ACT Center of Indiana

Excellence in Training, Research, and Technical Assistance

Newsletter

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Notes from the Directors

We've had a busy and exciting few months getting the ACT Center up and rolling. Most importantly, we've collected and prepared numerous aids to help you begin the implementation process. Our resource center now has many articles, books and book chapters, videos, and pamphlets that are available for you (free or at cost). We've also completed the first edition of our resource manual to assist in your efforts to implement ACT. Please call or e-mail the center to receive your copy. Our listserv is growing (contact vbannon@iupui.edu to join), and we envision it to be a dynamic resource for people to share their challenges and experiences in implementing ACT as well as a fast way to request/receive information. We have also posted our web-site. Please visit our site at http://psych.iupui.edu/ACTCenter/ACTHome.htm and let us know how we can make it most useful for your needs.

In addition to developing our resources, our training has gotten underway as well. Thus far, our ACT training is at two levels: a *broad-based* training and an *individualized* approach with specific teams. We like to start with the broad introduction to ACT so that all interested parties have a basic understanding of the ACT model. We conducted day-long trainings at Geminus Center (Sept. 2001) and at Madison State Hospital (Dec. 2001) and have given several presentations about ACT (e.g., NAMI Indiana conference, ICORPS). We are planning upcoming day-long training events in Indianapolis, Fort Wayne, and the southwest portions of the state (see "What's on the schedule?" section of this newsletter).

After attending our general overview of ACT, we visit sites that are starting their own ACT programs for an individualized in-service training about ACT. We will follow this with job shadowing with an existing ACT team and on-site mentoring with experienced ACT clinicians. We have started this process with two teams (Four County and Lawrenceburg) and are available to work with other agencies. Please contact us to set up a consultation visit.

Our ACT Center team is very excited about the state's ACT initiative (See the Update from DMHA section of this newsletter). Indiana is part of a national movement to implement evidence-based practices in order to better serve individuals with severe mental illness (see "Research Corner"). We know ACT works! We also know how challenging it can be to implement a new program to do ACT well (see the "New Year's Resolution #1" article in this newsletter). We are committed to helping you implement ACT and will assist you in any way we can. We are looking forward to working with you!

Michelle P. Salyers, PhD

Michelle McKasson, MA, LCSW

Stay up-to-date on ACT implementation in Indiana!

Join our listserv*! Through email, you can receive copies of announcements, papers, articles, website postings notices, resource & training materials, and more. Our listserv will be an avenue for answering your questions, discussing ongoing implementation issues, and facilitating support from other ACT teams and the ACT Center staff. If you would like to subscribe, email the following information to vbannon@iupui.edu: name, phone number, email address, affiliation (e.g., MHC name) and position, if applicable (e.g., case manager).

"The Basics Box"

Assertive Community Treatment Principles

- Individualized, comprehensive and flexible treatment, support and rehabilitation services
- Team members are direct providers of services
- Majority of contacts with consumers are in community settings
- Team is the fixed point of responsibility for services
- Services are provided on a time–unlimited basis
- Services are available 24 hours a day, 7 days a week
- Treatment is prompt and responsive

Update from DMHA

Richard DeLiberty
Deputy Director, Office of Transitional Services

The Family and Social Service Administration (FSSA) has a strong belief that people should receive services in their own community and that the care they receive should be of the highest quality and effectiveness. For the Division of Mental Health and Addictions (DMHA), this translates into a mandate to develop Assertive Community Treatment teams across the state.

DMHA believes that ACT works: that it helps keep people functioning at the highest level and out of hospitals. A lot of what DMHA did in the Hoosier Assurance Plan was with the hopes that it would create an environment where ACT would thrive. After all, Medicaid pays for the core ACT services, and the case rate system rewards cost effective care.

DMHA now believes that to institute ACT we need to intervene more directly. We need to describe clearly what we think needs to happen, and we need to arrange for funding for exactly that service. ACT is not for everybody that meets the state definition for serious mental illness. ACT is for those people that would otherwise be institutionalized or in group homes.

What can a provider be doing now?

✓ In the short run, you can start organizing services to come closer to approximating an ACT Team. An ACT Team integrates all of the services necessary and is self-contained. Develop and organize the team, using the fiscal flexibility that you already have.

