, in their own way, inspired and driven by Rudolf Otto's concept of the sacred as terrifying, irresistible and mysterious—the more you learn, the more there is to know. Spiritual care workers start from a non-diagnostic place of not knowing and a practice of deep listening, where clients may feel safer to express themselves. They also act as a countervail to the toxic religious influence and conspiracy theories to which sufferers from SMI/SU are particularly prone. A 'Report from the Field' from a Spiritual Health Practitioner serving 5 Vancouver ACT teams demonstrates clear need and appreciation but equally deep concern about the ability of one person to serve 275 clients and 92 staff. Together, we make the case for a full-time Spiritual Health Practitioner on every ACT team.

ACT Daily Team Meeting as Core Hub for Essential Communication and Collaboration

Lorna Moser, PhD

USA

Center for Excellence in Community Mental Health, Dept of Psychiatry, UNC-CH School of Medicine

Lorna Moser, PhD, is a Clinical Associate Professor in the Department of Psychiatry at the University of North Carolina at Chapel Hill. She is the Director of the Institute for Best Practices and provides training, consultation, and evaluation services in support of assertive community treatment (ACT) across the United States and abroad. Lorna is the co-author of the Tool for Measurement of ACT (TMACT), a contemporary measure of ACT fidelity, as well as co-developer of eTMACT, a software as a service (SaaS). Lorna conducts research examining the facilitators and barriers to higher-fidelity ACT implementation and was the Principal Investigator on the National ACT Study, funded by Arnold Ventures. Lorna has worked in various behavioral health settings, including on two ACT teams, and is a licensed clinical psychologist.

Learning Objectives

- List the core functions of the ACT daily team meeting and where teams typically do well and where they often struggle
- Describe the purpose of the client (patient) roll call and client log
- Explain how a "team approach" to service delivery is orchestrated through staff scheduling
- in the daily team meeting

Abstract

Assertive Community Treatment (ACT) teams meet four to five days each week for a daily team meeting that functions as the program's central mechanism for continuous data sharing and coordinated care. This meeting brings together recent assessment information, risk updates, engagement status, and emerging clinical or environmental concerns, allowing the team to adjust plans for the next 24 hours with shared situational awareness. It is also the primary venue for brief clinical case discussions, where multidisciplinary perspectives are integrated into a unified, person-centered approach.

The meeting's structure reinforces ACT's shared caseload model by ensuring that psychiatrists, nurses, peer specialists, substance use specialists, employment specialists, and other clinicians contribute to a common understanding of each individual's needs. Healthy debate within agreed-upon practices strengthens clinical decision making, supports fidelity to the model, and promotes consistent communication across disciplines. By design, the meeting enables rapid response to changes in the individual and/or their environment, while maintaining continuity and accountability across the team.

This presentation will examine how the daily team meeting anchors communication, collaboration, and timely decision-making for teams serving individuals with higher needs and higher risks. Drawing on data from a national U.S. ACT study, we will highlight common patterns in team performance, including areas where ACT teams demonstrate strong fidelity and areas where meeting processes are more vulnerable to drift. These findings will be used to illustrate practical strategies for strengthening daily team meeting routines, enhancing interdisciplinary coordination, and improving outcomes for the people served.

Stagewise Treatment - Tailoring Interventions to Readiness for Change

Deana Leber-George, M.Ed., LPCC-S

USA

The Center for Evidence-Based Practices, Case Western Reserve University

Deana Leber-George, MEd, PCC-S, is the Manager of Training and Consultation at the Center for Evidence-Based Practices (CEBP) at Case Western Reserve University. She provides technical assistance (consultation, training and evaluation) to service systems and organizations that are implementing evidence-based practices, emerging best practices, and other strategies that improve quality of life and other outcomes for people diagnosed with severe mental illness and substance use disorders.

Learning Objectives

- Explain the core elements of behavior change and describe how the Transtheoretical (Stage of Change) Model offers an evidence-informed framework for supporting individuals as they move through the change process.
- Differentiate among the stages of the Transtheoretical Model and apply interventions that are appropriate to a person's present readiness for engagement and movement toward change.
- Utilize approaches that effectively navigate ambivalence and build motivation for change across behavioral healthcare environments.

Abstract

Behavioral change rarely occurs in a single step; instead, individuals move through predictable phases that reflect increasing readiness to adopt and sustain new behaviors. A stagewise approach helps clinicians match interventions to where a person is in that process, ensuring care that is both clinically appropriate and responsive to the individual's current needs. By using a structured, evidence-supported framework, providers can more effectively guide clients through the change process and improve engagement, retention, and overall treatment success. Decades of research affirm that interventions tailored to readiness for change lead to stronger motivation, better adherence, and improved clinical outcomes across behavioral and physical health settings (Prochaska & DiClemente, 1986; Miller & Rollnick, 2023).

This training equips behavioral healthcare professionals with the practical knowledge needed to operationalize stagewise treatment in everyday practice. Participants will learn how to assess readiness, select interventions that reflect stage-matched needs, and apply strategies that help individuals advance toward meaningful and lasting change.