Transcript:

The Pivotal Role of ACT Team Leaders, What We Know

Presenter: Lynette Studer
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PRESENTER: Hello everyone, and welcome. Our webinar today is The Pivotal Role of ACT Team Leaders, What We Know. It is presented by Lynette Studer. This webinar is brought to you today by the Great Lakes MHTTC and SAMHSA, and the Great Lakes MHTTC is funded under one of the following cooperative agreements.

This presentation today was prepared for the Great Lakes MHTTC. The opinions expressed in this webinar are the views of the speaker and do not necessarily reflect the official position of DHHS or SAMHSA. The MHTTC network uses affirming, respectful, and recovery oriented language in all of our activities.

And just a few housekeeping details, if you are having technical difficulties today you can either individually message Kristina Spannbauer or Stephanie Behlman in the chat section at the bottom of your screen, and they'll be happy to assist you. Also if you have any questions for the speaker, you can put them in the Q&A section, which is also at the bottom of the screen, and we'll respond to those questions following the presentation.

You will be directed to a link at the end of this presentation, to a very short survey. We would really appreciate it if you could fill it out. It literally takes about three minutes. We are recording this webinar, and it will be available along with the slides on our website. That usually takes us about a week or 10 days.

Certificates of attendance will be sent to all who attend the full session, and they will be sent to you via email. If you would like to see what else we are doing, you can feel free to follow us on social media. And just a quick reminder that this is the first of four upcoming webinars. These are the dates of the following webinars, and more information on topics and how to register will be available on the Great Lakes MHTTC website.

Our presenter today is Lynnette Studer. Lynnette is a clinical assistant professor at the University of Wisconsin Madison Sandra Rosenbaum School of Social Work. She teaches MSW students in mental health field unit, as well as classes on mental health policies and services and advanced practice skills in mental health.

Prior to joining the UW Madison faculty, she held the position as both an agency policy specialist and state administrator with the state of Minnesota Department of Human Services Chemical and Mental Health Administration, overseeing and improving policy and the provision of technical assistance for the state's 32 assertive community treatment teams who serve individuals with serious mental illness. Dr. Studer holds a clinical social work licenses in both Wisconsin and Minnesota, and has been practicing clinical social work for over 20 years. We're excited to have her today, and I will turn it over to you.

LYNETTE STUDER: Can you hear me now?

PRESENTER: Yes, we can hear you.

LYNETTE STUDER: OK. My Zoom completely froze and I had to go out and come back in. So let me-- I didn't mean to panic you all.

PRESENTER: No, no worries.

LYNETTE STUDER: All right. Can you see the PowerPoint?

PRESENTER: Yep, it looks great.

LYNETTE STUDER: Perfect. All right. Thank you. Well there, the first glitch has been resolved already. So thank you everyone for already hanging in there with me. I'm super excited today to be able to share with you some information in regards to the pivotal role of the ACT team leader in assertive community treatment. And so I'm hoping that there are many of you out there doing that good work right now, so we'll get go ahead and get started.

The context for today is that this is one of a series of four webinars that we hope to bring to you that focuses specifically on the ACT team leader and the importance of that role within the implementation of the model itself. It stems from an ongoing project that I have with a wonderful colleague, Dr. Mimi Choy-Brown, who is at the University of Minnesota School of Social Work in the Twin Cities, and with the support and in conjunction with two of the mental health technology transfer centers, one the Pacific West, which is Washington state, Oregon, Idaho, and Alaska, and then our own Great Lakes technical transfer center, which is Wisconsin, Minnesota, Illinois, Michigan, and Ohio. I think I forgot one in there. Minnesota.

And so we're really excited to try over the next year to really robustly add to what we know about ACT team leaders, which is where all of you will come in. We really just hope to guide the knowledge and understand more what that ACT team leader is doing in an effort to really implement these services on a day to day basis.

Our learning objectives include just introducing the role of ACT team leader, and also looking at that through the lens of fidelity standards, identify two key elements that contribute to high fidelity ACT via the work of the team leader specifically, and then identifying one action step that you can take right after the seminar to improve fidelity to the ACT model.

So a quick little bit about why even study ACT team leaders, and full disclosure, I'm trained as a clinical social worker and was an ACT team leader for about 15 years on a rural team here in Wisconsin, one of the first rural teams that started back in the 1980s. I wasn't the leader in the 80s, but it started in the 80s, and constantly was wondering why we didn't have more information about team leaders.

And so when I'm asked this question of why do we study team leaders, I really give a simple-- maybe it's a little bit of a sarcastic answer back, just because this really matters, what the team leaders do matter. And if you are a team leader, you've been a team leader, you've been around team leaders, you know that this is a really key critical ingredient of the model.

