

ACT Center of Indiana

Excellence in Training, Research, and Technical Assistance

July 2004

Volume 3 ❖ Issue 3

NoTeS fRoM tHe DiReCtOrS

Co-Directors

Michelle Salyers & Mike McKasson



As we are beginning the summer, we are expecting a very busy and exciting time for evidence-based practices (EBPs) in Indiana!

The special Medicaid Assertive Community Treatment (ACT) rate has been implemented (see Indiana Division of Mental Health and Addiction's Medicaid Liaison Katy Howard's article in this issue, pg. 3). Certified ACT programs can now bill a special rate for ACT services, if certain conditions are met. This financial incentive will help support ACT programs for planning, coordination, and training. We have been getting numerous requests and are looking forward to the challenge of helping more programs implement high-quality, recovery-focused ACT teams.

Illness Management and Recovery (IMR) is also growing. On page 3 (cont'd pg. 5), we report on the preliminary results of a pilot study to integrate IMR and ACT. This has been a very successful program, and we are excited by the positive reports of consumers and ACT staff. In our two new grant-funded IMR projects, two of the programs have received

initial IMR training, and three others will be trained later this summer.

Integrated Dual Disorders Treatment (IDDT) - Through the Governor's office and the Indiana Division of Mental Health and Addiction, the state submitted an application for a SAMHSA-funded Co-Occurring Systems Integration Grant (COSIG). This grant would build an infrastructure to help implement and support integrated treatment for consumers with mental illness and substance use disorders. The ACT Center has been working hard to help lay ground work for the success of IDDT in Indiana with our SAMHSA-funded Phase I Community Action Grant in which we sought to build consensus and now our Phase II Community Action Grant where we are currently piloting IDDT in two new centers.

Supported Employment (SE) - We began collaborative training with the Supported Employment Consultation & Training (S.E.C.T.) Center to enhance SE in ACT programs. This group of ACT teams is receiving training on the evidence-based principles of SE.

Family Psychoeducation - Hea-Won Kim recently completed a needs assessment of mental health centers in Indiana. See page 7 for a brief summary. The full report will be available on our website soon.

Our ACT Center family is also growing. Congratulations are due to several of our staff members. Lia Hicks, one of our ACT Consultant/Trainers, recently had a healthy baby girl (Emma). Lorna Moser and Natalie DeLuca, Implementation Monitors for research and program evaluation, both got married in the past couple of months. Also, we are working on hiring a new ACT Trainer to help meet our growing needs (see job posting on pg. 4), and we hope to be able to introduce this newcomer in our next issue.

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INTRODUCING . . . Indiana Division of Mental Health & Addiction's Katy Howard!



Hi! I am Katy, DMHA's Deputy Director for Revenue Enhancement and Data, known by some as MediKaty (thank you, Charlie). In my role as Deputy Director, I am responsible for the management and oversight of policies and procedures of several exciting programs and areas: MRO, Mental Health Funds Recovery, the Medicaid 1915(c) Waiver for Children with SED, community data functions, and grant projects. The Revenue Enhancement Team has recently seen two years of work come to fruition with the approval of the State Plan Amendment to add ACT to Indiana Medicaid as a new covered service. Although there remain many details to consider, providers are now being reimbursed for ACT Services through Medicaid.

Developing the ACT State Plan Amendment was a very challenging and exciting process. I am looking forward to monitoring the utilization data and researching methods of improving our reimbursement and service coverage. The success of ACT will pave the way for the addition of other evidenced-based practices to our State Plan.

When I am not focused on DMHA's revenue and data projects, you can usually find me on the way to doggy daycare or the bark park with the canine loves of my life, Charley and Chile. (If they could talk, they would be spendown experts!) I spend a lot of my spare time throwing tennis balls, reading, thinking about finishing the sleeves on a sweater I started knitting two years ago, and saying "Charley, get off the counters" or "Chile, please do not chase the cat."



