California State University, San Bernardino
CSUSB ScholarWorks

Theses Digitization Project John M. Pfau Library

2009

The relationship between full service partnership intervention and rehospitalization rates of the severe and persistent mentally ill

Joseph Ralph Tena

Follow this and additional works at: https://scholarworks.lib.csusb.edu/etd-project

Part of the Psychiatric and Mental Health Commons, and the Social Work Commons

Recommended Citation
Tena, Joseph Ralph, "The relationship between full service partnership intervention and rehospitalization rates of the severe and persistent mentally ill" (2009). *Theses Digitization Project*. 4480.
https://scholarworks.lib.csusb.edu/etd-project/4480

This Project is brought to you for free and open access by the John M. Pfau Library at CSUSB ScholarWorks. It has been accepted for inclusion in Theses Digitization Project by an authorized administrator of CSUSB ScholarWorks. For more information, please contact scholarworks@csusb.edu.

THE RELATIONSHIP BETWEEN FULL SERVICE PARTNERSHIP INTERVENTION AND REHOSPITALIZATION RATES OF THE SEVERE AND PERSISTENT MENTALLY ILL

A Project

Presented to the

Faculty of

California State University,

San Bernardino

In Partial Fulfillment

of the Requirements for the Degree

Master of Social Work

---

by

Joseph Ralph Tena Jr.

September 2009

THE RELATIONSHIP BETWEEN FULL SERVICE PARTNERSHIP INTERVENTION AND REHOSPITALIZATION RATES OF THE SEVERE AND PERSISTENT MENTALLY ILL

A Project

Presented to the

Faculty of

California State University,

San Bernardino

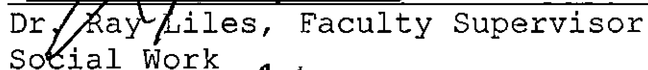
---

by

Joseph Ralph Tena Jr.

September 2009

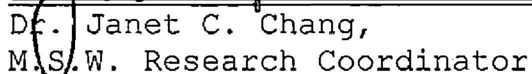
Approved by:



Dr. Ray Liles, Faculty Supervisor
Social Work

6/30/09
Date

Don Windham,
Inland Empire Mental Health FSP



Dr. Janet C. Chang,
M.S.W. Research Coordinator

ABSTRACT

This research project explored what treatment interventions prove effective in reducing psychiatric inpatient rehospitalizations among the severe and persistent mentally disordered population. The study was conducted as a 2 x 2 x 2 x 2 Between Subjects Factorial Quasi Experimental Design utilizing secondary data extracted from 40 randomly selected files. There were four predictor variables which included subsidized housing, group participation, crisis center services, and regular doctor visits. The outcome variable was the differentiation in hospitalizations while involved in a Full Service Partnership program.

The research did not reveal statistically significant reductions in rehospitalizations for any of the variables with the exception of the group participation variable. Those that utilized group services reduced their number of hospitalizations by approximately one visit during the time period studied. It is recommended that further study be employed on the individual, family, and community levels to assess programs that provide therapeutic interventions for those suffering from severe and persistent mental disorders. In

conclusion, frequent participation in group activities significantly reduces the need for inpatient hospitalizations among the severe and persistent mentally ill population.

ACKNOWLEDGMENTS

I want to thank Mr. Pryor of the Department of Rehabilitation for believing in me and giving me the opportunity to attend school. Your advocacy on my part changed my life forever. I wish to express gratitude to California State University's School of Social Work for providing an excellent opportunity for professional development and scholastic achievement. I wish to express thanks to all of the staff at "Inland Empire Mental Health's, Full Service Partnership" program for allowing me to work and be employed at your agency. Special thanks to Dr. Liles, a walking encyclopedia of social work knowledge and expertise, and as equally important, Dr. Davis for your kind words, your dedication to the students, and for allowing me to be myself. I will never forget you.

DEDICATION

This endeavor is dedicated to my mother and father who instilled in me the quality of social justice and the inherent worth of all individuals. I miss you. To my brother Phil, and sisters Renee and "Andy," without the three of you this would not have been possible. I love you all deeply.

TABLE OF CONTENTS

ABSTRACT iii

ACKNOWLEDGMENTS v

CHAPTER ONE: INTRODUCTION 1

Problem Statement 2

Purpose of the Study 4

Significance of the Project for Social Work 7

Research Question 8

CHAPTER TWO: LITERATURE REVIEW

Introduction 9

Theories Guiding Conceptualization 12

Therapeutic Models 14

Barriers to Recovery 22

CHAPTER THREE: METHODS

Introduction 24

Study Design 24

Sampling 25

Data Collection and Instruments 26

Procedures 27

Protection of Human Subjects 30

Data Analysis 30

Summary 31

CHAPTER FOUR: RESULTS

Introduction 33

Presentation of the Findings 33

Summary 34

CHAPTER FIVE: DISCUSSION

Introduction 36

Discussion 36

Limitations 41

Recommendations for Social Work Practice,
Policy and Research 42

Conclusions 43

APPENDIX A: DATA EXTRACTION SHEET 44

APPENDIX B: TABLES 46

REFERENCES 56

CHAPTER ONE

INTRODUCTION

As a result of the deinstitutionalization movement of the 1960s and 1970s, those with severe and persistent mental illnesses (SPMIs) fell through the cracks of the mental health system and were often left homeless and unmedicated. Inpatient hospitalization became the norm for crisis intervention and short-term intensive treatment. In addition, research indicates that a significant portion of those released from inpatient hospitalization will be readmitted shortly after their release. It would be fair to say that many of these mental health consumers have little or no resources available for recovery to be possible. This paper examines what treatment modalities are effective at reducing inpatient rehospitalizations and improving treatment outcomes.

The significance of this research is helpful to the field of social work practice as it explores assertive community treatment (ACT) and intensive case management (ICM) strategies that deal with the severe and persistent mentally ill population.

Problem Statement

While the Medical Model of mental health recovery addresses the neurobiological aspects of symptomology and is pathology-based, it fails to address the "multiple dimensions of an individual's life; physical well-being and safety, social interaction, economic status, and the ability to work and engage in pleasurable activities" (Swanson, Swartz, Elbogen, Wagner, & Burns, 2003, p. 474).

