ACT Center of Indiana

Excellence in Training, Research, and Technical Assistance

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NOTES FROM THE DIRECTORS

We begin this New Year with all sorts of excitement and anticipation!

During the last quarter, we applied for a grant from the National Institute on Disability and Rehabilitation Research to bring Illness Management and Recovery to our ACT programs. While we still plan to provide training on this topic, a grant would allow us to do the training more systematically and to collect data on how well it works. Although we submitted the proposal in November, we may not hear the results for a while yet. Keep your fingers crossed!

We have been gearing up for our work with the new Community Action Grant (CAG) we were awarded last fall. As we described in the previous newsletter, this grant will allow us to work on consensus building around the best way to provide integrated dual disorders treatment (IDDT). We recently had our first meeting with our IDDT CAG Sub-committee to discuss this advisory board's role in helping us figure out how to best use the resources of the grant and to plan activities for the upcoming year. We were also able to fund a workshop on IDDT with the grant and are planning similar trainings in the future.

We were very fortunate to have Robert Drake, MD, Ph.D., and Deborah Becker, M.S., visit us and provide a day-long workshop this past December. Dr. Drake presented on Integrated Dual Disorders Treatment, and Ms. Becker presented on Supported Employment and how to better integrate employment services on our ACT teams. Charlie Rapp, Ph.D., is also visiting and providing a day-long workshop on supervision issues in January 2003. We will have Dr. Rapp and his colleagues back in the spring of 2003 for more intensive training on this important topic.

We are also looking forward to having our first meeting with our ACT Center of Indiana Advisory Board at the end of this month. This board will help the ACT Center maximize evidence-based practices for adults with severe mental illness in Indiana. To do this, board members will learn about evidence-based practices, apply personal perspectives and experiences to help us improve mental health services, identify things our center should be doing, brainstorm strategies for overcoming systemic and specific programs' barriers, help the IDDT CAG Sub-committe plan activities, and more.

The 8 new ACT sites have all submitted applications for certification. DMHA will be visiting each of the programs and establishing whether programs meet state requirements for ACT certification. Congratulations to the programs for your hard work in getting your teams to this next big step!

Congratulations are also in order for Dr. Rollins…Angie recently defended her dissertation. Way to go!

Co-Directors

Michelle Salyers & Mike McKasson

IN THIS ISSUE

The Role of Indiana Family and Social Services Administration as It Relates to Mental Health Services

Excerpts from a speech (10/2002) given by John Hamilton, Secretary of the Indiana Family and Social Services Administration

"The Surgeon General's Report on Mental Health, released in 1999, states that following World War II, the 'joint policies of community care and deinstitutionalization led to dramatic declines in the length of hospital stay and the discharge of many patients from custodial care in hospitals.' As we know, these policies had severe consequences for many people, as the communities to which individuals were returning were not ready for them. The Report states that the 'policies were implemented without evidence of effectiveness of treatment and without a social welfare system attuned to the needs of hundreds of thousands of individuals with disabling mental illness.' The report then cites 'housing, support services, community treatment approaches, vocational opportunities, and income supports for those unable to work,' as the unmet needs. Indiana is not any different from the rest of the nation. Our hospital census has declined from over 8,000 in 1970 to less than 1200 today. We are serving far more people in the community than in the hospitals. In SFY2002, the Division of Mental Health and Addiction served approximately 62,500 adults and children with a mental illness in the community, and less than 2,300 in the hospitals.

"Along the way we learned several important facts:

1. What needs to be done goes beyond medical treatment.

2. Evidence-based practices must be implemented as much as possible.

3. Social supports and rehabilitation services are critical to the success of the individual in the community.

4. Collaborative efforts are necessary to achieve lasting outcomes.

5. Consumers are an untapped resource in their road to recovery."

The Surgeon General's Report

"The Surgeon General's Report is different from many reports in that it does not culminate with a list of recommendations. Rather, the report describes itself as an 'up-to-date review of scientific advances in the study of mental health and mental illnesses' from which overarching themes for the report are highlighted. Two of those themes deal with treatment: 1) A range of treatment exists for most mental disorders; and 2) The efficacy of mental health treatments is well documented. In an effort to encourage broad implementation of evidence-based practices, the New Hampshire-Dartmouth Psychiatric Research Center has identified six (6) practices, recognized in the Surgeon General's Report, for persons with schizophrenia that the Center is promoting. Let me talk about how Indiana fairs on those six."

