ACT Center of Indiana

Excellence in Training, Research, and Technical Assistance

October 2003

Volume 2 ❖ Issue 4

Notes from the Directors

Michelle Salyers & Mike McKasson

Many exciting things are happening in Indiana regarding evidence-based practices. We would like to share a few of these with you.

ACT - The Indiana ACT Standards are now official (administrative code; 440 IAC 5.2) and will be effective soon. (See page 7 of this issue for more details.) This has been a long process, but with the input and effort of many, ACT standards have now come to fruition. Indiana now has 3 fully certified ACT teams, 8 provisional, and 4 new programs in training. We have heard from several other centers planning to seek certification this year. It is great to see the growth of ACT across our state!

IDDT - Regarding integrated dual disorders treatment (IDDT), we were recently awarded a Community Action Grant Phase II (SAMHSA) to further promote IDDT throughout our state, including the continuation of our state level advisory board, implementing IDDT in 2 new centers (Grant Blackford and Adult & Child), and continuing our work with current IDDT programs.

IMR - Our newest projects will focus on Illness Management and Recovery (IMR). We recently were awarded a grant to integrate IMR onto ACT teams from NIDRR. A month later, our state DMHA was awarded a separate grant from SAMHSA to implement IMR in 6 other community mental health centers. Both projects should begin early next year. We are very excited to help bring this practice to so many centers!

SE - In collaboration with the SECT Center, we are expanding supported employment training in Indiana. We are bringing Linda Carlson (trainer with the National Implementing EBP Project) to train ACT Center and SECT trainers on evidence-based principles using the toolkit in the national project. This will enhance our ability to help centers provide high quality employment services to their clients.

Finally - Outcomes! As we described in the last issue of the newsletter, outcome monitoring is critical to implementing quality services. We have been working closely with several centers to help establish a computerized system to monitor several key consumer outcomes. This has been a sometimes slow and painful process, but once established, we believe this feedback system will enhance services, leading to further positive outcomes for consumers.

In This Issue

ACT Admission Criteria: Who is an appropriate referral to an ACT program?

Michelle Salyers, ACT Center Co-Director

The ideal in mental health treatment is that a mental health center provides a range of service options suited to consumers at different levels of needs. It makes little sense to provide high intensity services to individuals who are managing their illnesses well. ACT services are intended for consumers who do not appear to benefit from usual services (e.g., once-a-month case management). Specifically, ACT is designed for consumers with severe mental illness who have the most severe difficulties. These difficulties typically include:

* Frequent psychiatric hospital admissions
* Frequent use of emergency rooms
* Housing instability or homelessness
* Dual diagnosis (severe mental illness & substance use disorder)
* Problems with the law
* Recent discharge from long-term hospital

A rule of thumb is approximately 15% - 20% of consumers with severe mental illness in a community need ACT services. Many of these may include individuals not currently served by the mental health center. One of the important roles of an ACT program is to identify and engage these individuals.

ACT is a very effective approach that includes a team of people from different disciplines working together to provide individualized, intensive services. The team makes home visits, works hard to engage clients, and helps clients with the gamut of things including finding and maintaining housing and employment, helping reduce substance use disorders, budgeting, medications, learning coping strategies, etc. It is tempting to make these services available for everyone. However, ACT should be reserved for those most in need.

Admission criteria are important for several reasons:

ACT is very intensive. Providing too many services to someone who could do well with a different approach may not be beneficial in the long run and could interfere with the consumer's independence and recovery. Finding the right amount and type of services for individuals is important.

ACT is a time-unlimited approach, meant to provide intensive services for as long as consumers need the services. In Indiana, when consumers graduate from ACT, standards require that they have easy access back to the ACT team if needed. If the caseload is filled up with many people who do not really need ACT, there will not be room on the caseload for those that do.

