

ACT Center of Indiana

Excellence in Training, Research, and Technical Assistance

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Notes from the Directors

Where did the summer go? It's hard to believe that it's time for another update from the ACT Center.

We've had a flurry of training and research activity this quarter. Of the 8 sites starting new Assertive Community Treatment (ACT) programs (as of 10/28), 6 have completed their initial kick-off training, and 4 of these have started more intensive skills training. All of the ACT programs have had the initial baseline assessments done, and our program monitors will continue to make monthly visits as is outlined in the National Implementing EBP Project. On the Integrated Dual Disorders Treatment (IDDT) side of things (as of 10/28), we have had 2 kick-off trainings and are looking forward to the remaining 4. We are still in the initial assessment phase at several sites, but we are making progress towards getting the IDDT programs going.

We have also been awarded a Community Action Grant from Substance Abuse and Mental Health Services Administration (SAMHSA). The grant provides resources to expand Integrated Dual Disorders Treatment (IDDT) in Indiana. Read more about the grant and our goals on pg. 3!

In addition to our training in ACT and IDDT, we are excited to be working with Veronica Macy of NAMI to bring Illness Management and Recovery training to Indiana. This is another evidence-based practice that we would like to incorporate in our training. As Veronica discusses in her article (see "Words on Recovery: A Consumer's Perspective" pg. 2), recovery is a critical concept for all of us to understand and embrace. That is, we can help consumers take charge of their recovery process by teaching them the skills needed to manage their illness and meet their personal goals. We plan to start this work with our ACT programs and later expand training as we are able to.

We have recently added FAQs to our website (www.psych.iupui.edu/ACTCenter) as well as other things. Check it out, and let us know if we are addressing your questions and concerns. We still have a list of questions to answer from prior trainings, and we plan to update this page periodically. So, send us your questions!

Thanks to KEY Consumer Organization and NAMI for inviting us to be part of their annual conferences this year. We enjoyed talking with you all about ACT, IDDT, and our work at the ACT Center.

On a more personal note, some of you may have noticed a new name among us . . . Veronica Bannon is now Veronica Pedrick. Congratulations to Veronica and Nathan on their marriage!



<u>Topic</u>	<u>Page(s)</u>
Words on Recovery.....	2
New IDDT Grant.....	3
CM Perspectives on ACT.....	4-5
Up Close & Personal.....	5
Critical Components IDDT.....	6-7
What's on the Calendar?.....	8

Words on Recovery

A Consumer's Perspective

By Veronica Macy

Veronica Macy lives in Westfield, Indiana but hails from the Upper Peninsula of Michigan. Her best friend is her husband of 27 years, Ed. They are the parents of 3 adult children and 5 grandchildren. She owns her own business, Recovery Network Unlimited, where her motto is Reach with Hope. She is a certified Mental Health Recovery Educator in Mary Ellen Copeland's Recovery Model and is certified in 3 Education/Recovery Signature Programs of the National Alliance for the Mentally Ill (NAMI). Veronica currently serves as Indiana's Representative to NAMI's National Consumer Council and works part-time with NAMI Indiana as NAMI Indiana's Consumer Program Coordinator. She serves as a Commissioner with Indiana's Protection and Advocacy and also serves with the Division of Mental Health and Addiction on the Family and Consumer Affairs Council.

As a Mental Health Recovery Educator, she passionately promotes wellness and recovery with anyone who desires richness of life while living with a mental illness. Her commitment and desire for recovery is fueled by her personal experiences living with a mental illness as well as a strong sense of hope and personal responsibility she claims for herself and shares with others. This is what she shares about her thoughts on recovery.

Recovery was a word that was never shared with me during the 8 years when I was struggling daily just to keep alive while dealing with my mental illness. Survival was the approach to life for me and for my family. Those years as a wife and mother should have been filled with fond memories and cherished moments. Instead, keeping me alive was the main focus of the family. This same thrust continues to move me forward, but instead of survival, I use the word recovery . . . and instead of my illness controlling me, I control my illness. I have chosen to share my reality so as to make a difference in the way mental illness is seen and treated in today's society. I speak of recovery and wellness at every turn and on every road.

