

ACT Center of Indiana

Excellence in Training, Research and Technical Assistance

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Notes from the Directors

It finally seems like spring might really be here. And none too soon --- with the long winter and the uncertain economy, the sunny warm weather is a nice relief! This issue is filled with exciting new projects. Our newest study seeks to identify more cost-effective ways to assess fidelity, and it could potential reduce burden (on teams and assessors) and streamline monitoring for policy makers (Page 1). A new SAMHSA-funded project at Adult&Child is bringing new evidence-based services to older adults with mental health concerns, a

new population for the ACT Center (see Page 5). We also have updates on two ongoing projects. Lia describes person-centered planning initiatives on page 6 and Laura describes findings from her thesis on treatment success and failure on ACT teams (see page 7). Good news to celebrate...on Page 3, an Indiana ACT peer recovery specialist was honored this month with an award for his heroic work to assist others with severe mental illnesses. Congratulations Aris!



Comparison of Phone and Onsite ACT Fidelity Assessment Indiana DACTS Study

John McGrew, Ph.D.

A critical policy problem for mental health services research, generally, and a key focus of the ACT Center, specifically, is to discover cost-effective ways to successfully, accurately, and consistently implement evidence-based practices (EBP). As noted in the President's New Freedom Commission Report, EBPs tend to be difficult to implement accurately. Without careful attention to implementation, there is often wide variability in the degree to which programs adhere to the original design, with corresponding decreases in program outcomes. To help monitor and correct for variability in program implementation, there is now broad consensus on the need to verify program fidelity of ACT and other evidence-based practices. For example, several states,

including Indiana, now require that sites meet fidelity standards prior to being designated as an ACT program.

However, the mandate to assess fidelity comes at a cost. That is, with the increase in the numbers of programs implementing EBPs, the need to conduct onsite fidelity measurement has begun to place a very high burden on already overstretched State Mental Health Authorities. For example, the current standard fidelity instrument for ACT (DACTS) requires an onsite visit, which typically takes at least one day and a considerable investment of program and quality assurance resources to gather data (staff interviews, auditing of client records, etc.) and another day to score and write up the fidelity

assessment. In direct response to these and related problems in data reporting requirements, a national task force entitled, "EBP Reporting for URS and NOMS," was convened on September 13, 2007 in Bethesda, Maryland, sponsored jointly by SAMSHA and NASMHPD. Three members of the ACT Center were invitees to this meet-

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ing. One of the purposes of the task force was to identify alternative approaches to ensuring quality.

One explicit, but thus far untested, strategy for reducing fidelity burden is to use alternative methods of administration (e.g., phone based assessments). To begin to examine this question, the ACT Center has submitted a grant application to the VA to study alternate methods of fidelity assessment. In addition, starting in January, 2009, the ACT Center launched a pilot study to compare standard (two naïve raters) and enhanced phone-based fidelity monitoring (one naïve rater and one rater with extensive site experience) with onsite-based fidelity of ACT. To conduct the pilot, the DACTS will be administered twice, first via a phone interview with the ACT team leader, to occur no sooner than one month prior to the onsite visit, and second via the regularly scheduled onsite interview conducted by the consultant from the ACT Center assigned to the team. For half of the phone interviews, the two raters will be members of the research team who are not directly involved with training, consultation or supervision of the ACT teams. For the other half of the interviews, the two raters will be Dr. McGrew, the Principal Investigator, and the ACT Center consultant assigned to the site, who is familiar with the site and thus may provide a source of alternative/additional information for rating fidelity.

We will examine the degree to which the phone interview raters agree (reliability) and the correlation between phone and on-site assessments (validity). We will also collect information on the burden to the site and to the assessors of both the onsite and phone interviews including: time to complete, the degree to which the fidelity assessment is rated as burdensome. These data will help us examine the feasibility of such an

approach, give us estimates of reliability and validity, and initial estimates of cost-effectiveness.

The study is divided into two phases, phase one targets ACT programs scheduled to receive fidelity visits between January and June 2009 (these sites have already been contacted). Phase two will target programs scheduled for visits between July and December 2009 (sites will be contacted during May). Currently we have conducted phone interviews with 5 ACT programs and have secured permission to conduct interviews with another 9 sites. Preliminary data indicates that the phone interviews require about 1½ hours to conduct and another 1 hour to score. Team leaders are spending between 2 and 12 hours in preparation for the phone interview, with the average running around 7 hours. To date, we have comparison fidelity data for two sites, and thus far the phone and onsite total DACTS scores are similar [Site 1: 4.31 (phone) vs. 4.27 (onsite); Site 2: 4.42 (phone) vs. 4.46 (onsite)].