The revolving door policy of inpatient hospitalization is not only costly for the community; it has the potential to negatively impact the consumer's well-being by solidifying the hopelessness and stigmatization that many consumers experience from frequent hospitalizations. Being readmitted to a psychiatric hospital can be humiliating; it is the antithesis of self-determination, autonomy, and empowerment and often creates dependency on inpatient hospitalization as a treatment option. Several treatment interventions may reduce rehospitalizations; however, lack of resources such as medication, funding, and social support leave a significant portion of the homeless mentally ill population unable to care for themselves. As

a result, psychiatric symptoms increase due to lack of medication, followed by homelessness and a propensity for substance abuse as a form of self-medication. If an individual presents with severe symptoms of a mental disorder and is a threat to self or others, police may take the individual into custody and transport them to a mental health facility to be evaluated under the California Welfare and Institutions code 5150; a maximum 3-day involuntary hold without other review. This involuntary detention in a lockdown inpatient psychiatric facility is followed by release into the community without sufficient treatment resources being made available to the consumer. Not only are these interventions costly, they do little to address the environmental issues of the mentally disordered. The "revolving door" interventions into and out of acute care inpatient psychiatric facilities have become the norm for many communities in answer to the growing problem of the severe and persistent mentally disordered.

There are several treatment options that are known to reduce inpatient hospitalization; assertive community treatment (ACT) and intensive case management (ICM) services. Both of these are evidence-based practices and

incorporate the principles of client-centered, strength-based perspectives. In an effort to address this growing population of the mentally ill, Riverside County's (California) Department of Mental Health contracts with smaller, community-based agencies. One example of such a program is Inland Empire Mental Health (IEMH) Full Service Partnership (FSP) located in Southern California. IEMH is a pseudonym for an existing agency in the Inland Empire that chooses not to be identified for the purpose of this research project. IEMH's mission is to "Eliminate the impact of behavioral health problems for all people" (ISRC-Full Service Partnership Program Manual, 2006, p. 6). This task requires collaboration with other agencies that work with the SPMI. IEMH employs the principles of ACT/ICM treatment modalities and stands ready to serve those with SPMIs.

Purpose of the Study

The purpose of this study was to assess IEMH's Full Service Partnership program in Southern California in order to understand the relationship between FSP intervention and psychiatric rehospitalizations among the SPMI population. This program utilizes and incorporates

the principles of assertive community treatment (ACT) and intensive case management (ICM) models of mental health treatment into its service delivery. Clients are referred to IEMH by various Riverside County Mental Health agencies that traditional case management systems do not have the time or the resources to address.

Inland Empire Mental Health's clients consist of those with SPMIs that typically have little or no resources available and would benefit from long-term, ICM services. Many are homeless and present with such diagnoses as Schizophrenia, Schizo-affective, Bipolar I and II, and Major Depression. Many have been alienated from their families because of the extreme strain mental illness can cause family relationships. IEMH is usually "the last house on the block" to provide services for those with SPMI that traditional case management failed to provide.

Despite progress being made over the last three decades in restructuring mental health services there are still areas that need to be addressed. On both the macro and micro levels of social work, agencies and practitioners must constantly assess the services they provide or else become obsolete and perish. In addition,

service providers and practitioners must base their treatment delivery on "scientific epistemology" (Roberts & Yeager, 2006, p. 4). It is well documented that "good clinical practice must be informed by the best available evidence regarding treatment and diagnosis" (Roberts & Yeager, 2006, p. 6) whether it is evidence-based practice or evidence-based research. IEMH FSP employs both evidence-based practice and evidence-based research in assessing and restructuring program design in order to address the risk factors involved in working with those with SPMIs. Evidence-based practice influences therapeutic treatment by improving service delivery and gives practitioners a greater understanding of what works and what does not.

This research incorporates quantitative research methods utilizing clients' charts and records in order to understand the various interventions clients voluntarily utilize and to assess the positive and negative outcomes these may have on inpatient rehospitalizations and psychopathology. The independent variable is the comprehensive community-wide IEMH FSP program and its various program interventions and treatment groups.

Significance of the Project for Social Work

Traditional case management often proves ineffective in reducing inpatient hospitalizations and leads to poor outcomes for those with SPMIs. However, programs that implement the strategies of ACT/ICM and have a housing component have proven superior at reducing rehospitalizations and increasing positive outcomes (Nelson et al., 2007). Because Inland Empire Mental Health utilizes both ACT and ICM strategies it is important to understand how effective they are at reducing inpatient hospitalization and which of their several components may lead to more positive outcomes for consumers.

This study is important for the field of social work in that it will identify treatment modalities that positively impact what components lead to the homeless mentally disordered. In addition, this research will identify risk factors among the SPMI population that negatively affect outcomes. Additional research is necessary to stay informed of current treatment modalities in program delivery that increase the positive outcomes. Research indicates that nonparticipation in the various interventions offered by ACT and ICM services has

a cumulative effect that leads to increased symptomatology and inpatient hospitalization.

The complexity of the mentally ill population requires intensive dedication to research and program design. Mental health programs are in a state of constant revision and revitalization using current evidence-based research and practices as a guide for providing the "best-fit" for client-centered care.

Research Question

What is the relationship between full service partnership intervention and inpatient hospitalizations among the severe and persistent mentally ill clients in one Southern California private non-profit mental health agency?

CHAPTER TWO

LITERATURE REVIEW

Introduction

Inland Empire Mental Health's Full Service Partnership (FSP) program was founded three decades ago and functions as an Integrated Services Recovery Center (IRSC), which constitutes "five fundamental concepts of; community collaboration, cultural competence, client/family-driven mental health systems, wellness focus, and an integrated service experience" (ISRC-Full Service Partnership Program Manual, 2006, Section A, p. 6). Most of IEMH's clients have demonstrated "non-adherence or unsuccessful engagement with outpatient treatment" (ISRC, Section B, p. 12). The FSP program consists of five tiers or levels; the first one being *Stabilization.* This level consists of initial mental health services such as housing and a session with the FSP psychiatrist. The goal for level one is symptom stabilization and engagement in the treatment process. In addition, consumers identify and develop goals *they* would like to accomplish. Once they have stabilized, they move

on to level two which consists *of Recovery and Rehabilitation.*

Level two is for those that have exhibited some stability over their symptoms and are engaged in treatment at some stage. These consumers keep most appointments and have stable housing. Occasionally there may be intermittent crisis but these are addressed with the aid of a Personal Service Coordinator (PSC) or case manager. PSCs have no more than 15 cases at one time to allow for intimate and personalized treatment and to develop a trusting, working relationship with consumers. For those in crises, IEMH has an emergency housing resource; Hope Crisis Center [pseudonym], a 28 bed facility that lodges those waiting for housing or additional psychiatric care. In addition, Hope Crisis is utilized are to insure medication stabilization and/or transitioning to or from Emergency Treatment Services (ETS) or Intensive Treatment Facility (ITF). Hope is used in lieu of an inpatient, locked facility when harm to self or others is not indicated.

