

WHAT FAMILIES NEED TO KNOW ABOUT ASSERTIVE COMMUNITY TREATMENT (ACT) SERVICES

Bette Stewart

Assertive Community Treatment (ACT) is a clinical model of service for individuals with serious mental illness (schizophrenia, bipolar disorder or schizoaffective disorder) for whom traditional outpatient mental health services have not been effective. ACT can help reduce barriers to treatment and recovery by delivering mental health services to the consumer wherever they are in the community. It is not uncommon for consumers receiving ACT services to have co-occurring substance abuse disorders or severe physical health problems along with mental illness. ACT teams are designed to work with consumers who have multiple complex needs.

ACT staff members are accessible 24 hours a day, 7 days a week, 365 days a year, in case of a crisis or emergency.

By design, ACT services are intensive, and not all consumers require the level of care provided by an ACT team or meet specific criteria to be eligible for ACT. These services are best put in place when the consumer has not had success with the traditional approach of attending scheduled clinic visits, or been able to complete recommended treatments.

Eligibility criteria include a diagnosis of major mental illness and evidence that traditional mental health services have not been useful interventions. This may be revealed by having multiple hospitalizations, loss or

risk of losing housing, legal issues due to mental illness behaviors, or an inability to keep appointments.

Enrollment in ACT is voluntary, even if everyone involved in the consumers' support network feels it is the best treatment option. No matter how helpful this team approach sounds to supportive family members, clinicians, judges, and other interested parties, the consumer may decline ACT services.

Most urban ACT teams serve 100 consumers and are staffed by 12 full-time mental health professionals. Teams are comprised of a full-time psychiatrist, two or three nurses, two substance abuse and vocational specialists, therapists, case managers and a peer advocate who work together supporting the consumer's recovery goals. Rural teams serve fewer consumers with fewer staff members, but maintain a diversity of disciplines.

ACT teams have a very small staff member to consumer ratio, ideally one staff person to 10 consumers. Services are provided by multiple staff members, rather than from one clinician, common in more traditional service models. A benefit of working with different staff members is that there are various perspectives to every situation the consumer encounters. This team approach guarantees there will always be a staff member who knows the consumer and who can intervene on the consumer's behalf.

ACT teams are trans-disciplinary, meaning that different disciplines working together on the team (doctors, nurses, social workers, etc.) share their specific knowledge and expertise with each other to enhance the staffs' working skills. An example of this approach at work would be when the nurse discusses heat stroke symptoms during the



daily meeting, alerting staff members to look for signs while visiting consumers in the community; or, when the doctor reminds the team that certain medications may cause sun-sensitivity, so staff members can remind consumers to wear appropriate clothing when venturing outside. With this approach it is less likely that subtle symptoms or warning signs will be missed during a visit, no matter which staff member conducts the visit. It would not be unusual for a team nurse to go to a grocery shop with a consumer with diabetes to educate and support healthy food choices.

When consumers express interest in working, an ACT vocational specialist will help identify employment opportunities based on the consumers' interests and will assist them to pursue those interests. When there is a substance abuse concern, an ACT substance abuse specialist will assess the consumer's needs and partner with the consumer to help design a plan to meet that consumer's recovery goals. Because of the intensity of the services and diversity of the staff, ACT consumers are usually not referred to day programs or long-term substance abuse detox programs, unless medically necessary. The ACT model, with its low consumer to staff ratio, provides the intensity and frequency of visits not offered in traditional outpatient settings. The teams are staffed with substance abuse specialists and therefore intensive interventions can take place in the community rather than in inpatient settings. The approach taken by ACT is research-based and supports the integrated treatment of mental illness and substance abuse under one roof.

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From the Director's Desk

Lynn H. Albizo



As my last message to the membership, I would like to take the opportunity to reflect back on some of our accomplishments and thank all those who supported NAMI Maryland in the last four years. It has been a rewarding and challenging experience for me. In that time period, NAMI Maryland programs have grown and the organization has accomplished a great deal. Our education programs have

shown extraordinary growth. We have gone from Peer-to-Peer classes in three affiliates to now holding classes in nine affiliates statewide. New programs including, NAMI Connections, NAMI Basics and Hearts and Minds have been established and are growing throughout the state. The transformation projects have allowed our affiliates provide mental health resource materials and information to their communities and get the word out about NAMI.