Hamilton went on to discuss all six evidence-based practices. Here are his words on Assertive Community Treatment (ACT) and Integrated Dual Disorders Treatment (IDDT).

Assertive Community Treatment

"Assertive community treatment (ACT) is a team based case management program where all of the services needed to support a person in the community are provided through a small team that is multidisciplinary and whose members have a shared caseload. ACT is a well specified and researched program, and Indiana has a long history of research and activity around ACT thanks to IUPUI faculty like Doctors Gary Bond and John McGrew. Indiana is embracing ACT fully. FSSA/DMHA has developed a system for certifying ACT teams, and is contracting with the ACT Center of Indiana for technical assistance to the providers. Three teams are certified, with eight more planned for this fiscal year.

"Indiana's ACT teams are serving a wide variety of people. People who have suffered their first psychotic episode are being retained in the community, and people with long hospitalization histories are being re-integrated into community life.

"The Division of Mental Health and Addiction and the Office of Medicaid Policy and Planning are currently meeting and reviewing proposals that will make ACT a Medicaid covered service in Indiana. ACT will be a full

fledged option in the hands of the community mental health centers.

"While Indiana has not adopted the ACT model with the fervor of states like Wisconsin or Michigan, our approach is measured and built on sound science. While all of our providers are not likely to embrace the model, in most of Indiana consumers will have a real choice with traditional care in group homes and day treatment on one hand and ACT on the other.

"Indiana is one of seven states participating in a MacArthur Foundation / Dartmouth University project to measure the implementation of these six evidence based practices. Because of our work on ACT, and our commitment to move forward on ACT, we were invited into this select group seven states. Our share of the project is to concentrate on Assertive Community Treatment and on Integrated Services to persons with dual diagnoses."

Integrated Services for Persons with Dual Diagnoses (mental illness and addictions)

"I've been told that the most difficult patients to serve are those individuals whose mental illness is complicated by an addiction. I've also been told that this is a growing proportion of the people being treated in the public mental health system. Historically, this person was sent to two different providers for care. The mental health side would start service after a period of sobriety. The addiction side would provide service but not if any medications were provided. That doesn't make sense. In Indiana six community mental health centers are currently piloting the Dartmouth toolkit for this program. The toolkit provides a guide for how mental health and addiction services should be integrated.

"This is not an easy transition for these providers. The integrated services paradigm moves away from the 12 step model. It calls for motivational counseling and stages of change thinking that is rare in Indiana. A recent audit completed by the Center for Substance Abuse Treatment tells us that there is little besides the 12 step model in addictions treatment in Indiana, and case management in addictions is almost non existent. We have a long way to go, but the six pilot projects are a good start."

In terms of funding EBP's, Hamilton highlights the National Council on Disabilities Report stating adequate funding is needed to improve public mental health systems.

"... I won't propose that mental health has all the funding needed to provide appropriate services to eligible Hoosiers, but I do believe Indiana is on the right track. The closure of Central State Hospital was cited in this report as an example of how hospital funding could be successfully redirected to the community to support additional intensive services to meet the needs of individuals transitioning to the community."

FAQ Box

Q: How are families & consumers integrated into Evidence-based Practices like ACT & IDDT?

A: There is an increasing emphasis among EBP proponents on the need to actively engage and intervene with the client's family and other natural support systems. When possible, ACT and IDDT teams should make use of a client's natural supports, including family and friends, who often want to and can provide valuable help. Team interactions with supports include such activities as psycho-education, collaboration and communication about treatments, and interventions to enhance and promote positive interpersonal relationships. As with other activities, clients should be involved in decisions to actively engage with the family. In addition, in Indiana, each ACT and IDDT team is encouraged to create advisory boards consisting of family members and consumers to advocate for family and consumer perspectives and advise the team in general.

Dual Disorders Recovery: A Personal Account & Commentary

WHAT IT WAS LIKE

He described himself as hardworking at the job he had throughout high school. He played in the band and was a bandleader. He also went steady with his girlfriend for over a year, was on the Honor Roll, and graduated with Honors. At about age nineteen, he began to have what he now recognizes as *loose associations*. He also sees now that "…I began to drop out more than drop in." It was not until he was about twenty-two that he was diagnosed with schizophrenia and hospitalized while serving in the military.