ACT is expensive. However, ACT can also be cost-effective when serving clients with extensive hospitalization use (Latimer, 1999). But the research also shows that ACT is NOT cost-effective when serving clients who do not have this history. If extensive resources are being spent for clients who can be effectively served elsewhere, ACT will become a financial drain on the system. Centers and the state will not be able to maintain the ACT programs over the long haul.

ACT is effective, but this will be seen only when clients have clear need for the services. If ACT is being used for consumers who are already engaged in services and are able to meet many of their own needs, clear benefits of ACT may not be apparent. In these times of tight resources, if ACT is not being seen as effective, funders will not pay, and ACT will not be available for anyone.

Clear, objective admission criteria that focus on the most severe needs are critical for teams to follow. ACT should not become a "dumping ground" for people who are difficult to serve but otherwise do not meet ACT criteria. ACT also should not be used for clients who are doing well in other programs (although this depends greatly on the quality of other available services). We all have room to improve, but we might be able to get there in alternative ways. For example, a consumer who regularly attends day treatment might do well in supported employment or supported education.

Reference:

Latimer, E. (1999). Economic impacts of assertive community treatment: A review of the literature. Canadian Journal of Psychiatry, 44, 443-454.

Substance Abuse Treatment Scale (SATS)

Article by Angie Rollins, Implementation Monitor

As part of our efforts to implement Integrated Dual Disorders Treatment (IDDT) and to measure consumer outcomes for substance use disorders, we are encouraging programs to use the Substance Abuse Treatment Scale (SATS) developed by researchers at the NH-Dartmouth Psychiatric Research Center (McHugo, Drake, Burton, & Ackerson, 1995). The scale helps us to measure a consumerís stage of treatment for substance use disorders and is the basis for using a stagewise approach in the IDDT model: consumers at different stages of recovery require different sets of interventions to progress to the next stage (as opposed to all interventions focusing immediately on abstinence).

Although we are asking both ACT and IDDT teams to track consumers' SATS scores as a part of our consumer outcomes monitoring process at the state level, the SATS is a user-friendly way for any agency to assess a consumer's stage of substance abuse recovery and switch the intervention focus to that stage. The SATS includes 8 stages with behavioral anchors to make assessment easier and a ninth category (Not applicable) for when a consumer does not experience substance use issues. The SATS can be used clinically for any substance of abuse, but for outcomes measurement purposes, we ask that clinicians only rate consumers on their use of controlled substances and alcohol (i.e., not caffeine or nicotine). Clinically, however, the SATS could be used for planning appropriate stagewise treatment for abuse of any of these substances.

As clinicians are well aware, many consumers with severe mental illness struggle with multiple substances of abuse. In many cases, the consumer may be in a more advanced stage of recovery for one drug (e.g., "I've been clean from heroin for the past 6 years." = Remission #8), while they are in an earlier stage of recovery for another drug (e.g., "I keep talking with my case manager about how it might be a good idea if I didn't smoke so much weed, and that's probably true, but isn't in legal in some countries anyway?" = Early persuasion #3). In the case of multiple substances of abuse, we recommend that clinicians rate the consumer based on their most problematic substance at the time of the assessment. In this example, the score for the consumer would be Early persuasion #3, based on his/her marijuana use.

For copies of the SATS, please contact the ACT Center of Indiana for more information.

Mchugo, G. J., Drake, R. E., Burton, H. L., & Ackerson, T. H. (1995). A scale for assessing the stage of substance abuse treatment in persons with severe mental illness. Journal of Nervous & Mental Disease, 183(12), 762-767.

Substance Abuse Treatment Scale

0. N/A: Not Applicable
Not applicable. No history of substance use disorder.

1. Pre-engagement
The person (not client) does not have contact with a case manager, mental health counselor, or substance abuse counselor.

2. Engagement
The client has had contact with an assigned case manager or counselor but does not have regular contacts. The lack of regular contacts implies lack of a working alliance.

