ACT Center of Indiana

Excellence in Training, Research, and Technical Assistance

April 2003

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Directors' Notes

Co-Directors

Michelle Salyers & Mike McKasson

We are ìspringingî right along with our work at the ACT Center!

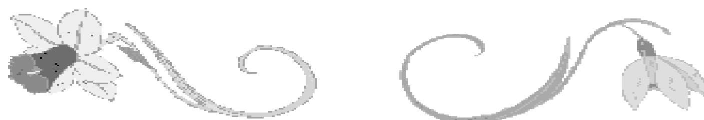
During the last quarter we worked with DMHA to apply for a second federal grant to fund Illness Management and Recovery (IMR). As described in the article ìNew Horizonsî (pg. 6), DMHA responded to an announcement by SAMHSA to apply for funds to implement and evaluate another evidence-based practice in our state. If funded, DMHA would work with the ACT Center to provide training in IMR to 6 community mental health centers in Indiana, following the same model of training and consultation we are currently using. Stay tuned for more details on IMR and our related projects.

In addition to working on our own grant applications, we have received numerous requests for consultation and assistance on other projects. In this last round of SAMHSA proposals, several states asked for assistance from the ACT Center to help them develop ACT standards, create a technical assistance center, and/or implement ACT. We have been very excited that others are looking towards Indiana as a model for implementation of ACT and other evidence-based practices.

In terms of training, we were pleased to host Charlie Rapp, Ph.D., in January as he and his colleagues presented the Outcomes-based Supervision Workshop. We had a great level of participation and enthusiasm for his talk. Thanks to all of you who attended! As their Computer Outcomes Monitoring Software becomes available, we will be distributing it to numerous Indiana agencies who have expressed interest in the consumer data monitoring and reporting application. We are also very excited to host Mary Brunette, MD, of Dartmouth Medical School and the NH-Dartmouth Psychiatric Rehabilitation Center, who will be presenting 2 day-long events in May (one in central Indiana (Indianapolis at IUPUI) and one in northern Indiana (Elkhart at Oaklawn)). She will discuss medical issues related to treating the dually-diagnosed population (mental illness and substance use disorders), the IDDT model, and motivational interviewing skills and techniques. Because her talk is very clinically-oriented and ìhands-on,î we needed to focus registration on a limited number of clinicians at each of our stateís mental health centers. See the ìWhatís on the Calendar?î section for upcoming events open to the general public on related topics.

Our ACT team leaders have given us many suggestions for improving ACT implementation. In a recent discussion, leaders gave us ideas of how teams can effectively use their psychiatrist time. Check out the article ìTick, Tock Doc Clockî for some ideas in this area. One of our team leaders, Bridget Bascom-Hinkle of Community Mental Health Center in Lawrenceburg, has written a very interesting article on the role of team members in implementing ACT (see ìACT Teamwork,î pg. 2-3). Bruce Jensen writes about the role of stakeholders in implementing IDDT (see ìThe Role of Stakeholders in Implementation of IDDT,î pg. 4). Together these articles highlight the importance of teamwork and varying perspectives that can be applied to the successful implementation of any evidence-based practice.

All of the 8 new ACT sites have been certified by DMHAÖcongratulations to the teams for your hard work in getting this accomplished! We would also like to congratulate the next set of ACT programs that DMHA has selected for ACT funding: BehaviorCorp, Tri-City Community Mental Health Center, and Wabash Valley Hospital. We are looking forward to working with you to help implement high quality ACT programs.



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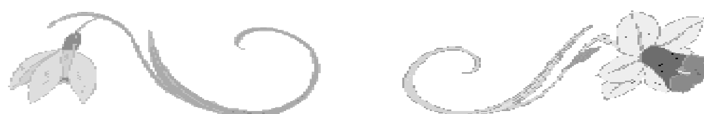
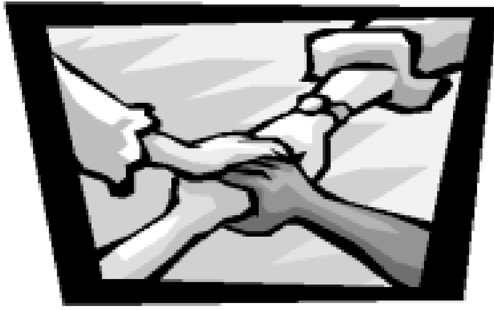




