Assertive Community Treatment (ACT) Model for Community Integration and Recovery in California

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About Today’s Presentation

Assertive Community Treatment (ACT) is an extensively researched evidence-based practice that consists of a transdisciplinary team who provide intensive services to people with serious mental illness and co-occurring substance use challenges to maximize their recovery outcomes. ACT has been shown to be effective in a variety of measures including reduction in hospital days and housing stability. The training will also review the fidelity measure (TMACT) and its application for Full Service Partnership teams, including those serving individuals with criminal justice backgrounds.
What we will cover

- Overview of FSP & ACT
- Research in support of it
- Relevance to people served who are justice involved
- Structure of the Model
- Relevance of fidelity
- Status of ACT implementation in CA
Special Thank you

• Support, training and coaching from two of the researchers and TMACT developers
  • Lorna Moser, PhD- Psychologist, Associate Professor - UNC Dept of Psychiatry, and Director of Institute for Best Practices within the Center for Excellence in Community Mental Health
  • Maria Monroe-DeVita, PhD- Psychologist, Associate Professor- University Of Washington Department Of Psychiatry and Behavioral Sciences and EBP Center

Lessons Learned from the Field and Statewide Implementation
Evolution of ACT: Then & Now

• Developed in 1970’s in Madison, WI (Stein & Test)- Inpatient staff made note of revolving door patients
• “Hospital without walls”
  • Focus on bringing comprehensive supports to individuals where they live
  • Major outcome of interest was decreased hospitalization
• Over 50 published empirical studies -- at least 25 are RCTs
• Core elements
  • Team approach ◦ flexible, comprehensive services ◦ fixed point of responsibility ◦ small ratio consumers to staff ◦ community-based ◦ 24/7 coverage ◦ time-unlimited
• ACT was developed for people with severe and persistent mental illness (SPMI) who have significant difficulty living independently, high service needs, and repeated psychiatric hospitalizations
• ACT is not a psychotherapy/clinical model, it’s a psychiatric rehabilitation model
  • The goal of psychiatric rehabilitation is to help disabled individuals to develop the emotional, social and intellectual skills needed to live, learn and work in the community with the least amount of professional support.
  • The overall philosophy of psychiatric rehabilitation comprises two intervention strategies (1) aims at developing the person's skills in interacting with a stressful environment and (2) developing environmental resources to reduce potential stressors.
• ACT is a first line and generally sole provider of all services an ACT beneficiary needs
• ACT services are flexible, based on the individual's needs and “ISSP goals”
Basic Charge of ACT Is...

To be the first-line, if not sole, provider of all the services that ACT consumers need

- Multidisciplinary team
- Transdisciplinary approach (links concepts and skills through a real-world context)

To provide flexible, individualized services reflecting what we know works

- Tailored to individual needs, short and long-term
- Delivered in consumer’s communities- daily life and family impact

To be recovery-oriented

- Treatment driven by consumer’s goals
- Emphasis on growth and possibilities

“promoting depth of understanding as well as adaptability to skills needed to succeed in our changing world.”
Making the Case for ACT

Prevalence of SPMI - 1 in 5

Lack of integrated, comprehensive services - too many silos

Go beyond traditional services (therapy, medications)

Helping people live in the least restrictive settings to thrive
Addressing Social Determinants of Health

Unemployment

Premature Death (up to 25 yrs earlier – 60% due to medical vs suicide)

20-30% of homeless population have SMI

Poverty

Nearly half actively abuse substances

Higher risk of incarceration, longer stays, more likely to be put in isolation

Trauma-historical, pervasive, invisible
ACT and National Movements

- U.S. Department of Justice (DOJ)- ADA and the Olmstead Decision
- Protection and Advocacy for Individuals with Mental Illness Program (PAIMI)
- 21st Century Cures Act
- SAMHSA funding to support ACT implementation
- Mental Health Technology Transfer Centers (MHTTCs)

"institutional placement of persons who can handle and benefit from community settings perpetuates unwarranted assumptions that persons so isolated are incapable of or unworthy of participating in community life."
ACT and FSP: SAMHSA’s Recovery Principles

