

### 33 Making Effective Choices: Choice Not Control

We make effective choices to steer our lives toward our hopes and dreams and away from harm. Individuals living in, and receiving treatment from, our power-over-people culture have lost the opportunity and experiences to learn to make effective choices. This workshop presents a choice making process with which people can regain self-control of their lives. CONTENT IS BEST SUITED FOR PARTICIPANTS AT ALL LEVELS; 50% DIDACTIC, 25% PARTICIPATORY, AND 25% EXPERIENTIAL.

*Presenters: David Heffron, BA, NHA, Regional Operations Director, Telecare Corporation, Long Beach, California; Scott Madover, PhD, MINT Trainer, Administrator/Regional Administrator, Telecare Corporation, Oakland, California; Jennifer Obermeyer, LCSW, Administrator, Telecare Corporation, Gresham, Oregon*

### 34 Creating Unified & Compassionate Relationships through Family Psychoeducation

This workshop is designed to introduce attendees to a Family Psychoeducation model called "Family Education & Support" (FES). The FES model is designed to assist families in understanding their loved ones struggles and ways to help support one another in healing the family system. FES can assist individuals with co-occurring mental illness and substance use issues gain a better understanding of their symptoms and make positive strides in their wellness and recovery program. CONTENT IS BEST SUITED FOR PARTICIPANTS AT ALL LEVELS; 50% DIDACTIC, AND 50% PARTICIPATORY.

*Presenters: Gavin Cherry, MS, ARISE Intervention Certification, Customer Relations; Kristen Fredrickson, MA, LCMHC, MLADC, ACT Team Leader, both of WestBridge Community Services, Manchester, New Hampshire*

### 35 Mastering the Stages

In the era of Recovery, Evidence Based Practices and Harm Reduction, we rely on clinical tools that are consumer-centered, flexible, and based on Harm Reduction principles. Some of the most important clinical tools are the Stages of Change (SOC) and the Stages of Treatment (SOT). Unfortunately, many clinical and case managerial team members are not comfortable working with them - or not familiar with the models. Moreover, many team members do not use SOC and SOT strategically. This workshop will provide definitions and simple ways to use these tools in our daily work. CONTENT IS BEST SUITED FOR PARTICIPANTS AT ALL LEVELS; 50% DIDACTIC, 25% PARTICIPATORY, AND 25% EXPERIENTIAL.

*Presenter: Luis O. Lopez, MS, HSBCP, QA/Director of Best Practices and Recovery Based Initiatives, Services for the Underserved, New York, New York*

### 36 Implementing EBP's in ACT: Fidelity & Technical Assistance

This session will provide an overview of the implementation and ongoing technical assistance for 10 Washington State ACT teams who provide a range of evidence-based practices (EBP's) such as Supported Employment, Illness Management & Recovery, and Integrated Dual Disorder Treatment. Presenters will describe how they utilize the TMACT fidelity tool to guide ongoing technical assistance to teams including an illustration of EBP implementation trends over 3 years and discussion of challenges. CONTENT IS BEST SUITED FOR PARTICIPANTS AT THE INTERMEDIATE TO ADVANCED LEVELS; 75% DIDACTIC, AND 25% PARTICIPATORY.

*Presenters: Shannon Blajeski, MSW, Trainer & Consultant; Maria Monroe-DeVita, PhD, Assistant Professor and Director, both of Washington Institute for Mental Health Research and Training, University of Washington, Seattle, Washington*

### 37 ACT and Transitional Age Youth

Since the implementation of ACT specifically designed for the Transitional Age Youth (TAY) population with severe and persistent mental illness, Orange County Behavioral Health Services has been able to demonstrate the need for this level of care to help our TAYs achieving recovery. Although there are vast numbers of literature defining the recovery model, it does carry different meaning for different cultures. We hope to share our successes and challenges. The attendees will also be able to hear personal accounts from some of our TAYs involved in the program. CONTENT IS BEST SUITED FOR PARTICIPANTS AT ALL LEVELS; 60% DIDACTIC, AND 40% PARTICIPATORY.

