ACT Center of Indiana

Excellence in Training, Research, and Technical Assistance

July 2003

Volume 2 ❖ Issue 3

Notes from the Directors

Co-Directors

Michelle Salyers & Mike McKasson

We hope you are enjoying what's left of a busy summer. First, we'd like to welcome our 3 new ACT sites: BehaviorCorp, Tri-City, and Wabash Valley. We've started meeting with each of these agencies and are gearing up for more intensive skills training with them this quarter. On the dual disorders front, we are pleased to welcome Jim Matthews (Gallahue) as statewide trainer/consultant for this project. He will be assisting 4 sites. In addition, Pat Browne (Midtown) will be acting as consultant for one site. Four of the IDDT sites will have an internal trainer for the model, and Jim and Pat will be assisting with the consultation piece. At the end of July, Jim, Pat, and 3 internal trainers (Martha Gibson from Midtown, Phyllis Scott from Cummins, and Becky Powell from CMH (Anderson)) attended a train-the-trainer workshop hosted by our colleagues in Ohio. We are excited to see this new phase of training for our state.

During this quarter, we were pleased to host Mary Brunette, MD, of Dartmouth Medical School and the NH-Dartmouth Psychiatric Research Center. She presented 2 all-day workshops in May (one in central Indiana (Indianapolis-IUPUI) and one in northern Indiana (Elkhart-Oaklawn)) on medical issues related to treating the dually-diagnosed population (mental illness and substance use disorders), the IDDT model, and motivational interviewing skills and techniques. Thanks to all of you who participated in these events.

We saw several of you at this year's annual conference of the ACT Association in San Antonio. Several of us presented at the conference. We look forward to seeing you at ACTA in Philadelphia next year. We also enjoyed DMHA's conference this summer on dual disorders and were pleased to see many of you there.

This summer we also hosted visitors from the Netherlands, Bianca van Dijk, Bert-Jan Roosenschoon, and Michel de Baan, who are implementing and researching ACT in their country. During their visit, we trained them on fidelity assessment, including a site visit to Adult & Child. Our visitors also presented to us "Mental Health Practices and ACT in the Netherlands." Their talk was very interesting,

Above (left to right): Natalie DeLuca, Bianca van Dijk, Gary Bond, Alan McGuire, Michel de Baan, Marc Lauritano, Veronica Pedrick, Kikuko Campbell, Bert-Jan Roosenschoon

highlighting the differences of our countries' mental health systems and implementation of ACT services. We were delighted to have Bianca, Bert-Jan, and Michel visit with us and for us all to mutually benefit by sharing information and gaining useful ideas for improvements and areas for growth. (See group picture above.)

We've also been busy on the research side of things. We recently applied for two new grants. One is a Phase II Community Action grant that would allow us to expand upon the grant we were awarded last year to implement IDDT in our state. The second proposal is to expand our capacity for consultation and training by partnering with several of our colleagues at the New Hampshire-Dartmouth Psychiatric Research Center, Kansas School of Social Work, and Thresholds. This project includes proposals for 12 different research projects that would help us better understand how to improve community integration for adults with severe mental illness.

We'd also like to share some ACT Center news. We are proud to announce that Angie Rollins will be the new Research Director for Thresholds in Chicago. This is a great move for her (and for Thresholds), but she will be sorely missed here! We wish you the best and look forward to our continued collaboration. We would also like to welcome our newest little ACT Center member, Christine…Hea-Won and family are doing well. And, congratulations to Alan McGuire, one of our graduate students, who recently married. We wish you and Shannon well!

See page 2 for details of what's included in this issue!

In This Issue

Our newsletter has gone electronic!

With our mailing list growing through the roof, we've decided to switch to an email and website-based quarterly newsletter. Starting with this issue, look for our newsletter over our LISTSERV or at www.psych.iupui.edu/ACTCenter. You can find all of our past issues on the website, too!