- Convey hope and respect for all
- Culture is central to recovery
- Informed and shared decision-making
- Build on the strengths = Look at what’s strong not what’s wrong
- Practices are person-centered
- Practices support full integration into their communities
- Promote self-determination and empowerment = right to make choices
• Full Spectrum of Community Services necessary to attain the goals identified in the Individual Services and Supports Plan (ISSP)

• Mental health services and supports including, but not limited to:
  • Mental health treatment, including alternative and culturally specific treatments.
  • Peer support.
  • Supportive services to assist the client, and when appropriate the client’s family, in obtaining and maintaining employment, housing, and/or education.
  • Wellness centers.
  • Alternative treatment and culturally specific treatment approaches.
  • Personal service coordination/case management to assist the client, and when appropriate the client’s family, to access needed medical, educational, social, vocational rehabilitative and/or other community services.
  • Needs assessment.
  • ISSP development.
  • Crisis intervention/stabilization services.
  • Family education services.

• Non-mental health services and supports including, but not limited to:
  • Food.
  • Clothing.
  • Housing, including, but not limited to, rent subsidies, housing vouchers, house payments, residence in a drug/alcohol rehabilitation program, and transitional and temporary housing.
  • Cost of health care treatment.
  • Cost of treatment of co-occurring conditions, such as substance abuse.
  • Respite care
FSPs modeled after ACT

• California’s Full Service Partnership (FSP) programs are modeled after the state’s experience with pilot recovery-oriented programs targeted to homeless individuals with serious mental illness (known as AB2034 programs).

• AB2034 and FSP programs are considered to be a modified version of ACT, as they provide individualized integrated services, flexible funding, intensive case management, and 24 h access to care.

• FSP programs can include “Assertive Community Treatment (ACT), an evidence-based practice - consistent with MHSA principles - where services can be delivered in the person’s home and are available 24 hours a day, 7 days a week,” which can be funded under Medi-Cal as a mental health rehabilitation service.

• There is an important opportunity to put monitoring systems in place to ensure that those resources are sufficient and efficiently used to change service delivery and support individual consumers to meet their recovery goals.

• Sources:
  • What Does It Take? California County Funding Requests for Recovery-Oriented Full Service Partnerships Under the Mental Health Services Act. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2929427/
ACT and Justice Involved Populations

2017: RCT of a “Forensic assertive community treatment (FACT)” program in Rochester

- 70 adults, psychotic d/o, arrested for misdemeanors

FACT program on average had fewer:

- number of arrests (0.8 compared to 1.3 arrests),
- days in jail (21.5 compared to 43.5 days),
- emergency department visits (0.8 compared to 1.9 visits) and
- hospitalization days (4.4 compared to 23.8 days).

In addition, compared to individuals in the control group, people in the FACT program on average had greater:

- days in treatment (305.5 compared to 169.4 days) and
- outpatient treatment contacts (112.0 compared to 14.1 contacts).

What’s different

- program staff are specially trained in criminal justice and there is significant collaboration between the mental health and criminal justice system

Forensic Assertive Community Treatment: Updating the Evidence

Forensic Assertive Community Treatment (FACT) is an adaptation of the traditional assertive community treatment (ACT) model for people with serious mental illness who are involved with the criminal justice system (Lamberti et al., 2004). ACT is a psychosocial intervention that was developed for people with severe mental illness (a subset of serious mental illness, marked by a higher degree of functional disability) who have significant difficulty living independently, high service needs, and repeated psychiatric hospitalizations (Stein & Santos, 1999).

FACT Brief:

• Forensic adaptations of high-fidelity ACT programs can improve both criminal justice and behavioral health outcomes for jail detainees with severe mental illness.

• These programs are not a panacea and must be carefully targeted to those most in need.

• Further research is required to refine the clinical model and identify interventions that can effectively address criminal as well as behavioral health outcomes.