There has been a lot of growth in the relationship between the affiliates and NAMI Maryland. We have made a number of efforts to build cooperation and support. These include: (1) affiliate conference calls, (2) recognition of affiliates in the newsletter and at annual meeting, (3) significant increase in use of affiliate grant funds to support affiliates, (4) affiliate leadership retreat and (5) improved communication. The New Executive director will be in a good position to continue to grow and develop these relationships.

I have been very pleased to represent NAMI Maryland in the area of advocacy since 2004. I look forward to continuing to represent NAMI Maryland as public policy consultant. There has been significant growth since I become involved with NAMI. I have worked extensively on building relationships with coalition members and with State representatives. As a result, we are seen as an important ally and have gained a valuable seat at the table. We are collaborators with the state in planning for mental health services in Maryland. Our opinion and concerns are taken seriously. The Mental Hygiene Administration is now very interested in the results of the Grading the States. We have set the stage for an annual advocacy day in Annapolis and for participating in larger legislative initiatives.

I hope that NAMI Maryland continues to make strides and I am proud to have been participated in its growth. I wish the best for the New Executive Director to meet the challenges to come.

— Lynn

From the President's Desk

Connie Walker, Capt, USN (Ret.)



It has been six years since my son returned from Operation Iraqi Freedom and was later diagnosed with a serious mental illness ... five years since I took NAMI's Family to Family (F2F) course. Taking it meant driving from Lexington Park to Baltimore and back every week for three months. That's a lot of time to think about what the course is exposing you to (besides East Baltimore in the dead of

winter). As I became involved in the classes, I'd start out on those drives feeling grateful that F2F existed. That morphed into being amazed at the dedication and compassion of the volunteers who were trained and certified to teach the class. As graduation approached, it struck me as incredibly sad that most people who lived in Southern Maryland and needed F2F would not be able to take it ... it was simply too long a drive to access it. Without fail, every week – for 12 weeks – I'd get home around midnight feeling really annoyed at having to drive 160 miles to get the education and support I needed to help my son and our family.

Fast forward to 2010, after four full and rewarding years as NAMI Southern Maryland's founder and first president, and as I begin my term as NAMI Maryland's president. While some things have changed (I'm cuter), one thing has stayed the same: I am in awe of the many men and women, of all ages, who voluntarily take on NAMI's vital mission for no pay and little recognition on a shoestring budget. NAMI volunteers – whether they have been trained and certified as family educators, peer mentors, or support group facilitators; serve as NAMI Ambassadors, advocates, and activists within the community, in Annapolis, and in Washington D.C.; or support an affiliate with administrative work, presence at community events, posting flyers – you name it – are the reason NAMI can do what it does. For that reason, I believe that NAMI Maryland's Board of Directors, the state office, and our staffed and resourced affiliates have a responsibility to reach out to and support the work and development of our volunteer affiliates as much as we can.

At the Board of Directors level, there are lots of ways to do this. We have a responsibility to know where NAMI MD's resources are going and ensure their use is optimized – our affiliates work too hard for us not to ensure this money is well spent. Another way is to encourage and support NAMI MD staff in finding new ways to achieve the mission and at the same time, extend its reach to affiliates and help to grow membership throughout the state. It can be done. Board members also can be a presence, wherever

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PROGRAM OVERVIEW

NAMI Maryland offers an array of education, support, training programs and services for consumers, family members, providers and the general public. Over the past year the state of Maryland has benefited from the multitude of services provided by our affiliates

EDUCATION PROGRAMS

NAMI Maryland's education programs have seen big and exciting changes in the past few months. Both NAMI Basics and Family-to-Family program materials have been updated and the new 3rd edition of Peer-to-Peer is being implemented in all participating affiliates. In July NAMI Maryland held its second Family and Consumer program statewide training at the Maritime Conference Center in Linthicum, Maryland. The Family-to-Family training produced 15 new teachers and the Peer-to-Peer training produced 9 new mentors. Thank you to the trainers and attendees for making this another successful weekend.

