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Notes from the Directors

Co-Directors Michelle Salyers & Mike McKasson

This issue of our newsletter contains articles that are very timely in relationship to the most recent Indiana Family and Social Services Administration's kickoff event for the transforming of mental health care in Indiana. It was very clear during the two day event in October that "recovery" will be the overarching goal of the transformation effort in Indiana.

Tim's article will help us have a better understanding of the recovery journey and how it relates to our own lives (page 2). To bring the message of recovery in the everyday workings of ACT team members, Lorna's article will challenge us in our responsibilities as payees of SSI/SSDI benefits to be recovery focused (pages 2 - 4). To enable ACT team members to practice recovery, we feel that the implementation of the evidenced-based practice of Illness Management and Recovery (IMR) on a team to be essential in assisting consumers in their recovery. Veronica will discuss the importance of building relationships with the consumer in their recovery journey and the use of the IMR Knowledge Skills Inventory in structuring future sessions and building a relationship with the consumer (pages 6 - 8). As always, Bob makes a very powerful statement regarding the rights of persons with a mental illness in our society (page 5). It will take a great deal of collaboration to achieve the transformation of the mental health in Indiana, and Charlie gives a very good example of how collaboration can make a difference in the system in his report on the Co-Occurring Planning Academy (pages 5 - 6).

In this . . .

Promoting Recovery Initiative: Demystifying "Recovery"

By Tim Stultz, IMR Consultant/Trainer

I have been asked by several people to help define "recovery" as if it is some unfamiliar concept. I find it interesting that people have a difficult time understanding it given that I have not yet met one individual who has not "made it" to recovery at some level or another. In fact, recovery is one of those unifying/shared experiences that we all have in common. When I say that, I mean that I have not yet met one person who has not had to conquer over something in their lives to be "better" people. That is what "recovery" is all about. It is about moving beyond whatever we have had to champion over and not allowing that event to define our lives. Each of us has had numerous challenges that we had to move beyond to get where we are today. We are all champions over those things, and our "recovery" proves it. For me, it was the fact that I was a poor student that did not use grammar and could not spell even common words until my senior year of high school. I had to take a remedial writing course to even attend college, yet I now have a Ph.D. (stands for piled high and deep you know!). Each one of us has met similar challenges, some much more serious, yet we have not allowed those experiences to define us. **We are not our failures, we are our successes.** We are what Barry Duncan calls "Heroic Clients." So too, the people at our hospital that we call "patients." They have also championed over much in their lives, often including living through the sigma of being dehumanized by being identified as only a diagnosis, not a person. Their challenge is great. Their journey heroic, our task as helpers is to promote heroism/recovery.

William Anthony states, "Recovery is described as a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills, and/or roles. It is a way of living a satisfying, hopeful, and contributing life even with limitations caused by illness. Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness."

To facilitate recovery we must be heroic in providing relationships with consumers that are based in respect and positive regard. We must be flexible and engage the consumer as an equal partner in the process of making meaning in their lives and setting meaningful goals for themselves, empowering them to become their own heroic self. They are not their failures, they are their successes.

In promoting their heroic self we build hope, confidence, personal responsibility, and self-determination. In promoting their heroic self we help them to move towards the path of recovery. It is a path well defined by all who have traveled it before, including ourselves.

Representative Payeeships

By: Lorna Moser, Implementation Monitor

Individuals with severe mental illness (SMI) who are served by ACT teams often meet criteria for supplemental security income (SSI) or social security disability insurance (SSDI). These entitlements are intended to meet basic living needs, such as housing, utilities, food, and clothing, when a disability results in significantly impaired functioning. The average supplemental security income (SSI) for disabled individuals is $531 a month (*Supplemental Security Income*, 2001). Moreover, a Department of Housing and Urban Development (HUD) report stated that,

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"Representative Payeeships" cont'd from pg. 2 . . .

among those receiving SSI, over 50% of their income went towards housing costs even when receiving assistance (U.S. Department of Housing and Urban Development, 2001).

Individuals with SMI may have a difficult time managing their money. Poor money management may be due to cognitive deficits, negative symptoms (e.g., lack of initiation to pay rent), positive symptoms (e.g., delusions regarding their financial status and obligations), or substance abuse. Additional barriers to effective money management that may seem more familiar to all of us include mere laziness or forgetfulness, and wanting things we may not be able to afford. Many individuals simply lack good money-management skills.

