Ohio Invests in Assertive Community Treatment (ACT) to Reduce Homelessness, Hospitalization for People with Severe Mental Illness

—by Paul M. Kubek

Columbus & Cleveland, OH—The State of Ohio is making another commitment to the health and well-being of people with severe mental illness who are most at-risk of psychiatric hospitalization, homelessness, and institutional recidivism by investing in the implementation of Assertive Community Treatment (ACT), the evidence-based practice for this high-risk, priority population.

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The Ohio Department of Mental Health and Addiction Services (OhioMHAS) recently funded the Center for Evidence-Based Practices at Case Western Reserve University to create the ACT Coordinating Center of Excellence (CCEO) to provide technical assistance to community-based mental health organizations that are currently providing ACT services and to those that wish to implement ACT and to integrate ACT with Integrated Dual Disorder Treatment (IDDT), the evidence-based practice for people with co-occurring severe mental illness and addiction to alcohol and other drugs.

The Center has hired Jon Ramos, BA, as Assertive Community Treatment director. Ramos is former director of the Ohio Coordinating Center for ACT (OCCA), a technical-assistance organization that was supported by The Health Foundation of Greater Cincinnati for over 10 years. Ramos has assisted 35 ACT teams in 30 counties in Ohio throughout his career. He currently assists 7 Ohio teams. He will continue to provide consulting, training, and evaluation services to these teams and organizations. Ramos will also collaborate with other consultants and trainers at the Center who provide technical assistance for the implementation of ACT and integrated ACT-IDDT, which has included multiple sites in Franklin County, Ohio and in Georgia, Indiana, Maryland, Michigan, New Mexico, Washington, Wisconsin, and the Netherlands.

“We’ve known Jon for a long time and have collaborated with him on several important implementation projects,” says Patrick E. Boyle, MSSA, LISW-S, LICDC-CS, director of implementation services at the Center for Evidence-Based Practices. “He has also presented numerous trainings with us at our semi-annual EBP conference, at regional training events in Ohio, and at national ACT conferences. We are very excited to have him as a member of our team of consultants and trainers.”

The multiyear partnership, Ramos explains, has helped develop a shared knowledge about how ACT and IDDT complement each other to create one of the best integrated services available.

“My collaboration with the Center over the last several years has enabled us to learn much about the simultaneous provision of ACT and IDDT on a

Our Center has provided technical assistance for ACT and/or integrated ACT-IDDT in these states and in the Netherlands:

- Ohio
- Colorado
- Georgia
- Indiana
- Kentucky
- Maryland
- Michigan
- New Mexico
- Pennsylvania
- Washington
- Wisconsin

[Editor’s note, 6/1/2014. This list and map have been updated to reflect current activities.]
single team,” Ramos says. “With the infrastructure and the knowledge and experience of the Center’s staff, as well as the support of OhioMHAS, we look forward to helping agencies and stakeholders expand quality ACT services across the state. I am excited and privileged to be a part of this team.”

CENTERS OF EXCELLENCE
According to Boyle, OhioMHAS expects to build upon the successes of the Health Foundation’s ACT initiative and increase the number of organizations in the state that are implementing this evidence-based practice. The new ACT CCOE at Case Western Reserve will help accomplish this goal.

Boyle explains that OhioMHAS funds several CCOE initiatives throughout the state as a formal commitment to priority populations and services. The Center for Evidence-Based Practices is the parent organization for two other CCOEs—the Ohio Substance Abuse and Mental Illness CCOE and the Ohio Supported Employment CCOE. These centers of excellence share resources and staff and, thus, knowledge of and experience with the integration of behavioral healthcare innovations.

“We are well equipped to advance Ohio’s emphasis upon the integration of behavioral healthcare approaches such as ACT and IDDT, Supported Employment/Individual Placement and Support, and many others,” Boyle says.

