



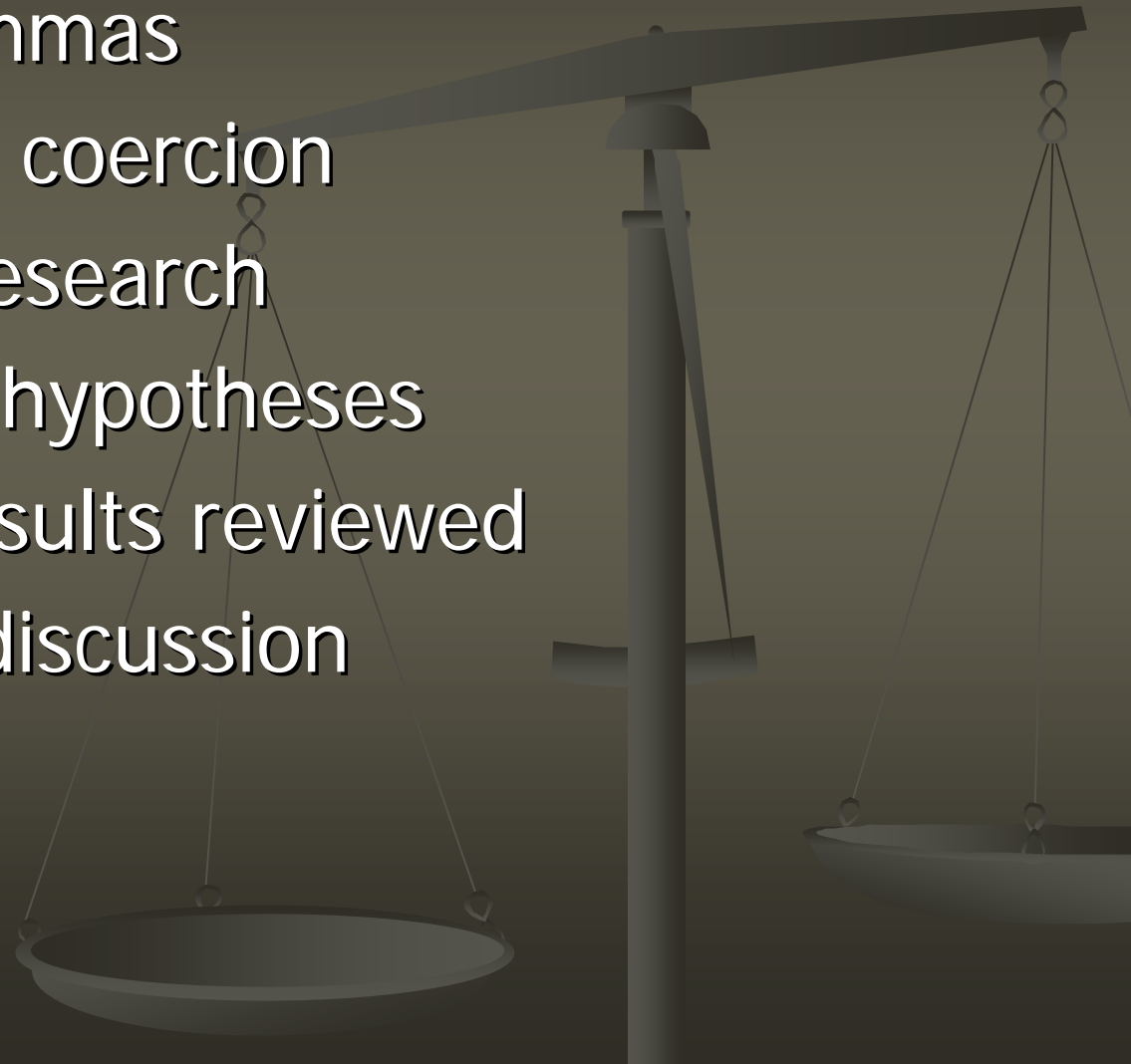
Beyond Program Fidelity: The Employment of Coercion by Teams Implementing the ACT Model

Lorna Moser, M.S.
Indiana University
Purdue University Indianapolis (IUPUI)