Individuals with SMI who are receiving entitlement payments may have a representative payee assigned to help manage their funds. A representative payee may be an individual or agency that directly receives entitlement money and makes sure that the individual's basic needs are being met with this money. The Social Service Administration (SSA) and the Veterans Administration (VA) reserve the right to appoint a payee for individuals receiving SSA or VA entitlements, respectively.

Representative payeeships may be designated for as many as half of all persons who receive disability benefits for a mental disorder (Kochhart & Scott, 1995). Although payeeships can be assigned to an individual not affiliated with the treatment system (e.g., relative or close friend), many clients have the mental health agency as the assigned payee, with the practitioner most often serving in this role. In a recent study of 95 community mental health centers in Illinois (Hanrahan et al., 2002), 59% of the centers directly provided representative payee services. Of the centers providing representative payee services, 76% of the centers indicated that the practitioners served this role.

There is no due process of the law in the assignment of a representative payee; that is, agencies can easily petition Social Security to have a representative payee assigned and there is very little recourse available for the client to challenge this request. The client may write a letter of appeal to the SSA or VA if he or she disagrees with the decision to assign a representative payee or the individual chosen as the representative payee. However, it is unclear how often such appeals happen and whether clients are provided sufficient information to be aware of this appeal process. An argument made by some is that the individual does not have a *right* to this money, but does have a right to getting his basic needs met when not able to do so on his or her own. Thus, the assignment of a representative payee is intended to assure that the client's *rights* to shelter, warmth (gas), and food are being met.

Once the rent and utilities are paid, money is often used to supply food and assure that clients have adequate clothing. The remaining money, here by referred to as the discretionary funds, is then provided to the client. How these discretionary funds are disbursed varies across clients and agency cultures. The remaining total sum of discretionary funds may be provided to the client after all bills have been paid or, conversely, the client may receive allowances in various increments (e.g., daily or weekly allotments).

In keeping with the idea of client empowerment, the objectives are always to be very aware of the purpose for how discretionary funds are disbursed and constantly have an eye on the goal of increasing a client's independence with money. Conversely, paternalistic interventions and unwarranted restrictions on the client's financial autonomy should be avoided. There is concern that ACT teams could be particularly prone to paternalistic interventions due to the nature and severity of the problems of clients targeted by ACT services and the degree to which ACT teams are involved in clients' affairs. Thus, it is all the more important that ACT teams closely attend to the nature of the payee relationship and how financial decisions are made.

Ideally, once a client is in agreement that a representative payee is needed to help manage funds, the client plays an active role in deciding how the discretionary funds are disbursed. Realistically, this may not always be practical or possibly ethical. A client who takes her lump sum of $230 and goes on a crack spree and then becomes agitated the last few weeks of the month as she has little or no money for food or cigarettes can certainly be a challenge for practitioners. In a study conducted by Hanrahan et al. (2002), disbursement practices were "moderately" to "highly" contingent on avoidance of substance abuse in 71% of the programs and on treatment adherence in 55% of the programs. In other words, the frequency of payments was related to the need to increase treatment adherence and abstain from substances.

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Also, although entitlements are intended to meet basic needs, clients should have the majority of the say in how they would like these basic needs met. For instance, client and practitioner's preferences may differ between a $450 one-bedroom apartment and a smaller, less clean $300 efficiency or subsiding on bologna sandwiches and eggs most of the week, versus buying an abundance of fresh vegetables and fruits. The idea is that we play a role in helping clients see the choices available to them so that they may weigh their options, but not put ourselves in the position to decide what is best for them.

The eminent psychologist Abraham Maslow is famous for his "hierarchy of needs" triangle. At the most basic level, we have physiological needs (e.g., hunger, thirst). Next we have a need for safety (e.g., shelter), belonging and love, esteem (e.g., sense of competence and mastery), and finally, self-actualization. Traditional therapy is often focused on personal growth and meeting higher needs, whereas treatment efforts in many community mental health centers may be more focused on assuring that basic needs are met. The recovery philosophy reminds us that we, as practitioners working with the severely mentally ill, need to attend to our clients' higher needs, as well. Representative payeeships, then, may be thought of as helping clients meet these basic needs so that more growth work can be conducted. The challenge is to meet these basic needs in a way that does not detract from our other objective of facilitating client empowerment and recovery.

