Are We There Yet?

From ACT Implementation to Sustainability

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Congratulations!

- This is a big job with no shortage of challenges
  - Often nothing else has worked
  - Disenfranchised, lost hope, forgotten dreams
  - High comorbidity
- Can also be the most rewarding
  - Seeing positive changes in people's lives – changes never experienced before
  - Working closely with team members that can share their expertise – opportunities for you to grow in your own work
- You are doing/can do it!

ACT's most robust outcomes

- ✓ Decreased hospital use
- ✓ More independent living & housing stability
- ✓ Retention in treatment
- ✓ Consumer and family satisfaction

Baronet & Gerber, 1998; Bedell et al., 2000; Bond et al., 2001; Burns et al., 2007; Coldwell & Bender, 2007; Gorey et al., 1998; Herdelin & Scott, 1999; Marshall & Lockwood, 2000; Ziguras & Stewart, 2000; Morrissey et al., 2013; Mueser et al., 1998

ACT cost-effectiveness data

- Latimer (1999) reviewed 34 ACT programs and found that ACT is cost-effective when:
  - Services are targeted toward persons who are high users of inpatient psychiatric services (>50 hospital days in prior year)
  - It is implemented with high fidelity to the ACT model
- Cost-effectiveness is greatest within first two years of admission (Domino, Morrissey & Cuddeback, 2013)

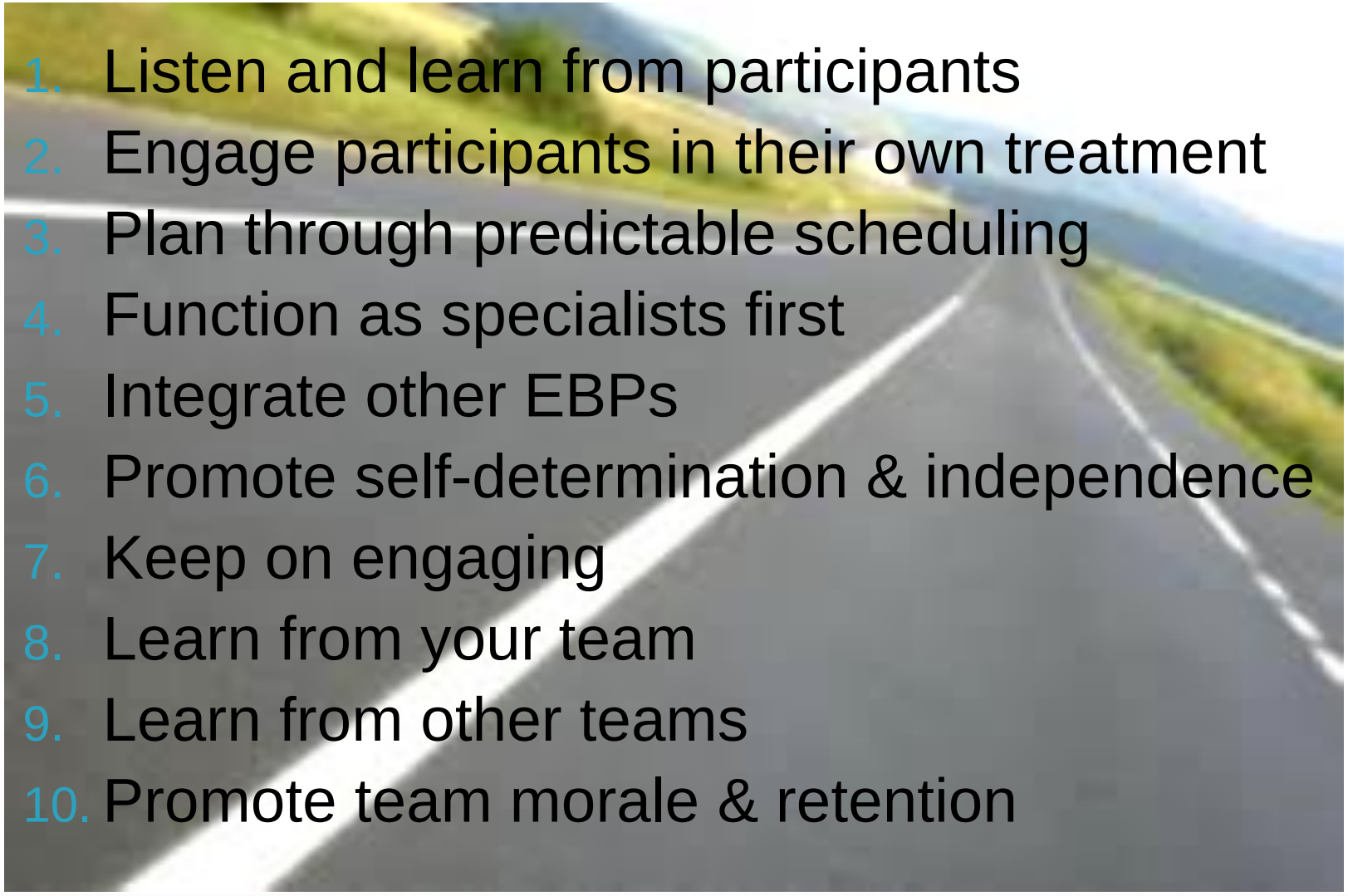
The future: Targeting a better life

- Improvement in social functioning and other areas of independent living
- Increases in sustained employment
- Reductions in substance use
- “…a home, a job, and a date on Saturday night.”

How do we get there?

Lessons learned from ACT teams around the U.S.

Roadmap to ACT Sustainability



1. Listen and learn from participants
2. Engage participants in their own treatment
3. Plan through predictable scheduling
4. Function as specialists first
5. Integrate other EBPs
6. Promote self-determination & independence
7. Keep on engaging
8. Learn from your team
9. Learn from other teams
10. Promote team morale & retention

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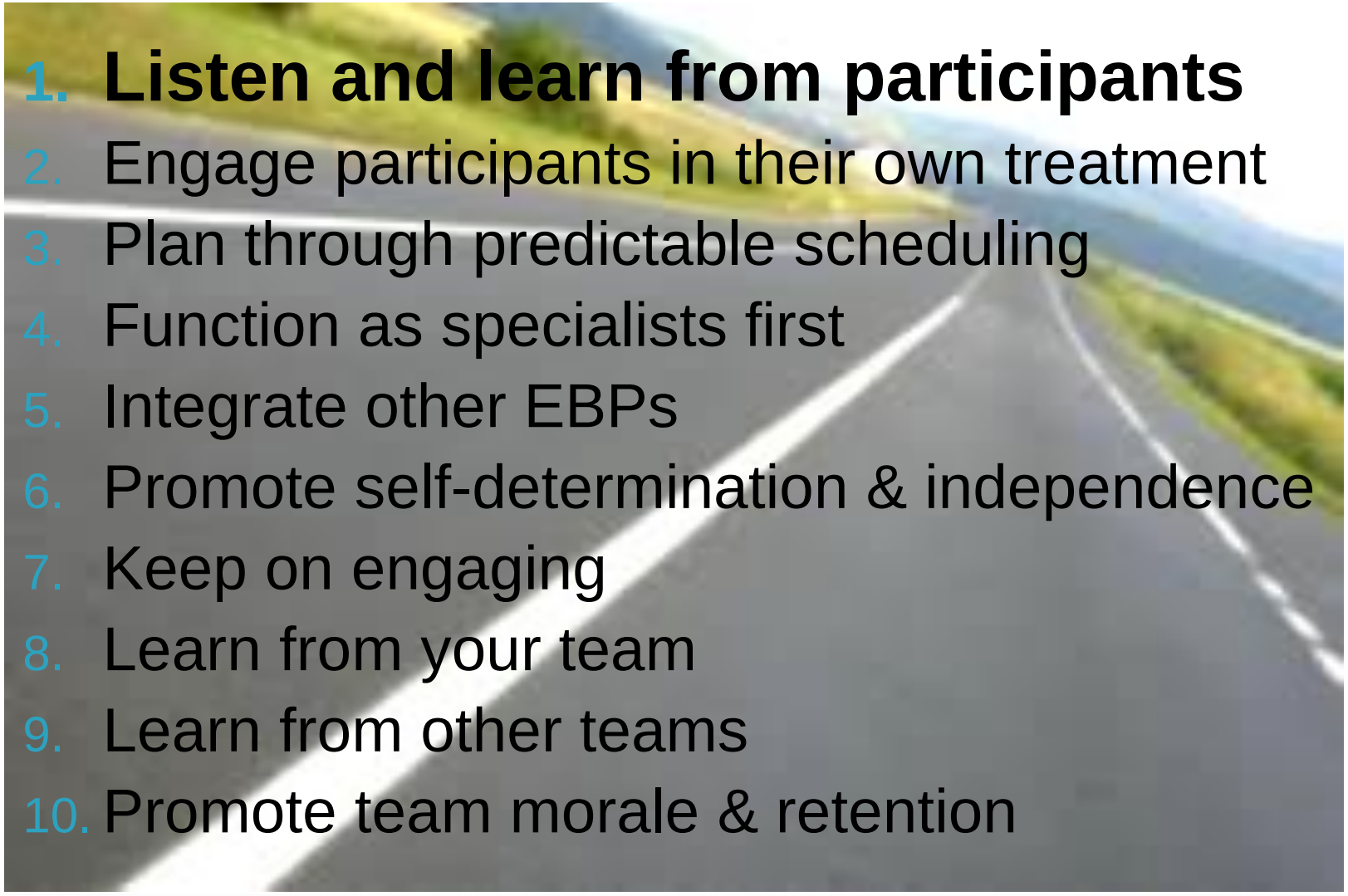

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It's all about the relationship!