"It didn't hit me as devastating. I didn't know what mental illness was when I got it. I was caught up in the process of making friends. Everybody was friendly and from someplace else." Early on, he responded to these events like anyone who faces mental illness. He was unaware of the implications, saw no need for changes, and so relapses continued. This describes a state of ***Pre-contemplation*** according to the **Stages of Change** concept [1-4]. Thus began a twenty-year process of recovery from both severe mental illness and substance related disorder.

WHAT HAPPENED

"I had an odd feeling going to my appointments. Everybody knows you're there for counseling. When things began to go well, I'd quit taking meds. I didn't know the cause and effect of taking meds and things going well. I didn't see the subtle changes for the better while on meds." The stigma faced by those who suffer mental illness contributes to making it difficult to accept, but he dutifully participated in treatment despite an incomplete understanding of what he faced. As time passed, he went through another stage in the process of change - ***Contemplation***. "It took me some time to figure out that things went well when I was on meds and didn't when I went off them. Once a psychiatrist thought I had been misdiagnosed and took me off meds. I bottomed out." He relapsed again. He went to live with his parents who continued to support him so he had *stable housing.*

"Hope is the essential thing."

"My counselor accepted me. Looking back I can see that he didn't have an agenda for me. He didn't tell me what to do so much as he listened and helped me explore options." In working with persons who have severe mental illness and substance related disorder, it has been shown that use of certain principles help the person along in the process of change. Although he felt the counselor "…didn't have an agenda for me," the counselor was using an approach that follows a clear course of action focused on the person which is consistent with **Principles of Motivational Interviewing:** [5, 6]

- ***Express empathy**, which demonstrates acceptance
- ***Develop discrepancy** by exploring the pro's and con's of the persons decisions
- ***Avoid argumentation** by accepting the person's own insights and plans
- ***Roll with resistance** by accepting and helping the person explore their ambivalence
- ***Support self-efficacy**, which instills hope

"He had no treatment plan in mind for me to comply with. Probably a great deal of frustration case managers feel comes from having specific expectations of their clients. They get frustrated that clients are not where the case manager thinks they ought to be." This is a common phenomenon that results from professional interventions appropriate to the ***Action Stage*** being applied in the earlier stages. It is a mismatch. The **Stage-wise Treatment** concept is driven by routine and recurring assessment for the stage of change and advocates that different interventions be applied in the different stages.

"I have a special place in my heart for my counselor. He was my life coach for a while. I trusted him." The rapport the counselor had established with this approach engendered trust. This factor was critical to *engaging* him in the early stages of the process of change. He felt accepted, safe to openly explore options at his own pace, and free from critique by the counselor. The counselor had employed a *non-confrontational approach.*

"It was key to get hooked up with the counselor."

"They gave me intelligence testing and aptitude testing and determined I was a candidate for college. Then the counselor helped me get tuition money from the state vocational rehabilitation services. I started out as a business major and worked real hard at it, but it didn't fit with me." He sought *meaningful activity* in his life. "I wanted to help other people with mental illness, so I decided to major in psychology. I was happier as a psychology major, but voc rehab wouldn't fund it so I took

out student loans. Maybe they figured someone with mental illness couldn't work in mental illness."
By this time, he had his own motivation to change and so did not let the lack of voc rehab money for tuition get in his way. The support and acceptance he had received early on from his family, counselor, and voc rehab enabled him to experience successes along the way despite the setbacks, relapses, and discouragement. He was encouraged by others, not demeaned because of what he did not yet know and did not yet do. It became clear to him that in order to be able achieve his goals in life he would have to continue doing things to manage his mental illness. He had progressed through the ***Action Stage*** of change with regard to mental illness treatment and recovery and begun to make sure he maintained the essential activities that had helped him get where he was.

"There were three things that helped me: showing up for appointments, voc rehab money for school, and taking meds." This began in 1992. But he continued to drink alcohol and had not yet seen a need to change that. He had been in ***Pre-contemplation*** with regard to what he eventually recognized as alcohol abuse.

"I got tired of feeling lousy the next morning."

He had gone through the ***Contemplation Stage*** realizing that his alcohol use might pose problems for him. "In 1995, I decided to quit. I tried it without AA but couldn't keep from going to the liquor store." He considered his options in the ***Preparation Stage***, and having tried one that didn't work, he decided to try another. "My counselor had mentioned AA , so I looked them up and went to a speaker meeting. I was impressed by the people who came up to me after the meeting and gave me their phone numbers. I hadn't said anything all night except when they asked who was at their first meeting. I got a 24-hour token. I never drank since. A lot of people find it not easy to quit." Having already had successes with his mental illness recovery and concluded that he needed to manage his own illness, he knew he needed to find out what he must do to quit drinking when he had not been able to do it on his own. His past successes left him confident in his prospects, so he took action for his own sake. He had progressed to the ***Action Stage*** in his substance abuse recovery.