February 13, 2006
NRI 16th Annual Research Conference
Baltimore, MD

Overview

- Treatment dilemmas
- Conceptualizing coercion
- Review of the research
- Current study's hypotheses
- Methods and results reviewed
- Questions and discussion



The Problem

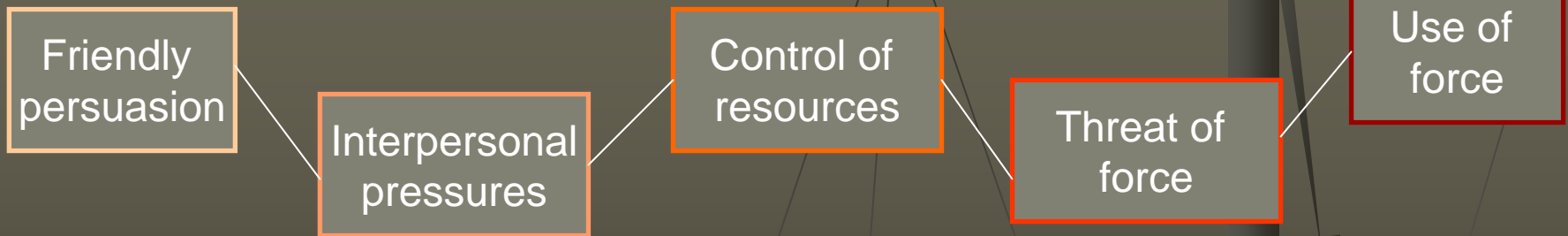


- Recovery philosophy and client empowerment
- Ethical dilemma:
 - Promoting client autonomy vs. providing treatment to those who need it (but not seeking it)
- More restrictive interventions may be used to facilitate adherence to treatment/abstinence from substances
 - How do we know when restrictive interventions are abused?
 - Need to understand base rates
 - Some ethical quandaries

Coercion in Mental Health Treatment

Coercion defined as a process by which an “agent” exercises certain types of control or power over a “target” (Carroll, 1991).

Continuum of restrictive practices



Examples:

- Involuntary commitment to treatment
- Control of valued resources (e.g., money, housing)
- Intensive monitoring of medications and substance use
- Withholding of information

Coercion in Mental Health Services: Current State of Knowledge

Clients experience greater coercion when:

- Interventions that are more restrictive (further down the continuum)
- Not having an explanation for WHY a more restrictive intervention is used
- More than one coercive intervention is used
- They are not adherent to treatment

Practitioners tend to use less restrictive interventions before more restrictive interventions

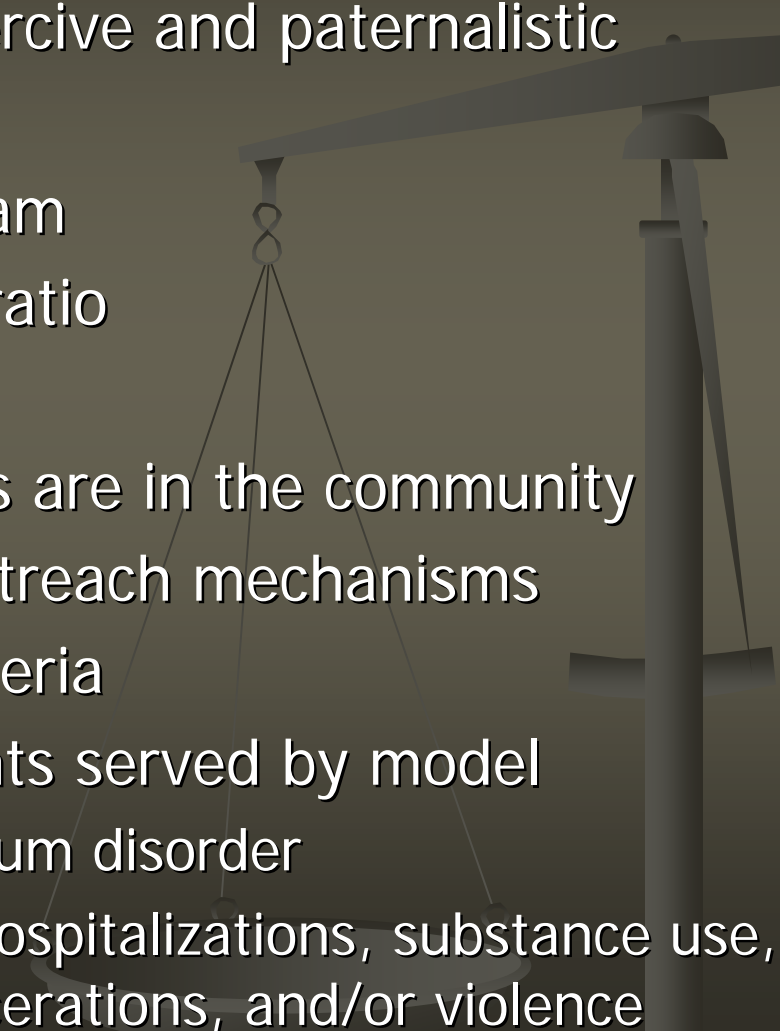
(Elbogen et al., 2003; Lidz, 1995; Lidz, 1998)

