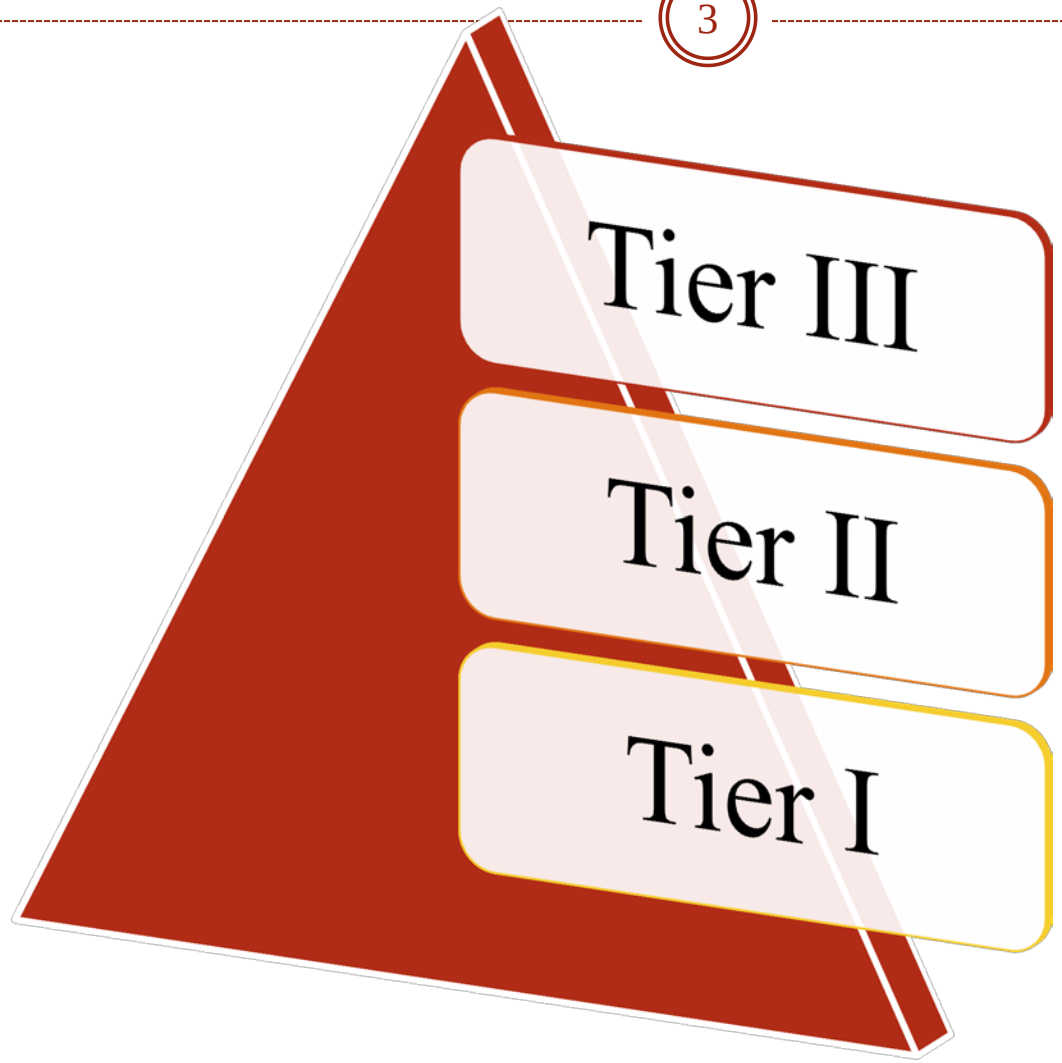
Tiered Supports and Tools in the Mental Health Field

COLLABORATION WITHIN DMH BETWEEN DBH & DD

Tiered Supports

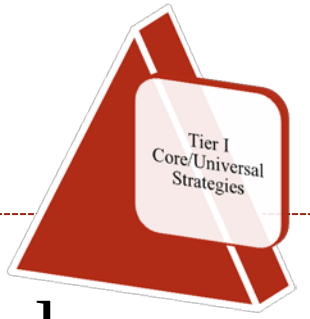
- Tiered support process
  - Identify the needs of individuals
  - Match the level of support to the level of needs
  - Assess Response to Intervention

