Rise and fall of an evidence based practice: Assertive Community Treatment, a case study in Indiana

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What is Assertive Community Treatment?

ACT History

- Developed during 1970s in Madison, WI
- Targeted revolving door client
- “Hospital without Walls”
- 1974, received American Psychiatric Association prestigious Gold Award
- Over 25 RCTs experimentally demonstrating effectiveness
- By 2003, implemented in 41 states (NAMI survey)

Stein LI, Test MA: Alternative to mental hospital treatment: I. conceptual model, treatment program, and clinical evaluation. Archives of General Psychiatry 37:392-397, 1980

Dixon, L. (2000). Assertive community treatment: Twenty-five years of gold. Psychiatric Services, 51, 759-765.

ACT basic elements

- Multidisciplinary staffing
- Team approach
- Integrated services
- Direct service provider (not brokering)
- Low client-staff ratios (10:1)
- More than 75% of contacts in the community
- Assertive outreach
- Focus on symptom management and everyday problems in living
- Ready access in times of crisis
- Time-unlimited services

ACT is reserved for the most severe clients with SMI

- Frequent psychiatric admissions
- Frequent use of emergency rooms
- Homeless or unstable housing
- Treatment nonadherence
- Dual diagnosis (SMI + substance abuse)
- Legal problems
- Discharge from long-term hospital

ACT attempts to provide comprehensive services

- Daily activities
- Housing
- Work
- Family/social life
- Entitlements
- Financial management
- Integrated treatment for substance abuse
- Counseling
- Medication support
- Health

ACT team is multi-disciplinary

- Psychiatrist
- Team Leader
- Nurse
- Mental Health Professionals/CMs
- Therapist/Social Worker/Psychologist
- Specialist team members
  - Addiction Specialist (sometimes)
  - Employment Specialist (sometimes)
  - Peer Recovery Specialist (infrequently)
- Administrative Help

ACT has a strong evidence base

Table 1. Comparison of ACT to Controls in 25 RCTs

	ACT Compared to Controls		
	Better	No Diff.	Worse
Hospital use	17 (74%)	6 (26%)	0
Housing stability	8 (67%)	3 (25%)	1 (8%)
Symptoms	7 (44%)	9 (56%)	0
Quality of life	7 (58%)	5 (42%)	0

***Source:** Bond, GR, Drake, RE, Mueser, KT, & Latimer, E. (2001). Assertive Community Treatment for People with Severe Mental Illness. Dis Manage Health Outcomes, 9: 141-159.

Conclusions About ACT Effectiveness

Large impact on:

- Hospital use
- Housing
- Retention in treatment

Moderate impact on:

- Symptoms
- Quality of life

Evidence weak for:

- Employment
- Substance use
- Jail and legal problems
- Social adjustment

Current Status : ACT is "Evidence-Based Practice"

- Schizophrenia PORT Recommendations
- Surgeon General's Report
- In 1998, PACT made Medicaid reimbursable
- Identified as EBP by various groups:
  - SAMHSA/RWJ Initiative: ACT identified as one of 6 EBPs
  - SAMSHA registry
  - Society of Clinical Psychology, APA Division 12
  - Veterans Administration
  - NAMI

Some challenges to ACT implementation

ACT is very expensive: Actual costs for Indiana urban ACT Team

- 16 FTEs; 100 consumers
- Salary & Benefits (direct) =$ 773,027
- Indirect costs =$ 343,693
- Total costs =$1,116,720
- Projected revenue =$1,398,303
- Projected profit =$ 281,583

- Cost per client =$11,167.20

Admin overhead = 10.35%

Annual clinician productivity = 1086 hours

Turnover rate = 10%

ACT is cost-effective only when implemented well and reserved for severe clients

- Cost per Consumer: $9,000-$12,000 per year
- ACT reduces hospital costs when:
  - Target heavy users: ACT saves money when programs serve consumers who are heavy users of psychiatric hospitals (>50 hospital days in prior year)
  - High fidelity: ACT saves money if program is faithfully implemented

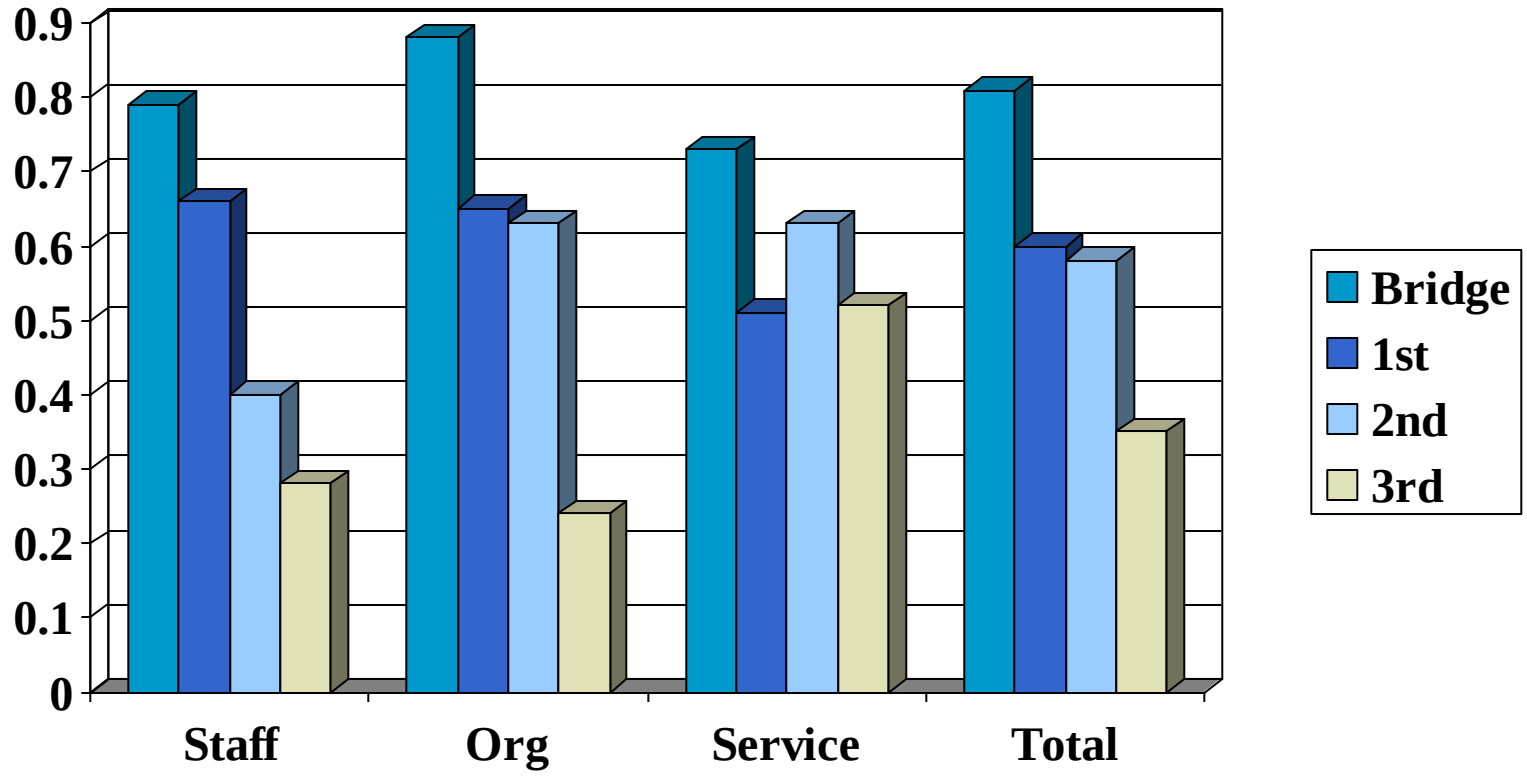
Latimer, E. (1999). Economic impacts of assertive community treatment: A review of the literature. Canadian Journal of Psychiatry, 44, 443-454.