• As the evidence base advances in these areas, FACT programs may become even more central to community efforts to help people with severe mental illness function in the community with minimal continued criminal justice involvement.

https://nicic.gov/forensic-assertive-community-treatment-updating-evidence
Solano FACT Team

GOAL:
• Keep folks out of jail & prison
• Avoid/reduce arrests
• Interface with CJ system
• expand and utilize for AB1810-Jail Diversion, AOT/Laura’s Law, Mental Health Court

Our team:
• Enroll only folks with SMI and prior arrests and detentions
• Jail Liaison carries initial assessment load
• Brief screening for eligibility when referrals sent from Public Defenders
• Court Reports streamlined
Fidelity Measure: provides FSPs with Goals

• Daily team meetings
• Role of the team members- sharing caseloads, who does what
• Development of specialty roles (voc. Specialist, SA specialist, peer specialist, housing specialist)
• Integration of prescriber and nurses
• Frequency, intensity and location of interventions
• Psychiatric rehabilitation approach
• Person-centered planning
ACT Structure
Team Approach

Engagement and Therapeutic Relationship (ALL)

Psychiatric and Medical
(Psych and Nurses with ALL Team Support)

Wellness Management and Recovery
(led by Peer Spec)

Psychiatric Rehabilitation

Supportive Housing

Family Psycho-education

Psychotherapy
(clinicians)

Crisis Services

Integrated Substance Use Treatment
(led by SUD Spec)

Vocational Services
(led by Emp. Spec)

Case Management
Transdisciplinary Team

Team Leader
Assistant Team Leader*
Program Assistant
Psychiatric Care Provider
Nurse

Co-Occurring Disorders Specialist
Employment specialist
Peer Specialist
Therapist*
Generalist

Housing Specialist*
Psych Rehab Specialist*
Family Support Specialist*
Why a Max 1:10 staff to client ratio?

1:9 or 1:8 likely best to support best practice
Conundrum with small teams ...

Absence of generalist positions. Why operating a *transdisciplinary* team is important.
Typical ACT service recipient

• Schizophrenia-spectrum disorder, bipolar disorder, or major depressive disorder with psychotic features; and
• Significant functional impairments and;
  • Comorbid substance abuse; and/or
  • Hx of frequent or long-term hospitalizations; and/or
  • Hx of frequent arrests/incarcerations or homelessness episodes.
• Have not (or likely would not) successfully received services from less intensive community based treatment programs
Availability

• Services are available 24/7, 365 days a year
• Teams operate with a 1st and 2nd shift (e.g., 11 – 7pm) on weekdays
• Services (med monitoring; psych rehab) provided on weekends to those most in need, as well as on holidays.
• ACT is on-call for crises (none or very minimal triaging)
  • Mostly operating a “warm-line”
Dose and Location of Services

- On average, across staff (best practice recommendations) ....
  - At least 75% services in the community
  - At least 2-3 contacts per week
  - At least 120 minutes per week (no less than 60 mins)
Why would someone need to be seen often?

They have multiple and complex needs benefitting from multiple team member contacts across the week.

They have significant impairments in functioning and/or cognitive impairments needing more frequent prompts and reminder to structure day.

They present with some safety concerns and more frequent supervisory check-ins is important.
Share and document assessment data from previous 24 hours

Create plans of action based on information shared

Develop a team schedule based on individual’s weekly individual schedules and plans of action
Engagement, Rapport-Building, Assessment, Planning (ALL)

Case Management (ALL, with minimal from Voc Spec)

Psychiatric and Medical (Psych and Nurses with ALL Team Support)

Wellness Management and Recovery (ALL, led by Peer Spec)

Psychiatric Rehabilitation (ALL)

Integrated Substance Abuse Treatment (ALL, led by SA Spec)

Supportive Housing – Resources (subsidies, landlords, etc) (ALL, led by Housing Specialist)

Employment and Educational Services (ALL, led by Voc Spec)

Family Psychoeducation (ALL)

Crises Services (ALL, possibly exclusion of Peer Specialists and Voc Specialists)

Psychotherapy (Licensed Clinicians/Psychiatrists, with support from unlicensed staff)
ACT Leadership: Team Leader and Psychiatric Care provider

One person operates as the Team Leader, working in close collaboration with the ACT psychiatric care provider.

Team Leader is the administrator and manager, and lead clinical supervisor.

Team Leader provides direct services to clients and natural supports.

Team Leader and Psych Care Provider work together to provide clinical leadership and guidance to the team.

Both take the lead around staff education and competency enhancement.