And then it turns out that a lot of other people actually care about this. So team leaders themselves care. Your team members certainly are invested in this. I'm sure many of you have examples of times when you've had good leadership versus leadership that hasn't been so great. So definitely team members, their job satisfaction hinges also on team leaders.

Your agency administration, administrators will care, both from a fiscal perspective, but also in a quality of care that is disseminating from your team down to clients and their families. County regional and state mental health authorities, I did a five year stint in state mental health authority in Minnesota, and it became really important on a macro level to try to figure out how do we improve services, and the key component in any of that is the team lead.

Then of course, community stakeholders, but most importantly families and service recipients. They care about how we approach our work in order to provide better services to their loved ones. We also know that it matters from a literature perspective, or other people have studied this to some degree. And I think this is the most startling statistic for me, that fewer than one in six individuals with serious mental illness in the United States receive adequate treatment.

And when you think about that, if you think for every one person that's in your ACT team there are five other individuals that aren't receiving those services but would be deemed as appropriate, that's a really startling statistic. And as a social worker, we just have to do better. We just have to do better than one out of six being offered treatment that works.

And we know what works. We have a lot of information out there around not just assertive community treatment, but other evidence based practices. But

we still have this gap that exists between research and practice. Some of the latest information that I've seen is that it takes anywhere from 12 to 20 years for us to translate what we find out in an academic or research setting into actually implementing it into practice.

And so if you think about that, that's a quarter to a third of a person's life waiting for our agencies at the county level or the state level to figure out how to provide these services for us. And of the programs that exist, we also know that there is a lot of challenges in implementing these in a way that they work. And so there are programs that are out there, but they might lack fidelity to the evidence based procedures, and that's not related to the programs not wanting to do right. There's a whole host of reasons that that might happen, probably resource deficiencies, you don't maybe have enough money, so then we fall into the trap of a little of something is better than nothing at all. So that gap is still something that we really need to pay attention to.

And we know that the gap leads to less benefits in a timely matter, and when we're working with people with psychotic illnesses or a lot of suicidality, time is of the essence in order to help recovery. So you would think since this model of care has been around for 30 plus years, and there's over 30 randomized controlled trials about this, you would think that there just must be a lot of information about the role of the team leader and what that person does.

And we have almost nothing. If you're a brand new team leader, you probably know this better than anybody. If you've tried to go out and do a Google search to find out what is this job supposed to look like, what am I supposed to do, you'll find that you don't know. There's not a lot of great resources out there for you. And that's after 30 years of us knowing that this model is something that can help people.

But we do know a few things. And so we know that the ACT team leader is part of the evidence based practice of ACT. You literally can't start an ACT program without a team leader, a prescriber. So we know that it's essential. Can't have a program without it. And we also know from literature on a study that had been done that team leaders can either be facilitators or barriers.

So we know that the team leaders can really either help move along bringing assertive community treatment to the clients, or we know that on the flip side of that, team leaders can really provide obstacles to implementation. And so what that says to me is that, again, it supports that idea that that's a really crucial role in implementing the model.

Research emphasizes that ACT interventions that have higher fidelity to the original ACT model actually have stronger outcomes. So as a team leader, knowing that the closer we can get to that evidence based practice, the more our consumers will benefit is another piece of knowledge we can add to what we know.

There's some guidance from the PACT manual. So the PACT manual was last updated in 2003, so arguably it's outdated or fastly continuing to be outdated, and there are only two paragraphs. And so the text itself is hundreds and hundreds of pages, but the team leader gets two little paragraphs in one of the first chapters, which really doesn't provide enough guidance to be helpful.

And then we have guidance from the tool for the measurement of assertive community treatment. So the TMACT, in short, is a quality improvement tool that really, in my opinion, does the best job of looking at a current program and the activities that they're doing and aligning that with the evidence based practice.

And so many of you maybe have gone through a TMACT evaluation, or you're familiar with it. And on this TMACT, which is our most current wonderful tool, we have two items that focus on the team leader. The first is that the team leader is just on the team. So that's defined by one full time equivalent. They have full clinical administrative and supervisory responsibilities. They don't have outside responsibilities outside of the team. So their time isn't pulled in other directions. They have a master's degree. They're licensed, and they should have three years or more of experience with adults with severe mental illness.

And then CT2, to CT stands for core team. So the second item on the TMACT is that the team leader is a practicing clinician. And so direct clinical services at least eight hours a week, and then clinical supervision, and in order to get the highest rating on the TMACT that is provided weekly to two staff who are consistently receiving the most supervision.

So again from all of that, we know that you need to be full time, dedicated to the team, you have to do at least eight hours of clinical practice and provide clinical supervision. But again, what's missing is how you do any of that, and what that really looks like. There's a lot of people that could fit this criteria, and that doesn't mean that they would be a successful team leader.