ACT is hard to implement
Failure to implement: Critical but not implemented ingredients (n=108 teams)

(McGrew et al., 1996)

Ingredient	Rating: Ideal	Rating: My team	"Implementation" gap
Involved in hosp dischg	88%	46%	42%
Work with supports	73%	36%	37%
Low staff turnover	76%	50%	26%
Psychiatrist involved	78%	52%	26%
Shared treatment planning	84%	59%	25%
Primary clinical authority	79%	55%	24%
Clearly identified pop.	83%	61%	22%
Involved in hosp admits	86%	66%	20%
Shared treatment provision	82%	62%	20%

Implementation tends to worsen over program generations (N=18)



McGrew, J., Bond, G., Dietzen, L., & Salyers, M. (1994). Measuring the Fidelity of Implementation of a Mental Health Program Model. *Journal of Consulting and Clinical Psychology, 62*, 670-678.

Implementation models

Implementation Research

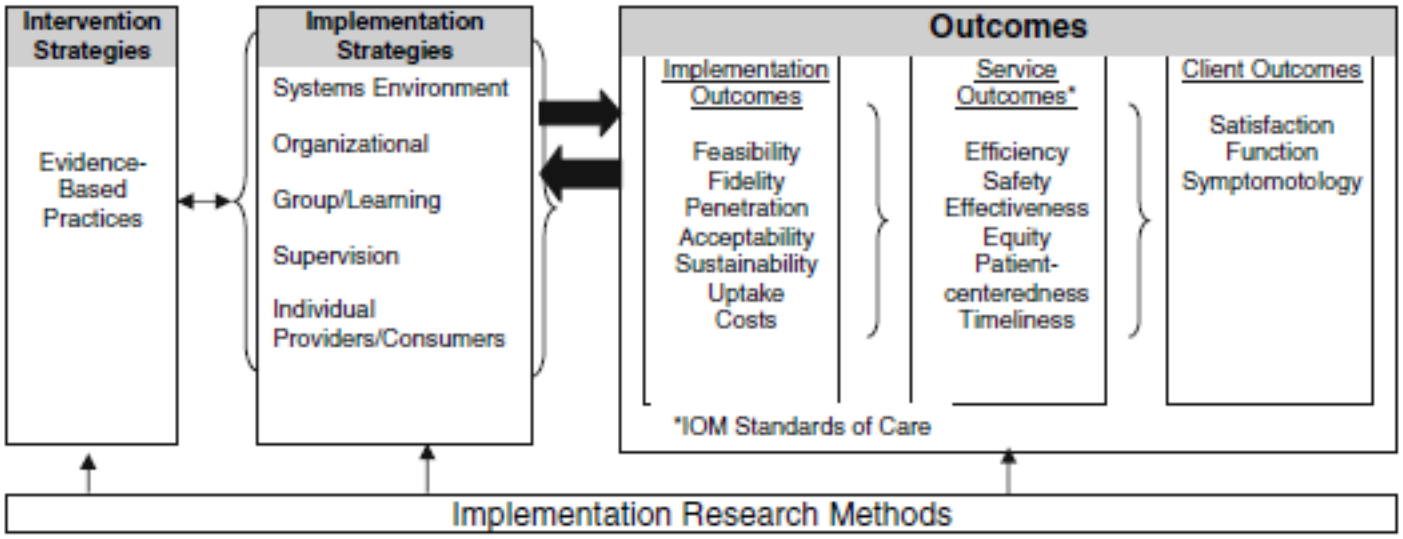
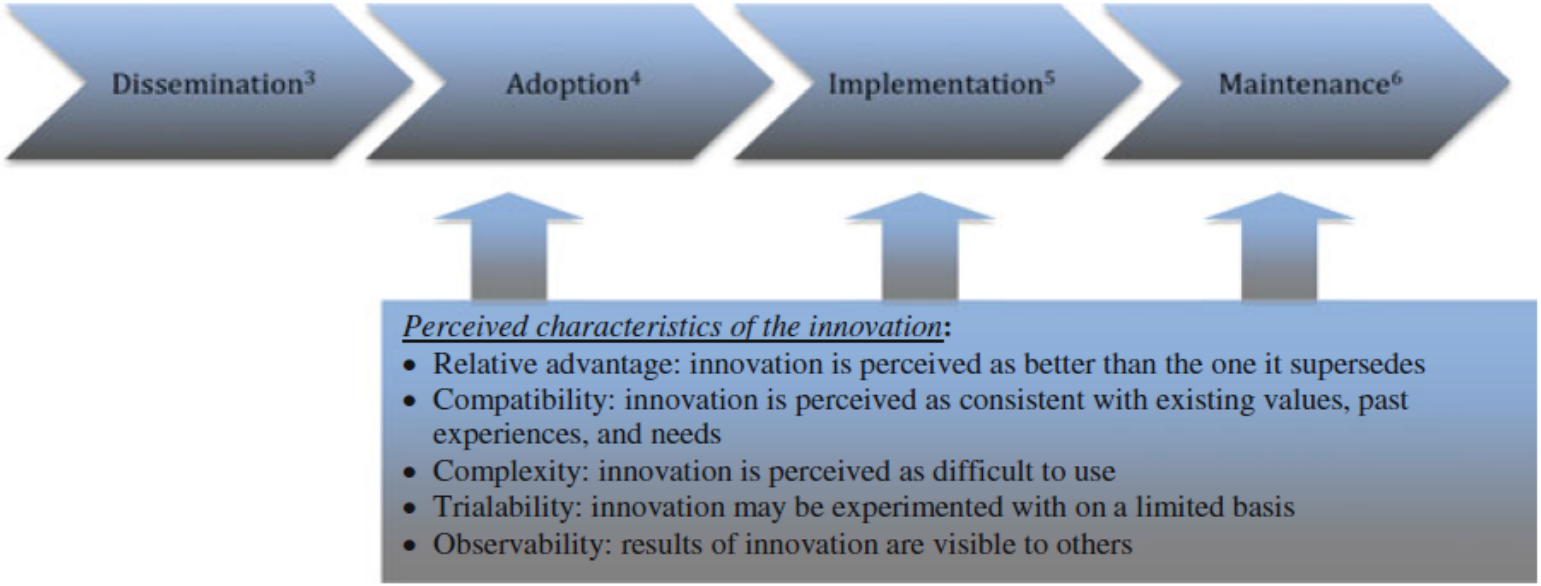


Fig. 1 Conceptual model of implementation research

Proctor, et al. (2009). Implementation research in mental health services: An emerging science with conceptual, methodological and training challenges. Administration and Policy in Mental Health, 36, 24-34.

