ACT Center of Indiana

Excellence in Training, Research, and Technical Assistance

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Notes from the Directors

Co-Directors

Michelle Salyers & Mike McKasson

Although a little late, this issue of our newsletter is very timely. As I write this introduction, I am attending a meeting to discuss how to measure recovery in mental health services. We spent the day discussing what recovery means and how to best measure these constructs. We also had some discussion on whether (and how) evidence-based practices support recovery.

We at the ACT Center believe that (when done well) evidence-based practices do promote recovery . . . all of them are aimed at helping consumers become better integrated into their communities. High quality evidence-based practices can also help instill hope for a better future and help consumers be better able to manage their own lives and pursue meaningful activities. These goals are consistent with the vision described in the President's New Freedom Commission on Mental Health on how to transform the mental health system.

Tim's article (see page 2) describes the transformation to a recovery orientation in one form of evidence-based practices – Illness Management and Recovery. Gary's article (see pages 3 & 4) does the same but for another evidence-based practice – Supported Employment. Although describing two different types of mental health services, the connecting thread is recovery – how these practices help consumers gain greater control and personal responsibility for their own lives, gain hope, and find meaning and purpose. We have made a commitment to help providers implement practices that work and look forward to continuing to support recovery through our research and training.

- Michelle

In this issue...

By Tim Stultz, Ph.D., HSPP
IMR Consultant/Trainer

Model Transformation:
From Illness Management to Illness Management and Recovery

Illness Management Recovery (IMR) is one of the six toolkits for evidence-based practices (EBPs). Components of IMR are supported by rigorous research on a target population. The IMR program has a treatment manual and a fidelity scale. All that sounds great, but what I like about it is that it is based on a radical principle that demands a paradigm shift from "Illness Management" to "Recovery." Not all of the evidence-based practices require this shift, yet it is extremely important, especially to consumers and providers. To get a better understanding of this issue, let's look at a brief history of traditional treatment.

Historically, the Medical Model has been the most prevalent model in mental health, viewing the disease state as a stemming from a chemical imbalance or physical abnormality. Treatment is provided by an expert, and the outcome is either a "cure" or the decrease in symptoms. Given that the Medical Model did not view Mental Illness as a disease that could be "cured," "patients" were often told that their "disorder" was a life long, chronic, progressive disease, and the best that they could hope for was control of their symptoms. One of the outcomes of this view was that the person became their illness; it was the illness that defined him or her by both the system of care and society. At its worst, the system promoted by the Medical Model led to discriminatory practice, paternalism, loss of hope, coercion, and the focus on medication management as the primary intervention with the goal of symptom reduction. Even at its best, the Medical Model did little to foster empowerment and active involvement. Consequently, folks that did well in that model remained dependent on the system of care and accepted their meager lot in life. To paraphrase Judi Chamberlin from the National Empowerment Center, compliance may help you maneuver within the system, but it will not help you to recover and move outside the system.

In the 1960's and '70's, notable "liberationists" who called themselves "exconsumers"/"survivors" began to form groups. They focused on empowerment, consumer choice, self-advocacy, self-management and hope. After much time, the federal government supported such groups financially and ultimately mandated that consumers should have a voice in the planning of services. The movement has gown and has been validated most recently by the Presidents New Freedom Commission on Mental Health by specifying that "Mental Health Care Is Consumer & Family Driven." While it is too cumbersome to document the consumer movement in this article, let it be said that if it were not for that movement, I do not believe we would be talking today about "**RECOVERY**." Truly, consumers had an important hand in the development of Illness Management and Recovery as an evidence-based practice.

The premise behind Illness Management and Recovery (IMR) is that people with mental illness are more than their diagnosis/illness. They are people who love and want to be loved, who want to work and have a family, own a car and home, and to live and participate in their community. How strange is it that our systems of care often do not support such a vision? In IMR, the person develops their own list of goals, whatever they may be, and it is these goals that are the focus of treatment. Forget the idea of "individualized treatment plans," **this is "personalized treatment" at its best!** Interestingly, the content areas found in IMR may sound very familiar: Recovery Strategies; Facts About Mental Illness; Stress-vulnerability Model; Building Social Support; Using Medications Effectively; Reducing Relapses; Coping with Stress; Coping with Symptom & Other Problems; Getting Your Needs met in the Mental Health System. These topics are not too different from what we already provide consumers. However, what we do not often provide is an **equal partnership** in the program with the consumer having the leading voice in goal development.