Coercion in Mental Health Services: Current State of Knowledge (2)

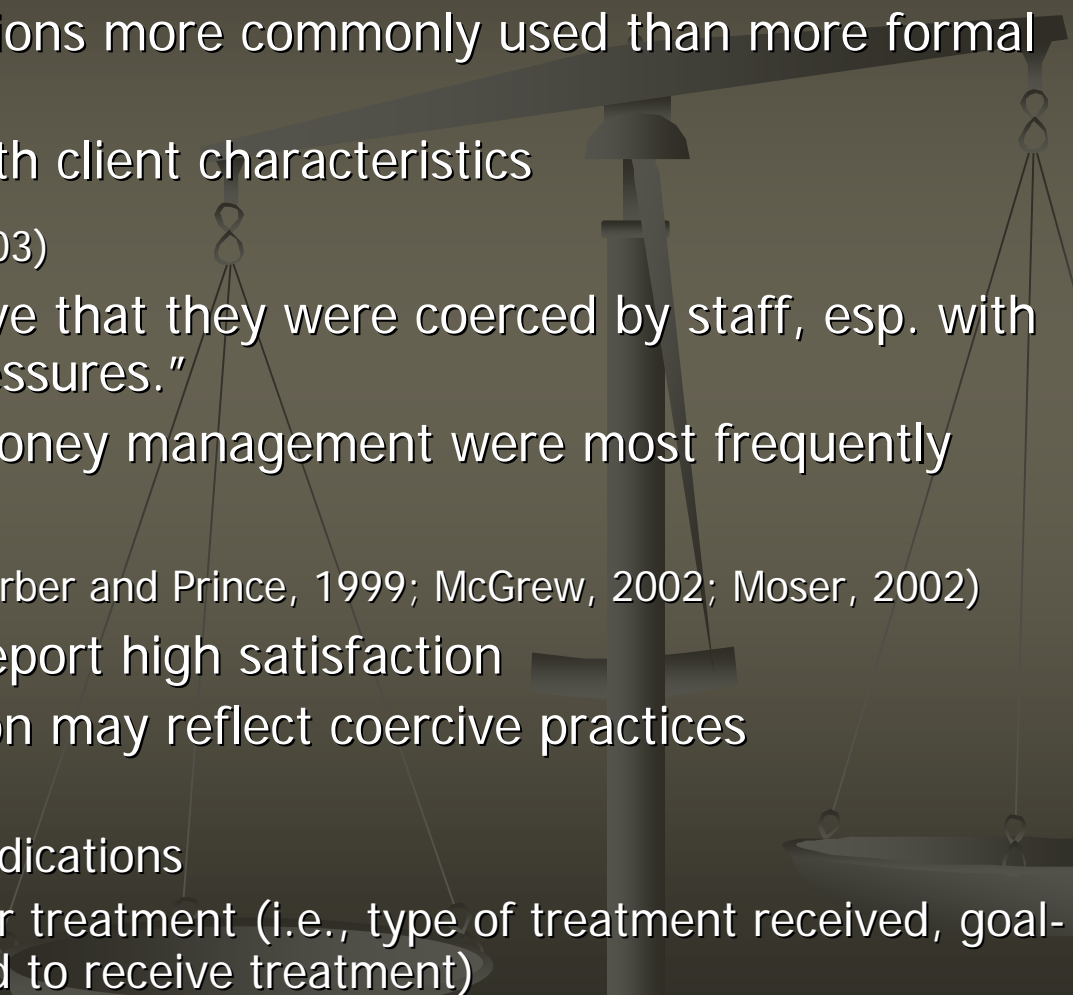
First U.S. study to obtain rates with which various leverages are used in the provision of mental health services (Monahan et al., 2005)