Diffusion of innovation



Key Terms:

1. *Innovation:* an idea, practice, or object that is perceived as new by an individual or organization (**Note**: "Innovation" is used interchangeably with "intervention" in this paper)
2. *Innovation-decision process:* the process by which an individual or organization passes from (1) initial awareness of an innovation to forming attitudes about and deciding to adopt or reject the innovation, to implementation and preliminary use, to consistent and committed use
3. *Dissemination*: targeted strategies to make potential adopters aware of an innovation and encouraged to adopt it
4. *Adoption:* commitment to begin using the innovation
5. *Implementation:* when an individual or organization puts an innovation to use
6. *Maintenance:* the degree to which an innovation is continued over time, particularly after attempts to diffuse the innovation end (also known as "sustainability")

Rogers, E. M. (2003). *Diffusion of innovations* (5th ed.). New York: Free Press.

National EBP Project: Strategies for assessing and ensuring quality

- Policy and administration
  - Program standards
  - Licensing & certification
  - Financing
  - Dedicated leadership
- Training and consultation
  - Practice-based training
  - Ongoing consultation
  - Technical assistance centers
- Operations
  - Selection and retention of qualified workforce
  - Oversight & supervision
  - Supportive organizational climate /culture
- Program evaluation
  - Outcome monitoring
  - Service-data monitoring
  - Fidelity assessment

Monroe-Devita et al. (2012). Program fidelity and beyond: Multiple strategies and criteria for ensuring quality of Assertive Community Treatment. Psychiatric Services, 63, 743-750.

Implementing ACT in Indiana

The rise of ACT

State level: Setting the stage, Factors supporting implementation

- Strong evidence base in research literature
- Prior successful research demonstrations of ACT in state
- Support of National bodies/reports (NASMHPD, Surgeon General, New Freedom Commission Presidential report)
- Consumer/family advocates (NAMI) (community action grants)
- Availability of local experts in ACT and in implementation science
- Ongoing successful public/academic liaison relationships
- Advocate/champion at DMHA
- NOTE: Top-down implementation

Working Framework

The 5 Critical Steps: Implementing a new EBP

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

(adapted from Drake, Mueser, et al., 2000)

1. Provide explicit criteria

- Contracted with experts to establish state standards and place them into regulatory law
  - Policies, procedures, and resources in place to monitor standards
- Adopted existing fidelity scale to measure implementation (Dartmouth Assertive Community Treatment Scale)
- Availability of manuals
  - PACT manual (recently revised, “A Manual for ACT Start-up”)
  - EBP toolkit (SAMHSA)
- Creation of Indiana specific manual
  - ACT Resource Manual (Indiana Guide)
- Availability of multiple training resources
  - www.mentalhealthpractices.org
  - www.psych.iupui.edu/ACTCenter
  - SAMHSA EBP toolkits available on line at: http://mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits

Sample of certification standard

ASSERTIVE COMMUNITY TREATMENT TEAMS CERTIFICATION

(C) Clinical staff to consumer ratio must be at least 1:10.

(b) Each regularly certified team shall meet the following regular operational standards:

(1) All consumers admitted to the ACT team must meet the admission criteria as defined in Sec. 4 *[section 4 of this rule]*.

(2) At least eighty percent (80%) of consumers must have 295-296 Axis I Diagnosis under Diagnostic and Statistical Manual of Mental Disorders, 4th Edition, published by the American Psychiatric Association (DSM IV).

(3) Highest intake rate during a six (6) month period shall not exceed five (5) consumers per month.

(4) The program shall operate at least eight (8) hours per day, Monday through Friday. On weekends and holidays at least two (2) hours of direct service shall be provided daily. A team member shall be on call all other hours.

(5) Consumers must be contacted face-to-face on average at least three (3) times per week.

(6) Consumers must be contacted face-to-face on average two (2) hours per week or more per consumer.

(7) At least seventy-five percent (75%) of all team contacts shall occur out of the office.

(8) An average of at least ninety percent (90%) of consumers shall have contact with three (3) or more team members per month.

(9) For a minimum of six (6) months, the team shall attempt at least two (2) face-to-face contacts per month for consumers who refuse services.

(10) At least eighty percent (80%) of inpatient admissions are planned jointly with the ACT team.

(11) At least eighty percent (80%) of inpatient discharges are planned jointly with the ACT team.

Lessons learned: Not all resources are useful

- EBP toolkits assume basic clinical knowledge and skills (listening skills)
- Practitioners trained in the National EBP Project and in Indiana often lacked these prerequisites

Type of Resource Materials Matters

- Keep it brief: Detailed workbooks NOT used
- Practical tools and tips (e.g., posters listing key principles, assessment scales, job descriptions, checklists) eagerly used

Sample quick lists

What kinds of services are provided by ACT teams?

Daily activities

Help with grocery shopping
Purchasing and caring for clothing
Improving housekeeping skills
Using transportation
Social and family relationships

Family life

Crisis management
Counseling and education for family members
Coordination with child/family service agencies
Supporting people in their role as parents

Work opportunities

Help preparing for employment
Help finding and keeping employment
Job coaching
Educating employers about severe mental illness

Entitlements

Assisting with applications
Accompanying consumers to entitlement offices
Managing food stamps if needed
Assisting with determination of benefits

Counseling

Oriented toward problem solving
Built into all activities
Goals addressed by all team members
Includes development of communication skills

Health

Education to prevent health problems
Medical screening
Scheduling routine visits
Linking to medical providers for acute care
Sex education/reproductive health counseling

Medication support

Ordering medications from pharmacies
Delivering medications if needed
Educating consumers about medications
Monitoring side effects

Housing assistance

Finding suitable housing
Helping negotiate leases and pay rent
Purchasing and repairing household items
Developing relationships with landlords

Financial management

Planning a budget
Troubleshooting financial problems
Assisting with bills
Increasing independence

Substance abuse treatment

Provided directly by team members
Recognizing substance use problems
Motivation to address the problems
Strategies to quit/cut back/reduce consequences
Relapse prevention

Indiana ACT Team Composition

- ✓ 1 psychiatrist (32 hours per week for 100 consumers)
- ✓ 1 team leader (qualified mental health professional with at least Master's degree)
- ✓ 1 or more substance abuse specialists
- ✓ 1 or more registered nurses
- ✓ 1 or more supported employment specialists
- ✓ 1 program assistant (support staff)
- ✓ mental health professionals and case managers, including peer specialists, can make up the remainder of the team

✓ 10 total team members for 100 clients

Indiana ACT Standards

2. Ensure supports for change (state level)

- Funding support
  - Renewable grants to offset startup costs ($300K/year)
  - Established new Medicaid billing rate for certified ACT teams
- Regulatory change
  - ACT certification rule
  - Tied Medicaid funding to certification
- Established ACT technical assistance center

ACT Center of Indiana

- Technical assistance center established July 2001 with state grant
- Collaborative effort