We're celebrating 3 years!



How time flies! The ACT Center of Indiana, established in July 2001, is going into its 4th year of existence. A big THANK YOU to all who have helped make our work rewarding & successful. We look forward to many more years providing you with quality training, research, & technical assistance for evidence-based practices (EBPs).

Thank you from all of us . . .

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As we continue to grow, please continue to let us know how we can provide you with the best service and care to meet your EBP needs. Call us at (317) 274-6735, email vpedrick@iupui.edu, or visit us at

ACHIEVING MEDICAID COVERAGE OF ACT IN INDIANA

An Update from Katy Howard, DMHA

It took two years, a lot of negotiating, and a strong commitment to our goal to achieve the addition of Assertive Community Treatment Service to our Medicaid State Plan, but we finally did it! The Centers for Medicare and Medicaid Services approved the retroactive State Plan on April 26, 2004. Our implementation of Medicaid ACT is paving the way for coverage of additional evidence-based practices under the Medicaid Rehabilitation Option.

There are many resources available to ACT Teams and providers who are considering creating ACT Teams that meet the Medicaid reimbursement rules. Here is a list of 3 useful resources:

* The DMHA ACT Team Certification Rule is at 440 IAC 5.2. (Go to www.in.gov/legislative/iac and click on TITLE 440 DIVISION OF MENTAL HEALTH AND ADDICTION. Open Article 5.2.)

* The Medicaid ACT Coverage Rule is at 405 IAC 5-21-8. (Go to www.in.gov/legislative/iac and click on TITLE 405 OFFICE OF THE SECRETARY OF FAMILY AND SOCIAL SERVICES. Open Article 5 and scroll down to 5-21-8.)

* The Medicaid Provider Bulletin on ACT Coverage is BT200413 and can be found at www.indianamedicaid.com along with a wealth of additional Medicaid information. (Click on "Bulletin List" under "Publications" in the menu on the right.)

The Revenue Enhancement Team at DMHA is working with OMPP and its contractors daily to address providers' concerns about service requirements, billing procedures, and policy clarifications. It is important to us that we are a good partner in creating the best ACT Program for each provider.

We look forward to sharing data with the provider community in August about our ACT billings to date. In the meantime, keep the questions and ideas coming to the ACT Center!



Update of the Real Systems Change Mini Grant Project Critical Ingredients of Consumer-Driven Practice: Integrating IMR, Peer Support Specialists, & ACT

By: Lia Hicks, ACT Consultant/Trainer,
Michelle Salyers, Co-Director,
Heather Baumgardner, Adult & Child ACT Team Leader
& Hea-Won Kim, ACT Consultant/Trainer

Adult & Child Center, a community mental health center in Indianapolis, Indiana, recently completed the 9-month evaluation of their state-funded project to integrate illness management and recovery onto their ACT team. As we described in an earlier issue ("New Horizons: Illness Management and Recovery," April 2003, v. 2 i. 2), Adult & Child was awarded a Governor's Council grant to encourage systems change. In July 2003, they hired a peer specialist, Karen Ring, to join the ACT team. She was trained by Veronica Macy to implement IMR, a structured curriculum to teach individuals who have psychiatric disorders how to manage their symptoms, encourage them to realize their potential, and to move towards their goals and lifelong recovery. The curriculum includes 9 modules, with weekly sessions over a 3-6 month period.

Prior to beginning the IMR program (and after completion), consumers completed a knowledge scale and a recovery beliefs scale to examine changes in key outcomes. At the end of the reporting period, only 4 consumers had completed the entire IMR curriculum. This was not a large enough group to examine statistical significance in change over time. For the four people with pre and post data, the average recovery belief score increased from 3.5 to 4.1 (on a 5-point scale). The average scores on the knowledge test were 89.7% correct at baseline and 91.9% correct after the program. In addition to the consumer surveys, we conducted a semi-structured interview of 14 consumers participating in IMR and 16 ACT team staff. Here we highlight some of the major findings from these interviews.

