ACT Center of Indiana

Excellence in Training, Research, and Technical Assistance

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Special Expanded Spring Edition

Volume 5 ❖ Combo Issues 1 & 2

Notes from the Directors

Co-Directors

Michelle Salyers

& Mike McKasson

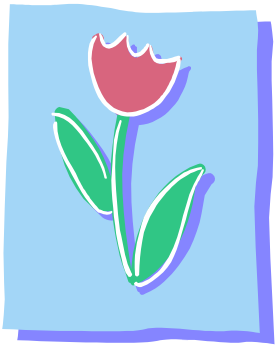
This is a special spring issue . . . double your entertainment and educational value we hope! As I read through the articles, I was struggling with the idea of how to tie them together for a coherent introduction (my own problem with symmetry and need for organization coming through). There are great things to read about our state transformation, research, implementation, and clinical work as well as inspirational notes about people and programs. Anything I could say seems woefully insufficient compared to what the actual articles bring themselves. And so with that, I hope this issues leaves you smiling as it has for me. - Michelle Salyers

In this Issue

Welcome to our Team!

We have grown quite a bit these past few months. Welcoming . . .

Eri Kuno, Ph.D., mental health services researcher joins us from PA. She is interested in policy planning issues and will be working with us on evaluating the impact of ACT and other EBPs. Our work with IMR has also been blossoming with the addition of Susan Jaeger, M.P.H. (IMR program coordinator), Tim Gearhart, M.S. (IMR Consultant/Trainer), and Tonya Eiden, M.S. (part time IMR Consultant). We are thrilled to have them join our team. You will be hearing more about them in future issues.



Consumer Services Review

Based on an article by Vicki Effland
Co-Director of the Technical Assistance Center for Systems of Care and Evidence Based Practices for Children and Families

In order to transform Indiana's mental health and addiction system, or any system for that matter, leaders must first understand what is working and what is not working in that system. The Family and Social Services Administration (FSSA), Division of Mental Health and Addiction (DMHA) and Indiana's Mental Health and Addiction Transformation workgroup have taken the first steps toward obtaining this valuable information. In January, two cross-system committees were convened to develop case review protocols to assess the quality of mental health and addiction services - one for children and one for adults.

The committee that met to create the adult's protocol included a consumer, a judicial representative, several community mental health centers, DMHA staff, a member of the SECT Center, and a member of the ACT Center of Indiana. Ray Foster, Ph.D. with Human Systems and Outcomes, Inc. (see http://www.humansystemsandoutcomes.com/home.htm to learn about this organization) facilitated the committee's work. The Consumer Services Review uses a case study approach to identify the status of a consumer, progress during the past 180 days and the performance of the service delivery practices used with the individual.

The task of the committee was to define status, progress and practice performance indicators based on the realities of Indiana's mental health and addiction system. A few of the indicators identified for Indiana's Consumer Services Review protocol included:

- Consumer status – safety, income adequacy, employment, living situation
- Consumer progress – improved coping/functioning, career development, risk reduction
- Practice performance – engagement of consumer, individualized service plan, resource availability

Throughout the development process, the committee was reminded that the purpose of the Consumer Services Review is to review and refine Indiana's mental health and addiction system. The goal is to get data that can be used for improving the quality of the system.

Drs. Groves and Foster are in the process of customizing Indiana's Consumer Services protocol for children and adults based on the committees' input. Once the protocol has been finalized, peer reviewers will be identified and trained (April, 2006). The expectation is that each community mental health center will identify two reviewers, one for adults and one for children. After being trained on the protocol, the reviewers will complete the Consumer Services Review for identified consumers receiving services from another mental health center. Note that the review process relies mostly on information obtained through interviews with key individuals involved with the consumer rather than information documented in case files. For example, a reviewer might conduct interviews with the consumer, significant other/family members, employer, therapist, case manager, and psychiatrist.

DMHA staff members are currently working closely with Drs. Groves and Foster to identify and train an initial team of peer reviewers. Initial reviews will be completed in May at five mental health centers in central Indiana and the remaining centers will be reviewed by the end of the year. Watch for more information on the implementation of the Consumer Services Review protocol on DMHA's website (http://www.in.gov/fssa/servicemental/), the IndianaSOC listserv and future editions of this newsletter.

The Potential Impact of Nurse Practitioners on ACT Teams

By Kara Williams
ACT Center Outcomes Advisor/Technician
CMHC, Inc. IDDT Coordinator

Community mental health centers (CMHCs) face the ongoing challenge of providing quality care to persons with severe mental illness (SMI) while staying within the confines of a yearly budget. One of the more costly areas of mental health services is that of medication management. One of the criteria for certification as an Assertive Community Treatment (ACT) Team is that a psychiatrist be a part of the team and the party primarily responsible for medication management. Although all members of the ACT Team take responsibility for medication management, it is the psychiatrist who will diagnose, prescribe, and subsequently monitor and adjust all psychotropic medications used by consumers on that team. Decisions about how much time the psychiatrist can be available to perform these duties affect budgetary decisions about other mental health services. Sometimes these budgetary considerations can affect either the amount and kind of services delivered to consumers on an ACT Team, or the number of consumers that a particular ACT Team is able to serve.