Potentially, phone administered fidelity should be much less burdensome (shorter administration time and no travel costs) compared to the current onsite visit. For large states implementing ACT programs, the introduction of phone fidelity assessments could contribute greatly to improving and maintaining the quality of ACT programs at reduced costs so that more individuals with mental illness can receive quality services. Moreover, phone based fidelity should be a win-win, in that there are likely to be savings both to the ACT program and to the quality assurance body. The ACT Center wishes to thank all the sites that have agreed to participate and welcomes any comments or concerns. We will publish an update of the study in the newsletter once it is completed.

Looking for a job? Looking for an employee?

The ACT Center of Indiana provides a section of our website for job announcements. If you are an employer and would like to advertise an open position, contact ACTCtr@iupui.edu. If you are looking for a job, just go to <http://www.psych.iupui.edu/ACT/HOME%20PAGE/Job%20Postings/Job%20Postings%20List.pdf> and look at the jobs being advertised.



Koesel, Carrico, Williams, Beldavs and Hickman

Aris Beldavs Receives “Heroes in the Fight” Award

Mark Hickman, ACT Team Leader, Centerstone West

Aris Beldavs, Peer Recovery Specialist at Centerstone West, was both nominated and selected as a winner of Heroes in the Fight. The main sponsor is Eli Lilly; co-sponsors included ARNI, Indiana Addictions Issues Coalition, Indiana Association for Infant and Toddler Mental Health, Indiana Coalition to Reduce Underage Drinking, Indiana Council of Community Mental Health Centers, Indiana Depression and Bipolar Support Alliance, Indiana Mental Health and Aging Coalition, Indiana Minority Health Coalition, Indiana Psychiatric Society, Indiana Psychological Association, Key Consumer Organization, Mental Health America of Greater Indianapolis, National Alliance on Mental Illness (NAMI) Indiana, and the National Association of Social Workers – Indiana Chapter.

The program celebrates dignity, courage, hope, and recovery in the ongoing treatment of persons with serious and persistent mental illness (SPMI) by recognizing “heroes” who provide care and support for persons with SPMI and their families.

Heroes in the Fight was implemented in partnership with the National Alliance on Mental Illness and the Mental Health America advocacy organizations in participating mental health communities across the United States. Eli Lilly and Company is responsible

for the program concept and costs, but is not be involved in the nomination process, selection of honorees or event planning.

The banquet was held at the Columbia Club on Monument Circle in Indianapolis on December 11, 2008. In attendance were Aris and his wife, Aris’s supervisor, ACT Team Leader Mark Hickman, Mark’s supervisor – Director of Adult Services, David Carrico, David’s supervisor – Centerstone West Senior Vice President, Suzanne Koesel and Suzanne’s supervisor – Centerstone Indiana’s CEO, Bob Williams

Aris was also the featured speaker at last week’s All-Staff Meeting of Centerstone Indiana in Nashville, Indiana. (This meeting was attended by all of the staff of the new Corporation which was the result of a merger between Center for Behavioral Health and QUINCO.) Aris spoke about his own recovery to his colleagues and his presentation led to him receiving a standing ovation.

Aris is an excellent employee who brings an example of hope and recovery success to our consumers and to our staff.

The Heroes in the Fight Web site is at http://www.heroesinthefight.org/Pages/home.aspx?oldUrl=http://heroesinthefight.org/nominate_a_hero/index.jsp

Up Close and Personal

Jennifer Wright, LCSW, ACT Center of Indiana Consultant/Trainer



Well, now that I've worked at The ACT Center for almost two years, I guess I should tell you a little about myself. I was born and lived in Indianapolis until I turned twelve at which time my family moved to Columbus, Indiana. I attended Purdue University where I received a Bachelor's Degree in Speech Pathology and Audiology. I also had a minor in Psychology and I loved those classes. I decided to take a position in the Day Treatment program at what was formerly known as Quinco Behavioral Health. I did that for about two years and then worked as a case manager for about six years. I also worked in addictions during that time.