What was most helpful about the program?

Although IMR was designed to be used by professionals, the majority (87.5%) of the staff spontaneously mentioned that the most helpful factor in the program was having a consumer provider. Several mentioned her skills, as well as the ability to establish rapport on the basis of shared personal experiences and the ability to inspire other consumers. Many (56.3%) also mentioned aspects specific to IMR, including the

(Cont'd pg. 5 . . .)

ACT CENTER JOB OPENING

- Consultant & Trainer for ACT -

The ACT Center of Indiana, a collaboration of the Department of Psychology at Indiana University-Purdue University Indianapolis (IUPUI) and the Adult & Child Center of Indianapolis, is a technical assistance center funded by Indiana Division of Mental Health and Addiction (DMHA) to help support initiatives to bring evidence-based practices (EBPs) like Assertive Community Treatment (ACT) to Indiana. Our approach is to combine training and implementation with ongoing program evaluation and research. We not only provide resources and other materials but also apply a hands-on, systematic approach to helping service providers implement EBPs throughout the state. Our organization enjoys an excellent reputation and growing credibility for providing progressive, quality training, consultation, research, and technical assistance.

Applications are now being accepted 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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focus on illness management, goal setting, and the structure of the program. Overall, several (31.3%) mentioned hope and motivation as the most important part of the program. The overall positive impact and inspirational nature of the program can be summed up by one staff member’s response: “In 15 years, this is the first new thing that’s made a huge impact. The key is having consumer as the clinician, and she brings hope to the clients.”

Consumers mentioned aspects of IMR, particularly illness management (57.1%), including knowledge, coping, relapse prevention, and medications. Many consumers reported that the focus on goals and personal interests (35.7%) and the structure of IMR (35.7%) were most helpful aspects of the program. Several also mentioned social support and interpersonal skills (28.6%). Many mentioned the consumer provider (42.9%). For example, “She’s gone through same thing. I can relate to her better. If she can do it, why can’t I do it?”

What was least helpful about the program?

The vast majority of the staff (81.3%) responded “Nothing/don’t know” to this question. Two comments were specific to IMR (repetitious and need more information). Some staff offered suggestions for improvement, including better integration with ACT (by learning more about IMR and knowing better where clients are and how to help). Some mentioned wanting to expand the program (18.8%), and another suggestion was to add a peer support component (e.g., with “graduates” of the program working with each other or other consumers). As with staff, many consumers also responded “Nothing/don’t know” (50.0%) when asked about the least helpful parts. Three (21.4%) reported that the program was long and/or repetitious.

What is it like working with a consumer provider?

When asked what it was like working with a consumer as an IMR recovery specialist, all staff had positive responses. The majority of staff (87.5%) described the new perspective and insights they are learning with a consumer on the team. For example, she can “point out when we fall into parental/protective role . . . when we are not being recovery focused.” Many also commented on the attitudes and philosophy the consumer specialist brings to the team (43.8%), particularly optimism and belief in recovery. Many described Karen’s skills and attributes that contribute to her success. Similar to staff, consumers also felt that the perspective and personal experience a consumer brings are important (57.1%), particularly in terms of engagement. For example, “Karen can relate because she has been through it.” Many consumers also reported that Karen’s optimism and positive attitudes are important (71.4%) — “She told me that I have potential. It’s encouraging.”

What has been the biggest change?

The major changes that staff members have seen as a result of the program are increased consumer confidence and trying new things (50.0%), particularly in participating in meaningful activities (43.8%). Several staff mentioned examples of consumers who have now started volunteer positions, being more active in their communities (e.g., church), and one who

initiated and ran a talent show. Staff also reported that consumers are managing their illness better (37.5%). Several also focused on the motivational changes such as increased hope and belief in recovery (37.5%). Regarding a particular success story, a staff member noted that the IMR program has been successful in “getting him involved back in life basically.” Staff also discussed the broader impact of IMR on the team itself. For example, “The hope we are giving clients now. The idea is yes, you have mental illness, but there are ways to move beyond, manage it. Big change in way we think and clients’ ideas - that there’s hope beyond the illness. Gives us hope, too.”