Like many other states, Indiana allows nurse practitioners, under the supervision of a physician, to assume most of the medication management duties for a mental health treatment team. Clearly, a nurse practitioner can perform these same duties at a lower cost than that of a psychiatrist. The question then becomes, can nurse practitioners provide medication management on an ACT Team without sacrificing quality of care?

In an attempt to answer this question, the ACT Center investigated two treatment teams at Adult & Child Center. Both teams operated according to the ACT model, although neither team (at the time of the study) was a certified ACT Team. One team employed a psychiatrist for medication management while the other team employed a nurse practitioner as both team leader and team prescriber. The investigators predicted that there would be equivalent levels of consumer satisfaction on the two teams (as measured by a consumer satisfaction survey specific to medication management issues such as time with the prescriber, explanation of side effects, etc), that there would be higher levels of team approach on the treatment team utilizing the nurse practitioner (as measured by a team questionnaire), and finally that both teams would receive equivalent scores on the Medication Management (MedMap) Fidelity Scale (a fidelity scale designed to measure specifically how well the medication management standards put forth by the ACT model are being adhered to on a particular team at both the prescriber and the organizational level).

The results of the study were, at times, surprising. The first prediction, that consumers on both teams would report equal levels of satisfaction, was not supported. Consumers on the psychiatrist's team reported significantly higher levels of satisfaction at the overall scale level. At the item level, the results suggested that consumers on the psychiatrist's team felt that their prescriber took more time with them and was more thorough during each med visit. The second prediction, that team members on the nurse practitioner's team would report higher levels of team cohesion (i.e., team approach) than members of the psychiatrist's team was also not supported. There were no significant differences found at the overall scale level. At the item level, however, there were some significant differences between the two teams. Members of the nurse practitioner's team showed more agreement with the idea that members of the team could work well together without letting ego or personality conflicts interfere, and they also showed more agreement with the idea that in the face of conflicts, team members felt free to express themselves openly in front of the entire team. The stronger endorsement of these two items at the very least suggests that members of the nurse practitioners team feel more comfortable with each other than do members of the psychiatrist's team. However, members of the psychiatrist's team were more likely to agree that they were satisfied with the amount of time that the prescriber is available to the team. This parallels the consumer perspective that the psychiatrist spends more time with medication management.

Finally, the third prediction, that both teams would receive equivalent scores on the MedMap, was mostly

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"Potential Impact . . ." cont'd from pg. 3 . . .

supported. At the organizational level, the nurse practitioner's team received slightly higher scores (with higher scores indicating better fidelity) than did the psychiatrist's team. Lower fidelity scores at the prescriber level suggested that both the psychiatrist and the nurse practitioner have room for improvement. The numbers suggested that the two team's fidelity scores were roughly equivalent.

The preliminary findings of this study must be interpreted with caution. Only two teams were compared, and both the psychiatrist and the nurse practitioner compared appeared to be excellent in their role as team prescriber. This study was particularly susceptible to potential confounds, as the consumers on the two teams were not compared in terms of severity of illness, diagnosis, or living arrangement and cannot be assumed to be equivalent groups. The personality characteristics of the members of the two teams, and particularly the psychiatrist and the nurse practitioner, are also potentially confounding. Finally, the differences found between the two teams in terms of both consumer and clinician satisfaction with the amount of time the prescriber is able to commit to medication management is likely confounded by the nurse practitioner's dual role as team leader.

This study sought to investigate whether nurse practitioners could be employed as the main prescriber for ACT Teams without sacrificing quality of care. While this study did not provide any clear-cut answer to this question, it does suggest that such an arrangement might be feasible. It certainly opens the door for further study and discussion.

Team Shining Stars

Highlight from
Kristin N. Redmond, MA
Team Leader, Team Park

Team Park is very proud to announce that our Supported Employment Specialist, Jennifer Malott, has been selected by Supported Employment Consultation & Training Center (SECT Center) to present at the National SECT conference in Boston this summer. She is a second generation employment specialist as she is following in her father's footsteps. Jen's aggressive approach has been very beneficial to our clients. She has pounded the pavement making connections throughout our community to ensure that our clients have the best possible chance of getting and retaining a job. Her efforts have resulted in a network of employers who welcome the opportunity to work with Jen and our Team.

Jen often goes the extra mile (or two) to ensure that our clients feel supported in their employment endeavors and believe that they are capable of sustaining a job. Even past the stage of job coaching, Jen maintains an open line of communication with the employers to ensure that all of their concerns are addressed. Presently twelve of our clients are gainfully working including one who recently spent two years in the state hospital.

These clients see this as an opportunity to better themselves and to be functioning members of society. It has been said that Jen is our "Lilo" as she is able to find a job that fits any client who is willing to work. For those who are not familiar with the Disney channel show "Lilo and Stitch." Lilo and her alien dog Stitch have made it their mission to find the perfect place for each of Stitch's cousins by finding a use for each of their unusual talents.

Who's making a difference on your team?

We'd like to hear from teams who are implementing Evidence-based Practices (EBPs) like ACT, IMR, and IDDT. Please write us and tell us about excellent clinicians on your team…

. . . How do they make a difference? What makes them stand out? What makes their work special? How do they promote EBPs? How are they making an impact? How are they a good example to others in implementing high-fidelity EBPs?