✓ Much of what an ACT team does can be billed to MRO or to clinic services. Much of medication monitoring or outpatient services, for instance, can be billed to clinic. People forget that home visits, when they are counseling and not case management, can be billed to clinic services. People get confused over the term medical necessity. The "R" in "MRO" is rehabilitation. That doesn't necessarily imply a medical model…remember, Medicaid pays for chiropractors and physical therapy. As long as the services are documented as necessary in the treatment plan and are within the definitions of the services, they are okay.

✓ Although it doesn't pay to teach someone how to make widgets, Medicaid pays for case management at the work place. Medicaid does pay to help someone to deal with personal adjustment issues around coworkers. Medicaid pays for a lot of case management. While it won't pay for more than two case managers at once, it will pay for 24 hours of case management in a day, if it is in the treatment plan.

✓ You can also use your other (HAP) money flexibly. Buy a client a bike if it helps them keep their job. Pay a family member for services if it helps keep somebody at home. Use consumers as staff, but pay them for their services.

✓ Develop something as close to an ACT team as you can afford to do. You may be surprised how close your present funding will take you. (cont'd on pg. 3)

What happens in the next year or so?

With the current budget situation, it is hard to tell. Our current SFY 2003 budget includes a $4,000,000 increase for SMI services. If we get it, some of that will probably have to pay for some more SOF Agreement type contracts. We still need to concentrate on long-term people in the hospitals. The SOF Agreement type contracts with mental health centers specifically to move people with long hospital stays into the community. What's left will go to ACT.

However, there is flexibility in the use of SOF agreement type funds that could be used to help pay for ACT. When we fund the SOF agreement type contracts, we prioritize the applications by three factors: cost, severity, and degree of integration. ACT services are much more integrated than any of the SOF contracts that we've approved. Moving 10 long-term SOF patients at $33,000 each would pay for an ACT Team, and new ACT Teams under SOF agreement types will be given priority.

When we do fund new ACT teams, we will continue to look at geographic diversity, but our next priority will be for teams that are already certified. You can seek certification now before funding is available. Several have indicated their intention to do just that.

In the long term, Medicaid . . .

In the long term, DMHA wants to see ACT as a Medicaid funded service, and we are already working in that direction. We are looking at a process where ACT is funded at a daily rate. That means that included in the rate is meeting time, travel time, and all of the non-funded services that make up ACT.

To do that we need to demonstrate to Medicaid that we can identify and certify ACT teams, and we are on the way to doing that. It has to be a rigorous process because doing anything short of the most rigorous leaves us open to a wide range of abuses.

We need to clearly define the target population, who can receive ACT program services. Early applications from our three pilots indicate that this may be harder than we thought. When this becomes a Medicaid service, it may be liable to prior approval. We need to be clear about who is eligible.

We need to put our certification standards for ACT into rules and regulations, and that takes a long time. We don't want to rush because our experience with the three pilot sites is helping us alter the standards to make them more viable. The rules get published; we hold hearings; the process takes six to 12 months. In the interim, we are using an administrative directive for ACT certification.

When we finally work with the Office of Medicaid Policy and Planning, there is another set of steps. ACT needs to be approved by OMPP's Medical Policy Group. In 1999, HCFA's "Dear Director" letter recommending ACT led to a denial by this committee. They found ACT to be cost prohibitive and not necessary. We promised to go back to the committee when we had more information.

The state needs to amend the Medicaid covered services rules to include ACT as a rehabilitative service. OMPP has more steps than we do in rule promulgation.

Medicaid also needs federal approval through a Medicaid State Plan Amendment. This approval takes a minimum of 90 days. Then there are a variety of miscellaneous things to do. We need to review and update memorandum of understanding between DMHA and OMPP. There need to be updates to the Medical Assistance Provider Manual and to the Reimbursement and Billing Guidelines. Finally, rates need to be developed. Again, we are hoping to develop ACT as a daily rate. By time we do this, there may be another evidence-based practice that we want to implement, and we can start the whole process from the beginning again.

THE ACT CENTER OF INDIANA WEBSITE IS HERE!!!

http://psych.iupui.edu/ACTCenter/ACTHome.htm

Check it out!