References

Hanrahan, P., Luchins, D. J., Savage, C., Patrick, G., Roberts, D., & Conrad, K. J. (2002). Representative payee programs for persons with mental illness in Illinois. *Psychiatric Services, 53*(2), 190-194.

Kochhart, S., & Scott, C. G. (1995). Disability patterns among SSI recipients. *Social Security Bulletin, 58*, 3-14.

Supplemental Security Income. (2001). Retrieved August 7, 2003, from http://www.ssa.gov/policy/docs/statcomps/supplement/2001/ssi.pdf

U.S. Department of Housing and Urban Development. (2001). *A Report on Worst Case Housing Needs in 1999: New Opportunity Amid Continuing Challenges, Executive summary*. Retrieved September 8, 2004, from http://www.huduser.org/publications/affhsg/wc99.htmlhttp://www.huduser.org/publications/affhsg/wc99.html

Up Close & Personal

Hello, my name is Alan McGuire. I am a research assistant and implementation monitor for the Illness Management and Recovery projects currently being conducted by Michelle Salyers and the ACT Center.

I am originally from Belpre, Ohio, which, if you have a really good map, you can find in the southwest corner of the Ohio. I did my undergraduate studies at Ohio Wesleyan University (OWU) in Delaware, OH. OWU is also where I met my wife, Shannon. We have been married for two years and have a handsome cat named Dmitri. In my free time, I enjoy waxing philosophical with friends (especially over a tasting consumable) and am an avid football fan. Go Colts!

I chose psychology as my major at OWU while thinking, "I'm sure I'll change my mind at least 10 times along the way." Instead, the more I learned about psychology the more I became interested. Then one day, I found myself filling out applications for Ph.D programs in clinical psychology. Since I had done undergraduate research on a local vocational program for people with severe mental illness, Gary Bond decided to give me a shot here at IUPUI.

Since that time I have worked on numerous projects, but I am currently enjoying learning more about helping consumers take control of their illness and progress toward more fulfilling lives through IMR. As I look toward the future, I plan on pursuing a career as a college professor and conducting research in services for people with SMI who are involved with the criminal justice system.

Freedom Matters

By Robert Reyes

My talk today is what civil rights activists used to call freedom talk or rights talk. The new prejudice is the prejudice against the mentally ill. We cannot have a great society until the mentally ill are free from the chains of intolerance, second-class exclusion, and hatred—self-hatred and hatred from a so-called compassionate society.

Power and freedom go hand in hand. You cannot have one without the other. They are inextricably woven together in a democracy. If you don't have self-determination, self-rule, self-government, or self-control, then you are not your own master—to put it plainly you are a slave to society, your government, your providers, or your family. Today do the mentally ill have social power? Do they have political power? Do they have economic power? All the answers point to an emphatic no.

We are submissive and child-like, because we don't have an equal footing. I've heard us called parasites and freeloaders. We are devoid of political freedom, social freedom, and economic freedom. Our hands and our lives of quiet desperation are empty of that most valuable of commodities—freedom.

If you watch Gone with the Wind or other old films and watch how slaves are wrongly or rightly depicted, then you will notice right away that the mentally ill show some of that embarrassing slave submission, that slave mentality, that slave attitude. I think that some—by no means not all—well-meaning providers keep the mentally ill down and make sure clients know their place.

We need to reinvent ourselves if we want a tolerant, color-blind, illness-blind society. We need to integrate and assimilate into the greater society, our neighborhood, the health-care community, and even our own family. Our mentally ill psyche must be a freedom-based psyche; and we can only do that by being more engaged, militant, and political.

Please raise your hand if you've taken your client to the supermarket. Raise your hand if you've taken your client to the doctor. Raise your hand if you've taken your client to church. Now most of you have taken your clients to the supermarket, the doctor, and to church. Now raise your hand if you've taken your client to get registered or helped your client to vote on election day.

Freedom like charity starts at home. We the mentally ill are not asking for a hand-out just a hand.

Indiana Team Attends Co-Occurring Planning Academy

By: Charles Boyle
Bureau Chief of Adults with Mental Illness
Indiana DMHA

Eighteen months ago, the DMHA made an application to SAMHSA to participate in a planning academy on dual diagnosis. That application was accepted, and we were invited to attend the "Third National SAMHSA Policy Academy on Co-Occurring Substance Abuse and Mental Disorders" in Philadelphia.

The purpose of the academy is: "To enhance the provision of co-occurring services in states and communities."