DECREASE OF HIGH-COST SERVICES
According to Ric Kruszynski, MSSA, LISW, LICDC, director of SAMI consulting and training, ACT is an important addition to the lineup of service innovations disseminated by the Center, which has been providing technical assistance for the implementation of Integrated Dual Disorder Treatment (IDDT) since 1999. ACT is one of the oldest and most widely researched evidence-based practices in behavioral healthcare for people with severe mental illness.

ACT is a multidisciplinary team approach with assertive outreach in the community. The consistent, caring, client-centered relationships have a positive effect upon outcomes and quality of life. People receiving ACT services tend to utilize fewer intensive, high cost services such as emergency department visits, psychiatric crisis services, and psychiatric hospitalization. They also experience more independent living and higher rates of treatment retention.

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ACT-IDDT INTEGRATION
Kruszynski explains that the inclusion of ACT in the Center’s list of technical-assistance services is a natural fit, because it is estimated that as many as 80 percent of people with severe mental illness who receive ACT services may also have a co-occurring substance use disorder (addiction to alcohol or other drugs). Therefore, organizations that implement ACT often add IDDT to address substance use disorders. IDDT acknowledges that abstinence from alcohol and other drugs is a long-term goal that occurs in stages of change over time. Therefore, it utilizes a client-centered, motivational, and stage-wise approach.

Kruszynski explains that clinicians and researchers originally developed IDDT in the 1990s on ACT teams. As a result, there is some significant overlap of items from the ACT and IDDT fidelity scales, which makes implementation of both synergistic. “If you were to lay the fidelity scales from both the IDDT and ACT models side-by-side, you’d find that at least 18 of the 26 components of IDDT are contained or addressed within the ACT model, and those that are not are still highly confluent with the ACT model,” Kruszynski says. “With ACT’s emphasis on the structure of the service and IDDT’s emphasis on the clinical interventions enacted within that structure, you have a perfect complementary fit.”

FRANKLIN COUNTY, OHIO
According to Scott Gerhard, MA, LSW, consultant and trainer at the Center, this natural fit for ACT-IDDT integration is evident in Franklin County, Ohio. Since 2007, Gerhard has teamed up with Ramos to help the Alcohol, Drug and Mental

People who receive ACT services often experience fewer emergency department visits, psychiatric crisis services, and psychiatric hospitalization.
Health (ADAMH) Board of Franklin County in its county-wide effort to implement these evidence-based practices. Four specialty teams at community-based organizations in and around the City of Columbus have developed integrated ACT-IDDT teams (some have also included components of evidence-based Supported Employment/Individual Placement and Support services).

The Board has routinely conducted service-utilization analyses of the initiative and has discovered that consumers who receive help from combined ACT-IDDT specialty teams experience a reduction in psychiatric hospitalization, crisis services, and residential services, which translates into a significant savings for the Franklin County system.

Gerhard explains that some of this success can be attributed to collaborations among several service systems in that county, including the community mental health agencies (outpatient care), the state psychiatric hospital (inpatient care), and psychiatric crisis services. There has also been collaborations with the criminal justice system (law enforcement, county jail, mental health court). Transitional and supportive housing services have also been included, because the community mental health agencies provide and/or utilize these services as well.

Gerhard explains that the ACT model encourages intersystem collaboration because people with severe mental illness served by ACT teams typically experience severe conditions and circumstances that are addressed by multiple systems.

“It is impossible for one system to address every need of these consumers,” Gerhard says. “The continuum and continuity of care that is created by the collaborations is essential. The ACT-IDDT team members are out there talking to people in other systems, and there are also formal meetings. This typically doesn’t happen in a large commu-

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ty like Franklin County. But the Board made this an expectation of the ACT-IDDT services, and the communication has improved immensely.”