The research shows us that consumers are more willing to work on **their own** goals, imagine that! Apparently, they are not too different from the rest of us after all. What the data says is that consumers who work toward "life" goals are more likely to also reduce symptoms and have fewer relapses or rehospitalizations. They are also less likely to remain dependent on our systems of care.

I believe that hope is the most important ingredient to recovery. Nothing builds hope as quickly as empowerment, and nothing builds empowerment as quickly as having a say in your life and working toward your own personal goal. That is what ILLNESS MANAGEMENT AND RECOVERY is all about. As such, it provides us a model for transformation.

Replacing Day Treatment with Supported Employment

Gary R. Bond, Ph.D., Research & Program Evaluation

Do our mental health services foster autonomy, or do they foster dependency? Autonomy involves having options and making informed choices about life, including where to live, how to spend time, whether to work and where to work, and who to associate with. Autonomy also means progression toward decreased dependence on mental health treatment. In this essay, I will be contrasting supported employment with day treatment, summarizing the research showing that day treatment programs can be closed down and replaced with supported employment teams.

Day Treatment

The everyday reality for many consumers with SMI includes oppressive routines characterized by boredom, loneliness, and isolation. For some consumers, sleep is an escape, with the number of hours spent sleeping exceeding that in the general population by an average of 1.5 hours a day (Krupa, McLean, Eastabrook, Bonham, & Baksh, 2003). Waking hours are dominated by "passive leisure" - e.g., sitting alone smoking cigarettes or watching television. To provide "daily structure" for individuals with SMI, many mental health centers encourage (or require) consumers to attend some form of day treatment. There are many variations of day treatment in the U.S. and elsewhere; they include partial hospitalization, day care, and "rehabilitative day treatment." The content of such programs vary widely, but many include skills training, group recreational activities, and arts and crafts.

Day treatment was originally conceived as a short-term alternative to hospitalization; early studies showed that day treatment programs reduced psychiatric hospitalization days. Day treatment is now widely used in the U.S. as a long-term treatment option, in large part because it is reimbursed through Medicaid. However, there is no evidence of any rehabilitation benefits to long-term day treatment for consumers with SMI (Marshall et al., 2001). Day treatment does not foster independence. Nor does it increase competitive employment, independent living, or social networks outside the day treatment program.

Supported Employment

Most individuals with SMI say they would like to work in competitive employment, defined as jobs that anyone can apply for, in regular places of community employment, and that pay at least minimum wage. Surveys show, however, that less than 15% of consumers are competitively employed. For ACT teams in Indiana, the current competitive employment rate is 10%. However, many practitioners do not believe that people with SMI can work or that they want to work.

Supported employment is an individualized approach to helping consumers get and keep competitive jobs that fit each individual's goals, preferences, strengths and abilities (Becker & Drake, 2003). Supported employment is effective when vocational services are integrated completely with mental health services. This integration supports a holistic approach to providing information and services to support the needs of each individual consumer. Integrated services require that employment specialists are active and equal partners with mental health practitioners on each consumer's mental health treatment team. This provides the most effective mechanism for collaboration to identify good job matches and appropriate supports for each consumer. (All of these principles, of course, are closely aligned with the ACT model.)

How supported employment fosters autonomy. The principles of supported employment directly support consumer autonomy in several ways: First, supported employment is based on the principle that all consumers who want to work are entitled to an opportunity to work, regardless of their psychiatric symptoms, substance abuse, or work history. Second, supported employment is an individualized approach in which consumers are assisted to find jobs that suit their preferences, strengths, and capabilities. Third, supported employment involves an active role for case managers in the vocational process, to help identify possible jobs and to help consumers manage their symptoms in order to succeed in the work place. Supported employment enlarges the case manager-consumer relationship to include a focus on what is needed to succeed in the world of work, often involving a shift in the justification for behavioral changes (e.g., improving your hygiene and how you dress will help you succeed in the job interview; if you come to work drunk, you will lose your job). Rather than case managers seeking to control consumers to behave appropriately, work may serve as the incentive to change. Fourth, supported employment aims at building the "natural" social network (including supervisors, co-workers, family members, and friends) as a way to foster long-term tenure in the work place and reduce dependency on treatment staff.

