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Excellence in Training, Research, and Technical Assistance

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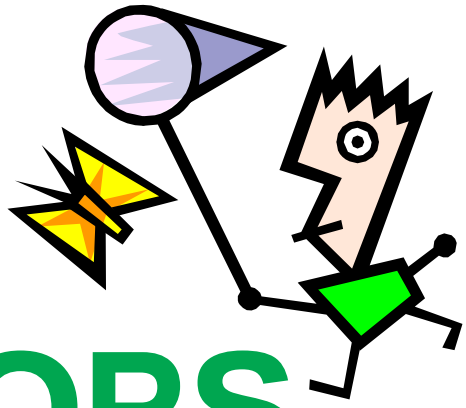

NOTES FROM THE DIRECTORS

Co-Directors
Michelle Salyers &
Mike McKasson

Our newsletter article opens with a truly inspiring message from one of our team members here at the ACT Center of Indiana. Bob portrays his experience of recovery and how his ACT team has been helping him along the way. He highlights several critical elements, many of which reflect the culture of the team — I think you will find parallels to the recovery culture described on pages 4 - 5. Veronica Macy, an ACT Center Illness Management and Recovery (IMR) Consultant and Trainer, also shares her journey of recovery and advocacy. In this issue, we also feature an article on implementation.

With the help of the many programs we have been working with, we have been learning a lot about successful implementation at the ACT Center. Gary writes about some of the critical factors of implementation that were discussed at a recent meeting he attended. Of course, our focus is on helping programs implement ACT and other evidence-based practices. When done in a recovery culture, this can lead to the kind of transformation that Bob so eloquently describes.

In this issue ...

What has ACT Done for Me?

By Robert Reyes, Consumer of ACT Services & ACT Center Administrative Research Assistant

What has ACT done for me? ACT has put meaning and substance in my life. Before ACT, I drifted like a leaf in the wind; I lost my bearings—rudderless, directionless. I felt no sense of place, no sense of purpose, no reason to get up in the morning and face the day. Before ACT and my recovery, I was asleep and, now I am wide awake. I know where I'm going, and I know how to get there.

Before I joined the ACT team as a consumer and as a research assistant at the ACT Center, I still had support from providers and family, but my case managers and therapists had a different mind set than the ACT team—more paternalistic, more dictatorial, less collaborative, though intense case management but without the ACT team approach. It's been said that ACT means "hospital without walls," but to me it's "treatment without judgment, care without coercion."

I was told from the get-go that ACT will be a team effort and that I the consumer, the client, will be the captain of the team. I know what is best for me. I know which medication makes me feel good. I know basically what makes me happy. Solutions ultimately must come from me. Solutions can't come from anywhere else. I must invest the time and effort to get my act together so to speak. I alone must be motivated to start the journey of recovery. This wasn't the mind set or attitude before ACT. A big change, change for the better. My mother always tells me that if you give a hungry person a fish, he's fed for a day; but if you teach him how to fish, he'll provide for himself the rest of his life. That is what ACT is doing: teaching me to fish, to provide for myself. I am the main provider of my well-being—this is the cardinal rule of ACT. The consumer is the main provider.

Some may say too many chefs make a bad outcome. A different saying comes to mind when I think of ACT: it takes a village; it takes a village to help the young, the voiceless, and the dispossessed. Just to be fair I'd like to borrow another phrase but from the other side of the political aisle: ACT makes sure no consumer is left behind.

What have I learned from ACT? The main thing is I am not a schizophrenic; rather I am someone that lives with schizophrenia. If I call myself a schizophrenic then that's all I am—just a schizophrenic. Just like sound bites in the media don't tell you much, so it is that a meaningless label doesn't define my whole being. I am much more—a Filipino-American, a college graduate with a BA in psychology, a research assistant, someone that likes movies and books and music, a son, an uncle.