- Of those with a rep payee (61% of sample), 15-31% reported that money was used as leverage in their life (7-19% for those without a rep payee)
- Housing was used as leverage for 23-40% of all ps
- Outpatient commitment was experienced by 12-20% of ps
- Experience of any leverage more common among those with lower functioning, multiple hospitalizations, higher-intensity outpatient service use, and longer total time in treatment.

Assertive Community Treatment (ACT)

- Criticized as being coercive and paternalistic
 - Description of model
 - Multidisciplinary team
 - Low client to staff ratio
 - Intensive services
 - Majority of contacts are in the community
 - Use of assertive outreach mechanisms
 - Strict discharge criteria
 - Characteristics of clients served by model
 - Schizophrenia-spectrum disorder
 - History of frequent hospitalizations, substance use, homelessness, incarcerations, and/or violence
- 

IS ACT Coercive?

- **Practitioner report** (Neale and Rosenheck, 2000)
 - Less coercive interventions more commonly used than more formal methods of coercion
 - Practices associated with client characteristics
 - **Client report** (Tschopp, 2003)
 - Majority did not perceive that they were coerced by staff, esp. with regard to “negative pressures.”
 - Verbal guidance and money management were most frequently reported interventions.
 - **Satisfaction studies** (Gerber and Prince, 1999; McGrew, 2002; Moser, 2002)
 - ACT clients generally report high satisfaction
 - Areas of less satisfaction may reflect coercive practices
 - Intrusiveness
 - Overemphasis on medications
 - Lack of influence over treatment (i.e., type of treatment received, goal-setting, feeling forced to receive treatment)
- 

Current Study



- Broad conceptualization of coercion
- Attempt to examine the rate at which ACT programs utilize various coercive interventions
- Development of novel and practical measures of coercion
- Examine possible predictors of coercion related characteristics of the:
 - Program
 - Practitioner
 - Client

Program Characteristics



ACT Fidelity



- Fidelity refers to the degree to which a team implements the critical ingredients of a model
- ACT is primarily defined:
 - by structural characteristics
 - as a way of organizing services
- The actual **processes** are neither prescribed by the ACT model nor measured by fidelity measures (exception of dual disorder treatment)

H1: Fidelity to the ACT model will not predict coercion.

Quality of Fundamental Clinical Processes



- Measurement of process variables
 - Critical therapeutic ingredients
 - Transcend a particular service model
 - Examples
 - comprehensive assessments
 - individualized treatment plans
 - individualized interventions
 - collecting and using client outcomes to reform services

H2: Lower quality of fundamental clinical services will predict greater coercion.

Practitioner Characteristics



Training



- Sophisticated clinical skills necessary to collaboratively work with difficult to engage clients (e.g., motivational interviewing)
- Development of sophisticated clinical skills
 - Natural abilities and general treatment philosophy
 - Formal training (e.g., academic program)
 - Workshops and agency-led training
- Problem:
 - Agencies often do not invest in training staff in clinical practices
 - Majority of practitioners providing treatment to individuals with SMI do not have advanced academic training

H3: Teams with practitioners with few advanced degrees will display greater coercion.

Attitudes

- Pessimism
 - The inclination to emphasize adverse aspects, conditions, and possibilities or to expect the worse possible outcome
- Paternalism
 - The inclination to interfere with a person's liberty, which is deemed justifiable because it is for the person's own good.
- Practitioners with pessimistic and paternalistic attitudes are more likely **not** to encourage personal growth or independence.

H4: Teams with practitioners who lack recovery-oriented attitudes (i.e., high paternalism and high pessimism) will predict greater coercion.