Day treatment conversion studies. Four studies have examined the consequences of replacing day treatment programs with supported employment. These studies examined day treatment programs in 6 mental health centers converting to supported employment and 3 comparison sites not changing their day treatment services. In every case, centers converting to supported employment programs showed a substantial increase in competitive employment rates, while the control sites did not. On average, then, the percentage of consumers obtaining competitive jobs nearly tripled (from 13% to 38%) after conversion of day treatment to supported employment, while competitive

pg. 3

(Cont'd pg. 4)

employment rates in nonconverting sites remained virtually static (12% before and 15% after) (Bond, 2004).

No negative outcomes were reported in any of these studies, except a small minority of consumers who reported missing the social contact they received in day treatment. Centers converting to supported employment met with overwhelmingly favorable reactions from consumers, family members, and mental health practitioners. What about consumers who did not gain employment when the day treatment programs closed down? They became more involved with their communities - spent time in their community centers, restaurants, parks, health clubs, out in contact with citizens of the community.

In one study, consumers who benefited the most from the conversion to supported employment were regular attenders of day treatment! *This finding suggests that day treatment may be stifling autonomy among consumers who are most cooperative.* In a second study, the consumers in the day treatment program that was closed down had been originally referred because they "had no rehabilitation potential." They had averaged over 8 years of attendance and none had any recent employment. *This finding suggests that consumers are sometimes written off by practitioners who misjudge the consumers' potential for independence.*

When these studies were first published, some readers hypothesized that because consumers had often been enrolled for years in day treatment prior to a conversion, they were better prepared to enter the work force. However, after the closure of one day treatment program, new admissions directly referred to the supported employment program (in other words, consumers who previously would have gone into day treatment) increased their rate of competitive employment to over 50% even more rapidly than former day treatment consumers. *There is no evidence that attendance in day treatment is a useful strategy for preparing consumers for competitive employment.*

Impact of competitive employment on consumer autonomy

- *When consumers work in competitive employment, it changes how others see them.* One study found that consumers were viewed as more competent when they were observed in community employment than when they were observed in a work readiness program.

- *When consumers work in competitive employment, it changes how they view themselves.* When consumers become employed, the change in role status leads to a reinterpretation of their identity to incorporate a more positive self-image. Several studies have shown that working in competitive employment leads to increased self-esteem, improved quality of life, and a greater sense of mastery. These changes seem to be cumulative over time (Bond et al., 2001).

- *Working in competitive employment improves consumers' economic independence.* This point is obvious; it is more complicated than it might appear at first glance because of the disincentives in the disability payment systems found in most countries. Nonetheless, one of the major advantages of working is that consumers have more discretionary money at their disposal.

- *Working in competitive employment decreases use of day treatment and other mental health services.* If one indicator of increased consumer autonomy is reduced involvement with the mental health service system, then it is encouraging that some studies suggests that this occurs for consumers who obtain competitive employment. However, research also suggests that continued involvement by mental health professionals over the long term is important for maintaining job; continued contact with professionals complements active involvement of community social networks.

- *Working provides meaningful daytime activity to combat boredom and isolation.* Some experts suggest that the structure provided by the routine of working and by the work environment help combat symptoms.

- *Working provides opportunities to develop alternative social networks outside the mental health community.*

Conclusion

Consumer autonomy is far more evident in mental health centers that have made employment as a central focus of services. Introducing supported employment into a mental health center, especially when it involves the elimination of day treatment, leads to a transformation of the roles of practitioners and of consumers.