"It can take years to develop the kind of relationship in which the (person) is known, understood, and accepted… so that (he or she and) the team can notice and celebrate even the small steps along the long road to recovery."

- Salyers & Tsemberis, 2007

Listen and learn from participants:
Get the most out of the assessment

- 7-8 core domains in the ACT Comprehensive Assessment
- Divvy up based on specialty areas/interests
- Complete “on the run”
  - Not an interrogation
  - In the context of providing services
  - While driving or walking
- Be conversational, applying your MI skills
- Assess stage of change within each domain

Transtheoretical Model of Behavior Change (Prochaska & DiClemente, 1983)

Early Stages of Change Readiness			Later Stages of Change Readiness	
Pre-Contemplation	**Contemplation**	**Preparation**	**Action**	**Maintenance**
"Not Ready" Does not recognize that s/he has a problem or engages in problematic behavior.	"Getting Ready" Recognizes that his/her behavior is causing some problems and is considering a change. More aware about the pros & cons, but *ambivalent* about change.	"Ready" Recognizes that his/her behavior is causing some problems and is considering a change. Consumer is *planning* for change.	Committed to making positive change(s) in his/her life.	Has not engaged in targeted problematic behavior for at least 6 months.
Approaches: Engagement & psycho-education/ Encourage to become more mindful of decision making and more conscious of the benefits of change	**Approaches:** Motivational interviewing – focus on what it would take to reduce the cons	**Approaches:** MI, building social support	**Approaches:** Substituting positive activities for unhealthy ones, rewarding for taking steps toward change, avoiding people and situations that tempt unhealthy behaviors.	**Approaches:** Relapse prevention

Listen and learn from participants:
Get the most out of the assessment

- Not just about answering a bunch of questions about the person
- Get from WHAT to WHY***
- Integrate information across team members/ domains
- Develop an Integrated Summary – the key to a useful treatment plan

WHAT to WHY informs HOW

WHAT: Not taking medications

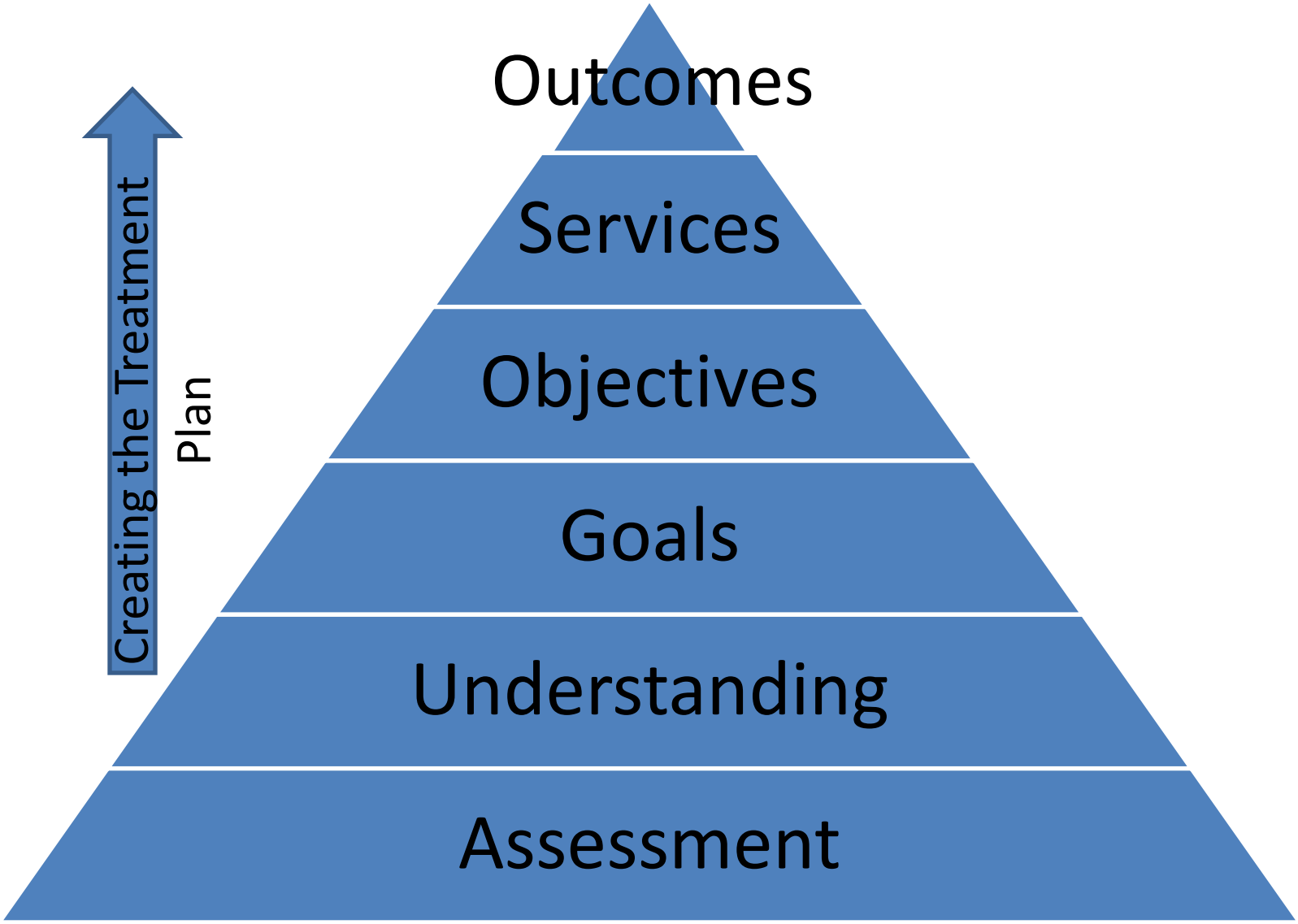
WHY

- Not working
- Side effects
- Paranoia
- Disorganization

HOW (interventions)

- Change dosage
- Change medications
- Psychoeducation
- CBT for psychosis
- Behavioral tailoring

Culture and Identity



Adams, N., & Grieder, D. M. (2014). *Treatment planning for person-centered care: Shared decision making for whole health.* London: Elsevier.