Recovery rings out hope. Words like renewal and self-discovery bring hope to the person living with a mental illness. It gives something to reach for. Something WE DO as individuals and something that NO ONE CAN DO FOR US. There are no limits with a vision of hope, and there are no limits or no requirements for recovery.

Each of us must advocate for ourselves to get what we want, need, and desire. Begin with the end in mind. We can relate all to well to Alice in Wonderland where it reads, " 'Would you tell me please which way I ought to walk from here?' 'That depends a good deal on where you want to get to,' said the cat. 'I don't much care where,' said Alice. 'Then it doesn't matter which way you walk,' said the cat." Too many people have internalized the messages of stigma and hopelessness and have become victims to their illness.

When our perspective changes from reaching out to be saved to one in which we work to heal ourselves and our relationships, the pace of our recovery increases dramatically. It is up to each individual to take responsibility for our own wellness. There is no one else who can do this for us. We make things happen. We take the first steps. We don't make excuses, blame others, or sit around acting like victims.

A chief injury to anyone living with a mental illness is the loss of one's self. We must reclaim the disowned self. Education and knowledge are active components of recovery that must accompany us on our journey. We search for resources and information that will help us. We learn what will work for us, and we learn the steps needed to take in our own behalf.

In this whole process - and recovery is an ongoing process - we need assistance, encouragement, and support as we work to relieve symptoms and get on with our lives. We need a caring environment without feeling the need to be taken care of. As people are introduced to communities and services that focus on recovery, people change, relationships change, and systems change one by one. Values and roles must come together and stand on a level platform. Consumers must not only hear and understand recovery. They must choose to experience it.





Integrated Dual Disorders Treatment Community Action Grant

Gary Bond, Chancellor's Professor at IUPUI and researcher with the ACT Center of Indiana, has been awarded a Community Action Grant from Substance Abuse and Mental Health Services Administration (SAMHSA). The grant provides resources to expand Integrated Dual Disorders Treatment (IDDT) in the state of Indiana. As clinicians already know, substance use disorders are present in 40 - 60% of consumers with severe mental illness (SMI). Consumers with both SMI and substance use disorders experience poor outcomes, such as higher rates of psychiatric relapse and hospitalizations, poor physical health, homelessness, legal problems, and victimization. Traditional treatment for clients with dual disorders comes in parallel form, where addictions and mental health treatment are separate and fragmented. We know that this form of treatment is ineffective. IDDT, on the other hand, is a clearly defined treatment model that integrates addictions and mental health treatment "under one roof" and has shown consistent effectiveness in rigorous studies, conducted by a variety of researchers and in a variety of settings, meeting criteria to be considered an evidence-based practice (EBP).

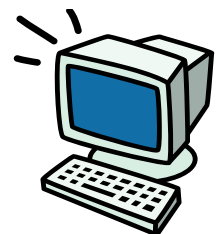
Unfortunately, IDDT services are not readily available in Indiana community mental health centers (CMHCs). At the state level, the Community Action Grant will help us to build

consensus to implement IDDT across a variety of stakeholders, including DMHA, Indiana Council of CMHCs, Indiana NAMI, and KEY Consumer organization. We will be holding 3 state-wide conferences over the next year to build consensus to implement IDDT, provide educational/motivational trainings for CMHCs who have not already decided to implement IDDT, and provide IDDT training to clinicians from CMHCs who are already adopting IDDT. We also will provide technical assistance to individual CMHCs in IDDT in conjunction with the National Implementing Evidence-Based Practice Project.

Our first conference of the year has already been scheduled! On December 9, 2002, the 6 sites implementing IDDT in our state and 11 sites implementing Assertive Community Treatment have been invited to send their substance abuse specialists, team leaders, and other key clinicians to IUPUI for a free day-long workshop covering clinical skills in IDDT. Robert Drake, M.D., Ph.D., a psychiatrist and national expert on IDDT from the New Hampshire-Dartmouth Psychiatric Research Center, will be conducting the workshop.

We hope that this will be the first of many productive activities and look forward to working with the various stakeholders in the state in our efforts to improve services to consumers with dual disorders.