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Innovative Team Interventions

By: Jane Williams, Ph.D.
Research and Program Evaluation

This is the first, of what we hope will be many, short descriptions of interesting and innovative techniques that team leaders and teams use to improve their functioning and ultimately outcomes for consumers. We hope this column will be a place that practitioners share ideas with each other about how to do your work more easily, more effectively, and with more fun. If you have an idea that you think others might like to try, please let us know.

One of the hallmarks of the ACT approach is the daily meeting to discuss the team's caseload and daily activities. One of the challenges of this meeting, for many if not all teams, is to keep the conversation focused and targeted on the consumers and to complete the caseload review within the allotted meeting time. For many teams, this meeting can become a source of frustration. Leslie Bissell, Team Leader for the Hamilton Center ACT Team, has recently shared with us her team's solution to this problem.

The Hamilton Center ACT Team recognized that they were expecting their team leader, Leslie, to hold the responsibility for morning meeting management. They relied on her to prod the conversation along and make sure that conversation was kept focused. Leslie states that, "I think I was holding on to the role of the one responsible for moving things along too often and as a result was the target for more team frustration than necessary. Once I realized that the team saw me in this role and was also willing to take it on in my absence (such as on days when I was on vacation), I made the conscious decision to give this responsibility back to the team."

She decided to adopt a new team member, named "Moovalong." Moovalong is a small stuffed cow that was purchased at the local dollar store. Moovalong sits in the center of the table during morning meetings. Everyone knows that his presence is meant to help focus the team on the purpose of the morning meeting. "Custody" for Moovalong rotates through the team, so that responsibility for keeping the meeting going is shared amongst the team members.

The team's response to Moovalong and the effect on morning meetings have both been positive. The team reports that having Moovalong on the table as a visible reminder to keep things moving helps them self monitor what they are reporting. They also reported that it helps take the pressure off it being any particular person's "fault" for prompting the meeting to move along. They can collectively blame the cow instead of making it personal. The team reports that they are also getting more out of their morning meetings, are able to be more relaxed and yet be able to communicate needs and concerns more clearly.

Leslie states that, "As a team leader this (*having Moovalong*) has lifted quite a burden from me as well. Having Moovalong also helps me give up this responsibility and helps me rely on the team more often too. Overall it seems that the team has embraced this addition to our morning meetings. Although the initial response from the team was slightly resistant or thinking that the cow was silly, the result has been nothing but positive. With 50 consumers, we are routinely reviewing each and coordinating services to be provided that day within 30 minutes. As a result, we have at least 30 minutes to staff difficult cases more often. We are laughing more now, communicating more openly and intentionally. We are taking more risks, asking more questions, and as a result, I believe the consumers are receiving even better service."

Up Close & Personal

Meet a Couple of Our Administrative Research Assistants!

Bob Reyes

&

Hello, my name is Bob Reyes. I am a data entry worker at the ACT Center and have been at this position for about a year and a half, the best and most meaningful job I've had, mainly because of the committed, intelligent people I work with.

I am from a small coastal town, Cagayan, in the Philippines - the Pearl of the Orient they call it. Then when I was four, my family moved to the cooler clime of Canada and stayed there four years. What I remember from Canada: the snow was over my head and that I received my first kiss besides my mother from a demonstrative French teacher for answering a question correctly.

At the end of the sixties and the start of a new decade, we moved to Schenectady, New York - new decade, new country, new beginning, the start of my American journey. I was struck right away by how friendlier Americans were than Canadians, the way they reached out to you, made you feel at home, their tolerance and good humor.

After two years in New York, we went to the heartland, Indiana, and I've been stuck here ever since - just kidding. At IUPUI, I majored in psychology and got a degree.

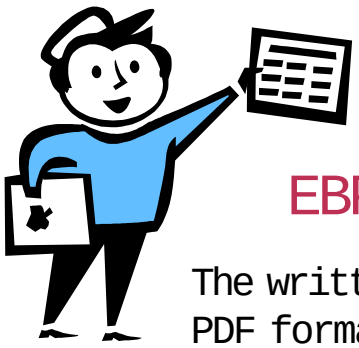
I suffer from what was once called an emotional illness. As a matter of preference, I like the term emotionally challenged rather than mental illness, disability, or brain disease. Every day can be a struggle akin to the struggle of apartheid or the struggle of our American forefathers, the quest for freedom, which was part of a title of a book by the preeminent psychologist B.F. Skinner, free from fear and the terror of not knowing who you really are. On this recent 9-11 anniversary, I am reminded by the quiet heroism of the ACT family and emotionally challenged Americans that this country allows you to be free and permits you to be whoever you want to be.