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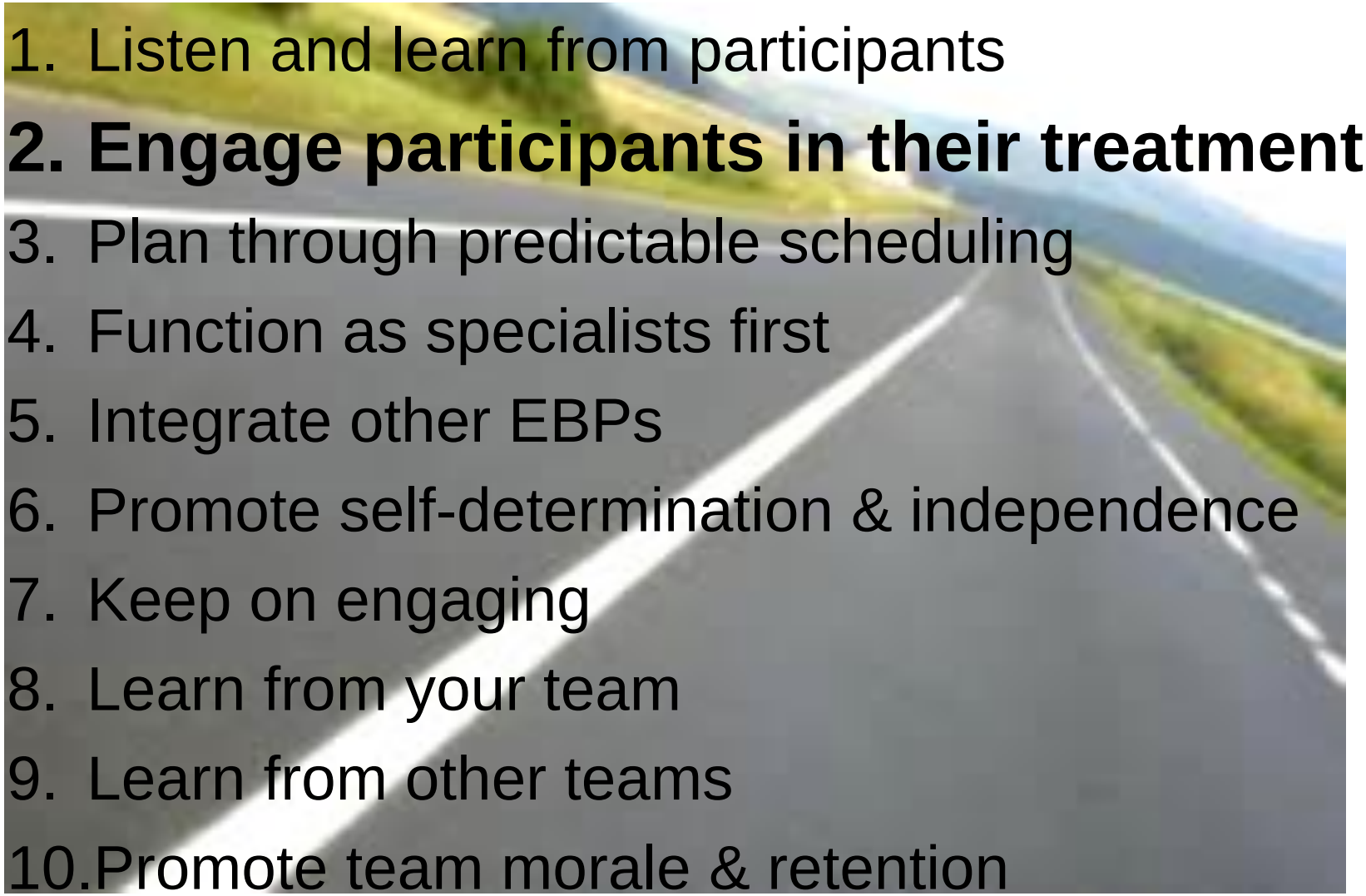

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Engage participants in their own treatment:

Use a person-centered planning approach

- Strengths-based
  - Emphasizes skills, personal attributes, and resources that bode well for success
- Individualized
  - Reflects the participant's (not team's) goals
- Holistic
  - Covers multiple life domains
- Specific
  - Indicates what the necessary interventions are, who is delivering them, and when
- Empowering
  - Puts the participant in the driver's seat – not just about "the meeting"

Adapted from Moser, 2013

Information to guide person-centered plan

- Things I have done over the past year
- Things I would like to accomplish this year
- My dreams for the future
- My and my family's/natural supports' strengths are…
- What is important to me – what I need in my life to be happy
- People who support me can help me the most by…

Information to guide person-centered plan

- The people I need in my life are/ The people I prefer not be involved are…
- What is important to achieve what I want, be safe and be healthy mentally and physically
- What I am willing to do to achieve what I want in my life
- How I will know when I'm done/ when I am ready to graduate

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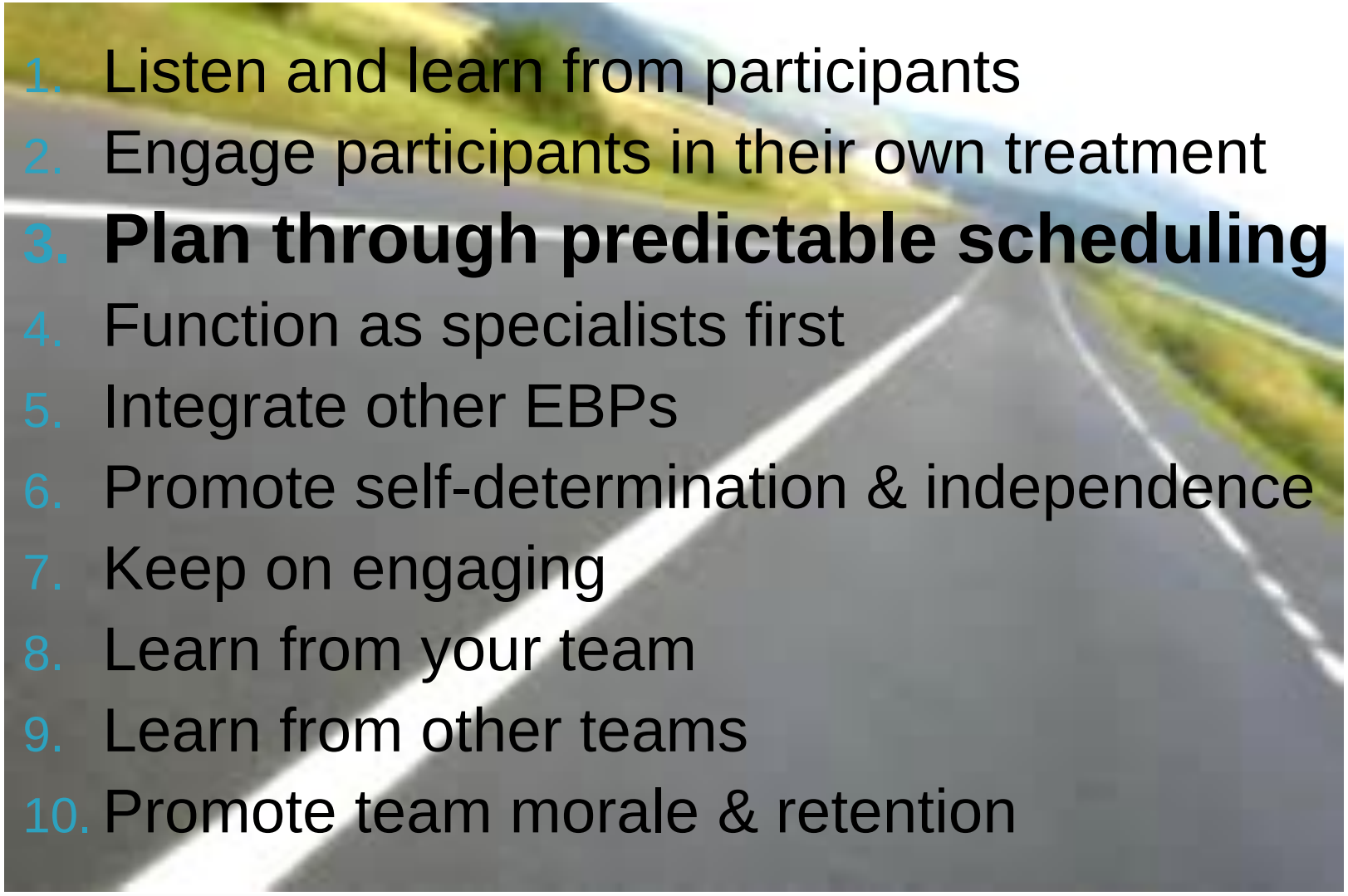

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Plan through predictable scheduling:

Implement Weekly Client Schedules

- Driven by the treatment plan
- Specifies the who, what, when, (and where) of planned interventions/contacts

Sample Weekly Client Schedule

Name: Joe Smith — Primary Staff: Jeff Thomas – Vocational Specialist

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
AM	9:30-10 Med management/ education – Jeff, Voc Specialist 10-12 Job coaching – Jeff, Voc Specialist		9:30-10 Med management/ed ucation – Jan, Peer Specialist		9:30-10:30 Med management; ADLs assistance and skills training, Sandra, Case Manager 11:00 – 11:30 Psych and med evaluation – Dr. Klein (3rd week of every month only)		
PM			1:30-2:30 Illness Management & Recovery – Jan, Peer Specialist			2-4 Social skills training in community – Weekend Staff on Rotation (2nd and 4th Saturday)	

Daily Team Schedule

- Most service contacts are already planned; don’t change
- Add in contacts based on:
  - Emerging needs (e.g., crises, appointments)
  - Proactive engagement
- Keeps the treatment plan alive!
- Better ensures specialized service delivery
- Reduces the number of unplanned contacts
- Likely prevents burnout