I have also learned from ACT that schizophrenia is a biological disease, a real medical problem, but mental illness, the actual illness is the way, the manner, the patterns of behavior, how you respond to personal, interpersonal and cultural, societal problems such as stigma, societal stigma, self-stigma, shame, problems of self-worth. The disease and the illness are two different things. I can't cure schizophrenia; my therapist or my doctor can't cure my schizophrenia, this biological, organic disease; but I can and the rest of the ACT team can help me manage the illness and transform mental illness into mental wellness.

My illness management is recovery-oriented. To me recovery means most of all acceptance, acceptance of my condition, my mental condition as well as the human condition, which of course is universal. John F. Kennedy once said, "Life isn't fair." I agree life

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"What has ACT Done for Me?" cont'd from pg. 2 . . .

isn't always fair, but still I have accomplished a lot and will accomplish much more in the future because I have faith in myself. I don't blame my illness for anything, but I also don't credit my illness for any of my accomplishments. I am neither ashamed nor proud of my schizophrenia. My condition doesn't define me, doesn't make me stronger or doesn't give me wisdom that I wouldn't have if I had been born differently—that is without schizophrenia. I am not any better or worse of a person or luckier or unluckier a person than you because of schizophrenia. Whatever talents and strengths I have God has given me.

I truly believe the noblest thing a person can do is to help everyone live with dignity by finding the humanity in us all, so thank you ACT.

Reyes, R. (2005, March 25). What has ACT done for me? Speech presented at ACT Center of Indiana Assertive Community Treatment (ACT) Start-up Skills Training.

Check Out the National Implementation Research Network

By Gary Bond, Ph.D., ACT Center Program Evaluation & Research

I recently had the good fortune to be invited to a meeting organized by the National Implementation Research Network (NIRN), whose co-directors are Drs. Dean Fixsen and Karen Blase. NIRN is located on the campus of the University of South Florida; see their web site: http://nirn.fmhi.usf.edu/. Dean and Karen have over 30 years of experience in implementing evidence-based practices. I was amazed by their recounting of their first-hand experiences in implementation; because so many parallel what we are learning here in the implementation of ACT teams and other evidence-based practices throughout Indiana. Moreover, they have found parallels across many different fields — education, criminal justice, children's mental health, and adult mental health. Because findings appear to replicate across fields, we can think of the science of implementation. That is, the implementation process includes a series of predictable stages, each requiring attention to specific tasks.

Fixsen and Blase and their colleagues have compiled a marvelous review of the implementation research literature available at their web site. Their resource material is not dry academic stuff; instead it contains practical insights into the implementation process. These insights can help us at the ACT Center do our job better and also help community mental health centers in developing new programs. Let me try to capture a flavor of some of their many pearls of wisdom:

- **Successful implementation requires the completion of stages.** While the stages (shown in Table 1 on page 4) are seldom perfectly sequential, the sequence has implications. For example, it is a mistake to provide training while an agency is still in the exploration stage (as we have found in Indiana!).
- **Selection of staff is critical.** As many agencies have found, drafting people to staff for a program is dicey. If you want your ACT team to be the best, hire the best people.
- **Program installation should precede start-up.** This principle says you should not start admitting clients until you have hired all your staff, located office space, obtained necessary resources, and completed initial training. If you try to shortcut the process, you jeopardize your start-up process. Hmmm . . .
- **The 3-hour rule.** In their initial efforts, Fixsen and Blase found that new sites located more than 3 hours away from their technical assistance center had poorer implementation than those closer by. The point is that face-to-face consultation is more effective than telephone contact. (With changes in strategy, you can overcome this "rule.")
- **Training components differ in their effectiveness.** According to one review of the literature (Joyce & Showers, 2002):
  - *Theory and discussion* increase knowledge among 10% of practitioners, but 0% change actual behavior on the job.
  - *Demonstration of a skill in a training* increases knowledge among 30% of practitioners, but 0% change actual behavior on the job.
  - *Having practitioners actually practice a skill in a training* increases knowledge among 60% of practitioners, but only 5% change actual behavior on the job.
  - *Coaching practitioners in the field* increases knowledge among 95% of practitioners and 95% change actual behavior on the job!