The third level is *Self-Management*. These consumers are comfortable with their illness, are actively pursuing personally designed goals and have assimilated into

community life. They participate in meaningful activities that may include work or school, and have mended relationships with their families and friends. Many have established peer relationships that will last a lifetime.

Level four is *Community Integration*. Level four is similar to level three but consumers have maintained housing for 12 months and are proactive in their recovery process. They have sense of direction and purpose in their lives and find joy in living.

Level five is the *Graduation* from FSP services. Consumers have successfully integrated into the community and are no longer dependant on FSP services. Occasionally, they may drop by the FSP program to offer support in peer-to-peer groups and instill hope for those still struggling with their mental illness.

Research indicates that inpatient hospitalizations are greatly reduced by community-based agencies that utilize ACT and ICM systems of recovery. These client-orientated systems address the multi-dimensional issues that face the mentally ill. One important factor in reducing inpatient rehospitalization is subsidized housing for the homeless. Due to lack of financial resources, ignorance, and the inability to navigate the

complicated systems that are engineered toward helping the mentally ill, many individuals with SPMIs are faced with homelessness. All of these individuals have rights but as Sullivan mentions, "having rights and no resources...is a cruel joke" (1992, p. 5). Homelessness is but one factor that affects rehospitalization rates. Another factor is access to outpatient psychiatrists and pharmacological intervention. The following literature review is not exhaustive, however it clearly identifies risk factors the mentally ill face, the interventions that prove effective at reducing inpatient hospitalization, and the treatment processes that ACT and ICM strategies utilize to reduce rehospitalization and improve treatment outcomes.

Theories Guiding Conceptualization

Woods and Robinson (1996) conclude that Psychosocial Theory was developed primarily from the efforts of case managers to "support the well-being of individuals and families and to respond to people's need to restore social functioning...and better their interpersonal relationships and life situations" (p. 555). Psychosocial treatment does not emphasize the pathological aspects of

a person's life but focuses on the aspects of the consumer that are "most capable of change" (Woods & Robinson, 1996, p. 555). Treatment begins with a thorough biopsychosocial assessment to determine what strengths the individual possesses with the objective of building on what the consumer "can do". To develop these strengths case managers must collaborate with other agencies in order to find optimal fits that address the client's needs. Collaboration stems from the idea that no one agency can possibly address the unique needs of a client. Collaboration does not mean that the individuality of the person will be compromised as this will play a key role in actualizing their optimal potential (Steinberg, 2004). Collaboration is based on the premise of "shared power," the client being the axis of the collaboration process (Graham & Barter, 1999, p. 6).

Client-Centered Theory is fundamental to this research. Carl Rogers believed that humans are basically growth-oriented and concerned about filling their potential and if they are accepted for who they are, the results will be positive (Rowe, 1996). It is when this potential is underdeveloped that the person experiences disequilibrium, and is left with a feeling of turmoil and

hopelessness. Client-centered therapy suggests that "when there is incongruence between the individual's self-concept and experiences with others, a state of anxiety results" (Rowe, 1996, p. 76). Client-centered therapy is based on the assumption that "the individual has the capacity to guide, regulate, direct, and control his or herself providing certain conditions exist" (p. 78). It is these "certain conditions" of client-centered case management the social work practice is determined to facilitate.

Therapeutic Models

The Clubhouse Model (CM) of peer-to-peer support began in 1948 by a group of former "patients" of a state mental hospital in New York City named The Fountain House (Mowbray, Lewandowski, Holter, & Bybee, 2006). As of 2000, there were over 350 clubhouses in 44 U.S. states and 21 other countries (Mowbray et al., 2006). The CM is a psychosocial rehabilitation (PSR) practice which embodies the principles of empowerment. Clubhouses instill a sense of confidence and agency, allowing members to make choices, pursue goals, reduce reliance on professionals, and make decisions independently (Mowbray

et al., 2006). However, in many clubhouses decisions concerning governance, budget issues, and allocation of funds to members in need is usually done with an outside board, staff, or administrator (Mowbray et al., 2006). Another model similar to the Clubhouse model is the Collaborative Recovery Model.

The Collaborative Recovery Model (CRM) consists of three guiding principles; "1, it is evidence-based; 2, it incorporates modularized competencies relevant to case management and psychosocial rehabilitation; and 3, it recognizes the subjective experience of the consumer" (Oades, Deane, Crowe, Gordon, Kavanagh, & Lloyd, 2005, p. 279). As well, there are six training modules consisting of two guiding principles with four specific protocols for clinicians to follow. The four protocols are motivational enhancement, needs assessment, collaborative goal technology, and homework assignments. The first guiding principle is that recovery is an individual process.

Individual recovery incorporates four processes as "determined by 14 articles by consumers and eight qualitative studies" and these are; "finding hope, redefining identity, finding meaning in life, and taking

responsibility for recovery" (Oades et al., 2005, p. 280). The second guiding principal for CRM is collaboration and autonomy support, which consists of the dialectic between one who is recovering and working alliance between an individual and clinician or a team of players (Oades et al., 2005). The first protocol of CRM is change enhancement.

Change enhancement is used interchangeably with motivational enhancement, originally termed "motivational interviewing" (Oades et al., 2005, p. 280) defined as "a directive, client-centered counseling style[s] for eliciting behavior change by helping clients to explore and resolve ambivalence" (Rollnick & Meiller, 1995, p. 325). This approach is goal-directed and client engineered and "*not imposed from without*" (Rollnick & Meiller, 1995) such as the suggestion of a clinician or counselor, however, the clinician may help by "identifying the advantages and disadvantages of existing and planned behaviors" (Oades et al., 2005, p. 280).

