

# Implementing ACT in Maryland

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# Maryland's Experience with Evidence-Based Practices

- Maryland was one of the eight original states to participate in the national “Implementing Evidence-Based Practices” demonstration project.
- Under this project, Maryland has successfully implemented Supported Employment and Family Psychoeducation in agencies throughout the state.

# Bringing Assertive Community Treatment (ACT) to Maryland

- Maryland's Mental Hygiene Administration applied for and received a federal grant to implement ACT in Maryland.
- Through a partnership with the University of Maryland's Evidence-Based Practice Center and the Systems Evaluation Center, implementation and evaluation activities began in Spring, 2004.

# Bringing Assertive Community Treatment (ACT) to Maryland

- Building on Maryland's commitment to integrate effective treatments into routine health care settings for those with severe mental illness, training and ongoing consultation on Assertive Community Treatment (ACT) is being provided to three sites.
- Upon successful implementation, and completion of Training of Trainer activities, these sites will become the ACT Training Resource Programs for the State.

# Bringing Assertive Community Treatment (ACT) to Maryland

- Maryland developed Mobile Treatment Teams in early 1990's
- Mobile treatment teams have some components of ACT but lack several critical components to be a high fidelity ACT team.
- At start of project, rates supported Mobile Treatment, but insufficient for ACT

# Bringing Assertive Community Treatment (ACT) to Maryland

- Phase I- three existing Mobile Treatment Teams are receiving formal ACT training and education from an expert ACT Consultant/Trainer.
- Two other mobile treatment team sites serve as comparison sites for the fidelity assessments and collection of consumer outcomes. They are not receiving ACT training nor close monitoring.

# Bringing Assertive Community Treatment (ACT) to Maryland

- Phase II – upon successful implementation of ACT, staff from these agencies will receive special training to become ACT trainers.
- Once trained, they will provide training and consultation to the comparison sites. In this manner they will have an opportunity to practice their training and consultation skills under supervision of the state ACT trainer.

# Bringing Assertive Community Treatment (ACT) to Maryland

- These sites will then become Maryland's **ACT Training Resource Programs.**

With ongoing support from the Evidence-Based Practice Center they will serve as mentors to other mobile treatment teams, offering training, coaching, job shadowing, on-site, off-site and telephone consultation.

# The Role of the Consultant and Trainer

- Provide formal training from the SAMHSA ACT “toolkit”
- Shadow staff to ascertain strengths/weaknesses
- Arrange for annual cultural competence and anti-stigma training
- Administer fidelity assessments every six months
- Provide consultation based on fidelity outcomes, observations
- Serve as “Doer” as distinct from the Monitor who is “watcher”

# Evaluation/Monitoring Goals:

- To evaluate the training materials and continued education efforts
- To assess program fidelity
- To observe the process of ACT implementation and identify strategies and barriers relevant to successful ACT implementation
- To examine desired consumer outcomes

# Quantitative Methods

- Staff Surveys
- Fidelity Assessments
- Provider Characteristics Survey
- Consumer Outcomes Survey
- Consumer Satisfaction Survey

# Consumer Outcomes Survey

## Data Collection:

- Informal interviews conducted by ACT program staff with consumers
- Consumer self-report

## Assesses:

- Psychiatric Symptomatology
- Housing Status
- Employment and Daily Role Performance
- Hospitalizations and ER Visits

## Administered:

- Every six months

# Consumer Satisfaction Survey

A partnership was established with On Our Own of Maryland (OOOMD), the statewide mental health consumer advocacy group, to collect consumer satisfaction information.

# Consumer Satisfaction Survey

## Methodology:

### Previous Method

- Informal interviews in the community by consumer interviewers.
- Yielded very low response rates due to issues such as consumers transportation difficulties and lack of consumer compensation.

### Current Method (pending IRB approval)

- Self-administered surveys mailed to consumers with telephone follow-up.
- Consumers have the option of mailing a completed survey or completing the survey over the telephone.
- Consumers receive \$20 money order for completed (at least 50%) surveys

## Assesses:

- Consumer satisfaction with ACT services

## Administered:

- Every six months

# Qualitative Methods

- Monthly Site Visits
- Interviews with Program Leader
- Interviews with Consultant/Trainer
- Staff Focus Groups
- Group Interviews with MHA Administrators

Goal	Activities
Evaluate the training materials and continued education efforts	Staff Surveys Monthly Site Visits Interviews with Program Leader and Consultant/Trainer Staff Focus Groups
Assess program fidelity	Fidelity Assessments: <ul style="list-style-type: none"> <li>– Dartmouth Assertive Community Treatment Scale (DACTS)</li> <li>– Medical Record Reviews (for service information, no identifying information collected)</li> <li>– Informal interviews with Staff, Consumers, and Family Members</li> <li>– Monthly Site Visits</li> </ul>
Observe the process of ACT implementation and identify strategies and barriers relevant to successful ACT implementation	Providers Characteristics Survey Monthly Site Visits Interviews with Program Leader and Consultant/Trainer Group Interviews with MHA Administrators
Examine desired consumer outcomes	Consumer Outcomes Survey Consumer Satisfaction Survey

# Lessons Learned

- Change takes time
- Engagement with staff essential
- Just because research shows the model works doesn't mean there won't be resistance
- Buy in from all levels is crucial
- Rewards are important – significant as motivators and energizers

# Lessons Learned

- States have strengths and resources – use them
- Collaboration between implementers, monitors and policy makers is critical
- Stick to your standards – don't compromise on quality
- High fidelity may not translate into having the ingredients necessary to being a successful TRP

# REQUIREMENTS FOR TRAINING RESOURCE PROGRAMS for ASSERTIVE COMMUNITY TREATMENT (ACT)

- Be recovery focused and person centered. The recovery and person centered philosophy shall be demonstrated in agency policies, procedures, spoken interactions, written documentation, and work with persons served.
- Commit to serve all eligible persons as evidenced by a no reject policy. This means serving persons in all community settings to include the streets, shelters, hospitals, and other locations requested by the person in need of services.
- Have individualized person centered planning.
- Provide services that are flexible, incorporating continuity of care throughout the service system to meet the person's needs.
- Provide outreach to engage persons in need of ACT services and to assist persons to obtain basic resources through building supports with other agencies to compliment ACT services.
- Meet the D.A.C.T.'s fidelity scale of a rating of at least 4.