Indiana assembled a team to attend the planning academy that represented a wide range of experience and opinion. That team consisted of: David Bozell, Charles Boyle and John Viernes of DMHA; Jerry Vance of the Department of Correction; Dean Babcock of Midtown MHC; Pam McConey of Indiana NAMI; Kim Churchward of the Allen County Superior Court; John McGrew of IUPUI; Patricia Miller, Indiana Senate; Ruth Summers of the ACES project; and Lisa Suttle of Richmond State Hospital. Scott Tittle of the

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"Indiana Team . . ." cont'd from pg. 5 . . .
Governor's office is on the team but did not attend the meeting in Philadelphia.

Prior to the event, there was a two day pre-academy meeting where team members got to know each other and began the planning process by listing some strengths, weaknesses, opportunities, threats, and service gaps. At that two-day meeting, we also developed a mission statement that became the starting point of our planning at the academy.

Our plan at this point is basic, but future meetings and the addition of new planning team members will fill out the plan very quickly. At this time, the plan addresses: financing, corrections, use of primary healthcare, timely access to treatment, development of evaluation measures, and development of a comprehensive workforce.

The team wants to add representatives from Medicaid, Department of Health, faith-based organizations, Indiana Criminal Justice Institute, Higher Education Commission, health professionals, vocational rehabilitation professionals, and state offices of rural health and minority health.

The Academy included several breakout sessions in which the team members could hear from experts in various areas. This was supplemented by the team member inviting to the state sessions any presenter they thought would benefit the teams planning efforts.

Participating states included Arkansas, Delaware, Indiana, Kansas, Maryland, Montana, New York, Pennsylvania, and Rhode Island.

It was a pleasure to have a representative from DOC attending this event. We learned that there are 4,000 prisoners that are presently receiving treatment. That is a sizeable population. Those individuals will be released and in need of continuing treatment or support services.

It is the goal of the planning committee to develop a definitive picture of where Indiana is going with services for the dually diagnosed.

If the level of sight seeing is a barometer of the quality of a conference or training, then we are happy to report that no one on the Indiana team saw the Liberty Bell or Independence Hall or any other sites while those attractions were open.

Building Relationships in IMR

By: Veronica Macy, IMR Consultant/Trainer

What makes Illness Management and Recovery (IMR) different from other programs? A good number of programs have come and gone, taking with them the hope and the encouragement that people are going to get better. This has been equally disappointing and dispiriting for both the practitioners as well as the clients.

Recovery is making the difference! Recovery, one of the main goals of IMR, means sitting with and allowing people to find their voices and thus empowering them to find and define their own individualized personal recovery goals. IMR helps people regulate and maintain their own journey of recovery. And, **"Recovery is Possible."** These factual statements are offering empowerment and fulfilling goals. **Recovery** is also promoting and generating a glimmer of hope and a spark of enthusiasm for many professional and para-professionals who spend long hours with overwhelming work schedules but who are passionate and dedicated in helping individuals gain or regain some meaning in their life through IMR.

I want to introduce another core principle that is promoted and encouraged in IMR but has not had much emphasis put on it: RELATIONSHIPS**.** I believe it to be much harder to experience recovery without having and experiencing relationships. Recovery is the big "buzz" word in today's mental health system and rightly so, but there first must be a structure where recovery can be incubated, nurtured, realized and experienced by the "client's relationships."

Relationships between practitioners and clients across all service systems need to be defined and identified too. And it will be best if it is understood, accepted and practiced by the practitioners first. It is in the building of a trusting relationship that the client's eyes and heart will be opened to recovery. For most clients, relationships do not appear to be present, or they exist but are unhealthy. And for the most part clients are skeptical, uninterested and appear distant or not motivated for relationships. And perhaps this relationship building is new to the IMR practitioners as well.

You can start your relationship in your first session, the Orientation Session (Appendix 1 in the IMR Workbook). If you feel that you have more time to spend

together with your client, you can start with your second intervention tool (Appendix 2) the Knowledge and Skills Inventory (KSI). This inventory will give you an even greater opportunity in developing your relationship. And remember, the number of sessions you use with a client doesn't matter. The idea is to take as much time as you and/or your client needs to feel comfortable with what you have just completed. The Orientation Session and the KSI are essential for starting to build the foundation for future sessions and, most importantly, for building your relationships together.

