

ACT Center of Indiana

Excellence in Training, Research, and Technical Assistance

January 2004
 Volume 3 ❖ Issue 1

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Co-Directors

Michelle Salyers & Mike McKasson

e Directors



Happy New Year!

This last quarter has involved a great deal of planning at the ACT Center. The Community Action Grant to implement IDDT at Grant-Blackford Mental Health Center and Adult & Child Center will increase the availability of high quality services designed for adults with severe mental illness and substance use disorders. We also have been working with DMHA and several mental health centers in the state to plan the two new Illness Management and Recovery (IMR) projects. Veronica Macy discusses IMR in more detail on page 8 of this issue. The ACT Center is working on our own planning as well. We just had a 2-day strategic planning event to help solidify our goals and future plans. We are looking forward to working closely with our advisory board and other interested stakeholders to help make our vision a reality.

We enjoyed participating in the Intensive Weekend Workshop on ACT, hosted by the Indiana Consortium for Mental Health Services Research. As John McGrew describes on pages 2 and 3, there were many interesting discussions about the future of ACT. One area that is often a topic of question and concern is how to discharge people from ACT. As ACT is effective in helping people move towards recovery, people will naturally need less of the intensive services. However, when and how people are discharged are important factors in continued success of consumers. In addition, as we discussed in the last issue of our newsletter, ACT is designed to serve a very specific population. If teams began serving a broader population, they may find a need to transition people to more appropriate services. On page 5, Mike McKasson discusses some of the factors involved in successfully transitioning and discharging consumers from ACT.

This quarter also involved a lot of work on outcomes collection. We have been working closely with the 15 ACT teams and 5 IDDT programs to institute the computerized outcomes package as discussed in an earlier issue. This has not been an easy task . . . we appreciate all of the hard work the programs have put forth to make this happen. A standardized way to report and use outcomes will be helpful for state and local planning, supervision, and demonstration of all the work that our teams and consumers are doing. We are looking forward to presenting reports on this process in upcoming issues.



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ACT of Past, Present, & Future: Report on a Recent ACT Conference



By John McGrew
ACT Center
Program Evaluation
& Research

Together with the Indiana Consortium of Mental Health Services Research, the ACT Center recently hosted a 2-day conference at the IUPUI Conference Center. The workshop was entitled “Assertive Community Treatment (ACT): Where have we been, where are we going?” Several ACT Center personnel presented. Day One featured 3 presentations focusing on where we have been, and the Day Two featured 3 presentations focusing on where we should be going.

Day One - ACT: Where have we been?

Day One kicked off with a presentation on *Evidence-Based Practice (EBP): The Big Picture* by Gary Bond of the ACT Center. Dr. Bond documented the explosion in interest in EBPs across a variety of disciplines, from general medical practice to psychotherapy to psychiatric services such as ACT. He also noted the difficulties in defining what is and is not an EBP. For example, what evidence is sufficient to designate an approach as evidenced-based (consumer stories of being helped vs. formal randomized controlled trials), what outcomes are critical to assigning EBP status (e.g., ability to reduce hospitalizations, improved recovery) and who should decide (expert panels vs. disinterested non-experts). One critical issue is that different groups often use different criteria and, thus, may identify different EBPs, even when presumably examining the same areas of services. He then discussed the National Implementing EBP Project, of which Indiana is a part, and the 6 practices designated by that group. Dr. Bond noted that in addition to deciding what practices are evidence-based, administrators must decide which ones to implement and in what sequence. Dr. Bond noted that EBPs vary greatly in their costs, and that one selection algorithm may be to start with the least costly EBP (e.g., Illness Management and Recovery (IMR) is likely the least expensive of the six EBPs in the National EBP Project). Dr. Bond also noted that, based on the National EBP Project, some EBPs seem to be more clearly articulated (e.g., ACT is very clearly articulated, whereas Integrated Dual Disorders Treatment (IDDT) is less so) or may already be partially adopted as part of normal practice (e.g., the home visits characteristic of ACT) and thus may be easier to implement.