Tiered Supports



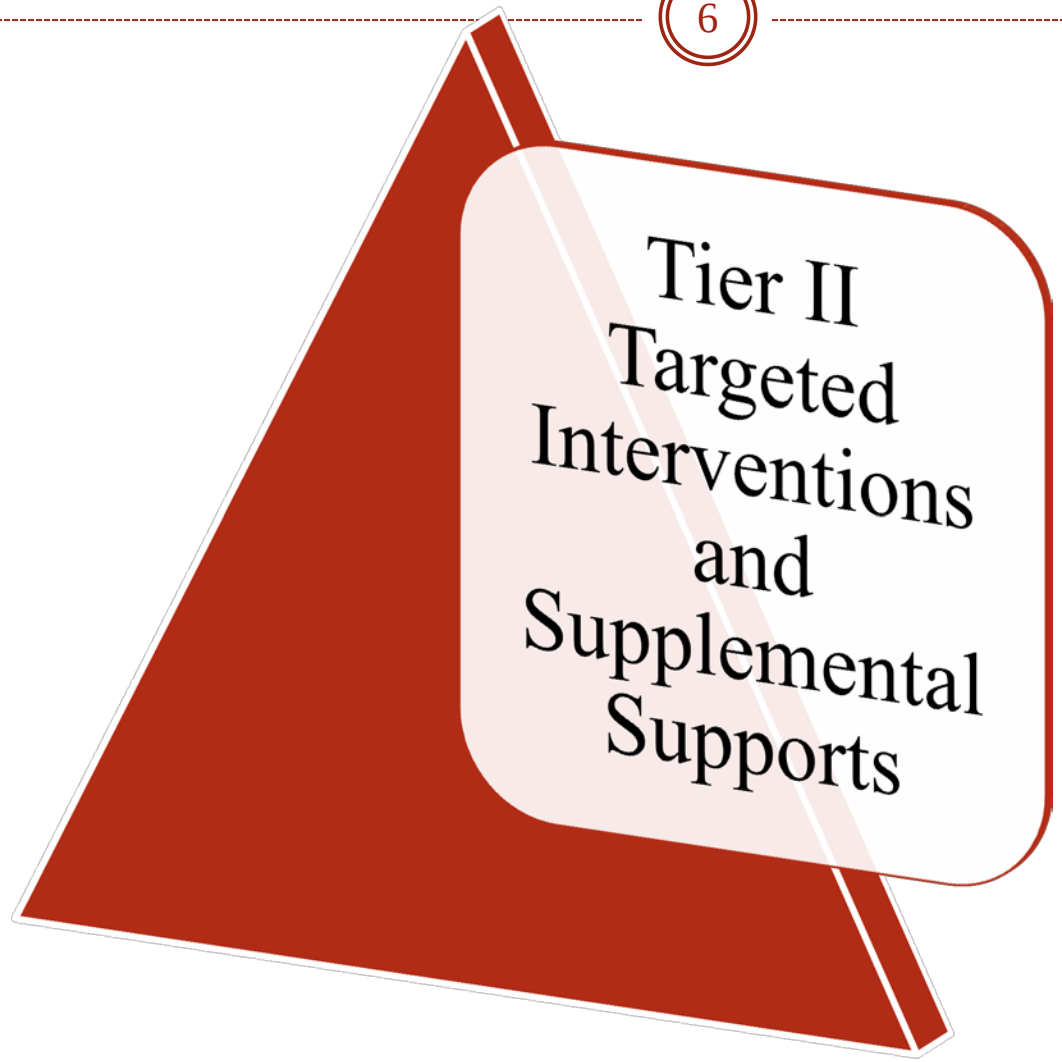
Tiered Supports

Tiered Supports



- Elements of the Universal Strategies in place
  - Measures of Quality of Life
    - Physical and Social Environment
    - Meaningful Day
    - Choice and Communication
    - Life Values
    - Positive Interactions and Relationships
    - Acquisition of Skills
    - Systems of Reinforcement
    - Data Driven Decision Making

Tiered Supports



Tiered Supports

- Focused strategies and targeted interventions of Tier II
- If base is solid and all components are in place
  - 80% of concerns are resolved at Tier I
- TIER II DOES NOT REPLACE TIER I
- If everyone uses it then it is not a Tier II it is a Tier I -
- Based on need

Tiered Supports

- All staff have easy access to processes
- Should be interventions that can be continually available
- Minimal time to implement
- Align with Mission, Vision and Values
- Staff skilled in the intervention
- There can be consistent implementation
- Matches why the behavior is occurring

Tiered Supports

Tiered Supports

- Most intensive supports
- Interventions at Tier I and Tier II have been implemented with fidelity and integrity
  - Implementation has been documented and data substantiates need

The Tiered Supports and Tools in the Mental Health Field

CENTER FOR BEHAVIORAL MEDICINE: KANSAS CITY

CBM: A Quick History

- Originally known as the Western Missouri Mental Health Center
- Department of Mental Health Hospital since the late 60's
- UMKC Department of Psychiatry and a training facility for many other mental health professionals
- Acute facility and only Psychiatric ER in Kansas City until July 2009
- Long Term facility today

CBM: Current Structure

- 2 Units: long term care – 40 beds
- IST Unit- 25 beds
- Group Homes- 65 beds
  - 2 Mental Health Group Homes
  - 3 Waiver Mental Health Group Homes
  - 1 Supervised Apartment Complex

First Asset:2011

- One Unit Selected: 3C
- One Group Home Selected: Esperanza
- Reasons for the Asset:
  - Change in Mission of the organization
  - New Goals of a New Administration
  - Desire to be moving in a positive direction as an agency

Results of the First Asset

- Unit 3C
  - Needs of patients are being met
  - Some staff are working to build relationships with patients already.
  - Some staff are implementing informal reinforcement at high rates
  - Should look at ways that patients have access to preferred items.
  - Tools training should be encouraged for all staff to help teach desirable behaviors.
  - Work to align behavioral expectations with reinforcement systems.

Results of the First Asset

- 3C's Response:
  - Unit Manager and Psychologist had immediate buy in
  - All nursing staff enrolled in Tools training at CBM
  - Change in reinforcement systems
  - Sweet Solutions

Results of the First Asset

- Group Home: Esperanza
  - Most staff worked consistently to build relationships with residents.
  - Some Staff are implementing informal reinforcement at high rates
  - Most individuals seem to have many aspects of their lives that are important for having a meaningful day.
  - Should look into ways for residents to have input into schedules.
  - All staff should be trained in Tools.
  - Align behavioral expectations with reinforcement systems

Results of the First Asset

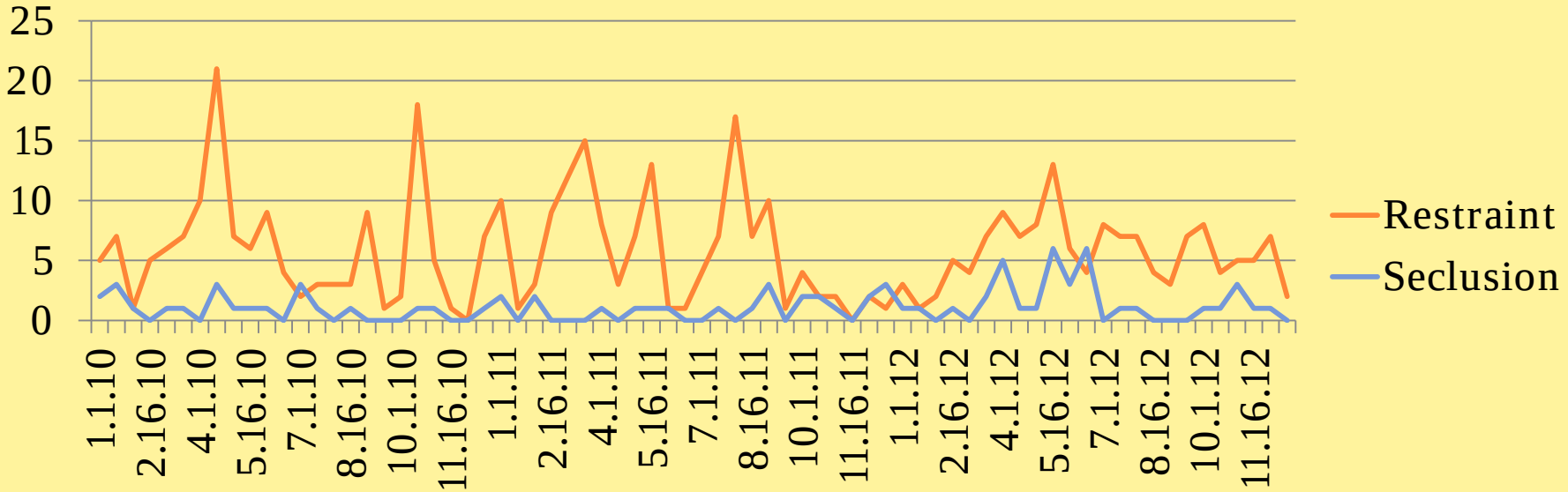
- Esperanza's Response:
  - Director became a Tools Trainer and bought in to this.
  - Staff started attending the Tools Training
  - Survey taken about what the residents like to do
  - Schedules based on survey results.
  - Change in Leadership at Esperanza....

