International Journal of Psychosocial Rehabilitation

ISSN 1475-7192

(Proudly Serving our Web Based, International Readers Since 1996)

Volume 2

July 1997-1998

A WEB BASED PEER REVIEWED PUBLICATION FOR MENTAL HEALTH PRACTITIONERS, CONSUMERS & APPLIED RESEARCHERS

This private *NON-PROFIT* professional publication and associated web-based, information archive service is dedicated to the enhancement of practice, program development, program evaluation and innovations in mental health and substance abuse treatment programs worldwide. Its goal is to provide a public forum for practitioners, consumers and researchers to address the multiple service needs of patients and families and help determine what works, for whom under a variety of circumstances.

WWW. PSYCHOSOCIAL. COM

The International Journal of Psychosocial Rehabilitation
Volume 2
July 1997 – June 1998

Feature Articles

The International Journal of Psychosocial Rehabilitation
Volume 2
July 1997 – June 1998

A PUBLICATION FOR MENTAL HEALTH PRACTITIONERS, APPLIED RESEARCHERS & CONSUMERS

This professional peer reviewed publication and data archive is dedicated to the enhancement of program development, evaluation and innovations in mental health and substance abuse treatment programs worldwide. Its goal is to provide a public forum for practitioners, consumers and researchers to address the multiple service needs of patients and families and help determine what works, for whom under a variety of circumstances.

This peer reviewed Journal was created in 1996 by practitioners, mental health program managers and mental health consumers to provide international practitioners, scholars and consumers with a forum to publish and discuss their practices that have been successful in their particular region and cultures. IJPR is not associated with any university or governmental institution, nor is it part of any old boy or other professional network. It was created to provide information to an international readership about issues related to psychosocial rehabilitation and associated topics.

Articles on psychosocial interventions, psychopharmacotherapy, mental health primary care, institutional and community care innovations, decentralization, policy changes, community & regionally based systems, and program evaluation are given particular attention. However, all articles that relate to psychosocial rehabilitation will be considered.

We invite comment from all readers on any and all subjects published in this journal, including the journal format itself. Feel free to comment on the Bulletin Board as well.

The International Journal of Psychosocial Rehabilitation
Volume 2
July 1997 – June 1998

Standards for Publication, Submission Guidelines, And Editorial Review

This peer reviewed Journal is dedicated to the continuing development and ongoing evaluation of psychosocial rehabilitation, ACT programs and therapeutic techniques. As such, all articles remotely pertaining to such treatment will be considered for publication. However, the International Journal of Psychosocial Rehabilitation reserves the right to reject any and all articles, but will only do so in cases in which article content does not apply to the goals of the Journal.

Style: Though this journal maintains the publication standards set forth in the American Psychological Association's Publication Manual, we also recognize this may not be available to all practitioners throughout the world. We therefore view the manual as guidelines and not religious canon. Do your best to comply with the style manual, but submit your material anyway.

The International Journal of Psychosocial Rehabilitation
Volume 2
July 1997 – June 1998

An Impact Evaluation Model and Quality Improvement Mechanism for Mental Health Programs in Developing Countries

Arthur J. Anderson
Consulting Clinical Psychologist - Honduras

Abstract: *Discusses the rationale for using responsive evaluation in mental health and substance abuse programs. Demonstrates the need to include both standard and local indicators in evaluation studies and how this can be used by all the stakeholders of a program to continue the quality improvement initiatives of any mental health program in a way that incorporates all levels of data and opinions. Presents and actual evaluation proposal and instruments in both Spanish and English.*

An Impact Evaluation Model and Quality Improvement Mechanism for Mental Health Programs in Developing Countries

In both mental health and substance abuse treatment, it may be that there are no resistant patients; only resistant programs and clinicians, who are reluctant to change their mode of service delivery to meet their patient's needs. To determine the extent to which programs and service models meet the needs of patients, program evaluations must be performed to assess the impact of the entire program and therapeutic environment (Anderson, 1997). Only then can rates of efficacy and effectiveness be objectively determined and improvements panned, initiated and reviewed to continue the improvement of services over time. Thus, program evaluation and continuous quality improvement can be incorporated into a comprehensive quality of care mechanism to more closely match services with the changing needs of patients, families, funding sources and all other stakeholders over time (Guba and Lincoln, 1981, 1989).

This brief article details a strategy of program evaluation and quality improvement that has been successfully used in programs located in the United States and in Honduras (Anderson, 1997a). Written as a program research proposal, the following outline proposals and associated instruments serve as tools that can be applied to almost any mental health or substance abuse program setting.

This evaluation strategy consists of two groups of indicators; standard and local indicators. Standard indicators, listed below, were developed in such a way as to be applicable to all mental health programs. Generally, these indicators are analyzed by a skilled evaluator who can statistically manipulated the large volume of program, demographic and clinical data. However, for the purposes of determining treatment benefits on a programmatic level, simple descriptive statistics can be used on these indicators to demonstrate levels of programmatic efficacy. Local

indicators are patient, infrastructure, process or other program characteristics that are mutually agreed upon for study by all the stakeholders of a program. These stakeholders include clinicians, administrators, funding sources, families and of course patient representatives.

The local indicators allow all the stakeholders of the program to determine what additional indicators are needed to demonstrate their program's effectiveness. As the data from both sets of indicators is accumulated monthly or quarterly, trends develop which require actions from some or all of the stakeholders to improve that area of the program. Once problems have been resolved, new indicators can be developed to continue the positive change process. Over time, this process serves to continually improve patient services and match treatment to the needs of the patient, instead of matching the patient to the needs of the program.

T1 ----------T2----------T3----------->

Collaboration ------>measure------>Data Reporting & Action ------->measure----->Data Rept. & Action----->

The following evaluation proposal and tools serve only as a model. Please feel free to use all or part of it and the associated instruments for any evaluation project you wish to undertake. I have provided the proposal in both English and Spanish for your convenience. Though originally written for programs that treat mentally ill chemical abusers in Honduras, it and the model can be applied to almost any mental health program setting.

- - - - - - - - - - -

Project Impact Research Proposal Summary

An Evaluation of Integrated and Disease Specific Programs for Mentally Ill Chemical Abusers

Objectives:

1. To identify the most effective mental health and substance treatment strategies in Honduras that may be generalizable to developed nations and other developing countries.

2.. To introduce a 'state of the art' impact evaluation model in a developing Latin American country. This should not only provide health and mental health program data, but provide a comprehensive strategy for sustained program/project evaluation and a mechanism for continuous quality improvement within individual health programs in Honduras.

3. To provide the ministry of health with a strategy to monitor treatment efficacy across health and mental health sectors and sub-sectors.

Introduction: Patients diagnosed with severe mental illness who also suffer from other psychiatric and medical disorders present a variety of individual, social, fiscal and political challenges not only for program funding, but planning and implementing effective rehabilitative treatment programs as well. This is especially true in Honduras and Central America where programs operate at minimal funding levels. Severe mental illness coupled with severe personality, behavioral, addictive, cognitive or physical disease, stretches the ability of community based treatment programs to effectively treat these patients. This has led to the development of a wide variety of treatment models designed to serve the multiple needs of these patients (Bachrach, 1984; Drake, 1989, 1991; Minkoff 1987). An evaluation of the clinical

effectiveness of these models would not only lead to more cost effective use of limited treatment resources, but more importantly, improve clinical treatment options for the dually diagnosed throughout Central America.

Focusing a program model evaluation on current treatment programs for the most commonly reported dually diagnosed population, mentally ill chemical abusers (MICA), would demonstrate the differential rates for effectiveness for the most commonly used program models. These results would be invaluable to Honduran and international policy planners, administrators, legislators and program developers who must design and implement the most effective treatment programs possible with limited resources.

Treatment programs for the dually diagnosed primarily fall into two main categories: disease specific and integrated program models (Minkoff,1991). Disease specific program models tend to focus treatment on what they consider to be the primary area of distress and minimize the importance or urgency of other areas of dysfunction. Many substance abuse treatment programs and traditional hospital based mental health programs typically model their treatment programs in this manner. Integrated program models, found in both hospital and community based settings, are designed to provide individualized treatment planning and services which focus attention on all areas of patient dysfunction are designed to aggressively treat all patient symptoms and associated problems within a single program.

The development of these models has not been based so much on the clinical efficacy, but more on availability of funding and political interest in treating specific patient populations (Humphreys & Rappaport, 1993). This fragmentation of program models has been perpetuated through the development of artificial and arbitrary administrative divisions at the federal, state and local levels without regard to clinical measures of success for the various program models. This is not only the case in industrialized countries but in developing nations as well. Consequently, it is possible that many public sector and grant funded programs continue to be financed through a variety of funding streams with little or no demonstrable clinical success. This siphons critical funds from those programs that use more clinically viable models.

An evaluation of relative treatment outcomes for these two main program models would demonstrate the effectiveness of each model to treat chemical abusers. These results would also enable program planners to create or modify existing programs to more effectively treat their target dual diagnosis populations. Using responsive evaluation methodologies, in which specific clinical program indicators are studied along with indicators chosen by the program's clinical team, the programs under investigation in this pilot study will not only derive efficacy data but have a clear mechanism to continuously improve the quality of care far into the future. Thus, not only will there be data as to program model's effectiveness, but a quality improvement mechanism to improve health and mental health care into the future.

A large proportion of chemical abusers (50-70%) also suffer from concomitant psychological disturbances. In this respect they can be considered dually diagnosed. Dually diagnosed patients in general and specifically MICA patients have complex treatment needs and interactive symptomatology that requires a more integrated approach than is generally employed (Breakey, 1987). It therefore seems likely and is hypothesized that integrated treatment models would be clinically more effective in treating the dually diagnosed MICA patient than population specific models. Evaluating the positive treatment outcomes produced by each program model, treating a similar patient population, should demonstrate the relative clinical effectiveness and cost

effective utility of each program model to treat the dually diagnosed. In addition, the use of the local participants (or stakeholders) in the study to first assist in the design of the local indicators, then participate in the measurement of all the indicators, and finally meet periodically to derive action plans that address programmatic deficits will continue quality improvement of both programs under investigation and serve as models of quality improvement to other, similar programs in Honduras.