The second protocol of CRM suggests that the unmet needs of a consumer are an important motivator and adopts a "negotiated approach to need" (Oades et al., 2005, p. 280). The needs of the SPMI clients Inland Empire

Mental Health serves can best be understood by utilizing Maslow's *hierarchy of needs* and serves as a model for prioritizing an assessment of needs. Next, collaborative goal setting and striving toward these goals assist the consumer with self-determination and efficacy. The final protocol of CRM entails the use of homework which consists of three stages; "review, design and assignment" (Oades, et al., 2005, p. 28). The goal of homework is to provide a tool for exploration, recognition, and implementation of attitudes and behaviors which may be barriers for recovery and assist the consumer in developing a plan and a dream for the future.

Assertive community treatment (ACT) has long-term implications which address the multi-dimensional aspects of a person's life. This article is important as it provides the contextual framework in which the reduction of inpatient hospitalizations can be understood. Those with SPMIs require full-time attention from a multi-disciplinary team consisting of, but not limited to: clinical staff, personal service coordinators, psychiatrists, nurses, drug and alcohol counselors, a housing component, and employment development. In addition, "Treatment fidelity has been positively

associated with improved outcomes in several community-based interventions including… assertive community treatment and integrated dual disorders protocols" (Bruns, Suter, Force, & Burchard, 2005, p. 521-522). ACT programs collaborate with many agencies throughout the county to find and employ services that one agency alone cannot provide. One goal is to reduce inpatient hospitalization and, should a person need hospitalization, reduce the amount of time a consumer is inpatient. Another goal is to bring self-awareness, self-sufficiency, and self-determination to the client.

Because mental health services are vulnerable to government cutbacks in economic downturns many persons with SPMI can find themselves homeless (Nelson, Aubry, & Lafrance, 2007). Many ACT and ICM facilities are adopting what is called the "Housing First Strategy" which focuses on providing the consumer with housing before treatment services begin. This "starting point" considers person-in-environment and seeks to address the immediate needs of those homeless with severe MDs. Because ACT programs are instrumental in reducing homelessness among the SPMI, one "clear-cut" outcome of this research is reduced inpatient hospitalization (Nelson et al., 2007,

p. 359). ACT and ICM strategies of reducing homelessness among the SPMI population are superior to traditional case management alone. However, ICM without ACT components had the weakest impact of the different treatment alternatives studied (Nelson et al., 2007). In addition, this article indicates more research is needed concerning subgroups and intervention strategies that prove effective in reducing homelessness.

The empowerment approach to social work is defined as "the process of helping individuals, families, groups, and communities to increase their personal, interpersonal, socioeconomic, and political strength and develop influence toward improving their circumstances" (Barker, 1999, p. 153). Empowerment is the antithesis of the Medical Model which tends to create dependency and loss of autonomy, the client playing a passive role in the recovery process. The empowerment process is not a passive role but a "reflexive activity, a process capable of being initiated and sustained only by (those) who seek power or self-determination" (Lee, 1999, p. 224). In addition, empowerment can only be sustained if a person's basic requirements of food, clothing, shelter, and economic security are met (Lee, 1999). Having these basic

requirements met creates a firm foundation in which personal goals and desires can be explored. The empowerment process can take on many forms. One empowering component of ACT/ICM treatment team is the self-help and mutual-aid approach utilizing peer-to-peer models of recovery.

The mutual-aid approach "relies on spontaneous communication and interactions" among peers, and the "exchange of strengths," all under the umbrella of a "democratic-humanistic" environment which empowers individuals by taking part in the decision-making process (Steinberg, 2004, p. 3). In addition, this environment fosters respect for self and others since everyone's feelings are important and are taken into consideration before any decision is made (Steinberg, 2004). This process is similar to the aboriginal "passing of the feather;" the one in possession of the feather expressing his/her desires and goals for the group without interruption. Then the feather is passed to the next person in the circle. The mutual-aid approach is a strengths-based perspective that embodies the principles of self-determination, autonomy, and advocacy. In line

with the mutual-aid approach is cognitive behavioral therapy.

Dr. David D. Burns states in his book, The Feeling Good Handbook, that cognitive behavioral therapy (CBT) is popular because it is "common sense" therapy that is quick, effective, and has been clinically proven to reduce depression, many times without the use of antidepressant medication (1999, p. xiv). The premise is "you can change the way you feel by changing the way you think." Those with depression usually incorporate self-defeating belief systems that sabotage joy and intimacy with others, which leads to social isolation and compounds depression. Cognitive behavior addresses these self-defeating perspectives and interpretations of antecedents that prove to be false. For the SPMI population, "delusions are defined as false beliefs held with unusual conviction, which were not amendable to logic" and these same "hallucinations represent a severe part of the psychiatric symptom spectrum [and] occur in up to 74% of patients with schizophrenia and cause significant morbidity" (Landa, Silverstein, Schwartz, & Savitz, 2006, p. 1).

Barriers to Recovery

While it is important to know what is working in an ACT/ICM agency it is equally important to understand the barriers to recovery. But first, here is one explanation of what recovery *is* and what it *is not*. Recovery for those with SPMI is not complete eradication of mental health symptoms but the "amelioration of symptoms," (Happell, 2008, p. 1). Recovery does not mean that one will never be hospitalized again but that the frequency and time in hospital will be reduced. Recovery does not mean that one will secure a job and keep it the remainder of their life; it means restoring one to usefulness within the community they live and "engaging in pleasurable activities" (Swanson, Swartz, Elbogen, Wagner, & Burns, 2003, p. 473).

Happell (2008) indicates in her research of consumers' perspectives of mental health services that barriers to recovery include: hearing the illness, not the person, staff paternalism, negative attitudes of service personnel, psychiatrist claiming drug/alcohol abuse without evidence, psychiatrist who ask a set of questions without considering consumer input, and doctors who prescribe the same medication at higher doses even

though the client states they don't believe it is the right medication to begin with (Happell, 2008, p. 7). These attitudes disempowered individuals and often leave consumers unwilling to participate in program activities as they felt they weren't being heard (Happell, 2008).