Supervision

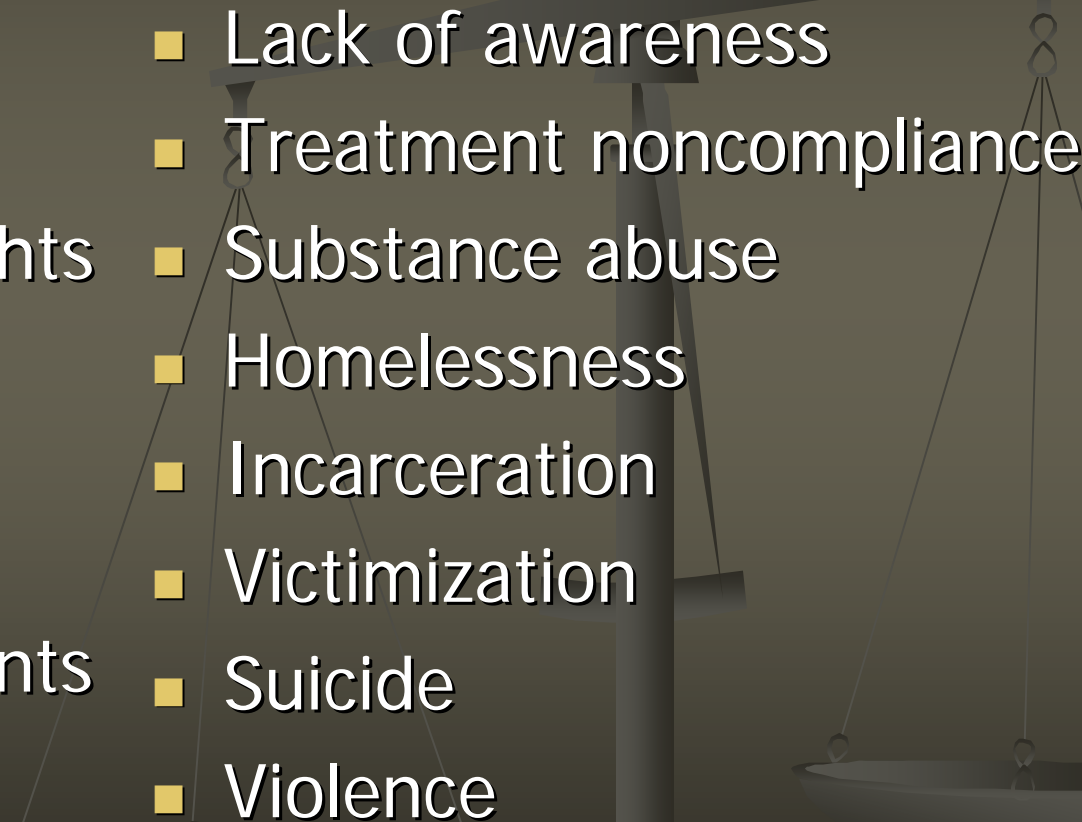


- Crucial for staff development
 - Modeling and teaching new skills and philosophies
 - Facilitating accurate application of skills already obtained through academic training
 - Means for providing support
 - **Client-centered** supervision
 - Focuses on clients' goals, strengths, weaknesses, as well as treatment barriers and strategies
 - Provided frequently, and ideally is scheduled (i.e., not only on the fly)
- n H5: Teams with practitioners who receive frequent client-centered supervision will be less coercive.

Client Characteristics



Schizophrenia Symptoms and Psychosocial Sequelae (1)

- 
- Hallucinations
 - Delusions
 - Disorganized thoughts and speech
 - Social withdrawal
 - Apathy
 - Cognitive impairments
 - Lack of awareness
 - Treatment noncompliance
 - Substance abuse
 - Homelessness
 - Incarceration
 - Victimization
 - Suicide
 - Violence

Schizophrenia Symptoms and Psychosocial Sequelae (2)

- In summary
 - The illness can undermine the ability to reason
 - The costs of lack of treatment can be very high

H6: Teams serving clinical populations with higher rates of certain client characteristics and related psychosocial sequelae will be significantly related to greater coercion