Methodology:

This investigation will evaluate patient outcomes for two treatment programs at in Honduras that treat mentally ill chemical abusers. The purpose of this is to determine the relative value of each program to treat MICA patients. Clinical outcomes in a traditional drug and alcohol treatment program, a disease specific substance abuse treatment program, will be compared with outcome data from a more comprehensive, community based rehabilitation program that uses an integrated program model. Since both programs have goals of rehabilitating MICA patients over a six month period and promoting long term, drug free community tenure, have similar staffing patterns and are located in the same geographic area, a comparison of program outcomes, based on standard indicators, can be performed to determine the relative value of integrated and disease specific treatment models to treat these patients.

All mentally ill chemical abusing patients who enter the programs during the 6 month period of the study will be included in the investigation. Thus, the investigator(s) must be on site to rate patients during the six month period of the data collection, and remain available for an additional three months to analyze data and continue to refine the data set on the local indicators. For this proposed investigation, the treatment program admission criteria of a major Axis I diagnosis in addition to substance abuse will be the same for both programs. Thus, the patient 'pool' for these two programs are assumed to be identical for the purposes of this study (See Subject Selection). This, however, will be confirmed through the analysis of variance between the groups on the dimensions of age, diagnosis, GAF level at the onset of treatment, and duration and type of substance abuse.

Indicator Selection: In addition to using a set of standard indicators that can be applied to almost any health care program, both programs will also be asked to determine three to five local indicators of successful treatment that are particular to their programs. This information will be of greatest value to the quality improvement component of this study. As information becomes available on both sets of indicators (standard and local) the major stakeholders of each program can agree on the remedial actions necessary to improve the quality of care and improve future performance. If this process continues beyond the six month scope of this pilot study, the net result will be a trend toward improving care on a local programmatic level. Such quality improvement mechanisms are currently not in use in programs that serve the street people and poor of Honduras.

Subject Selection: The patients for both programs under study will be selected on the basis of their meeting the diagnostic admission criteria for the programs. Patients who are ambulatory and not in need of acute care, who are diagnosed with a major Axis I disorder and/or an Axis II diagnosis, and have additional substance abuse diagnosis are admitted to both programs directly from street and other referral sources and will be included in the study upon admission to the programs.

Patient Characteristics: Programs goals of patient rehabilitation and functional community assimilation of mentally ill chemical abusers within a six month time frame are generally the same for each program model. In addition, both program models require patients to meet the target diagnostic and functional criteria for treatment in the programs and from the programs' point of view are expected to functionally improve to the point of community readiness. Since this study compares patient outcomes against the program goals, we can consider the patient populations identical only in this respect. Both groups are comprised of male and female MICA patients with similar backgrounds from the same geographic location.

Standard Indicators and Data Analysis

The two programs will be evaluated by the following standard criteria:

Indicator 1: Successful Treatment Outcomes This will be determined by results of the Level of Functional Assessment scale (Modified)(LOFA); a 53 item scale that quantifies functioning across independent areas of social, cognitive and physical skills (Uehara, Smulker & Newman, 1994. Within two weeks of admission, each patient will be rated on the LOFA . Level and type of addiction will be noted along with other diagnostic and demographic data on the Patient Information Sheet. Patients will be rated again at three months and again at their six month point in the program to note changes in their functional level due to their treatment. All data will be recorded on the Patient Information Summary Sheet.. Patients who reach a GAF level of at least 70, as determined by their LOFA equivalent score, will be counted as meeting their program's objectives for successful treatment outcomes.

Indicator 2: AMA Discharge Within the context of this evaluation, the percentage of patients who do not complete treatment and who leave the programs against medical advise will be compared across programs as a measure of the treatment program's inability to meet the needs of the target population. Since both program models have clinical failures of this type, the percentage of patients who leave each program against medical advise or for cause will be included as AMA Discharge measures of negative clinical outcomes..

Indicator 3: Correlation of Service Hours delivered. A correlation between actual number of service hours delivered and the percentage of successful treatment outcomes per program will be performed to evaluate whether variable amounts of treatment affect overall program outcomes and success. This will demonstrate any relationship between amount of services delivered and successful treatment outcomes.

Indicator 4: Subpopulation Outcomes Differential success rates between diagnostic subpopulations (i.e. schizophrenic, substance abusers versus mood disordered, substance abusers), will also compared to determine whether the models are best suited to one sub-population or another. This measure will be applied to the criteria indicators listed above.

Indicator 5: Relative Rates of Recidivism Percentage rates of patient recidivism for program graduates will also be determined as a measure of the program's relative inability to effectively rehabilitate their target MICA population. Recidivism within the context of this study is defined as any patient who returns to the streets or resumes substance abuse activities.

Indicator 6 - Patient Satisfaction Patients in both groups will complete a Spanish version of the NYSOMH standard patient satisfaction survey at the six month point in their program or upon

successful completion and discharge from the program. This will provide a measure of the patients' qualitative level of satisfaction within each program model.

Indicator 7: Cost Efficiency Rate Relative cost per service unit will be determined for patients who successfully meet the goals of the program (See Indicator 1). This measure is included to illustrate differential program costs for those patients who met program goals and is considered a gross measure of program efficiency within the context of this study.

Local Indicators: The two programs will also be asked to form a committee which includes all the stakeholders that may have interest in each program. This may include the governmental monitoring agencies, funding sources, program directors, clinical staff and administrators. The stakeholder committee will be asked to select at least three outcome indicators that reflect effectiveness of treatment. Once determined, these indicators will be monitored, measured for six months, analyzed by the committees and reported in addition to the standard indicators. Once reported on, these two committees will develop action plans to address deficit areas determined in either the standard or local indicators for their particular programs. These committees will meet after the next interval (three months) and develop action plans to either address problematic areas determined through local indicator data measures and/or develop new action plans for the next three month interval.

Expected Results, Potential Benefits and Reporting Findings:

1. Based on similar studies of this kind (Anderson, 1996), we can expect to see higher levels of clinical efficacy in the integrated program design than in the disease specific program model. This should not only be reflected in the cost efficiency results but in the clinical indicators as well.

2. Deficit program areas should emerge that are specific to these particular programs. Such statistics and qualitative data will point the way toward improving the quality of future quality of care in the respective program models.

3. Since the results of this investigation will be shared with the respective programs, the program models can be modified to increase positive clinical and fiscal gains in each program.

4. Study results will not only be made available to the grant funding sponsors, but will also be reported to the ministry of health to assist in their future mental health planning efforts. The responsive evaluation methodology research model, used in this investigation, will be outlined in detail and reported to the ministry for use in follow-up impact investigations. This will ensure sustainability of the impact evaluation effort and mechanism for continuous quality of care improvements in both health and mental health sectors.

INSTRUMENTS (English & Spanish)

- - - - - - - - - - - - - - - -

(SPANISH VERSION)

Propuesta de Investigación sobre impacto de programas

Evaluación comparativa de modelos de atención integrales y de tratamiento específico para farmacodependientes con problemas mentales

Objetivos:

1. Identificar los tratamientos más efectivos para alcohólicos y farmacodependientes con problemas mentales que puedan ser replicados en otros paises, tanto en desarrollo como industrializados.

2. Introducir un modelo de evaluación de impacto que permita no solamente obtener datos sobre salud y salud mental, pero también definir una estrategia para la evaluación contínua de programas y proyectos y que ofrezca un mecanismo para el mejoramiento contínuo de la calidad de estos programas y proyectos.

3. Ofrecer al Ministerio de Salud estrategias para monitorear la eficacia de los modelos de tratamiento ofrecidos en salud y salud mental.

Introducción : Pacientes que han sido diagnosticados con enfermedades mentales serias, quienes también sufren de otros problemas médicos presentan retos individuales, sociales, económicos y políticos no solamente para el financiamiento de programas dirigidos a ellos, pero para la implementación de programas efectivos de rehabilitación. Esto es particularmente cierto en Honduras y otros países Centroamericanos donde estos programas operan con un mínimo de financiamiento.

Enfermedades mentales serias acompañadas de problemas de personalidad, comportamiento, adicción y problemas físicos, sobrepasan la capacidad de atención de programas que funcionan a nivel comunitario. Para resolver esta problemática se han desarrollado varios tipos de programas diseñados para dar respuesta a las necesidades múltiples de estos pacientes. La evaluación de la efectividad de los diferentes tipos de programas resultará en una mejor utilización de los limitados recursos disponibles, y lo que es más importante, mejorará el tratamiento para pacientes diagnosticados con enfermedades mentales y farmacodependencia y-o alcoholismo.

Programas de tratamiento para pacientes con enfermedades mentales y farmacodependencia y/o alcoholismo tienen dos modalidades principales: las que tratan problemas específicos y las que ofrecen tratamiento integral (Minkoff, 1991). Los programas que ofrecen tratamiento específico tienden a enfocar el tratamiento al área de mayor disfuncionalidad y a minimizar la importancia o urgencia de tratar los síntomas considerados secundarios. Muchos programas de tratamiento para alcohólicos y farmacodependientes, así como programas dentro de los hospitales ofrecen esta modalidad de tratamiento. Los programas de tratamiento integral que se encuentran en algunos hospitales y clínicas comunitarias han sido diseñados para ofrecer planes de tratamiento individualizados y servicios de atención que tratan todos los síntomas del paciente agresivamente dentro del mismo programa.

Una evaluación de los resultados de estas dos modalidades diferentes de tratamiento demostrará la efectivdad de cada modelo para pacientes con problemas de farmacodependencia y/o alcoholismo. Los resultados de la evaluación permitira a los planificadores de programas que modifiquen programas existentes o que creen nuevos programas para tomar en cuenta los resultados de la evaluación del tratamiento de este tipo de pacientes. Los programas objeto de esta investigación utilizarán metodologías modernas de evaluación mediante las cuales se estudiaran indicadores de éxito del programa, así como indicadores de eficacia seleccionados por el personal profesional del programa. Esto permitirá obtener datos sobre efectividad del

programa y también mecanismos para mejorar continuamente la calidad de atención de los programas.

Metodología:

Esta investigación evaluará los resultados del tratamiento recibido por los pacientes en dos programas que dan atención a personas con problemas mentales y problemas de farmacodependencia y/o alcoholismo. El objetivo es determinar la efectividad relativa de cada programa para ofrecer tratamiento a este tipo de paciente. Los resultados clínicos de un programa tradicional que ofrece servicios de atención a farmacodependientes y/o alcohólicos con problemas mentales serán comparados con los resultados de un programa que ofrece atención integral al mismo tipo de paciente. Dado que ambos programas tienen el objetivo de rehabilitar a los pacientes en un período de seis meses y ofrecer servicios que promuevan la conducta prosocial en los pacientes, que ambos programas tienen personal similar y están ubicados en la misma área geográfica, se puede realizar una comparación de los resultados del programa, basada en indicadores estándar para determinar la efectividad relativa de los diferentes modelos para tratar este tipo de pacientes.