Tools of Choice

- First classes in 2012 at KCRO
  - 7 staff trained-
    - 6 from 2B
    - 1 from Esperanza
- A couple of trainings at CBM offered
- Discretion of the Supervisors
- Discretion of the Employees
- All Clinical Staff Pro-Act Trained- preferred method
- A Team Formed

Tools in Mental Health

- Common Concerns:
  - Psychiatric Diagnosis-
  - Behaviors
  - Aggression: Rates of Restraint and Seclusion: Pre -Tools



Tools of Choice

- 2013: CBM begins training
  - 57 new staff trained
    - Mostly from 3C
    - Rehab staff starts getting involved
    - Esperanza Director leaves- half of staff trained
    - Lakeland starts working to get trained
    - Highlands becomes 100% trained
    - Crossroads starts getting trained
    - Director of Nursing takes Tools and supports the training in July
    - Director of Security takes Tools in December and supports the training

Tools of Choice

- 2014: Year of Momentum
  - 112 new staff trained
  - Group Homes made it mandatory for all staff to be trained with most already achieving this.
  - 3C is 100% trained
  - Rehab 100% trained
  - Security, Social Work, Dietary, Environmental Services start attending
  - Most of Administration is trained
  - 1 Psychiatrist brings his treatment team to a training
  - Part of New Employee Orientation for all staff

Tools of Choice

- 2015....
  - All Group Home Staff will be trained by July 2015
  - In the first 4 months 55 new staff trained
  - FLT has indicated that all staff are to take the Tools training
  - Accounting is starting to have staff attend
  - New Culture of CBM
  - Emphasizing that Tools is for everyone and it is how we engage with each other....not just with the clients!

Tools of Choice

- 2016....
  - Continue to emphasize that Tools is for everyone and it is how we engage with each other....not just with the clients!
  - 350 staff trained to date
  - Incorporate Tools into treatment team process
  - Incorporate Tools into event/incident debrief
  - Reemphasize Vision – Mission - Values

2nd Asset Completed

- Full organization surveyed
  - 2 Units
  - IST Unit
  - Group Homes and Apartment Complex