ACT TeamWork

Words from Bridget Bascom-Hinkle
ACT Team Leader in Indiana

Hello, my name is Bridget Bascom-Hinkle, and I am the team leader for the ACT team at Community Mental Health Center in Lawrenceburg, Indiana. I began my employment with CMHC, Inc. in 1995 and have worked with the Community Support Services Division since my hire. When I was asked to share our experiences in the implementation process, I asked myself where I would begin or what I would say. After pondering several areas for discussion, I decided to share perspectives from a team leader role and the impact this role has had in adhering to the Indiana Standards for ACT Teams and the fidelity of the ACT model. I would like to take this opportunity to share some of our experiences throughout the certification process and offer support for team leaders and team members in their journey toward certification.

Our ACT team presently serves 57 consumers over three counties. The catchment area is comprised of rural and urban counties. The staff composition of team REACH includes a psychiatrist, two nurses, four case managers, a substance abuse specialist/case manager, employment specialist, and me as team leader. Although our team was established over a decade ago and adopted many of the concepts of an ACT team, there were changes that were required over the past year for us to achieve our goal of full fidelity to the model.

The road to full certification as an ACT team in the state of Indiana was not always a smooth one. There have been many challenges along the way that we had to hurdle to get to this point today. These challenges included team unity, communication, trust, accountability, engaging difficult clients, and serving rural counties. As a team leader, I understood my commitment and enthusiasm to the model were vital. Without a clear understanding of the model and the effectiveness of this model in serving the most challenging population in mental health, I would not be able to provide an environment where my enthusiasm and commitment would be contagious. I believe this helps to establish credibility with the team, creates a solid foundation, and enables them to understand the need for these changes to better serve the consumers. By far, the most challenging aspect was establishing team unity through communication, trust, and accountability. During the hiring process, our team was established with new staff to the agency and existing staff. It was very difficult to facilitate the transition from a traditional case management approach in the minds of traditionally autonomous clinicians and convince them that sometimes change can be good and beneficial to the consumers. I attempted to tackle this challenge by performing group interviews for hiring staff. The intention was for the team to decide what clinicians would be a fit with our team. This would enable us to develop better communication amongst team members and enhance our ability to trust one another. In effort to continue to engage the internally hired staff, I worked with them to define ways that would allow them to feel more in control of their daily schedule. For example, we developed a schedule assigning a shift manager for different days of the week to delegate assignments to the team. I empowered staff to create and facilitate groups and activities that would be beneficial to the consumers, and in supervision with staff, I continuously focused on individual strengths of each team member and what he or she could contribute to the success of our ACT team.

Communicate. Communicate. Communicate. My job requires a great deal of listening as well as sharing of information. I meet with all team members individually on a weekly basis for supervision and give them an opportunity to address any issues or concerns they may be having at the present time. During this time, I often encourage them to speak with team members and/or provide time during daily team meetings to resolve any conflicts within the team as a team. I believe I have learned a lot from my team by allowing them to take the leadership role in resolving our conflicts as a team. It has helped us to establish accountability and not point fingers as we might have historically been tempted to do.

By utilizing the input of all team members, we have been able to engage more clients that have been a challenge to serve in more traditional treatment settings within our agency. It is amazing how creative team members can become when given an opportunity to demonstrate their creativity with others during group discussions. Another approach we have found successful is building upon existing relationships between consumers and staff and gradually introducing more of the team to the consumer.

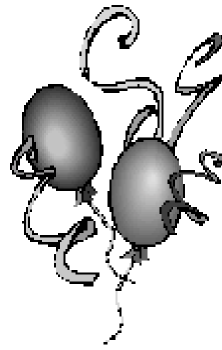
Contíd next page . . .

In combating the challenges of serving the rural counties, we developed core treatment teams for each individual consumer. The core treatment team consists of the psychiatrist, nurse, team leader, and a minimum of two case managers. These team members rotate home visits with consumers in rural areas and engage in frequent informal coordination and planning in addition to regularly scheduled treatment planning meetings. This helps to improve communication among the team about the direction for treatment. We believe it has allowed us an opportunity to provide more services to consumers in areas that are very rural and have not received a great deal of treatment services in the past.