*Presenters: Clayton Chau, MD, PhD, Associate Medical Director, Orange County Health Care Agency, Santa Ana, California, Assistant Clinical Professor, Department of Psychiatry, University of California Irvine, Irvine, California; Tracy Rick, MSW, LCSW, Service Chief I, Orange County Health Care Agency, Behavioral Health Services, Anaheim, California*

# Implementing EBP's in ACT:

Implementing EBP's for DB  
Mental Health & Justice  
Population

ACTA Conference  
May 13, 2011  
Huntington Beach, CA

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# Act in Washington State

ACTA in Washington State

- 2007 - Implemented 10 ACT teams.
- State of Washington Department of Behavioral Health & Recovery (formerly Mental Health Division) provided program oversight.
- DBIIR contracted with Washington Institute for Mental Health Research & Training to provide training, technical assistance & fidelity reviews.

## WA-PACT RSNs & Selected Providers

Team 1: DESC  
Team 2: Navos  
Team 3: DESC

Compass Health  
Catholic Youth & Family Services  
South Central  
Greater Columbia  
Timberlands  
Southwest  
Columbia River Mental Health Services  
Good Samaritan  
Behavioral Health Resources  
Killip Mental Health Services

Legend:  
= Full Team  
= Half Team

## Initial ACT Training:

### On-Site Team Start-up:

- Two trainers: local expert & national consultant.
- One full day on-site with each team. (10 visits total)
- ACT 101. (evidence, outcomes, service components)
- Daily Operations. (daily organizational staff meeting/treatment planning with weekly client schedules)

### Regional Core Skills Training

- Motivational Interviewing
- Supported Employment
- Strengths-based assessment & person-centered planning
- Safety & Therapeutic Boundaries

## Booster & Team Specialist Trainings

- ACT Booster Training and Burnout Prevention. (6-8 months post-startup)
- Integrated Dual Disorder Treatment. (6-8 months post-startup)
- Team specialist skill development trainings (Supported Employment, I/DDT & formal wellness (IMR/WRAP)) (18-30 months post-startup)

## Ongoing Technical Assistance: 2007 - 2008

- July 2007 (Western WA teams) and September 2007 (Eastern WA teams): Onsite technical assistance as needed. (typically visiting team, observing daily organizational team meeting, troubleshooting daily processes.)
- Monthly case consultations by phone with national consultant and local consultant.

## Technical Assistance Review

- Began formalizing technical assistance in a more targeted skill format.

Example: In-state MINT Trainers familiar with ACT held two 1/2 day Motivational Interviewing trainings with each team.

- Continued ongoing technical assistance around daily processes.
- Began tailoring technical assistance more formally to fidelity review results.

## Fidelity

- Often called “model” or “program” fidelity
- Definition: The degree to which a program includes features that are critical to achieving the intended outcomes
- Typical purposes of fidelity measures
  - Compare actual with intended intervention
  - Ensure replication and/or prevent drift
  - Ensure validity of interpretation of results
  - Measure strength in multi-site studies
  - To guide performance improvement efforts\*\*\*

## Fidelity: An Overview

- The degree to which a program includes features that are critical to achieving the intended outcomes
- Model fidelity is positively correlated with outcomes
  - Outcomes typically come too slowly to use exclusively as feedback
- Fidelity tools have many purposes
  - Our primary purpose: To guide performance improvement efforts

## Our Approach to Fidelity

- ⊗ Use enhanced TMACT protocol & data collection forms
- ⊗ Review teams in pairs – independent & consensus ratings
- ⊗ 1 1/2 - 2 days per review
- ⊗ Data sources:
  - ⊗ Team survey & Excel spreadsheet
  - ⊗ Chart reviews (20% randomly selected)
  - ⊗ Daily team meeting observation
  - ⊗ Treatment planning meeting observation
  - ⊗ Team member interviews
  - ⊗ Consumer interviews (typically in a group)
  - ⊗ Review of daily team meeting tools
- ⊗ Conducted every six months x first 2 yrs/ now annually

## Summary of Enhancements

- Evidence-based practices
  - ACT is a platform for delivering comprehensive services
  - Many effective services available for adults with severe mental illness
- Staffing roles
  - In Treatment/Services
  - Within the Team
- 4 items assessing person-centered planning practices
  - If misused, ACT services have the potential for being coercive and paternalistic.
  - Operating from a recovery model arguably epitomizes high fidelity ACT