Need resources on ACT?
Have questions or comments?
Want to register for training?
Join our electronic mailing list?

CONTACT VERONICA
ADMINISTRATIVE COORDINATOR

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Research Corner: Five Articles You Should Read

Gary Bond, Research & Program Evaluation, ACT Center of Indiana

Assertive community treatment (ACT) has been identified as one of six evidence-based practices by a national panel of leading experts on services for people with severe mental illness. The others are: supported employment, proper use of medications, family psychoeducation, integrated dual disorder treatment, and illness management. All but the last of these have been described in a series of articles that appeared in *Psychiatric Services* over the last year (See list at end of the article). The final article is expected to appear early next year.

What is meant by an evidence-based practice (EBP)? In the current context, this is a practice that has been shown through rigorous research to be effective in achieving important outcomes that are part of the recovery of persons with severe mental illness. In addition, EBPs are well-defined practices with specific implementation guidelines.

Each of the articles listed below summarizes the research that justifies the status as an EBP. Each describes the typical outcomes, any limitations for providing the EBP, and suggested strategies for overcoming the barriers to implementing them. Types of barrier that must be overcome include financial, regulatory, attitudinal, and informational barriers. One common theme for all of the EBPs is the need to involve key stakeholders, including state level administrators, center directors, supervisors, practitioners, consumers, and family members.

Indiana is part of a national movement to systematically implement EBPs in order to provide the very best treatment for people with severe mental illness. This trend toward EBPs is indicated by state conferences on this topic recently held in Illinois, Maryland, and New York, to name just a few. Among the states with vigorous statewide plans in place to implement EBPs in a systematic way are Kansas, Vermont, New York, Maryland, New Hampshire, Ohio, and Oregon.

Although the current initiative of the Division of Mental Health and Addictions concerns the implementation of ACT, all of the other EBPs listed above serve as natural complements to ACT. In other words, ACT provides an organizational framework for supported employment, family psychoeducation, and all of the other EBPs mentioned above. Consequently, the focus on ACT naturally leads to further consideration of these other practices.

The state of Indiana is collaborating with a national research team headed by Robert Drake at Dartmouth Medical School that is working toward widespread implementation of all EBPs and determining the best strategies to achieve these goals. The Dartmouth EBP Project has established six "implementation kit development groups" who are creating videotapes, manuals, brochures, PowerPoint presentations, fidelity scales, and other materials that can help mental health centers in the EBP adoption process. Completion of these materials is expected during 2002. In subsequent newsletters we will be updating you on the progress of this effort.

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New Years Resolution # 1

Implementing ACT: Strategies for making this resolution stick!

Jane Williams, Organizational Evaluation & Management, ACT Center of Indiana

Creating change in our individual behavior is difficult in every aspect of our lives. We can all probably relate to past New Year's Resolutions where we've tried to make changes in our exercise, diet, or smoking habits and can appreciate how difficult it is to change long-standing behavior. Making coordinated changes amongst a **group** of individuals can seem even more daunting. As many agencies begin to think about making changes, like implementing ACT, it is important to first recognize that this will require a substantial change in how people are used to thinking about their work and may be a challenging and potentially threatening task for each of them. Below is a brief discussion of why change is so difficult, along with a brief discussion of issues and suggestions we think agency directors should consider when attempting change.

Why is change so difficult?

When we first enter a new job or agency, there is a great deal of new learning that must take place. This includes learning about our individual role, job duties, and expectations for performance. In addition, we learn a great deal about what the agency values, what behavior the agency rewards, and what its beliefs are about how to "work with clients." These values may include beliefs about how individuals with severe mental illness (SMI) can be involved in vocational programs, how housing should be coordinated, or beliefs about case management (e.g. individual approach vs. team approach).

As a new employee, you begin to learn and accept these agency values and reinforce them by changing your behavior on the job. This results in everyone holding similar beliefs and values and behaving in similar ways (e.g., case management style). Other agency members and the agency itself reinforce this new behavior, and the result is a very strong, deeply rooted set of behavioral patterns. When we try to instill a change in an agency, we are challenging the very values and beliefs that drove the development of the agency and staff behavior, much like trying to change the highly developed root system of a very large, strong and established tree.