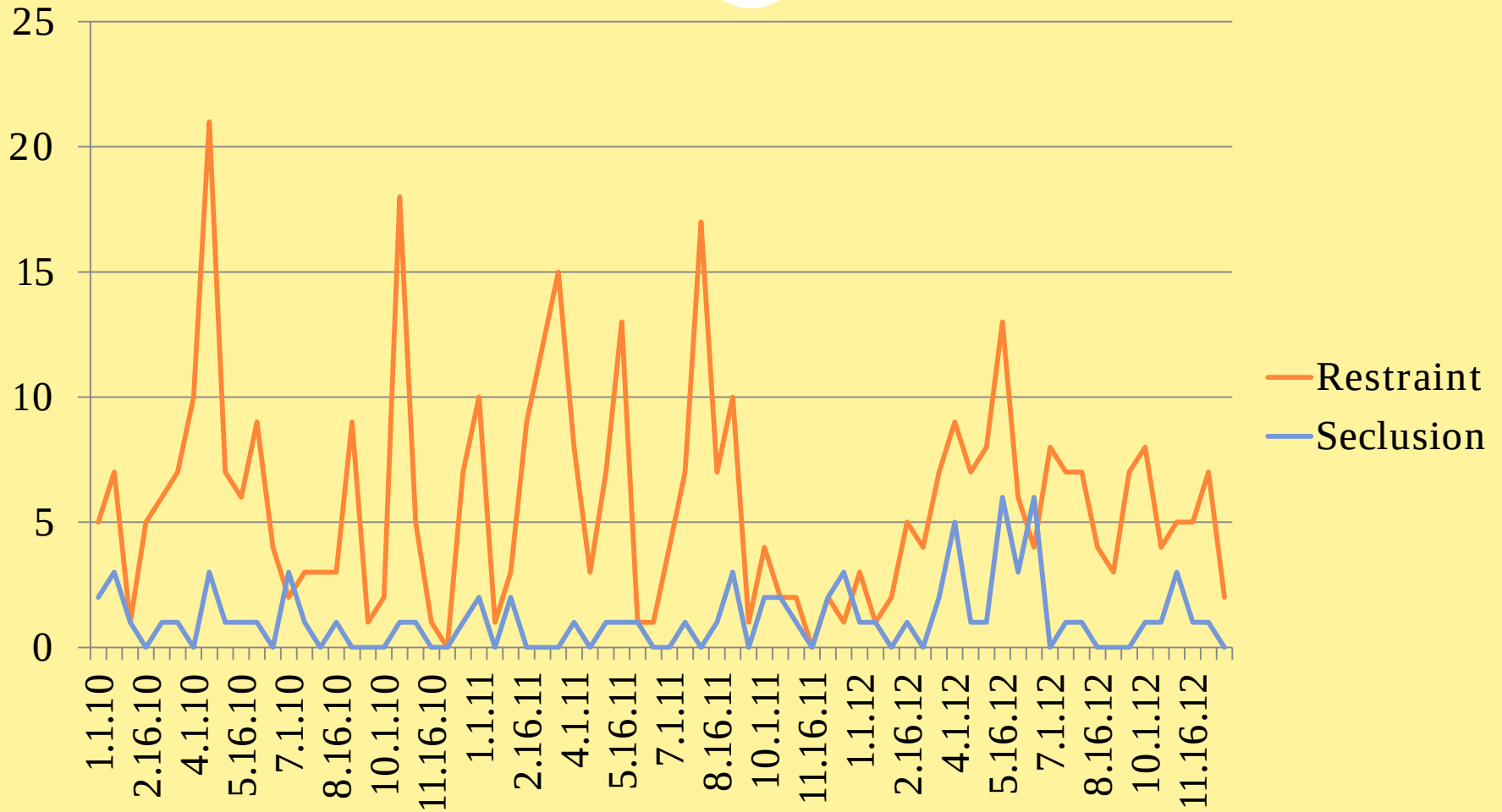
Results of 2nd Asset

- Agency Wide:
  - Tools has been implemented and is helping to build relationships.
  - The group homes are helping residents have a more meaningful day – still limited on the units
  - There is greater choice in the group homes than on the unit.
  - Not all of the staff have bought into Tools and are committed to making a change.
  - The “therapeutic staff” are seen as the ones responsible for teaching new skills.
  - Level System is used and not set up in a “To Do” terms way.

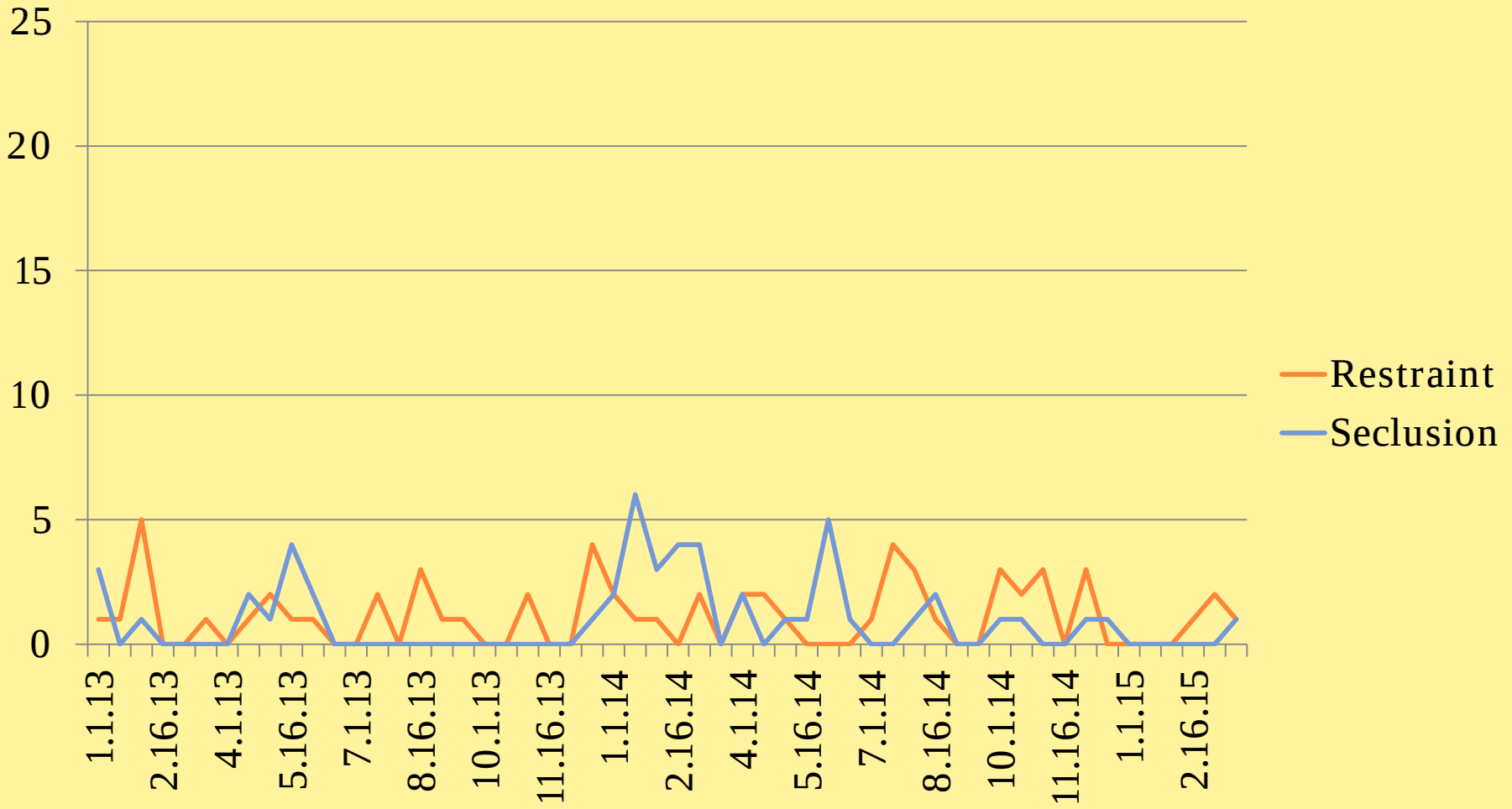
Results of 2nd Asset

- 3C:
  - Noted improvements in general
  - Level system is in place
  - Increase in relationship building noticed on the unit
- Esperanza:
  - More choices being offered
  - Believed that a change in the leadership and staff turn over at a critical time this is being counted more as a new baseline