The 2nd presentation focused on the *History and Current Status of ACT in Indiana*, presented by John McGrew, substituting for Michelle Salyers who was unable to attend. The presentation summarized the development of ACT, the research base establishing ACT as evidence-based, the pg. 2 widespread dissemination of ACT across the United States, and the history of ACT in Indiana. Dr. McGrew outlined the three-pronged approach of DMHA in establishing

ACT in Indiana: (1) creating ACT standards and a credentialing process for ACT teams in the state, (2) establishing an ACT Training Center to provide expertise, training, and support to the state and to new ACT teams, and (3) creating short-term (i.e., annual grants of \$333,000 per team) and long-term (i.e., a Medicaid ACT rate) funding mechanisms to support the high costs of operating an ACT team in Indiana. He then reviewed the success in implementing ACT in Indiana, with 15 new teams created in 3 years, and, as reported in the last newsletter, steady measured increases in fidelity to the ACT model over time.

The 3rd presentation focused on *Implementing ACT, Barriers and Solutions: A Provider’s Perspective* by Mike McKasson, co-Director of the ACT Center and Director of Adult Services at Adult & Child CMHC. Mr. McKasson noted several barriers to establishing ACT teams: (1) limited buy-in by the organization (e.g., from a stages of change perspective, stakeholders may be at different stages in their decision to support the implementation of ACT), (2) financial stability of the organization (e.g., ACT is costly, especially in hiring staff, and may be difficult for organizations already at risk financially), (3) not clearly understanding the ACT model (e.g., believe they are already doing ACT), (4) difficulties in recruitment, training, and retention of staff, especially with regard to certain specialties such as nursing and psychiatry, and (5) difficulties in maintaining fidelity to ACT. Mr. McKasson then outlined some potential solutions to these barriers: university/provider cooperation in providing training useful to providers, DMHA-sponsored training internships, ACT advisory boards assigned to each team, ongoing and onsite training, ACT-specific funding mechanisms.

Day Two - ACT: Where are we going?

The 1st presentation, by John McGrew of the ACT Center, focused on *ACT Controversies and Theoretical Loose Ends*. Dr. McGrew noted several gaps in the research base for ACT: (1) *for whom*: a lack of research on how ACT performs or can be modified to serve different client groups, such as transition-aged youth or persons with co-occurring MR/DD, (2) *by whom*: a lack of clear understanding of many of the issues in staffing an ACT team (e.g., what are the characteristics of a good ACT team member?; can a nurse practitioner substitute for a psychiatrist on a team?; must ACT teams be multidisciplinary, such as is required in PACT or do the smaller generalist teams favored by many teams in states like Michigan work equally well?), (3) *in what settings*: a lack of clear understanding of how ACT performs or can be modified to serve individuals in different settings (e.g., very rural areas) and mental health systems (e.g., fee-for-service vs. managed care, US vs. non-US), (4) *using what techniques*: ACT has often been described as a black box with little to no specification of the critical clinical elements (e.g., although ACT has clear goals - work or improved ADLs, specific techniques for achieving goals are not specified). Dr. McGrew then outlined complaints from several constituencies concerning ACT: (1) administrators complain that ACT focuses on processes (e.g., fidelity) rather than outcomes,



A New Face at DMHA

Get to know Diana Williams!

I joined the Division of Mental Health and Addiction as the Bureau Chief of Addiction Services in August of 2003. In this position, I am responsible for applying for the Substance Abuse Prevention and Treatment Block Grant (SAPT) each year and overseeing the use of its money. I ensure that the requirements of the SAPT Block Grant are fulfilled such as peer reviews, TB requirements, and capacity protocol. I am the “addiction expert” for consumers and staff, and I meet with addiction providers about state initiatives, goals, and objectives.

I have 18 years of experience in the field of addiction. For the last 10 years, I have been the Clinical Supervisor at Tara Treatment Center, a free standing addiction treatment center in Franklin, Indiana. I have a Bachelor’s degree in psychology from Marian College and a MSW from IUPUI. I have also been teaching an introductory course on addiction to the social work graduate students at IUPUI and this semester will be teaching a general psychology class at Marian College.