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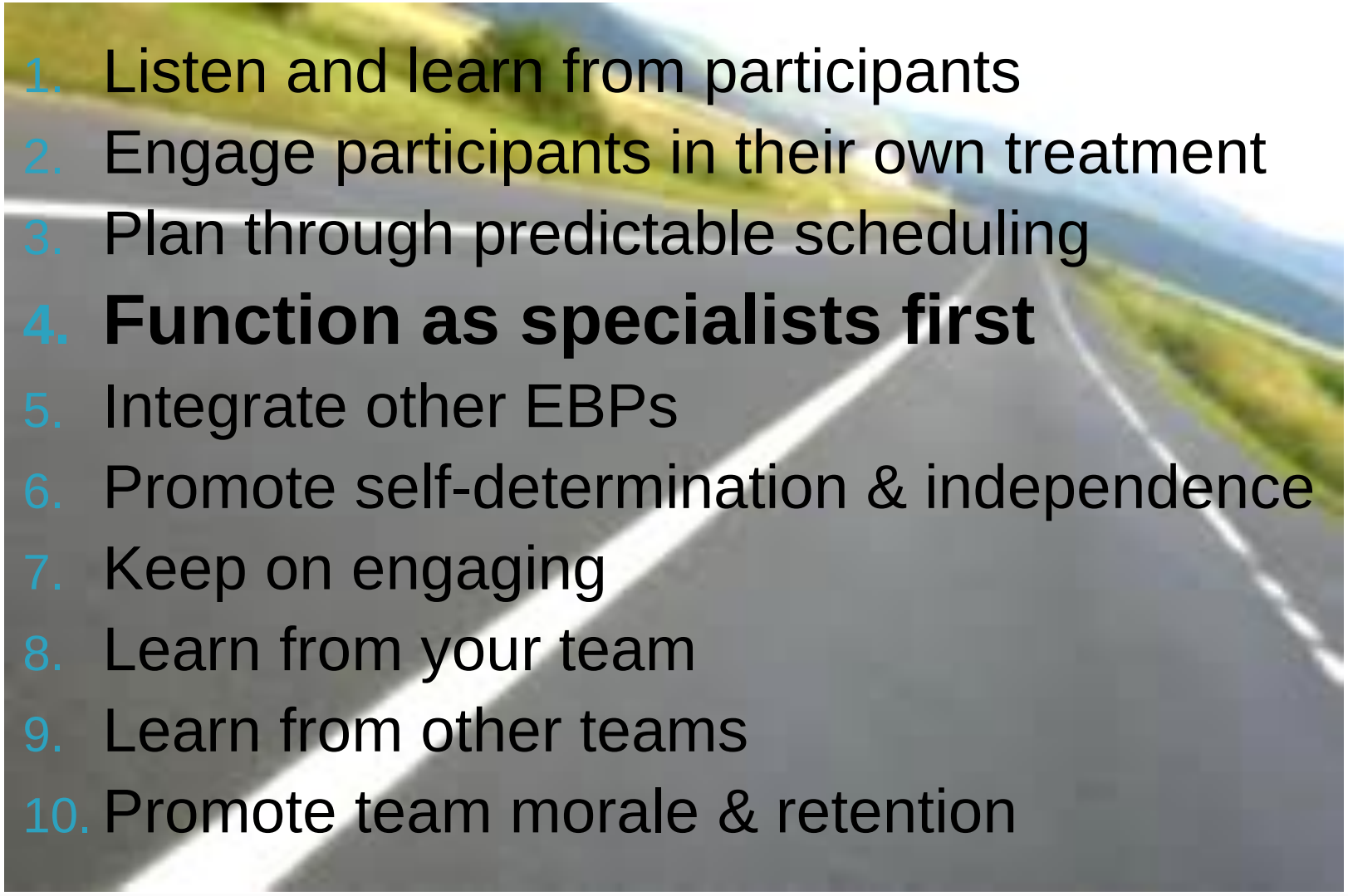

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Function as specialists first: *Balance "conflicting" roles*

- **Specialist Role**
  - Each ACT team member has own "specialty"
    - Protects that specialty time on team
  - Takes lead on implementing specialty-specific services
  - Cross-trains other staff in that specialty area
- **Generalist Role**
  - Each ACT team member needs to be flexible enough to do whatever it takes to help
  - Also needs to be open to learning skills related to other specialty areas
- **Cross-training → Transdisciplinary team**

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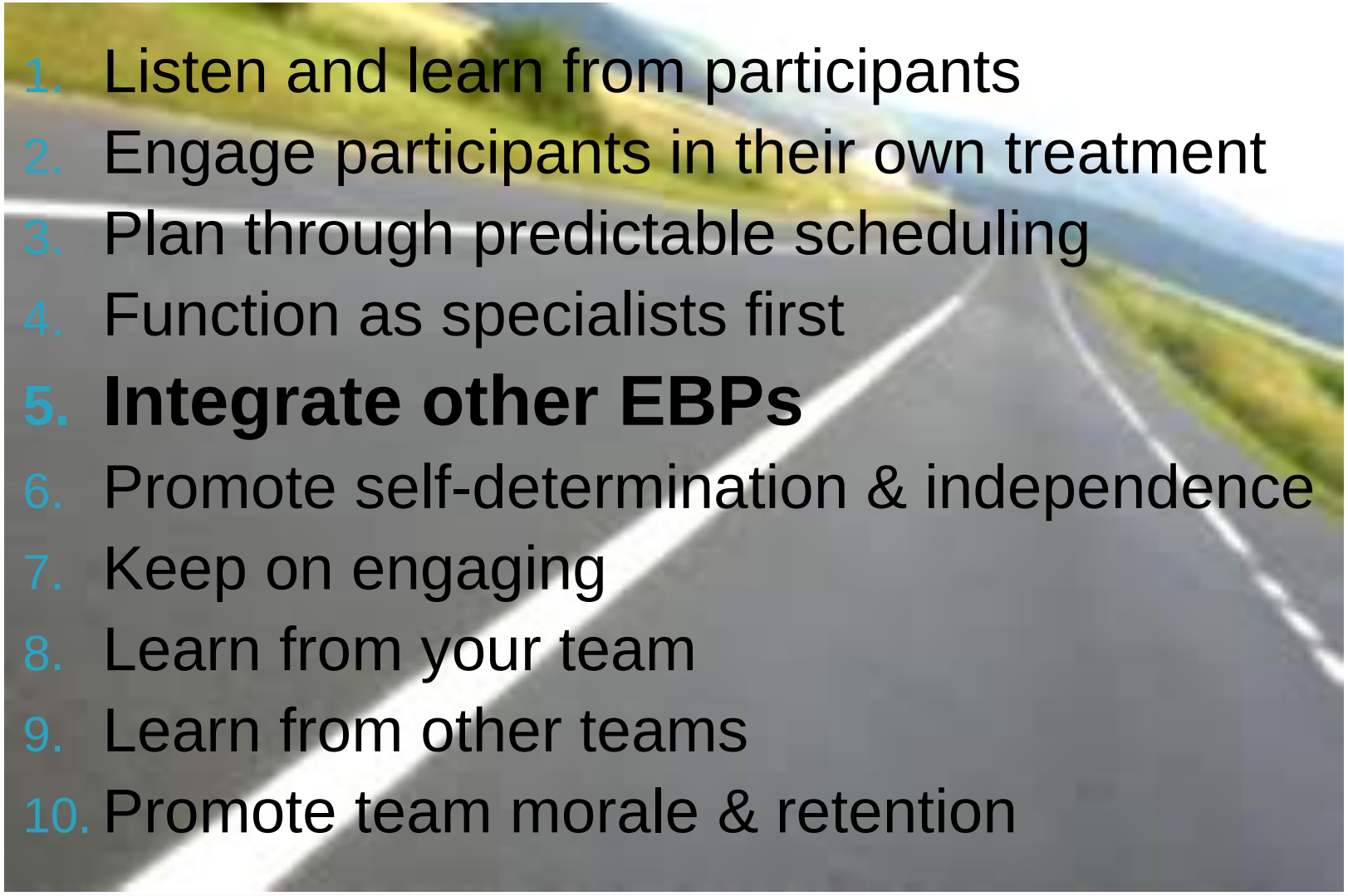

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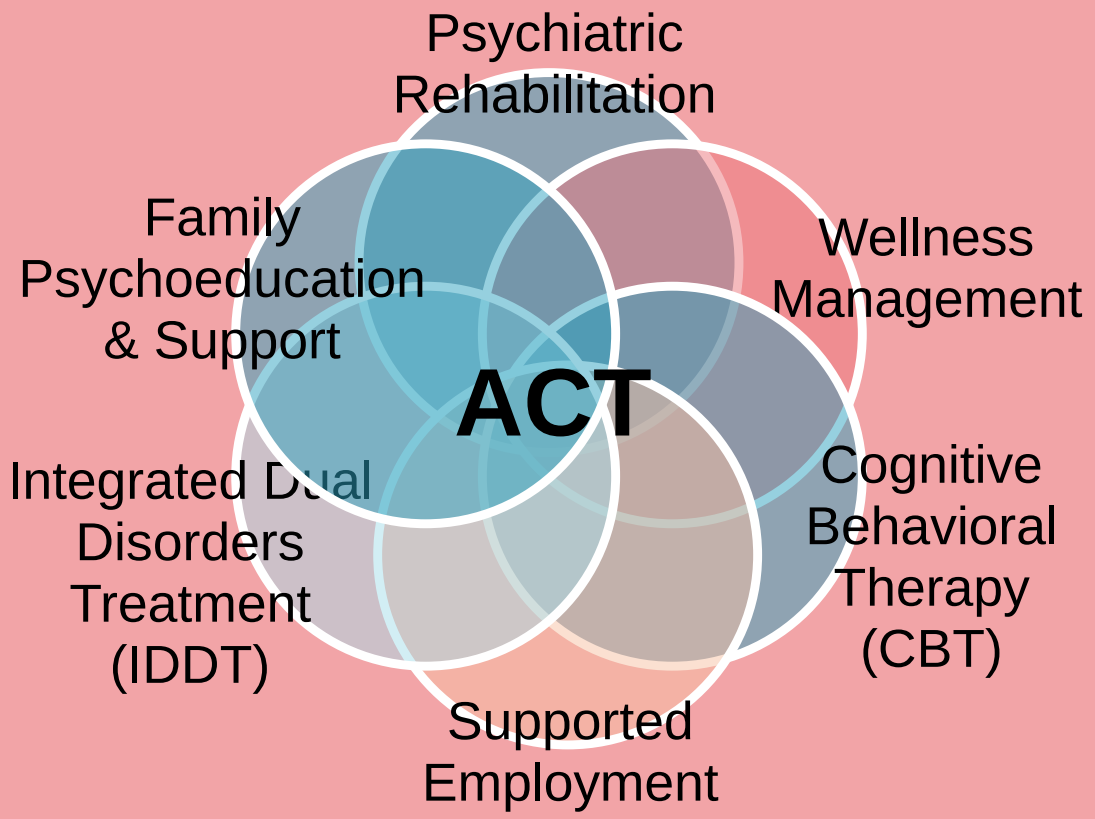
Integrate other EBPs:

The key to teaching skills!



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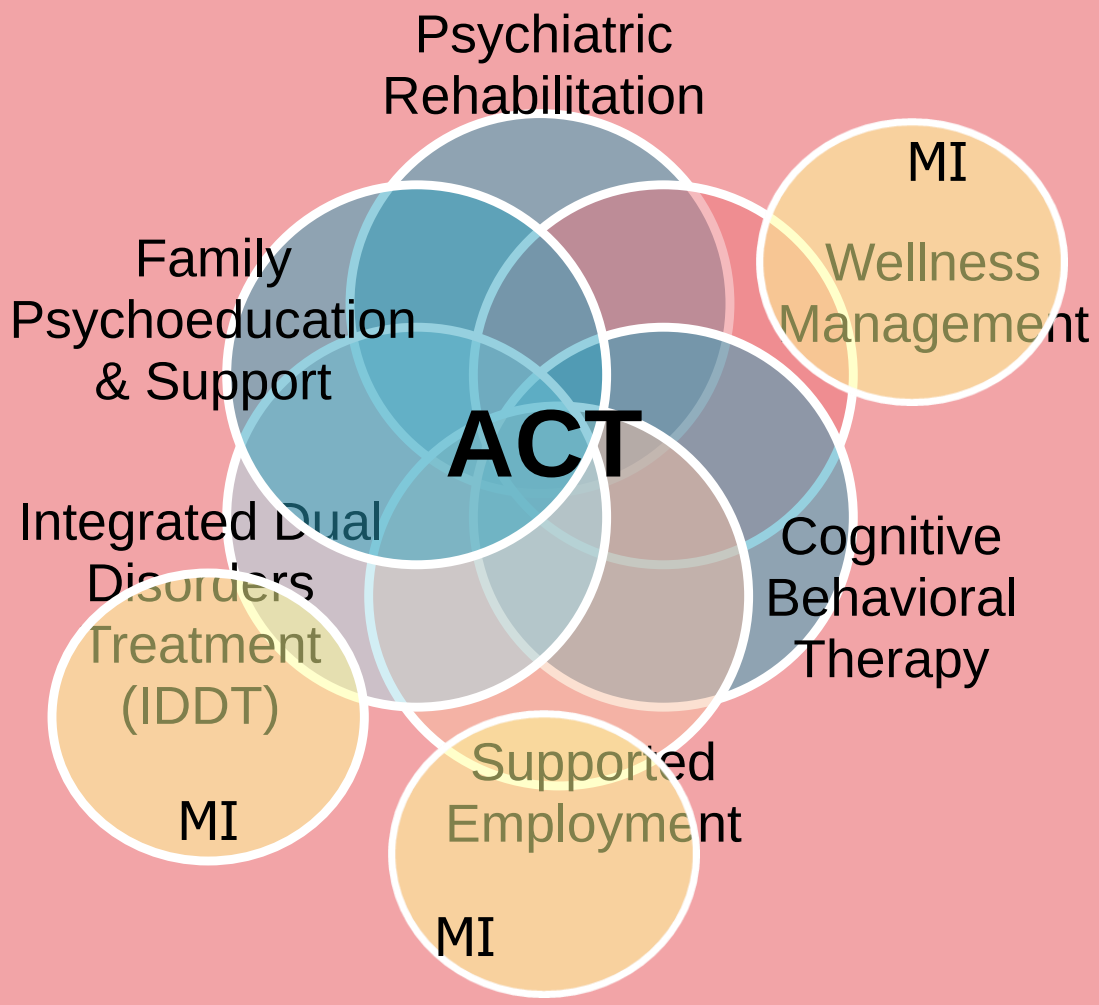

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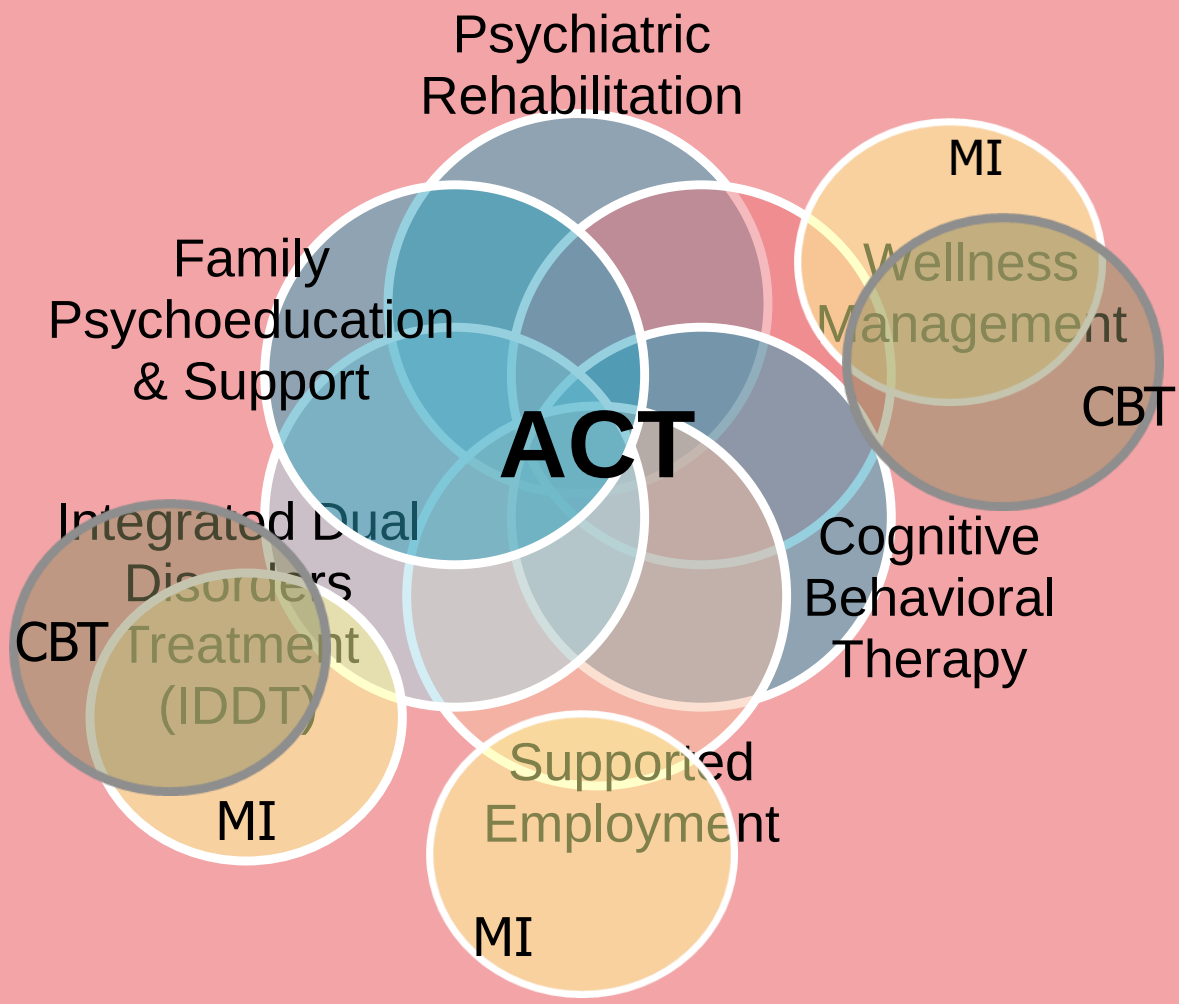

Integration of other EBPs: Who takes the lead?