At the end of the first year of collecting data, we have been able to celebrate many successes as a team. Sharing the data with team members has allowed everyone to see the difference our services make for the consumers and serve as a reward to all. Not to mention, it provides more credibility to what we all know, and that is ACT WORKS!! Successes for our team have been measured in numbers as well as satisfaction with our services. Our number of hospital and incarceration days continues to decrease. More consumers are seeking employment. The quality of life has improved for many of our consumers as they are maintaining better lifestyles in the community. Consumers have voiced their satisfaction with the accessibility of team members to them and the services the team is providing to them. We continue to have better relationships with our consumers because we are able to provide more services to them. The team has begun to enjoy the luxury of going on vacation and not worrying about planning coverage for consumers while they are gone. They are aware and trust that services will remain intact and uninterrupted despite their absence from the team.

These successes were especially apparent to me this past year. While I was on FMLA for the last 3 months of the year, our team continued to strive for improvement and provide quality care to the consumers as evident in our data collection and consumer satisfaction. It was with the ACT teamís hard work and commitment to these consumers we are able to celebrate the successes noted above.

Furthermore, the success of our team doesnít stop with just the team and consumers but has been an agency wide effort. Without the support of our Executive Director Joe Stephens and Community Support Services Division Director Bill Hardy, we would not have made it this far. They have truly been open to our ideas and willing to help us in obtaining all the tools necessary for successful implementation of the ACT model.



Congratulations to the 3 New ACT sites approved by Indiana DMHA!

(3/2003)

BehaviorCorp (Carmel)
Tri-City CMHC (East Chicago)
Wabash Valley Hospital (West Lafayette)

Here is a list of the Indiana sites already working hard across the state...

11 Existing ACT Sites

Approved 7/2001

Adult & Child Center (Indianapolis)
Community Mental Health Center (Lawrenceburg)
Four County Counseling Center (Logansport)

Approved 4/2002

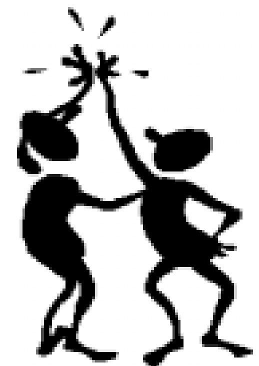
Cummins Mental Health Center, Inc. (Avon)
Hamilton Center (Terre Haute)
Midtown CM HC (Indpls)
Northeastern Center (Kendallville)
Oaklawn Psychiatric Center (Elkhart)
Park Center (Fort Wayne)
Quinco Behavioral Health Systems (Columbus)
Swanson Center (Michigan City)

6 IDDT Sites

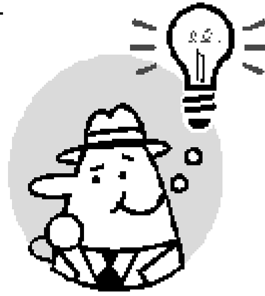
Approved 5/2002

Center for Behavioral Health (Bloomington)
The Center for Mental Health (Anderson)
Cummins Mental Health Center (Avon)
Four County Counseling Center (Peru)
Gallahue Mental Health Services (Indianapolis)
Midtown CMHC (Indpls)

We look forward to working with all these approved teams as well as others who are interested in implementing EBPs like ACT and IDDT in the future.



The Role of Stakeholders in Implementation of IDDT



By Bruce A. Jensen
IDDT Consultant & Trainer
ACT Center of Indiana

What Are Stakeholders?

Anyone who has a stake in what happens. This includes consumers, families or other supports, practitioners, program leaders, and representatives from the state mental health authority and federal government. All work together in Integrated Dual Disorders Treatment (IDDT) as critical partners for planning, implementing, and sustaining change.

Why is Stakeholder involvement important?

The IDDT Initiative stems from years of work at the national level and is suppoted by the Substance Abuse and Mental Health Services Administration (SAMHSA). Based on broad experiences related to implementing EBPs such as IDDT, it has been shown that many programmatic changes require broad support in order to effectively bring about true change. This broad consensus has also been shown to significantly improve outcomes in sustaining the change over time. In 1998, SAMHSA and two of its centers ñ the Center for Mental Health Services (CMHS) and the Center for Substance Abuse Treatment (CSAT) ñ supported a meeting of state mental health commissioners and alcohol and drug abuse directors in a ì National Dialogue on Co-occurring Mental Health and Substance Abuse Disorders.î They concluded:

ìThere must be agreement among all key stakeholders ñ including Federal, State, and community officials; policy makers; mental health, substance abuse treatment and primary health providers; consumers; and advocatesñ about the need for, and the value of, treatment systems working together to improve consumer outcomes.î

How is that done in Indiana?