Diana Williams

MSW, LSW, NCACI, CADACII

(2) clients complain that ACT may be paternalistic and ignores the central importance of recovery, (3) family members are concerned that the establishment of EBPs, like ACT, ignores the voices of families and consumers (e.g., in the designation of what are critical outcomes, in who is at the table to decide what is an EBP). Dr. McGrew then noted that although there is consensus concerning the critical structural/organizational ingredients of ACT, it is based on “pre-scientific” evidence (e.g., surveys of experts, the norms occurring in established programs), not on formal tests of the model that contrast teams with and without specific ingredients. Finally, Dr. McGrew noted a lack of understanding of the clinical ingredients, or mechanisms of action, of ACT. For example, does ACT work by increasing medication compliance, by creating a social network to support the individual, and/or by enhancing client agency? Current research cannot answer these questions.

The 2nd presentation focused on *ACT Enhancements* and was presented by Angie Rollins, formerly of the ACT Center and currently the Director of Research at Thresholds in Chicago. Dr. Rollins noted that ACT can serve as an excellent organizational structure for introducing enhancements to services for persons with SMI. Further she speculated that the future of ACT may be in adding other EBPs within the ACT structure. She noted that two such enhancements have recently been introduced in Indiana, the introduction of Integrated Dual Disorders Treatment (IDDT) and Illness Management and Recovery (IMR) onto ACT teams. Dr. Rollins noted that neither practice needs to be limited to ACT. However, both IDDT and IMR provide coverage in areas underdeveloped in traditional ACT. IDDT provides techniques to serve the at least 50% of persons with co-occurring substance use on ACT teams; IMR provides techniques that focus on client empowerment, recovery and choice, and introducing an explicit dynamic that serves to counteract the frequent criticism that ACT fails to embrace choice or consumer recovery. Finally, Dr. Rollins outlined an ACT program at Thresholds that focuses on serving persons with SMI discharged from jail. Additional program features of the jail-to-community ACT team include very low client:staff ratios (1:6), high intensity services (daily contact), and

seamless integration with the jail (e.g., serving clients while still in the jail, meeting clients at the gate on day of discharge). She reported encouraging preliminary data demonstrating decreased hospital use and jail days for those in the program compared to the year prior to being jailed.

The 3rd and final presentation of Day Two was entitled the *Future of Case Management* and was presented by Charles Rapp of the University of Kansas. Dr. Rapp began by noting that 10 years previously he had been asked to make similar predictions and that, although all the predictions had reflected important wishes for the progress of case management, few had come to pass. This illustrated the important point that systems tend to change very slowly, when they change at all. Dr. Rapp then provided some context by outlining the history of services for those with SMI, noting the progression from asylum and institutionalization to community mental health programs to community support programs. He noted that each incarnation marked important progress towards enhanced community integration although each still fell short of the goal. Dr. Rapp observed that the community support movement, for example, really was community replacement (individuals worked, learned, played, and were treated within the CSPs, and were not integrated into the community). Dr. Rapp noted that the next step in case management will be support for true community integration. He then outlined the many barriers to integration (e.g., consumer, provider, and community fears, segregated programs, mentalism, poverty). Dr. Rapp then noted that change must progress along a hierarchical pyramid of organizational needs, with training at the top and clarity of goals/vision and organizational support at the base. Implementation failures often occur when interventions target a higher organizational level (e.g., training) when the problem may exist at a lower level (unclear system outcomes). The ACT initiative in Indiana seemed to conform to the necessary process. Finally, Dr Rapp predicted that ACT enhancements, such as those outlined by Dr Rollins, reflect one important operationalization of the goal of true support for community integration.

THUMBS UP



From Charles Boyle
Bureau Chief of Adults
with Mental Illness

FROM DMHA

Indiana Division of
Mental Health & Addiction

(Envy and Pride are two of the seven deadly sins. In this article, I confess to both.)

Several months ago, a center director commented that DMHA does not provide much in the way of positive feedback to providers. That comment struck a chord with me because I realized that it is true and I was one of the offenders. We don't tell providers about the good that is done and how much it is appreciated. Too often we get so used to services that we begin to take them for granted.

As the writer of the Mental Health Block Grant, I have the opportunity to attend the annual block grant conference. At that meeting, state planners spend a fair amount of time talking about programs and innovation in their states. For years, I listened without much to share. I envied what other states were doing.