3. Early Persuasion
The client has regular contacts with a case manager or counselor but has not reduced substance use more than a month. Regular contacts imply a working alliance and a relationship in which substance abuse can be discussed.

4. Late Persuasion
The client is engaged in a relationship with a case manager or counselor, is discussing substance use or attending a group, and shows evidence of reduction in use for at least one month (fewer drugs, smaller quantities, or both). External controls (e.g., Antabuse) may be involved in reduction.

5. Early Active Treatment
The client is engaged in treatment, is discussing substance use or attending a group, has reduced use for at least one month, and is working toward abstinence (or controlled use without associated problems) as a goal, even though he or she may still be abusing.

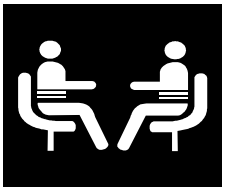
6. Late Active Treatment
The client is engaged in treatment, has acknowledged that substance use is a problem, and has achieved abstinence (or controlled use without associated problems) but for less than six months.

7. Relapse Prevention
The client is engaged in treatment, has acknowledged that substance abuse is a problem, and has achieved abstinence (or controlled use without associated problems) for at least six months. Occasional lapses, not days or problematic use, are allowed.

8. In Remission or Recovery
The client has had *no* problems related to substance use for over one year and is no longer in any type of substance abuse treatment.

ACT DOC TALK: Part I

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



Introduction

My name is Dr. Osuntokun. I am currently a staff psychiatrist with Midtown Mental Health Center spending half of my time doing outpatient psychiatry in the traditional continuous treatment clinic and the other half with the Assertive Community Treatment team, which has been running about a year now.

I did my residency training at Indiana University. I had done some training in the United Kingdom before I moved to the States and after my training went to practice at a state facility in northwest rural Iowa. I just moved back to Indiana at the end of 2001. I am a Board Certified Psychiatrist; my main interest is in general adult psychiatry and the ACT model.

I am married and have been so for seven years. I have two great kids, a son who is five and a half and a daughter who is three and a half. My wife is a pediatrician at St. Vincent's.

Q&A with Dr. Osuntokun
(Interview by ACT Consultant/Trainer Lia Hicks)

Q. Lia: What benefits have you found or have you seen for both staff and consumers as a result of the ACT model in general?

A. Dr. Osuntokun: For consumers, I think it helps bridge the gap that...exist[s] where they have to come to a sort of artificial setting to get treatment...ACT sort of bridges a gap between the client and the provider where the providers come into the client's world, so to speak. I think the level of intensity also can be kind of a good thing in that you can attend to patients quicker. You can see to crises a lot sooner. There is a lot more that you can do besides just having a client come into the clinic and ask them a few questions in ten to fifteen minutes. I think the benefits are of not just focusing on symptoms but on functioning. I think this is a treatment model that really emphasizes the importance of recovery not only in the form of symptom reduction but also in functional areas. For an ACT client, it might mean that they learn to clean themselves up or "pick up" their apartment or get groceries by themselves. I think steps toward that direction, as small as it might seem, are huge steps in these patients' lives - those who have been disabled mid-teens-early twenties and havenít been able to work or live independently. These are some of the things that the ACT model definitely provides.

It doesn't stop there. While the client benefits, it gives me time to highlight the benefits as a staff member. I think it makes me know the patient even better than in the case of...less frequent appointments with traditional outpatient patients, where perhaps half of the time I have to go over the charts again to figure out whether or not I am really involved in their treatment or try to search for a family history. These are people that I see fairly regularly, so it really keeps me on top of what's going on in their lives. You almost become part of the patient's life. I certainly hope the patient sees ACT as not intrusive but a part of what is going to make them functional. So for me - and I hope for the staff as well - it helps us know clients better and feel more than just a psychiatrist or a nurse and a patient and get to talk about more things than just treatment.