So I joke that the struggle is real, that we continue to be really poorly defined and no one has really stepped back to help us describe who we are and what we do. And that can be really hard. For those of you that are team leads, if I asked you, tell me what you do in a day, that could be a real challenge trying to sum up, especially given that every day, every hour can be very different based on the needs of your clients that you're serving, and your team.

So the summary of what we know is that it's indispensable. We know that team leaders absolutely have to be there. They're indispensable. And we really know that there's just no study that has looked specifically at ACT team leaders. We don't have a description of who these exceptional leaders are. We don't have information on how they approach their leadership. And we

really have no understanding how they influence or impact leading high fidelity teams. We just-- we don't.

So I tried to begin to chip away at some of that. So the information going forward is actually from research that I've done to complete my dissertation, and my purpose was to understand and describe the role and the contribution of team leaders to ACT. I just really wanted to step back and to start the dialogue and try to figure out a jumping off point.

So I have three specific goals that I wanted to do. I wanted to describe the team leaders, who they were. I wanted to understand their approach to leadership, so what they did and how they did it, and to understand the roles that they might be playing to promote high fidelity to ACT.

My plan was since I wanted to understand and really look at team leaders that were doing this well, or were considered successful team leaders, I wanted to look specifically at those teams. So in research lingo, that was I decided to do a collective, meaning more than one, study of different teams and their leaders.

So I went to each team and did an in-depth three days on site where I was observing and doing some interviews with team leaders who had been identified as very strong team leaders across the nation, and also in order to be able to have some confidence that they had teams that were practicing from a high fidelity perspective, I had a criterion that they had to score a 4.1 or higher on their latest TMACT.

And so the TMACT is rated from one to five, and the latest TMACT needed to be within the last 18 months, and it had to be the same team leader. And I wanted team leaders that had been there more than two years, because I felt like they could describe more of what they were doing, and they would have had larger time span of experiences.

I turned to experts, national experts, to help me identify which teams might be willing to participate, and I ended up choosing three teams, one in Minnesota, St. Paul, one in Nebraska, which was Lincoln, Nebraska, and one that was outside of Philadelphia in Pennsylvania. And I went to these teams and I did in-depth interviews with the team leaders, days worth of interviews with the team leaders.

I talked to agency administrators, I talked to all team members that were willing to participate, I talked to psychiatrists, and then observed the daily team meetings, made sure I observed a treatment planning meeting, and shadowed with the team lead. So when they went out to do clinical work, if the client was agreeable to having me come along, I sat in the back seat and kind of watched what was happening with the team leads.

So the findings that are coming up on the bulk of the next few slides are the reported similarities and differences between the leaders that I found. While I did analysis across all three of those teams, I'm reporting on only two of those teams, Minnesota and Nebraska, just because that's the route that my dissertation went. So just so you know, these are the results from the Minnesota and Nebraska teams, and they are the similarities between the teams.

So the first aim, what I found, and as I'm going through these, if you are a team leader I'll be interested to see if you feel like you can identify some of your own characteristics within this list. Again, this is based on an n of two, so that's certainly going to be a limitation. But I'll be interested to understand if you see some of your own practice in some of these teams or some of these findings.

So the first was that these team leaders had a personal job match. Their jobs just fit them. They liked people that had mental illness. They liked to be busy. They enjoyed leadership, and they enjoyed the direct practice part. So they really liked the balance of it, and they were very focused on recovery and rehabilitation. And that will show up in a few more of the findings, but they really believed that people with these illnesses can go on to live full lives that are worth living, and that really was a fit of the ACT model with their value system. So they really had this job match.

They were optimistic and hopeful, and that sounds a little like yeah, people are optimistic and hopeful. But they really-- one of the quotes that a team member gave me was that quote, "they drive hope for the clients," unquote. So these weren't folks that were pessimistic. They were realistic. It wasn't like they were always coming in and were invalidating of how hard the job was. But they were very optimistic and hopeful, and really created that environment for their team

They had a high amount of emotional intelligence. And so for those of you that are a little less familiar with that, emotional intelligence has kind of four components to it. One is that it's self-aware. So these team leaders were really self-aware and reflective of their own practice, and reflective of how they were interacting with other people, especially their team members.

They had high self management. So these team leaders did not get over emotional. They did not blow up and kind of go off, kind of blow up over situations. They really were able to manage their own emotions and be really calm, and that allowed for there to be some stability and predictability across the team members.

They were socially aware, and did a really nice job of knowing what they needed to say to other team members, but also assessing how that might be received. So if they really needed to point something out, but a team member was really struggling and having a tough day, they might hold that instead of

just going and saying it. So they really have that ability to be aware of how their messaging was coming across.