Our newsletter is now online!
www.psych.iupui.edu/ACTCenter/NEWS.htm





Case Manager Perspectives on Assertive Community Treatment: Critical ingredients, Clinical ingredients, & Variations in Implementation

John H. McGrew, Ph.D. Bernice Pescosolido, Ph.D. Eric Wright, Ph.D.
Indiana University Purdue University Indianapolis and Indiana University, Bloomington

Objective: The paper sought to identify case manager 's perspectives on the critical ingredients and the therapeutic mechanisms of action of Assertive Community Treatment (ACT). ACT is an effective model of community treatment for persons with severe mental illness (SMI) (1-8). Although there is strong evidence that ACT is successful (e.g., decreased hospitalization use, increased overall level of functioning), the essential structural and organizational program elements that underlie ACT effectiveness have not been clearly established empirically. Few experimental (9) or quasi-experimental studies (10) have been conducted with the express purpose of establishing the importance of particular elements of ACT. The majority of the published research that has attempted to identify the critical elements empirically has relied on more indirect methods. One method to help identify the core ingredients of an intervention is to ask informed stakeholders in the model (11). For example, McGrew and colleagues (12) asked ACT experts to rate a list of possible critical ingredients of ACT and also asked a sample of ACT clients to nominate helpful elements of ACT (13). The current study asked ACT workers to provide their perspective on the critical elements of ACT. ACT workers also were asked their opinions about the critical clinical elements or mechanisms of action thought to underlie ACT success.

Method: ACT teams (n=73) attending the National Assertive Community Treatment Conference rated the degree to which 16 clinical activities were beneficial to clients and rated the importance to the ideal team and the characteristicness for their team of 27 possible critical ingredients.

Results: Twenty-four of twenty-seven possible critical ingredients were rated very important by at least 50% of the teams. Full-time nurse on team was rated as the most important ingredient, and medication management was rated as the most beneficial clinical activity. (See tables below.)

Conclusions: ACT team perspectives on the critical ingredients agree closely with the findings of a previous survey of ACT experts (12). Case managers strongly endorsed the team approach (e.g., shared caseloads) and medical aspects of ACT (e.g., medication management, full-time nurse, involvement in hospital decisions).

Top 10 rated ACT elements

ACT element	Mean importance rating (1=very important, 5=not important)	% rating very important
FT nurse on team	1.03	97
Team involved in hospital admissions	1.08	93
Team involved in hospital discharge	1.10	90
All team involved in tx planning	1.10	90
Caseload less than 100 clients	1.10	91
Daily team meetings	1.10	93
Caseload ratio less than 12:1	1.11	91
> 50% of srvc in home or community	1.13	89
Shared caseloads for treatment	1.14	88
Team has primary clinical authority	1.17	86



Top 10 rated therapeutic mechanisms of action

Therapeutic mechanisms of action	Mean rating (1=very beneficial, 7=not beneficial)	% rating very beneficial
Medication management	1.19	93
Continuing assessment	1.38	75
Regular home visits	1.45	71
Providing problem solving support	1.52	67
Shared caseloads	1.55	65
Accessing medical care	1.66	56
Providing adequate housing	1.73	54
Providing social support	1.87	52
Money management	2.00	46
Increasing social contacts	2.05	34




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UP CLOSE & PERSONAL

FEATURING: LORNA MOSER, IMPLEMENTATION MONITOR



Hello! My name is Lorna Moser, and I recently joined the ACT Center of Indiana as one of three Implementation Monitors for the National Evidence-Based Practices Project. My job duties entail working with selected Indiana sites in their efforts to implement either assertive community treatment (ACT) or integrated dual disorders

treatment (IDDT). I am also a doctoral student in the Clinical Rehabilitation Psychology program here at IUPUI. This particular program and the ACT Center are a perfect fit for both my interests and previous experiences. It is quite disheartening to see psychology programs' lack of attention in the treatment of severe mental illness. IUPUI is an exception, and I am thrilled to be working with such eminent researchers in this field.

I have worked as both an employment specialist and a case manager on an ACT team in Milwaukee, Wisconsin. I appreciated the many challenges and rewards in working with such a neat group of clients. Funny enough, no formal education could have taught me all that I have learned just having spent time with individuals with a severe mental illness and their families. So many fond stories I accumulated over those few years! I recently obtained my master's



degree in clinical-counseling psychology from Illinois State University. As part of my thesis work at ISU, I created a client satisfaction measure for use in ACT programs. This continues to be a work in progress, and I plan to continue with my revisions and administrations.