  (Clinical and Academic partnership)
- Diverse team

  (Trainers, Researchers, Clinicians, Consumers, & Family Members)
- Clinical partner had model program

Role of ACT Center

- Provided consultation, training, fidelity monitoring in Indiana
  - 31 ACT teams between 2001 and 2009
  - 5 Integrated Dual Disorders Treatment programs
  - 8 Illness Management and Recovery Programs
  - In 2008, expanded to “general recovery orientation consultation” for 5 mental health centers

Supports for change (local level)

- Secure local agency commitment
  - Make information available to stakeholders (tailored information packets)
  - Consensus building prior to implementation
  - Ensure buy-in from key personnel (medical director, nursing director, adult services director, CEO)
  - Willingness to collect fidelity, consumer outcomes, staff outcomes
  - Money talks!
- Identify and resolve problem areas
  - Meets a clinical need
  - Philosophical match
  - Competing models/priorities (e.g., day treatment, group homes)

Tailored messaging

Building Your Program

Tips for Mental Health Authorities

Why should mental health authorities be interested in ACT?

ACT is for a relatively small group of consumers who are diagnosed with serious mental illness, experience the most intractable symptoms, and, consequently, have the most serious problems living independently in the community. Because of the severe and recalcitrant nature of their symptoms, these consumers are more likely to:

- frequently use emergency and inpatient medical and psychiatric services,
- be homeless or live in substandard housing,
- be involved in the criminal justice system, or
- use illegal substances.

From a purely fiscal perspective, these consumers are the heaviest users of the most expensive resources. More importantly, they personally suffer the most extreme and devastating consequences of having a serious mental illness.

Traditionally, the mental health system has not been successful in engaging these consumers in effective treatment. However, ACT teams can successfully help consumers who have extensive needs to live safely and autonomously in the community.

Building Your Program

Tips for Agency Administrators and ACT Leaders

Whether your agency is interested in enhancing an existing program or developing a program anew, you will need a broad range of activities to successfully implement ACT. This section outlines the range of implementation activities in which agency administrators and ACT leaders are often involved.

Recruit team members for your ACT program

ACT teams are different from other programs that may operate in your agency. The consumers who are eligible for ACT are those who have the most serious psychiatric symptoms and who, consequently, have the most severe problems with social functioning.

Typically, ACT programs serve consumers who:

- have extensive histories of psychiatric hospitalization,
- are homeless,
- have co-occurring substance abuse or medical problems, and
- are involved in the criminal justice system.

More supports (local)

- Medical staff availability and support (psychiatry/nursing**)**
- Ongoing accountability to state/technical assistance
  - Fidelity
  - Outcomes
- Local Consumer/family advocates (NAMI)
  - Community action grants SAMSHA

3. Provide initial clinical training

- Stepped roll-out, multiple cohorts
- Key role of ACT Technical Assistance Center
  - Training free
  - Brought in additional outside consultants (MI)
- Didactic information in multiple formats
  - Written, audio, visual
  - Materials tailored to location
  - EBP toolkit, manuals
- Job shadowing existing teams
- Practical applied exercises
- Availability of model program in state

Toolkit


EVIDENCE-BASED
PRACTICES
KIT
Knowledge Informing Transformation
Building
Your Program
Assertive
Community
Treatment
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Mental Health Services
www.samhsa.gov

4. Provide ongoing support

- Provided by ACT Center
- Each site assigned trainer who provided follow-up consultation visits
- Training focused on EBP implementation issues as identified by fidelity assessment
- Established system for training new staff
- Local, ongoing regular in-service training
- Statewide, outside workshops & conferences
- ACT Center newsletter, listserv and monthly phone calls

Sample site fidelity report

	Current Scores	Indiana Averages 2010 - 2011	Indiana Averages 2008 - 2009
H1: Small Caseload	5	5.00	5.00
H2: Team Approach	4	4.75	4.83
H3: Program Meeting	5	5.00	5.00
H4: Practicing Team Leader	5	3.94	4.30
H5: Continuity of Staffing	3	3.06	2.87
H6: Staff Capacity	5	4.50	4.70
H7: Psychiatrist on Staff	5	4.44	4.17
H8: Nurse on Staff	5	4.63	4.96
H9: Substance Abuse Specialist on Staff	5	4.25	3.83
H10: Vocational Specialist on Staff	5	3.88	3.78
H11: Program Size	3	3.75	4.43

Items	Score	DACTS Standards	Comments
H1: Small Caseload	5	DACTS "5": 1:10 or smaller caseload size	**Your team is currently serving 34 consumers with 6 staff (excludes psychiatrists) for a ratio of 1: 5.67, which is very good.**
H2: Team Approach	4	DACTS "5": At least 90% of clients have contact with more than 1 staff in 2-week period.	**Based on electronic medical records, extracted by the team leader, 28 out of 34 consumers were seen by 2+ staff in the past 2 weeks, which is 82.35%.**
H3: Frequency of team meetings	5	DACTS "5": Must meet at least 4x weekly, review all consumers, full time staff should attend all meetings, part-time staff should attend at least 2 each week.	**According to team leader report, criteria fully met. The team meets at least 4x each week, reviews all consumers, full time staff attend meetings, and part time staff attend at least 2 meetings each week.**
H4: Team leader provides services	5	DACTS "5": TL provides 10 hrs or more of direct service weekly	**Team leader is reportedly providing about 10.9 hours/week of client direct service, based on an assumed 20 hours available for clinical work and 50% of that available for direct service, which equals 54.5% of time providing services. This meets the standards.**
H5: Continuity of staff	**3**	**DACTS "5": Less than 20% turnover in past 2 years**	**According to team leader, the team has had 4 turnovers out of 7 staff positions over the past two years, with two turnovers in the substance abuse position and two turnovers in a case manager position. This equals a 57.14% turnover for the last two years. The acceptable/ideal criteria for this item requires less than 39%/20% turnover in two years.**

Newsletter

ACT Center of Indiana
Excellence in Training, Research, and Technical Assistance

April 2004
Volume 3 ❖ Issue 2

Notes from the Directors

Co-Directors
Michelle Salyers &
Mike McKasson

Spring is the time to celebrate new growth, and we are eager to report on the growth of evidence-based practices (EBPs) in our state. Our updated map on page 2 outlines the location of 15 assertive community treatment (ACT) programs, 7 integrated dual disorders treatment (IDDT) programs, and 6 illness management and recovery (IMR) programs across the state. We also note 4 additional programs that will be implementing IMR in the near future. This expansion of evidence-based practices is very exciting!

Of course, the key reason to implement evidence-based practices is to help consumers in their recovery. Each of these practices has been shown through strong research to be effective in helping consumers with severe mental illness become more integrated into the communities in which they live. This community integration happens by staying out of the hospital and away from alcohol and drugs, by living in safe, affordable housing, by obtaining competitive employment, and by working towards meaningful personal goals. On page 4, a consumer shares his story of how an ACT program (that also provides IMR services) is helping him reach his recovery goals. We are also focusing on consumer outcomes at the program level and have been making progress in documenting major outcomes by programs across the state (see page 3).