Don't have access to email or the internet? Like a printed copy mailed to you? Just let us know! For those receiving the electronic version, please feel free to forward or print and share with others!

Improved Fidelity in Indiana's ACT Programs: It's Happening!

By Kikuko Campbell & Gary Bond

As part of the work of the ACT Center in helping community mental health centers around the state implement ACT, we have been using tools known as *fidelity scales.* These are scales that measure whether a program is implemented according to the program principles. We are pleased to report the progress of Indiana ACT teams implemented since 2000.

The basic premise for using fidelity scales is that **programs that most successfully implement evidence-based practices have the best outcomes**. This finding has been borne out in research studies (Bond, Evans, Salyers, Williams, & Kim, 2000). Fidelity scales have many practical and research uses. One practical use is to provide guidelines for implementing an evidence-based practice in a new state or region, as is happening today in Minnesota, New York, Iowa, and other states. A second use is for a state authority to monitor progress of programs involved a statewide dissemination. A third use of fidelity scales, which is perhaps the most valuable in the work of the ACT Center, is to provide *site-specific feedback.* In this application, fidelity assessors give concrete and specific feedback to individual sites as they go through the growing pains of start-up. We have found that it is useful to make ratings of a program at "baseline," that is, before the program has actually been officially started. This gives program leaders a sense of how far they need to go to achieve full implementation. Subsequently, routine use of fidelity scales provides an objective, structured way to give feedback about program development. Furthermore, fidelity scales provide an excellent method to diagnose program strengths and weaknesses. Trainers from the ACT Center prepare fidelity reports, which give specific feedback about the degree of progress as well as where programs need to improve.

Developed in 1998 in consultation with a national group of ACT researchers, the Dartmouth ACT Scale (**DACTS**) has become one of the most widely used fidelity scales for ACT programs (Teague, Bond, & Drake, 1998). The DACTS consists of 28 items tapping the critical ingredients of ACT ("*Small Caseload*," "*Substance Abuse Specialist on Staff*," "*Explicit Admission Criteria*," "*Time-Unlimited Services*," etc.), each rated on a five-point, behaviorally-anchored scale with a score of 5 indicating *full implementation,* 4 indicating *moderate implementation,* and the remaining scale points indicating increasingly larger departures from the ACT standards. The DACTS Total score is used to identify the overall fidelity of the program. It consists of the mean across 26 of the 28 items. (Two items that were added after the initial psychometric study—"*Program Size*" and "*Role of Consumers on Treatment Team*"—were excluded from the Total). Based on research, **the standard for a high fidelity ACT program is a score of 4.2 on the DACTS** (Salyers, Bond, Teague, et al., 2003).

Cont'd next page . . .

To maximize the validity of data collection procedures, fidelity assessments are conducted through a daylong site visit, with multiple sources of information including chart review, review of written materials (e.g., policy, handouts), observation of team meetings, and semi-structured interviews with the program leader, practitioners, and consumers. At least two trained assessors are present during a fidelity visit, who rate the items independently and then compare their ratings to reach a consensus rating for each item after the site visit.

As reported in our previous newsletters, as part of the National Evidence-Based Practices Project, Indiana is providing state-of-the-art training technology and consultation, along with fidelity monitoring, to 8 ACT and 6 integrated dual disorders treatment programs newly established in 2002. As part of the National EBP Project, we are conducting fidelity assessments every 6 months. We have fidelity information for these 8 ACT teams (**2nd Cohort**) and 3 ACT teams that have been operating since 2000-2001 (**1st Cohort**).

The graph below shows the participating programs' fidelity over time as measured by DACTS Total. For programs of the 2nd Cohort, fidelity ratings have been obtained at kick-off (**Time 1**) and at 6 months (**Time 2**). One program has not yet had the 6-month fidelity assessment and is not included in the graph. For programs of the 1st Cohort, Time 1 fidelity ratings were obtained at least 6 months after their kick-off date and Time 2 ratings were obtained at a 12-month interval. This is reflected in their much higher Total score at Time 1 compared with the 2nd Cohort programs.