CHAPTER THREE

METHODS

Introduction

This chapter outlines the methods used to measure the differences in inpatient hospitalizations between those individuals who may have utilized services available through the non-profit, community-based, FSP program of Inland Empire Mental Health. In an effort to better understand the relationship between the FSP program of Inland Empire Mental Health and the rehospitalization rates of the severe and persistent mentally ill, this study examined whether four specific interventions utilized in the program (subsidized housing, group participation, crisis center services, and doctor's care) were effective in reducing the number of inpatient hospitalizations of program participants.

Study Design

Using secondary data analysis, this study was conducted as a 2 x 2 x 2 x 2 Between Subjects Factorial Quasi Experimental Design. There were four predictor variables each with two levels as either being yes the individual utilized the services, or no the individual

did not utilize such services. Those four predictor variables included subsidized housing, group participation, crisis center services, and regular doctor visits. There was one outcome variable utilized in the present study which included the change in hospitalizations since involvement in FSP. This figure was calculated based on the difference in the number of hospitalizations in the year prior to FSP and the number of hospitalizations since participation in FSP.

Sampling

The target sample included 40 randomly selected files, representing approximately 20% of the 200 clients receiving FSP services from Inland Empire Mental Health. Of those 40 clients, 15 were female and 25 were male. The age range was from 24 to 57 years, with a mean age of 39.93 years. The average length of time in the program was 4.9 months. Fifteen of the participants experienced homelessness prior to participation in the program, which dropped to just 4 individuals after participating in the program.

Of the 40 participants, 16 utilized the subsidized housing services available through the FSP program, 11

utilized one or more of the group resources, 19 utilized the crisis center services, and 38 maintained regular doctor visits available through the program.

Data Collection and Instruments

The study utilized secondary data extracted from 40 randomly selected files of FSP IEMH clients. The files were alphabetized and every 5th consumer was selected until 40 participants were chosen. The researcher was granted access to review the selected files and record only the data necessary to provide a description of the participants which included age, sex, length of participation in IEMH program, and the history and current status of homelessness due to its relationship to the housing component of the program. Data was also extracted from files related to each of the four predictor variables included participation or lack thereof in services available through FSP including subsidized housing, group participation, crisis center services, and regular doctor visits. Finally, data was extracted from client files and a SPUDS report was accessed to determine the number of times a client utilized the Riverside County Inpatient Treatment

Facility (ITF). This information was used to determine the number of hospitalizations experienced in the year prior to involvement in FSP, as well as the number of hospitalizations experienced since involvement in the program. That data was then utilized to formulate the criterion variable, representing the change in hospitalizations since being involved in the FSP IEMN program.

Procedures

The objective of the FSP program is to utilize ACT and ICM strategies to provide integrated treatment for those with severe and persistent mental illness. In their efforts to treat and rehabilitate those individuals with severe and persistent mental illness the FSP program offers housing supports, groups to improve social skills, cognitive behavioral therapy, employment development, and living skills. All of these services are designed with the intent to produce better outcomes, including reducing the number of inpatient hospitalizations for those who suffer from severe and persistent mental illness.

Upon entering the IEMH FSP program, an extensive biopsychosocial history is taken which includes

descriptive information such as client's age, sex, past experience with homelessness, and a history of hospitalizations is provided. At that time, the individual is assigned to a case manager.

Consistent with FSP principles, the case manager attempts to provide housing support first, as it is deemed to be a basic need toward rehabilitation and integration back into the community. Once housing is established, the individual is assigned to a doctor and put on a regular appointment schedule in order to meet their need for medication and oversee the effectiveness of such treatment. There is no formal system in place to accurately monitor the administration of the client medications.

In addition to regular doctor visits for medication oversight, the individual is encouraged to participate in the groups offered at FSP. These options include Cognitive Behavioral Therapy (CBT); Department of Rehabilitation (DOR) groups that focus on job skills and job skills training and resume preparation; Wellness Recovery Action Plan (WRAP) groups that discuss barriers to wellness and ways in which one may overcome such barriers; and finally, Recovery, Empowerment, and

Advocacy Skills (REAS) groups in which participants discuss various tools that can be utilized to assist them in their treatment and rehabilitation efforts. Individuals can participate in any or all of the groups available.

IEMH FSP clients may utilize the Hope Crisis Center that provides services similar to those available in an inpatient mental health treatment facility. However, services through the crisis center are voluntary and the client is free to leave at any time. This service is utilized by those individuals who may have more severe symptoms and require supervision and care during the treatment and stabilization process.

All records are maintained and compiled by case managers which includes noting which services were utilized during involvement with the IEMH FSP program. These files contain all of the information described in the present study. Using the data extraction sheet outlined in Appendix A, all relevant data was extracted from the files in a secure location on site.

Protection of Human Subjects

Given that the study was based on secondary data, direct informed consent was not required. However, authorization to complete the study was granted by program administrators. Furthermore, in the interest of protecting client privacy and anonymity, at no time was the researcher able to take the records off site. The researcher was granted access to client files and transferred only relevant data to a data extraction sheet that did not in any way identify the client. Each data extraction sheet was assigned a number and at no time was a client's name or any identifying information used. Completed surveys were kept in a locked box in Inland Empire Mental Health's FSP office safe.

Please see Appendix A for a sample of the data extraction sheet utilized for the purposes of collecting the data.

Data Analysis

All data was input into SPSS for analysis. The four predictor variables were subsidized housing, group participation, utilization of crisis center services, and attendance of regular doctor visits. The outcome variable

was constructed based on the differences between inpatient hospitalizations in the year prior to FSP participation and inpatient hospitalizations since FSP participation, representing the change in rehospitalizations since involvement in FSP.

Initially, the researcher intended to analyze the data using a four factor ANOVA. However, upon screening the data for normality, all data was normally distributed with the exception of the data for the outcome variable of rehospitalizations. The analysis indicated that the data for this variable was significantly skewed. Therefore, a nonparametric alternative was utilized given that the data violated assumptions of normality. Due to the nominal nature of the criterion variables, and the skewed ratio nature of the outcome variable, the Mann-Whitney U Test was selected for the final data analysis. A significance level of $p < .05$ was used for the purpose of analyzing all significance levels.