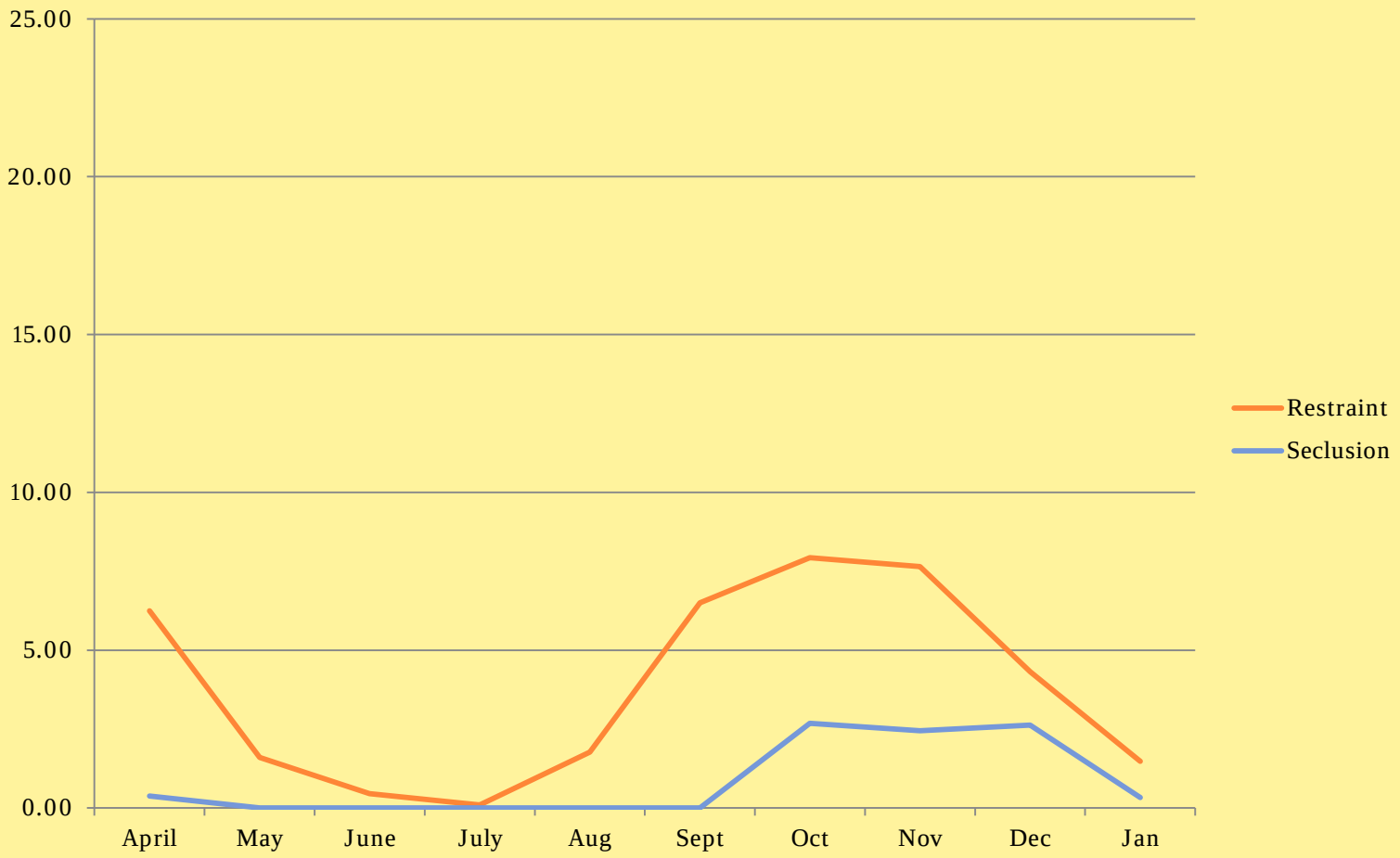
Restraint and Seclusion Rates
Pre- Tools



Restraint and Seclusion Rates
Post Tools Year 1-2-3



Restraint and Seclusion Rates
Post Tools Year 4



Future Directions

- Facility Leadership and A Team a more cohesive group
  - Feedback loop between A team and Facility Leadership
- Goals being developed for the agency
- All CBM Staff trained in Tools
- New Culture of CBM!!!!

The Tools in the Mental Health Field

TRUMAN MEDICAL CENTERS BEHAVIORAL HEALTH ACUTE CARE FACILITIES

Truman: A Quick History

- Truman Medical Center (TMC) Hospital Hill was dedicated four decades ago, but its roots go back more than a century.
- Its forerunner was General Hospital, Kansas City's first hospital, built in 1870 then rebuilt in the 1920s.
- In 1957, TMC became the teaching hospital for the new University of Missouri-Kansas City Medical School, a major component in Hospital Hill.
- The new medical school and connected hospital were dedicated in 1976.
- TMC and UMKC School of Medicine were established on Hospital Hill and joined with the old county hospital, which became Truman Medical Center East.
- In early 2000, the names were officially changed to Truman Medical Center, Hospital Hill and Truman Medical Center, Lakewood.

TMC BHED

- TMC took over the Behavioral Health Emergency Department on June 16, 2009.
- Formerly, the Emergency Department was operated by the State of Missouri as part of Western Missouri Mental Health Center.
- TMC has operated the facility with the same model and has served approximately 30,000 patients in the past six years.
- The hybrid model of having two entrances to the TMC Emergency Department (the main entrance and the behavioral health entrance), separated by two streets and 500 yards, proved to be an ongoing challenge under federal hospital regulations.

TMC BHED

- As a result, the TMC BHED closed in September 2015.
- TMC, the community, and the State of Missouri are seeking a solution that will work in the current regulatory environment.
- Patients located in the Behavioral Health inpatient units at both TMC Hospital Hill and Lakewood are unaffected by the closure.
- Inpatient units remain open, and community outpatient services continue.
- TMC remains committed to serving those with behavioral health needs in the community.