I think it really makes a difference for the staff. Baby-steps are made almost every day, and ACT makes it a little easier to see those benefits than in someone you follow in the traditional clinic. With the ACT Team, we are more able to see progress, so feedback for us is quicker. I think that's obviously quite important in the kind of work that we do, to see results more quickly and clearly. Those are some highlights as to what benefits this has been for m[e] and my staff and hopefully for the patients.

Q. Lia: Could you describe for us what a typical day on the ACT Team might look like for you in your role [as an ACT Team Psychiatrist]?

A. Dr. Osuntokun: It starts with the team meeting. The way I have divided my time, I don't always attend the morning meeting as much as I wish I could. So, I spend two mornings out of the week...and three afternoons with the ACT Team. Regardless [how] I start each day, I'm there by sort of going through with the staff members what happened the day before or earlier that day if I'm there in the afternoon....Typically through the week, I will set my own schedule as to people that I really want to see - either those that are on high need or those that I maybe have seen three weeks ago. Ideally, I see everyone every month and some four or five times a month or more frequently. So, with my schedule of people that I want to see that particular day, I can add or subtract depending on what was discussed in the meeting and the level of acuity of other patients that I might put on the list, so that I can get an idea of what I'm going to do the rest of my day. Of course, with the meeting, we run through every patient very quickly, and my additions are usually where there is a specific question about medications or some therapeutic approach towards a particular patient or some input into a patient's overall treatment. Afterwards, we sort of break off.

Generally, I do my visits myself. I would say out of close to fifty clients, there are very, very few that I expect to come in and see me. So, it's after that I sort of head out on my own on visits. Some are not necessarily scheduled with the patient, and I think that is another benefit that I feel in terms of closeness; trust has been gained...Most of them hear my voice, or I give them a call as I'm right outside their door and say,

Cont'd next page . . .

"Ms. X, I'm here." This has worked very well for me. I can't recall any incident where either someone has said, "No, you can't come in," or sort of hostile towards me and say, "Get lost," or something like that. In a morning, again depending on geographic location I might get up to, if they're all close together, eight to nine, and ten clients. In an afternoon, again geographic location is a significant factor in how many people I get to see. The other day I was able to make eleven visits in the afternoon. I didn't catch all of them at home, but I'd say nine out of eleven I was able to have a good visit with.

Q. Lia: How does that compare to your no-show rate in the other part of your job when people do have to come to the office?

A. Dr. Osuntokun: Just recently we tried to see how our no-show rates in our traditional clinics ha[ve] an impact on how our clients get treatment. And each time I would say out of ten clients scheduled for that morning there are maybe three no-shows and two cancellations. I will end up seeing only five or six clients that morning or afternoon.

On ACT, it is almost like the no-show rating is not applicable at times unless they are not in and this is someone who I would expect to be out at work or something; I didn't call ahead and that's why they are not in. So our show rate is pretty high I would say. [Also, with ACT, contact is] based on the patient's condition. I may even go back that same day and see the same client if something has come up. Of course, the other team members are having contacts with individuals rather frequently in the form of case management needs or medication monitoring, so it really works well in terms of a nicely knitted network of support for the patients.

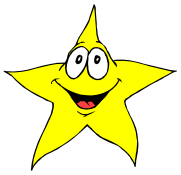
Q. Lia: You mentioned doing a lot of home visits. What's been your experience with the home visits, and what differences have you seen or how have you seen that the home visits help as opposed to traditional office visits?

A. Dr. Osuntokun: That I think is also part of the real story behind the ACT Team because you get to see these folks again in their world and their lifestyles. Patients who come in can attempt to give a description of what is going on with them back at home, but I don't think until you really see their environment, their neighbors, you don't start to get even half the picture of what's going on in their lives and how treatment really is progressing. I think the home visits really have opened a huge area of exploration and knowledge for me, where a patient who simply says "I'm feeling down" or "I'm hearing voices" really does not always interpret into "Let's increase your medication" or "Let's get you into the hospital"...In fact, for me...the ability to do those visits has really given...me is [understanding] that the medicines really are not as important as I've always believed, in the sense that yes they are essential but it's not necessarily the changes I want to make from those medicines that always do the trick...