Send your stories to vpedrick@iupui.edu today!

Join our ACT Center of Indiana Team!

JOB OPENING
Consultant & Trainer for ACT

The ACT Center of Indiana, a collaboration of the Department of Psychology at Indiana University-Purdue University Indianapolis (IUPUI) and the Adult & Child Center of Indianapolis, is a technical assistance center funded by Indiana Division of Mental Health and Addiction (DMHA) to help support initiatives to bring evidence-based practices (EBPs) like Assertive Community Treatment (ACT) to Indiana. Our vision 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. Our approach is to combine training and implementation with ongoing program evaluation and research. We not only provide resources and other materials but also apply a hands-on, systematic approach to helping service providers implement EBPs throughout the state. Our organization enjoys an excellent reputation and growing credibility for providing progressive, quality training, consultation, research, and technical assistance.

Applications are now being accepted for an ACT Consultant/Trainer. Salary and benefits are competitive with other university settings and based on education and experience. Position within the IUPUI Department of Psychology based out of the Roudebush VA Medical Center in downtown Indianapolis, Indiana.

Job Description

- Provide initial and ongoing training and consultation on the ACT model to new and existing ACT teams in Indiana. This is done via various media and communication modes – face-to-face, phone, email, didactic presentations, interactive practice exercises, shadowing ACT staff "in action," advocating for teams at various stakeholder levels
- Consultation in areas of implementing ACT including planning the implementation process with administrators and site steering committees, certification process, admission criteria, outcome monitoring
- Liaison between ACT teams and the ACT Center/DMHA
- Participate in monthly conference calls and quarterly regional meetings for ACT team leaders
- Complete fidelity visits and reports on ACT teams
- Consultation and training for ACT teams or technical assistance centers outside of Indiana (as needed)
- Occasional presentations to various stakeholder groups in the state (e.g., DMHA, NAMI, etc.)
- Opportunities to present at and attend state and national conferences related to ACT and EBPs

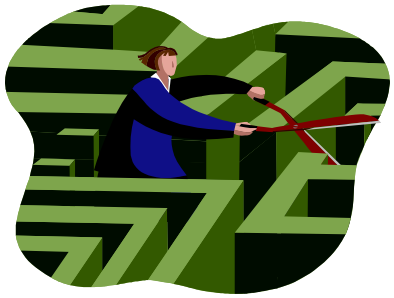
Important Skills/Qualities

- Recovery orientation and belief in the importance of research to guide practice
- Knowledge of the ACT model and direct experience on an ACT team (highly preferred)
- Teaching abilities (ability to make formal presentations as well as working one-on-one with staff)
- Flexibility, time management skills, and self-starter
- Interpersonal skills (engaging and empathetic, open and willing to learn, clear communication, team player)
- Master's degree preferred, bachelor's degree required
- Writing and research skills are a plus

Apply by sending letter and resume/vitae OR for more information, contact:

Michelle P. Salyers, Ph.D.
Co-Director, ACT Center of Indiana
IUPUI Department of Psychology
c/o Richard L. Roudebush VA Medical Center
1481 West Tenth Street, 11-H, Room D6007
Indianapolis, Indiana 46202

Phone: (317) 554-0000 x4419
Fax: (317) 554-0114 (ATTN: Michelle Salyers)
Email: mpsalyer@iupui.edu
Website: www.psych.iupui.edu/ACTCenter



Getting Our Act Together

By: Tim Stultz
ACT Center IMR Consultant/Trainer

On March 20th, 2006, Dr. Michelle Salyers, Co-Director of the ACT Center of Indiana, provided a talk at Logansport State Hospital. The talk was entitled, "Recovery Oriented Services: Strategies for Implementation." The talk was requested in response to the growing realization that while the hospital has a history of implementing best practices, there is also a long history of such practices "dying on the vine." Most initiatives, even important initiatives that have been supported by the Governor's office have had poor follow through. Consequently, implementation is one of the most important issues that we need to address.

Dr. Salyers provided a list of Five Critical Steps necessary to implement a new program (adapted from Drake, Mueser, et al., 2000). They are:

1. Provide explicit principles, guidelines, and implementation criteria.
2. Ensure administrative and environmental supports for change.
3. Provide clinical training.
4. Provide ongoing training/supervision/consultation.
5. Collect quantitative information on process and outcomes to improve the program.

As Dr. Salyers discussed each specific area, I realized that leadership focuses almost exclusively on clinical training as the means to "implement" change. The data are clear that without repeated follow up and review, training is like peeing in brown pants, it gives you a warm feeling, but no one really notices. I also realized that the principles involved in implementing a new program with a system or hospital are, in fact, the same principles necessary for an individual to set and move toward their own goals. The parallel is clear to me, and it is no wonder that we struggle so much in providing consumers with what they need to succeed in implementing and maintaining change when we have not been able to provide those very elements to our own initiatives. Truly, we need to get our act together.