Graphing the fidelity scale score is a simple way to visualize progress of implementation. As you can see, all programs demonstrate greater fidelity over time. **On average, the DACTS Total for the newly established programs in the 2nd Cohort increased from 3.5 at kick-off to 4.1 at 6 months.** Also encouraging is that by the 6-month point, program fidelity of three of the 2nd Cohort programs improved by approximately 1.0 point on the DACTS.

Another feature of graphing fidelity is to examine a cut-off score for "full implementation." Programs can use this score as a target and can gauge how they measure up. Research indicates the following cut-off scores for DACTS: programs with the total exceeding 4.2 are classified as "high fidelity ACT teams" while those with the total exceeding 4.0 but falling short of 4.2 are classified as "achieving moderate implementation." Based on these cut-off scores, **all three of 1st Cohort programs are classified as high fidelity ACT teams at Time 2,** where they have been in operation for at least 1.5 years. What is exciting is that 3 of the 8 programs in the 2nd Cohort are already classified as high fidelity ACT teams at 6 months! Over the next year we expect further improvements in program fidelity.

References

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Salyers, M. P., Bond, G. R., Teague, G. B., et al. (2003). Is it ACT yet? Real-world examples of evaluating the degree of implementation for assertive community treatment. Journal of Behavioral Health Services & Research, 30, 308-324.

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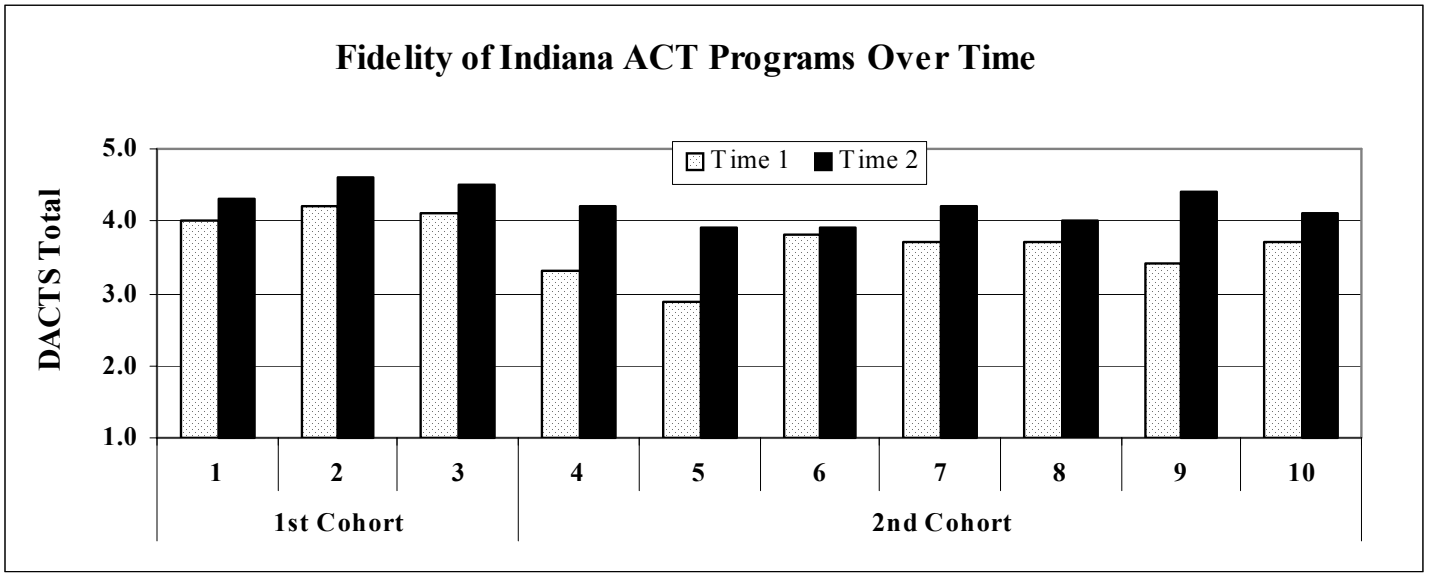