Summary

This chapter discussed the methods used to measure the differences in rehospitalizations since involvement in FSP between those individuals who either utilized or

did not utilize one of the four services available through participation in the FSP program including housing subsidization, group participation, crisis center services, and regular doctor care. These four services served as the four criterion variables each with two levels; yes, the individual utilized the said service, or no, they did not. The inpatient hospitalization as discussed serves as the outcome variable w, and between the independent variable, a nominal variable.

This section also discussed the specific design of the study, the size and selection process for the present sample, and the procedures utilized in the compilation, collection, screening, and analysis of the relevant data. Finally, a discussion of the protection of human subjects, and protection of the data collected was also provided.

CHAPTER FOUR

RESULTS

Introduction

The present study hypothesized that there would be a significant reduction in rehospitalizations between those that utilized services available through the FSP program and those that did not utilize such services. The four specific services analyzed in the present study included subsidized housing, group services, crisis center services, and regular doctor visits. It was expected that those who utilized these services would show significantly fewer rehospitalizations than those who did not take advantage of these services. In addition, the rehospitalization rates were measured by analyzing the difference in number of hospitalizations experienced one year prior to signing with FSP, to that of the number of hospitalizations experienced after signing with FSP.

Presentation of the Findings

Given that the data for the outcome data violated assumptions of normality, the data was analyzed by way of four Mann-Whitney U Tests comparing the difference in hospitalizations between those that utilized each of the

four services measured in the present study including subsidized housing, group participation, crisis center services, and maintaining regular doctor visits. The test did not reveal significant reductions in rehospitalizations for any of the variables with the exception of the group participation variable. Those results did show significant reduction in rehospitalizations between those that utilized group services than those did not utilize group services, $U = 132.50$, $p < .05$. Those that utilized group services showed a mean hospitalization of 1.55 visits, while those that did not utilize group services showed a mean hospitalization of just 0.59 visits. This indicates that those that utilized group services reduced their number of hospitalizations by approximately one visit over those that did not utilize group services. Therefore, they experienced approximately one less hospitalization than those who did participate in group services.

Summary

This chapter discussed the results of the non-parametric analysis of the differences in hospitalizations between those that utilized four of the

services available in the IEMH FSP program than those that did not including; subsidized housing, group services, crisis center services, and regular doctor visits. The results of this analysis revealed a statistically significant reduction in rehospitalizations for the participants that used group services while those that did not utilize group services showed little reduction in rehospitalizations.

CHAPTER FIVE

DISCUSSION

Introduction

It was hypothesized at the beginning of this research project that the services provided by Inland Empire Mental Health (IEMH) Full Service Partnership (FSP) program would significantly reduce inpatient hospitalizations among the severe and persistent mentally ill. One variable proved effective in reducing inpatient hospitalizations among participants studied; frequent participation in FSP groups. The three variables that did not indicate statistically significant reductions in rehospitalizations were the subsidized housing component, crisis intervention services, and regular psychiatric doctor visits. However, it is believed that if clients had not utilized these three services, inpatient hospitalizations may have increased.

Discussion

Inland Empire Mental Health's Full Service Partnership (FSP) program is strongly based in psychosocial theory which was development primarily by the efforts of case managers to restore a consumer's

social functioning and improve their interpersonal and life skills. The FSP staff does not focus on the "pathological" issues of the client but explores and recognizes the strengths of the consumer. This is accomplished through individual and group interventions designed to assist the client in reaching their full potential. Frequent group participation was statistically significant in reducing inpatient hospitalizations.

The FSP program employs the principles of client-centered theory as the agency recognizes that individuals have a better chance of reaching their full potential if conditions exist that improve and support the individual's self-concept. In contrast, if the consumer's potential is compromised or underdeveloped the person experiences a state of anxiety and hopelessness [disequilibrium] which may be a factor in inpatient rehospitalizations. What this means in terms of practice is that if conditions exist that empower individuals to reach their full potential, the more likely they are to feel emotionally balanced [equilibrium] and less likely to be hospitalized.

Inland Empire's Mental Health FSP program embodies the principles of the recovery model as it promotes

empowerment, advocacy, and self-determination. The recovery model is *quality of life* directed and does not imply that in individual will never be hospitalized again, but offers skills and a healing environment that may reduce the negative impact symptoms have on an individual, thus reducing the need for inpatient hospitalizations.

Of the four independent variables studied; subsidized housing, consumer participation in groups, utilization of FSP's Hope Crisis Center in lieu of inpatient hospitalization, and regular attendance with the FSP psychiatrist; regular attendance in groups significantly reduced inpatient hospitalizations.

Although subsidized housing was thought to reduce inpatient hospitalizations significantly, the research did not indicate this. It may be understood that although housing does play a part in the successful treatment of those with severe and persistent mental illness, it was not statistically significant when it came to reducing inpatient hospitalizations in this study. One explanation is that some of the participants in this study had financial resources available to secure housing and two; a portion of the consumers studied lived with significant

others such as family and/or friends. However, only four of the program's participants were homeless at the time the research was gathered.

Consumer participation in group activities led to a positive outcome and appears to be the deciding factor in reducing inpatient hospitalizations and improving treatment outcomes. Case managers often have a difficult time getting many of the consumers to participate in these groups so quite often incentives are offered if one attends groups. For example, if a consumer attends the Recovery/Empowerment/Advocacy/Skills (REAS) group they are invited to eat a hot lunch that has been prepared in advance. Perhaps this is why this group is one of the most successful groups as far as participation. Another group recently developed that is a tremendous success is an anger management group; however, this group was added after this research project was designed and approved so it was not included in this project.

Consumers' often chose to enlist the aid of IEMH's Hope Crisis Center when they were feeling unstable or there had been significant changes made in medication and the FSP psychiatrist believed it would be in their best interest to have 24-hour monitoring. This crisis service

is cost effective and does not unnecessary tax the limited space available in an emergency inpatient hospital. In addition, those who chose to utilize crisis services in lieu of inpatient hospitalization often feel empowered as it is not viewed as a hospitalization in the technical sense, but viewed as a viable option in their recovery process.