As an IMR trainer, implementing IMR means implementing the program from a whole systems perspective. However, that does not mean we have to reinvent the wheel. IMR at the system level requires the leadership to revisit their strategic plan and involve all of the stakeholders, including consumers, in that plan. It involves the leaders laying out the strategic plan and empowering the staff to develop their own means of obtaining those goals. It means empowering staff to openly discuss consumer's wants/needs/wishes in a manner that empowers them and ensures that those goals are incorporated in the plan. It involves a means of accounting for those goals and the processes that we believe will lead to those goals. It means that we all understand that if something is important, we must be able to measure it, and that only with such measurement can we manage it. It involves 360 degree feedback without fearing honest responses. It involves reporting numbers with integrity and transparency, not to respond with a sting, but with ointment meant to heal or a cheer meant to inspire and celebrate.

Ultimately, getting our act together means embracing implementation like a new found love. The beauty of it is: once you experience it, it is a love that transforms.

Service Needs and Perceived Barriers to Developing Partnerships with Providers: Family Perspectives

By Hea-Won Kim, ACT Consultant/Trainer & Michelle Salyers, Co-Director

Although the inclusion of significant others in the mental health services is recommended as part of best practice, research has suggested that families continue to express a great degree of dissatisfaction with the amount and quality of services they receive as well as with the interactions family members have with mental health professionals (Biegel, Song, & Milligan, 1995; Dixon et al., 2001; Hanson & Rapp, 1992). The purposes of this study are to examine family members' views about the extent to which mental health programs provide services to families and include them in the treatment of their relatives with SMI, and to identify barriers to developing collaborative partnerships with providers. This study builds on a recent state-wide survey assessing these issues from mental health professionals' perspectives (N=453). Family's perspectives were also compared to providers' views on the same issues.

Method: A needs assessment was conducted with randomly selected family members (N=222) of the National Alliance on Mental Illness (NAMI) Indiana, using a self-administered mail survey. The survey was developed based on previous research (e.g., Kaas, Lee, & Peitzman, 2003) and includes questions about background information, current level of services families received, their perception about the interaction with providers, and barriers to developing a partnership with providers.

Results: Most family respondents were females (83%) and Caucasians (96%). On average, they were 61.4 years old and had been a member of NAMI for about 8 years. About 72% of respondents were parents and 46% graduated college or have a higher education. Respondents reported that about 50% of their relatives have schizophrenia spectrum diagnosis and 36% are living with families. On average, the relatives are 40 years old and have been ill for 16 years. Over 65% of relatives were receiving services from community mental health center/ outpatient clinic.

The majority of families (62.8% to 84.3%) reported that they 'never' received 13 out of 16 types of services in the last 6 months. The most frequently received types of services were being included in the treatment planning (21.3%), information about the relative's mental illness (18.8%), and being informed of the relative's progress (13.9%). The least frequently provided services were providing information on community resources (3.6%), providing family therapy (5.1%), and teaching identification of early warning signs of relapse (5.1%).

More than half of family respondents identified variables related to work/agency (e.g., too many demands on staff, lack of support from agency to provide family services) as well as financial burden of services to families as major barriers. The overall amount of services families received was significantly related to their positive interaction with providers such as being supportive of family involvement, recognizing family burden, and seeking family's input ($r=0.29$ to 0.42, $p=0.001$ to $p=0.00$) and was significantly related to fewer perceived barriers ($r= -0.38$, $p=0.008$).

When provider perspectives were compared to the families', there were significant discrepancies. In general, providers agreed that they did not provide many services to families in the last 6 months, but they reported significantly higher overall level of services than did family members (means: 1.4 vs. 0.7, $t=13.1$, $p<.000$) when the services were rated on a 4-point scale (0=never, 1=not very often, 2=sometimes, 3=very often). In addition, providers held significantly different perspectives about barriers: providers viewed client/family factors (e.g., family's lack of interest,

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"Service Needs . . ." cont'd from pg. 7 . . .
client's refusal to involve families) as major barriers, while family reported work/agency factors (e.g., too many demands on staff, lack of agency's support) as more major barriers, followed by staff related factors (e.g., lack of staff's interest, staff's skepticism about value of including family).

Implication: Consistent with previous research, families of persons with SMI are not receiving services to meet their needs. The findings on discrepancies in two perspectives suggest that more training would be helpful to improve providers' understanding of family's needs as well as their skills and knowledge so that they can be more responsive to families and develop a partnership with families.

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How do You Measure a Smile?

By Charles Boyle and Rhonda Bergen
Indiana Division of Mental Health and Addiction

"Friendly state visits" was a term created for visits made to Assertive Community Treatment (ACT) teams that did not include certification, fidelity measures, training or data collection. These visits were made by Rhonda Bergen and me to three ACT teams. This is a report, of sorts, on those visits.

I wanted to visit these teams because I feel too isolated from the real work and real successes of the ACT teams. I review the data that comes to this office from the ACT Center of Indiana. I see those outcomes in the form of numbers and reports. I knew that there was more going on in the field than ever shows up in the outcome data. While researchers and funding agencies need to see measurable outcomes, those data do not reflect the daily triumphs of the teams and of the individuals that are enrolled on an ACT team. I needed to hear about those.