Converting Day Treatment to Supported Employment

By: Gary Bond

Four studies have been conducted examining the effectiveness of converting day treatment services to supported employment (Bailey, Ricketts, Becker, Xie, & Drake, 1998; Becker et al., 2001; Drake et al., 1994; Drake, Becker, Biesanz, Wyzik, & Torrey, 1996; Gold & Marrone, 1998). These studies have involved 6 different sites converting from day treatment to supported employment, 5 of which closed down their day treatment services altogether (Becker et al., 2001; Drake et al., 1994; Drake et al., 1996) and one which curtailed its day treatment services (Bailey et al., 1998). The first study involved a comparison with a center that did not initially convert its services (Drake et al., 1994), but later did (Drake et al., 1996), the second compared a portion of their program that converted to a group of clients not involved in the conversion (Bailey et al., 1998), the third compared two centers undergoing conversions to one that did not (Becker et al., 2001), and the fourth was a before-after comparison of a day treatment program in which clients had averaged over 8 years on attendance and had been referred to the program because they had "no rehabilitation potential." Altogether, these studies included 317 clients in sites converting to supported employment and 184 clients in the comparisons sites. During the baseline period (ranging from 3 to 12 months), the employment rate was 11% in the conversion sites and 12% in the comparison sites. During follow-up (ranging from 3 to 18 months) 43% of the clients in the supported employment sites worked competitively, compared to 17% of the clients in the comparison sites.

On average, then, the percentage of clients who work quadruples after conversion of day treatment to supported employment.

References

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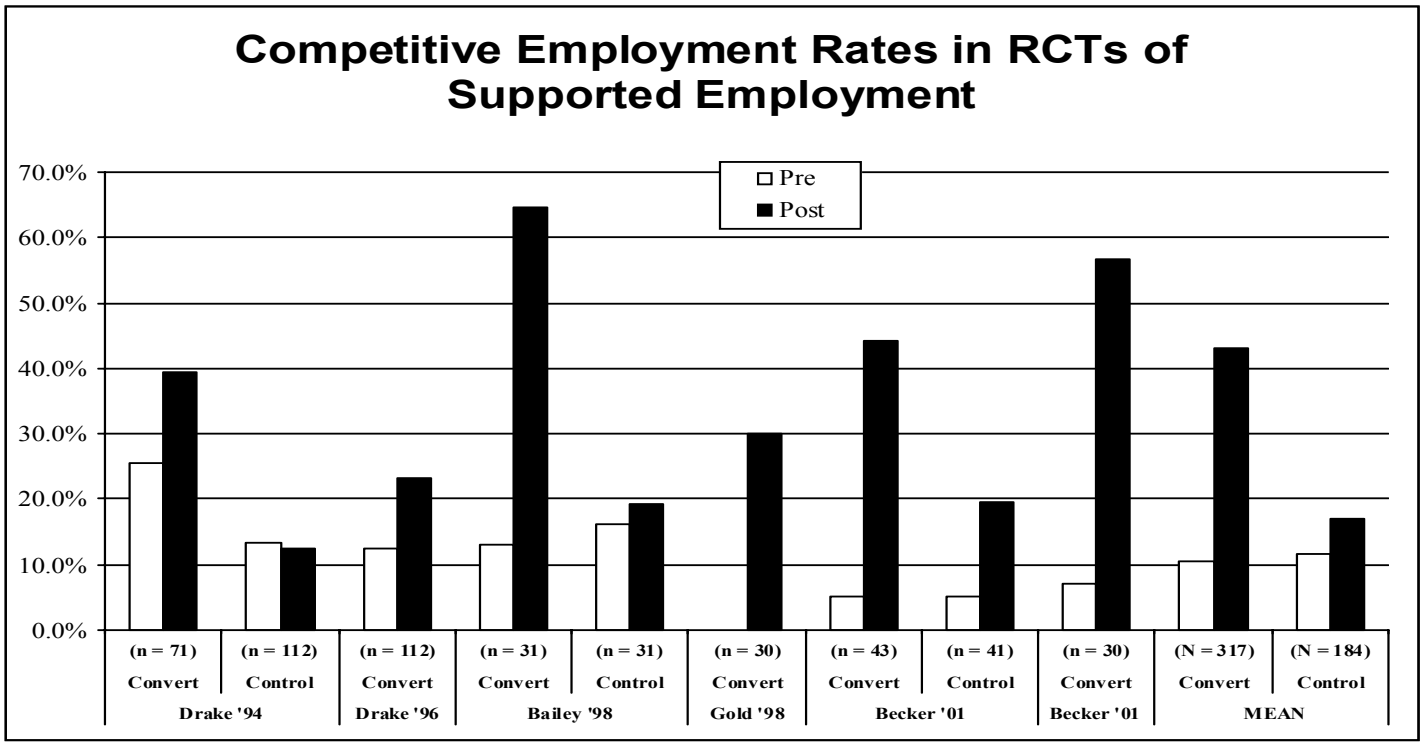
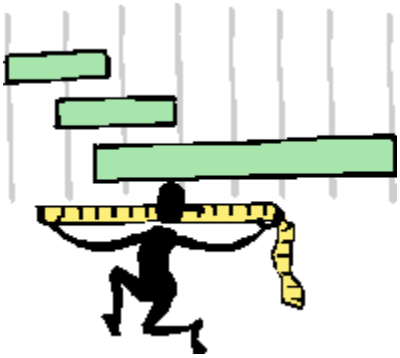