Thanks to the hard work and dedication of stakeholders in these programs, we are thrilled to help make these quality services available to more and more consumers throughout our state!

In this issue...

Steps not always sequential. Ongoing support/clear standards

- Change implementation standards when needed
  - Adaptation to feasibility concerns
    - Ongoing changes to standards (e.g., loosening requirements for RNs, to accept LPN; nurse practitioner for psychiatrist)
  - Changing ACT criteria to ensure accurate implementation
    - Establishing clear inclusion criteria

Sample section: admission criteria

Please check the conditions that apply:

Condition 1. State-Operated Facility (SOF) Related: Condition met: ☐ Yes ☐ No

Individual meets 1 of the following:

- ☐ a) Has been discharged from a State-Operated Facility (SOF) in the past 12 months
- ☐ b) Currently has a civil commitment and an SOF referral form has been completed and filed with the SOF and is on a waiting list to be admitted to a State-Operated Facility (SOF)

Condition 2. Psychiatric Hospitalization/Juvenile Placement: Condition met: ☐ Yes ☐ No

Individual has experienced 1 of the following in the past 12 months:

- ☐ a) 2 or more psychiatric or substance abuse-related hospitalizations
- ☐ b) 1 psychiatric or substance abuse-related hospitalization in excess of 10 days
- ☐ c) 2 or more juvenile placements in a private, secure facility licensed by the Department of Child Services
- ☐ d) 1 juvenile placement in a private, secure facility licensed by the Department of Child Services in excess of 90 days

Condition 3. Emergency Room Visits: Condition met: ☐ Yes ☐ No

Individual has experienced 3 or more psychiatric or substance abuse related emergency room visits in the past 12 months.

Condition 4. Sub-Acute Facility Admission(s): Condition met: ☐ Yes ☐ No

Individual has experienced 1 of the following in the past 12 months:

- ☐ a) 3 or more admissions to a DMHA-certified sub-acute facility
- ☐ b) 1 admission to a DMHA-certified sub-acute facility in excess of 30 days

Condition 5. Legal Involvement: Condition met: ☐ Yes ☐ No

Individual has experienced 1 of the following in the past 12 months:

- ☐ a) More than 1 arrest or other* contacts with law enforcement (including active probation or parole)
- ☐ b) 10 or more days of incarceration (including Department of Correction youth facility or local juvenile detention facility excluding shelter care beds in the detention facility)

**Other contacts with law enforcement might include police contacts directly targeting the individual for disturbance or behaviors that did not result in his/her arrest but are considered an indicator of service intensity need.*

5. Collect quantitative information

- Monitor fidelity every 6 months
  - Fidelity scales, state standards
  - Identify key components (e.g., service contacts)
- Monitor key consumer outcomes (COMP software, supplemented by existing state data collection)
  - Hospitalization, Housing, Employment, Substance Use, Incarceration
- Feedback to team (outcome-based supervision)
  - Graphs, charts, rewards/incentives

Some Barriers

- Funding
- Staffing
- Admission criteria
- Understanding the model
- Clinical practice

Funding Barriers to ACT

- Lack of compensation for on-call, after hours, and weekend coverage
- Unrealistic staff "productivity" expectations
  - Travel time, training time, meetings
- Billing procedures
- ACT is expensive (Other EBPs, too)

SOLUTION: ACT rate

Staffing Barriers

- Starting a team from scratch vs. retooling existing program/staff
- Recruiting/hiring appropriate staff, particularly difficult for specialty and medical staff
- Adequate team size to provide comprehensive services
- Integrating/defining specialty roles
- Turnover

SOLUTION: Changing standards for medical personnel, different standards for rural and urban teams

Starting a New Team

Positives:

- All team members starting at same level
- Less resistance to change
- May have previous EBP experience
- Openness to new model
- Less likely to keep individual caseload

Negatives:

- May take more time to establish team
- Less familiar with candidates to be hired

Reworking Existing Team

Positives:

- Known staff
- Use of existing resources
- Staff knowledgeable of system

Negatives:

- Resistance: “We have always done it this way.”
- More likely to keep existing individual caseload
- Did I volunteer for this?

Admission Criteria Barriers (Defining the target population for the EBP)

- Poorly specified criteria
- Poorly defined admission process
- Poorly executed process
- Admission decision made external to team
- Rate of new intakes too fast

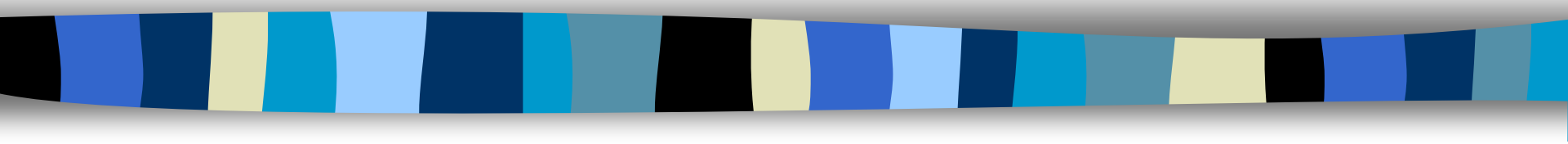
Understanding the Model Barriers

- Think they are already doing “The Model”
- Misperceptions of the model components
- Following the letter but not the spirit of the model (focus on meeting intensity criterion vs. focus on recovery)

Clinical Practice Barriers

- New program interferes with or is incompatible with existing clinical practice:
  - Shared caseloads
  - Community-based services
  - Weekend/evenings

Implementation success



Indiana ACT Sites

(Sites as of 05/2007)

31 ACT Sites:

Approved 7/2001 (Cohort 1)
Adult & Child – Team Sier (Indianapolis)
CMHC – South Team (Lawrenceburg)
Four County (Logansport)

Approved 4/2002 (Cohort 2)
Cummins (Danville/Avon)
Hamilton Center (Terre Haute)
Midtown – Team 1 (Indianapolis)
Northeastern Center (Kendallville)
Oaklawn (Elkhart)
Park Center (Ft Wayne)
Quinco (Columbus)
Swanson Center (Michigan City)