I obtained my Masters Degree in Social Work in 2002 from IU School of Social Work and did medical social work for a while. I returned to mental health and was an outpatient therapist and State Hospital Liaison for a couple of years. I came to Adult and Child Mental Health Center in 2005 where I worked for a school-based program and then became a Team Leader for the sub-acute unit.

I started my position as a Consultant and Trainer at The ACT Center in April 2007. It is an amazing experience being close to the research and practice of mental health evidence-based practices.

I started working on my PhD in Social Work in the fall of 2008. My area of research interest is the intersection of mental health and criminal justice as it specifically relates to persons with serious mental illness in prison. I plan to do my dissertation around this theme. I hope to finish my PhD by the time I am forty. I am not going to tell you when that is, but it's creeping up on me quickly.

I have a life partner, two children, two dogs and three cats. My house is a zoo on most days, to which I am sure many of you can relate. We live in Columbus. In my leisure time (yeah, right), I enjoy watching a bit of t.v. (House, CSI, Law and Order), reading (anything that is not for school), going to the movies, riding bikes with my kids, playing board games with my family and playing our Wii.

Share Your Success Stories

We are looking for stories about recovery related to Assertive Community Treatment (ACT) or Illness Management and Recovery (IMR) and would like to hear directly from consumers about how ACT or IMR have helped.

We would appreciate your time and effort in encouraging any consumers you know that may want to share their stories. By gaining the knowledge of positive experiences from consumers, we hope to help other consumers, mental health advocates, and providers to improve recovery outcomes;

Any questions or concerns can be sent to dshimp@iupui.edu or call (317) 988-2074. Again, we appreciate any encouragement and support you can provide.

We look forward to hearing from you and will let you know if your story was selected for the website or newsletter!

JOIN OUR LISTSERV

We would like to invite you to join our listserv. We believe the listserv will be beneficial, educational, and helpful to your understanding and implementation of evidence-based practices (EBPs) such as Assertive Community Treatment (ACT), Integrative Dual Disorders Treatment (IDDT), and Illness Management and Recovery (IMR) as well as other statewide and nationwide initiatives.

If you would like to be added to our listserv, please send your name, phone number, email address, with whom you are affiliated (e.g., mental health center name), and your position if applicable (e.g., case manager) to ACTCtr@iupui.edu. Please share this opportunity with others who may be interested. Thank you for your time and interest!

SAMSHA Awards Adult&child \$1.23 Million to Implement Evidence-Based Practice for Older Adults with Mental Health Issues

Angie Rollins, Ph.D., Research Director, ACT Center of Indiana

The number of people 65 and older with psychiatric disorders in the United States is growing dramatically and is expected to reach 15 million in 2030. Many of these consumers will not seek mental health treatment from specialty providers but will instead seek help within their primary care setting. Unfortunately, the current availability of effective mental health services within primary care is minimal at best and is expected to be woefully inadequate to address the needs of the Baby Boomer generation as they age. Adult&Child and the Windrose Health Network have partnered to build infrastructure to address this gap in care by delivering an enhanced version of Improving Mood Promoting Access to Collaborative Treatment (IMPACT) services to older adult suffering from symptoms of depression. IMPACT is a collaborative care model designated as an evidence-based practice for older adults with depression. The project involves implementation of the IMPACT model through co-location of primary health-care and mental health services in a new health center serving the southside of a metropolitan Indianapolis. As is typical with the IMPACT model, a social worker trained in brief problem-solving treatment for depression will be housed in the healthcare clinic and will collaborate with a primary care physician, as well as with a consulting psychiatrist for difficult cases. The current project expands the IMPACT model to include outreach to community service agencies and other entities who serve the elderly, such as local churches, adult day care, and assisted living centers. The program also bor-

rows from the Geriatric Resources for Assessment and Care of Elders (GRACE) model to provide in-home assessment and nurse care coordination efforts outside the clinic for a variety of geriatric needs, if necessary. Over the course of this three-year project, we expect to directly serve 200 older adults (60 and over) struggling with depression residing in the region surrounding this clinic: southern Marion and Johnson counties in central Indiana.