Being able to come to the patient's home, them feeling relaxed with a physician (let alone a psychiatrist) [there]... makes a huge difference. The therapeutic relationship is very different. It is a lot better; it is much more relaxing. You get such a nice picture of the real person, especially regarding medications, sitting in the living room, the cats all over you (and lord knows I hate cats...no I can tolerate cats, but not too close, I'm working on that). But you do begin to get a sense of comfort around this patient...You feel that they are much more relaxed, and they can ask you things that touch on what is related to their treatment that you are trying to provide. You don't always have that time restriction; "I've got to get you out in ten minutes, because of my next patient." I can listen and get a feel for what the patient's real needs are, and so it really does add a nice dimension to the knowledge one has about the client.

Be sure to look for Part II of Lia's interview with ACT Psychiatrist Dr. Osuntokun in the January 2004 issue of the newsletter!

A New Face at DMHA



An Introduction to Cathy Boggs

On June 30, I joined the Indiana Division of Mental Health and Addiction as Deputy Director of Planning, Policy and Regional Services. In this role, I am responsible for developing community partnerships to expand regional and community-based services across Indiana. As deputy director, I lead two teams: Regional Services and Policy, Legislation and Priority Implementation. The Regional Services team acts as the division's liaisons to consumers and providers. The Policy, Legislation and Priority Implementation team has responsibility for policy development and the relationships with consumer and family organizations, the legislature, universities, and DMHA advisory groups.

Prior to working at the division, my experience has been in the private and not for profit sectors. My most recent positions focused on the insurance industry where at Conseco I was a Program Manager, leading legal merger programs and HIPAA projects, and at Indianapolis Life Insurance Company where I served as Director of Project Management. I have also worked for EDS where I was responsible for account management of EDS's Indianapolis clients focusing in sports operations.

Up Close & Personal

Gary Bond, Ph.D.
ACT Center Researcher

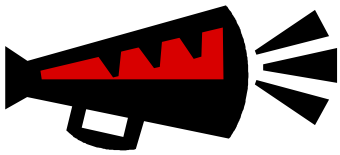
As one of the researchers at the ACT Center, I am happy to be working closely with long-time friends Michelle Salyers and Mike McKasson along with a great, supportive group of folks. My main role at the Center is that of senior researcher for the National Evidence-Based Practices Project. My day job is as a faculty member in the psychology department at IUPUI, where I have worked for 20 years. As a faculty member, I gain enormous satisfaction mentoring graduate students, including the crew involved with the ACT Center. My interest in ACT dates back to 1979, when I took a job as Director of Research at Thresholds, a psychiatric rehabilitation agency in Chicago. At the time I had just recently finished my graduate training at the University of Chicago and was teaching at Northwestern University. Thresholds had just started a controversial new program known as the Bridge, which was based on the Madison PACT program. My friends in graduate school, who were trained in psychoanalysis and all the modern theories of psychotherapy, thought the Bridge program was weird because of its home visits and attention to details in everyday living. Who ever heard of working with unmotivated clients? If they don't come in for their appointments, then they are not ready! I did not know much about mental illness when I began working at Thresholds, but I immediately fell in love with the pragmatism and humanism of psychosocial rehabilitation and with doing research on programs to help consumers get jobs and to live independently. I get up every day with the same passion and enthusiasm for my work as I felt the day I started. In the 1980s, I led a series of research studies on the ACT model, both at the Bridge and here in Indiana. In 1990, I hired John McGrew to be project coordinator for one of these studies, which we called the Richmond Project. John is now my colleague on the psychology faculty and at the ACT Center. Mike McKasson also played a key role in the Richmond Project, providing training and monitoring for 6 mental health centers developing new ACT programs. I consider the Richmond Project to be a precursor to the ACT Center. Michelle Salyers also worked with me on several of these ACT projects, serving as project coordinator for a statewide ACT initiative in Illinois in the mid-1990s.