- Integrated Dual Disorders Treatment (IDDT):
  - Substance Abuse Specialist
- Supported Employment:
  - Vocational Specialist
- Empirically-based Psychotherapy (e.g., CBT):
  - Master's level clinician(s)
- Wellness Management & Recovery Services:
  - Peer Specialist
- Psychiatric Rehabilitation:
  - Designate a team member
- Family Psychoeducation & Support:
  - Designate a team member

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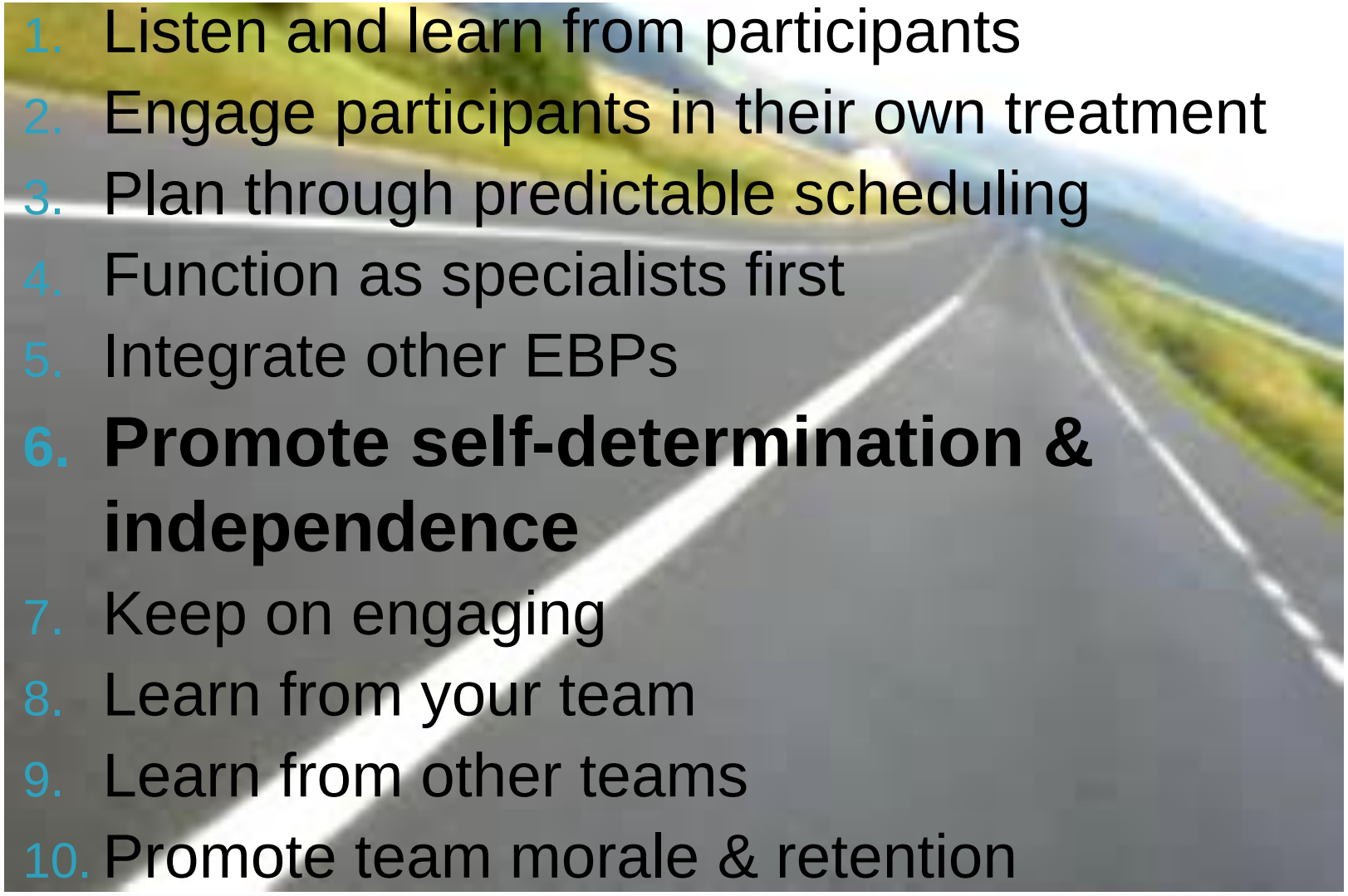

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Promote self-determination & independence: *One of the keys to recovery!*

- Help participants to develop a greater awareness of meaningful options available to them
  - Travel on their own
  - Living with someone who isn't a great influence
- Honor daily choices when you can
  - When to wake up
  - When/what to eat
  - What to wear
- Teach skills!
  - Means reducing the team's overall supervision

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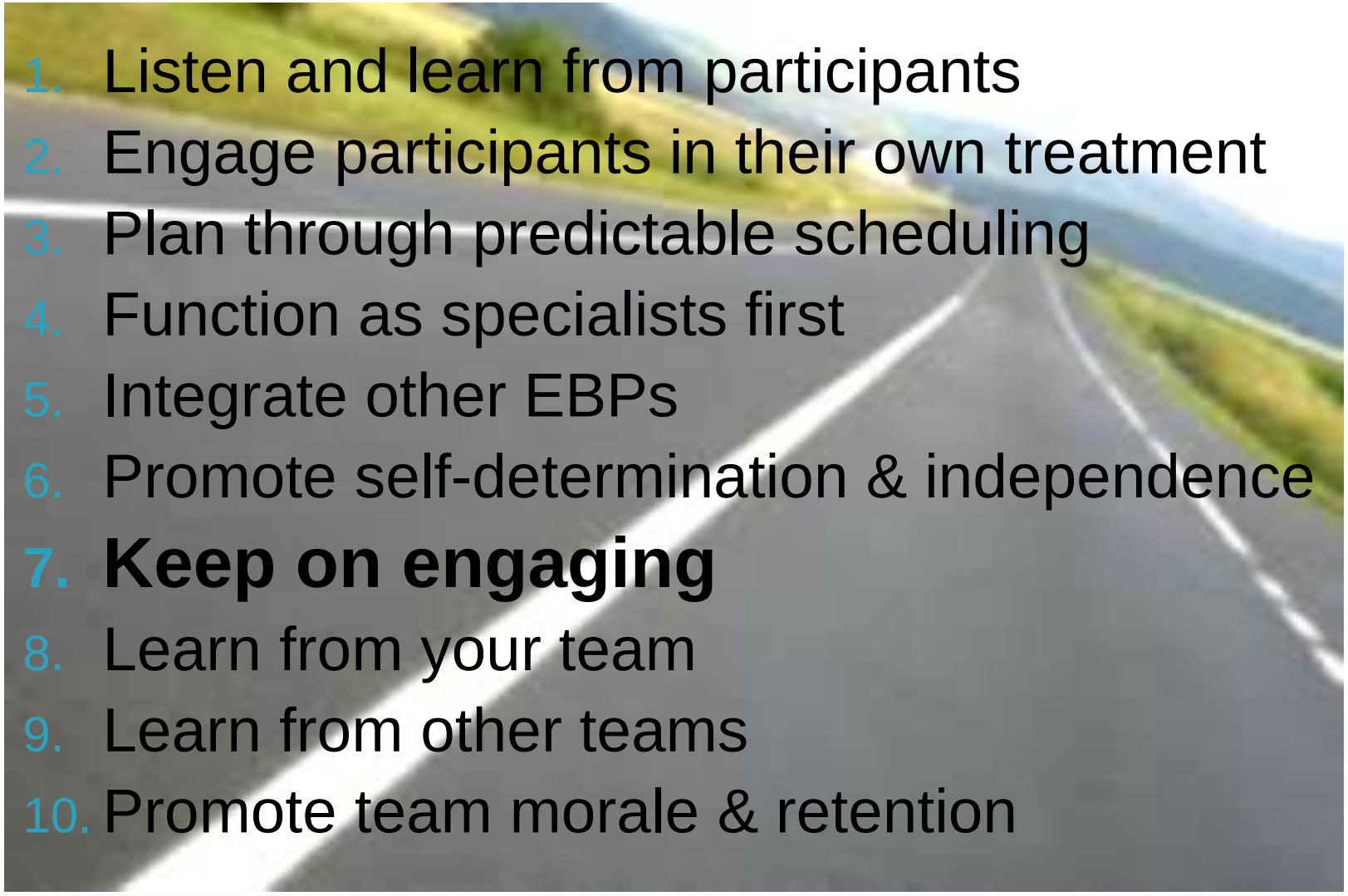

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Keep on engaging:
Balance & tailor your approach

- Assertive outreach is critical
- Prevents from falling through the cracks
- Does not mean “aggressive” or “coercive”

Engagement in ACT services:
Key Assumptions

- People often have experiential reasons for reluctance to receive services and/or be mistrustful of others
- People have an innate desire to grow and progress, but
- Sometimes they have lost hope and have difficulty seeing other possibilities
- Change can be very hard, isn't always a straight shot upward
- Need to recalibrate our recovery expectations

Adapted from Morse, 2013

Engagement Principles & Strategies

- Match participant preferences and backgrounds
- Meet on their own terms, own turf
- Look to address immediate needs; assist quickly
- Be dependable; deliver on your promises
- Maximize your accessibility
- Engage with activities as well as conversation

Adapted from Morse, 2013

Engagement Principles & Strategies

- Be sensitive to the need for distance
- Understand and provide empathy/validation for reasons *not* to engage
- Don’t overwhelm
  - Brief, frequent contacts
  - Give permission not to engage
- Engagement never stops!