Todos los pacientes que ingresen al programa durante un período de tres meses, con problemas de farmacodependencia y/o alcoholismo serán incluidos en la investigación. Para esta investigación los criterios de admisión con una diagnosis de Axis I, además de farmacodependencia y/o alcoholismo deben ser los mismos. Por lo tanto, el grupo de pacientes de estos dos programas será considerado idéntico para propósitos de este estudio (ver el párrafo sobre selección de pacientes). De cualquier manera, esto será confirmado mediante un análisis estadístico.

Selección de indicadores: Además de utilizar un grupo de indicadores estándar que pueden ser utilizados en cualquier tipo de programa de atención médica, ambos programas deberán seleccionar entre tres a cinco indicadores particulares a cada programa que permitan determinar el éxito del tratamiento. Esta información será de mucha utilidad para el componente de mejoramiento de la calidad del tratamiento de estos programas. A medida que se obtenga información sobre todos os indicadores (estándar y particulares), los interesados de cada programa pueden ponerse de acuerdo en acciones necesarias para mejorar la calidad del tratamiento y mejorar la operación futura del programa. Si este proceso continúa después de los tres meses del estudio piloto, el resultado será una mejora a nivel de programación local. Al presente, estos mecanismos de mejoramiento de la calidad del tratamiento no son frecuentemente utilizados en programas que ofrecen servicios a personas con problemas de farmacodependencia y/o alcoholismo.

Selección de pacientes: Los pacientes para ambos programas incluidos en este estudio serán seleccionados con base en los criterios de admisión a los programas. Estos serán solamente pacientes que son AMBULATORY y han sido diagnosticados con problemas de Axis I o Axis II y adicionalmente tienen problemas de farmacodependencia y/o alcoholismo.

Características de los pacientes: Los objetivos de ambos programas incluyen la rehabilitación y la promoción de conducta prosocial en los pacientes en un período de tres meses. Además, ambos programas requieren que los pacientes cumplan con los criterios de admisión para tratamiento dentro de los programas y desde el punto de vista de los programas se espera que éstos mejoren al punto de estar listos para su reinserción en la comunidad. Dado que este

estudio compara los resultados relacionados a la mejora de los pacientes con los objetivos del programa, los grupos de pacientes se considerarán idénticos únicamente en este aspecto. Ambos grupos estarán compuestos por hombres y mujeres de BACKGROUND similar y de ubicación geográfica similar.

Indicadores estándar y análisis de datos:

Los dos programas serán evaluados mediante los siguientes criterios:

Indicador 1: Tratamiento exitoso. Este será determinado a través de los resultados de la escala de nivel de conducta funcional (LOFA). Esta es una escala de 53 itemes que cuantifica la conducta funcional en diferentes áreas, tales como el abilidades sociales, cognitivas y físicas. Dentro de las primeras dos semanas de ser aceptado en el programa, a cada paciente se le administrará la prueba LOFA. Se anotará el nivel y tipo de adicción junto con otra información relacionada al diagnóstico y datos demográficos en el formulario de Información sobre el paciente. A los pacientes, se les administrará nuevamente la prueba el dia en que son dados de alta del programa.

Indicador 2: Dada de alta. En el contexto de esta evaluación, el porcentaje de pacientes que no completen el tratamiento y que dejen el programa en contra de la recomendación médica, serán comparados en los dos programas mostrando la inabilidad de los dos programas de dar respuesta a las necesidades de la población meta. Dado que los programas sufren de fracasos de este tipo, el porcentaje de pacientes que deja el programa sin aprobación médica o por alguna otra cause será incluido como un indicador de resultados negativos.

Indicador 3: Correlación de horas de atención. Se hará un análisis de corelación entre el número actual de horas de atención ofrecidas y el porcentaje de tratamientos exitosos por programa para evaluar si la variación en horas de atención afecta el resultado y éxito del tratamiento ofrecido por cada programa. Este análisis mostrará la relación entre horas de atención y éxito del tratamiento.

Indicador 4: Resultados por grupo de pacientes. Tasas de éxito entre grupos de pacientes (por ejemplo, esquizofrénicos con problemas de farmacodependencia y/o alcoholismo comparados con pacientes con desorden de conducta a nivel del afecto y con problemas de farmacodependencia y/o alcoholismo) también serán comparadas para determinar si los tratamientos son más exitosos en un grupo de pacientes que en otro. Estas medidas se aplicarán a los indicadores 1 a 3. 4

Indicador 5: Tasas relativas de recaída. Los porcentajes de pacientes que completan el tratamiento y recaen serán utilizados como una medida de la efectividad del programa en la rehabilitación de la población meta. En el contexto de este estudio, se define la recaída como una reversión a la conducta aberrante que conlleva el uso y abuso de fármacos, alcohol y drogas, después de un período de abstinencia y ajuste social satisfactorio.

Indicador 6: Satisfacción del paciente. Los pacientes en ambos programas completarán un cuestionario estándar para dar su opinión sobre el programa y el tratamiento recibido a los tres meses de haber iniciado el programa o al ser dados de alta. Esto aportará información cualitativa sobre la satisfacción del paciente con el programa y tratamiento.

Indicador 7: Costo eficiencia. El costo relativo por unidad de atención será determinado para pacientes que cumplen con los objetivos del programa (ver indicador 1). Se incluye esta medida para mostrar la diferencia en costos unitarios para pacientes que cumplieron con los objetivos del programa y es considerada una medida bruta de la eficiencia del programa en el contexto de este estudio.

Indicadores locales. Se espera que cada programa conforme un comité que incluya a todos los interesados en el programa. Este comité puede incluir instituciones de gobierno, donantes, directores del programa, personal médico y administradores. El comité deberá seleccionar por lo menos tres indicadores de resultados que reflejen la efectividad del tratamiento. Una vez que estos indicadores han sido definidos, se les dará seguimiento mensualmente . Los resultados serán analizados por los miembros del comité quienes serán responsables de elaborar un plan de acción para resolver áreas problemáticas en el siguiente mes.

Resultados esperados, posibles beneficios y resultados del estudio

1. Con base en estudios similares (Anderson, 1996) se espera obtener mejores índices de eficacia del programa que ofrece servicios de atención integral a los pacientes comparado con el programa que ofrece tratamiento a enfermedades específicas. Esto se debería ver reflejado no solamente en los indicadores de costo eficiencia del programa, sino también en los indicadores clínicos.

2. Se espera identificar áreas problemáticas en los programas. Los datos estadísticos así como la información cualitativa recopilada permitirá mejorar cualitativamente la atención y tratamiento ofrecidos a los pacientes.

3. Dado que los resultados de este estudio serán puestos a disposición del programa respectivo, estos podrán hacer modificaciones en su funcionamiento para mejorar los aspectos clínicos y financieros.

4. Los resultados del estudio serán puestos a disposición del Ministerio de Salud para su utilización en el proceso de planificación y definición de estrategias de atención a la salud mental. La metodología de evaluación participativa utilizada en el estudio será descrita en detalle y entregada al Ministerio de Salud para que la institución la utilice en futuras evaluaciones de impacto de programas bajo su responsabilidad. Esto puede asegurar la sostenibilidad de este esfuerzo de evaluación de impacto y también puede servir como un mecanismo para el mejoramiento de la calidad de los servicios de atención de salud y salud mental.

INSTRUMENTS (English & Spanish)

References

Anderson, A. J. (1997). Methodological Approaches in Mental Health Services Research and Program Evaluation. International Journal of Psychosocial Rehabilitation. 1(1), 3-20.

Anderson, A. J. (1997a) A Comparative Impact Evaluation of Two Therapeutic Programs for Mentally Ill Chemical Abusers. International Journal of Psychosocial Rehabilitation. 1(1), 34-46.

Bachrach, L.L. (1984). The homeless mentally ill and mental health services: An analytical review of the literature. In H.R. Lamb. (Eds.) The homeless mentally ill (pp. 11 33). Washington DC: American Psychiatric Press.

Breakey, W.R. (1987). Treating the homeless. Alcohol and Research World, 11, 42 47.

Drake, R.E., Antosca, L., Noordsy, D.L., Bartles, S.J., Osher, F.C. (1991). Specialized services for the dually diagnosed. In K. Minkoff and R.E. Drake (Eds.), Dual diagnosis of major mental illness and substance disorder (New directions in Mental Health (pp. 67 67). San Francisco: Josse Bass.

Drake, R.E., Osher F.C., Wallach, M. (1989). Alcohol use and abuse in schizophrenia a prospective community study. Journal of Nervous and Mental Disease, 177, 408 414.

Drake, R., Osher, F., Wallach M. (1991) Homelessness and dual diagnosis. American Psychologist, 46(11), 1149 1158.

Guba, E.G. & Lincoln, Y. (1981) Effective Evaluation. San Francisco: Josey Bass.

Guba, E.G. & Lincoln, Y. (1989) Forth Generation Evaluation. Newbury Park, CA: Sage Publications.

Humphreys, K., & Rappaport, J. (1993). From the community mental health movement to the war on drugs. American Psychologist, 48(8), 892 901.

Minkoff, K. (1987). Beyond deinstitutionalization: A new ideology for the postinstitutional era. Hospital and Community Psychiatry, 38, 945 950.

Uehara, E.S., Smukler, M., & Newman, F.L. (1994). Linking resourse use to consumer level of need: Field test of the level of need care assessment (LONCA) method. Journal of Consulting and Clinical Psychology, 62, 695 709.

(Return to Cover Page)

Criteria Based Voluntary and Involuntary Psychiatric Admissions Modeling

Peter Micheels, Clinical Psychologist - Bellevue Hospital Center
Louis F. Cuoco, Associate Executive Director - The Bridge Inc.
Frank Lipton, Deputy Commissioner - NYC Human Resources Administration
Arthur J. Anderson, Consulting Clinical Psychologist - U.S. Mission, Honduras

. . . . . .