Previously I encouraged team members to write down successes and send those to me. That did not get the response I hoped for because, as I now realize, it requires additional time and writing on the part of a team member, and it is not as easy as I anticipated. It made more sense for me to visit the source than it did to request a written version of those successes.

I visited ACT teams at Oaklawn, along with Rhonda Bergen of this office, Hamilton Center and some time ago, Tri-City. The last one was an unannounced spur of the moment event, but it was equal to the planned visits in that I came away feeling great about the work that was being done. At each site, there was a free flow of stories that were all worthy of note.

The time allotted to me during those visits did not permit great details in the events that were told. The comments I heard underscored that the data I receive does not begin to tell the real story of ACT.

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"How do you measure . . ." cont'd from pg. 8 . . .

Employment was a recurring topic. People that were working had a pride that did not exist before. One team reported that even people who had lost employment due to the employer losing a contract were still proud and pleased of the work they held. That reinforced the concept of the power of employment and the major part it plays in all of our lives, especially for those we work with and for.

There were stories of people coming out of isolation and people that were now shopping on their own or with little assistance. There were stories of people that are going out to get their hair done. There were events where at first the person would only crack open the door to receive medications or to talk to an ACT team member, and now that person is looking forward to the visits with an open door.

I was told of people that were hospitalized for over 20 years that are now living independently. The data shows that as one hospitalization and does not reflect the wonder of someone working in the community when before they knew only the grounds of the state hospital.

The benefits of earlier recognition of relapse and earlier interventions were mentioned. Also mentioned by a team was the discovery of unknown medical issues. A consumer hid some medical problems for fear of being re-hospitalized. The ACT team made the discovery and secured needed medical attention. I heard about a woman that held her own art show and the excitement and joy that produced. I learned of ACT teams working with other community providers (physicians, dentists, local ER's) resulting in not only better continuity of care but better community collaboration as well. I learned that sometimes the ACT teams provided a substitute family where bridges had been burned.

All of the events and successes stay with me, but what I find myself going back to is the outward expression of a changed life: a smile. I heard about smiles of recognition and acceptance of the team where before there was paranoia and suspicion. I heard about smiles of someone that had dental work done through the efforts of the ACT team, and that person is smiling for the first time in fifteen years. There are smiles of accomplishment, smiles of well being, smiles of success, smiles of belonging, and smiles of being better off than before. A team member at Hamilton Center, Case Manager Rod Hatcher, said that data does not measure a smile. As I drove home, I realized how correct that comment was. I later realized he named this article. I don't know how to measure a smile. They exist, and the ACT teams are seeing them every day. They may be a measure of success that is not measured. They should be. The fact that smiles were mentioned in some form or another at each visit tells me that smiles are an important indicator to the teams.

I now know that there are individuals that are smiling because of ACT. I also know that there are ACT team members that should be smiling because of the changed lives they are seeing every day. I also know that there is one state employee that is smiling because of the three visits and the changed lives he learned about. Take a few moments to count the smiles that you have caused and that have been given to you because of the efforts of the team.

How do you measure a smile? It can't be captured in a database. It can't be assigned a price or be worked into a formula. But those smiles are part of the successes that the ACT teams are seeing every day. I know I left the meetings with the ACT teams with a smile.

If there were a measure of a smile, mine would have been at least a ten on a ten point scale after those visits.

NON-TRADITIONAL DRUGS OF ABUSE AMONG SEVERELY MENTALLY ILL ADULTS

Craig Andler, LSW, ICADC, CCS, CADAC IV
ACES Program Manager

Research on nicotine consumption and the severely mentally ill is growing. However, a host of substance consumption appears to remain relatively undetected. In over twenty-five years of work with the deinstitutionalized, severely mentally ill, consistent reports from the consumers about high volume intake of caffeine, sugar, salt and over-the-counter drugs led to greater attention to assessment of chemicals consumed. Prescription and non-prescription drug effects may be a significant source of chemical interaction, side effects, and adverse reactions. The potential benefits to consumer-based outcomes are many, and the implications for illness management and recovery are great. Here are some suggestions for those with a curiosity in this area.

First, at a point where rapport has developed, ask the consumer to describe "a day in your life." Be specific about starting before getting out of bed. Encourage them to describe each activity as the day progresses, i.e. "smoked a cigarette, got out of bed, went to the bathroom, made some coffee", etc. Work with the consumer to get a vivid picture of a typical day, with particular attention to the day's intake of food, fluids, and other substances. As a baseline, here is what we have found in the majority of consumers:

- Daily nicotine intake above dependence criteria in DSM.
- Daily caffeine intake above dependence criteria in DSM
- Daily sugar intake above FDA predictions for US citizens.
- Daily salt intake above FDA predictions for US citizens.
- Self regulated quantity and frequency of over-the-counter medications including:
  - Antacids
  - Analgesics
  - Laxatives
  - Cold medications
  - Sinus medications
  - Allergy medications
  - Nasal decongestants
  - Diuretics and medications related to menstrual problems
  - Sleep aids
  - Diet medications
  - Energy enhancement drugs

The old phrase "If a little is good, a lot is better" frequently finds new life in the self-regulation of the above medications. Most important to this process is the creation of a respectful, open, and accepting environment for the consumer to respond with pertinent information.