## Overview of the TMACT

- 47 items; 5-point anchored scales
- 6 subscales:
  - Operations & Structure (OS): 12 items
  - Core Team (CT): 7 items
  - Specialist Team (ST): 8 items
  - Core Practices (CP): 8 items
  - Evidence-Based Practices (EP): 8 items
  - Person-Centered Planning Practices (PP): 4 items

- ST1. Substance Abuse Specialist on Team
- ST2. Role of SA Specialist (In Tx)
- ST3. Role of SA Specialist (Within Team)
- ST4. Vocational Specialist on Team
- ST5. Role of Voc Specialist (In Employment Services)
- ST6. Role of Voc Specialist (Within Team)
- ST7. Peer Specialist on Team
- ST8. Role of Peer Specialist

... At least 1.0 who meets local standards for certification as a substance abuse or co-occurring disorder specialist. Preferably has training or experience in IODT. Percent of consumer contacts involving specialty activities, as well as team's responsibility for substance use services (see EP1), is considered in rating this item. Refer to Formula in Protocol.

1	2	3	4	5
Less than 0.25 FTE substance abuse specialist with at least minimal qualifications OR Criteria for a "2" rating met, except qualifications standards	0.25 - 0.49 FTE substance abuse specialist with at least minimal qualifications OR Criteria for a "3" rating met, except qualifications standards	0.5 - 0.74 FTE substance abuse specialist with at least minimal qualifications OR Criteria for a "4" rating met, except qualifications standards	At least 1.0 FTE substance abuse specialist with at least minimal qualifications, but whose specialist activities comprise 50% time with EPI rating of 4 OR 0.75 - 0.99 FTE substance abuse specialist with at least minimal qualifications OR At least 80% of consumer contacts involve specialist-related activities (vs. generalist) OR Criteria for a "5" rating met, except qualifications standards	At least 1.0 FTE substance abuse specialist with at least minimal qualifications OR At least 80% of consumer contacts involve specialist-related activities (vs. generalist). If less than 80% of contacts & team scores a "5" or "4" on EPI, specialist activities may comprise 50% or 65% time, respectively

... Provides integrated, stage-wise treatment to ACT consumers who have a substance use problem. Core services include: (1) conducting comprehensive substance use assessments that consider the relationship between substance use and mental health (2) assessing and tracking consumers' stages of change readiness and stages of treatment; (3) Using outreach and motivational interviewing techniques; (4) Using cognitive behavioral approaches and relapse prevention; (5) Treatment approach is consistent with consumer's stage of change readiness.

1	2	3	4	5
Substance abuse specialist provides 1 or fewer dual disorder treatment services.	Substance abuse specialist provides 2 dual disorder treatment services (i.e., 3 services are absent).	Substance abuse specialist PARTIALLY provides 3-4 dual disorder treatment services (i.e., 1 or 2 services are absent), but up to 2 services are only PARTIALLY provided OR all 5 services are provided, but more than 2 are PARTIALLY provided.	Substance abuse specialist provides all 5 dual disorder treatment services, but up to 2 services are only PARTIALLY provided.	Substance abuse specialist FULLY provides ALL 5 dual disorder treatment services (see under definition).

... (1) modeling skills & individual consultation; (2) cross-training other team members to help them identify substance use issues, monitor progress in treatment, & provide stage-wise treatment for dual disorders; (3) attending all daily team meetings; & (4) attending all treatment planning meetings for consumers with dual disorders.

1	2	3	4	5
Substance abuse specialist does not perform any of the 4 functions within the team.	Substance abuse specialist PARTIALLY performs 1 or 2 functions within the team.	Substance abuse specialist performs 2 functions within the team.	Substance abuse specialist performs 3 functions within the team.	Substance abuse specialist performs ALL 4 functions within the team (see under definition).

... Team has at least 1.0 with at least 1 year of experience in employment services (e.g., job development, job coaching, supported employment). Percent of consumer contacts involving specialty activities, as well as team's responsibility for substance use services (see EP2) is considered in rating this item. Refer to Formula in Protocol.