And then they put a high amount of energy into relationship management with each individual team member, and really looked at their relationship with each team member in its own light, and team members knew this. Team members really liked this, and they felt like while they're part of a team, they also knew that each one of them had special recognition from the team leader. So these team leaders really had a lot of emotional intelligence.

They recognized that their influence connects directly to the team and the consumers. And so they understood that their attitude, or how they approach things, would impact the team, and then those team members are going out and impacting consumers. So they were very careful to not get into the woe is me, because they knew if they shared at a team meeting, this really sucks. This is hard. I don't know why we're doing this. And then imagine those team members in turn going out and seeing their clients for their next contact. It's going to be hard to break out of that. And so they really recognized that.

And there was a really great example one of the team leads, the lead from Lincoln brought up, in that she talked about having a staff member in the past who was always late to work, and she had done everything that she could to try to manage that before going to the next stage of writing up that person.

And she finally said, at some point I had to write her up, because it was impacting the clients. And I told her that while I wasn't thrilled with having to do it, that I can't have the program assistant call the client yet again to say that she's late. So that recognition actually helped her to do things that were unpleasant, but she knew she needed to do them because they directly connected to the client, and the care the client was getting.

They were respectful and trustworthy, they had so much credibility. They did what they said they would do when they said they would do it, and team members just knew that they were there for them. The sixth was this belief in energy, which I found kind of interesting. They created the space to have positive energy, and they both referred to it as energy. One talked about taking the pulse of the team every day to see where they were at, and then one said that she really is mindful of the energy in the room during team meetings.

And I think a lot of us do this. I don't know that we would define it in that way. But the kind of like, let's take a breath, let's all of us just take a breath, let's step back. And then other times the other team leader had this infectious energy that the team said, it's just fun to be around her. It was just exciting to go in and be around.

And then both were highly skilled clinicians. They really knew their stuff. They understood the intersectionality between mental health and substance use

and physical health and medications and they were really seen as knowing and being able to be somebody that could really answer questions for people.

So this was what I came up with from the aim of trying to describe who these team leaders were. So the second aim was understanding how they did it, what they're doing in their jobs and how they did it. And so this is a little bit more expansive than the first aim, because as you can imagine, there's a whole lot that ACT team leaders do and different ways that they do it.

So the first was that they function as a role model and a teacher, and that was really defined best by team members saying they're in the trenches with us. Our leaders do not ask us to do something that they themselves would not be willing to do, and through that the team leads were really role modeling what they wanted.

An interesting thing in this category was that they also role modeled how work-life integration happens. These were not team leaders that missed their vacation days or that didn't take them or that put in 60 hour work weeks for weeks at a time without balancing that. And I found that to be a really-- and this study happened before the pandemic, but even more important now. It's easy to say things and then not do it, and then you send mixed messages to your team members. So I thought that work-life integration and balance was an interesting thing to role model.

They set really clear and high expectations. Both joked that they were probably a little bit more competitive than they wanted to be. And that really showed up in their desire to just do their best that they could do. They set really high and clear expectations, and that allowed them to then hold the team accountable for meeting those things, and not in a pejorative way, but kind of like this is where we're striving to try to get better.

They were problem solvers and decision makers. They really both reframed obstacles as opportunities. They didn't get stuck. They would remind people that a client is somehow attached to the problem, and so we need to be creative and figure out a way around this. It was nice, neither one of them blamed the client or the staff when things went wrong. So I think that's really important.

In our mental health system today, sometimes if we apply an intervention and it doesn't work, some of us can be really quick to say, well, the client just wasn't motivated. It was the client's issue. And that really ends up blaming, which doesn't help anyone. They didn't do that. They were really able to just say this is what it is, let's figure out how to do it.

And they also had this balance of both autocratic and democratic decision making. So they knew when to take issues to the team for further discussion. A worker would bring something to them and they would say let's take it to team tomorrow, and they knew when they just had to make the decision. And

I think that that's really important to have that fluidity, because it can impact team dynamics and direct client care. So having that balance was interesting to find with both of them.

They were a planner. They were super organized. There's not much more to say of that. They enjoyed knowing what was happening in the day and knowing the bigger picture. They were, similar to the aim one where it was a good job fit, they really had a lot of complex and multiple responsibilities, and they really loved that. They loved that no day was ever the same.

One person talked about multiple hats, like at 9 o'clock I can be wearing my supervisor hat, by 9:30 I'm wearing my crisis management hat, by 10:00 I'm wearing my admissions hat, and they just really loved that and derived a lot of personal job satisfaction from that. They talked about it being like putting together a puzzle every day, and some days you're able to put it all together, and other days not so much.

