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### Title

Policy Suggestions and Practice/Research Perspectives on Treatment Objectives and Outcomes

### Permalink

<https://escholarship.org/uc/item/8h94s09v>

### Journal

Public Affairs Report, 43(1)

### Author

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### Publication Date

2002

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**Policy Suggestions and Practice/Research Perspectives on  
Treatment Objectives and Outcomes**

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January 12, 2002

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Presented at The Mental Health and Public Policy Symposium  
Coping with Mental Illness and Crafting Public Policy  
Saturday, January 12, 2002, Wheeler Auditorium, University of  
California, Berkeley

Jointly sponsored by: Institute of Governmental Studies, University of  
California, Berkeley  
and University of California San Francisco, Office of Continuing  
Medical Education

**Policy Suggestions and Practice/Research Perspectives on  
Treatment Objectives and Outcomes**

**Professor Steven P. Segal**

There is expanding emphasis on empirically-based model programs combining psycho-social treatment with the effectiveness of atypical anti-psychotics and SSRIs in meeting the care needs of people with serious mental illness. This emphasis is reflected in demonstration programs that are the basis for proposed policy initiatives throughout the United States. These efforts are paralleled, however, by increasing concern for the welfare of this population. Given the need to relate empirically -based knowledge to practice and policy initiatives, this paper discusses the objectives and outcomes of treatment, how individual outcomes are related to treatment objectives, and how the social context of care and client participation in treatment objectives effect such outcomes. It addresses these issues from the perspective of the mental health research literature, clinical practice, observation of

model programs, and four studies: a twelve year followup study of a probability sample of all individuals with a history of psychiatric hospitalization living in supervised residential care facilities in California (Segal & Aviram, 1978; Segal & Kotler, 1993), a nine hospital study of psychiatric emergencies and their 12 month outcomes (Segal, Egley, Watson, & Goldfinger,1995) , and two studies of Self Help Agencies and Co-located Community Mental Health Centers (Segal, Silverman, & Temkin,1995; Segal, Hardiman, & Hodges, 2001).

## **The Social Context of Treatment**

*The mentally ill are extremely vulnerable to adverse social context changes and (if) treatment is not robust its positive contributions are easily overwhelmed by negative circumstance.* For example, one half of the elevated death rates reported for people with schizophrenia can be attributed to the poverty circumstances their illness has forced them into (Segal & Kotler, 1987). No mental health treatment program I have

observed that has received attention as a model of care has flourished without affordable housing. Deinstitutionalization is not directly responsible for the mentally ill on the streets. By my guestimate, the pre-1980 representation of the mentally ill among the homeless population was about 8%; today it is about 33% (Segal & Baumohl, 1977). Thus, a full decade after Deinstitutionalization much of the seriously mentally ill had housing. Housing policies coupled with their vulnerability have put the mentally ill on the street, (specifically) urban renewal and the reduction of support for new affordable housing (Belcher and Deblasio, 1990).

The mentally ill are extremely vulnerable to the vicissitudes of the policy process. For example, while AB2034 is an excellent attempt to bring comprehensive integrated care services to the criminal justice involved and homeless mentally ill, its reliance on the granting mechanism instead of general budget increases with appropriate utilization review makes the long-term nature of this effort tenuous at best (and) subject to cyclical changes in public policy population

interests. The ephemeral nature of such efforts are further illustrated by the limited duration of Bronzon Demonstration programs in California (Wright-McCorquodale-Bronzan Act, 1988) and the past use of financial incentives to foster the reduced use hospitalization (California Mental Health Services Act, 1984). The latter incentives, designed to allow the investment of inpatient care savings in outpatient programs, were subsequently eliminated leading to reductions of over 50% of State general fund investment in the care of the seriously mentally ill (Okin,1992).

## **Treatment Objectives**

The objective of treatment is to provide quality care, the definition of which lies with the stakeholders in the interaction. *The mental health professional's perspective emphasizes technical quality in the therapeutic interventions; the patient's perspective, personal involvement in the decision process regarding their own care, and the administrative perspective, efficiency in service delivery.* From the

perspective of therapeutic interventions, treatment objectives include the provision of medications, psychotherapy, as well as social role supports, supplements, and substitutive residential environments. These interventions allow the person with mental illness to offer sound information for accurate diagnosis and to participate in an active treatment regimen. Noncompliance with the treatment regimen or inaccurate information on the client's past experiences leads to treatment failure. The most pervasive finding in all this research is that when the client is properly engaged (and even the client who is mute or hostile can be so engaged) the outcomes are better. This is reflected, to cite a few examples, in the power of individual involvement in the choice of residential care facility in influencing positive functioning outcomes (Segal & Aviram, 1978), the importance of patient engagement in psychiatric emergency service outcomes (Segal, Egley, Watson, & Goldfinger, 1995), and the general role of client involvement in self help agency decision making (organizational empowerment) in predicting self direction in one's life (personal empowerment) and