TMC Behavioral Health Acute Care
Current Structure

- Inpatient Behavioral Health units at Truman Medical Centers are designed to give individuals aged 18 years and older an opportunity to receive professional, cost-effective, mental health services in a nurturing and caring atmosphere.
- Our services are provided by a multidisciplinary team comprised of Psychiatrists, Psychologists, Pharmacists, Psychiatric Nurses, Qualified Mental Health Professionals, Substance Abuse Counselors, Rehabilitation Therapists, Chaplains, and Mental Health Technicians.
- We offer individualized treatment to help individuals feel more in control of their life.
- CAPACITY: 50 adult beds at Hospital Hill; 16 senior adult beds at Lakewood

First Contact

- Summer 2014: Assoc. Admin. of Behavioral Health, Jackie Griffin, and Director of Rehabilitation Services, Rob Ellis, decide to investigate the possibility of bringing Tools training to TMC BHAC
- Fall 2014: Milieu Coordinators Roxanne Pendleton and Katie Chepulis attend Tools three-day (18hr) classes at the Center for Behavioral Medicine state hospital, begin to practice the Tools in TMC BHAC, and remain in dialog with BHAC leadership & Rita Cooper at KCRO about bringing Tools training to TMC

Tools Trainers and Next Steps

- Winter 2014:
  - Milieu Coordinators complete six-day (48-hour) Tools Train the Trainer course with KCRO
  - Additional frontline staff member from TMC BHAC takes three-day (18hr) Tools classes at CBM and begins practicing Tools at TMC BHAC
  - Milieu Coordinators work on Tools Trainer competencies and receive mentoring from KCRO staff
  - Six more frontline staff complete (18-hour) Tools training at KCRO
  - Feedback—The acute care setting requires some different information and modified approaches

Deploying Tools in Acute Care

- Spring 2015: Tools classes offered to TMC BHAC staff
  - Tools training promoted at monthly BH Management meeting where all BH departments are represented
  - 24 BHAC staff complete Tools two-day (16-hour) classes
  - These staff include Director of Nursing, Director of Inpatient Psychology, Staff Psychologist, Director of Rehabilitation Services, and Associate Director of Nursing
  - Based upon strong, direct, and ongoing feedback from TMC BHAC leaders, significant revisions are made to the training

Tools in Acute Care

- Summer 2015:
- Some Examples of Our Modifications for acute care environment—
  - We must sometimes be coercive in acute care for the safety of all; rather than "Avoid Coercion", we "Practice Respect" and limit our coercive behaviors
  - Rather than teaching "Stay Close", we teach how to "Build and Maintain Rapport"
  - We train on the intersection between CPI and Tools; we train when to appropriately use each
  - In acute care, we are very cautious of initiating touch, and we are sure to educate staff on appropriate touch, when not to touch, and maintaining professional, healthy boundaries at all times
  - For safety purposes, most of our reinforcement is either verbal (praise) or involves some kind quality time with staff
  - We do not teach "Set Expectations"; we train regarding our psychologist-written Staff/Patient Behavior Response Plans

Tools in BH at TMC

- Fall 2015: Tools offered to other BH departments
  - More BHAC frontline staff receive training
  - More BHAC leadership receive training
  - BH outpatient staff from Patient Access, PTSD, and TMC Futures programs attend training
  - BH Director of Workforce Development attends training
  - BH Administrator attends training

Tools in BH at TMC

- Winter 2015: Tools Training becomes more specialized to TMC setting
  - We developed a 4-hour "Basic Communication Tools for BHAC" course, designed for new inpatient staff during orientation.
  - We renamed our 16-hour, highly-adapted course "Communication Tools for Behavioral Healthcare".
  - We continue to modify courses after each training, based on feedback.

Tools in BH at TMC

- Summary
  - **To date, 68 TMC BH staff have completed training**
  - **This number includes BHAC Mental Health Technicians, Unit Clerks, Nurses, Psychologists, Qualified Mental Health and Substance Abuse Professionals, Rehabilitative Therapists, Clinical Team Managers, Interns, Chaplains, and Leadership, as well as staff from BH Administration, BH Patient Access, BH Futures, and BH PTSD services**

Tools in BH at TMC

- **Vision—**
  - **All BHAC leaders and managers complete training by Summer 2016**
  - **All BHAC staff complete training within two years**
  - **All new BHAC staff complete Basic (4-hour) course during Orientation**
  - **Basic (4-hour) course to be offered as Refresher course for staff who have had some form of Tools training in the past**
  - **TMC BH Professional Development Committee is interested in the Basic course being offered to all BH staff with the option of CEUs**

Questions and Answers

nirn National Implementation Research Network

Implementation Brief

January 2009 Dean L. Fixsen & Karen A. Blase Number 1

Implementation: The Missing Link Between Research and Practice

"As anyone knows who has worked in the field, implementation of new practice is the biggest challenge of all."

—Hollin & McMurran, 2001

THERE IS A GREAT DEAL OF DISCUSSION about the need to revitalize the nation's infrastructure. New roads, bridges, schools, and public buildings need to be built using the latest in green technology. Current infrastructure needs to be repaired and retrofitted. This brief makes the case that our human services infrastructure for effective implementation requires a similar investment so that effective programs and practices can be widely adopted and used to produce socially significant outcomes. In the United States, the federal government spends over $95 billion a year to fund research to help create new interventions and over $1.6 trillion a year to support services to citizens (Clancy, 2006). However, research results are not being used with sufficient quantity and quality to impact human services and have not provided the intended benefits to consumers and communities. For example, the Institute of Medicine (2001) found that human services typically are inconsistent, often ineffective, and sometimes harmful to consumers. These conclusions were echoed in reviews by the Surgeon General (U.S. Department of Health and Human Services, 1999; 2001) and the President's New Freedom Commission on Mental Health (2003). The failure to utilize research rests in large part on a faulty or non-existent implementation infrastructure. Current implementation attempts are not making use of the best implementation science related to practice, service, and system change. There are too many weak bridges to nowhere and too much hopeful, but faulty, thinking about how science will move to service.

The "to" in science to service

In the past two decades researchers and policy makers have focused considerable attention on how to define an "evidence-based" program. Such definitions are helpful when practitioners, providers, and policy makers need to *choose what they will invest in on behalf of consumers.* But such lists are not much help in moving science to service. As we attempt to make use of the results of sound science, we are coming to realize that the "to" in science to service represents a whole new set of activities called "implementation." For many years, science to service has been seen as a passive process that involves "diffusion" and "dissemination of information" that makes its way into the hands of enlightened champions, leaders, and practitioners who then put these innovations into practice (Rogers, 1995; Simpson, 2002). In this approach, researchers do their part by publishing their findings then it is up to managers and practitioners to do their part by reading the literature and making use of the innovations in their work with consumers. This passive process is well accepted and serves as the foundation for most federal and state policies related to making use of evidenced-based programs and other human service innovations. For example, federal technical assistance (TA) grants fund information gathering, publications and meetings to share information, and training sessions to provide more detailed information in a lecture-discussion format. Using this process, hundreds of millions of dollars are spent each year on the diffusion and dissemination of information in human service domains. While such diffusion and dissemination efforts are necessary they are not sufficient for supporting implementation efforts to solve national problems.