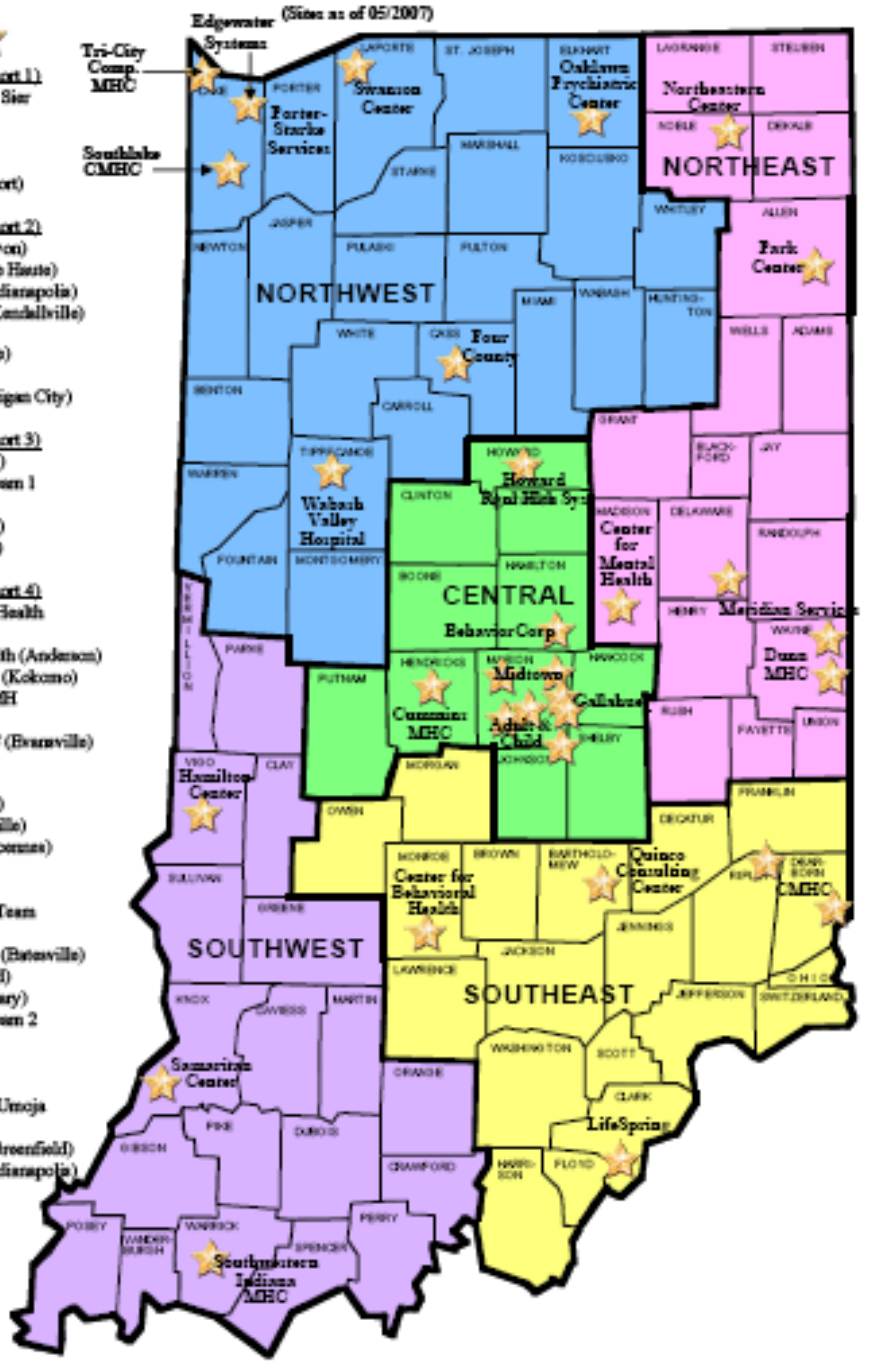
Approved 3/2003 (Cohort 3)
BehavioreCorp (Carmel)
Meridian Services – Team 1 (Muncie)
Tri-City (East Chicago)
WVH (West Lafayette)

Approved 9/2004 (Cohort 4)
Center for Behavioral Health (Bloomington)
Center for Mental Health (Anderson)
Howard Rgnl Hlth Sys (Kokomo)
Southlake Center for MH (Merrillville)
Southwestern IN MHC (Evansville)

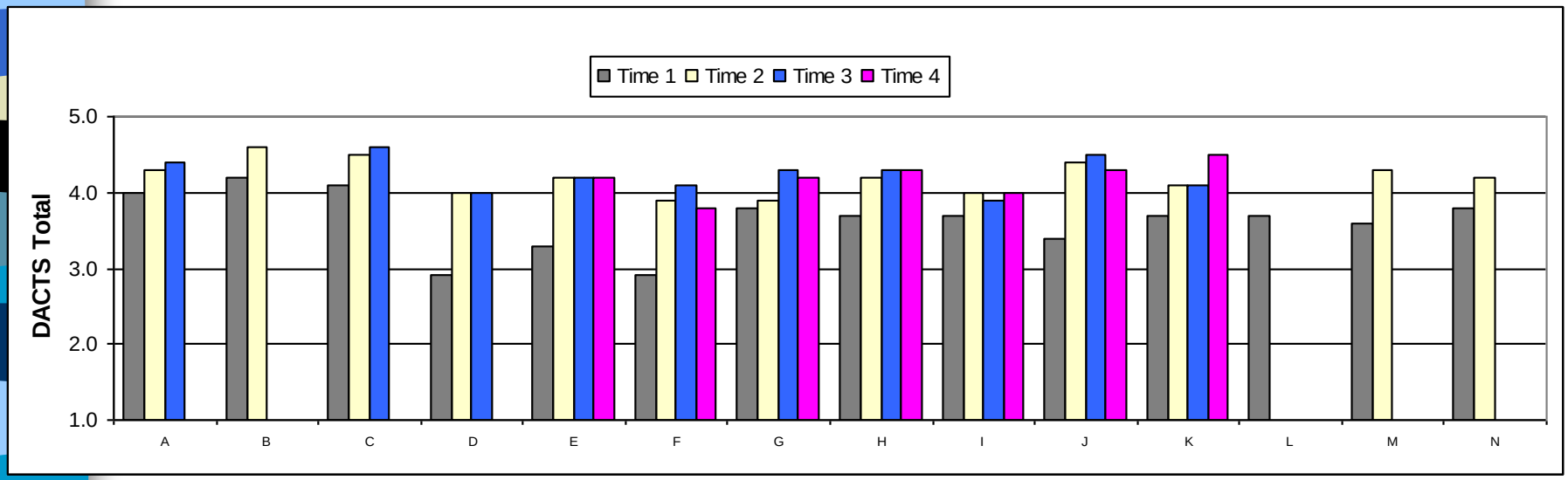
2005 (Independent 4)
Gallahue (Indianapolis)
LifeSpring (Jeffersonville)
Samaritan Center (Vincennes)

2006 (Independent 5)
Adult & Child – Case Team (Indianapolis)
CMHC – North Team (Batesville)
Dunn MHC (Richmond)
Edgewater Systems (Gary)
Meridian Services – Team 2 (Richmond)