On a more personal note, I grew up in Kenosha, Wisconsin (the mid-point between Milwaukee and Chicago). I feel like I am making a tour of the mid-west, as I grew up in Wisconsin, moved to Illinois, and now am in Indiana. I have been maintaining a long-distance relationship with my boyfriend of 5 years. He will be finishing up his education and joining me here in Indianapolis this December. I have three cats at the moment: Judas, Ned, and "outdoor kitty." Judas has diabetes and receives two insulin shots a day, Ned is neurotic and very needy, and, as you may have figured out, "outdoor kitty" remains unnamed as s/he is a stray cat that I care for, and I am desperately trying not to get attached with her or him! Finally, as a graduate student, I am not supposed to have much of a life. However, I refuse to live by that philosophy and enjoy spending time with friends and family. I also consider myself a "want-to-be" artist. I like to both paint and develop movie plots (these generally do not leave my head).

Critical Components of Integrated Dual Disorders Treatment

Bruce Jensen
IDDT Consultant & Trainer

Below we will address the Critical Components of the IDDT model, which are the culmination of extensive research by and in collaboration with the New Hampshire-Dartmouth Psychiatric Research Center over the last several years. But first, a brief review . . .

In a previous edition of the ACT Center Newsletter, we discussed Integrated Dual Disorders Treatment (IDDT) by answering basic questions such as those immediately below. We also emphasized the need for IDDT based on the 50% prevalence of lifetime substance related disorders in seriously mentally ill (SMI) populations, highlighted barriers to treatment integration stemming from historic separation of mental illness and substance abuse treatments, and reviewed the some essential caveats from the 1997 SAMHSA report, *Improving Services for Individuals at Risk of, or with, Co-Occurring Substance Related and Mental Health Disorders*, about the need for integrated approaches. This was followed by descriptions of the roles to be played by various Stakeholders in implementing IDDT as have been initiated by the National Implementing Evidence Based Practice (EBP) Project currently underway in Indiana through the ACT Center of Indiana in collaboration with the New Hampshire-Dartmouth Psychiatric Research Center (PRC).

What does the term “Dual Disorders” mean?

Simply put, the concept of *dual disorders* is mental illness and substance use disorders occurring together in one person. It is recognized that each is a primary disorder with its own etiology, symptoms, and course. It is not expected that one is the cause of the other, although they each can affect the other.

What is IDDT?

It is treatment of substance use disorder and mental illness together on the same team at the same location at the same time. It is more than merely combining aspects of mental illness treatment with aspects of substance abuse treatment. It is a model in itself. Faithful use of the IDDT model as measured by the IDDT Fidelity Scale has been shown to improve client outcomes compared to parallel or sequential treatment.



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- *Updates giving you a better, broader sense of our purpose & projects
- *ACT Standards 7/02 Policy in PDF! Annotations included
- *FAQs - a galore of questions & answers covering a wide range of EBP-related topics. Send us your questions!
- *And much more!

What are the critical components of IDDT?

1. Integration

** Same team, same location, same time*

Team members are trained in mental illness, substance abuse, and especially, integrated dual disorders treatment. This results in fully integrated assessment, treatment planning, individual counseling, and case management specific to the person. Rather than sending people to separate mental health and substance abuse services, team members work together providing an integrated array of services that best meet individual needs. The IDDT implementation project seeks to address this via fidelity assessment, training, and consultation.

2. Stage-wise interventions

** Recognition that recovery occurs in stages*
** Addressing interventions appropriate to stage of change*

The transtheoretical model identifies five stages of change; precontemplation, contemplation, preparation, action, and maintenance. In the **precontemplation** stage, there is no intention to change behavior.