1	2	3	4	5
Less than 0.25 FTE vocational specialist with at least minimal qualifications OR Criteria for "2" rating met, except qualifications standards.	0.25 - 0.49 FTE vocational specialist with at least minimal qualifications OR Criteria for "3" rating met, except qualifications standards.	0.5 - 0.74 FTE vocational specialist with at least minimal qualifications OR Criteria for "4" rating met, except qualifications standards.	0.75 - 0.99 FTE vocational specialist with at least minimal qualifications. At least 80% of consumer contacts involve specialist-related activities (vs. generalist). OR Criteria for "5" rating met, except qualifications standards.	At least 1.0 FTE vocational specialist with at least minimal qualifications. At least 80% of consumer contacts involve specialist-related activities (vs. generalist). If less than 80% of contacts & team scores a "5" on EP2, specialist activities may comprise 65% time.

... Vocational specialist provides supported employment services. Core services include: (1) engagement; (2) vocational assessment; (3) job development; (4) job placement (including going back to school, classes); (5) job coaching & follow-along supports (including supports in academic settings); & (6) benefits counseling.

1	2	3	4	5
Vocational specialist provides 2 or fewer employment services.	Vocational specialist provides 3 employment services (i.e., 3 services are absent).	Vocational specialist provides 4-5 employment services (i.e., 1 or 2 services are absent), but up to 3 services are only PARTIALLY provided OR all 6 services are provided, but more than 3 are PARTIALLY provided.	Vocational specialist provides all 6 employment services, but up to 3 services are only PARTIALLY provided.	Vocational specialist FULLY provides ALL 6 employment services (see under definition).

(1) modeling skills & consultation (2) cross training to other team members to help them to develop supported employment approaches with consumers in the team (3) attending all daily team meetings & (4) attending all treatment planning meetings for consumers with employment goals

1	2	3	4	5
Vocational specialist does not perform any of the 4 functions within the team.	Vocational specialist PARTIALLY performs 1 or 2 functions within the team	Vocational specialist performs 2 functions within the team	Vocational specialist performs 3 functions within the team	Vocational specialist performs ALL 4 functions within the team (see under definition).

Team has at least 1.0 FTE team member who meets local standards for certification as a peer specialist. If peer certification is unavailable locally, minimal qualifications include the following: (1) self identifies as an individual with a serious mental illness, who is currently or formerly a recipient of mental health services, (2) is in the process of his/her own recovery, and (3) has successfully completed training in wellness and recovery interventions.

1	2	3	4	5
Less than 0.25 FTE peer specialist on team OR less than 1.0 FTE peer specialist with inadequate qualifications	0.25 FTE to 0.49 FTE peer specialist who meets at least minimal qualifications.	0.50 FTE to 0.74 FTE peer specialist who meets at least minimal qualifications OR at least 1.0 FTE peer specialist with inadequate qualifications OR more than 2 peer specialists fill the 1.0 FTE.	0.75 FTE to 0.99 FTE peer specialist who meets at least minimal qualifications. No more than 2 Peer Specialists fill the 1.0 FTE.	At least 1.0 FTE peer specialist who meets at least minimal qualifications. No more than 2 Peer Specialists fill the 1.0 FTE.

Peer Specialist on the team performs the following functions: (1) coaching and consultation to consumers to promote recovery and self-direction (e.g., preparation for role in treatment planning meetings); (2) facilitating wellness management strategies (e.g., WRAP, IMR); (3) participation in all team activities (e.g., tx planning, chart notes) is equivalent to fellow team members; (4) modeling skills for & providing consultation to fellow team members; and (5) providing cross-training to other team members in recovery principles and strategies.

1	2	3	4	5
Peer Specialist performs 1 or fewer functions on the team.	Peer Specialist FULLY performs 2 functions on the team OR 2 to 3 functions PARTIALLY.	Peer Specialist FULLY performs 3 functions within the team OR 4 to 5 functions PARTIALLY.	Peer Specialist FULLY performs 4 functions within the team.	Peer Specialist FULLY performs ALL 5 functions within the team (see under definition).

### Evidence-Based Practices (EP)

- EP1. Full Responsibility for DD Services
- EP2. Full Resp. for Vocational Services
- EP3. Full Resp. for Wellness Management
- EP4. Integrated Dual Disorders Tx Model
- EP5. Supported Employment Model
- EP6. Engagement & Psychoeducation w/ Natural Supports
- EP7. Empirically-Supported Psychotherapy
- EP8. Supportive Housing Model

The FULL TEAM (1) considers interactions between mental illness and substance abuse, (2) follows cognitive-behavioral principles, (3) does not have absolute expectations of abstinence and supports harm reduction, (4) understands and applies stages of change readiness in treatment; and (5) is skilled in motivational interviewing.