SUPPORT PROGRAMS

Integral to NAMI's central missions, support groups are the backbone of grassroots outreach to those coping with the stresses of serious and persistent brain disorders. NAMI Maryland currently has over 25 support groups that are offered through our affiliates for both individuals living with mental illnesses and their family members.

NAMI Connection is a recovery support group program facilitated by and for adults living with mental illness. There are thirteen groups presently running in Maryland and the numbers are continuously growing.

TRANSFORMATION

This September funding for the Transformation Project will come to an end. All participating affiliates did a fantastic job of getting the message of connecting physical and mental health out to their local communities. The four-part education program on physical and mental health, Healthy Hearts and Minds and the brochure dissemination project has been implemented in seven NAMI Maryland affiliates since June 2010. The NAMI Maryland office has been and continues to receive an outpouring of positive comments regarding this project and requests for more resources. Thank you to everyone who made the Healthy Hearts and Minds, and engaging Consumers and Family Members in the Transformation Process projects possible.

For more information on attending one of the education or support programs offered by NAMI Maryland, or on becoming a facilitator, please visit www.namimd.org or contact Erica Sullivan at 410-884-8691 or esullivan@namimd.org. You can also contact your local affiliate or visit the NAMI National website at www.nami.org.

We at NAMI Maryland appreciate the generosity and participation of every single person involved in helping to make possible the invaluable programs offered throughout the state.



Local NAMI Maryland Affiliates

NAMI Allegany	301-724-2866
NAMI Anne Arundel	443-569-3498
NAMI Carroll	410-857-3650
NAMI Cecil	443-955-4963
NAMI Frederick	240-379-6186
NAMI Harford	410-879-0111/410-893-4968
NAMI Howard.....	410-772-9300
NAMI Lower Shore.....	410-208-3328
NAMI Metro Baltimore.....	410-435-2600
NAMI Montgomery.....	301-949-5852
NAMI Prince George's.....	301-429-0970
NAMI Southern MD.....	301-904-9926
NAMI Washington.....	301-824-7725

NAMI Maryland's charity designation numbers:

4186: The Maryland Charity Campaign for State Employees and Retirees (private and state donors) & Central Maryland-Private Sector

80114: Combined Federal Campaign of the National Capital Area

8568: The United Way

President's letter from page 2

we live, by ensuring affiliates in our area know we would like to be invited to their events... attending them as we are able...and when we go, listening as much as we talk. At the state office level — NAMI MD staff can respond quickly and professionally to affiliates' requests for information or assistance or say "I don't know, but I will get back to you" if that's the case — and then do that. Of course there are other examples ... but I'm running out of room for this column! I don't want to let our staffed and resourced affiliates off the hook, and so pose this question to them: What can your affiliate do — you know who you are! — beyond its borders, to work as partners in affiliate development and growth in regions that are close by and need to develop? What can your affiliate do to help grow NAMI membership throughout the state?

As I write this in August, NAMI Maryland is in transition. My journey as your state president began in mid-June, and our next Executive Director will be onboard soon. I can think of no better time to take a fresh look at ourselves and work together — the Board of Directors, the State Office, and every one of our Affiliates — to make NAMI Maryland as strong as it can be, state-wide.

NAMI Maryland 2010 Annual Education Conference

Mental Health: Putting the Pieces Together

NAMI Maryland 28th Annual Education Conference will be held at The Sheppard Pratt Conference Center on Thursday, November 4, 2010. This year's theme is Mental Health: Putting the Pieces Together. This year the goal is to spotlight how every component of the mental health system is an integral piece of recovery.