For the next 3 years, the program is free to consumers, thanks to a federal grant from the Substance Abuse and Mental Health Services Administration (SAMHSA), part of the United States Department of Health and Human Services. The \$1.23 million grant covers the cost of infrastructure to build and implement the practice, the direct services, and evaluation by the ACT Center. Adult & Child was one of only 16 programs who received funding, out of over 250 applications from across the country. At the ACT Center, we also see this grant as an important product of our NIMH-funded Interventions and Practice Research Infrastructure Program that funds Rollins' position as Research Director, collaborating with Adult & Child staff in seeking external grant funding.

The new program, called "Senior IMPACT," is up and running and ready to take referrals. It is located at 8404 Sear Terrace, Indianapolis, IN 46227, in the Countyline Family Health Center of Windrose Health Network. To make referrals or contact program staff, please call 317-893-1440.

Person-Centered Planning Update

Lia Hicks, MBP, QMHP, ACT Center of Indiana Lead Consultant/Trainer

It's hard to believe that it has been nearly two years since Neal Adams and Diane Grieder, authors of Treatment Planning for Person-Centered Care, were in Indianapolis to provide the first two of four days of "train the trainer" person-centered planning (PCP) training & consultation. The ACT Center consultants along with staff from Larue Carter Hospital and each of the 4 Indianapolis-based CMHCs (Midtown, Gallahue, Behaviorcorp and Adult & Child) came together to receive this training and ongoing consultation. The aims were to successfully implement PCP within each of the agencies, as well as to identify effective training and consultative methods such that PCP could be available to other mental health centers across the state. Core members of the original trainers continue to meet quarterly to discuss implementation progress, barriers, and success stories. One of the central themes that impacts implementation at all of the agencies is the fact that changing core practices across a large system takes time. Each agency has had a lot of success over the past two years, and efforts continue presently towards full implementation of PCP.

The ACT Center consultants have been working hard to disseminate information, training, and consultation about PCP across the agencies with which we work. The length and depth of the training has

varied from 2-3 hour overviews, to 2-day in depth training. There is no doubt that we have bombarded the ACT teams with information around PCP and stages of change, but we also know that the ACT teams represent only a small number of the staff that work within Indiana's community mental health centers. For sustainable real practice change to occur around person-centered care, there must be persons from all levels within an agency on board supporting the change and long-term implementation plans must be welcomed.

In November, three of the ACT Center consultants had the opportunity to do a 2-day PCP training with about 25 staff from Howard Regional Systems in Kokomo. The training was followed up with monthly conference calls where assessments and person-centered plans are shared and feedback is provided. The monthly calls will continue through the summer with a plan for follow up training in the Fall of 2009 to reinforce skills and help those staff be prepared to be "PCP trainers" within their own agency.

Our hope at the ACT Center is to continue to have opportunities to provide agency-level training and consultation, much like that being done with Howard Regional, as a means to assuring that all persons served by Indiana CMHCs are partners in receiving the best mental health services available.

Staff Changes at the ACT Center



Tim Gearhart, lead IMR and Recovery trainer/consultant has taken a full-time clinical position to be near home and travel less often. We still collaborate with Tim, but miss his smiling face and sense of humor! The other ACT Consultant trainers have added some recovery-related consultation to their work, and we have brought in other trainers as needed for specific projects.

Defining Treatment Success and Failure in ACT

Laura Stull, BA, ACT Center of IN Research Assistant

One strategy for identifying the critical ingredients of ACT, as well as the aspects of treatment that could be modified to improve ACT services, is to closely examine treatment successes and failures. Currently there is no clear definition of what constitutes treatment success or non-success in ACT. Although some have suggested decreased hospitalizations or increased community tenure as indicators of treatment success, others have emphasized enhanced quality of life or recovery. Thus, an important first step is to define success and failure in ACT. I will discuss some findings from a study of staff and consumer perspectives on treatment success and failure in ACT. Data were collected as part of the ACT Center of Indiana’s Interventions and Practice Research Infrastructure Program (IP-RISP) grant from the National Institute of Mental Health to study the recovery-orientation of ACT teams, which has been described in previous newsletter issues. The data reported here is part of my master’s thesis.

Staff and consumers from four ACT teams in Indiana participated in the study. Staff were asked to nominate consumers on their teams who were most and least successful, and a consensus list of the three most successful and the three least successful were identified. We then interviewed these six consumers from each of the four teams (24 total) about their views of success in ACT, in order to understand how they viewed themselves, their progress, and what factors contributed. We also interviewed six staff from each of the teams (24 total) and asked them to reflect on each of the six consumers identified and to discuss the level of success and the factors they believed contributed for each person. Using qualitative techniques guided by grounded theory, we identified consistent themes and examined how these themes differed across a number of dimensions. The similarities and differences between staff and consumer definitions of treatment success and failure will be described next.