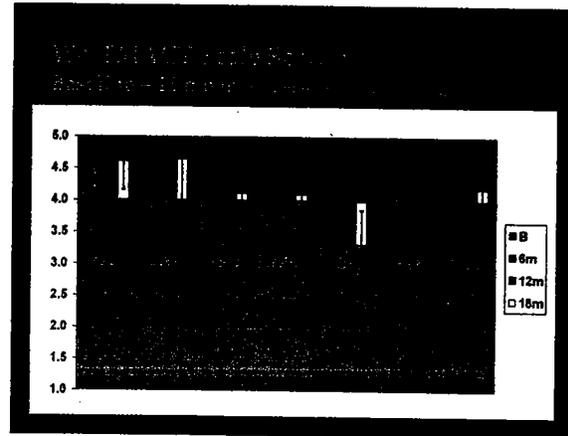
1	2	3	4	5
Team primarily uses traditional model (e.g., 12-step programming, focus on abstinence). Criteria not met.	Only 1 - 2 criteria are met	Only 3 criteria are met.	Team primarily operates from IDDT model, meeting 4 criteria.	Team is FULLY based in IDDT treatment principles and meets all 5 criteria (see under definition).

The FULL TEAM (1) values competitive work as a goal for all consumers, and believes that: (2) a consumer's expressed desire to work is the only eligibility criterion for SE services, (3) on-the-job assessment is more valuable than extensive prevocational assessment, (4) placement should be individualized and tailored to each consumer's preferences, and (5) ongoing supports and job coaching should be provided when needed and desired by consumer.

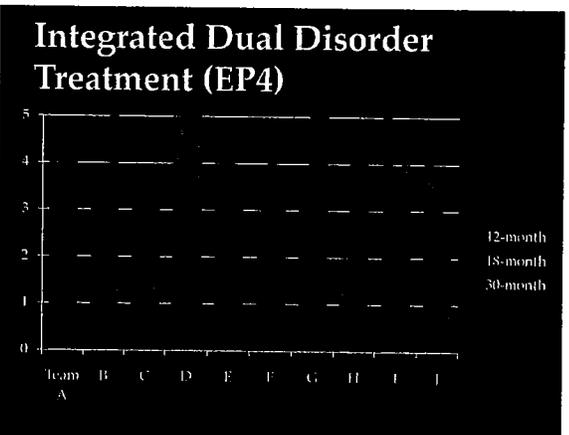
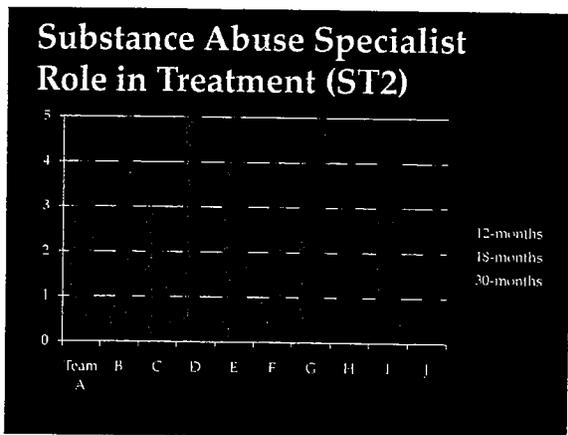
1	2	3	4	5
Team does not embrace supported employment (SE) model.	Only 1-2 criteria are met	Only 3 criteria are met	Team primarily embraces SE model, meeting 4 criteria.	Team FULLY embraces SE model and meets ALL 5 criteria (see under definition).

Wellness management services are directly provided by the ACT team rather than by an external program or provider (e.g., a WRAP group run by the team's agency rather than the ACT team itself).