The most frequently mentioned biggest change noted by consumers was in their level of motivation and hope (64.3%). “Being able to know somebody has mental illness and can get a job. I feel like I can get a job maybe not right away, but down the road.” Several also mentioned specific examples of being more involved in meaningful activities (35.7%) including volunteer positions, church involvement, and pursuing hobbies and education. Many also mentioned managing their illness better (28.6%) and improved relationships (21.4%).

General Summary of Impact

Overall, consumers in IMR are reporting a great deal of success and satisfaction with the addition of this evidence-based practice to the ACT team. Additionally, the ACT team has also grown as clinicians with the addition of a peer specialist to the team. The peer recovery specialist position in combination with the IMR curriculum has helped to move the ACT team to practicing with a true recovery orientation. This has helped many consumers participate in meaningful activities and to report greater hope and confidence.

Although the mini-grant project is ending, Adult & Child is continuing and expanding the IMR program. Their goal is that over time, all consumers will have the opportunity and desire to utilize the IMR curriculum as part of their recovery and treatment. IMR is gradually being integrated throughout the agency. For example, the current peer specialist is an active advisory board member, speaks to a variety of stakeholders, and provides an orientation to IMR for new staff and visitors of the ACT program. Over the next year, Adult & Child also plans to hire additional consumer recovery specialists onto other teams and programs within the center.

This project has helped to further evolve the overall culture of the agency; moving them even further away from a medical deficit model/focus to an agency that practices with consumers’ recovery and personal goals’ at the core of all services and practices. Lastly, Adult & Child can’t emphasize enough how pleased they are that consumers have been and continue to be able to realize a greater level of recovery through the addition of this program. We are looking forward to continuing to help others integrate IMR.



Visit Us on the Web
www.psych.iupui.edu/ACTCenter
Check it out!

Up Close & Personal



...with Hea-Won Kim **ACT Consultant & Trainer**

Hello, my name is Hea-Won Kim. I have been working as one of the ACT Center's ACT Consultant/Trainers since August 2001.

I am originally from Seoul, South Korea. I majored in social work in college, worked and volunteered at various social welfare agencies serving people with physical or mental disabilities and their families. Through these practice experiences, I became very interested in learning more about mental health issues (especially severe mental illness (SMI)), effective service models, and delivery systems. When I came to the University of Wisconsin-Madison for my Master's degree in social work, I was very excited to find out that the innovative community-based program (PACT) was developed in Madison. During my Master's and Ph.D. programs, I had great opportunities to work with consumers and their families at both an ACT team and psychiatric hospitals, and I also worked on several different research projects studying families of people with SMI. One thing I feel very fortunate for is

that I had Mary Ann Test (one of founders of the PACT model) and Debbie Allness (co-author of the PACT manual) as my mentors throughout graduate training.

When we moved to Indiana (because my husband got a faculty position at Indiana University Medical School) in 1999, I started working with Dr. Gary Bond on several research projects and also worked at Adult & Child as a clinician to maintain my tie to practice. Since 2001, I have been a faculty member in the School of Social Work at Indiana University and have been enjoying teaching students at all three levels (from undergraduate to Ph. D programs).

In addition to implementation of ACT, I have very strong interest in working with families of people with SMI. I am conducting a state-wide needs assessment to examine the extent to which mental health programs in Indiana provide services to the families of adults with SMI as well as what can be helpful to develop such services. I am very interested in implementing Family Psychoeducation as one of the evidence-based practices (EBPs) in Indiana.