Our featured keynote will be on Family-to-Family as an Evidence-Based Practice. The speaker is Dr. Lisa Dixon, a professor of psychiatry at the University Of Maryland School Of Medicine and principal investigator for the study. Dr. Dixon will present the up to date results of the Family-to-Family study. The four-year study, funded by NIMH, was done in existing Family-to-Family classes in Baltimore City, Montgomery County, Frederick County and Howard County.

Our renowned workshop presenters include: Dr. Steven Sharftstein, CEO and President of Sheppard Pratt; Dr. Brian Hepburn, Executive Director of the Mental Hygiene Administration, and Kim Burton, the Director of Older Adult Programs at the Mental Health Association of Maryland. Workshops will cover topics such as: Federal Health Care Reform, Access to SSA Disability Benefits, Consumer Quality Teams and Adolescent Opioid Dependence.

For more information the conference please visit the NAMI Maryland website at www.namimaryland.org, email us at info@namimd.org or call the office at 410-884-8691.

We look forward to seeing you there!

Michelle Carras



NAMI Maryland board member, Michelle Carras will be honored on October 7, 2010 by the Howard County Commission on Disability Issues with the leadership award in the category of adult community advocacy. The award is given to individuals who live or work in Howard County, who happen to have a disability and who has shown leadership in the area of community

advocacy. Michelle's commitment to NAMI Maryland and NAMI Howard County and her leadership in the area of disability empowerment in the Howard County made an ideal candidate for this award.

Michelle teaches Peer-to-Peer in Howard County and is also an In Our Own Voice presenter. She is an active member of the NAMI Maryland Board of Directors and was recently appointed Secretary to the Board. In addition she is an active member of the public policy committee and is working on developing a volunteer program in the NAMI Maryland office. Michelle also participates in presentations with other individuals with disabilities to groups at Howard County General Hospital and has been active in the community regarding the use of person first language and treating people with disabilities as you would others, with dignity and fairness. She was a team captain for NAMI Walks and raised over \$1000 to support NAMI.

Michelle has been a strong advocate for educating the community about mental illness, reducing stigma and helping individuals with their own recovery. Michelle has recently accepted a part time position to work as a peer counselor on a mobile crisis team in Howard County and will be attending Johns Hopkins University School of Public Health where she will be pursuing a Master's Degree in public health so that she can continue to help communities. Michelle is a true inspiration to us all.



(ACT) Services from page 1

Every team member becomes familiar with each consumer through a daily meeting where full staff attendance is required, and each consumer's recovery goals are addressed. In this forum, short term goals are noted and staff members are assigned to carry out the interventions identified in the individual treatment plan. Interactions during the past 24 hours with the individual, their family or other informal supports are reported. Upcoming appointments are logged to assure that a staff member will follow-up, to either accompany to or remind the consumer of the appointment. Alerts or concerns are documented, and a strategy for intervention is immediately planned. All staff members are mobile and prepared to see the consumer in the community, including the psychiatrist and nurses.

ACT staff members are accessible 24 hours a day, 7 days a week, 365 days a year, in case of a crisis or emergency. After hour calls are limited to crisis and emergencies, defined by individual needs. The daily meeting alerts staff to any impending concerns, which can usually be addressed during working hours. If a consumer's symptoms increase or they are at risk of relapse, support can be boosted and a plan put into place before a crisis emerges.

Every team has an after hours number answered by a team staff member familiar with the consumer. A staff member can speak with the consumer, strategize a plan to deal with the situation, and most often, make a plan to see the consumer first thing the following day. Staff members consult with the team psychiatrist when there is a crisis. If a crisis circumstance cannot be addressed by phone, the psychiatrist will decide the course of action to be taken. Some teams have the capacity to go out after hours, but all teams have the ability to call for 911 assistance. When 911 is called, a team staff member will liaison with the emergency personnel and will be involved in the decision making process.

Anytime police or 911 are called by a family member the ACT team should be notified,

so they can interface with the police officer, EMT or emergency room doctor. Staff members will be able to provide medication information and any additional information to the appropriate professionals involved in the crisis.