A key activity in the implementation of IDDT (and all EBPs including ACT) is the development of consensus. At the level of local communities, this is done in the 6 IDDT sites via the establishment of an Implementation Steering Team (IST).

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

The purpose of the IST is to provide direction and oversight in the implementation of IDDT. ISTs should include all relevant stakeholders. Using such a team enhances consensus building, provides different perspectives, and improves the chances for effective implementation over time. The IST may serve as the group that develops the *Implementation Plan* for the specific agency and community. Agency leaders are to establish the IST as part of their participation in the IDDT and are assisted in its early formation.

ISTs are facilitated in the development of local stakeholder groups at the agency/community level to solicit input in planning, implementing, and sustaining change. In addition, they are asked to use established strategies for system change in assuring that all agency clinicians develop or refine knowledge and skills in substances of abuse and how they affect mental illness, substance abuse assessment, motivational interviewing, and substance abuse counseling. Consultation, training, and technical assistance are provided by the National Implementing EBP IDDT project and the ACT Center.

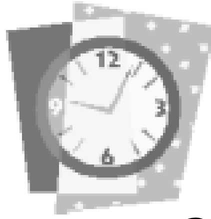
Where can I get more information?

Each of the six IDDT sites in Indiana can make copies of stakeholder-specific materials from their IDDT Implementation Resource Kits. You can also contact the ACT Center of Indiana for further information.

Conclusion

If you are interested in treatment of or recovery from severe mental illness and substance use disorders, then you are a Stakeholder. The process of implementing IDDT needs your input. Please consider the ways in which you can contribute to improved outcomes for yourself, your loved one, or your agency.

Watch for more on IDDT & ìWhat ELSE can Stakeholders do?î in future issues of this newsletter!



Tick, Tock Doc Clock

For full certification, Indianaís ACT standards require psychiatrists to devote at least 16 hours/week to ACT per 50 ACT clients (12 hrs/wk for provisional certification). When asked how an ACT program can use their allotted psychiatrist time more effectively, our Indiana ACT team leaders had several suggestions. In addition to participating in treatment planning meetings and seeing clients for medication reviews, there are many other ways that psychiatrists can work with the ACT team.

Make home and community visits to clients. Some MDs regularly see clients in their homes as other ACT team members do. This helps engage consumers on the team and gives a more balanced picture of how the person is functioning on a daily basis.

See clients more frequently. Typically, medication reviews take place once a month or so. Some consumers may need more frequent visits, particularly those who are in crisis, unstable, or at risk of hospitalization. If a consumer is ìbuilding upî to a hospitalization, the MD may even schedule daily check-in visits to help avert a hospitalization. With the ACT model, it is more feasible for the MD to titrate services based on client need rather than payor source.

See clients longer than usual. Medication reviews are often a brief check-in. Doctors can spend more time with clients, getting to know them, their symptoms, side effects, medication preferences, strategies they use to cope, etc. by extending some of the meeting time with consumers. This time can also be used by the MD to provide client and family education about the clientís symptoms, development of coping strategies, and medication. The MD can work in tandem with other team member during these extended contacts to provide services to the client and family.

See clients differently. One psychiatrist occasionally has lunch with consumers in the community. Another is starting a fitness group with clients on the ACT team. There are different possibilities for interacting with consumers than only on medication reviews and crisis visits.

Be actively involved in treatment planning and problem solving. One team has weekly staffings to review clients with difficult problems. The psychiatrist is an active participant in these meetings as well as in regular treatment planning meetings. Another team has weekly individual treatment planning meetings (2 hours long). The MD, team leader, and several other team members meet to discuss treatment plans.

Provide supervision. The standards require that the MD supervise the nurses on the team and oversee the medication management system. One team noted that their doctor meets with the nurses at the end of each day to briefly review the medications for the day. The MD can also work with the team leader to provide clinical leadership to other members of the ACT team.