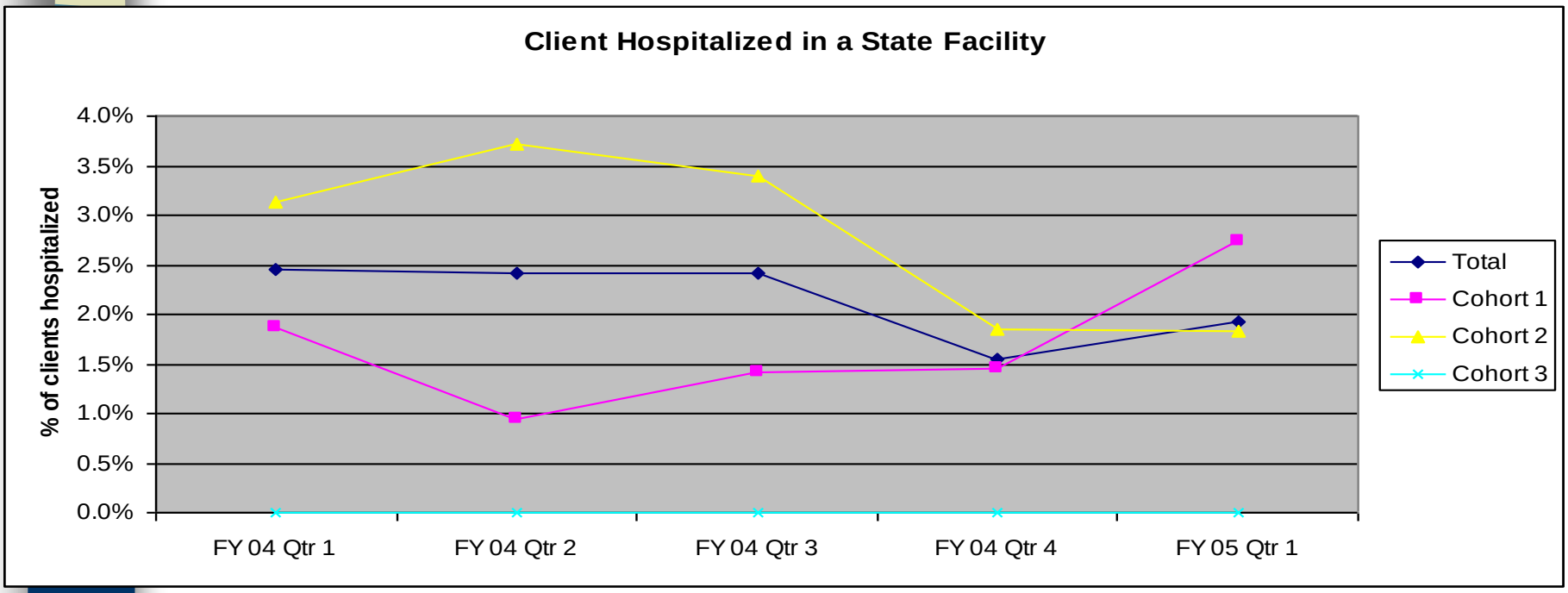
2007 (Independent 6)
Adult & Child –Team Umoja (Indianapolis)
Gallahue – A Team (Greenfield)
Midtown – Team 2 (Indianapolis)



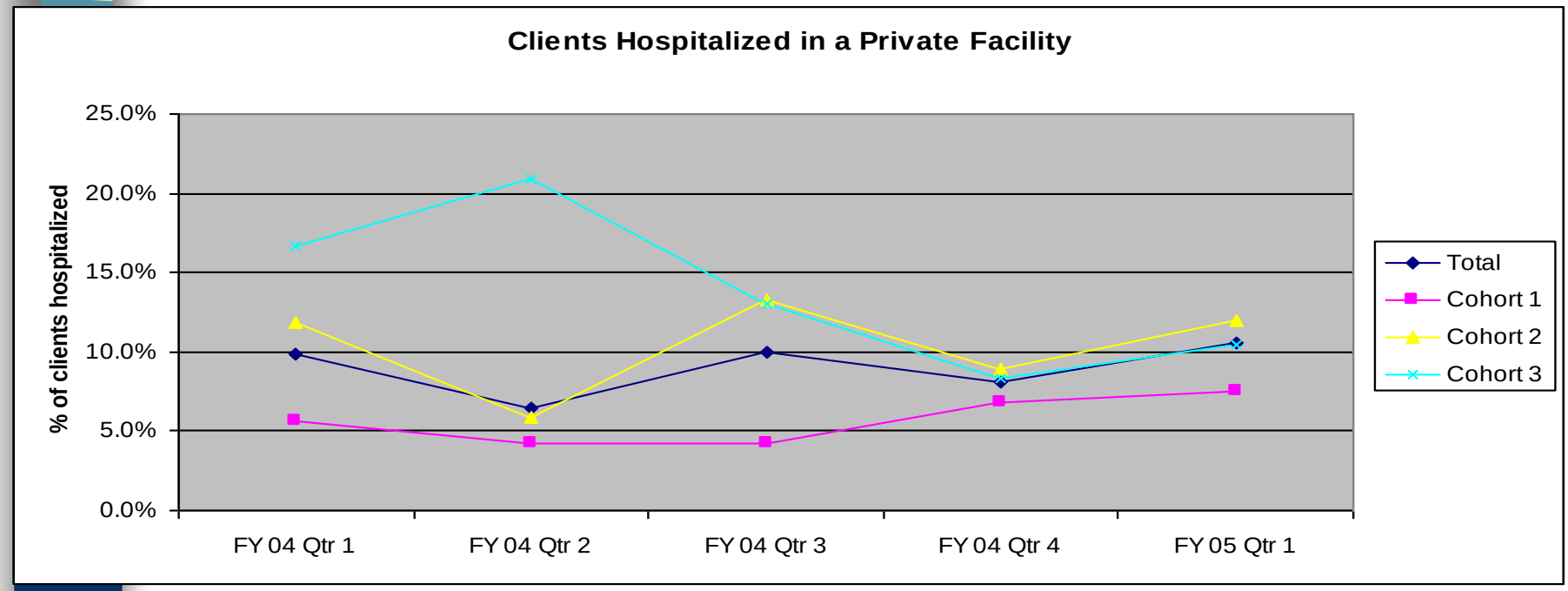
Fidelity of Indiana ACT Programs improves and meets criterion over time