On a more personal note, my husband and I met at the University of Wisconsin-Madison when both of us were in graduate school. We have two children who are the center of our world. Nicholas is 7 years old, who is proud of being a big brother to our 10 month-old daughter, Christina. She is cruising all over the place and practicing her first steps. Thanks to Nicholas, I have become a big fan of Disney movies, but I like any good movies. I love taking our children to the park for a walk on Sunday afternoons and reading books together. I also like cooking and find it fun and stress-relieving.



Needs Assessment of Services for Families of Persons with Severe Mental Illness: Mental Health Professionals' Perspective

By Hea-Won Kim,
Michelle P. Salyers,
& Hollie MacKay

Over the last several decades, research has documented the extent of family burden and need for services among families who have a loved one with a psychiatric disorder. Based on this research, many experts have recommended providing services to families (e.g., family psychoeducation) as a part of best practices. However, research has suggested that families continue to express a great degree of dissatisfaction with the amount and quality of services they receive as well as with the interactions family members have with mental health professionals. The purposes of this study were to examine mental health professionals' views of the degree to which their programs provide services to families and to identify barriers to developing such services.

Method: A state-wide needs assessment was conducted with mental health professionals serving people with severe mental illness (SMI) in community mental health centers (CMHC) in Indiana. Of 30 CMHCs, 28 had staff members responding to a self-administered mail survey. A total of 453 staff were included in the final report.

Results: More than half of the staff reported that they 'never' or 'not very often' provided 11 out of 15 services to families of consumers on their caseload in the last 6 months. The most frequently provided types of service were providing emotional support (43%) and practical advice about how to cope with specific situations (37%). The least frequently provided services were providing family therapy (2.4%), teaching identification of early warning signs of relapse (10%), including family in the client's treatment planning (11%), and referring family to support groups (12%). The majority of staff acknowledged the stigma of mental illness that families deal with (89%) and did not view family as a causal agent in development of mental illness (71%). However, over 96% believed that family's emotional climate can affect client's illness, and over 60% reported that families often have their own mental health problems and unrealistic expectations about client's progress. About 75% of staff endorsed the benefits of family interventions, but only half of respondents reported that they felt comfortable with their knowledge in this area. More than half of respondents identified variables related to family or client (e.g., family's lack of interest, client's refusal to involve families) and their heavy workload as major barriers to providing family-based services. They did not view lack of support and guidance from the agency nor their competency as significant barriers. Mental health professionals who have more positive attitudes provided more services to families and perceived barriers at a less extent. Only 38% reported that they had ever received training for working with families, and the majority of respondents (83%) indicated an interest for training on how to work with families.

Findings from this survey help us better understand gaps in current services for families and barriers to providing such services. However, they represent only providers' perspective. To get a complete picture, we plan to conduct a similar survey from the family perspective. We believe that developing collaborative relationships with families is very important to recovery process of consumers and we would like to help mental health programs address these needs in the future.



Contact us if you would like more information or have questions.

We would love to hear from you!

ACT Center of Indiana

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The ACT Center of Indiana is a collaboration of the IUPUI Department of Psychology and Adult & Child Center of Indianapolis.
Funding for the ACT Center is provided by Indiana Division of Mental Health and Addiction (DMHA).

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.

What's on the calendar?

Upcoming Events & Trainings



ACT BOOSTER SESSION
Presented by ACT Center of Indiana
August 19-20, 2004
Indianapolis, Indiana

Free, 2-day ACT skills training for new teams and staff, new additions to established teams, and programs seeking to implement ACT in Indiana

Contact vpedrick@iupui.edu or (317) 274-6735 for more details and registration information!
Registration deadline: August 2, 2004

Important Note: Due to the growing interest in ACT and the anticipated demand for this training, attendance will be limited to the first 50 registrants. However, for staff who may not be able to attend this round of booster training, we do plan to have additional booster sessions (same content and schedule) in the future, which will be held regionally at different locations throughout the state at various times during the year.