Individuals in this stage are unaware of their problems. A person in the **Contemplation** stage is becoming aware or aware that a problem exists but is not yet committed to take action. In the **Preparation** stage, the person intends to take action soon and has taken some ineffective actions in the recent past. They are weighing various options for the best approach to take. **Action** is the stage in which individuals actually succeed in changing their behavior in addressing their problems. This stage includes specific behavioral changes and involves concerted time and effort. In the **Maintenance** stage, people work to prevent relapse and consolidate the gains made during the action stage. For dually disordered individuals, this involves behaviors that extend from six months or longer past the initial action. In IDDT, each disorder follows this pattern and can be affected by behaviors associated with the other disorder and its symptoms.

In IDDT all interventions (including ancillary rehabilitation services) are determined by the person's stage of treatment or recovery. The specific interventions addressed to the assessed stage of change are: **Precontemplation** ñ Engagement - Outreach, practical help, crisis intervention, develop working relationship, assessment; **Contemplation & Preparation** ñ Persuasion - Education, set goals, build awareness of problem, family support, peer support; **Action** - Active Treatment - Substance abuse counseling, medication treatments, skills training, family support, self help; and **Maintenance** - Relapse prevention - Relapse prevention plan, continue skills building in active treatment, expand recovery to other areas of life.

Effective incorporation of these concepts within an organization or program requires routine, systematic assessment for stage of change. Treatment planning as well as individual and group interventions must address clients with regard to the assessed stage of change. Skills training of clinical staff assists in the development of specific competencies in this area. Process and outcome measures as well as quality assurance mechanisms must be in place within the organization to assure true fidelity to the IDDT model over time.

3. Assertive outreach

** Services are provided where they are needed*

Outreach is critical to addressing the needs of consumers in the early stages of recovery. That means

that services are provided in people's homes, where they work, and in other community settings where support is needed.

4. Motivational counseling

** Consumer driven, client choice*
** Focus on client goals and function*

An empathic, supportive, yet directive counseling style provides conditions within which change can occur. There is a focus on the client's strengths rather than weaknesses and a respect for the client's autonomy and decisions. Treatment is individualized, client-centered, and does not depersonalize the client by using labels like "addict" or "alcoholic." Use of empathy (not authority or power) helps the development of a therapeutic partnership. Less intensive treatments focus on early interventions and extend motivational approaches into nontraditional settings. There is recognition that mental illness and substance abuse disorders exist along a continuum and require new treatment goals, which involve interim, incremental, and even temporary steps toward ultimate goals.

5. Substance abuse counseling

** Shared decision-making*

Acknowledging difficulties for clients in early stages of change, counseling provides support for a realistic view of change through small steps and helps the client identify high-risk situations and develop appropriate coping strategies to overcome these. Counseling then assists the client in finding new ways to reinforce positive changes made and begins a process of liaison to self-help.

Conclusion

The Integrated Dual Disorders Treatment Project of the National Implementing Evidence Based Practice (EBP) Initiative relies upon available research evidence in an ongoing process of implementing and sustaining IDDT within organizations. Support for the implementation takes many forms and involves many stakeholders in order to be successful, faithful to the model, and sustained over time. **Watch future editions of this newsletter for more details about *the Role of Stakeholders in Implementation of IDDT in Indiana.***



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**INDIANA UNIVERSITY
PURDUE UNIVERSITY
INDIANAPOLIS**

School of Science
Department of Psychology
402 North Blackford Street, LD 124
Indianapolis, IN 46202-3275

ACT Center Direct Phone: (317) 274-6735
Psychology Office Fax: (317) 274-6756
ACT Listserv: IUPUI-ACT-CENTER-L@listserv.iupui.edu
Website: www.psych.iupui.edu/ACTCenter

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



What's on the calendar?

UPCOMING KICK-OFF TRAININGS

To learn the basics and more about ACT and IDDT, we welcome you to attend any one of our upcoming Kick-off Trainings. Please contact the ACT Center of Indiana if you would like more information!

Upcoming ACT Kick-offs

Cummins (Danville/Avon)	11/19/02
Hamilton (Terre Haute)	11/13/02

Upcoming IDDT Kick-offs

Four County (Logansport)	TBA
CMH (Anderson)	TBA
Cummins (Danville/Avon)	TBA
Gallahue (Indianapolis)	TBA

“Our board’s aboard!”

The ACT Center of Indiana Advisory Board will start meeting in 2003.
Let us know if there are things you think our board can help us with!