Train the ACT team. One team gave examples of in-service training that their psychiatrist has recently given (e.g., current use of ECT, atypical antipsychotic medications).

Be available. One team schedules one hour a day of open time for the psychiatrist. If clients need urgent attention or have missed previously scheduled appointments, this time can be used for client contact. When the time is not needed for direct client contact, this time may also be used for supervision of nurses, planning with the team leader, or other ACT-related issues that may arise.

Be involved. The psychiatrist should be an active and integral part of the ACT team, not just the person the consumer sees for medications. Attending daily team meetings, ongoing discussions with team members and consumers, participation in treatment planning and problem-solving meetings, supervision, and being creative in using the time to help the growth of the ACT team are all important ways to be involved.

Check out our website @ www.psych.iupui.edu/ACTCenter

Info, News, Resources, Job Postings, and More!

New Horizons: Illness Management and Recovery

Update by Michelle Salyers, ACT Center Co-Director

In addition to ACT and IDDT, we are embarking on an exciting new area of evidence-based practice: Illness Management and Recovery (IMR). IMR is a structured approach to helping adults with severe mental illness manage their lives more independently. IMR provides a set of specific techniques to educate consumers about their illness and related issues, such as medications and side effects, and train them to use successful skills and strategies to cope and prevent relapse.

Benefits of IMR

IMR is a simple, cost-effective way to give consumers back the control of their illness so they are empowered to pursue their recovery goals. IMR embodies the principle of self-determination and is based on the idea that when consumers are in charge of their own lives and provided the means necessary to make informed choices, they will make better decisions than if they are directed by medical personnel to ìcomplyî with a treatment plan. Through illness management, consumers learn to proactively address issues such as symptoms, medications, worries about relapse, or depression, so they are freer to pursue recovery goals such as employment, creative activities, and friendships.

Like ACT and IDDT, *IMR works!* These techniques have been shown to result in more effective use of medication, reduced symptom severity, and reduced relapse and hospitalization rates. IMR is also considered one of the six evidence-based practices for adults with severe mental illness.

Upcoming IMR Projects

The ACT Center is becoming involved in several projects that will help bring IMR to Indiana. Adult & Child Center was recently awarded a competitive mini-grant from the Governorís Council on Home and Community Based Services to incorporate IMR on their certified ACT team (Team Siear). In this project, a consumer peer specialist will be hired to be a member of the ACT team. Veronica Macy will be working with that person and the rest of Team Siear to teach them how to use IMR. The grant will allow a pilot study of IMR. Once this program is successfully in place, The ACT Center can help replicate this project to bring IMR to the rest of Indiana.

We have also applied for federal funds to support IMR in Indiana. As mentioned in our previous newsletter, we applied to NIDRR to fund the integration of IMR on several ACT teams in Indiana. If that project is funded, we would work intensively with 2-4 ACT programs to train them in IMR. One of the key aspects of that grant is to identify a consumer peer specialist and an ACT clinician to work together as specialists in IMR for the whole ACT team. We believe that this focus of training will increase the integration of IMR on the team.

Most recently, we worked with DMHA on their application to Substance Abuse and Mental Health Services Administration (SAMHSA) to systematically bring IMR to Indiana. If this project is funded, two trainers from the ACT Center will provide individualized consultation and training to 6 Indiana mental health centers to help the agencies implement IMR to a high degree of fidelity. The process will follow our model of consultation and training that we have used for ACT and IDDT. This will include working intensively with several stakeholder groups in the agency (e.g., administrators, clinical staff, consumers, family, and other pertinent community members). Training will involve broad-based kickoff presentations, in-depth skills training, and on-going monitoring and supervision throughout the project. We will evaluate the effectiveness of the training, the fidelity of implementation, and select consumer outcomes every 6 months throughout the project. This evaluation will be central to providing corrective feedback to the current implementation efforts and will help guide planning of future implementation in other entities across the state.

We are continuing to work on ways to expand our capacities to bring other evidence-based practices to you. We are very excited about our endeavors in the area of IMR and believe this will build on the many positive changes that are already occurring in our mental health system.