Implementation: The missing link

New evidence is accumulating regarding a more purposeful, active, and effective approach to implementation. Implementation is the art and science of incorporating innovations into typical human service settings to benefit children, families, adults, and communities. We use the term "innovation" to include programs and practices that have a strong research base (e.g. "evidence-based programs") as well as other programs and practices that have potential benefit to consumers, communities, or provider organizations (e.g. data based deci-

The mission of the National Implementation Research Network (NIRN) is to advance the science and practice of implementation, organization change, and system transformation to help solve social problems.

sion support systems, electronic record systems, targeted fund raising approaches, skill-based hiring methods).

Recently, a comprehensive review of the implementation evaluation literature and current successful practices was completed and a synthesis of that information resulted in new ways to view the methods needed to make better use of science in typical human service settings (Blase & Fixsen, 2003; Blase, Fixsen, Naoom, & Wallace, 2005; Fixsen, Naoom, Blase, Friedman, & Wallace, 2005; Wallace, Blase, Fixsen & Naoom, 2008). From an implementation point of view, doing more and better research on a program or practice itself does not lead to more successful implementation. A series of meta-analyses and detailed assessments of the strength of research findings for certain practices and programs may help a consumer, agency, or community select a program. However, more data on program outcomes will not help implement that program with fidelity and benefits for the intended recipients. "Discovering what works does not solve the problem of program effectiveness. Once models and best practices are identified, practitioners are faced with the challenge of implementing programs properly. A poorly implemented program can lead to failure as easily as a poorly designed one" (Mihalic, Irwin, Fagan, Ballard, & Elliott, 2004).

Results from the synthesis of the implementation literature and best practices yielded two major theoretical frameworks that can guide practice and research efforts to move science to service more effectively and efficiently. The first framework describes the stages of implementation. The second framework provides a view of the core components of implementation.

Stages of Implementation

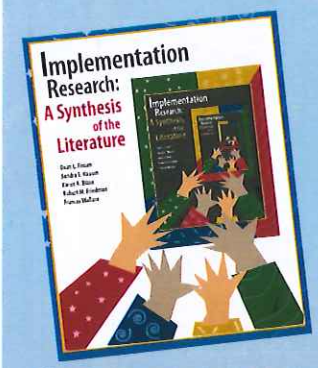
The literature is clear that implementation is a process that takes two to four years to complete in most provider organizations. It is a recursive process with steps that are focused on achieving benefits for children, families, provider organizations, human service systems, and communities. It appears there are six functional stages of implementation: exploration, installation, initial implementation, full implementation, innovation, and sustainability. The stages are not linear as each impacts the other in complex ways. For example, sustainability factors are very much a part of exploration and full implementation directly impacts sustainability. Or, an organization may move from full implementation back to initial implementation in the midst of unusually high levels of staff turnover.

Core Implementation Components

Based on the commonalities among successfully implemented programs across many fields, core implementation components have been identified (Fixsen et al., 2005). The goal of implementation is to have practitioners (e.g. foster parents, caseworkers, therapists, teachers, physicians) use innovations effectively. To accomplish this, high-fidelity practitioner behavior is created and supported by core implementation components (also called "implementation drivers"). These components are staff selection, pre-service and in-service training, ongoing coaching and consultation, staff performance evaluation, decision support data systems, facilitative administrative supports, and system interventions. These interactive processes are *integrated* to maximize their influence on staff behavior and organizational functioning. The interactive core implementation components also *compensate* for one another in that a weakness in one component can be overcome by strengths in other components.

Conclusion

Stages of Implementation and stage-related work together with effective use of the Core Implementation Components are two key frameworks for creating an effective implementation infrastructure. We need to build, utilize, and evaluate implementation infrastructures and strategies if we are to achieve significant outcomes for consumers and communities. We must learn how to implement well-researched programs and practices effectively on a national scale. In their report of findings from the Blueprint Replication Initiative, Elliott and Mihalic (2004) stated that although ten Blueprint programs studied had completed the necessary efficacy and effectiveness trials and had met the rigorous evaluation standards required for certification as a Blueprint program, they were not prepared to deliver their programs on a useful scale. Only four of the ten programs had the organizational capacity to deliver their program to ten or more new sites a year. According to the authors, "Although we have taken giant strides in determining what works and promoting the use of science-based programs, we have lagged behind in building the internal capacity of designers to deliver their programs" (Elliott & Mihalic, 2004, p. 48). Building implementation infrastructure, effective implementation and scale-up strategies, and capacity is an international priority if we are to reap full advantage from the evidence based program movement. The bridge from science to service must be built, repaired, maintained and improved.



All references included in this document can be found at http://www.fpg.unc.edu/~nirn/resources/publications/Monograph/