The three most commonly mentioned themes by consumers and staff when defining treatment success are provided in Table 1. Success was defined most frequently by staff and consumers according to positive changes in consumer characteristics, including changes in behaviors (e.g., more assertive) and in attitudes (e.g., feeling happy). Consumers also defined success for themselves based on having

their basic needs met and on things that the team did (e.g., getting needed help from the team). In contrast, staff were more likely to define success based on consumers being more socially involved with others, including family and friends. Staff were also more likely to talk about medications, which included consumers taking medications, getting meds on their own, and not having meds delivered as often.

Table 1. Definitions of Treatment Success

Consumers	Staff
1. Consumer characteristics (e.g., feel happy, increased confidence, more assertive)	1. Consumer characteristics
2. Meeting basic needs (e.g., housing, food)	2. Social involvement with others (e.g., socially connected, family reconciliation)
3. ACT team (e.g., get help that need from ACT, team not doing everything, needing team less)	3. Medications (e.g., taking medications, getting on own, not having delivered as often)

Table 2 lists the three most commonly mentioned themes given by consumers and staff when defining treatment failure. It is interesting that, similar to definitions of treatment success, consumer characteristics were frequently mentioned. In regards to treatment failure, the consumer characteristics which were discussed included negative behaviors (e.g., lying, risky behaviors) and attitudes (e.g., pessimistic, forgetful). The extent to which consumers are “blamed” by themselves and others for failure in ACT has not been documented previously and deserves further attention. When defining failure, consumers mentioned not taking medications more often than staff did. In contrast, staff mentioned taking medications more often when defining and describing the process of success. Thus, medications were seen as central to both staff and consumers, but the emphasis for consumers was in explaining failure, whereas for staff it helped to explain success. Consumers were also more likely to mention aspects of the ACT team (e.g., team not helping). In contrast, when defining treatment failure, staff were more likely to mention consumers’ substance abuse and not having their basic needs met.

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The ACT Center of Indiana is a collaboration of the IUPUI Department of Psychology and Adult & Child Center of Indianapolis.

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Our mission is to integrate research and practice to promote implementation of and continued commitment to high-quality, recovery-focused, evidence-based practices for adults with severe mental illness.

To change your subscription to the ACT Center of Indiana semi-annual newsletter, contact ACTCtr@iupui.edu or (317) 988-4189.

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Table 2. Definitions of Treatment Failure

Consumers	Staff
1. Consumer characteristics (e.g., negative attitudes, lying, not progressing)	1. Consumer characteristics
2. Not taking medications	2. Substance abuse
3. ACT team (e.g., ACT not helping, controlling everything)	3. Basic needs not met (e.g., no place to live, no food, no money)

One notable finding is that hospitalizations were mentioned infrequently as a definition of success or failure by both staff and consumers, despite the emphasis within the ACT model on reducing hospitalizations. Research has found that consumers of ACT consistently demonstrate reduced hospitalization rates and that ACT has demonstrated advantages over other forms of treatment based on reductions in hospital use. Thus, research suggests that one indicator of treatment success within ACT is decreased hospitalizations. However, the findings of the current study suggest that ACT staff and consumers

view treatment success and failure more broadly.

In conclusion, themes identified as aspects of treatment success and failure provide an avenue for understanding critical ingredients of ACT and aspects of treatment that could be modified to improve services. Based on the perspectives of 48 ACT staff and consumers, the critical factors in defining success and failure within ACT are clearly related to the characteristics of the consumers themselves. Overall, definitions of treatment success are consistent with notions of recovery, including a focus on internal conditions of the consumer and on establishing relationships. In helping to understand the process of treatment, findings varied as a function of the outcome – success or failure. These findings suggest that success and failure are defined in many different ways and are defined differently by both staff and consumers. Thus, researchers may need to broaden their perspectives on what constitutes treatment success and failure in ACT. Furthermore, it is critical for staff to consider consumer perspectives when thinking about treatment success and failure, as consumers seem to paint a unique picture of their own progress in treatment.