Both area advocates for the team in the larger agency and system.
<table>
<thead>
<tr>
<th>Psychiatric Care Provider Services</th>
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<tbody>
<tr>
<td><strong>Clients seen often</strong></td>
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<tr>
<td>(majority ~6 weeks, all within 3 months)</td>
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<tr>
<td>• Co-Clinical Leadership of the Team and Management of ACT Medical Team (Nursing)</td>
</tr>
<tr>
<td><strong>Brief Therapy</strong></td>
</tr>
<tr>
<td>• Consultation and Education to Team Members. Attending Daily Team Meeting and Planning Meetings. Psychiatric Back Up.</td>
</tr>
<tr>
<td><strong>Screening, Assessing, Coordination, addressing HealthCare needs</strong></td>
</tr>
<tr>
<td>• Community-Based Contacts</td>
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</table>
Nursing Staff: community/public health component

| Prevention | Work inside and outside clinical walls to prevent or address obesity, diabetes, injuries, communicable diseases, sex ed |
| Coordinate | Integrate care across providers to improve health equity |
| Lead | Collaborate with transdisciplinary team |
| Educate | About healthy behaviors, environments, choices |
| Protect | Educating about environmental hazards, emergencies |
| Promote | Health equity and health as a shared value for community inclusion |
| Advocate | Promote practices and process to improve health and access to other supports - helping find safe places to walk or bike, access to healthy food, violence prevention, trauma informed care |
# Integrated Treatment For Co-occurring Disorders

| Holistic and Integrated View of Substance Abuse | How mental health impacts substance use, and how use impacts mental health  
Both are attended to and addressed at the same time, and following a stages of change treatment model |
|-------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Stages of Change Readiness Assessment and Treatment | Outreach, harm reduction, motivational interviewing with those in earlier stages of change readiness.  
Active substance abuse counseling (using CBT techniques), relapse preventions, self-help groups, ongoing MI for those in later stages of change readiness. Group and individual work. Assist with medical detox and inpatient residential needs. |
| Harm Reduction | Goal is to minimize damage as most people will not reach a point of abstinence for some time.  
Decrease intake amount, toxicity, environmental risks (legal, safety), health and physical harm risks (safe needle use), |
Individual Placement and Support-Supported Employment and Education

Engagement
- Work or school as a solution to problems
- Embraces "zero exclusion" principle
- Focus is on *competitive employment*
  - Coordinating with fellow team members to understand strengths and interests

Assessment
- Completes and uses the Career Profile
- Focuses on what person is most interested in
- Movement to job search is quick

Job Development
- Seeking to find a good match
- Gets to know local employers

Job Supports
- Job coaching
- Strategic supports for employment and school
- Problem-solving logistical challenges/accommodations

Benefits Counseling
- Understands work incentive options
- Reporting expectations
- How working impacts SSI, SSDI, food stamps

*IPS Employment Center*
Wellness Management and Recovery

- Recovery is supported through helping people develop understanding and skills to manage their own wellness, and advocate for their own needs.
Supportive Housing

Housing Readiness

Homeless → Shelter → Transitional → Permanent

- medical
- mental
- behavioural
- income
- landlord relationship

Housing First

Homeless → Permanent → Life Stability

- medical
- mental
- behavioural
- income
- landlord relationship

Watch out for boredom and loneliness

Permanent, Decent, Community-Based, Safe, Affordable
Psychiatric Rehabilitation

- Self-Efficacy
  - Capacity (knowledge and skills)
  - Readiness
  - Resources and Supports
  - Environment

Actual Functioning
Family Psychoeducation and supports

- Help develop/expand natural supports
- Provide psycho-education to natural supports
- Assist with problem-solving
- Provide skills training
  - Skills and supports for parent consumers, including navigating custody
Empirically-Supported therapy

- Individual and/or group
- Licensed therapist on team is ideal;
- All staff can develop basic therapeutic skills
Evidence-Based Practices & Program Fidelity
Program Fidelity

What is an Evidence-Based Practice?
• Based in theory and has undergone scientific evaluation, replication, and
• Usually comes with
  • An Implementation manual
  • Tool to measure fidelity: “Fidelity Scale”