Notes: Drake '94 and '96 based on 1-year baseline and 1-year follow-up; Bailey (1998) baseline based on 3-month period before conversion and post data based on final 3-month period of follow-up year; Gold '98 based on indeterminant baseline period before conversion and 1-year follow-up; Becker '01 based on 6-month baseline and 18-month follow-up.



_ _ _Meaningful Measures_ _ _

The Importance of Monitoring Outcomes

By: Michelle Salyers

The driving force behind all we do in mental health services is the improvement of consumer outcomes. We want to see those we work with feel better and lead healthy fulfilling lives with meaningful activities and strong relationships. How do we know when we are meeting these goals? As practitioners, you can see these results when working closely with the consumers on your team. But without a systematic way to monitor outcomes, it is difficult to see the larger picture, for example, patterns over time or changes for a group of people such as the caseload a team is serving.

From the work of Deming (Deming, 1986) and the quality improvement movement in industry, we know that organizations that are focused on simple measurable goals are generally more successful at achieving these goals. In other words, organizations in which workers discuss desirable goals on a frequent and continuing basis in team meetings, use observable indicators as a way of communicating achievement of team goals, and ensure goals are the shared objective of all staff tend to be successful in the target areas. Thus, the very act of focusing on outcomes can further improve them.

As Charlie Rapp, Ph.D., discussed in his presentation here in January 2003, numbers can have a dramatic effect on our behavior. The balance in your bank account, the price of stock in your retirement fund, the number on your bathroom scale…each of these can be a strong motivating factor in our everyday behavior. Similarly, attention to the numbers showing progress on our program goals can be motivating for a team.

Outcomes can also provide a powerful message to payors…that the services they are paying for are actually working. We know from prior studies that evidence-based practices work. But it is still vital to show funding sources (e.g., Medicaid, DMHA), lawmakers, and other policy-level stakeholders that these practices are working *in Indiana* and that they are worth the effort and money being invested.

Clearly, attention to outcomes is important, but what is the best way to accomplish this? Outcome measurement should be *pertinent*, reflecting the goals of the program…what areas do you and the consumers you serve hope to impact most? Measurement should be *simple* and *objective*. If outcomes are too detailed or too complex, they will not be measured, or they will not be measured *accurately*. Outcomes should be *useful*. It does little good for a program to compile data without seeing their progress on those outcomes.