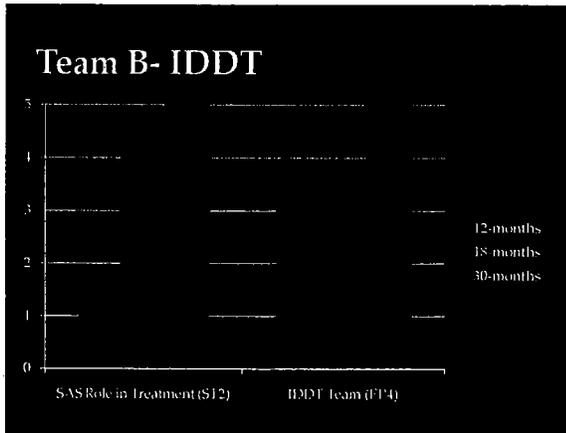
1	2	3	4	5
Less than 20% of consumers in need of wellness management services are receiving them from the team.	20 - 49% of consumers in need of vocational services are receiving them from the team.	50 - 74% of consumers in need of vocational services are receiving them from the team.	75 - 89% of consumers in need of vocational services are receiving them from the team.	90% or more of consumers in need of vocational services are receiving them from the team.



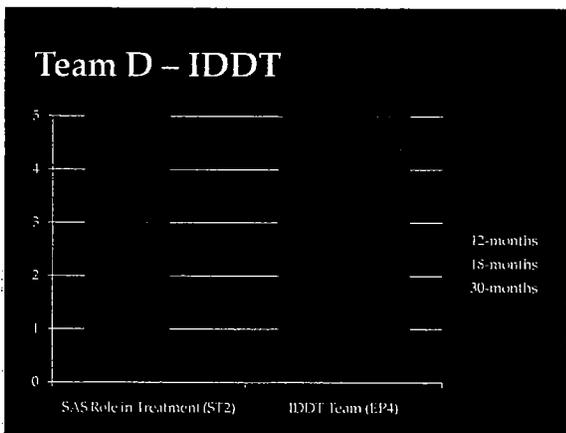
- ### IDDT Implementation: WA-PACT
- Approximately 6-8 months after start-up, teams attended a large group IDDT training.
  - Between 12 and 18 month fidelity reviews, each team received on-site Motivational Interviewing training.
  - At approximately 25 months, team leaders and substance abuse specialists attended an IDDT booster training.
  - TMACT fidelity reviews at 12, 18 & 30 months.



- ### Team B- IDDT
- Most of team attended initial IDDT large group training after serving clients for 6 months.
  - Loss of substance abuse specialist shortly after. (6-months after start-up)
  - New substance abuse specialist hired by 12-month review and attended a state-sponsored training on IDDT.
  - Both team leader and whole team subscribed to and championed IDDT model allowing SA Specialist to develop their service delivery as a new clinician on the team.
  - Overall most consistent growth of IDDT services in state.



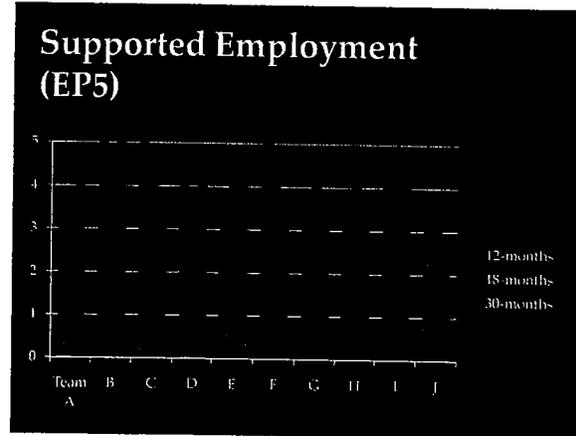
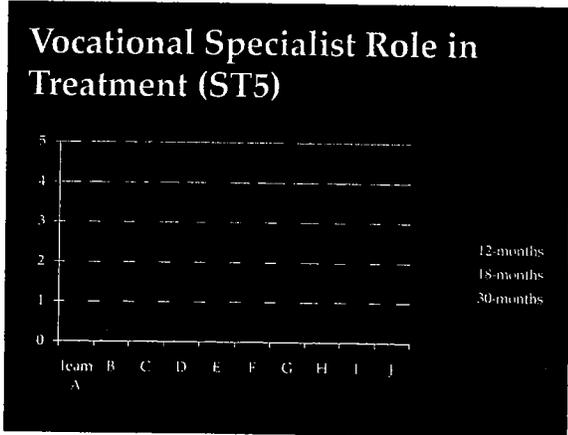
- ### Team B- IDDT
- Started out with strong substance abuse specialist at 12-18 months, implemented IDDT services.
  - Substance abuse specialist abruptly left her position within one month of the 30-month review.
  - Team utilized technical assistance to start using "whiteboard" to stage clients and continue to work from a stage-wise treatment framework despite loss of specialty position.
  - Peer specialist also in recovery, began running dual disorder group.
  - Team leader, skilled in IDDT model, picked up the individual substance abuse counseling.
  - Despite receiving lower score for specialist at 30-months, still received a '5' on IDDT item EP4.