They had direct, open, and transparent communication styles. They did not send mixed messages to the staff. They did not avoid unpleasant conversations, and people really felt that there was transparency. I think that one of the main components of what ACT team leaders have to do is figuring out how to manage the dynamics within a team. And I've seen team leaders just get so frustrated, and I am definitely in this category too, when you want to say to some team members, just figure it out. We're grown adults.

And so every team has it where when people are getting frustrated or burnt out, the gossiping happens. Or you walk into your team meeting room and somebody is complaining about another team member. What was nice is that there was this environment within both of these teams where the leaders would say, like if they walked into a room and they heard that, they would say to the team member that was saying that, you need to address that with the other person. And I want you to do that by the end of tomorrow. And that way it held accountable, but it also put the onus back onto the team member, because it wasn't the team leader's job to fix that.

They both were willing to get involved if it didn't resolve, because anyone knows that if your team is dysfunctional the work isn't going to get done. But they really were able to create that responsibility within the team through their direct styles. They were mindful of individual needs. In their clinical supervision they would ask, are you getting what you need from me? What are some of the barriers in your job right now, and how can I help fix that?

And the team members really felt like they could bring anything to these team leaders, and the team leaders would help them problem solve it. Now that's not to say that they would do that and if what the team member needed was at detriment to the team or to the clients, it wasn't that they were going to say, yeah, go ahead, take five months off, no problem, everybody can cover. But

they really were open to getting that feedback of how they could do their jobs better to support the individuals on the team.

They promoted the strengths and professional growth. One of the team leaders would start out by saying, you're not going to be here forever. We all move on, and so what do you need out of this job to really promote your future professional growth? What do you want? Where do you see yourself in five years? And they would do that and then help figure out how the job could support some of that growth.

So if someone wanted to learn more about substance use, they would make sure that they were paired up with the substance abuse specialist on assessments, and they would go on that person's team so that they could grow in their knowledge of that. If they thought they wanted to be in a managerial or leadership position, the team leader in Lincoln would take people out with her then when she was doing screenings, and then have a conversation about what she was seeing from that admissions perspective.

And they both were great at identifying the strengths and figuring out how they could incorporate that into the person's job. So if somebody was really awesome at art and they were doing crafts, they might figure out how can we do a craft group here that can decrease social isolation with some of our clients, and still have a staff person that's really excited to run that group? So they understood and assessed the strengths of each person, and were able to utilize that for professional growth.

If I had to pick one of my most favorite findings from this entire study, it would be number 10, in that they really served as the team's protector. And I wasn't-- I don't know why I wasn't expecting that, but they really both deliberately took on the responsibility of trying to nurture and protect the team members in the team as a whole.

And so it was this very deliberate idea. And the team leader and Lincoln actually said to me, I think I spend as much time thinking about how to nurture and make sure my team is doing all right as I spend thinking about the services that we're delivering to the client. And so this idea of taking care of the team extended to the personal well-being of each team member, how they were doing, making sure that each team member got recognition and validation for what they were doing really well in, figuring out how to support the team, making sure that every birthday was recognized and making sure that they really had what they needed to do the work, and constantly checking in that was really important.

And then additionally they really looked at their role as being a buffer for the team. So when new state mandates were coming down, or there was something that was going to directly impact their job that the agency was considering, these leaders really took it upon themselves to make sure that how they communicated that information to the team buffered them from the

stress of some of that. And that was a constant daily thing that each team leader did.

Because they did that, I got quotes from team members like, I know my team leader will go to the wall for me. I'm never alone. I know that I can do anything out in the field, and when I come back, even if I screwed up, my team lead is going to be there at my side as we're figuring out the solution to this. So the team members really felt this.

And the last thing in this category that I really liked was that one of the team leads looked at this protective buffering as beginning in the hiring process. And so I want to read her direct quote, because I think it was really powerful and it might be a strategy people could use. But she said, the first interview I usually keep to about 10 or 15 minutes for any new staff, in part because I think so much of hiring is really intuitive. The first question I always ask people is if they could give me three words or short phrases that describe their perceptions or beliefs about mental illness, and usually I can tell pretty quickly a couple of things.

One, you know if they kind of have some of the same values around recovery and seeing people's potential as the rest of the team. And if they don't have that value, they are instantly out of the running. The other thing is that I can pretty quickly tell how they are at concisely organizing their thoughts and sharing information, which I see as a really critical feature of being part of the team. You know you need to be able to summarize things. So I thought that that was really interesting, that even this idea of protecting the team started at an interview with a new team member.

And then they created a recovery and person centered environment. They made sure that every team meeting people were talked about in person first language. They really, from posters on the wall to just how the team discussed clients, both in treatment planning meetings and daily team meetings, this idea that people can and will get better, and it's the team's job to help figure out how they are able to do that. They always saw the person behind the illness. The illness was never front and center for them.