In the case of Indiana ACT teams, state standards require that teams track progress on hospitalization, level of independent living, and employment outcomes on a quarterly basis. We would also encourage programs to track substance use and incarcerations as well. These are 5 basic domains with relatively objective measures.

In the past, we have provided simple tracking systems using Excel spreadsheets that programs could use. Now we recommend the *Consumer Outcomes Monitoring Package* (COMP) (Press, Marty, & Rapp, 2003) developed by Charlie Rapp, Ph.D., and colleagues for the National EBP Project. The COMP software allows clinicians to enter consumer level data on a variety of areas and can produce user-friendly reports. Programs can use these reports in supervision, to track areas in which the program appears to be having a positive impact and to identify those areas that the program needs to focus on. Visual representations, e.g., bar graphs over time, can serve as a powerful stimulus for program development. The COMP software is available and is currently being refined for use in Indiana.

The bottom line is that monitoring outcomes is crucial to the success of any mental health service. There are many ways this can be accomplished, and we suggest one easy tool. Regardless of the approach you use, we are happy to consult with our programs on these issues. Our trainers will be discussing the process with teams during our upcoming visits.

References

Deming, W. E. (1986). Out of crisis. Cambridge, MA: Massachusetts Institute of Technology, Center for Advanced Engineering Study.

Press, A. N., Marty, D., & Rapp, C. A. (2003). Consumer Outcome Monitoring Package. University of Kansas.

Recommended Resources

Integrated Treatment for Dual Disorders: A Guide to Effective Practice
Kim T. Mueser, Douglas L. Noordsy, Robert E. Drake, & Lindy Fox (2003)

Brief Description (excerpt from website):
This comprehensive clinical handbook provides virtually everything needed to plan, deliver, and evaluate effective treatment for persons with substance abuse problems and persistent mental illness. From authors at the forefront of the dual disorders field, the book is grounded in decades of influential research. Presented are clear guidelines for developing integrated treatment programs, performing state-of-the-art assessments, and implementing a wide range of individual, group, and family interventions. Also addressed are residential and other housing services, involuntary interventions, vocational rehabilitation, and psychopharmacology for dual disorders. Throughout, the emphasis is on workable ways to combine psychiatric and substance abuse services into a cohesive, unitary system of care. Designed in a convenient 8½" x 11" format, the volume contains all needed assessment forms, treatment planning materials, and client handouts, most of which include permission to photocopy.

Key Features:

* First book to present an evidence-based integrated treatment framework for dual disorder

* Authors have national reputation; Mueser speaks often

* Tons of reproducibles, handouts, assessments for real clinical practice

* Comprehensive: every aspect of treatment addressed

* For both psychiatric and addictions professionals

List Price: $42.00
See website for more details! www.guilford.com

Evidence-Based Practices in Mental Health Care
American Psychiatric Association (2003)

Brief Description (excerpt from website):
As the first attempt to synthesize the movement toward widespread implementation of evidence-based mental health practices, this groundbreaking collection articulates the basic tenets of evidence-based medicine and shows how practices proven effective by clinical services research could improve the lives of many people.

Intended to stimulate much-needed public discussion, these remarkable contributions cover both *general issues*, such as . . .