Now when I attend these meetings, I can talk proudly about what Indiana is doing. I have found states that are not even attempting some programming and services like supported employment or assertive community treatment (ACT). In Indiana, I have a fantastic supported employment resource in the S.E.C.T. Center that I can let others know about. I have also told handfuls of people what we are doing in ACT and have bragged about the ACT Center of Indiana. I have been able to share experiences in integrated dual disorders treatment (IDDT), and now I can brag that we are doing Illness Management and Recovery (IMR) as well. For several years, I have been feeling better and better about what Indiana is doing.

This all came into a quick focus for me at a recent meeting in Cleveland sponsored by SAMHSA. In

the back of the meeting room was an information table. On that table were five booklets describing innovative programs: Homeless Outreach, IDDT, ACT, Supported Employment, and the Children's Continuum of Care.

I realized that Indiana is doing all five of the programs! We are not followers. We are leaders. We are not hoping that someday we might start a program; we have started them. We are not listening to what others have done; they are listening to us! As just one example, other states have contacted the ACT Center to learn what great things Indiana is doing and directions we are taking.

I am excited and proud of what Indiana is doing. What you are doing at the ACT Center of Indiana in ACT and IDDT in addition to other evidenced-based practices is on the leading edge of the progress that we are making. You are bringing Indiana to the forefront of evidence-based programs.

What you are doing is not only noticed by a few people in the central office but also by those on the federal level as well. It is noticed, and envied, by other state offices.

It is difficult in a short article to let you know how much you are appreciated. Maybe this will help sum it up. Each year the Block Grant is reviewed by a peer review team. The Block Grant is a presentation of the state's mental health system. During our review meeting, a woman from another state said, "If I had a mental illness, I would want to be treated in Indiana."

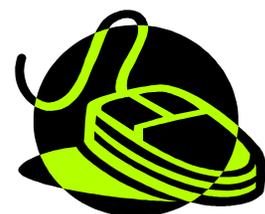
I don't know about you, but I think that is high praise.

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Transitioning Consumers from an ACT Team to Less Intensive Services

By Mike McKasson, M.A., LCSW
ACT Center Co-Director

When the PACT (Program of Assertive Community Treatment) model was first developed, the philosophy was to have a consumer stay with the team forever; however, it has been recognized in practice that some consumers are able to move to less intensive services after achieving their recovery goals. To assist the consumer in their recovery efforts, it is important that consumers have the option of moving on to less intensive services as they are better able to manage their illness. The purpose of this article is to raise awareness of the transitioning process and the importance that it may play in the success of the consumer once they leave the team and receive treatment from another provider. It is the ambition of this author that with feedback from ACT teams, a more detailed and pragmatic publication can be developed to guide teams in the area of transitioning consumers from an ACT team to less intensive treatment. This article will focus on criteria to discharge a consumer from the team, transitioning process to another provider, and rapid return to the team if the consumer has a relapse and needs more intensive services.

I. Discharge Criteria

The team will need to develop a discharge process in their clinical practice guidelines. The consumer and team should have agreed on criteria for discharge included in the treatment plan. The criteria should be reviewed with the consumer during treatment team reviews. The following is an example of discharge criteria that can be found in The PACT Model of Community-Based Treatment for Persons with Severe and Persistent Mental Illnesses: A Manual for PACT Start-Up by Deborah J. Allness, M.S.S.W. and William H. Kenoedler, M.D.:

Discharges from the program shall occur when consumers and program staff mutually agree to the termination of services. This shall occur when consumers:

- a. Move outside the geographic area of responsibility. In such cases, the program staff shall arrange for transfer of mental health service responsibility to a provider within the geographic area to which the consumer is moving. The program shall maintain contact with the consumer until the service transfer is arranged,
- b. Demonstrate an ability to function in all major roles areas (work, social, and self-care) without requiring assistance from the program for at least two years, with this determination to be made both by the consumer and program staff, OR
- c. Request discharge, despite the team's best efforts to develop a treatment plan acceptable to them.