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NIRN article cont'd from pg. 3 . . .

- **Commitment follows outcomes.** Practitioners are more passionate about doing the practice when they start getting results.
- **Ask your customers how you are doing.** Fixsen and Blase consistently found that they received tremendously constructive feedback from program staff, consumers, and their advisory boards about how well implementation was going. In Indiana, I don't know if we have fully exploited this feedback loop.
- **First you do it right, then you do it differently.** The research shows that it's better starting out by seeking very high fidelity to the model. Once this is achieved, then developing innovations can be worthwhile. If you make changes from the beginning it's more difficult to problem-solve if there are start-up problems.
- **High fidelity implementation is possible with dedicated staff, adequate resources, and attention to training and monitoring**.

I hope these examples inspire readers to take a look at the NIRN web site, and to learn more about the science of implementation. Drawing on the wisdom of others, we can learn to avoid pitfalls and can follow examples of successful implementation strategies.

References

Fixsen, D. L., Naoom, S. F., Blase, K. A., Friedman, R. M., & Wallace, F. (2005). Implementation research: A synthesis of the literature. Tampa, FL: University of South Florida.

Joyce, B., & Showers, B. (2002). Student achievement through staff development (3rd ed.). Alexandria, VA: Association for Supervision and Curriculum Development.

Table 1. Stages of Implementation

- **Exploration and Adoption:** Key stakeholders at an agency have made the commitment to adopt a practice, fully understanding what this commitment entails.
- **Program Installation:** Program has obtained the necessary staffing, office space, and other resources to make the practice possible.
- **Initial Implementation:** Program is fully operational with high fidelity.
- **Full Operation:** Practice is accepted practice at the agency.
- **Innovation:** *First do it right, then make improvements.*
- **Sustainability:** Keep practice going over time, even with staff turnover.

Are you practicing in a recovery culture?

Michelle P. Salyers, Ph.D.
Co-Director, ACT Center of Indiana

Recovery should be the guiding vision of mental health services. The President's New Freedom Commission on Mental Health has called for a *transformation* of the mental health system that focuses on *consumers and their families as partners*, with *shared decision-making* and access to *high quality treatment* based on the *best scientific evidence* (President's New Freedom Commission on Mental Health, 2003). Moreover, the system should focus on outcomes of *recovery and resilience*, not just managing symptoms. That is, we need to focus on helping consumers be "able to live, work, learn, and participate fully in their communities."

Prior to this report, consumers and mental health advocates have long been calling for such a system transformation (e.g., Anthony, 2004; Deegan, 1988), but changes have been slow. One key example of this tension between recovery and scientific evidence is assertive community treatment (ACT). Although ACT is widely considered evidence-based practice, some observers have questioned its recovery orientation.

ACT programs historically have focused on systems goals of reducing utilization of expensive mental health services (i.e., emergency rooms, hospitals) while devoting lesser attention to consumer-defined goals such as employment and development of social networks (Bond, Drake, Mueser, & Latimer, 2001). In addition, ACT uses assertive outreach and is designed to serve consumers with the most severe problems and a history of difficulty engaging in traditional

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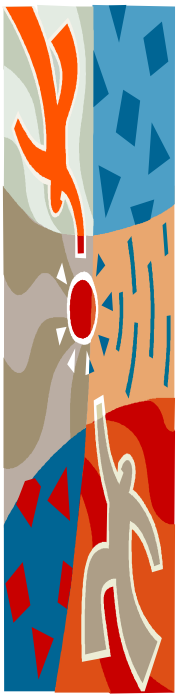
"Recovery Culture?" cont'd from pg. 4 . . .

services. For example, some strategies of engagement include repeated attempted contact despite refusals, close medication monitoring, and the use of outpatient commitment and representative payeeships. Such methods appear to contradict recovery-oriented values of client choice, empowerment and responsibility. If applied indiscriminately or with force or threat, these approaches are in clear violation of recovery-oriented practice.