And then finally they established a really fun and positive work environment. The team members really enjoyed going to work. The team leader in Lincoln said that laughter equals cohesiveness. And so they really tried to figure out how to make it fun. All three of the teams that I was at, they did potlucks. I think it's funny that I'm talking about potlucks, but people figured out how to celebrate a tough week by having people bring in and have a meal over either team meeting or coming back to the office. So people really enjoyed working at these places.

So I joke, when people say, what did you learn in your dissertation? I said, I learned that team leaders are mama bears, and they have lots of potlucks.

But I do think that the themes behind that are really important for us to think about when we're leading our own teams.

All right, so we're nearing the stretch, home stretch here. So aim three was just to understand how team leaders impact fidelity and how they think about it. And so what I found in this area was that they do play a very critical role. If you have a team leader who's not thinking about fidelity or the evidence based practice of ACT, you're going to have a team that isn't moving in that direction.

So they played a really critical role. They promoted and sustained it. They got their team to buy into the importance of that. And I thought the most effective strategy that I saw with these two team leaders was that they connected a change in fidelity directly to client outcomes. So for example, if maybe they scored lower on the employment specialist, and really being able to go out and find people meaningful work, they were able to come back and say, let's get this score up in the next round, because that's going to make clients get more work, and that's going to provide them with a richer life. And so they were really able to connect it.

The TMACT and the fidelity review wasn't just some audit for them. They really took it as this is a way that we're going to be able to improve. And so that leads into the second finding, was that they really utilized it for a guide in all of their decision making. When there were things that would come up, they considered well, what does the evidence based practice say? And then we'll decide what route to go from that. So it was kind of a constant lens that they were assessing program decisions through.

In one of the examples that the team lead in St. Paul had given was that the psychiatrist was there for one less hour one day, and the program assistant said well, why don't we have these clients come into the office? We can fit more people in if we bring them into the office. And her really stepping back and saying no, I think it's really important that we still figure out instead of just this conveniently working for us, the model really-- we should send the doctor out so that he can see what's going on in that house, and so we'll see one less person this week. We'll move them to next week. So really using the evidence based practice as a guide.

And they integrated high fidelity into their daily team practices. You could see that in the tools that they were utilizing. You could hear that in the conversation that they were having. They really were able-- the team leads, and then I would say the subsequent team members, really made decisions from that lens.

There was an example of seeing hospitalized clients, and they were really far away. The client was hospitalized really far away, and kind of making sure that they could still go see that client, and shifting other people's schedules to

make that happen. And instead of just saying, again, it's kind of convenient for us to not have to drive all of that way. So let's just not go see that person.

One of the things that I also found really interesting was how they both looked at ACT fidelity, and they looked at that as ACT fidelity is the structure of their program, but then they were allowed really great flexibility and creativity within that structure. And so one of the quotes was, structure, structure, structure, and then complete flexibility.

And I sometimes describe it as if you're building a house, you don't want your foundation and your two by fours, you want those to be pretty scientifically sound. You want to know your concrete is not going to bust, and you want to know that your two by fours are going to hold up in a storm or hurricane.

But then within your house you can design the rooms the way that you want them to be. You can put in carpet or hardwood floors. You can-- right? So there's that creativity, but you want the infrastructure there. And I think about that with ACT fidelity. Let's put the infrastructure in and know that that's solid because of the science behind it, and then our team can be flexible and creative within that.

They both really had really solid knowledge of the evidence based practice of ACT. They had both on their own work and research and deliberate understanding of what the model says and the logic behind that, which I think infiltrated into their decision making. And then they had outside support, so each team leader had direct agency administrations that supported the work that they were doing, and supported them to the fact that they were kind of hands off.

So they were given a lot of autonomy to do what they needed to do to make the team operate and work. And I'm sure that that factors into trustworthiness and their credibility within the agency as a leader, but they really did have that support. They didn't constantly have to be fighting fights with their upper management.

A difference that they had was that they both had very different support from their state mental health authorities. So one team leader really had excellent support to implement ACT, and the other actually identified their DHS as a barrier to high fidelity ACT. And then I'm going to breeze through the differences, because there's a lot more than this, and the more team leaders we would look at, the more differences that we would get.

But there was some differences in the demeanor of the team leaders. One was super calm. She practiced from a Buddhist perspective, and you could just tell that was the culture there when you walked in based on how the office was set up, and when people would interact with her she was super calm, very matter of fact.

The other team leader had almost this infectious energy, and she described herself as sometimes bouncing off the walls. And both were equally effective, and so I liked that, because it shows that we can have a lot of variety amongst team leaders and still meet our objectives. There was a difference in how they approached change. One said we're going to always have change and really promoted that so that the team members were always prepared for change. The other one didn't shy away from it, but didn't call it out as much as the first one.