Abstract: *This exploratory study examined acute care admissions criteria for voluntary and involuntary patients admitted to a large municipal hospital. Symptom presentation for both voluntary and involutary admissions were analyzed along with the mode of patient arrival, domicile information and psychiatric hospitalization history; using the Bellevue Psychiatric Audit, Structured Clinical Interview, mental status examination and psychiatric interview. As expected, it was found that symptom presentation upon arrival was the primary basis for admission. However, it was determined that hospitalization judgements are not solely based on the full range of diagnostic information. Intrapsychic distress and objective symptom severity are not always taken*

into account when determining the need for involuntary hospitalization. Those patients who presented with symptoms that could be behaviorally rated and assessed were hospitalized more often than those who suffered from more internalized distress, without a strong behavioral component. This has a critical impact on patient's course of treatment and strong implications for admissions policy in both secondary and tertiary treatment settings.

INTRODUCTION : Municipal hospitals have long been utilized by various sources including the police to determine whether an individual was an imminent danger to himself or to others for the purpose of acute hospital admission or related treatment. Bittner (1) has argued that "the decision to invoke the law governing emergency apprehension is not based on an appraisal of objective features of the case. Rather, the decision is a residual resource, the use of which is determined largely by the absence of other alternatives. "To warrant official police action a case must also present a serious police problem..." That is to say a situation which is considered to be a danger to life, to physical health, to property and to the order in public places.

The added burden of deinstitutionalization has severely taxed the resources of facilities such as these in. They struggle with the sheer volume of these cases. New York City's Health and Hospitals Corporation, particularly, Bellevue Hospital Center has been widely used in this manner due to the existence of a 24 hour psychiatric emergency room in addition to the general hospital emergency room. HHC facilities perform more voluntary and involuntary admissions assessments than any other hospitals of their kind. The number of Emotionally Disturbed Patients (EDPs) brought to HHC facilities by police and emergency services personnel between 1976 and 1988 have increased by 1600%. In 1976 1030 cases were treated, while in 1988 17,617 cases were seen in the psychiatric emergency room.

During this same period there was a corresponding reduction of 28.5% of State Psychiatric beds between 1978 1988; 22% less beds available to New York City and a 52% reduction in HHC transfers to New York State Psychiatric Centers (SOMH facilities) from 1981 1988. In fiscal year 1988, only 49% of the HHC patients requiring intermediate or long term psychiatric care were transferred to SOMH facilities.(2)

In the past twenty five years, inquiries have been made into compiling a possible profile of those individuals that would inflict bodily harm upon themselves or others and require involuntary admission and those who do not. Studies concerning the clinician's ability to predict violent behavior have generally agreed that dangerousness is difficult to predict with any degree of accuracy.(3,4)

Rubin and Mills (5) performed a retrospective examination on the prehospitalization behavior of voluntary and involuntary patients in order to determine the precipitating factors in each instance. They found that patients admitted involuntarily had higher incidences of "dangerous acts directed towards others" than voluntary patients. No significant differences were discerned when comparing the degree of harm caused by either group. Further, the overwhelming majority of the patients' "harmful acts" were either threats or acts which caused no harm to the victim.

Yesavage et al (6) examined the relationship between civil commitment for dangerousness to others and violent acts with behavioral ratings made immediately after commitment. The hostility scale of the BPRS (Brief Psychiatric Rating Scale) resulted in the sole statistically significant difference between subjects who were and those who were not considered dangerous to others. Specifically these were patients who were admitted as "dangerous to others" ($p<.05$) and those patients who "had one or more assaultive events" ($p<.001$). The other BPRS scales did not demonstrate significant differences between the groups.

Similarily, McNeil and Binder (7) found that over two thirds of their sample had a violent episode within the first 72 hours of admission to an acute psychiatric unit. Their findings suggest that there is a relatively high degree of short term predictive validity when assessing an emergency commitment situation.

Gerson and Bassuk (8) concluded that "the essential task in the emergency room is to delineate those factors which can be readily translated into a dispositional choice". They call for "a model aimed at a relatively rapid evaluation, containment, and referral of the patient in crisis." A pragmatic model which integrates "an evaluation of both the patient's and the community's adaptive resources and competence' and minimizes the more subtle diagnostic considerations. In their review of the literature they found that symptoms and not diagnosis are related to judgments about the nature of the emergency room visit. (9,10)However, before such a model can be developed, a phenomenologic evaluation to determine what intrapsychic and behavioral factors exist which are commonly used by ER staff to make an admissions determination. By determining the diagnostic and other biopsychosocial biases that exist in current involuntary and voluntary admissions practices a clearer understanding of the full current admissions criteria can be more fully understood. This could then lead to more effective and diagnostically appropriate use of the psychiatric emergency room and acute hospitalizations in general.

How do potential psychiatric inpatients present when they arrive at the hospital's emergency room? Does the symptomatology of involuntarily admitted patients differ from that of those admitted voluntarily? Can a symptom profiles be constructed to facilitate the decision making process on the part of the clinician and or other social agent (police officer, protective services worker, community based social services...) to make more adequate and effective clinical and fiscal use of the hospital emergency room and inpatient facilities?

By phenomenologically examining current practice with regard to admission criteria for voluntary and involuntary admissions trends should appear which can then be used as a baseline for policy change and more effective admissions criteria modeling.

PROCEDURE

This investigation examined the symptom profiles of two patient samples admitted to Bellevue Hospital Center. Each of these samples was differentiated into two groups those patients who were either admitted voluntarily (with the patient's consent) or admitted involuntarily (determined by psychiatric evaluation to be at risk to self or community). Analysis was performed between and within samples to distinguish the

major symptom constellations for voluntary and involuntary admissions to Bellevue Hospital Center inpatient psychiatric units.

Subjects

Voluntary and Involuntary Chart Review Sample

This sample consisted of 50 voluntary and 50 involuntary adult male and female patients selected at random from Bellevue Hospital Center admissions in 198l. The selection procedure consisted of 10 random days selected for each of 5 randomly chosen months during a 1 1/2 years period (198081). From each day one voluntary and one involuntary admission was arbitrarily chosen. Symptom descriptions were obtained from the evaluation of the admitting physician and from the Bellevue Psychiatric audit BPA (BPA,). The BPA is a symptom checklist which identifies major symptomatic disturbance and assigns a numerical severity weight (03) to each symptom. The criteria for inclusion of symptoms into the present investigation depended on a BPA symptom weight of greater than zero.

Of the 100 patients studied 37 were male and 63 were female. Mean age was 30.85; S.D.=11.23 years; range 2166 years. Between the voluntary and involuntary admissions groups there were no significant differences with regard to age, sex, race, educational level. Patient diagnosis included: schizophrenia (56), acute psychosis (4), alcohol abuse (4), drug abuse (2), major affective disorder (3), personality disorders (14), other (7). In addition to symptom identification, voluntary and involuntary patients group within this sample were evaluated for current housing situation, psychiatric history, and mode of arrival; and no significant differences were established for housing situation or psychiatric history. However, significant differences were identified in mode of arrival.

SCI Tested Sample

This sample consisted of 20 voluntary and 20 involuntary adult male and female psychiatric patient admitted to Bellevue Hospital Center in 1987. Patients were selected at random as they entered the hospital for psychiatric evaluation. The Structured Clinical Interview (11) was administered by trained independent interviewer to both the voluntary and involuntary groups. The SCI is a symptom rating scale administered by trained examiner which rates patients along 10 subscales and an overall severity scale to yield standard scores. Mean standard scores for the 10 SCI symptom subscales and the SCI symptom severity scale for each group was determined and analyzed both within and between groups.

This second sample included 26 males and 14 females. Mean age was 31.775 years; S.D.=11.11 years; Range 1960 years. Between the voluntary and involuntary groups there were no significant differences with regard to age, sex, race educational level, or diagnosis. In addition, patient diagnostic distribution did not significantly differ from that of the first sample. Current patient housing situation, psychiatric history and mode of patient arrival were also examined for both the voluntary and involuntary admission groups; with significant differences being established only for mode of arrival.

ANALYSIS

Symptom levels for voluntary and involuntary patients were analyzed within and between samples to establish gross symptom differences between voluntary and involuntary patient admissions. Chi Squared statistics were obtained to demonstrate differences between the levels and constellations of symptoms of voluntary and involuntary patients in both samples. Analysis of variance was performed on the voluntary and involuntary SCI measured sample to demonstrate intergroup symptom differences. Mode of arrival was analyzed for these groups within and between samples. All significant statistical differences between the voluntary and involuntary groups of both samples are detailed in the results.

Table 1

FREQUENCIES OF SYMPTOMS IN SAMPLE OF 50 VOLUNTARY AND 50 INVOLUNTARY PSYCHIATRIC ADMISSIONS

SYMPTOM	% Voluntary Pts.	% Involuntary Pts.	Pearson Chi Squared (d.f.=1)
Anxiety, Fears, Phobias	42	8	11.56
Grandiosity	2	12	9.31
Antisocial Attitudes/Acts	2	20	7.36
Anger, Irritation	14	38	5.54
Agitation	14	34	4.16
Suicidal Ideation	50	28	4.00
Psychomotor Agitation	8	24	3.10
Assultiveness	2	14	2.57
Disorientation	0	10	2.46
Sleep Disturbance	34	18	2.33
Inappropriate Affect	14	28	1.33
Suspiciousness	8	20	1.14
Disorganized Thought	34	46	0.90
Suicidal Gesture/Act	8	16	0.89
Dizarre Appearance	10	18	0.64
Depressed Mood	44	34	0.40
Dependency, Helplessness	4	10	0.28
Sexual Problem	4	0	0.21
Apathy	0	4	0.10
Social Withdrawal	14	8	0.09
Hallucinations	46	40	0.08
Homicidal Ideation	12	10	0.07
Appetite Impairment	16	12	0.00
Delusions	42	38	0.00
Drug Abuse	14	12	0.00
Incoherence	8	10	0.00
Disorganized Speech	12	10	0.00
Psychomotor Retardation	14	16	0.00
Grimacing, Posturing	2	4	0.00
Guilt, Worthlessness	6	4	0.00
Alcohol Abuse	14	14	0.00
Mutism	2	2	0.00
Somatic Worries	6	6	0.00
Memory Impairment	8	8	0.00
Homicidal Gesture	0	0	0.00
Tremors	0	0	0.00
Obessions, Compulsions	0	0	0.00