When beginning a change process then, it is important to recognize that you are challenging strong behavioral patterns that took time to develop and thus, will take time to modify and change.

What can you do to help facilitate change in your agency?

1. Acknowledge that change will be difficult and that a person's natural inclination is to **not** change. It is important to recognize that old ways of "doing the job" were not wrong, in fact, they likely were successful for staff and the organization at that particular time. Thus, when change is introduced, people may experience fear of what is to come with the change and a fear of losing control. These highly emotional issues need to be acknowledged as valid and real. It is also important to recognize that not everyone will be able or willing to change, and thus, there may be some turnover during this kind of process.

2. Include staff (e.g., case managers, psychiatrists, psychiatric nurses, vocational specialists) **and other important stakeholders** (e.g., family and consumers) in the change process. Ask for their opinions, suggestions, and feelings about the implementation of ACT. Employees are likely to be more accepting of change, feel more control over the change, and perceive it as a fairer process if they feel they are a part of the process *and* the solution. This may lead to a greater sense of ownership for the solution and increased motivation to have the solution succeed.

3. Letting go of old patterns of behavior is one of the most difficult yet important aspects of change as these patterns have been long established and are quite strong. Agencies can help change these patterns by discontinuing the reinforcement of old behavior (i.e., eliminate any incentives that would continue to reinforce undesired behavior, review policies that may reinforce undesired behavior).

4. Reinforce the desired behavior at every opportunity. Habitual behavior develops because it has been positively reinforced over time. To change behavior, there must be an effort to start reinforcing the new. For example, as an new ACT team develops, it will be important to verbally and/or publicly praise their behavior so they 1) are aware of exactly what behaviors are desired and 2) are more likely to repeat those behaviors. Similarly, make sure that personnel policies provide incentives to implementing the desired change (i.e., include change expectations in performance appraisal yearly objectives).

5. Agency level directors need to be visible in this process. Agency staff are more likely to accept and endorse the change if they perceive that those in power are also fully behind the change. For instance, directors and individuals with power need to be visible at important ACT team functions like training, kick off events, etc. If staff members perceive that the director's support is not genuine, they will respond by not behaving in ways to support the change. For instance, if the staff members believe that the agency director doesn't really believe in the efficacy of ACT, the implementation will be less than successful.

(cont'd on pg. 6)

6. Agencies need to provide staff with the appropriate training if they want them to create the change. We wouldn't expect an individual to improve their diet without some nutritional knowledge, nor should we expect individuals to suddenly become a high functioning ACT team without the necessary tools. Not only will training provide them with tools, but it should also have a positive impact on the team members' confidence to implement ACT and their commitment to its value for those individuals with SMI.

In summary, when beginning a change process, it is important to recognize that this is a challenging process that will take some time to develop. Old behavior and habits developed over a long period of time, thus developing new behaviors will also take time. Given this, it is important to remember and continually remind yourself and those involved that with the appropriate attention and persistence, change can be successful.

For additional resources on change:

- The Change Book: A Blueprint for technology transfer. (2000). Addiction Technology Transfer Centers. www.nattc.org
- Rapp, C. A. and Poertner, J. (1992). Social Administration: A client-centered approach. Longman: New York.
- Harvard Business Review on Change. (1998). Harvard Business School Publishing.

Up Close & Personal

Mike McKasson, MA, LCSW
Co-Director, ACT Center of Indiana

As the Co-director of the Act Center of Indiana, I would like to take this opportunity to introduce myself to you. Besides my position as Co-director of the ACT Center, I am also the Director of Adult Services at Adult and Child Mental Health Center, and I have been in this position for almost five years. I have worked in the field of community mental health for over 25 years now, which qualifies me for the "old-timers club." Over the past 25 years of my career, I have been very fortunate in having the opportunity to work in several different settings and positions. Those experiences include program director of an ACT team in a rural community mental health setting, project director of a NIMH sponsored research project (developing ACT teams), coordinator of residential services, staff therapist/case manager, and several university-level teaching positions. These experiences have been rewarding and helpful in increasing my knowledge and skill in developing services for persons with a mental illness. I am most thankful for the relationships that I have had over the years with consumers and their families. They have been my best teachers.