Many practitioners have reported that they did not feel the inventory was necessary, that it didn't take much time before both they and the client became stuck, decided to try the inventory, completed it and learned significantly from it. Using the KSI has many advantages and opens many possibilities. No matter how long you have known the client, it will be beneficial for both the practitioner and the client to complete the inventory.

The KSI is helpful in the following ways:

(1) Increases your understanding of the person's life experiences (keep it positive), both their present and their past experiences, including their strengths and their challenges.

(2) Gives opportunity in create a non-suspicious, non-judgmental, and comfortable setting where a mutual and collaborative relationship can develop. This may be the only chance you will get with some of the clients. Some have started working with IMR in the client's home or over a soda at some fast food restaurant. Be creative and step outside of your box.

(3) Showing that IMR is a different kind of program, one where the client works in a partnership with you the practitioner. Let them know that they are viewed as the expert in their illness and that their voice does count.

Change is possible, and most all clients are capable of implementing that change. IMR's KSI can be used as the stimulus that will start the collaborative relationship that will start the recovery process. Clients need to hear and feel that making changes in their lives is possible. Part of your job is making sure the client hears and feels that they are competent and capable of accomplishing the changes that they want and need.

You will want to ask the questions in a conversational style, or you may want to use your own questioning style as long as you keep to the inventory's main points. They will help you understand your client better and will also help them to identify their own personal recovery goals. There are 9 topic areas that are opened up for discussion in the KSI with numerous sample probes. Do not feel that all the questions within the 9 topic areas need to be asked. Ask the questions as you would talk to a friend whom you haven't seen in years. In a sense, you are asking, "What have you been doing with your life, and what's gone on." Of course, the answers to those questions will not be answered during the inventory, but it will be a start. And remember you can go back to the inventory any time you feel it is necessary.

Let the client know that there is no right or wrong answers, nor are the answers seen as good or bad. Like a team of detectives, a genuine partnership, both the practitioner and client are gathering and gleaning information within the bounds of a safe and friendly atmosphere, forming a memorable and important bond and relationship, which can change the life of both client and practitioner.

Using the acronym **RECOVERY** will highlight and give some key points to help you remember and understand how best to use this inventory:

Respect Respect must be the first and most prominent characteristic you communicate and impart. You do this by actively listening to every word the client says, the successful goals and accomplishments, as well as the missteps and disappointments. Because of trials and tribulations, many clients have become demoralized and stigmatized by society, the mental health system, and even by themselves. A good start to recovery is the client's mere presence at the session and his/her willingness and courage to share private information, which deserves your deepest respect.

Empathy Sharing in the clients' experiences is critical. This involves seeing the world through the client's eyes, thinking about things as the client thinks about things, feeling things as the client feels them. When clients feel that they are understood, they open up even more.

Communication This may be the most important part of the inventory for you as the practitioner. How you communicate will show and reflect if you are genuine, forced and artificial or if you are really interested in them. Your ability to be an active listener with a non-judgmental attitude is a must. Allowing the client to shape the

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conversation will show your unconditional concern for them. You are there to facilitate and record the communications. It's not about you; what the client thinks is of prime importance –it's all about collaboration.

Opportunity Having the opportunity to stop, look back, share, reorganize and regroup ones life with no other purpose than to be heard and cared for may be the first experience for some clients. Routine questions to them have always been centered on their illness and failures and not on any strengths or successes of the past or present.

Validation Validating a person's reality and his or her personhood creates a trusting situation. Just having the opportunity to voice their experiences without any consequences gives substantial support to individuals, who, for the most part, have received very little in the mental health system.

Equality Knowing that you are not the only person going through life with a mental illness can generate the attitude of "I want to try this out too." Giving your client a sense of fitting in and a feeling of normality regarding their illness is a good life-affirming, recovery-oriented strategy and approach you can offer.

Resiliency Is a power that almost every client has and uses. If they did not, they would not probably be with you right now. This ability to bounce back after horrifying and probably long-term experiences must be viewed and affirmed back to the client as their strength and a positive quality that they posses. Helping the client to see and understand how successful they have been in life can be viewed as a primary and major step in their recovery process.

You This is one of the most important main beliefs you can leave with the client. "You are responsible for your recovery process. Your recovery will depend on your self-determination and your commitment to your wellness. I will help you learn what you need and will show you how to do it, if you need it, but, you will be responsible for your recovery. We will build a safe and non-judgmental, and trusting relationship to start you off on your maiden journey of recovery."