Table 2
Mode of Arrival

MODE OF ARRIVAL	Vol. Pts.	Invol. Pts.	Chi Squared (d.f.=1)
Chart Review Sample			
Self	26	7	11.28
Intimate	5	6	0.09
Police	9	31	12.10
			23.47
SCI Sample			
Self	12	3	5.40
Intimate	6	11	8.33
Police	7	6	0.08
			13.81

Figure 1
SCI Symptom Profiles
Voluntary and Involuntary Admissions

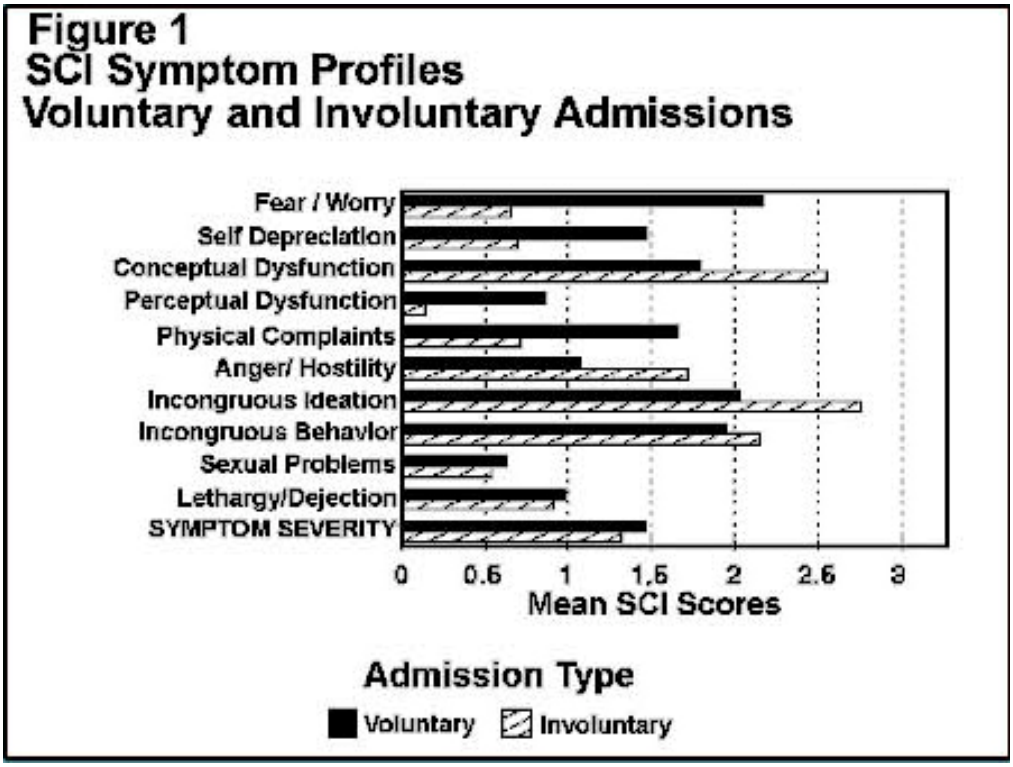

Table 3
Pooled Variance SCI Sample

Symptom	Pooled Variance T
Fear/Worry	3.907
Self Depreciation	2.888
Conceptual Dys.	2.667
Perceptual Dys.	2.172
Physical Complaints	1.726
Anger/Hostility	1.482
Incongruous Ideation	1.350
Incongruous Behavior	0.440
Sexual Problems	0.209
Lethargy/Dejection	0.023
SYMPTOM SEVERITY	0.531

The results illustrated in Tables 1-3 and Figure 1, listed above, demonstrated significant differences between the symptom constellations of patients admitted voluntarily and those admitted involuntarily to Bellevue Hospital Center. These symptom differences have an effect on the mode of arrival to the hospital and the probability of admission to an inpatient psychiatric units.

Voluntarily admitted patients, regardless of their diagnosis, tended to possess an internally focused constellation of symptoms and differed significantly from the symptoms of those patients who were admitted involuntarily. Patients who were admitted involuntarily tended to present symptoms that were either externally focused or projected.

The results in Tables 1 and 3 and Figure 1 illustrate the internal and external constellations for the two patient groups and variance between the groups. Patients seeking assistance and admitted voluntarily possessed significantly greater levels of fear, anxiety, self depreciation, physical complaints, depressed mood, suicidal ideation, sleep disturbance and perceptual dysfunction than involuntarily admitted patients. Those patients who were admitted against their will were determined to possess significantly higher levels of grandiosity, conceptual (cognitive) dysfunction, anger/hostility, incongruous ideation/behavior, antisocial attitudes/acts, motor and affective agitation, and suspiciousness than the voluntarily admitted groups.

The differential constellation of symptoms between the two groups was consistent for each sample, though symptom evaluation procedures and instruments differed for each sample. In general, the voluntarily admitted patients possessed internally focused symptoms. This constellation could be conceptualized as an intrinsic constellation. Symptoms in this constellation tend to have internal origins and are

focused on the internal state of the patient. Involuntarily admitted patients present symptoms that could be thought of as an extrinsic symptom constellation; with an external origin and focus as construed from the patients point of view.

The differential symptom constellation correlated with and was confirmed by the mode of arrival. Table 2 demonstrates that voluntarily admitted patients possessed an intrinsic constellation of symptoms. These patients were more likely to recognize their need for medical/psychiatric assistance and would seek out such assistance. Those patients presenting more of an extrinsic constellation were not as likely to recognize their need for assistance and were more likely to be brought to the hospital by a friend or the police.

Finally, while overall symptom severity did not differ significantly between the two groups in the SCI measured sample, patients admitted voluntarily tended have a marginally greater level of symptom severity (Table 3). This finding leads to the speculation that patients possessing an intrinsic constellation of symptoms require a greater degree of symptom severity in order for the symptoms to be noted and used in the psychiatric admissions process. The involuntarily admitted patient's extrinsic constellation was more readily noted in the intake evaluation and thus, a lower overall severity level was necessary to confirm the need for hospitalization.

DISCUSSION:

The results of this investigation are consistent with the previously noted Gerson and Bassuk analysis. Presenting symptoms are generally used as a basis for determining the type of emergency room visit. Overlaying the mode of arrival and results of structured behavioral and symptom assessments, it is clear that current practice and emergency room hospitalization judgements do not take diagnostic nor intrapsychic distress and objective symptom severity into account when determining the need for involuntary hospitalization. To determine the conditions, factors and symptom severity necessary to hospitalize patients against their will, more comprehensive objective measures need to be employed then are commonly used in emergency room practice today.

Current emergency room clinical assessment techniques are biased in their approach and may account for at least part of the inaccurate assessment of need for involuntary hospitalization. Most admissions are currently made on the basis of an unstructured clinical interview and historical information provided by the patient and external, familial and social sector service staff. Because of this, all three informational contexts represent sources of bias that color the admitting clinicians judgement.

Psychiatric Residents, Psychological Interns, Social Workers and Nurse Practitioners often use a loose, unstructured interview that generally reflects their particular level of training and competency. Often essential intrinsic, intrapsychic symptom and diagnostic information is inconsistantly noted by these professionals. Patients presenting with more overt, extrinsic, behavioral disturbances are often assumed to be more disturbed and require hospitalization. Such clinicians may overlook other patients who present with less dramatic, internally based symptoms. This is clearly the case in this study where patients with severely dysfunctional intrinsic symptoms tended not be involuntarily hospitalized as readily as those who possessed more extrinsic symptoms.

Depending on the level of reality testing, presenting patients have an active stake in the outcome of the psychiatric admissions evaluation. If they desire hospitalization they will exaggerate and confabulate their type and degree of symptom severity. This is particularly true with the seriously and persistently mentally ill who have histories and multiple hospitalizations. Thus, these patients have learned to present severe extrinsic symptomatology and welcome voluntary hospitalization. Patients who do not desire hospitalization often present more realistic, negative symptom constellation and are probable less likely to confabulate their symptom type or severity. In fact, these patients may often attempt to mislead interviewers as to the true nature of their symptoms. This is an attempt to lead psychiatric interviewers into believing they do not require acute hospitalization. Again, this is consistent with the outcomes of this investigation and may lead to inappropriate treatment and release of these individuals from emergency rooms.

Finally, the familial and social service sector staff who escort patient to emergency rooms may also be introducing a bias into the system well. These escorts have independently determined the need for inpatient hospitalization and are likely to be strong advocates for hospitalization. In addition, because of the advocacy position they are forced to adopt a strong admissions posture with emergency room staff regarding the need for admission. This introduces and extra symptomatic bias into the admissions process. Consequently these patients are more likely to be admitted regardless of their true symptomatology. The outcomes of this study (table 2) demonstrate these bias artifacts as well.

Underlying this entire investigation lies the questions of psychiatric prediction of level of dysfunction and relative probability of harm to self or others. In a global sense, one might assume that low GAF Axis V patients who present with extrinsic symptoms would be excellent candidates for involuntary hospitalization. The underlying assumption here is that these patients are least able to control their behavior, since their symptom constellations are of an overt, behavioral nature, and are more likely to inflict harm to self or others. This is essentially and behavioral, Axis V bias in the admissions process.

As demonstrated in the voluntary and involuntary groups for both measures and the results of the escorted patient assessment, severe intrapsychic distress and dysfunction is not related a particular level of overt function. The related symptoms appear to be internal and intrinsic and do lead to accurate GAF assessment, thus clouding and biasing the diagnostic and assessment in the emergency room. Thus the measures for assessing such dysfunction are biased against this population of dysfunctional patients. This is also confirmed by Schrader (11) who found that Axis V assessments were invalid predictors of prognosis and long term functioning, which was one of the key reasons for the Axis V development, and consequently an invalid predictor of involuntary hospitalization.

Due to the obtained results, it is clear that objective assessment tools that reflect true levels of both extrinsic and intrinsic symptomatology be developed and employed in emergency rooms to more adequately determine the need for hospitalization. Using present techniques and related assessment technology the least severe patients who

voluntarily present for treatment are considered for hospitalization before the more severely effected patients.

In order to more fully understand the impact of underlying symptomatology of these two differential groups of patients and develop models of voluntary and involuntary hospitalizations that will facilitate more effective use of the psychiatric emergency rooms to accurately assess the need for costly hospitalization, there must be a greater reliance on objective criteria and measures used to assess patients symptomatology and severity of pathology.