improved functioning( Segal & Silverman, 2002). There are significant numbers of individuals who do not appreciate the extent or danger of their disability but we have a long way to go before we can successfully distinguish such individuals from those who have experienced repeated system failures (i.e. by way of inappropriate, inadequate, and aversive care). Such individuals are frequently unwilling to risk another attempt at system interaction.

We know that people avoid treatment for fear of civil commitment (Campbell & Schraiber, 1989). We also know that people evaluated at Psychiatric Emergency Services, the site where most civil commitments are initiated, come to treatment with differing attitudes toward care and hospitalization and these attitudes are significant in shaping the course of treatment.

Of 683 evaluations at nine California public hospital psychiatric emergency rooms, 33% of the patients were against hospitalization, 24% were ambivalent toward hospitalization, and 18% were seeking hospitalization. In 24% of the cases a preference was unclear.

Among the *group against hospitalization*, 55% were retained and 45% were released. Results indicate that the retained patients in this group were more dangerous and disturbed than others. All were generally afforded procedural due process and quality clinical care during their evaluation in the PES. Excessive staff workloads, however, adversely influenced the decision process. Psychiatric emergency services need additional resources to insure that this process is not corrupted by the lack of adequate staffing (Segal, Laurie, & Segal, 2001).

Among those *preferring hospitalization*, 62% were retained and 38% were released. Bi.e. denied access to inpatient care despite their avowed wish to be hospitalized. This is a very high risk population as the Goldstein case in New York illustrates. **Failure to provide requested care has sometimes ended in violent acts.** For this population, severity of dangerousness and mental disorder, and poor functional status accompanied by the absence of less restrictive alternatives to hospitalization, were effectively employed as triage

criteria in determining who should be denied access to inpatient care. At twelve months follow up, fewer deaths were observed in the group denied admission, and no other significant outcome differences were recorded (Segal, Laurie, & Franskoviak, 2001b).

Among the *ambivalent group* of patients coming to the PES, 78% were retained and 22% were released. Patients ambivalent about accepting hospitalization were more treatable, evaluated as less likely to benefit from hospitalization, and had no less restrictive alternative placement available. PES patient's ambivalence toward hospitalization was related to deficits in treatment resources matching patient need. The coercive element in the civil commitment evaluation for ambivalent patients was their acceptance of a less than appropriate treatment alternative, hospitalization (Segal, Laurie, & Franskoviak, 2001a)..

The PES under the dangerous standard can be a model of care giving if properly supported. Using coercive detention at other points in the civil commitment process has been less consistent and poorly studied. Further, we have very limited understanding of outpatient civil

commitment and other types of assisted treatment mechanisms. We don't know whether such procedures will enable people with serious mental illness to benefit from available treatment or avoid adverse outcomes over the long-term. The benefits and costs of such mechanisms need to be better understood before they are adopted (Ridgely, Petrila, & Borum, 2001).

### **Treatment Outcomes**

There is no mind-body separation in treatment outcomes for the seriously mentally ill. Medically necessary treatment is a fully integrated bio-psychosocial program. Outcomes include: reduced symptoms, avoidance of adverse experiences (death, violent crime, criminal detention), improved quality of life (not just satisfaction but both independent and assisted social functioning) and personal empowerment (enhanced control over one's life situation) over the long-term (for this is a long-term condition).

The PES and Inpatient Care. In county general hospital PESs we observed that quality of care was related to patient outcomes. Most

notably, appropriate patient engagement was associated with a lower probability of retention and improved functioning at time of PES exit even after controlling for the severity of entry problems (Segal, Eagley, Watson, & Goldfinger, 1995)

There also remains an important role for hospital inpatient care, at least in the absence of adequate alternatives. Our follow up studies have showed that early release from post PES admission has contributed to the recycling of patients back into the PES.