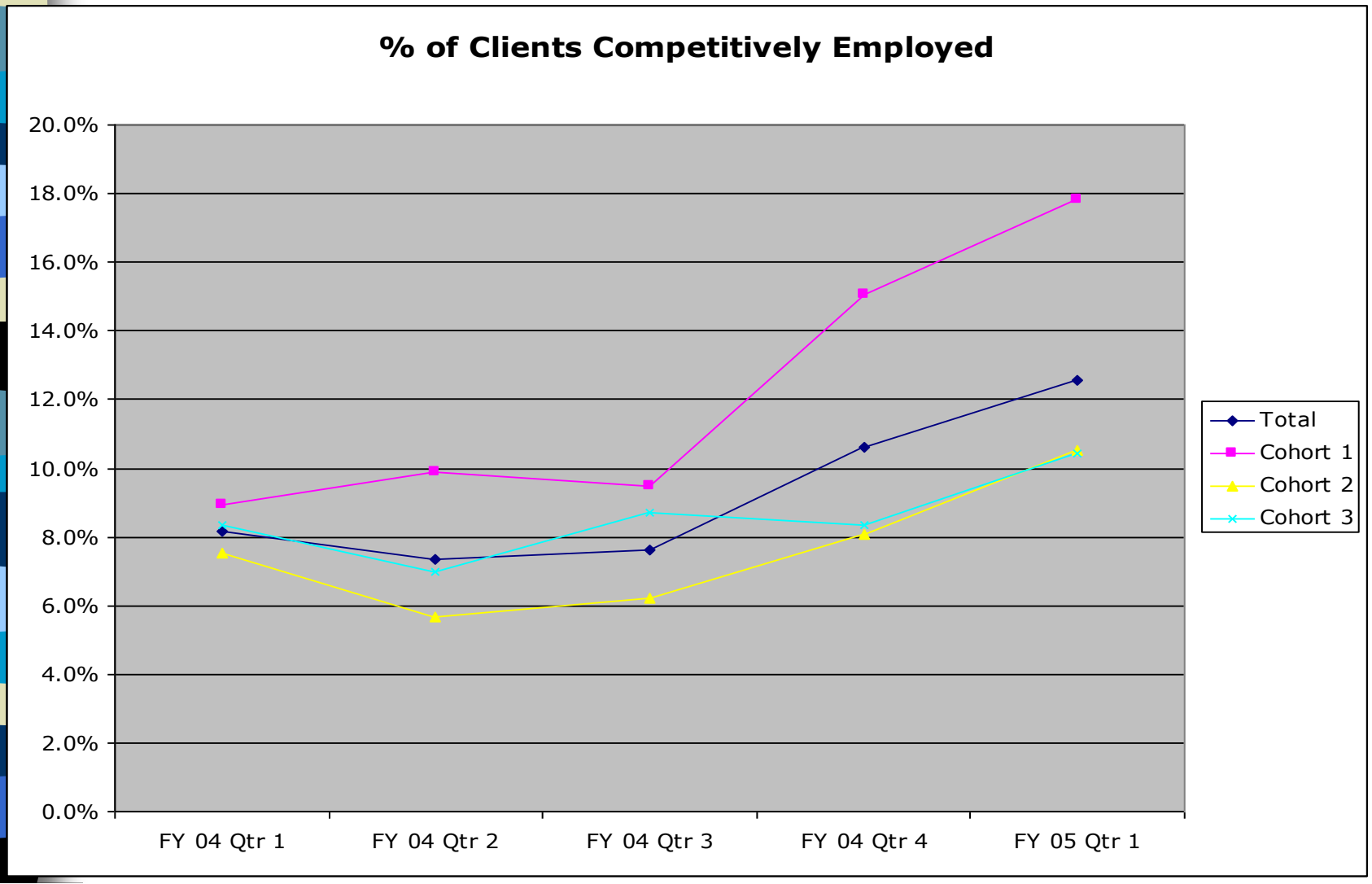
State Hospital Rates trend down for two cohorts



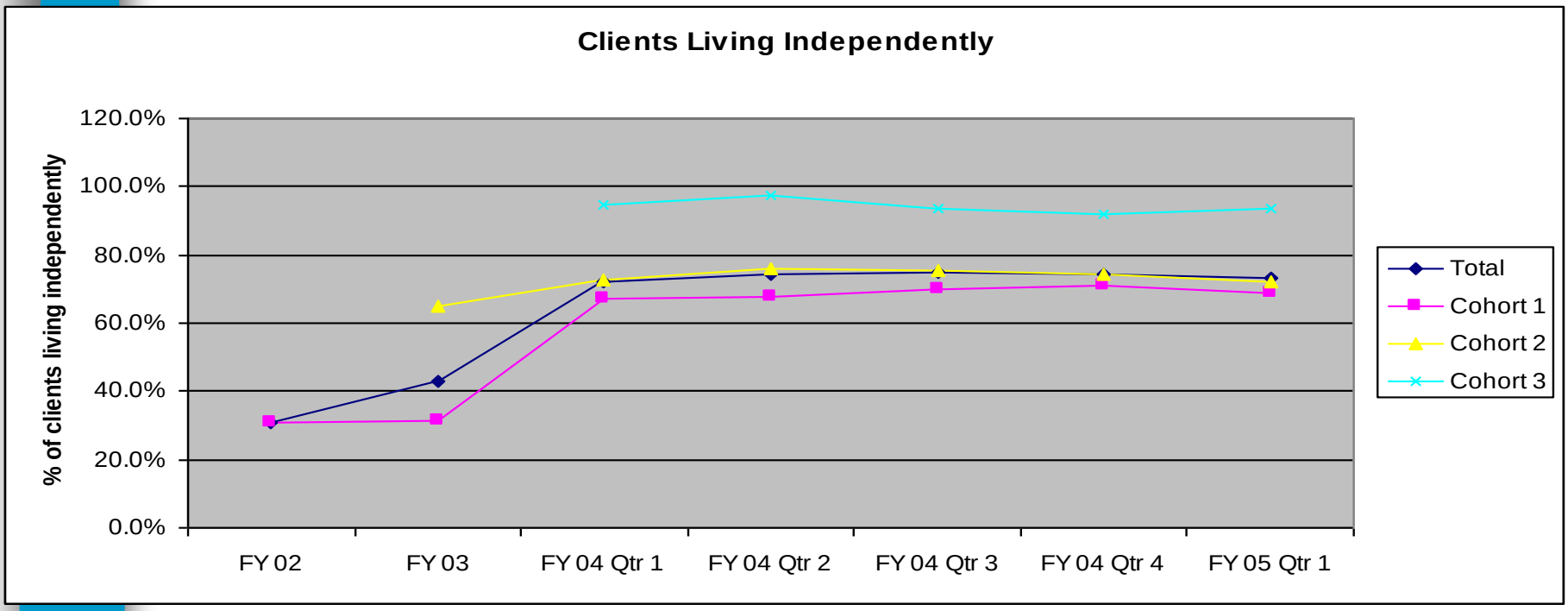
Private Hospital Rates Flat



Competitive Employment Rates Increase



Independent Living Rates Increase



Areas of weak implementation at one year: Indiana

Adequate psychiatric time	4.08
24 hour coverage	4.04
Vocational staff	3.92
Intensity of services	3.64
Integrated SA treatment	3.52
Work with supports	3.36

De-implementation of ACT

The fall of ACT

State level factors

- Loss of champion (Adult Services Director)
- Changes at the top, new Director, new adult services chief
  - philosophical differences in strategies to achieve recovery outcomes
  - top-down, non-consultative model for change
- Lack of stakeholder involvement in changes
- Great recession
  - Funding squeeze (less money for all operations)
  - ACT taking large chunk of discretionary budget

State level factors

- Defacto control of mental health funding by Medicaid, not DMHA
- Funding changes
  - Discontinuation of DMHA pilot/maintenance funding (300K)
  - Sweeping revisions in Medicaid funding
    - New 5 tiered rates based on client disability level
    - ACT rate discontinued, replaced by much lower psychiatrist consultation rate
- Reduced and then discontinued funding for ACT center
  - Reduced TA had limited support for phone certification and some onsite followup training

Local factors

- Overall financial squeeze on budgets
- Discontinuation of state funding support for ACT
- Lack of compensating financial resources (medical center, private funding)

Local factors

- Tepid support for full model
  - Didn’t buy in to all elements of model as critical (psychiatry, daily team meetings)
- ACT nonsympathetic/noncapable Team leader
  - Lack of accountability from local administrators
- No internal champion on management team

The end of the story

- ACT Center continues with federal grants, no longer in partnership with local provider or with state, not focused on ACT
- No certified ACT teams in Indiana
- Fewer than 10 sites attempting ACT-lite

Thanks for your attention!
IUPUI: Stop by and be friendly