And then there were different ownerships of the team. And this was interesting. One team leader would refer to her team as my team, and say whatever they go out and do reflects on me, so I'm accountable, I'm where the buck stops. And the other team leader never referred to it as her team, referred to it as our team, and didn't have-- I don't want to say pride, because they both were really proud of the work of the teams that they were doing, but really didn't see herself as elevated or different amongst her-- you know, as other team members.

And then they both had different motivators for accountability. One team leader was really like, I'm accountable to this team and to the consumers. And then the second team leader took that a little bit farther and said I'm not just accountable to my team and the consumers, but I'm also accountable to my mental health authorities. I'm accountable to my agency. I'm accountable to the community. So they extended that accountability a little bit more outside of the team.

So I have talked at you for 40 some minutes, and I would love-- I've been somewhat ignoring the chat just so that I can stay focused, but I'm wondering if people even would just want to say anything or share any thoughts about any of the findings. If it seems like yeah we do that, or anything that you found interesting. Please feel free to share that in the chat, would be great. I'll be really interested to see what your thoughts are.

Sometimes I think when we do the work, there was a lot-- and I had the same experience where I was like, well yeah, some of those are just like yeah, that's what we do. Of course you have leaders that are respectable. But I don't think that we've ever really tried to label that and name what we do. So this was, again, my attempt to try to do that.

So let me-- I'm going to go past that. I wanted to share, there are some limitations. No research is ever perfect, so the sampling was not the best, because I used experts to tell me where these great teams were, and I might have missed out on a whole lot of team leaders that are doing great work that just are under the radar of some of these folks.

Arguably, three days, a random three days with a team, as far as the modality to collect your data, is certainly not good, right? Just think of the different ebbs and flows of a team over a year, and for me to just kind of pick three days, I'm

sure there's 100 other things that I missed, just because I was only there for three days.

And then I have a bias. I really feel team leaders are super important, so maybe I interpreted the data from that lens more than I wanted to. But there certainly-- I bring my own biases into the crucialness of team leads. And then just by focusing on team leads I could have missed some context. So some of these team leaders might have had excellent assistant team leaders that do a lot of the work and the support how these team leaders look, and I would have missed that because I'm so focused on the team lead I would have missed some of the context to that.

So just to kind of help you be able to take something from this into your own practice, and whether you want to use the chat or just think about this, but just one thing that you feel that you could do that could improve your focus on fidelity, or help your team move forward. And I put up the slide from the third-- the findings from the third question that I asked.

But really I feel like any of these findings can go to support higher fidelity ACT, whether that's focusing more attention on your team members, whether that's trying to create more laughter and cohesiveness. I think all of those things, my hypothesis is that all of those things end up mattering, and certainly end up mattering to having decreased turnover, which we impacts client outcomes.

So I just want to leave you with this, and we'll turn it over for some questions and I'll try to get to those. But I feel like what this team leader stuff, we only know a drop, and what we don't know is an ocean. And so Mimi and I really want to extend a genuine invitation for you to participate in helping us try to define ourselves as team leaders in this. And so we'll be reaching out and trying to-- through our webinars, and then through a survey, we're going to really be trying to get a better picture of what you all do and to show the significance of your role to the overall mental health system, to be really honest.

So I want to thank you all for participating in joining us. Our emails are right there. And let me see if there are any questions in. Were there--

PRESENTER: We do have a couple of questions.

LYNETTE STUDER: Awesome.

PRESENTER: The first one was very easily answered, could we get your email address. And we will also make sure that that is with any of the other information that we send out. So it will be on the slides that will be posted. The next question is, what is the best resource or maybe a few resources-- yes?

AUDIENCE: I'm sorry, I don't want to interrupt you, but did you want to--

PRESENTER: Oh, thank you. Thank you. One of the things, Lynette, we had talked about doing was a quick poll.

LYNETTE STUDER: Oh, yeah.

PRESENTER: And in the beginning we were shaken up a little bit by that. So we're going to do that quickly so that as we go forward you'll have kind of a better sense of what people are doing or where people are.

LYNETTE STUDER: I'm sure the lead speaker dropping off right as you give it to me was a little panicky.

PRESENTER: We were fine. You did great. But while people are filling out this poll, the other question was, what are some of the best resources that ACT team leaders should reference or utilize in leading a successful team to ensure fidelity?

LYNETTE STUDER: That's a great question. I think one of the best things you can find is somebody who's done it and become their new best friend. And I say that just because I think that mentor relationship can be really important. The other-- and I think I saw Stacey Smith on-- there is an ACT listserv that if you're not on I think is also a really excellent way to post a question and have people from all over the United States and even outside of the United States be able to kind of guide the question and give a lot of different potential answers for it.