Second, find a comprehensive guide to prescription and non-prescription medications. We have found the annual editions of "A complete Guide to Prescription & Nonprescription Drugs" by H. Winter Griffith, M.D. to be accurate and useful with consumers because of its easy to read format. Gathering information on the potential side effects and adverse reactions for each of the substances will be enlightening to say the least.

Third, work with your nursing staff to build a working body of knowledge on interaction effects with medications. This will include concepts such as:

- Antagonistic effects
- Additive effects
- Synergistic effects
- Supra-Additive potentiation effects
- Tolerance and cross tolerance effects

Additionally, you will find the nursing staff a valuable resource on medication issues generally.

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"Non-traditional . . ." cont'd from pg. 10 . . .

Fourth, be sure to share this information with the treating psychiatrist and work to get involvement in this process.

Fifth, as indicated in the treatment planning process, work with the consumers to provide information tailored to their individual experiences. Avoid describing the broad lists of medication related side effects for either prescribed or non-prescribed drugs. This may avoid the consumer acquiring more concerns about the prescribed medications. Focus on the consumers concerns, being particularly attentive to points where they attribute effects to the psychotropic medications. When the timing for contemplation appears indicated, provide information on those effects that are also possible from the other chemicals they consume. Consider pointing out the quantity and frequency of each. For example, we found that caffeine intake per day could range from 1000mg to 2500mg for many consumers. As a stimulant in addition to nicotine and large amounts of sugar, the potential sources of restlessness, low concentration, and impulsivity are numerous to say the least. In the presence of antipsychotic and/or antidepressant medications, a wide spectrum of interaction may be indicated. Building discrepancy and decisional balance here may be very productive in recovery processes.

Last, when consumers have significant benefit from management of prescription and non-prescription medications, work to support the sharing of these benefits among peers. In summary, we live in an age that encourages "fast, fast, fast relief" and "better living through chemistry." As we know, "the Devil is in the details." And in this case, knowledge about chemicals and the impact of prescription and non-prescription drugs generally may be keys to helping consumers take another step in their recovery.

Interpreting Fidelity Ratings: Balancing Individual Elements with the Big Picture

By Lorna Moser, Implementation Monitor
& Natalie DeLuca, ACT Consultant/Trainer

If you have a headache, you may take an aspirin, and for good reason – aspirin has been tested and shown to be effective for reducing pain. If the pain is really bad, you may take two. Why not take three? Or 30? The reason is obvious – even if a treatment is proven effective, there comes a time when more of a good thing is not necessarily helpful, and in extreme cases, it could even be dangerous! As assessors of Assertive Community Treatment (ACT) programs, we've begun to consider a similar question of what the right "dose" might be for many components of ACT services.

To give some background, we'll first describe program fidelity and then talk about the challenges of creating a fidelity scale. We'll then describe some interesting examples of what we mean when we talk about too much of a good thing as it relates to our experience assessing ACT program fidelity.

Basic Fidelity Concepts

In mental health services, program *fidelity* is the degree to which a program adheres to the critical elements of a specific model. A *fidelity scale* is a tool used to measure this adherence. Ideally, a fidelity scale serves as a list of the critical ingredients of a model, and high scores on each item would reflect the ideal "recipe" for success. When assessors rate programs using fidelity scales, they are measuring how much of each key ingredient is present.

Fidelity scales serve multiple purposes, both practical and research. One main reason that fidelity is important is because studies have shown that ACT programs that have high program fidelity generate better consumer outcomes compared to programs that are low-fidelity. Fidelity ratings also provide a consistent

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way to measure program improvement over time, and allow comparisons to be made between different programs following the same model. Undeniably, fidelity measures are key tools for successful program implementation. However, fidelity scales are not without their errors, and it is important for researchers and practitioners to openly discuss not just their strengths, but their limitations as well. Of these challenges, we'll focus most on the idea of "dosage" – that is, when, if ever, does "more" equal "better?" When ACT teams exceed the standard set for full implementation, are they demonstrating even better practice, or possibly poor practice?

Development of Fidelity Scales

The development of a reliable and valid fidelity scale can be a challenging task. Ideally, a fidelity scale should capture the *essence* of a program's philosophy. The scale should be composed of items that assess the critical elements of that model. A fidelity scale should also represent the most *salient* characteristics of a model, while avoiding characteristics that transcend multiple models. For instance, we know that the therapeutic alliance is essential for any treatment model, including ACT. However, assessment of the therapeutic alliance is purposefully left out of the Dartmouth ACT Scale (DACTS), as it does not serve to discriminate between ACT and non-ACT models.

After the task of identifying critical ingredients of a model, scale developers must then identify a set of anchors used to rate each item. The DACTS and several other fidelity measures of evidence-based practices utilize 5-point scales, where the low end of the range (scores of 1 or 2) reflects poor practice or no implementation of that element, and the high end (scores of 4 or 5) reflect excellent practice or high fidelity implementation of that element (see **Figure 1** for an example of a fidelity scale item from the DACTS). The real challenge for scale developers is defining what equals "full implementation" of a given element. These decisions may arise from expert consensus, current practice, or the theoretical foundation for the model.