**INTEGRATING BEHAVIORAL HEALTHCARE**

According to Co-Director Robert J. Ronis, MD, MPH, the Douglas Danford Bond Professor and Chairman of the Department of Psychiatry at the Case Western Reserve School of Medicine, and Co-Director Lenore A. Kola, PhD, associate professor of social work at the Jack, Joseph and Morton Mandel School of Applied Social Sciences (school of social work) at Case Western Reserve University, the Center for Evidence-Based Practices has gained a national reputation for its expertise in the implementation and integration of behavioral healthcare innovations. The Center is a partnership between the Mandel School and Department of Psychiatry.

Ronis explains that ACT has a long history in other states of being a very important and effective evidence-based practice for community mental health and addiction services, but it is one of the more under-utilized in Ohio. For example, a basic tenet of ACT is a limited caseload of 10 to 12 consumers per case manager—a caseload that is shared by a multi-disciplinary team of service providers. However, the “business-as-usual approach” in many community mental-health agencies has been a ratio of 40 to 60 consumers per case manager. He adds that the Center’s consultants will help organizations stay focused on the core components of ACT as outlined in the ACT fidelity scale and, thus, help them achieve the positive outcomes that research demonstrates is possible.

“Our Center has a long record of success with implementing high-fidelity evidence-based models,” Ronis says. “The credibility we have earned with agencies and providers over the past thirteen years leave us perfectly situated to integrate ACT as a central competency for evidence-based community treatment.”

Kola explains that the Center’s expertise in technology transfer—the translation of research into practice—comes from its systematic method of providing consultation, training, and evaluation services.

“Our consultants and trainers have developed a method for technical assistance that combines knowledge from research with their practical experiences in the community,” Kola says. “Our method is firmly rooted in the traditions of social work and community psychiatry. We are dedicated to disseminating practice-based knowledge and to educating and training health and behavioral health professionals to be leaders who respond effectively to contemporary challenges.”

**RECOMMENDED READING**


This past summer, the State of Ohio created a new integrated Ohio Department of Mental Health and Addiction Services (OhioMHAS) with a merger of two separate departments, one that focused on mental health services and another that focused on addiction services.

OhioMHAS’ investment in Assertive Community Treatment (ACT) is intended to enhance outcomes and quality of life for people with severe mental illness and substance use disorders who are the most at-risk of hospitalization, homelessness, and institutional recidivism. It is one of several initiatives that demonstrates OhioMHAS’ commitment to the enhancement of integrated behavioral healthcare.

We asked two leaders at OhioMHAS for their perspectives about enhancing services to this priority population.

Mark Hurst, MD, medical director

**Q1:** What is your vision for Assertive Community Treatment (ACT) in the State of Ohio and its potential impact upon emergency psychiatric services and inpatient services provided by Ohio’s regional psychiatric hospitals?

**A1:** Research of the past few decades has clearly confirmed that ACT yields good clinical results for individuals with severe and persistent mental illness AND financial savings. We have seen this in Ohio as well. A recent project in Franklin County supported ACT teams in several mental health centers and found that the utilization of services in Ohio’s Regional Psychiatric Hospitals dropped significantly not long after individuals entered into treatment. As more communities adopt the ACT model, we should see further improvements in our abilities to help patients reside in communities, become employed, and contribute substantially to Ohio in many ways.

Afet Kilinc, PhD, PCC-S, clinical policy advisor

**Q:** How does Ohio’s investment in Assertive Community Treatment (ACT) and Integrated Dual Disorder Treatment (IDDT) align with the new mission of the newly merged Ohio Department of Mental Health and Addiction Services?

**A:** The Department’s investment in ACT and IDDT supports the OhioMHAS priority for integration of mental health and substance use treatment services and helps integrate the technical assistance for these evidence-based practices to better serve the needs of the providers who are increasingly implementing ACT-IDDT-blended teams to serve the most vulnerable and needy of our population.
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ABOUT US

Evidence Matters is a newsletter that highlights online stories from the Center for Evidence-Based Practices at Case Western Reserve University in Cleveland, Ohio. We welcome and encourage your comments, questions, and suggestions. A free PDF of this publication may be obtained online:

www.centerforebp.case.edu/resources/tools/evidence-matters-archive

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