These objective measures must include a detailed assessment of both intrapsychic, affective and behavioral dysfunction and distress and be rapidly applied and readily available to all emergency room professionals and paraprofessionals who assess patients for admission.

The results of this investigation underscore the need for the development of such tools and further investigation into psychiatric emergency room modeling for admissions. Without such tools and patient modeling both patients and society as a whole will continue to incur patient and social costs surrounding inappropriate admissions of marginally dysfunctional patients and failures to admit patients who require hospitalization to prevent them from further deterioration, distress and harm to self an others.

References

1. Bittner E : Police discretion in emergency apprehension of mentally ill persons. Social Problems 4:278292. 1967

2. Crisis in Mental Health : Issues Affecting the Health and Hospitals Corporation's Psychiatric Inpatient and Emergency Room Services Summary Data. January 1989.

3. Cocozza, J Steadman, H : The failure of psychiatric predictions of dangerousness: clear and convincing evidence. Rutgers Law Review 29: 10941101, 1976.

4. Rofman E, Askinazi C, Fant E : The prediction of dangerous behavior in emergency civil commitment. American Journal of Psychiatry 137:10611064.

5. Rubin L, Mills M : Behavioral precipitants to civil commitment. American Journal of Psychiatry 140:603606. 1983

6. Yesavage J, Werner P, Becker J, Mills M: Shortterm civil commitment and the violent patient. American Journal of Psychiatry 139:11451148. 1982.

7. McNeil D, Binder R: Predictive validity of judgment of dangerousness in emergency civil commitment. American Journal of Psychiatry 144:197200. 1987

8. Gerson S, Bassuk E: Psychiatric emergencies : an overview. American Journal of Psychiatry 137:111. 1980

9. Trier T, Levy R : Emergent, urgent, and elective admissions. Archives of General Psychiatry 21: 423430. 1969

10. Muller J, Chafetz M, Blane H: Acute psychiatric services in the general hospital: 111 statistical survey. American Journal of Psychiatry, October supplement 4653. 1967

11. Hardesty, A., Burdock E.

12. Schrader G., Gordon M., & Harcourt R. (1986) The Usefullness of DSMIII Axis IV and Axis V assessments. American Journal of Psychiatry (Jul), Vol 143(7), 904907.

The International Journal of Psychosocial Rehabilitation
Volume 2
July 1997 – June 1998

A Review of Research on the Effectiveness of Self-Help Mutual Aid Groups

Elaina M. Kyrouz, Ph.D. & **Keith Humphreys, Ph.D.**

Veterans Affairs Health Care System and Stanford University School of Medicine
Palo Alto, California

For the past few decades, researchers have been evaluating the effects of self-help/mutual aid groups on participants. Most research studies of self-help groups have found important benefits of participation. Unfortunately, few of these studies has gotten into the hands of self-help group members, clearinghouse staff and others who wish to advocate for self-help/mutual aid. The purpose of this chapter is to help correct this problem by summarizing the best research on the effectiveness of self-help groups in a brief and clear fashion.

As we read over research on the effects of mutual help groups, we noticed a common confusion. Many studies that claim to study self-help groups are actually studies of psychotherapy or support groups solely led by a professional who does not share the condition addressed by the group. We excluded such studies from this review. Instead, we focused on groups where the participants all shared some problem or condition and ran the group on their own. In a very few cases, we included studies where a group was co-led by a professional and by a self-helper. Professional involvement in an advisory or assistance capacity did not rule a study out of consideration, because in the real world, many member-run self-help groups use professional advisors.

We have been selective about the methodological strengths of the studies we chose to summarize. Many studies have demonstrated that if the current members of any self-help group are surveyed at any given time, the members will respond positively about the group and say that it helps them. Such studies (which are sometimes called "single-group cross-sectional surveys") have some value, but they do not tell us much about how members change over time, or whether members change more than non-members. For this reason, we focus here primarily on studies that compared self-help participants to non-participants, and/or gathered information on mutliple occasions over time (that is, "longitudinal" studies). Because we focus primarily on such studies, the following is only a subset of research on self-help effectiveness. At the same time, it is a methdological stronger subset of studies and thus should be more convincing to people outside of the self-help movement.

In the brief summaries below, we have tried to use as little jargon as possible. One excpetion to this rule is to use the scientific convention of using the letter "N" to refer to the number of people participating in each research project. For the sake of space and simplicity, we have generally omitted most details about how the study was conducted and about secondary findings. Readers who wish to have further details about any particular study can use the reference information provided to locate the original sources.

Research Reviews

Mental Health Groups

Edmunson, E. D., J. R. Bedell, et al. (1982). Integrating Skill Building and Peer Support in Mental Health Treatment: The Early Intervention and Community Network Development Projects. *Community Mental Health and Behavioral Ecology*. A. M. Jeger and R. S. Slotnick. New York: Plenum Press: 127-139.

After ten months of participation in a patient-led, professionally supervised social network enhancement group, one-half as many former psychiatric inpatients (N=40) required rehospitalization as did non-participants (N=40). Participants in the patient-led network also had much shorter average hospital stays (7 days vs. 25 days). Furthermore, a higher percentage of members than non-members could function with no contact with the mental health system (53% vs. 23%).

Galanter, M. (1988). Zealous Self-Help Groups as Adjuncts to Psychiatric Treatment: A Study of Recovery, Inc. *American Journal of Psychiatry* 145(10): 1248-1253.

This study surveyed 356 members of Recovery, Inc., a self-help group for nervous and former mental patients, and compared them to a 195 community residents of similar age and sex. Although about half of the Recovery Inc. members had been hospitalized before joining, only 8% of group leaders and 7% of recent members had been hospitalized since joining. Members used more outpatient non-psychiatric resources than did the community sample.

Kennedy, M. (1990). Psychiatric Hospitalizations of GROWers. Paper presented at the Second Biennial Conference on Community Research and Action, East Lansing, Michigan.

This study found that 31 members of GROW, a self-help organization for people with chronic psychiatric problems, spent significantly fewer days in a psychiatric hospital over a 32-month period than did 31 former psychiatric patients of similar age, race, sex, marital status, number of previous hospitalizations and other factors. Members also increased their sense of security and self-esteem, decreased their existential anxiety, broadened their sense of spirituality, and increased their ability to accept problems without blaming self or others for them.

Kurtz, L. F. (1988). Mutual Aid for Affective Disorders: The Manic Depressive and Depressive Association. *American Journal of Orthopsychiatry* 58(1): 152-155.

This study found that 82% of 129 members of the Manic Depressive and Depressive Association reported coping better with their illness since joining the self-help group. The longer they were members and the more intensely they were involved with the group, the more their coping had improved. Further, the percentage of members reporting being admitted to a psychiatric hospital before joining the group was 82%, but the percentage reporting hospital admission after joining was only 33%.

Lieberman, M. A., Solow, N. et al. (1979). "The psychotherapeutic impact of women's consciousness-raising groups." *Archives of General Psychiatry* 36: 161-168.

32 participants in women=s consciousness-raising groups were studied over a 6 month period. Over the course of the study, participants reported decreased distress about their target problem, increased self-esteem, and greater self-reliance. They also reported greater identification with feminist values and politics.

Raiff, N. R. (1984). "Some Health Related Outcomes of Self-Help Participation." Chapter 14 in *The Self-Help Revolution*, edited by Alan Gartner and Frank Riessman. New York: Human Sciences Press.

Highly involved members of Recovery, Inc. (N=393, mostly female and married), a self-help group for former mental patients, reported no more anxiety about their health than did the general population. Members who had participated for two years or more had the lowest levels of worry and the highest levels of satisfaction with their health. Members also rated their life satisfaction levels as high or higher than did the general public. Members who had participated less than two years, were still on medication, lived below the poverty level, or lacked social-network involvements also appeared to benefit from group participation, although to a lesser degree.

Weight Loss Groups

Grimsmo, A., G. Helgesen, et al. (1981). Short-Term and Long-Term Effects of Lay Groups on Weight Reduction. *British Medical Journal* 283: 1093-1095.

These researchers conducted three studies of mostly female participants in 8-week peer-led weight-loss groups in Norway (Grete Roede Slim-Clubs). The first study gathered information from 33 women before, during, immediately after, and 1 year after participation. Participants lost an average of 14.3 pounds while they were in the group, and had kept almost all of it from coming back by the end of the year (they had an average of 12.1 pounds less weight). The second study surveyed 1000 people who had completed the group from 1 to

5 years previously, and found that average weight loss remained stable for the first couple of years and was still 5 - 6% below starting weight after 5 years. The third study surveyed more than 10,000 participants before and immediately after participation, and found an average weight loss of 15.2 pounds.

Peterson, G., D. B. Abrams, et al. (1985). Professional Versus Self-Help Weight Loss at the Worksite: The Challenge of Making a Public Health Impact. *Behavior Therapy* 16: 213- 222.

This study compared 30 employees assigned to a professionally-led weight-loss group with 33 employees assigned to a peer-led group. Both groups used "Learn to Be Lean" workbooks based on behavioral therapy principles. Members of both groups lost weight in equal amounts over a six-month period. The peer-led group was only half as costly as the professional-led group.

Addiction-Related Recovery Groups

Alemi, F., Mosavel, M. Stephens, R. et al. (1996). "Electronic Self-Help and Support Groups." *Medical Care* 34(Supplement): OS32-OS44.

This was a study of 53 pregnant women who had a history of drug use. Participants, most of whom were African-American, were assigned either to attend face-to-face biweekly self-help group meetings (N=25) or to participate in self-help meetings operated over a voice bulletin board accessed by phone (N=28). In the bulletin board group, participants could leave voice mail messages for the entire group to hear. Significantly more women participated in the voice mail group (96% of those assigned) than in the face-to-face self-help groups (32% of those assigned). Bulletin board participants made significantly fewer telephone calls and visits to health care clinics than did individuals assigned to participate in the face-to-face group. Both groups has similar health status and drug use at the end of the study.

Christo, G. and S. Sutton (1994). Anxiety and Self-Esteem as a Function of Abstinence Time Among Recovering Addicts Attending Narcotics Anonymous. *British Journal of Clinical Psychology* 33: 198-200.