- ### IDDT Implementation: 12-30 month themes
- Some connection between a team's embrace of IDDT philosophy and rating of SA Specialist. (i.e. teams that embraced stage-wise treatment/harm reduction typically had a SA Specialist providing a more full spectrum of treatment.)
  - Conversely, teams that showed a more fractured view of the IDDT philosophy seemed to have a SA Specialist who wasn't fully implementing IDDT services.

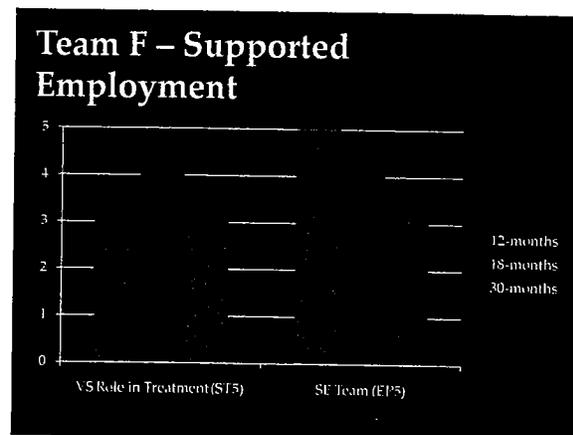
- ### IDDT Implementation: 12-30 month themes
- Stronger IDDT orientation in more transdisciplinary teams – teams that suffered from less turnover and worked closely together seemed to keep a strong IDDT philosophy from year to year.

- ### Supported Employment: WA-PACT
- Start-up training included Supported Employment model overview.
  - Most feedback/technical assistance on Supported Employment followed fidelity reviews.
  - One Supported Employment booster training for team leaders and V5 at approximately 20 months post start-up.
  - Post-30 month reviews (2010-2011) teams receiving individualized Supported Employment training/technical assistance.



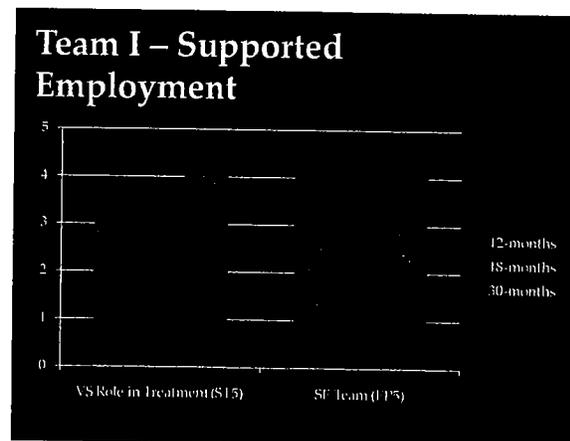
### Team F – Supported Employment

- Major team turnover (team leader, multiple staff) at 12-months, VS has remained since start-up.
- VS struggles to implement full Supported Employment model.
- Team Supported Employment orientation has experienced drift since 12-month review.
- Team leader focused on more of a traditional vocational rehabilitation model.
- VS difficulty protecting 80% specialty time.



### Team I – Supported Employment

- Operated with 2 FTE VS for first 30-months.
- Both VS struggled with preserving 40% specialty time. (total of 80% VS time for 100-client team)
- Agency Supported Employment orientation in flux during team development, unclear message on providing fidelity SE services.
- Technical assistance provided at 18, 30-months may have helped VS fidelity scores.