In Figure 1, the anchors are easily measurable, and range from 1 contact to 4 or more contacts per week for the consumers served by an ACT team. There is no "cut off" for a *maximum* number of visits that is considered to be high fidelity. What if a team, on average, saw consumers 6 times in a week? What about 20? Similar to the aspirin example above, it could be that at some point, too many service contacts might not be ideal. The current way that we measure this item doesn't take into account an "ideal" or "maximum" dose not to be exceeded. In this case, we can see that some fidelity scale items may miss out on identifying bad practice when a team far exceeds the standard set for high-fidelity.

Figure 1. Item from Services Subscale, Dartmouth ACT Scale (DACTS)

Criterion		Ratings/Anchors				
		(1)	(2)	(3)	(4)	(5)
S5	FREQUENCY OF CONTACT: high number of service contacts as needed.	Average of less than 1 face-to-face contact / week or fewer per client.	1 - 2 / week.	2 - 3 / week.	3 - 4 / week.	Average of 4 or more face-to-face contacts / week per client.

Examples of the Dosage Problem

How do we reconcile the discrepancy between fidelity ratings that tells us what is "good" and what may be "too much?" As frequent users of fidelity scales, particularly the DACTS, we strive to collect data not just for making ratings on individual items, but also so that we can develop a holistic understanding of the degree to which the team embraces the underlying philosophy of the ACT model. Much like psychological test data must be interpreted within the context of a comprehensive assessment, it is crucial to interpret a team's performance

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on fidelity items in light of the bigger picture – this usually requires looking at performance on other fidelity items that may be related.

Consider two different ACT programs – they both provide a high frequency of consumer contacts, such that they exceed the standard for full implementation (i.e., higher than the minimum required to score a "5" on the fidelity item shown in Figure 1). However, when examining the context more closely, as captured by data collected to make ratings for other fidelity items, we see that Team X is providing the full-range of services (i.e., not brokering services), is adequately-staffed, and has made individualized services a high priority. Team Y, however, has instituted a more regimented schedule of conducting intensive medication monitoring that accounts for the majority of visits, as the team does not provide a full array of psychosocial services. This example of two teams with the same item-level rating, but with vastly different practices and understanding of the ACT philosophy, shows that sometimes providing *more* service does not necessarily mean providing *better* service. Instead, a high score on this particular fidelity item may be an indication that Team Y's services may be paternalistic, or that they are not striving to meet consumers' individualized needs and goals.

In contrast, with some fidelity scale items on the DACTS, doing more (i.e., exceeding the criteria to receive an item score of 5) likely does indicate better services. The DACTS item "Explicit Admission Criteria" (Item O1; see **Figure 2**) is arguably one such example.

Figure 2. Item example from Organizational Boundaries Subscale, Dartmouth ACT Scale (DACTS)

Criterion		Ratings/Anchors				
		(1)	(2)	(3)	(4)	(5)
O1	EXPLICIT ADMISSION CRITERIA: Program has clearly identified mission to serve a particular population and has and uses measurable and operationally defined criteria to screen out inappropriate referrals.	Program has no set criteria and takes all types of cases as determined outside the program.	Program has a generally defined mission but the admission process is dominated by organizational convenience.	The program makes an effort to seek and select a defined set of clients but accepts most referrals.	Program typically actively seeks and screens referrals carefully but occasionally bows to organizational pressure.	The program actively recruits a defined population and all cases comply with explicit admission criteria.

Because of the high intensity, comprehensive services, and outreach-orientation of a good ACT program, enrollment is best suited for a small proportion of individuals with severe mental illnesses; therefore, having a clearly defined target consumer population is central to a high-quality ACT team. A team that receives a "5" on this item may be using explicit admission criteria to screen potential consumers, with the vast majority of referrals from the pool of consumers already receiving services from the parent organization, only occasionally screening external sources for referrals. However, if a team went above and beyond in terms of active recruitment (e.g., routinely visiting homeless shelters and persons living on the street to help identify potential ACT consumers in a thoughtful and systematic way), it may be an indicator that that the team more fully embraces the ACT philosophy of serving those who have not engaged in more traditional mental health services. In this case, it seems unlikely that a team could exceed the minimum standard defined for full implementation to the detriment of the consumer and/or practice.

For some items, exceeding the standard set for a 5 is likely not a positive or negative reflection of the team's practice, but more a consequence of individual program circumstances, such as location. For example, to

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score a 5 on the "Community-Based Services" (Item S1), at least 80% of face-to-face contacts must take place in the community. A key philosophical underpinning of ACT is that 1) the team is targeting a group of consumers who do not reliably attend office-based appointments and 2) are in need of comprehensive services that are best delivered in real-world settings (e.g., home, café, or job). Team X may provide 95% of the services in the community, not because they are significantly better than Team Y who just meets the 80% criteria, but because Team X's service area has poor public transportation, making it difficult for consumers to make it to the office.