What is Fidelity?
• The degree to which a program includes features that are critical to achieving the intended outcomes
• Program fidelity is positively correlated with improved outcomes and cost-effectiveness
<table>
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<tr>
<th>Value of Program Fidelity</th>
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<tbody>
<tr>
<td><strong>Quality</strong></td>
</tr>
<tr>
<td>Higher-fidelity teams yield better outcomes</td>
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<tr>
<td><strong>$</strong></td>
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<tr>
<td>More cost-effective</td>
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<tr>
<td><strong>Research</strong></td>
</tr>
<tr>
<td>Helps ensure (or question) reliability and validity of research findings, and helps with exploring relevant contextual factors impacting fidelity.</td>
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<tr>
<td><strong>Innovation</strong></td>
</tr>
<tr>
<td>Provides a conceptual base from which to make informed adaptations and innovations</td>
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Implementation Sciences

**Effective innovations X Effective implementation = (+) Outcomes**

- Critical to success
- “Implementation Teams help
  - develop the staff competencies required by the evidence-based program,
  - help administrators adjust organization roles and functions to align with the program, and
  - help leaders in the provider organization fully support the process of using the program and incorporating the necessary implementation supports.”

http://nirn.fpg.unc.edu/learn-implementation/implementation-stages

Fixsen, Blase, Timbers, & Wolf, 2001
Balas & Boren, 2000

Substantial Return on Investment
ACT Fidelity Measurement
From DACTS to TMACT
Dartmouth ACT Scale (DACTS)  
(Teague, et al., 1998)

- Most widely used ACT fidelity measure
- Incorporated into SAMHSA EBP (Toolkit) Project
- Sometimes used as “a start” for accreditation/funding

- 28 items/ 5-point anchored scales
  - (1 = not implemented; 5 = fully implemented)
- 3 subscales (structure informed by McGrew et al., 1994)
  - Human Resources
  - Organizational Boundaries
  - Services
Example of DACTS Item:
O4. Responsibility for Crisis Services

<table>
<thead>
<tr>
<th>Domain</th>
<th>Rating</th>
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<tbody>
<tr>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Responsibility for Crisis Services</td>
<td>Not responsible for handling crises after hours</td>
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</table>
DACTS Use and Concerns

- Earlier form of the DACTS was developed as study-specific research component
  - Expanded, extended to other ACT studies as DACTS
- Use became widespread
  - ACT manual not yet available
  - Format useful for training
  - Effective tool for differentiating ACT
- Limited attention to omissions/limitations
  - Distinction between fidelity measure and program specifications not always appreciated
- Not fully consistent with National ACT Standards
- Little grounding in program theory
- Primary focus on structure (vs. process)
- Specific measurement gaps:
  - Assessment & treatment planning
  - Team & staff functioning
  - Recovery orientation
  - Treatment & rehabilitation interventions
  - Item calibration
From DACTS to TMACT: Changes

- DACTS = 28 items
- Revised (22 items)
  - Rescaled anchors
  - Modified assessment
- Removed (6)
  - Items not particular to ACT
  - Folded into another
- Added (25)
  - New items judged critical to ACT
  - Extracted/expanded concepts embedded in earlier items

- TMACT = 47 items
Tool for Measurement of ACT (TMACT)

Assessment of processes for high fidelity ACT
- Recovery-oriented services
- Evidence-based practices
- Functions promoting a trans-disciplinary team

Measurement of specific features
- Recovery-oriented practices, esp. person-centered planning (vs. practitioner-centered medical model)
- Specific treatment & rehabilitation interventions
- Team functioning (vs. team structure)
- Staff roles in treatment & team (e.g., vs. staff FTE)

Team Recalibration as needed

Improved reliability, validity, sensitivity, guidance
TMACT: A Snapshot

- 47 items that assess 120+ elements
- Look at the structural features of the team (staffing, boundaries of care, target population, level of care, types of service provided)
- Evaluate the quality of care
  - Are staff able to operate within their areas of specialty?
  - Are staff knowledgeable and skilled in psychosocial evidence-based practices?
  - Is treatment person-centered and promoting individual’s self-determination and independence?

### CP6: Responsibility for Crisis Services

The team has 24-hour responsibility for directly responding to psychiatric crises. Team is evaluated on whether they meet the following criteria: 1) The team is available to individuals in crisis 24 hours a day, 7 days a week; 2) The team is the first-line crisis evaluator and responder (if another crisis responder screens calls, there is very minimal triaging); 3) The team accesses practical, individualized crisis plans to help them address crises for each individual; and 4) The team is able and willing to respond to crises in person, when needed.