**Long-term Supervised Care.** Long-term supervised residential care for the seriously mentally ill leads to reductions in psychiatric symptoms, improved general health, and improved assisted social functioning (i.e functioning mediated by the efforts of others). This is a big positive for those truly unable to meet their own basic needs. Yet, this comes at the cost of reductions in independent social functioning and concomitant increases in institutional and or supported environment dependencies (Segal & Kotler, 1993; Segal & Moyles, 1979). Again, these outcomes should be acceptable for many who cannot make it on

their own. The dependencies and reductions in independent social functioning, however, contribute to increased vulnerabilities to the social context that can be devastating in an unstable policy environment that fails to support necessary housing and comprehensive integrated treatment alternatives. Once you put someone into such a long-term program they will require extended guaranteed long-term support.

**Since, in the past 30 years, it has been difficult to depend on the State to insure continued environmental supports and relatives will not be around forever, it is important to enable people to be less vulnerable by engaging them as actively as possible in achieving their own positive outcomes, especially the enhancement of their independent functioning.**

Despite all such efforts serious mental illness will leave a significant number of individuals in need of long-term residential care. Dorothy Dix, is spinning in her grave, at the size of the prison and jail populations with major mental illnesses. Over 150 years ago, she fought the battle for State responsibility for the care of this population given full

awareness of the difficulties involved in providing long-term protected care under local financing schemes. While, the State hospital is not the answer, long-term State supported care, for those who require it, in a full spectrum of housing environments is one big part of the solution. The abandonment of State responsibility for such care has lead to the concentration of the mentally ill in jails and prisons, their infection with a myriad of additional health and social ills and the disruption and often destruction of their families.

**Outpatient care.** Aggressive social casework, similar to the Program in Assertive Community Treatment (PACT) Model design, was effectively employed in California, Wisconsin, Michigan, and New York and other states during the late 1960s and early 1970s. Long before the Stein and Test PACT demonstration, it was the type of social casework practiced by the Bureau of Social Work in California throughout the late fifties and 1960s. The results of such efforts are primarily gains in assisted functioning. That is, reductions in the use of hospitalization, made possible by mediated service provision that keeps the individual

out of the facility or in more recent studies, reductions in homelessness or criminal justice detentions again made possible by staff facilitation of housing access or interposition with criminal justice officials. The value of such assisted outcomes should not be underestimated. They make life livable for this population. These outcomes, however, do not signal an end to the individual's vulnerability or the curing of his/her condition. They exit as long as they are guaranteed by program effort and once eliminated, unless progress is made in the independent functioning area, they leave the individual vulnerable to the same social situation.

In California, the destruction of the Bureau of Social Work, a Statewide organization responsible to the total care of the seriously mental ill was a key factor in the failure to provide adequate community-based care over the past 30 years. This was accomplished as part of a policy process that shifted responsibility for the mentally ill to the counties, and lead to the abandonment of State responsibility for all but the seriously mentally ill offender population.



The shift to managed care has increased the difficulties of providing comprehensive care to all but the gold card patients who incur excessive hospitalization costs. Limited by medical necessity criteria, community mental health agencies have developed a division of labor with consumer-lead services. The latter provide the social care and case management and the former medication. The extensiveness of this partnership has become increasingly evident in our recent study results on service utilization at co-located self help and mental health service agencies. The strength of the consumer run self help organization is laudable and requires continued and extensive support. Its efforts belie the claims of those who would underrate the contributions of the seriously mentally ill to their own care. Self Help Agencies are providing extensive services especially in the form of social support networks and vocational opportunities that enable people with mental illness to participate in meaningful decision making that enhances personal empowerment. In encouraging this effort we must not abandon professional case management efforts and must put an end to the general

de-professionalization of the field. The loss of professional biopsychosocial case management skills will prove detrimental over the long-term.

### **Policy Suggestions**

1. Develop a full spectrum of State sponsored housing supports including independent living, supported housing, supervised housing and group care facilities for the seriously mentally ill. These facilities need to include true alternatives to hospitalization (as opposed to rented rooms at single room occupancy hotels) as well as permanent supported housing arrangements.

Working through the homeless services system is unconscionable. It subjects people with serious mental illness to what has become a breeding ground for biopsychosocial ills. It places them at risk of increased involvement with substance abuse, tuberculosis, AIDS, and the criminal justice system.

2. Stop using hospital retention as a negative indicator, for many it is a necessary life saver.
3. Support efforts to give the patient/client an active role in decisions about their own care both within professional and through self help programs. When at all possible the we need to help the person retain responsibility for themselves.
4. Use coercive interventions with caution and only after underwriting efforts that protect the seriously mentally ill against structural abuses.
5. Stop using the grant mechanism as a funding means. We know an integrated system of care works. Fund the system, not model programs that disappear when they are no longer sexy.

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