ACT can best be thought of as a way of *organizing* services, but it does not specify the *context* in which ACT services are delivered (e.g., how engagement mechanisms are used, how providers interact with consumers). Fidelity scales can tell us how well a program is following the structural and organizational aspects of the model but does little to tell us the broader context of how ACT teams are fostering recovery.

Are you practicing ACT (or other mental health services) in a way that promotes recovery? The table below may help you determine the context in which you are providing services. If we are to truly transform the mental health system so that consumers have access to the highest quality of services, we need to pay close attention to how those services are being delivered. Are consumers and their supporters active, informed partners in treatment decisions? Do we believe that those we serve can recover from the devastating effects of mental illness? Are we communicating that hope in our daily interactions with them? These are the types of questions we should be addressing if the goal is a recovery-driven system.

Table 1. Non-Recovery and Recovery Cultures*



Non-Recovery Culture	Recovery Culture
Low expectations	Hopeful with high expectations
Stability/maintenance is the goal	Recovery is the goal
There is no clearly defined exit	Clear exits; graduates return/share
Little or no access to information	Easy access to information
Compliance is valued	Self determination, critical thinking, and independence are valued
Coercion is used to achieve compliance	People become the experts in their own care
People are protected from trial/error learning	People take risks and have "right to fail"
One-size fits-all treatment approach	Wide range of programs and non-program options
Consumers live in "treatment centers"	Opportunities for community integration with choice
Consumers are judged by their level of motivation	Restoring hope creates new choices
Medication is the primary tool	Medication is one of several tools
Emphasis is on treatment	Peer support and self-help valued

*From META peer employment training workbook.

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Anthony, W. A. (2004). The principle of personhood: the field's transcendent principle. *Psychiatric Rehabilitation Journal*, *27*(3), 205.

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Up Close & Personal

Meet Veronica Macy
IMR Consultant & Trainer

Hello, my name is Veronica Macy. It was challenging to write an "Up Close and Personal" article about myself. It seems that I have lived six lives. Every area was and is important to what I am today, but I will start with the last and most meaningful time frame. There was a 15 year span of my life, which started when I was about 38, that was met with many challenges in the arena of mental health. During those years, I became personally aware of what was working in the mental health field and what was not. I was neither functioning nor aware of who I was and what I was supposed to be doing. It was during this time that I had extensive experiences in the mental health field and had to work extremely hard at learning how to manage my well being. I now call it my learning years at the College of Hard Knocks, although at the time life felt empty, worthless, and very painful.

My resilience and hard work were not my only reason for experiencing recovery. I had a caring, respectful physiologist who was committed to recovery and always gave me hope and encouragement. Another reason for getting my life back was my husband. He walked by my side the whole journey. He was extremely supportive and never held me back even when he knew I was going in a wrong direction. I call this personal responsibility, and I learned a lot of this. My spirited determination, my supportive therapist, and my faithful husband are all why I am able to do what I do today. I continue and always will work on maintaining my recovery.

As I felt I could move outside in the real world, I decided to look for a job. In July of 2000, I started working with KEY Consumer Organization as a mental health advocate and recovery specialist. As I am experiencing recovery, the position of advocate and trainer was and still is my heart's desire. In June of 2001, I was appointed by the Governor to serve on the Indiana Protection and Advocacy Services Commission which is a position I still hold today as Vice Chair of the Commission. I have also served on several State and National Taskforces representing the Serious Mentally Ill.