### Formal Wellness Services WA-PACT

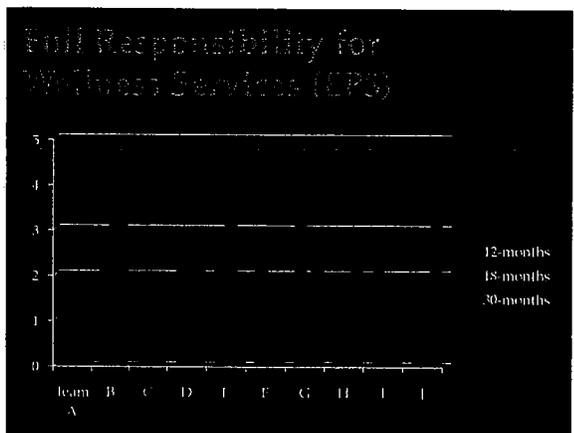
- Before more intensive SE training/technical assistance, VS focused on "what they knew" e.g. stronger focus on skills rehabilitation, running "job groups," working with the DVR system, working in collaboration with local sheltered work and/or starting their own sheltered work, focusing strongly on "school."
- 1 team VS implemented full SE model at start-up.

### Peer Specialist Role in Treatment (STS)

- Leadership (agency and/or team leader) with mixed attitudes toward Supported Employment model tended to have less implemented VS role in treatment.
- Teams with mixed attitudes toward Supported Employment model tended to have less implemented VS role in treatment.
- Failure to preserve specialty time negatively impacted VS role in treatment.

### Formal Wellness Services WA-PACT

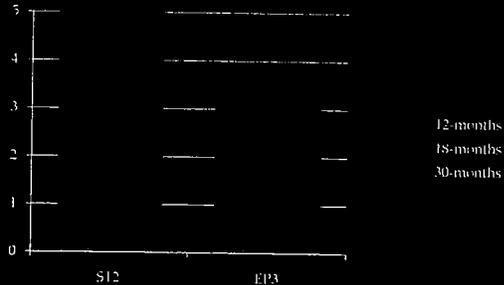
- WRAP (Wellness Management & Recovery)
- IMR/WMR (Illness Management & Recovery)
- Other formal wellness strategies driven by team/peer specialist.
- Most technical assistance for wellness services occurred through TMACT fidelity review recommendations with specific follow-up as needed.



### Team D: Formal Wellness

- Strong peer specialist (PS), with team since inception.
- Transdisciplinary nature to team, e.g. ACT clinicians & PS share roles in running WMR group as well as dual disorders group.
- Team accessed very little technical assistance to run WMR group, parent agency championed WMR implementation.
- Steady increase in wellness penetration rate, (33%-66% from 12-30 months).

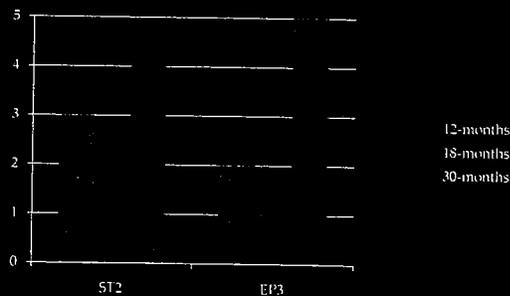
### Team D: Formal Wellness



### Team D: Formal Wellness

- Hire of new PS between 18-30 month review had significant impact on both PS role in treatment (ST2) and penetration of wellness services (EP3) during 30-month review.
- Team had significant turn-over at approximately 24 months resulting in re-training in ACT model & IDDT/SE/Wellness.
- New PS was a "self-starter", quickly took on the formal part of the PS role and sought out technical assistance on starting IMR groups.
- By 30-month review, wellness penetration rate had jumped to 93%.

### Team J – Formal Wellness



### Formal Wellness: 12-30 month themes

- Implementation of formal wellness services largely tied to peer specialist skill level/interest as well as coaching/supervision by team leader.
- Cross-training of formal wellness across team helpful.
- Lower fidelity ratings in EP3 speak to the need for more formal training and consultation in specific wellness approaches across the team.

### Next Steps for WA-PACT:

- Continuation of yearly TMACT fidelity reviews.
- Individualized team-based IDDT technical assistance.
- Continued individualized team-based Supported Employment training & technical assistance.
- Wellness management: Received a three-year grant from NIMH to develop and pilot-test IMR within ACT teams.

### Issues/Challenges in Implementing EBP's within ACT

- Integration of another EBP
- Staff turnover
- Team funding
- Training/TA funding
- Specific and distinct clinical skillset for IDDT, Supported Employment & Formal Wellness services.
- Team Leader EBP Champion vs. putting EBP on "back burner"
- "Just do it" phenomenon.
- Mixed adoption/support of EBP's in larger community.

Presenters

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