My wife Karli and I met at the University of Chicago when both of us were in graduate school. We are empty nesters, unless you count our two cats and parakeet. Our daughter Risha is a chemist working for a biotech firm in Silicon Valley. Our son Matthew is a senior at Grinnell College studying math and economics. We are all Chicago Cubs fanatics; we cheered the successes of this season and suffered the pain of its eventual outcome. I am a workaholic and don't have any hobbies, although I enjoy jogging and aerobics (usually around midnight). I also like to send email jokes and try to see the humor in life.

REMEMBER
Our newsletter has hit the web!

With so much interest in our newsletter, it's now available through email & our website. Look for our newsletter over our LISTSERV or at www.psych.iupui.edu/ACTCenter!

Like a printed copy mailed to you? Just let us know!



Update: ACT-related Rules in Indiana

The Indiana ACT certification final rule (otherwise known as administrative code; 440 IAC 5.2) is just around the corner! The rule was signed by the Secretary of State on September 30th and is effective thirty days after the signing. When it is available, it will be included on the Indiana Legislative Services Agency's website. Indiana Division of Mental Health and Addiction's (DMHA) Administrative Codes†are Title 440 at www.in.gov/legislative/iac/title440.html. Stay tuned to this web address for posting of the ACT certification final rule (Article 5.2) as well as other DMHA administrative codes.

Also more to come on progress of the Office of the Secretary of Family and Social Services' ACT Medicaid rule (Title 405 IAC 5; http://www.in.gov/legislative/iac/title405.html) anticipated to be finalized by early next year.

Information provided by Pam Johnson, Certification & Licensure Projector Director at DMHA)

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At the ACT Center, we've been using Pathways as our meeting and event caterer for about one year now. Their food, service, and people are all outstanding. We hope you'll try them out, and surely you'll agree!

More about Pathways

Information provided by
Nancy Washburn, Pathways Team Leader

Pathways is a psychosocial rehabilitation program designed after the Clubhouse model. It operates as a work ordered day, and daily tasks include "anything that is required to keep us operating." Meetings are run by members, and all members have input in decision making. Three of the Pathways staff are peers who add a needed dimension and perspective to the team. At Pathways, there are five work "units" that members can participate in:

Outreach: calling and visiting members, bringing members to Clubhouse
Maintenance: keeping the building clean and free of minor repair for daily operations
Kitchen & Catering: cooking and serving lunch daily, providing catering services, and performing any & all tasks to keep the kitchen in compliance with Board of Health standards
Clerical/computer: answering phones, printing records, and billing, inventory, and skill-building activities - the skills one can gain are too many to list!
Convenience store: selling snack food, drinks, and personal items

Members also give cross-training to one another, teaching each other skills in the different work units. Social activities are also scheduled for after the workday. All monies raised/made by the Clubhouse go towards the purchase of new equipment.

Pathways is located at: Adult & Child Center, Inc.
3841 South Emerson Avenue
Indianapolis, Indiana 46203

ACT Center of Indiana

Excellence in Training, Research, and Technical Assistance

INDIANA UNIVERSITY
PURDUE UNIVERSITY
INDIANAPOLIS

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

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

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.

For your Calendar...

Upcoming Events

November 5-7, 2003
Indiana Conference of Rehabilitative Psychiatric Services (ICORPS)
24th Annual Conference
Location: University Inn, West Lafayette, IN
Visit www.ICORPS.info for more details!

December 8-10, 2003
Indiana Association for Persons in Supported Employment
13th Annual Indiana Institute for Supported Employment Conference
Location: Holiday Inn Select North, Indianapolis, IN
Visit www.inapse.org for more details!

Let us know of upcoming events for our newsletter calendar!
We're open to your suggestions for new articles & postings and ways we can better serve you & the community!