Adapted from Morse, 2013

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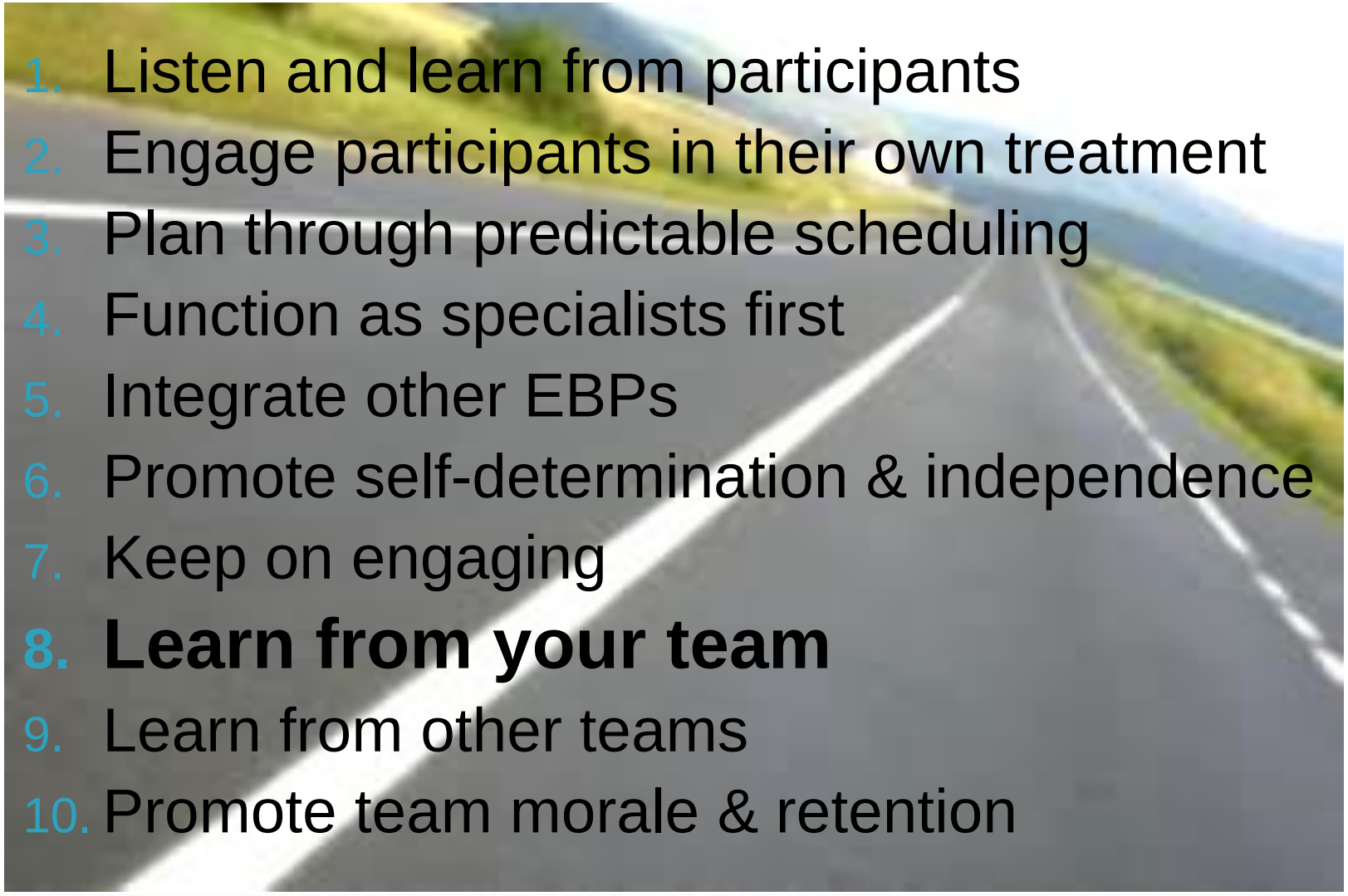

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Learn from your team
Leverage your multidisciplinary crew

- Cross-training, cross-training, cross-training
  - At least once a month
  - ~20-60 minutes
  - Rotating team members and topics
  - As big as a full EBP; as small as one aspect of a particular practice
- Supervision
  - Group and/or individual
  - Includes field mentoring, case-based consultation, feedback on clinical tools

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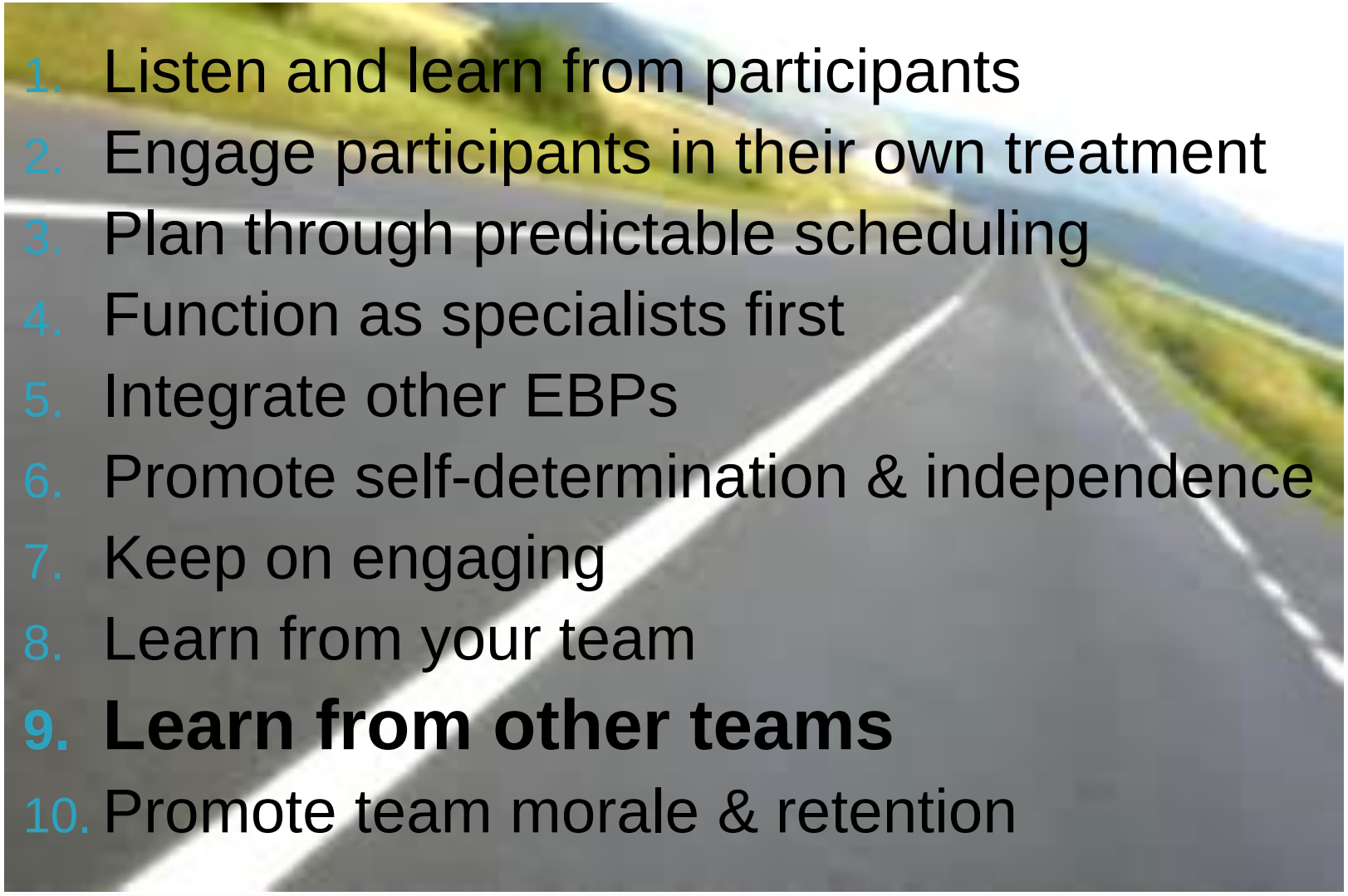

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Learn from other teams
Look at the expertise around you!