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<th>1</th>
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<th>3</th>
<th>4</th>
<th>5</th>
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<tbody>
<tr>
<td></td>
<td>Team has no responsibility for directly handling crises after-hours.</td>
<td>Team meets up to 2 criteria at least PARTIALLY.</td>
<td>Team meets Criterion #1 and PARTIALLY meets 2 to 3 criteria.</td>
<td>Team meets 3 criteria FULLY and 1 PARTIALLY.</td>
<td>Team FULLY meets all 4 criteria (see under definition).</td>
</tr>
</tbody>
</table>
TMACT Subscales

Operations & Structure (OS)
- 12 items
- Examples: Team Approach (OS1); Daily Team Meeting-Quality (OS4); and Transition to Less Intensive Services (OS9)

Core Team (CT)
- 7 items
- Examples: Team Leader (CT1); Role of Psychiatric Care Provider in Treatment (CT4); Role of Nurses (CT7)

Specialist Team (ST)
- 8 items
- Examples: Co-Occurring Disorders Specialist on Team (ST1); Role of Employment Specialist Within Team (ST6); Role of Peer Specialist (ST8)

Core Practices (CP)
- 8 items
- Examples: Community-Based Services (CP1); Assertive Engagement Mechanisms (CP2); Intensity of Services (CP3)

Evidence-Based Practices (EP)
- 8 items
- Examples: Full Responsibility for Employment and Education Services (EP2); Engagement & Psychoeducation with Natural Supports (EP6); Empirically-Supported Psychotherapy (EP7)

Person-Centered Planning & Practices (PP)
- 4 items
- Examples: Person-Centered Planning (PP2); Interventions Target Broad Range of Life Domains (PP3); Client Self-Determination & Independence (PP4)
TMACT and Outcomes

Longitudinal Study (WA, N=10 teams, 18 mo)
- Higher fidelity was associated with:
  - Fewer state hospital days per month
    - Not significant for highest users
  - Fewer local hospital days for high users
  - Fewer crisis stabilization unit days


Correlational Studies
- Higher-fidelity ACT associated with higher retention rates and higher rates of individuals in competitive employment (examination of both WA and NC ACT teams; Teague, Moser, Monroe-DeVita, 2015)
- Examination of NC ACT Data (77 teams):
  - No significant difference in fidelity for urban vs non-urban teams (teams in cities with population density of 50,000+ = “urban”)
  - No significant differences in fidelity given team size (small, medium, or large)
  - Longer standing NC ACT Coalition members had significantly higher fidelity than non-members or more recent members
Critical Elements For Implementation

• TA team starts training on ACT and EBPs  
  • IPS, SUD, WRAP, Shared Decision Making, PCP, etc.
• Use TMACT as roadmap
• Set-up ways to do ongoing fidelity evaluation  
  • Dedicated staff ensures consistency and shared understanding
• Programs may not get it until first baseline review
• Providing ongoing consultation

https://sph.unc.edu/research/explore/implementation-science/
ACT Dissemination

More people need ACT than what is available
Prevalence of ACT

- ACT available in at least 42 U.S. states
  - Wide variability in oversight and funding, number of teams
  - Wide variability in fidelity to the model

- Other countries have implemented ACT, or a modified version:
  - E.g., Canada; Japan; UK; Norway; Netherlands; Spain
How many ACT Teams Do We Need?

- If the national prevalence rates for SMI is 4.5%* (conservative estimate being 3% of the total population for SPMI) – people who truly need ACT.
  *Solano, a Medium county with a population of 445,458 means that at least 3% or 13,363 people may need ACT. We only have 3 FSP teams serving approx. 200 people.

- Research shows that ACT is only cost-effective when serving the most in need.

- Conversely, many people may appear to “need” ACT when in fact they simply need some decent quality and consistent case management/peer services
  - Need to attend to broader system array, and mental health workforce development

Barriers to High Fidelity ACT Implementation

- Lack of agency change culture
  - Only willing to make incremental changes
  - Embraced practices contrary to ACT model
  - Resistance to other EBPs

- Ineffective agency admin and team leadership
  - Understanding of ACT
  - Allocation of resources
  - Personnel management

- Staffing
  - Competency
  - Team conflict
  - High turnover

- Lack of agency change culture
  - Only willing to make incremental changes
  - Embraced practices contrary to ACT model
  - Resistance to other EBPs
Recovery Outcome Measures Matter

What are typical outcomes we track now?