And then I know that reaching out-- you can certainly email me and we can figure out who you can connect with. I have been so fortunate to be involved with so many really exceptional team leaders who really have no problem mentoring. And so I'd be happy to do that too. But yeah, there's just not a lot of resources still. The TMACT, I think, is really great. It tells you what the program should look like. And so getting your hands on that can be good too. It's a great question.

PRESENTER: Just quickly, here's the results of the poll.

LYNETTE STUDER: Look. These are our people. Here we are. Sometimes I wonder, where are we? That's awesome. 122 of us. It's a small but an elite group. So thank you, thank you for filling that out. Interesting, the majority of folks by far are five years or less. Even 50% are two years or less. Yeah, it's a hard job but it also is so very rewarding too. Thank you.

PRESENTER: So we have about three more questions and five more minutes, so we should be able to whip through these. Does the team leader hold a caseload as well as part of their duties?

LYNETTE STUDER: I've seen it both ways. And so there is flexibility in and around that. I've seen it happen where sometimes the team leader is there a

longer period of time, and through turnover they end up taking on maybe a little bit more case management, and having a caseload. If they do have a caseload, I'll say it should be really abbreviated, like one or two. It shouldn't be a full caseload, because there's no way you can do the administrative and leadership parts of your job while doing that clinically. And so if you do have one, to have a lower.

And then I have seen some team leads where they don't take it, because they're always on call, they're always the person that are backups and things like that. And so it kind of just depends, I think, on your actual situation. But from an ACT perspective there isn't direction that you have to or you shouldn't. So it's kind of individualized. And it changes over time, I think.

PRESENTER: OK. We have another question. Did you interview any program participants or families?

LYNETTE STUDER: I didn't interview any families, and I did interview more informally program participants at their treatment planning meetings, and then also when they were dropping in to the team office, but I didn't, and initially I had wanted to do that, and then it became an issue of time and how much time I had on site. But that is a voice that's missing out of here that I really would have appreciated being able to do. It's a good question.

PRESENTER: Great. The next question is what are the next steps in researching the characteristics of a team leader, or perhaps a larger sample?

LYNETTE STUDER: Oh, what a great question. So that's part of what Mimi and I are hoping to do. So right now we're creating an actual survey that we hope with the help of Great Lakes and the Northwest technical assistance centers to be able to disseminate that out, and to get your-- we will solicit ACT team leaders to participate in that.

And then from there-- our hope is that it grows bigger, and that we could actually create, whether that's a manual or an intervention or something that a new team leader could have to say this is what it looks like and this is kind of the lessons learned. So we're having the listening sessions earlier on this year, and then more webinars where we're hoping to get more information. And then we'll be sending out a survey. Thanks.

PRESENTER: Just a couple quick more. Should peers have a caseload?

LYNETTE STUDER: That's a good question. I know Stacey's on. I've seen it both ways, but I think more often than not, they don't, because they're considered on every person's team. But again, the model itself doesn't provide direction on that. So there's individuality with that. But I don't want to call on Stacey, but Stacey works at the UNC ACT TA center, and I know that she's on, and so maybe she can put something in the chat. Oh, go ahead, Anne.

PRESENTER: Sorry. She just did put some information about the listserv in the chat for us.

LYNETTE STUDER: Thanks. But yeah, you can email me about the peer caseload and we can have more of a conversation about that. But I did just want to shout out, and before we end up going, that one of the team leaders that was part of my study, I see that she's actually in this room. So I just wanted to give a shout out and a thanks to her, because some of these findings are based on her wonderful leadership. And both these team leaders have moved. On they're not ACT team leaders anymore. They're higher up in the ranks of their agencies. So they're continuing to do the good work, just not in the ACT team.

PRESENTER: Great. I just want to let people know, because people's schedules are pretty tight, that we do have a couple more questions, but we will be happy to have Lynnette answer those in writing and put them up on the website when we post the slides and the transcript and the recording. So if you put a question in and we did not get to it, I apologize, but we will certainly answer it. And I just want to thank you, Lynnette, for your incredible presentation, and for everyone taking the time to listen.

LYNETTE STUDER: Yeah. Thank you, everyone. And thank you so much for all the hard work you're doing in the pandemic to just keep people safe. I really appreciate that. That doesn't go unnoticed. And make sure to mark your calendars to join us for the February webinar. We'd love to continue the conversation. So thank you everyone.

PRESENTER: And we'll put all that information also on the website.

LYNETTE STUDER: Perfect.

PRESENTER: All right.

LYNETTE STUDER: All right.

PRESENTER: Thanks, everybody.