Although regular monthly appointments with the FSP psychiatrist showed no significance in reducing inpatient hospitalizations, it is believed that without this service inpatient hospitalizations would increase as consumers would not have access to psychiatric services otherwise. As other research indicates, adherence to a regular psychotropic regime greatly reduces the negative symptoms often associated with the severe and persistent mental ill population. In this research, only 2 of the 40 participants did not regularly attend monthly psychiatric appointments. In addition, inpatient hospitalizations are not viewed as a "failure" on the part of the consumer or the staff but viewed as an appropriate intervention to aid the severe and persistent mentally disordered in his or her recovery process. Psychosocial theory supports this statement as inpatient hospitalization often

improves the individual's sense of well-being and proves beneficial in restoring social functioning.

Limitations

The limitations in this study include the sample size of 40 which limits generalizability. If all 200 consumers of the FSP program had been studied, the three variables that did not indicate significance may have as research was leaning in this direction. Of the 40 participants studied, 12 had never been hospitalized in Riverside County but may have been hospitalized in another county or state.

In addition, when a consumer is hospitalized, case managers enter statistical data into an interagency computer program designed to track this information and is subject to human failure or error. Although research information was checked against several sources, it is possible that some information was entered into the database incorrectly or not at all by case managers. In addition, past hospitalizations were measured from one year prior to signing with FSP to one year after; however, in some cases the consumer had not been signed into the FSP program for one year.

Recommendations for Social Work Practice, Policy and Research

It is recommended that further study be employed on the individual, family, and community levels to assess programs that provide therapeutic interventions for those suffering from severe and persistent mental disorders. In addition, further studies need to be done on the impact peer-specialist and drop-in centers such as the Clubhouse Model of community support have in reducing inpatient hospitalizations in Riverside County. Drastic budget cuts to the State's mental health system will mean that consumers have fewer options to successfully address their mental health issues. In addition, with the closure of Perris and Temecula Mental Health services, consumers are left with even fewer options to successfully address their mental health issues. Studies need to be done to determine what impact this will have on the existing resources available to those that present will mental illness. It is also recommended that community-based rehabilitation programs include a substance abuse component as research indicates this intervention leads to positive outcomes in the successful treatment of those with co-occurring disorders. Further studies into the

role and needs caregivers have in working with the severe and persistent mentally ill would be beneficial as they may provide alternatives to the community mental health setting.

Conclusions

Frequent participation in Inland Empire Mental Health's FSP program group activities significantly reduces the need for inpatient hospitalizations among the severe and persistent mentally disordered population. The multidisciplinary teams of intensive case management and assertive community treatment modalities prove instrumental in addressing the multidimensional needs of the severe and persistent mentally disordered. Inpatient hospitalization is not viewed as a failure on the part of the consumer in addressing his or her mental health issues. Crisis center services are said to empower individuals by allowing them to make informed choices about their recovery. The psychosocial model is a strengths-based perspective which supports the well-being of individuals and families and restores social functioning while being committed to client self-determination, advocacy, and autonomy.

APPENDIX A

DATA EXTRACTION SHEET

Data Extraction Sheet

Number: ______

Age: __________

Sex: M(1) ☐ F(2) ☐

Subsidized housing? Y(1) ☐ N(2) ☐

R&B(1) ☐ B&C(2) ☐ SRO(3) ☐ Relatives(4) ☐ Other(5) ☐

History of Homelessness? Y(1) ☐ N(2) ☐

Homeless since joining IEMH? Y(1) ☐ N(2) ☐

Length IEMH services.

1-3 Mos (1) ☐ 4-6 Mos (2) ☐ 7-9 Mos (3) ☐ 10-12 Mos(4) ☐
13-15 Mos (5) ☐ 15+ Mos (6) ☐

Participation in IEMH groups.

Living Skills: Y(1) ☐ N(2) ☐
CBT: Y(1) ☐ N(2) ☐
DOR: Y(1) ☐ N(2) ☐
WRAP: Y(1) ☐ N(2) ☐
REAS: Y(1) ☐ N(2) ☐

How many times hospitalized 1 year prior to IEMH FSP? ______

Hospitalizations since signing with IEMH FSP? ______

How many times have you utilized IEMH's Crisis Center? ______

FSP doctor regularly? Y(1) ☐ N(2) ☐

APPENDIX B

TABLES

Table 1. Descriptive Statistics

	N Statistic	Min Statistic	Max Statistic	Mean Statistic	Std. Statistic
Age	40	24	57	39.93	10.995
Home History	40	0	1	.38	.490
IEMH Homeless	40	0	1	.10	.304
Length Svcs	40	2	6	4.90	1.033
Valid N	40				

Descriptive Statistics

	Skewness		Kurtosis	
	Statistic	Std. Error	Statistic	Std. Error
Age	-.020	.374	-1.516	.733
Home History	.537	.374	-1.805	.733
IEMH Homeless	2.772	.374	5.979	.733
Length Services	-.967	.374	.532	.733
Valid N				

Frequencies

Statistics

	Gender	Sub Housing	Living Skills	FSP Crisis Center	Regular Doc FSP
N					
Valid	40	40	40	40	40
Missing	0	0	0	0	0

Table 2. Gender

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid				
Male	25	62.5	62.5	62.5
Female	15	37.5	37.5	100.0
Total	40	100.0	100.0	

Subsidized Housing

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid				
No	24	60.0	60.0	60.0
Yes	16	40.0	40.0	100.0
Total	40	100.0	100.0	

Homeless History

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid				
No	25	62.5	62.5	62.5
Yes	15	37.5	37.5	100.0
Total	40	100.0	100.0	

Homeless since IEMH

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid				
No	36	90.0	90.0	90.0
Yes	4	10.0	10.0	100.0
Total	40	100.0	100.0	

Group Participation

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid				
No	29	72.5	72.5	72.5
Yes	11	27.5	27.5	100.0
Total	40	100.0	100.0	

Utilization of FSP Crisis Center

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid				
0	21	52.5	52.5	52.5
1	7	17.5	17.5	70.0
2	4	10.0	10.0	80.0
3	3	7.5	7.5	87.5
4	2	5.0	5.0	92.5
5	1	2.5	2.5	95.5
9	1	2.5	2.5	97.5
10	1	2.5	2.5	100.0
	40	100.0	100.0	

Regular Doctor Visits FSP

	Frequency	Percent	Valid Percent	Cumulative Percent
Valid				
No	2	5.0	5.0	5.0
Yes	38	95.5	95.5	100.0
Total	40	100.0	100.0	