ACT services are designed to encourage consumers to do as much for themselves as possible. If a consumer needs help making a phone call, or needs help learning how to take public transportation, staff members are available to assist. One purpose of the team is to empower the consumer to do as much for themselves as possible. The level of assistance and support can be adjusted to meet the consumers' changing needs. When new to the team, consumers may need daily contact, either face-to-face or via phone. As consumers become more comfortable and are engaged with the team, the level of staff involvement is modified as needed. In a crisis, the team can rally, providing the amount of intervention necessary to support the consumer through a period of illness relapse, increased stress, or other changes. Hospitalizations may be averted by the team's flexibility and ability to be proactive. Engagement, or getting to know the consumer and developing a trusting working relationship can go on for many months and for some consumers, years. This is a vital process for consumers and staff to begin working together. This extended period of time allows consumers the opportunity to develop trusting relationships with multiple staff members.

Communication with the consumer's support network is an important piece of the service ACT provides, but isn't always possible without consent from the consumer. Working with informal supports (family, employers, landlords, etc) is an integral part of ACT's structure.

Family concerns should never be ignored by ACT staff, even if consumer consent for communication has not been given. Staff members without this consent cannot provide information about anyone who may be in treatment with the team, or even

whether they are in treatment with the team. However the team can provide general information about mental illness and about the mental health system, and families can provide information or report their concerns about their family member to a staff member.

ACT staff members are dedicated to helping support each consumer's recovery goals. ACT teams have staff members who believe in the philosophy of self-directed care, and that recovery from mental illness is possible.

Maryland began training Mobile Treatment Teams to become ACT teams in 2004. There are 10 ACT teams in the State that meet the high standards set forth by the model. ACT teams are currently located in Baltimore City, Washington, Frederick, Montgomery, Anne Arundel and Prince George's Counties. New teams are starting in Harford, Howard, and on the Lower Shore (Dorchester, Somerset, Wicomico, Worcester, and parts of Caroline) Counties.

If you are interested in learning more about ACT teams in Maryland, please contact Bette Stewart at 410-598-1791 or bstewart@psych.umaryland.edu. More information about ACT can be found at: <http://mentalhealth.samhsa.gov/cmhs/CommunitySupport/toolkits/community/default.aspx>



Spotlight on an Affiliate: Lower Shore Maryland

NAMI Maryland Lower Shore has shown a lot of growth and progression in the past year. Covering all of Somerset, Wicomico and Worcester Counties, this affiliate has been expanding and building awareness of mental health and NAMI in their community.

Connie and Ben Rammer, Ann and Dell Palmer and Patti Weiss are just a few of the members who have been volunteering to sustain and expand NAMI programs in their communities. As an affiliate, they have been building stronger relationships with mental health providers and community organizations. Making connections with their local hospitals, health departments and On Our Own of Maryland, a statewide mental health consumer education and advocacy group, this affiliate has been receiving multiple requests for NAMI presentations and outreach. Working together, On Our Own of Maryland, and NAMI Lower Shore put on a presentation on the Anti-Stigma Project in September 2010. "Stigma...In Our Work, In Our Lives" is an interactive workshop designed to reduce stigmatizing attitudes, behaviors, and practices with the mental health and substance abuse communities.

In June 2010 at NAMI Maryland's Annual Meeting, NAMI Lower Shore received the "Outstanding Affiliate," award to recognize all of the hard work they have done over the past year. Connie Rammer and her son came all the way from Berlin, MD to Columbia to represent their affiliate and accept the award on their behalf.

NAMI Maryland would like to thank everyone in the Lower Shore affiliate for working so hard to support our mission to improve the quality of life for individuals with mental illnesses and their families.



Study finds NAMI Family to Family Course is an effective evidence based practice

The preliminary findings are in and researchers have confirmed, what NAMI families know, that NAMI family-to-family course is effective in helping families impacted by mental illness. While there is clear evidence that families have a major impact on the health outcomes of adults with serious mental illnesses, little has been known about the effectiveness of education and support groups in helping family members cope with having a relative with mental illness. Researchers at the University Of Maryland School Of Medicine received a grant from the National Institute of Mental Health to conduct a four year study the benefits of participating in a peer-directed family-to-family education program to enable people to effectively handle the mental illness of a relative or loved one.