Up Close & Personal

Featuring

Lia Hicks
ACT Consultant & Trainer
ACT Center of Indiana

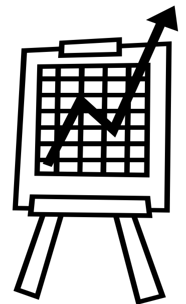
Hello, my name is Lia Hicks, and as some of you already know, I am one of the ACT Centerís ACT Consultant/ Trainers. I have held this position since January 2002, working directly with 5 of the 11 certified ACT teams in Indiana as well as serving as coordinator of shadowing site visits for all ACT teams. Prior to my involvement with the ACT Center, I was an ACT Team Leader for 7 years at Adult & Child Mental Health Center in Indianapolis. I have actually been employed for 10 years at Adult & Child Center, working in an SGL facility and as a case manager prior to the team leader position. Prior to Adult & Child, I worked for Wabash Valley Hospital while completing my B.S. in Individual and Family Development from Purdue University. Believe it or not, my original career plans were to be ìthe next Jane Pauley,î but I realized after taking a few communication classes at Purdue that I was not ìToday Showî material. I actually started in the mental health field working part-time in a group home during college, then taking a similar full-time position after graduation, thinking it was my ìtransitionî job before finding my ìdream jobî (whatever that was). Well, here I am a decade later happy that I never ìtransitionedî out of the mental health field.

I feel fortunate to be a part of the re-emergence of ACT in Indiana. Being a member of the ACT Center of Indiana has and continues to be a great experience. I am able to work closely with individuals from various backgrounds and disciplines, while participating in cutting edge national research on ACT, IDDT, and other evidence-based practices. These experiences are constantly broadening my perspective and knowledge about mental health systems, human nature, and myself.

Having practiced ACT at the clinical/team level now allows me the opportunity to provide realityñbased consulting and training with other ACT teams. Understanding and following fidelity standards is immensely important to the success of an ACT team, but there are also the never-ending day-to-day challenges that exist within our agencies, communities, and lives that must be addressed for teams to function. It is very rewarding and exciting to watch new teams learn, grow, and strengthen, and I enjoy being able to use some of my own experiences to help teams both ìavoid making the same mistakesî as well as provide ìhelpful hints to make things easier. î

On a more personal note, I grew up in LaPorte, Indiana (near Lake Michigan) but have lived in Indianapolis for 10 years. I have been married to my wonderful husband for 3 Ω years, and we have a twoñyear-old son who is truly the center of our world. I spend a lot of time watching ìSpongeBob SquarePantsî and ìElmo,î but my ìadultî interests are spending time with family and friends and tending to my three cats, two dogs, and my aquarium. I also love to scrapbook.

Our mailing list has grown!



With so much interest in our newsletter, we've decided to switch to an email and website-based newsletter. Starting with our July 2003 issue, look for our quarterly newsletter over the ACT Center Listserv and at www.psych.iupui.edu/ACTCenter. Not on the listserv yet? Email vbannon@iupui.edu to subscribe today!

Please contact us if you do not have access to email or the internet and would like a printed copy mailed to you. (For those receiving the electronic version, please feel free to print and share with others!)

ACT Center of Indiana

Excellence in Training, Research, and Technical Assistance

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To change 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. Printing and mailing by Campus Design, Print & Mail IUPUI.

What's on the calendar?

UPCOMING EVENTS

ACTA 2003 Conference

19th Annual Assertive Community Treatment Conference
Promoting Recovery by Enhancing Team Competency
June 26-28, 2003
Pre-Conference Institutes - June 25, 2003
Marriott Rivercenter - San Antonio, TX

Promoting recovery by multi-disciplinary teams (like ACT) working together to provide comprehensive, community-based psychiatric treatment. Supporting work to enhance individual and team competencies to ensure the most capable practitioners and best functioning teams possible.

Visit www.actassociation.org/conference for more details and a downloadable conference brochure.

For more information, contact:
ACTA
Phone: (810) 227-1859
Email: conference@actassociation.org

Indiana DMHA 2003 Conference

Co-Occuring Disorders: Developing Clinical Expertise
Within Integrated Systems of Care
July 14 - 16, 2003
The Westin Indianapolis - Indianapolis, IN

The conference will promote the integration of services for individuals with co-occurring mental health and substance use disorders and contribute to increased competence and awareness across disciplines of issues affecting the provision of services to dually diagnosed individuals.

Audience: Mental health & addiction clinicians, administrators of mental health & addiction service treatment programs, and consumers of both types of services

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