Concluding Comments

As frequent users of the DACTS, we have both a strong regard for its usefulness, and some respectful questions as to how key program components are defined and measured. Despite the inherent challenges of measuring fidelity in a way that is consistent, accurate, and useful, regular attention to program fidelity is critical to conscientious implementation. The comments in this article are intended to provide a richer context for the important process of interpreting fidelity scores, and to prompt administrators, team leaders, and practitioners to take a step back to view fidelity scores as part of an integrated, dynamic whole. The main caution we offer is to avoid the temptation to reify the fidelity scale, or even worse, any single item on it. Rather, the most successful and resilient ACT teams appear to be the ones that commit first to the philosophy, and then trust that performance on the fidelity measure will reflect this commitment. Our brief comments here on the difficulty of accurately pinpointing correct "dosage" for any one component of ACT services is meant to remind all of us about the importance to an understanding of and commitment to the overarching philosophies of ACT and recovery from mental illness.

to Share

From Leslie Bissell, Hamilton Center ACT Team Leader

Just wanted to pass on a word of thanks for an idea that someone sent out awhile ago. At the time, our team morale and communication skills were suffering since the lost of 3 staff in 5 months. Someone recommended using "pet peeves" to give the team a chance to voice frustrations during a scheduled team meeting.

What I did was created little peeves (creatures drawn on brown paper) and gold stars for the team to write down frustrations as well as what they see that each other is doing well. We posted them in the office – "what we do well" (gold stars) and "what we want to change" (peeves). They were anonymous. Although at first they were a bit apprehensive, most participated with gusto and were able to voice similar themes – everything from "some people talk to much during the morning meeting" to "we help consumers stay safe in the community."

We discussed the themes at the end of a morning meeting (took about an hour) and identified specific things we want to change. I put up a flip chart that outlined the goals ("Today we will: Listen to each other, be concise, be patient and use positive language") I think it is helping us all refocus on the big goal of helping consumers by taking care of each other.

Over the next few weeks I planned to post a new motivational thought and highlight the gold stars and peeves that seem to fit, along with a challenge to the team on what they will do to make things better.

Just wanted to pass it along. Thanks for your feedback and support! GGGGOOOOOOOO ACT!!!!

Up Close & Personal

with Jenna Godfrey

Hello! My name is Jenna Godfrey. I am a third year graduate student at Indiana University-Purdue University Indianapolis (IUPUI) researching Illness Management and Recovery with Dr. Michelle Salyers.

I was born in Coldwater, Michigan and moved to Fort Wayne, Indiana at the age of 5. I lived in Fort Wayne until age 12 at which time my family moved to Carmel, Indiana. My mom is a math teacher at Lawrence Central High School, and my dad is a CPA who recently started his own accounting business. He also does contract work for FEMA managing the flow of money at natural disasters. My older brother is at Wayne State (Detroit) for his residency in Orthopedic Surgery.

I graduated from Carmel High School and attended Indiana University in Bloomington for undergraduate study in psychology. I first became interested in psychology my junior year of high school. Prior to then I had the somewhat unrealistic goal of becoming a marine biologist but realized I get horrible motion sickness on boats in the ocean and am afraid of sharks. And so my dream was crushed until I took an elective psychology course at Carmel and discovered I was the only one of my friends who really enjoyed it. I majored in psychology at Indiana University (IU Bloomington) and worked as a mental health aide for the state of Michigan during the summers to gain clinical experience.

My particular interest in studying schizophrenia grew from my abnormal psychology course at IU. I began conducting research with my professor, Dr. Bill Hetrick, with whom I then worked with for 3 years. My research with Dr. Hetrick involved the etiology of schizophrenia rather than treatment and services. I came to IUPUI to continue studying the etiology of schizophrenia with Dr. Jovier Evans. Dr. Evans left IUPUI at the end of my first year, and I was absorbed as Dr. Gary Bond's student. While I was extremely upset when this first occurred, I now realize it was the best thing that could have happened. I never had much passion in studying the etiology, but my interest in schizophrenia kept me going to some degree. My experience as a mental health aid exposed me to the many flaws in the mental health care system, and at the time, I felt powerless to fix them. Now I feel I am making a difference in the way people with mental illness are treated, which is something I am very passionate about. While my path has not been entirely linear, I feel I am beginning to discover what makes me tick and look forward to what the future may hold. Because my other passion in life (thus far) is travel, a long-term dream goal would be to spread EBPs to another country while living there for a few years. I hear Spain is nice!

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INDIANA UNIVERSITY
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Department of Psychology
c/o Richard L. Roudebush VA Medical Center
1481 West Tenth Street, 11-H, Room D6005
Indianapolis, Indiana 46202

Phone: (317) 554-0000 x3119
Fax: (317) 554-0114

Website: www.psych.iupui.edu/ACTCenter
General LISTSERV: ACT-CENTER-L@listserv.iupui.edu

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 quarterly newsletter, contact Veronica Pedrick at vpedrick@iupui.edu or (317) 554-0000 x3119. Newsletter created, designed, & edited by V. Pedrick.

Things to think about...and do!

How are we doing?

We are always looking for your constructive feedback. Please contact us with your thoughts and comments on how we can better serve you.

Also, we may be contacting you soon to fill out an online evaluation of technical assistance services. Our staff are committed to providing high-quality services that meet the needs of the mental health service providers we work with. Your input is important to us.

Interested in joining our team?

We are currently seeking applicants to help us meet our ACT training and consultation needs. Please see page 5 of this newsletter for more information.