WHAT IT'S LIKE NOW

The last of the **Stages of Change** is ***Maintenance.*** He now continues a set of disciplines that assures his continued stability and abstinence. He takes medication, continues to attend AA, and considers his social relationships important, too. It has enabled him to acquire a bachelor's degree in psychology. It has helped him to help people, which he does in his job as the Acting Director for Key Consumer Organization, a statewide consumer advocacy and support program. In that capacity, he has a significant role in putting on a statewide Consumer Conference each year. He conducts support groups at Hoosier House, Cummins Mental Health Center, and Gateway, a group home of the Mental Health Association. He also works part-time as Night Coordinator at La Verne Lodge. In addition, he serves on the Governor's Task Force on Home and Housing Issues, the Consumer Advisory Board of the Indiana Division of Mental Health and Addictions, the Our Town Board, the Gallahue Community Hospital Advisory Board, and the Advisory Board of the ACT Center of Indiana. He has realized his pursuit of *meaningful activity*. And he continues to look ahead.

"I want to plan for retirement like everybody else."

"I've been happily married for five years and have a 20 year old step daughter who is a junior at Purdue. She's a statistics major." In his spare time, he has recently resumed working toward a Black Belt in Korean martial arts. "I'm considering getting education so I can become a mental health counselor at a mental health clinic. I want to be a role model for others and give them hope. I'll call the VA and voc rehab counselors to go back to school. I'm now better able to plead my case for funding. I wish they'd pay my student loans."

He is David Thomas. **He always was.** Since he is successfully managing his recovery from the mental illness and substance abuse that may have obscured his true identity, it now shines through. He is a very likeable guy whom I consider to be my friend.

David achieved recovery and deserves acknowledgement for this noteworthy accomplishment. The support he received in the early stages of recovery helped him to experience successes that encouraged him on the way and helped him to know that his own actions made the most difference. He came to know that his recovery was his – for his own good. He came to "comply with treatment" as a means to his own ends, not for the sake of others or to please them.

David has received support from many sources, but many persons faced with both mental illness and substance related disorders do not experience the successes he did early on. They become overwhelmed by discouragement. It is a potent obstacle to recovery. David's story demonstrates how appropriately timed interventions that convey acceptance and respect can have an impact on a person's recovery experience.

Interview and commentary by Bruce A. Jensen, MA, ACT Center of Indiana, Consultant and Trainer for the Integrated Dual Disorders Treatment (IDDT) Project, a national Evidence-based Practice initiative of the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Robert Wood Foundation

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CLARIFICATION

The matter of nomenclature in the area of comorbid mental illness and substance related disorders has been rife with potential for confusion. Different areas of the country and various practitioners have coined several terms. The following reflects a few:

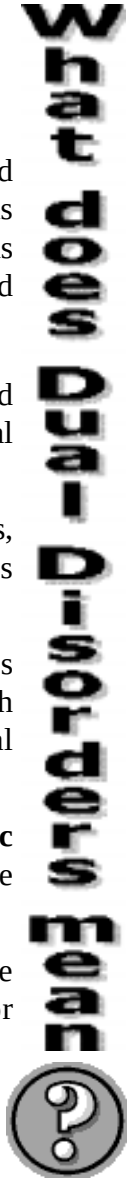
MICAA: Mentally Ill, Chemical Abusers, and Addicted. Denotes the severely mentally ill chemical abuser.*

MIDAA: This denotes the inclusion of Mental Illness, Drug Addiction, and Alcoholism in various combinations as dual/multiple disorders.*

CAMI: Chemical Abusing Mentally Ill. Denotes Chemical abuse or dependence as primary with personality disorders (but without severe mental illness).*

CAMI, with Substance Induced Psychotic Episodes: Same as CAMI with induced acute symptoms.*

MISA: Mentally Ill Substance Abuser. May denote various combinations of dual disorders with or without severe mental illness.*



In other areas, the convention is to use the term **MICA** (mental illness and chemical abuse) and **SAMI** (substance abuse and mental illness).