I do have a life other than work although my wife, Vicki, may not agree. Vicki and I have been married for 25 years and have 2 children. Our oldest child is Kate, and she is now married and living in North Carolina. Our son Kenton will finish his senior year in High School this school year, and he is planning to attend IUPUI. The prospect that both of our children will be independent leaves us with more time to travel. This will mean camping, canoeing, and backpacking throughout the National Park system. I have just recently started on my lifelong ambition to hike the entire Appalachian Trail (2100 Miles). I will be hiking the trail in sections with a friend of thirty years. This past October we started the trail in Georgia and completed 60 miles, and next year we will start where we left off and hike 150 miles. At this rate, we may finish the trail when we both reach the age of 83, so this is a long-term goal.

I am looking forward to working with providers, family members, and consumers in the development of ACT teams in the state of Indiana. (cont'd on pg. 7)

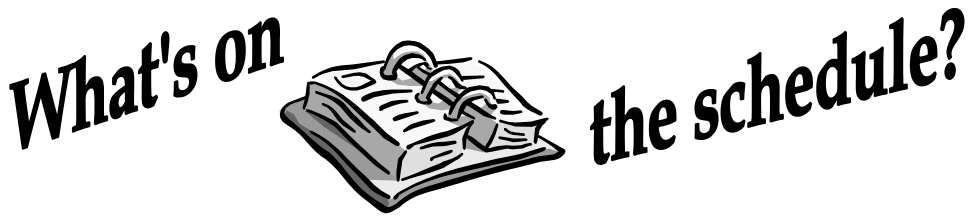
Michelle P. Salyers, Ph.D.
Co-Director, ACT Center of Indiana

I am a clinical psychologist and an Assistant Scientist in the Department of Psychology at IUPUI. I am currently working on several projects related to psychiatric rehabilitation for adults with severe mental illness. In my role as co-director for the ACT Center of Indiana, I am responsible for the administration and management of the center. But my biggest job (I mean joy) is raising my three kids. Eleni, age 7, is currently training to be a prima ballerina and a "cicologist." My 3 year old, Jacob, enjoys construction like his dad, and Max, who is 4 months old, is still working on sleeping through the night. In our "free time," my husband Phil and I like to golf and go to the movies (especially for the popcorn).

Professionally over the past 12 years, I have worked on several studies of ACT programs in Indiana, Illinois, Pennsylvania, and Michigan. Through these experiences, I have been impressed by the successes ACT programs can have. I have been equally impressed with how challenging it can be to make the program work well, particularly in the initial stages of development.

In addition to my professional involvement in ACT, I have a personal interest as well. My younger brother has struggled with schizophrenia and substance abuse issues for years. Throughout this time, he has received services from a variety of programs including traditional substance abuse treatment, inpatient hospitalization, day treatment, and group homes—all with little lasting impact. I have long thought that he would benefit from the intensive, community-based services that ACT programs provide.

I am very excited by the opportunity to help ACT grow in Indiana so that these services will be widely available to people like my brother. Research in the area of psychiatric rehabilitation has shown that ACT does work and provides methods for helping agencies implement new programs. I believe that by working closely with administrators, providers, families, and consumers, we can build successful ACT programs across the state.



If you are interested in attending an event below or want to schedule individual training or consultation for your organization, please contact Veronica Bannon at vbannon@iupui.edu or phone (317) 274-6735 for more information. We look forward to hearing from you. Thank you for your interest!

Recent Trainings

December 7, 2001 — Madison Regional ACT Training — Hosted by Madison State Hospital
Thank you to all who attended!

OPEN REGISTRATION

February 1, 2002 — Indianapolis Regional ACT Training — RSVP deadline 1/29/02

Future Trainings

March 2002 — Fort Wayne Regional ACT Training
March or April 2002 — Southwest Indiana Regional ACT Training

We want to hear from you!

What do you think about our first newsletter?

What would you like to see in future newsletters?

How can we better serve your needs?

Let us know by contacting us.

The ACT Center of Indiana is a collaboration of the Department of Psychology at Indiana University Purdue University Indianapolis (IUPUI) and the Adult & Child Center of Indianapolis.
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Excellence in Training, Research, and Technical Assistance

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