Members of Narcotics Anonymous (NA) self-help groups (N=200) who stayed off drugs for three years or more while they were members showed no more anxiety and no less self-esteem than a comparison group of 60 never-addicted students. The longer people remained members while staying off drugs, the less anxiety and the more self-esteem they experienced.

Emrick, C. D., J. S. Tonigan, et al. (1993). Alcoholics Anonymous: What is Currently Known? In *Research on Alcoholics Anonymous: Opportunities and Alternatives*, edited by Barbara S. McCrady and William R. Miller. New Brunswick, NJ: Rutgers Center of Alcohol Studies, pp. 41-75.

Using meta-analysis of more than 50 studies, these authors report that AA members stayed sober more if they (1) had an AA sponsor, (2) worked the "twelfth step" of the program, (3) led a meeting, (4) increased their degree of participation over time, or (5) sponsored other AA members. The study also found that professionally treated alcoholic patients who attend AA during or after treatment are somewhat more likely to reduce drinking than are those who do not attend AA. Membership in AA was also found to reduce physical symptoms and to improve psychological adjustment.

Hughes, J. M. (1977). Adolescent Children of Alcoholic Parents and the Relationship of Alateen to These Children. *Journal of Consulting and Clinical Psychology* 45(5): 946-947.

This study compared 25 Alateen members with 25 non-members who had an alcoholic parent and 25 non-members with no alcoholic parent. Adolescents with an alcoholic parent who were members of Alateen experienced significantly fewer negative moods, significantly more positive moods and higher self-esteem than those who were not members. In fact, Alateen members had self-esteem and mood scores similar to those of adolescents who did not have an alcoholic parent.

Humphreys, K., B. E. Mavis, and B. E. Stoffelmayr (1994). Are Twelve Step Programs Appropriate for Disenfranchised Groups? Evidence from a Study of Posttreatment Mutual Help Involvement. *Prevention in Human Services* 11(1): 165-179.

One year after being admitted to a public substance abuse treatment agency, Caucasion- and African-Americans were attending mutual help (Narcotics Anonymous, Alcoholics Anonymous) groups at the same rate. African-American participants (N=253) in NA and AA self-help groups showed significant improvements over twelve months in six problem areas (employment, alcohol, drug, legal, psychological, and family). African-American self-help group participants had significant more improvement in their medical, alcohol, and drug problems than did African- American patients who did not participate in self-help groups after treatment.

Humphreys, K. and R. H. Moos (1996) Reduced Substance-Abuse-Related Health Care Costs among Voluntary Participants in Alcoholics Anonymous. *Psychiatric Services*, 47, 709-713.

Over a period of three years, alcoholics who initially chose to attend AA were compared to those who sought help from a professional outpatient treatment provider (total N=201). Those who chose to attend AA had 45%

($1826) lower average per-person treatment costs than did those who chose outpatient treatment. Despite the lower costs, AA attenders also experienced significant improvements in alcohol consumption, dependence symptoms, adverse consequences, days intoxicated and depression. These outcomes did not differ significantly from those of alcoholics who chose professional treatment. This was true both at one year and at three years after the beginning of the study.

Jason, L. A., C. L. Gruder, et al. (1987). Work Site Group Meetings and the Effectiveness of a Televised Smoking Cessation Intervention. *American Journal of Community Psychology* 15: 57-77.

This study compared the effects of two smoking cessation programs at work. One hundred and ninety-two workers viewed a television program and used a self-help manual, while 223 workers had these materials supplemented by 6 self-help group meetings. Group meetings were led by recruited smoking employees who had been given a three-hour training session in how to lead groups. The two programs were implemented at 43 companies. Initial rates of quitting smoking were significantly higher for the 21 companies that used self-help groups (average of 41% vs. 21% of participants). Group participants also smoked significantly fewer cigarettes per day, with lower tar, nicotine and carbon monoxide content. Three months later, an average of 22% of group participants had continued not to smoke, compared to 12% in companies with no self-help groups.

McAuliffe, W. E. (1990). A Randomized Controlled Trial of Recovery Training and Self- Help for Opiod Addicts in New England and Hong Kong. *Journal of Psychoactive Drugs* 22(2): 197-209.

This study randomly assigned volunteer graduates from substance abuse treatment programs (N=168) to participate in RTSH (Recovery Training and Self-Help), an aftercare program that combined professionally led recovery-training sessions with peer-led self-help sessions. Participants in the recovery program significantly reduced their' likelihood of relapse into opiod addiction compared to those who received only referrals to other programs and crisis- intervention counseling. The RTSH program helped unemployed participants find work and reduced criminal behavior.

McKay, J. R., A. I. Alterman, et al. (1994). Treatment Goals, Continuity of Care, and Outcome in a Day Hospital Substance Abuse Rehabilitation Program. *American Journal of Psychiatry* 151(2): 254-259.

Male substance abuse patients (N=180, 82% African American, mostly low income) who participated in self-help groups (Alcoholics Anonymous, Narcotics Anonymous) after treatment significantly reduced their frequency of alcohol and cocaine use by the 7-month followup. Participants with high self-help attendance rates used alcohol and/or cocaine less than half as much as did those with low self-help attendance. This was true regardless of previous substance use and whether or not they completed a 4-week hospital rehabilitation program. Hence, the effects of self-help groups were not simply due to motivation or other characteristics of the individuals who participated.

Pisani, V. D., J. Fawcett, et al. (1993). The Relative Contributions of Medication Adherence and AA Meeting Attendance to Abstinent Outcome for Chronic Alcoholics. *Journal of Studies on Alcohol* 54: 115-119.

A group of 122 mostly male, White alcoholic patients admitted to short-term hospital treatment programs participated in this study. In the 18 months following treatment, the more days the patient attended Alcoholics Anonymous self-help meetings, the longer their abstinence lasted. AA meeting attendance improved abstinence considerably more than did adherence to prescribed medication.

Tattersall, M. L. and C. Hallstrom (1992). Self-Help and Benzodiazepine Withdrawal. *Journal of Affective Disorders* 24(3): 193-198.

This study followed members (N=41) of TRANX (Tranquilizer Recovery and New Existence), a British self-help organization that provided telephone counseling and support groups to its members. Members were mostly White women who had been addicted to tranquilizers for an average of 12 years. During a 9-month period, members of the group were more likely to stop using tranquilizers than were individuals (N=76) who made an initial telephone contact but did not become a member. Most members (73%) also reported that the symptoms for which they had initially been prescribed tranquilizers improved, and 65% reported that they were at least moderately satisfied with their withdrawal in terms of its effects on their subjective quality of life.

Walsh, D. C., R. W. Hingson, D. M. Merrigan, et al. (1991). A Randomized Trial of Treatment Options for Alcohol-Abusing Workers. *The New England Journal of Medicine* 325(11): 775-782.

Workers assigned to participate in Alcoholics Anonymous self-help groups reduced their drinking problems over a two-year period. Furthermore, compulsory AA groups (n=83) did not significantly differ from compulsory inpatient treatment (N=73) in their effects on job-related outcomes of participants. Costs of inpatient treatment averaged 10 percent less for AA participants than for hospital rehabilitation participants.

Bereavement Groups

Caserta, M. S. and Lund, D. A. (1993). Intrapersonal Resources and the Effectiveness of Self-Help Groups for Bereaved Older Adults. *Gerontologist* 33(5): 619-629.

Widows and widowers over age 50 who participated in bereavement self-help groups (N=197) experienced less depression and grief than nonparticipants (N=98) if their initial levels of interpersonal and coping skills were low. Those with initially high interpersonal skill levels also benefitted from participation if they participated in the groups for longer than eight weeks.

Lieberman, M. A. and L. Videka-Sherman (1986). The Impact of Self-Help Groups on the Mental Health of Widows and Widowers. *American Journal of Orthopsychiatry* 56(3): 435-449.

This study followed 36 widowers and 466 widows, 376 of whom were members of the bereavement self-help group THEOS. Over a period of one year, THEOS members who formed social relationships with other group members outside group time experienced less psychological distress (depression, anxiety, somatic symptoms) and improved more in psychological functioning (well-being, mastery, self-esteem) than did non-members and members who did not form such relationships.

Marmar, C. R., M. J. Horowitz, et al. (1988). A Controlled Trial of Brief Psychotherapy and Mutual-Help Group Treatment of Conjugal Bereavement. *American Journal of Psychiatry* 145(2): 203-209.

Bereaved women who sought treatment for grief after the death of their husband were randomly assigned to either professional psychotherapy (N=31) or self-help groups (N=30). Self-help groups worked just as well as the therapy. Participants and non-participants in the self-help groups reduced stress-specific and general psychiatric symptoms such as depression equally. They also experienced similar improvements in social adjustment and work functioning.

Vachon, M. L. S., W. A. L. Lyall, et al. (1980). A Controlled Study of Self-Help Intervention for Widows. *American Journal of Psychiatry* 137(11): 1380-1384.

Women (N=162) whose husbands had died within the past month were studied over a two-year period. Half of these women were assigned to participate in a "widow-to-widow" program. After 6 months in the program, participants were more likely than non-participants to feel more healthy and to feel "better," and less likely to anticipate a difficult adjustment to widowhood. After 12 months, participants were more likely than non-participants to feel "much better," to have made new friends, and to have begun new activities, and were less likely to feel constantly anxious or to feel the need to hide their true emotions. Participation facilitated adjustment both inside the person (in their relationship with themselves) and outside the person (in their relationships with others).

Videka-Sherman, L. and M. Lieberman (1985). The Effects of Self-Help and Psychotherapy Intervention on Child Loss: The Limits of Recovery. *American Journal of Orthopsychiatry* 55(1): 70-82.

This study compared White, mostly female bereaved parents who had received psychotherapy (N=120) to those who attended a Compassionate Friends (CF) bereavement self-help group sporadically (N=81), actively (N=25) or actively with social involvement with group members outside the group (N=97). Active participation in the self-help group accompanied by involvement with group members outside the group increased bereaved parents' comfort in discussing their bereavement with others and reduced parents' self-directed anger. Psychotherapy did not have these effects. CF members reported that group involvement had increased their self-confidence, sense of control, happiness, and freedom to express feelings, and decreased their depression, anxiety, guilt, anger, and isolation.

Diabetes Groups

Gilden, J. L., Hendryx, M. S., et al. (1992). Diabetes Support Groups Improve Health Care of Older Diabetic Patients. *Journal of the American Geriatrics Society* 40: 147-150.