- Learning who's doing well in specific areas of organization and practice
- Shadowing onsite; direct observation
- Picking one another's brains informally
- Cross-training across teams
- Establishing informal learning collaboratives

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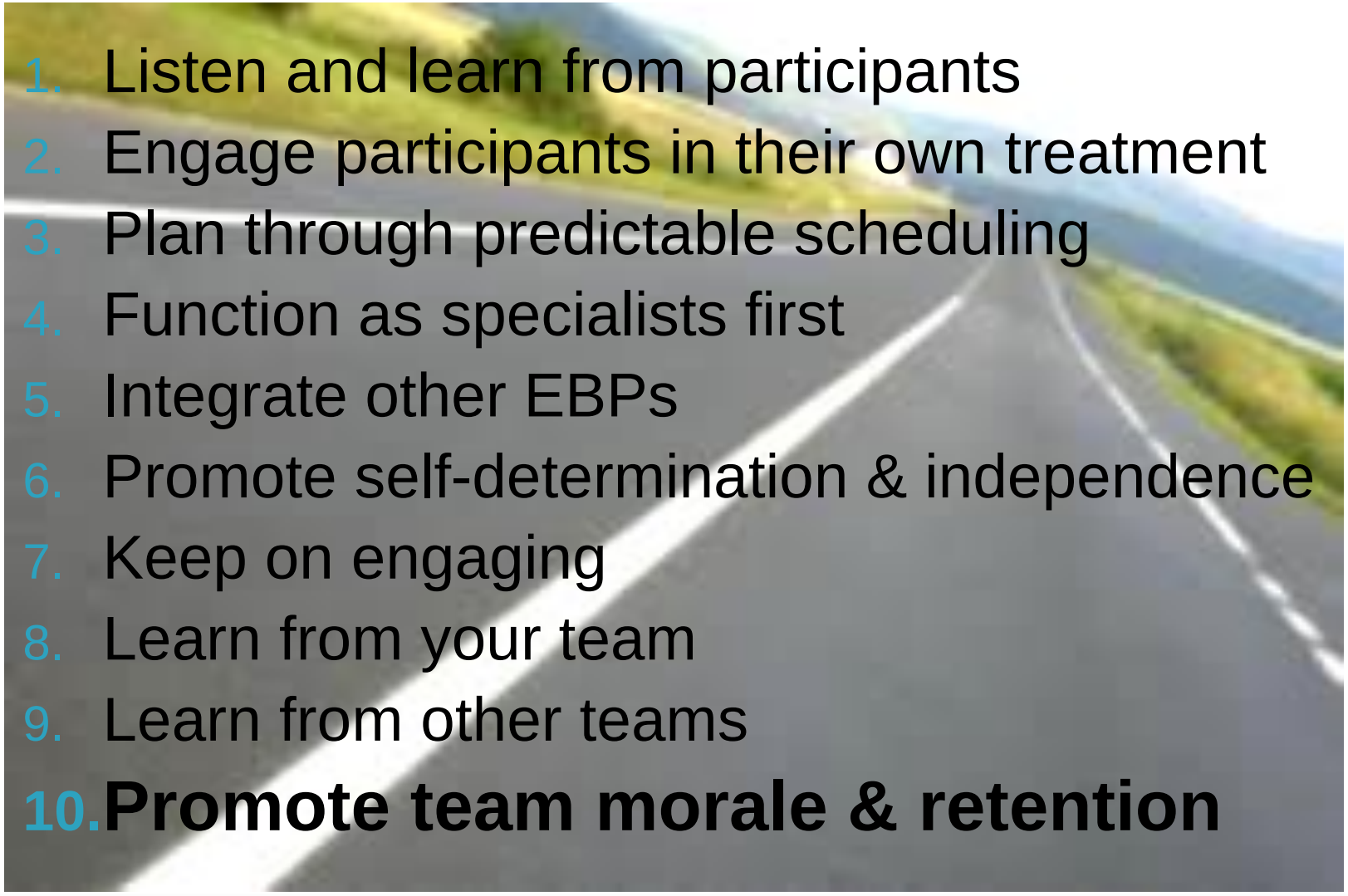

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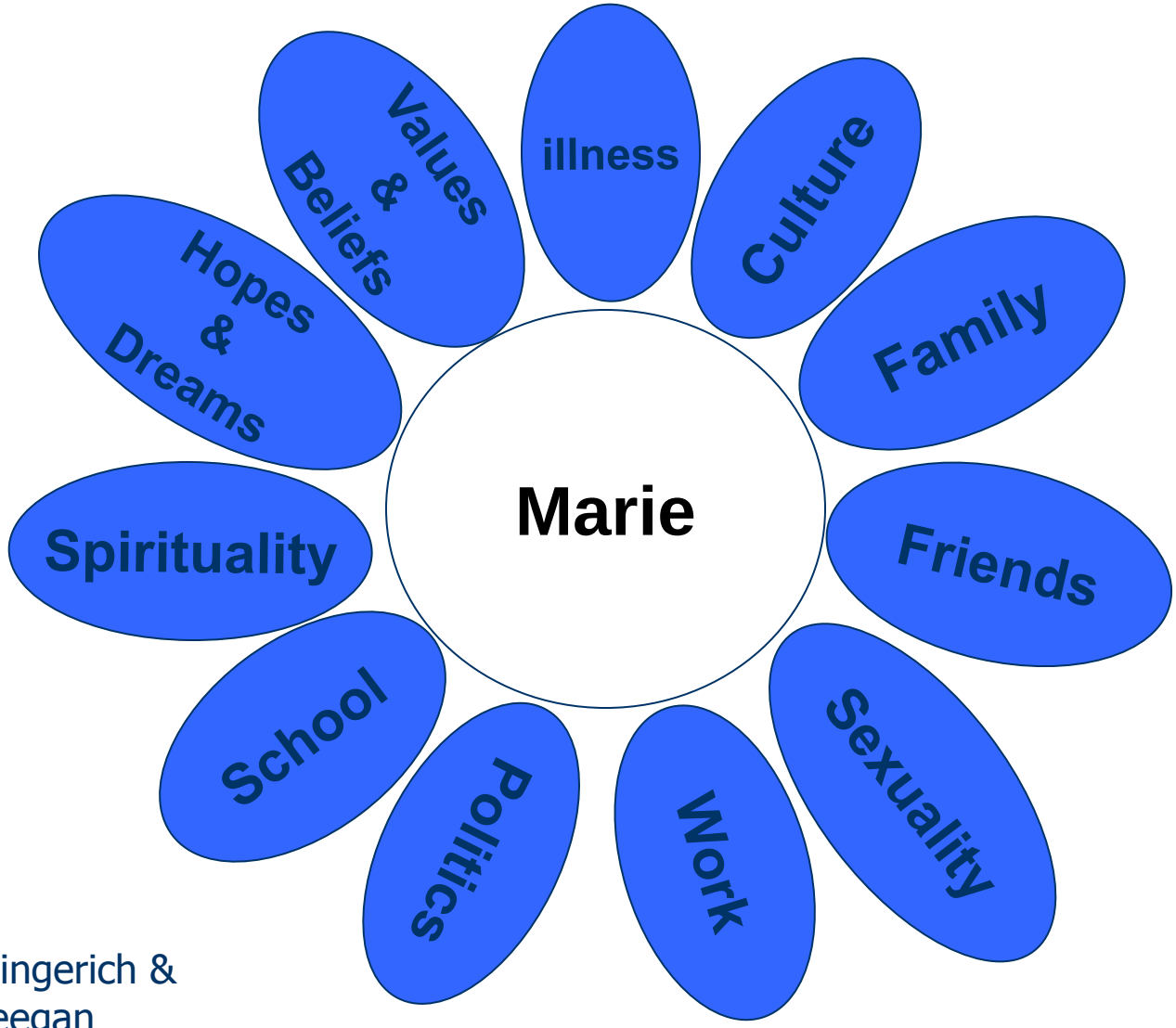
Promote team morale & retention
Keep yourselves happy & healthy!

- Regular team meals or other activities together
- Modeling after DBT
  - Consultation team meetings once a week
  - Mindfulness practice before meetings
- Quarterly/semi-annual team retreats
- Implementation and follow-up on Individual Wellness Toolkits

How I am Seen By Others After Being Diagnosed With Mental Illness

Courtesy of Gingerich & Mueser via Deegan

Recovery: Putting myself back in the center of my life (illustration based on P. Deegan)



Courtesy of Gingerich & Mueser via Deegan

With gratitude & credit to my colleagues:

Gary Morse, PhD

Places for People

Community Alternatives for Hope, Health, and Recovery

Lorna Moser, PhD

ACT Technical Assistance Center

UNC Center for Excellence in Community Mental Health

Thank you for this opportunity!
And best of luck!

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