In September of 2001, I left KEY and started my own company, Recovery Network Unlimited, where my motto is "With Hope One Reaches." It was during this time that I was seeking all the knowledge I could and was being certified in several recovery/education programs. I wanted to be able to share them with others. I started out contracting with NAMI Indiana as a Consumer Program Coordinator and Educator. It was during this time with NAMI, I became certified in all of their education/recovery programs that consumers could participate in. I also became a state and national trainer in several of these programs; "Provider Education," "In Our Own Voice," "NAMI C.A.R.E.," and "Peer

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"Up Close and Personal" cont'd from pg. 6 . . .

to Peer." Over the years, I have served as a Board Member for NAMI Indianapolis and Vice Chairman of the National NAMI Consumer Council, serving on many committees, locally and nationally.

While I was working with NAMI Indiana, I planted the seed for an Indiana Consumer Council. I and several other peers helped organize the Council. The Consumer Council is an important and valued component of NAMI Indiana. During my working with NAMI, I met many wonderful, recovering, highly educated peers, which even gave me more hope that recovery is possible.

In May of 2002, I traveled to Brattleboro, Vermont for a one week training with Mary Ellen Copeland learning WRAP "Wellness Recovery Program" and became a certified Mental Health Recovery Educator. I found WRAP to be a very organized program which had almost the same recovery components that I used in my recovery, but it was written in an easy and practical model for anyone to use. The W.R.A.P. program strengthened and confirmed my desire to continue to educate myself and moved me to commit myself to helping others to learn all they can about themselves and their recovery journey. I returned again to Vermont in May of 2004 and became a Master Level Trainer, which allows me to certify others to teach WRAP. I have certified four people in Indiana to teach WRAP and look forward to training more. Mary Ellen is my friend and mentor. I admire her passion and commitment in offering recovery and her strong believe that recovery is possible.

Currently (and why you are reading this article), I work with the ACT Center as an Illness Management and Recovery (IMR) Trainer and Consultant. Believing that recovery is possible as well as all my trainings and experiences in the mental health field positioned me to IMR. I believe IMR works. I know that no matter where one is on their road to recovery, there is hope for a better life. IMR is where I believe individuals, professionals, and peers alike will learn what recovery can look like, that recovery is possible, and what is needed to enjoy it.

Now on a personal note . . . I grew up in the Upper Peninsula of Michigan in the little town of Munising, which is on the shores of Lake Superior and surrounded by the Hiawatha National Forest. I truly enjoy the beauty of the nature I was raised in, and I still yearn for the woods. It was there that I met my husband and my best friend of 30 years, Ed, who was serving in the U.S. Air Force. My mother and four siblings still reside there, so I do get to visit. My Great-Grandmother was an American Indian, and I sometimes feel like the trees and the woods are talking to me. (And this happens when I am really doing well!!) We returned to Indiana in 1984 to help care for my father-in-law whose health was failing.

We have been blessed with three children, who are now adults and married. Between them, we are also blessed with 1 grandson and 6 granddaughters, all age eight and under. Holidays and birthdays are always exciting and special to me. My family life is my first priority (I try to keep it that way) and gives me great pleasure and good memories. Sometimes I feel like I have been given these opportunities to make up for some of the lost time when our children where growing up. We did all survive - our daughter is a teacher, our 1st son a police officer, and our 2nd son is a firefighter. Ed and I feel blessed with what we have. My life is full and very rewarding. I am very pleased to be able to give back in someway to others by being involved in IMR. I enjoy the most in IMR when I am able to offer hope to others who need it. I do believe my motto does say it all "With Hope One Reaches." Thanks for your time. Sincerely, Veronica Macy

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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 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

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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, designed, & edited by Veronica Pedrick.

What's on the Calendar?

21st Annual Assertive Community Treatment Conference
May 18-20, 2005 in Tampa, Florida
For more information, call (810) 227-1859, email conference@actassociation.org, or visit www.actassociation.org

ACT Start-up Skills Training
June 23-24, 2005 in Indianapolis, Indiana
More details and registration information to be posted on LISTSERV soon!

If you are an ACT, IDDT, or IMR team member, consumer, and/or family member or friend of someone receiving these evidence-based services and would like to share your perspective or success story, we would love to hear from you.

Email vpedrick@iupui.edu OR send written correspondence via U.S. mail.