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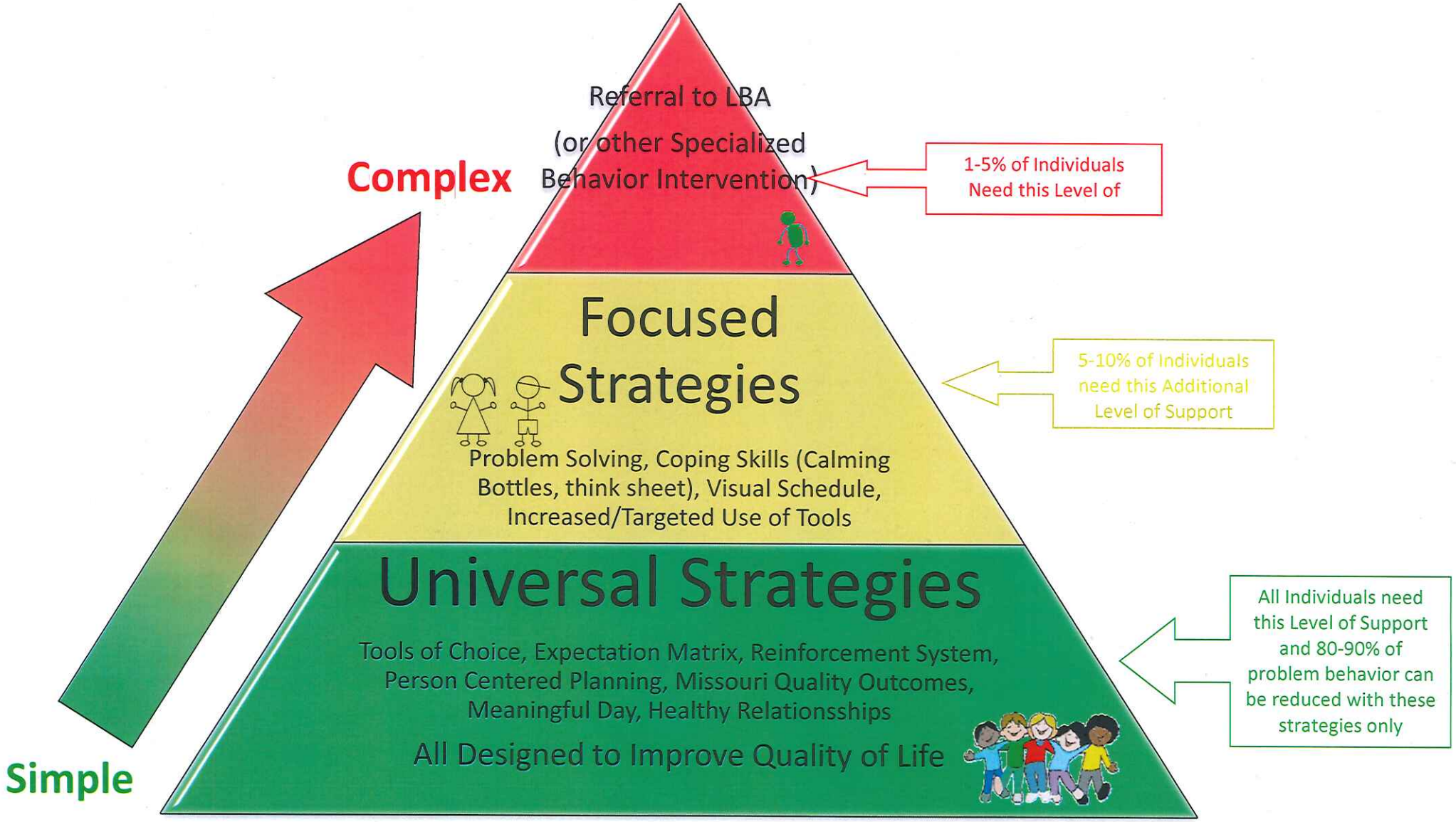

LEARN HOW YOUR AGENCY CAN GET STARTED, CONTACT:

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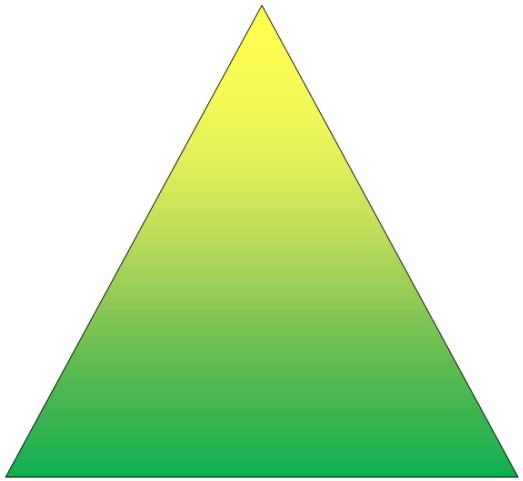
DEPARTMENT OF MENTAL HEALTH

DIVISION OF DEVELOPMENTAL DISABILITIES

Behavior Resource Team

Agency Tiered Supports



Building Sustainable Systems and Improving Quality of Life

For More Information:
http://dmh.mo.gov/dd/tieredsupports.html

What is Agency Tiered Supports Consultation?

- ✓ A statewide system to support agency based teams to build internal systems to implement positive practices effectively. Agency Tiered Supports focuses on:
  - Healthy, Positive, Enriched Environments
  - Administrative support, participation & leadership
  - Common approach to teaching and providing encouragement for what to do and what not to do
    - ➢ Clear, consistent, positive expectations
    - ➢ Procedures for teaching expected behaviors (and functional skills)
  - Continuum of Procedures for encouraging expected behaviors

What's in it for me?

- ✓ Decreased staff turnover
- ✓ Better trained staff
- ✓ Happier employees who feel valued and appreciated
- ✓ Improved quality of life and less crisis behavior for supported individuals
- ✓ Decreased need for higher level behavior support services
- ✓ Improved individual outcomes
- ✓ Improved agency outcomes

How might the Behavior Resource Team (BRT) assist me?

- ✓ They will complete an agency systems evaluation (ASSET) and provide recommendations for enhanced systems.
- ✓ Tiered Support Consultants will attend agency team meetings to facilitate and provide support in the development of agency systems.
- ✓ They will schedule and offer networking opportunities with other participating agencies to provide on-going support collaboration.
- ✓ They may assist in developing/building internal systems to encourage on-going data collection, analysis and review.
- ✓ They will provide monthly event report data for analysis and review.
- ✓ Access to the Tools of Choice training and coaching to improve basic universal strategies.
- ✓ They may provide some second tier consultative strategies for individuals who need additional support beyond basic universal strategies.
- ✓ Regional workshops for networking with agencies and obtaining information to enhance systems.

Systems

Agency Tiered Supports Consultation is an <u>on-going process</u> of planning, development, implementation and review of universal and specialized strategies to improve system sustainability and quality of life.

The use of effective interventions without implementation strategies is like serum without a syringe; the cure is available but the delivery system is not. Fixsen, Blasé, Duda, Naoom and Van Dyke, 2010