Frequencies

	Gender	Sub Housing	Group Participation	FSP Crisis	Regular Doc FSP
N					
Valid	40	40	40	40	40
Missing	0	0	0	0	0
Skewness	.537	.424	1.048	2.409	-4.292
Std. Error Skewness	.374	.374	.374	.374	.374
Kurtosis	-1.805	-1.919	-.953	6.247	17.285
Std. Error Kurtosis	.733	.733	.733	.733	.733

Mann-Whitney Test

Table 2. Subsidized Housing

	N	Mean	Std. Deviation	Min	Max
DV Recoded RR	40	.8500	1.23101	-2.00	3.00
Subsidized Housing	40	.40	.496	0	1

Ranks

Subsidized Housing	N	Mean Rank	Sum of Ranks
DV Recoded RR			
No	24	19.44	466.50
Yes	16	22.09	353.50
Total	40		

Test Statistics

	DV Recoded RR
Mann-Whitney U	166.500
Wilcoxon W	466.500
Z	-.734
Asymp. Sig. (2-tailed)	.463
Exact Sig. (1-tailed Sig)	.486

Table 3. Group Participation

	N	Mean	Std. Deviation	Min	Max
DV Recoded RR	40	.8500	1.23101	-2.00	3.00
Group Participation	40	.28	.452	0	1

Ranks

Group Participation	N	Mean Rank	Sum of Ranks
DV Recoded RR			
No	29	18.00	522.00
Yes	11	27.09	298.00
Total	40		

Test Statistics

	DV Recoded RR
Mann-Whitney U	87.000
Wilcoxon W	522.000
Z	-2.290
Asymp. Sig. (2-tailed)	.022
Exact Sig. (1-tailed Sig)	.028

Table 4. Crisis Center

	N	Mean	Std. Deviation	Min	Max
DV Recoded RR	40	.8500	1.23101	-2.00	3.00
Utilized Crisis Center	40	.4750	.50574	.00	1.00

Ranks

Utilized Crisis Center	N	Mean Rank	Sum of Ranks
DV Recoded RR			
No	21	17.31	363.50
Yes	19	24.03	4456.50
Total	40		

Test Statistics

	DV Recoded RR
Mann-Whitney U	132.500
Wilcoxon W	363.500
Z	-1.893
Asymp. Sig. (2-tailed)	.058
Exact Sig. (1-tailed Sig)	.069

Table 5. Regular Doctor FSP

	N	Mean	Std. Deviation	Min	Max
DV Recoded RR	40	.8500	1.23101	-2.00	3.00
Reg. FSP Doctor	40	.95	.221	0	1

Ranks

Reg. Doctor FSP	N	Mean Rank	Sum of Ranks
DV Recoded RR			
No	2	21.50	43.00
Yes	38	20.45	777.00
Total	40		

Test Statistics

	DV Recoded RR
Mann-Whitney U	36.000
Wilcoxon W	777.000
Z	-.129
Asymp. Sig. (2-tailed)	.897
Exact Sig. (1-tailed Sig)	.926

REFERENCES

Barker, R. (1999). *The social work dictionary.* Washington, DC: NASW Press

Bruns, E., Suter, J., Force, M., & Burchard, J. (2005). *Journal of Child and Family Studies*, 14(4), 521-34.

Burns, D. (1999). *The feeling good handbook*. New York: Penguin Group.

Graham, J., & Barter, K. (1999). Collaboration: A social work practice method. *Families in Society: The Journal of Contemporary Human Services.* Families International, Inc. (p. 6).

Happell, B. (2008). Determining the effectiveness of mental health services from a consumer perspective: Part 2: Barriers to recovery and principles for evaluation. 2008 Australian College of Mental·Health Nurses Inc.

Inland Empire Mental Health. (2006). *ISCR—Full service partnership program manual.* (pg. 6).

Landa, Y., Silverstein, S., Schwartz, F., & Savitz, A. (2006). Group cognitive behavioral therapy for delusions: Helping patents improve reality testing. *Journal of Contemporary Psychotherapy*.

Lee, J. (1999, p. 224). "The Empowerment Approach to Social Work Practice." In F. Turner (Ed.), *Social Work Treatment*. (pp. 218-249).New York, NY: The Free Press.

Mowbray, C., Lewandowski, L., Holter, M., Bybee, D. (2006). The clubhouse as an empowering setting. *Health & Social Work*. Vol. 31, No. 3.

Nelson, G., Aubry, T., Lafrance, A. (2007). A review of the literature on the effectiveness of housing and support, assertive community treatment, and intensive case management interventions for persons with mental illness who have been homeless. *American Journal of Orthopsychiatry*. Vol. 77, No. 3, 350-361.

Oades, Deane, Crowe, Lambert, Kavanagh & Lloyd. (2005). Collaborative recovery: an integrative model for working with individuals who experience chronic and recurring mental illness. *Australasian Psychiatry*. Vol 13, No 3. p. 279-84.

Roberts, A. & Yeager, K. (2006). Foundations of evidence-based social work practice. New York, NY: Oxford Press. (pg. 4, 6).

Rollnick, S, & Miller, W. (1995). What is motivational interviewing? *Behavioral and Cognitive Psychotherapy*. 23, 325-334.

Rowe, W. (1996). "Client-centered theory: A person-centered approach." In F.Turner (Ed.), *Social Work Treatment*. (pp. 69-93). New York, NY: The Free Press.

Steinberg, D. (2004). *The mutual-aid approach to working with groups*. New York, NY: The Haworth Press.

Sullivan, P. (May, 1992). Reclaiming the community: The strengths perspective and deinstitutionalization. *Social Work*. Vol. 37 Issue 3, (p. 204-209).

Swanson, J., et al. (2003). Effects of involuntary outpatient commitment of subjective quality of life in persons with severe mental illness. *Behavioral Sciences and the Law*. 21: pp. 473-491). Published online in Wiley InterScience. (www.interscience.wiley.com).

Wituk, S., Shepherd, M., Slavich, S. Warren, M., Meissen, G. (2000). A topography of self-help groups: An empirical analysis. *Social Work*. Mar, Vol. 45 Issue 2, p. 157, 9p.

Woods, M. & Robinson, H. (1996). "Psychosocial theory and social work treatment." In F. Turner (Ed.), *Social Work Treatment*. (pp. 555-580). New York, NY: The Free Press.