* Implementing practices in routine mental health settings, including strategies for disseminating evidence-based practices to staff members

* Ensuring that efforts to implement such practices are informed by the knowledge and experience of administrators, clinicians, patients, and advocates

* Integrating evidence-based practices with the recovery model and focusing on guidelines and algorithms for pharmacologic treatment of people with severe mental illness

* Identifying the policy implications of the movement, particularly in public-sector settings, and describing eight courses of action for addressing the gap between science and practice

and *specific practices*, such as

* Describing critical components of practices for which substantial evidence exists, such as supported employment, dual diagnosis services, and assertive community treatment

* Developing an evidence base for particular populations, such as children and adolescents and geriatric patients; and for clinical subgroups, such as patients with severe mental illness and posttraumatic stress disorder—and implementing a range of practices for each population

List Price: $19.95
See website for more details! www.appi.org

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Check out our website @ www.psych.iupui.edu/ACTCenter

ACT Certification Rule Nears Completion

An Update from
Charles Boyle
DMHA Bureau Chief
for Adults with Mental Illness

The process for creating a certification rule is a cumbersome one. There are numerous steps and regulations to follow for promulgation of a new rule. The premise for these regulations is to guarantee ample opportunity for public comment on the proposed rule.

The ACT certification rule is nearing final steps in the process. This rule may qualify as one of the most reviewed rules DMHA has ever had. From the start over two years ago we have had the input of providers, consumers, family members, administrators, and researchers involved in developing what has become the ACT rule.

While we operated under the Administrative Directive for ACT, we made adjustments as we learned of issues that were not working as we intended. The Administrative Directive was amended several times.

The Administrative Directive was the base for the ACT certification rule that had its public hearing on July 22. At that hearing, two people were present to make comments and an additional five letters were received. Some changes to the proposed rule are being made as a result of the comments. If those changes are deemed substantial, the process of promulgation starts over.

No rule satisfies all affected, and the ACT rule that is nearing finalization may have some areas that will need changing in the future. With all of the opportunities for public feedback on this rule, many of you had some part in developing and amending this rule. You were part of the process or at least you were invited to be part of the process.

Being part of the regulatory body is not often an exciting experience, but it has been exciting to be involved in the development of ACT in Indiana. My colleagues agree. If you asked Pam Johnson or Jill Chambers of DMHA, you would learn that it is also rewarding to make a site visit to see a rule being put into practice.

Up Close and Personal

Mike Brady
ACT Consultant & Trainer
ACT Center of Indiana

Hello, my name is Mike Brady. As some of you already know, I am one of the ACT Center's ACT Consultant/ Trainers. I have held this position since January 2002. Prior to my involvement with the ACT Center, I have been in the mental health field since 1991 and most recently employed at Adult & Child since 1996. My experiences in the field have included working as a case manager, intake and crisis coordinator, psychiatric tech, Crisis Prevention Institute instructor, and currently a team leader.

I grew up in Kokomo, Indiana and have lived in the Indianapolis area since 1990. I have been married to my lovely wife Julie since 1995. We have three children. Jordan, our oldest son, is 6 years old. Madison, our daughter, is 5 years old. Austin, our youngest son, is one year old.

Another aspect to my life is my military career. I am currently a Major in the Indiana National Guard, serving as the Commander and Chief Briefing Officer for a Public Affairs detachment. I first enlisted in 1982 in the Marine Corps. I spent four years on active duty and then transferred to the Army National Guard, serving in the Field Artillery.

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To change your subscription to the ACT Center of Indiana quarterly newsletter, contact Veronica Pedrick at vpedrick@iupui.edu or (317) 274-6735. Newsletter created & edited by V. Pedrick.

WHAT'S ON THE CALENDAR?

Upcoming Events

September 12, 2003
KEY Consumer Conference on Recovery
Location: The Garrison at Ft. Harrison
Audience: Providers, consumers, family members, community
Call (317) 205-2500 or visit www.keyconsumer.org for more details!

October 4, 2003
National Alliance for the Mentally Ill (NAMI)
State Conference – Together We Make A Difference
Location: North United Methodist Church, 38th & Meridian
Audience: Providers, consumers, family members, community members
Call (317) 925-9399 or visit www.namiindiana.org for more information!

November 5-7, 2003
Indiana Conference of Rehabilitative Psychiatric Services (ICORPS)
24th Annual Conference
Location: University Inn, West Lafayette, IN
Audience: Mental health service providers
Visit www.ICORPS.info for more details!