The NAMI Family-to-Family Education Program is a 12-week class with a highly-structured standardized curriculum, conducted entirely by trained family members of those with a mental illness. The goal is to provide education about mental illness and treatments, emotional and practical support, and problem solving and communication skills for those dealing with the mental illness of a family member. This free course, taught by NAMI volunteers in communities across the country, has enrolled and graduated over 100,000 family members.

Principal investigator, Lisa Dixon, M.D., professor of psychiatry at the University of Maryland School of Medicine and her research team worked with existing Family-to-Family Education Programs in Baltimore City, Montgomery County, Frederick County and Howard County and enroll approximately 300 adult members in the study. Half of the participants enrolled in the class right away and the other half was assigned to a control group that waited for three months. Participants who received the class have been compared to those who waited for three months. All participants were evaluated prior to enrollment, three months into the study and nine months after their initial evaluation to determine how well they retained what they learned in the program.

As part of the study, Dr. Dixon also investigated the benefits to patients of having a family member participate in the program. The results of this study suggest, among other things, that the Family-to-Family Education Program enhanced family members' empowerment and reduced their subjective burden of mental illness by diminishing worry and displeasure. The results of the study will be presented by Dr. Lisa Dixon at the NAMI Maryland annual education conference. These positive results should help NAMI Maryland and its affiliates make the case that family to family is a wise investment for public and private funders.

SAVE THE DATE!



Date	Event	Location
November 4	Annual Education Conference	Sheppard Pratt Conference Center Baltimore, MD
November 12-14	NAMI In Our Own Voice presenter training	St. Mary's Seminary Baltimore, MD
January 7-9, 2011	NAMI Connection facilitator training	St. Mary's Seminary Baltimore, MD
February 25-27, 2011	NAMI Family-to-Family teacher training	Maritime Institute Conference Center Linthicum, MD

For more information on the events listed above please call the NAMI Maryland office at 410-884-8691 and ask for the listed contact or feel free to send us an e-mail at info@namimd.org.



The 2010 Annual Education Conference



*Mental Health:
Putting the Pieces Together*

**Thursday, November 4, 2010
Sheppard Pratt Conference Center**

You don't want to miss this opportunity!
Visit <http://namimd.org> for more information.

Join Public Policy Committee

Help review bills, formulate positions, or write testimony. This is a chance to make your voice heard in Annapolis. Contact NAMI Maryland at info@namimd.org. To view NAMI Maryland's Public Policy platform, go to www.namimd.org.

CONNECTIONS is published quarterly by NAMI MD – National Alliance on Mental Illness of Maryland. Letters, articles, and responses are welcomed and encouraged. NAMI MD reserves the right to edit all submitted materials. Please submit all materials no later than the dates listed below:

- Nov. 15, 2010 (Winter Issue)
- Feb. 15, 2011 (Spring Issue)
- May 15, 2011 (Summer Issue)

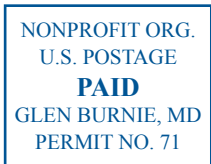
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NAMI Maryland
10630 Little Patuxent Pkwy, Suite 475
Columbia, MD 21044
410-884-8691
info@namimd.org

NAMI Maryland

10630 Little Patuxent Parkway
Suite 475
Columbia, MD 21044

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National Alliance on Mental Illness*



NAMI Maryland

National Alliance on Mental Illness of Maryland

10630 Little Patuxent Parkway
Suite 475
Columbia, MD 21044
410-884-8691
Toll Free Helpline: (800) 467-0075
E-mail: info@namimd.org
Website: www.namimd.org

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Contribute to NAMI Maryland so that we can continue our mission to improve the quality of life for persons diagnosed with serious mental illnesses and their families.

I want to make a difference by:

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To join NAMI or to make online donations, go to our website at www.namimd.org or call your local affiliate. See page 3 for affiliate phone numbers.

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