- # of Clients Served
- Total # of clients hospitalized once
- # of clients hospitalized more than once
- Total # incarcerated
- # of clients exp. homelessness

What about...

- # of people admitted to psychiatric units, medical units, detox units, crisis stabilization or jail and length of stay for each
- # of people who became homeless or obtained housing
- Employment (competitive, self sufficient vs not, unemployed, actively looking for work, not looking, etc)
- Participation in community based opportunities/resources
- Social connections and supports
- Education endeavors
- Rep payee
- Guardianship
- # with substance abuse issues
- Stages of change
Review of Some Key Ingredients for Enhancing Quality of ACT (Mancini, Moser, et al, 2009)

- Adequate Funding
- Championship and Leadership
- Fidelity Monitoring
- Certification (ideally tied to fidelity)
- Training and Technical Support
Continued- Lessons Learned

Emery's Excellent Adventures in Florida and North Carolina
### CA County/Mental Health Plan’s Role is Key

<table>
<thead>
<tr>
<th>Funding</th>
<th>Licensing for ACT</th>
<th>Technical Assistance</th>
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</thead>
<tbody>
<tr>
<td>• Start-Up Money</td>
<td>• Standards reflected moderate to high fidelity</td>
<td></td>
</tr>
<tr>
<td>• Medicaid Reimbursement for ACT</td>
<td>• Auditing process and accountability</td>
<td></td>
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<tr>
<td>• Case Rates vs. Encounter Billing</td>
<td>• Money contingent on meeting standards</td>
<td>• Guided use of toolkits or other reliable source</td>
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</table>

• Team assigned a consultant
• Fidelity reviews and feedback
Intentional Implementation Process

What we did (State level)
• State service definition with CMS/Mercer
• Align rates to support high fidelity
• Support the state ACT coalition with TA funds
• Train statewide MCO, providers as evaluators
• Train in multiple EBPs- IPS, IDDT, SUD, Peer Support, Shared Decision Making
• Continuously assure people this was important

Tips for CA (County level)
• Write a policy in line with MHSA, address any barriers to billing
• Incentives- Develop tiered certification/reimbursement from start
• Start a regional coalition, support each other with training/consulting
• Cross-train to include QI, clinicians,
• Build Trust in the practice improvement process – Fidelity Evaluation is NOT an AUDIT
What made a Difference in NC?

- Local MCO (MHP) support esp. with Case Rates, Service authorizations, Training and TA
- Training/TA & consultation support - members of coalition scored higher
- Good person-centered planning processes in place
- Agencies with leadership trained in TMACT scored better

88 teams
5,768 clients being served
Avg team size was 66 clients

11 did not make it

33 scored between 3.7+

44 scored between 3.0-3.6 initially
North Bay Area Regional Implementation
Q8 Are you considering implementing ACT within your FSP team?
Our Next Steps

- **Training January 29-30, 2019**
- **Starting Regional ACT Learning Community- April 11, 2019**
- **Use TMACT as a ROADMAP to identify doable fidelity items**
- **Bring Trainers back for Fidelity Evaluation Training**
- **Refocus the use of specialists/clinicians & train**
- **Start baseline fidelity evaluation across bay area teams FY19-20**
Questions & Discussion
Please find UNC and other TMACT-ers on social media:

- [https://www.facebook.com/institutebestpractices/](https://www.facebook.com/institutebestpractices/)
- [https://twitter.com/unc_cecmh_TA](https://twitter.com/unc_cecmh_TA)

Interested in being a part of a larger ACT community? Sign-up to join our listserv!

- [http://www.institutebestpractices.org/sign-up-form/](http://www.institutebestpractices.org/sign-up-form/)
Info

Resources:

- “Solano ACT Resource Guide” Handout
- University of North Carolina Institute for Best Practices: http://www.institutebestpractices.org/act/description/
- University of Washington PACT website: http://depts.washington.edu/ebpa/projects/pact
- Ohio Case Western University Center For Evidence-Based Practices: https://www.centerforebp.case.edu/practices/act
- California- CIBHS FSP Toolkit: https://www.cibhs.org/publication/fsp-toolkits

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