II. Transitioning Process

The transitioning process will be crucial in the success of the consumer without the ACT team's support, and it will need to be planned well. The team will need to include the transitioning process in their clinical practices guidelines. The following is an example of procedure for the transition process:

Example: Transition Process

1. If after treatment plan review it is agreed on by the consumer and the ACT team that the discharge criteria has been met and the consumer wishes to try less intensive treatment, the staff will be responsible for identifying an appropriate provider(s).
2. The primary case manager is then to discuss the alternate providers found with the consumer.
3. If the consumer selects a provider, the case manager will be responsible for making the referral.
4. After the Authorization to release information has been signed, the appropriate information can be shared with the selected provider. This is the responsibility of the primary case manager.
5. A discharge plan will be written with the consumer.
6. A meeting between the new provider, primary case manager, consumer, and consumer's family will occur to review the discharge plan.
7. The team will continue to be responsible for maintaining services to the consumer until the consumer is fully engaged with the new provider and that the services offered prove to meet the consumer's needs.
8. Once a decision has been made that the consumer no longer needs to receive services from the ACT team, the consumer's chart is to be closed.
9. The team will make follow-up contact every 3-months for the first year after discharge to ensure that the consumer has made the transition successfully.

III. Rapid Return to the Team

With those consumers that have achieved their goals of recovery and are able to transfer to less intensive services, it will be important to develop a method to return to the team for services in their discharge plan. The primary case manager will need to meet with the consumer and the consumer's family to identify what conditions (e.g., loss of job due to symptoms, hospitalization, etc.) would need to occur to seek a return to the team. The plan should be in writing and consist of the conditions to return, who to contact and how, and how often the team will follow-up with the client. It will be best to review this information with the consumer, family members, and the new provider in a face-to-face meeting. In this meeting, it should be decided when the ACT team will terminate their services since it is going to be important that the team continue contact with the consumer until they have fully engaged with the new provider. It would be advisable that the team develop a procedure on making follow-up contacts with consumers that have transitioned to less intensive services. This will better ensure that the consumer has made the transfer successfully. The data gathered could prove to be helpful in improving the transitioning process for future consumers.

Conclusion

Hopefully, it is clear that the decision to transfer a consumer from an ACT team to another provider is not a simple matter of just sending a referral. This needs to be a very systematic, well thought-out process that includes the consumer and their family. It is also important that discharges occur based on agreed criteria and not concerns about funding. Our focus should stay on assisting the consumer in the road to recovery. Just pg. 5 remember working in an ACT team is challenging, but "ACT Works."

ACT DOC TALK:

Part II

Interview with Dr. Olawale Osuntokun Staff Psychiatrist - Midtown Mental Health Center

Below you will find the continuation of an interview with Dr. Osuntokun, staff psychiatrist at Midtown Mental Health Center who works with Midtown's Assertive Community Treatment team. The interview was conducted by Lia Hicks, an ACT Consultant/Trainer at the ACT Center of Indiana. Part I of this interview can be found in the October 2003 v2i4 ACT Center of Indiana newsletter.

Q. Lia: What do you find most rewarding about being a psychiatrist on an ACT team?

A. Dr. Osuntokun: I get to clean people's houses. I get to move refrigerators. I get to drive them around to where they want to go. I've attempted to administer injections. I've got my street clothes with me, and I can get out of my tie and jacket. I think those are really important because it makes me feel that I'm doing more than writing prescriptions - not that that's what a traditional psychiatrist does, but this takes it a lot further, several notches further. I feel very connected to the patients. I can give examples of a patient, that all we talk about most of the time is his work at the card shop. He has brought me in to view the cards, and I've bought some . . . [T]he reason I bought them was because I liked the cards, and he sees me not just as a psychiatrist but as someone he can relate to on a different level . . . [T]hat is quite special. For me also it is just so much more rewarding. Again, you feel like you're doing more than just being a physician.

[Also] I think we all benefit from working as a team - [a] team that is a little different also than a traditional team. We get to know each other; it is a very small family, and as we know our patients, we know each other better and work better. We start thinking alike, and I think that also goes in with the ACT model where we allow some cross training to occur. It's also relaxing even though you are running around. For me, driving around the streets is just perfect. I like to do that. I like to be outside. I have a lot more energy than just sitting in my office waiting for clients to come in and see me.