An earlier issue of the ACT Center Newsletter in an article entitled, "Critical Components of Integrated Dual Disorders Treatment" by Bruce Jensen under the subtopic, *What does the term Dual Disorders mean*, the definition was given as, " . . . mental illness and substance abuse disorders occurring together in one person." This may have given the reader the impression that the only dual disorder is mental illness and substance abuse, which is false. A more accurate way to portray the term dual disorders would be to state that it *includes* mental illness and substance abuse disorders occurring together in one person rather than that it *means* this exclusively.

For the purposes of the article in question, the term *dual disorders* in fact means mental illness and substance abuse disorders occurring together in one person. For the Integrated Dual Disorders Treatment Project in which the ACT Center is participating, the focus is more specifically upon persons with ***severe*** mental illness and comorbid substance abuse disorders.

*5 terms adapted from: Sciacca, K. (Summer 1991). "An Integrated Treatment Approach for Severely Mentally Ill Individuals with Substance Disorders." New Directions for Mental Health Services, Jossey Bass Publ., #50.

Up Close & Personal

Featuring: Angie Rollins Implementation Monitor

Hello, my name is Angie Rollins. I am a Research Associate in the IUPUI Department of Psychology, and some of you already know me as one of the Implementation Monitors for the Implementing Evidence-based Practices Project. I recently completed a clinical psychology pre-doctoral internship at the University of Maryland School of Medicine in Baltimore and just finished my Ph.D. in Clinical Rehabilitation Psychology at IUPUI in December 2002.

My original career goals were to go to law school and proceed into politics. But during my first two years of college, I became disenchanted with law as a profession and decided to drop out and figure out what I wanted to do with my life. After four years of waitressing, I returned to college and tried my hand volunteering at a state hospital in Cincinnati. Everyone said I'd be miserable, but I actually loved working with clients there! So after hunting for a graduate school program focusing on clients with severe mental illness, I ended up studying under Gary Bond at IUPUI. Since then, I have worked on a variety of research projects in psychiatric rehabilitation, but I would say that my main interests are supported employment and dual disorders treatment, along with fidelity and program evaluation for mental health services in general. I also have a longstanding interest in the treatment of people with severe mental illness in the criminal justice system and would like to incorporate that into an academic program of research one day.

In graduate school, my clinical experiences have included work at Midtown Community Mental Health Center, Indiana Women's Prison, Indiana University Alzheimer's Disease Center, and Larue D. Carter Memorial Hospital. On my internship, I worked primarily in a CMHC serving clients with severe mental illness in inner city Baltimore, 80% of whom have had a co-occurring substance use disorder. That year taught me about the unbelievable demands of serving this population successfully with the constant demand for increased productivity levels. But despite such demands, I will always try to remember one of my clients who told me that, because she was no longer using cocaine and had a job, "I think my daughter can be proud of me now." Recovery takes on different shapes and sizes, and I hope we can help more of our clients achieve it with our work here at the ACT Center of Indiana.

On a more personal note, I hail from the hills of southern Indiana. I have a large and loving extended family who strongly advocated for my return to Indiana for this job. I have an amateur green thumb and enjoy watering my flowers or sitting on my front porch in my free time. I love good movies and books, and I try to save time for the Sunday newspaper each week. I also still suffer from a mild addiction to politics and love to catch Chris Matthews' show Hardball whenever I get home from work in time to see it!

Stay Tuned for More Interesting Articles in Upcoming Issues

- The Role of Stakeholders in Implementation of Integrated Dual Disorders Treatment
- ACT & IDDT Program Staff & Consumers - Surprises, Challenges, Successes, & Words of Wisdom
- Future Workshops and Conferences
- What Research Tells Us about Evidence-based Practices

Are there things you'd like to see in our newsletter? Contact us today!

ACT Center of Indiana

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What's on the calendar?

UPCOMING TRAININGS & EVENTS

ACT Center of Indiana Workshop

Dr. Charles A. Rapp
January 24, 2003

Charles Rapp, Ph.D., Professor at the School of Social Welfare and Director of the Office of Mental Health Research and Training at University of Kansas, is a leading expert on strengths-based case management and outcomes-based supervision. He will be giving a free full-day workshop focusing on major topic areas such as principles of client-centered management/supervision, managing by outcomes, methods for managing/using information, reward-based environment, and transfer of training. Open to ALL who are interested, but pre-registration required.

For more details and/or to register, contact:
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DMHA 2003 Conference

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

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. Speakers include: Kenneth Minkoff, M.D., Robert Drake, Ph.D., Victor DeNoble, Ph. D., and Laurie Markoff, M.D.

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

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