Male diabetic patients were randomly divided into three groups. The first group (N=8) received no intervention. The second group (N=13) received a six-session education program on diabetes self-care. The third group (N=11) received the education program plus 18 meetings of a patient- led self-help group. The patient-led group focused on coping skills, group discussions, structured social activities, and continuing diabetes education. At the end of the study, those who participated in both the education program and the patient-led group had better diabetes knowledge and quality of life and lower depression than non-participants. The participants in the peer-led group also reported less stress, greater family involvement, and better glycemic control than the patients who recieved no intervention.

Simmons, D. (1992). Diabetes Self Help Facilitated by Local Diabetes Research: The Coventry Asian Diabetes Support Group. *Diabetic Medicine* 9: 866-869.

Researchers assessed members of a self-help group for South Asian diabetics in England (N=53) for levels of glycated haemoglobin and knowledge about diabetes. Those who attended the group twice or more during a year had a significantly greater drop in glycated haemoglobin levels and a significantly greater increase in

knowledge about diabetes. Although professionals helped start the group, it continues to operate independently, emphasizing education, mutual support, information sharing, and family social activities.

Caregiver Groups

Minde, K., N. Shosenberg, et al. (1980). Self-Help Groups in a Premature Nursery--a Controlled Evaluation. *Behavioral Pediatrics* 96(5): 933-940.

Parents of premature infants were randomly assigned to participate in support groups in a hospital. The weekly groups (1.5 to 2 hours long) focused on coping and were co-led by a mother who had had a premature infant and by a nurse. Speakers were also brought in from outside periodically. Compared to 29 parents who did not participate, the 28 participants visited their infants in the hospital significantly more often, and touched, talked to, and gazed at their infants more often during visits. Participants also rated themselves more competent at infant care. Three months after their babies were discharged, group participants continued to show more involvement with their infants during feedings and were more concerned about their infants' general development.

Toseland, R. W., Rossiter, C. M., and Labrecque, M. S. (1989). The Effectiveness of Two Kinds of Support Groups for Caregivers. *Social Service Review*, September: 415-432.

This study divided 103 adult women caring for frail older relatives into three conditions: participation in a peer-led self-help group, participation in a professional-led support group, and no participation in either group. Groups met for eight weekly two-hour sessions. Both groups focused on enhancing coping skills. Compared to non-participants, women who participated in either type of group experienced significantly greater (1) increases in the size of their support network, (2) increases in their knowledge of community resources, (3) improvement in their interpersonal skills and ability to deal with the problems of caregiving, (4) improvement in their relationships with their care receivers, and (5) decreases in pressing psychological problems.

Groups for Elderly People

Lieberman, M. A. and Bliwise, N. G. (1985). Comparisons Among Peer and Professionally Directed Groups for the Elderly: Implications for the Development of Self-Help Groups. *International Journal of Group Psychotherapy* 35(2): 155-175.

This study compared participants (86 women and 22 men) in peer-led and professionally-led SAGE (Senior Actualization and Growth Explorations) self-help groups for the elderly to those who were on a waiting list to join the groups. Members of both types of SAGE groups felt they achieved their desired goals to a greater extent than those in the waiting-list group. Participation in either SAGE group also reduced psychological problems, such as nervousness and depression.

Cancer Groups

Maisiak, R., M. Cain, et al. (1981). Evaluation of TOUCH: An Oncology Self-Help Group. *Oncology Nursing Forum* 8(3): 20-25.

This study surveyed 139 members of TOUCH, a self-help group for cancer patients in Alabama. TOUCH focuses on teaching its members about cancer and training them to be peer counselors to help other patients. The longer members participated in a group, the more they improved their knowledge of cancer, their ability to talk with others, their friendships, their family life, their coping with the disease, and their following of doctors' orders. The percentage of people indicating their coping was very good after TOUCH was 59%, more than double the percentage indicating it was very good before TOUCH (28%).

Spiegel, D., Bloom, J. R., Kraemer, H.C. and Gottheil, E. (1989). "Effect of psychosocial treatment on survival of patients with metastatic breast cancer." *The Lancet* October 14: 888-891.

Participants in this study were 86 women undergoing treatment for metastatic breast cancer. A subset of these women (N=50) were randomly assigned to have their oncologic care supplemented with a weekly support group. The support groups were co-facilitated by a therapist who had breast cancer in remission and a psychiatrist or social worker. The sessions focused on living life fully, improving communication with family members and doctors, facing death, expressing emotions such as grief, and controlling pain through self-hypnosis. On average, support group participants lived twice as long as controls (an average of almost 18 months longer).

Chronic Illnesses

Becu, M., Becu, N., Manzur, G. and Kochen, S. (1993). Self-Help Epilepsy Groups: An Evaluation of Effect on Depression and Schizophrenia. *Epilepsia* 34(5): 841-845.

A group of Argentine researchers conducted a 4-month longitudinal study of 67 epileptic patients who participated in weekly self-help group meetings. Epileptic patients trained by psychologists led the groups. Group participants had decreased depression and other psychological problems over the course of the study.

Hinrichsen, G. A., T. A. Revenson, et al. (1985). Does Self-Help Help? An Empirical Investigation of Scoliosis Peer Support Groups. *Journal of Social Issues* 41(1): 65-87.

Adults with scoliosis who had undergone bracing or surgery and participated in a Scoliosis Association self-help group (N=33) were compared to adults with similar treatment who did not participate in the group (N=67). Compared to non-participants, group participants reported (1) a more positive outlook on life, (2) greater satisfaction with the medical care they received, (3) reduced psychosomatic symptoms, (4) increased sense of mastery, (5) increased self-esteem, and (6) reduced feelings of shame and estrangement.

Nash, K. B. and K. D. Kramer (1993). Self-Help for Sickle Cell Disease in African American Communities. *Journal of Applied Behavioral Science* 29(2): 202-215.

This study focused on 57 African Americans who had been members of self-help groups for sickle-cell anemia. The members who had been involved the longest reported the fewest psychological symptoms and the fewest psychosocial interferences from the disease, particularly in work and relationship areas.

Sibthorpe, B., D. Fleming, et al. (1994). Self-Help Groups: A Key to HIV Risk Reduction for High-Risk Injection Drug Users? *Journal of Acquired Immune Deficiency Syndromes* 7(6): 592-598.

Injection drug users (N=234) who had shared a dirty needle in the previous 30 days were followed over six months. Those who attended self-help groups (mostly Narcotics Anonymous and Alcoholics Anonymous) during that time were almost twice as likely to report reducing or eliminating their risk of exposure to HIV compared to those who did not attend such groups.

Note:
Preparation of this paper was supported by National Institute of Alcohol Abuse and Alcoholism Grant #10652 and the Department of Veterans Affairs Mental Health Strategic Health Group.

The International Journal of Psychosocial Rehabilitation
Volume 2
July 1997 – June 1998

A Critical Look At Current Concepts of Personality Disorders: Moral vs. Medical Aspects

Marcelo Caixeta, M.D.
Psychiatry Service ASMGO Medical Center Goiania, Brazil

Reprint: International Journal of Psychopathy, Psychopharmacology and Psychotherapy 1996, 1 (1).

A Critical Look At Current Concepts of Personality Disorders: Moral vs. Medical Aspects

1. DSM IV (APA,1995) states that personality disorders lead to distress or impairment. However, all mental disorders lead to that, as do many "normal" behaviors. For example, a "normal" criminal does things that lead to distress . . . do all criminals have a personality disorder? Someone who goes through a divorce will often have some kind of impairment in his or her psychological equilibrium . . . does such a person have a psychiatric disorder? People who think only about themselves, and do things that totally disregard the interests of others . . . such people are narcissists . . . but if they are considered ill, we are defining illness as something other than a medical concept.

2. The medical concept of disease should defined as involving some self disadvantageous biological process. (Scadding, 1967)

3. Psychiatry is psychological medicine. We could say that for a person to be classified as a "psychiatric patient," they must display the effects of a biological self disadvantageos process upon their thinking, feeling or behavior.

Thus, according to the paragraph above, criminals, people reacting to the stress of divorce, or narcissists should not be seen as "sick" since they are searching for behaviors that could improve their lives.

4. According to this point of view, anti-social people would be considered to have psychiatric problems only when committing self disadvantageous crimes . . . such as attempting a robbery in the presence of the police. Anti-social people who refrain from such self-defeating behaviors should be considered “normal criminals. They should be of concern to the criminal justice system not to physicians and the medical community.

5. While, according to our conceptualization, narcissistic, passive-aggressive and paranoid persons do not have, psychiatric disorders, their personality traits often predispose them to develop true medical diseases. We see in daily clinical practice that narcissists become depressed or aggressive when they do not fulfill their objectives; obsessives become anxious when they lose control over some aspect of their life, and so on. But in these cases the medical problem is not their personality . . . their personality has simply predisposed them to develop the medical entity. This process is paralleled by the predisposition to myocardial infarction that accompanies anxiety. The medical entity is the infarct, and not the individual's

anxious personality. The later is not a central concern of Medicine. We obviously can try to modify some such factors, but such factors are not "medical entities". If they were, cardiologists might consider "anxiety" as a cardiological entity.

6. We are not denying that some psychiatric diseases can lead to personality disorders. It is well known that people in a manic episode may shown many kinds of disturbed behavior (similar to behaviors seen in people with personality disorders) such as anti-social behavior and hypersexuality. But, once the biological disorder is gotten under control, their behavioral symptoms disappear. This is quite different from what happens with some of the DSM-IV "personality disorders."

7. Some people with borderline, antisocial, schizoid and obsessive compulsive personality disorders may have a "true" psychiatric disorder. Such people display self disadvantageous behaviors, and they often show a lessening of such behaviors following psychopharmacologic treatment. The anatomical, electrical, and neurochemical markers of their underlying biological disturbances are in the process of being discovered.

8. If mental health professionals do not pay attention to such considerations, we risk confusing medical and moral problems. Such confusion can only have deleterious consequences for both the medical and criminal justice systems.

References

1. American Psychiatric Association. DSM IV. Artes Médicas. Porto Alegre-BR. 1995.

2. Scadding,JG:(1967) Medical Diagnosis. Lancet 2: 877-882.

The International Journal of Psychosocial Rehabilitation
Volume 2
July 1997 – June 1998