Q. Lia: Additionally, how has it affected your practice as a psychiatrist? You kind of mentioned earlier that ACT has kind of taken you in a different direction in your life and in your career than maybe you had originally thought. Could you talk a little bit more about that?

A. Dr. Osuntokun: Gaining an appreciation of how much of an impact we have on patients and they in turn have on us as providers. If you are able to appreciate that, you begin to, I believe, become more in tune, more interested in the patient and what they have to say rather than, "I'm the doctor. You need to listen to me." And it's not about simply letting patients do what they want to do. It becomes a more equal cooperation . . . "Do you want to do this?" "Well, how about we try this?" "How about me taking you down to see what I'm talking about?" The patient feels that [you] are not just giving directions, but . . . you are actually listening to them. So, for me being able to listen better, being able to give the patient a chance to choose their own goals, their own targets, is a lot easier. It seems like we have taken some extra steps in relating, connecting, [and] building that relationship with the patient rather than the patient just seeing us as pushing pills. I think those are some really big ways in which it has changed my approach in treating clients.

It's certainly translated to my clients as well in the outpatient clinic where I think I am more likely to go out and see a patient in their home who probably can't come in to see me because of their symptoms. I will try and get a home visit done; I want to see what is going on. There are all kinds of things that go on in clinics where a patient hasn't come in for the past three months, six months, so the decision is made to close the case. It really does get me thinking, "Why hasn't this person come in and sought treatment? Could it be the diagnosis has prevented them from coming back and continuing treatment?" So, those are some things that have certainly changed about me.

Again, my appreciation for my own wellness has also been brought into the picture. The impact of these serious illnesses on people's lives, it's just tremendous. When you see these little changes, it makes you appreciate more what you've got. I think that gives you more of a good feeling coming to work. For me, I get less discouraged when I hear that someone is "freaking out" or called ten times. "Don't worry. We saw them yesterday, we'll probably see them today; we'll see them tomorrow again." We will try something as soon as we see what is going on so that we can catch it quickly and do something, as opposed to messages left on my voicemail saying, "I'm about to do something drastic," and yet their next appointment is in a week . . . [and] I look in my schedule, and I can't fit them in anywhere.

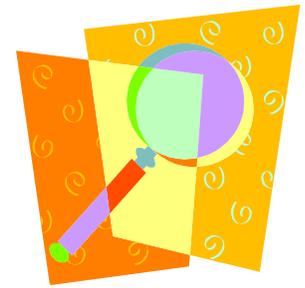
Q. Lia: How about challenges? What are or have been your biggest challenges with working with an ACT Team or implementing ACT?

A. Dr. Osuntokun: Of course, it is a different approach, different strategies, different rules, different criteria that I have to work with. Of course, the DACTS assessment helped us to look at what we are missing and what we were meant to touch upon. I think managing time has been the biggest challenge for me. My time is staggered, and there are a number of new things that we have to do to really show that we are following the model. I think setting more time to be able to do treatment plans has been one. I think as we get in the groove of things, it will become a lot easier to set up, . . . plan ahead, and then do quickly. I really can't think of much else that has got in the way. I think really learning to do things differently - the expectations, the different things that one has to implement. One thing that I haven't been able to consistently do is more cross training and set a time for it. Most of the time there is a quick consult, what's going on, what do I think. What I really want to do is to be able to set out thirty minutes one afternoon or a lunch . . . and then just be able to talk on a specific topic of interest to the team.

Q. Lia: In closing, what additional things might you have to add, or even specifically, what kind of advice would you give to other psychiatrists that are thinking about joining an ACT Team or maybe have come on to an ACT Team and want to get some more information?