Dawn Shimp

Hi, my name is Dawn Shimp. I'm an Administrative Research Assistant at the ACT Center of Indiana. I started working at the ACT Center in August 2003 part-time. I do data entry of research information, keep Endnote files updated, transcribe tapes of interviews, and help with any clerical jobs that need done.

I was diagnosed with Schizoaffective Disorder in May of 1999. I love working at the ACT Center. The people here are very understandable when it comes to my diagnosis. I feel like I'm making a real contribution towards helping others like me with their mental illnesses.

My pride and joy is my 21 year old daughter, Jami Schwarzwalder, who was married in May 2004. She will be graduating in the Spring 2005 from Butler University with a degree in Elementary Education. She intends to be a School Librarian which requires 2 more years of education in Library Sciences.



"Hear Ye, Hear Ye: Read All About It!"

EBP Toolkits now available on the web

The written materials from the EBP Toolkits are now available in PDF format for downloading from the SAMHSA website. Go to ...

www.mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits

SAMHSA hopes it will only be a few more weeks before the printed versions with videos are available.

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PATHWAYS COOKBOOK

The cookbook is the second completed by Pathways Clubhouse. It is titled "Home Cookin' with Pathways II." The cookbook was completed and assembled by the members of Pathways Clubhouse, a program sponsored by Adult & Child Center, Inc. Pathways serves clients with severe mental illness and provides experiences for members through structure, various activities, and utilizing personal abilities.

The cookbook costs $10.00. Those interested can contact Pathways via e-mail at pathwaysclubhouse@netzero.net or by calling Pathways Clubhouse directly at (317) 882-3699, ask for Jeremy or Donna. Checks can be made out to "Pathways Clubhouse."

Pathways
3841 S. Emerson Ave.
Indpls., IN 46203

Pathways also caters! Call for more details.

We encourage you to let us know how we can continue to provide you with excellent, quality service and care.

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To change your subscription to the ACT Center of Indiana quarterly newsletter, contact Veronica Pedrick at vpedrick@iupui.edu or (317) 274-6735. Newsletter created, designed, & edited by Veronica Pedrick.

ACT CENTER OF INDIANA
SEEKING ACT CONSULTANT & TRAINER

The ACT Center of Indiana is now accepting applications for an ACT Consultant/Trainer. Salary and benefits are competitive with other university settings and based on education and experience. Position based out of IUPUI Department of Psychology in downtown Indianapolis, Indiana.

Job Description

- Provide initial and ongoing training and consultation on the ACT model to new and existing ACT teams in Indiana. This is done via various media and communication modes – face-to-face, phone, email, didactic presentations, interactive practice exercises, shadowing ACT staff "in action," advocating for teams at various stakeholder levels.
- Consultation in areas of implementing ACT including planning the implementation process with administrators and site steering committees, certification process, admission criteria, outcome monitoring.
- Liaison between ACT teams and the ACT Center/DMHA.
- Participate in monthly conference calls and quarterly regional meetings for ACT team leaders.
- Complete fidelity visits and reports on ACT teams.
- Consultation and training for ACT teams or technical assistance centers outside of Indiana (as needed).
- Occasional presentations to various stakeholder groups in the state (e.g., DMHA, NAMI, etc.).
- Opportunities to present at and attend state and national conferences related to ACT and EBPs.

Important Skills/Qualities

- Recovery orientation and belief in the importance of research to guide practice
- Knowledge of the ACT model and direct experience on an ACT team
- Teaching abilities (ability to make formal presentations as well as working one-on-one with staff)
- Flexibility, time management skills, and self-starter
- Interpersonal skills (engaging and empathetic, open and willing to learn, clear communication, team player)
- Writing and research skills are a plus

Apply by sending letter and resume/vitae OR for more information, contact:

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