A. Dr. Osuntokun: I think obviously flexibility. Definitely be involved in searching for a team that works well with each other. I think a sort of self-exploration as to what they want and what to them is important. Again, for me, it just magically fit in really well with my idea of what I saw in myself as a physician and the difference I could make as a physician. I think exploring a level of comfort with the types of clients that fall under the ACT population. You certainly have to be comfortable with that and a high tolerance of frustration in all things, going slowly. I think it's a good experience of working with a lot of people because you are not only going to be training yourself to be more obliging to the patients, but there are other staff members who probably have more contact with the patient than you do and really might truly know the patient more than you. I think just being able to do things differently, meeting the patients at home, somewhere...not in the clinic. I have had clients ask me if I would play tennis with them, a game of basketball, or ask me if I have time for lunch or dinner sometime. That may be kind of crossing the boundaries, but lunch can be arranged. I've transported patients. I think anything could be possible in getting the patient well, and if it's something the patient wants and something that doesn't cross boundaries . . . why not.

UP CLOSE



& Personal

Amanda Jones - Implementation Monitor

Hi! My name is Amanda Jones. I am a first-year graduate student at IUPUI, and I have just joined the ACT Center this fall as an implementation monitor for a few sites trying to start up integrated dual disorders treatment (IDDT) programs.

I am originally from Annapolis, Maryland, but my partner and I just moved to the Midwest from Boston, Massachusetts, where I received my Master's in general psychology from Brandeis University in early 2001. After earning my degree, I eventually found a job working for a small consumer-run nonprofit in Boston called Consumer Quality Initiatives (CQI). CQI's mission was to bring the concerns of mental health consumers to the attention of practitioners and policymakers throughout the state of Massachusetts. To accomplish that goal, we interviewed consumers at various mental health facilities, wrote reports based on the interviews, and passed the information on to the state's mental health authority and the insurance company paying for many of the services. In talking to the individuals at state hospitals, private inpatient units, day treatment centers, substance abuse programs, clubhouses, and outpatient clinics, I learned that consumers desperately want the same opportunities as the rest of the population to work, develop relationships, have families, and live fulfilling lives. With extra support, I believe many consumers can accomplish these goals.

When I decided to apply to doctoral programs, I was excited to find out that Gary Bond and the ACT Center are working to implement proven programs that support consumers trying to reach their personal goals. Now I am thrilled to join the ACT Center, and I look forward to working with some of you in the future as we try to improve the lives of people with serious mental illnesses.

ACT Center of Indiana

Excellence in Training, Research, and Technical Assistance

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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 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 & edited by V. Pedrick.

Illness Management & Recovery: A New Practice ~ A New Process By Veronica Macy, IMR Consultant & Trainer

Transformation of the mental health system in the United States has been the theme for quite some time now. One of the six goals that were set by The New Freedom Commission on Mental Health & sent to the President of the United States was "Excellent Mental Health Care is Delivered & Research is Accelerated." The ACT Center of Indiana is in position to offer another evidence-based practice that will help accomplish this goal - Illness Management and Recovery (IMR).

Clinicians & family members as well as individuals who live with a severe mental illness have routinely worked to help improve the capacity to manage ones illness & work towards personal goals. IMR curriculum successfully integrates psychosocial & medical approaches. The concept is nothing new, but the "package" of IMR does offer the identification & standardization of core ingredients of illness management skills to enable all to do what they are already trying to do in a more organized, systematic, & effective manner.

IMR curriculum consists of 9 modules:

- * Recovery strategies
- * Practical facts about mental illness & treatment
- * The stress-vulnerability model
- * Building social support
- * Effective use of medication
- * Reducing relapses
- * Coping with stress
- * Coping with symptoms
- * Getting needs met in the mental health system



IMR curriculum uses practical & recognizable core teaching techniques to help people learn information & skills for IMR:

- * Motivation-based strategies
- * Education techniques
- * Cognitive-behavioral techniques

IMR works from several essential & decisive principles, which facilitate the potential significant impact of IMR. These initiatives must be realized by clinicians, family members, & persons living with a mental illness:

- * Hope
- * The person is the expert
- * Personal choice is paramount
- * Practitioners are collaborators
- * Practitioners demonstrate
- * Respect is always present

Hope is the starting point. Recovery is an end. Seeing IMR as *another new practice or new process* won't make for success. The implementation of IMR's critical principles mentioned above will enable all individuals involved to move beyond where they are in recovery. IMR needs to become a way of life, not just another program. The transformation will then become a reality for all, clinicians, family members, & most importantly, the individuals themselves who live with mental illness. Let's look to 2004, & see the effects!