Program characteristics

Fidelity to the ACT model

Program characteristics

Quality of fundamental
clinical services

Practitioner characteristics

Attitudes
Pessimism
Paternalism

Practitioner characteristics

Academic training

**Client Centered
Supervision**

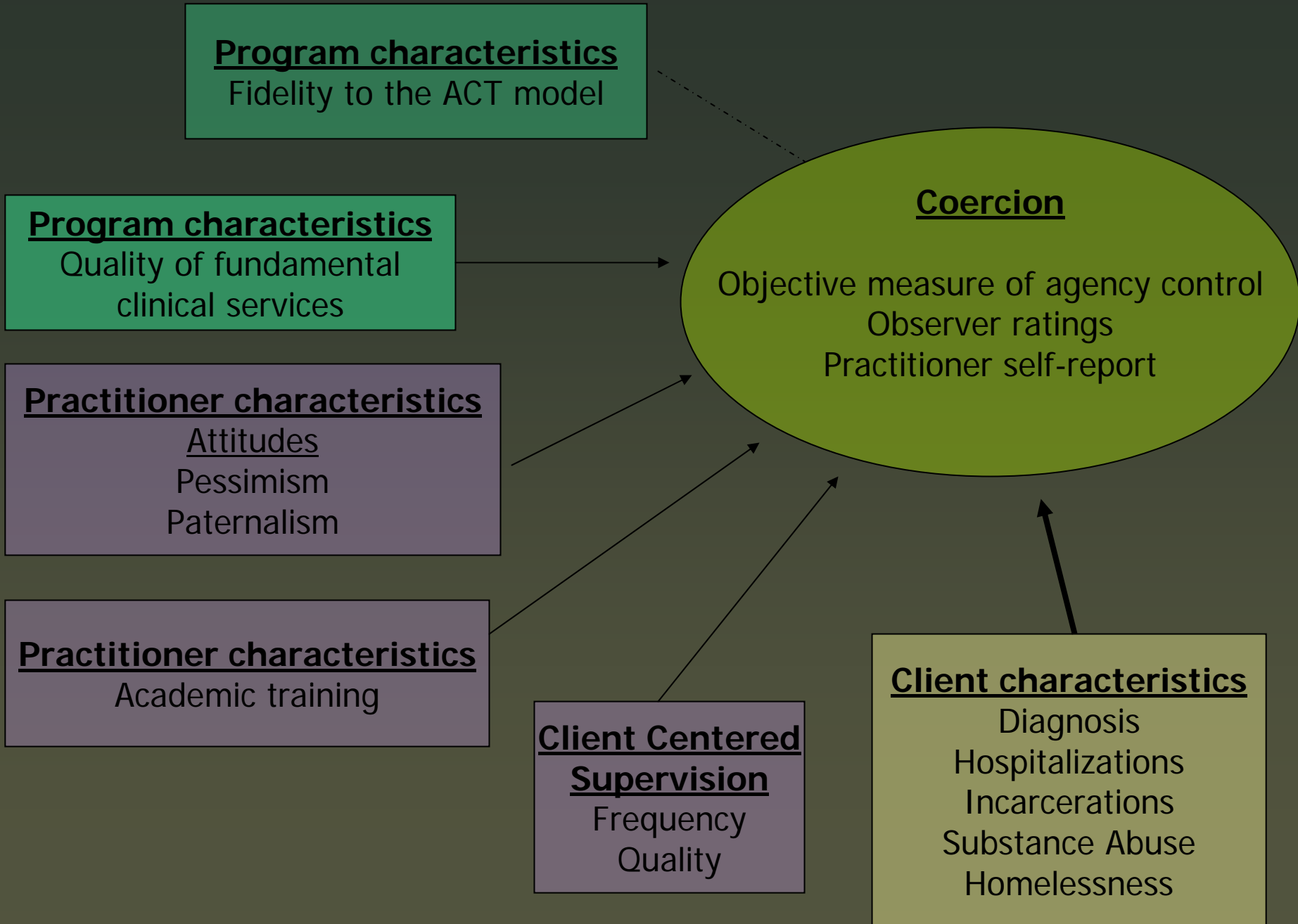
Frequency
Quality

Client characteristics

Diagnosis
Hospitalizations
Incarcerations
Substance Abuse
Homelessness

Coercion

Objective measure of agency control
Observer ratings
Practitioner self-report



Methods



Design:

- Cross-sectional

Sampling pool consisted of all 30 mental health agencies in Indiana

Participant Sample:

- 25 teams implementing ACT in Indiana
- 200 practitioners

Sampling: Inclusion Criteria

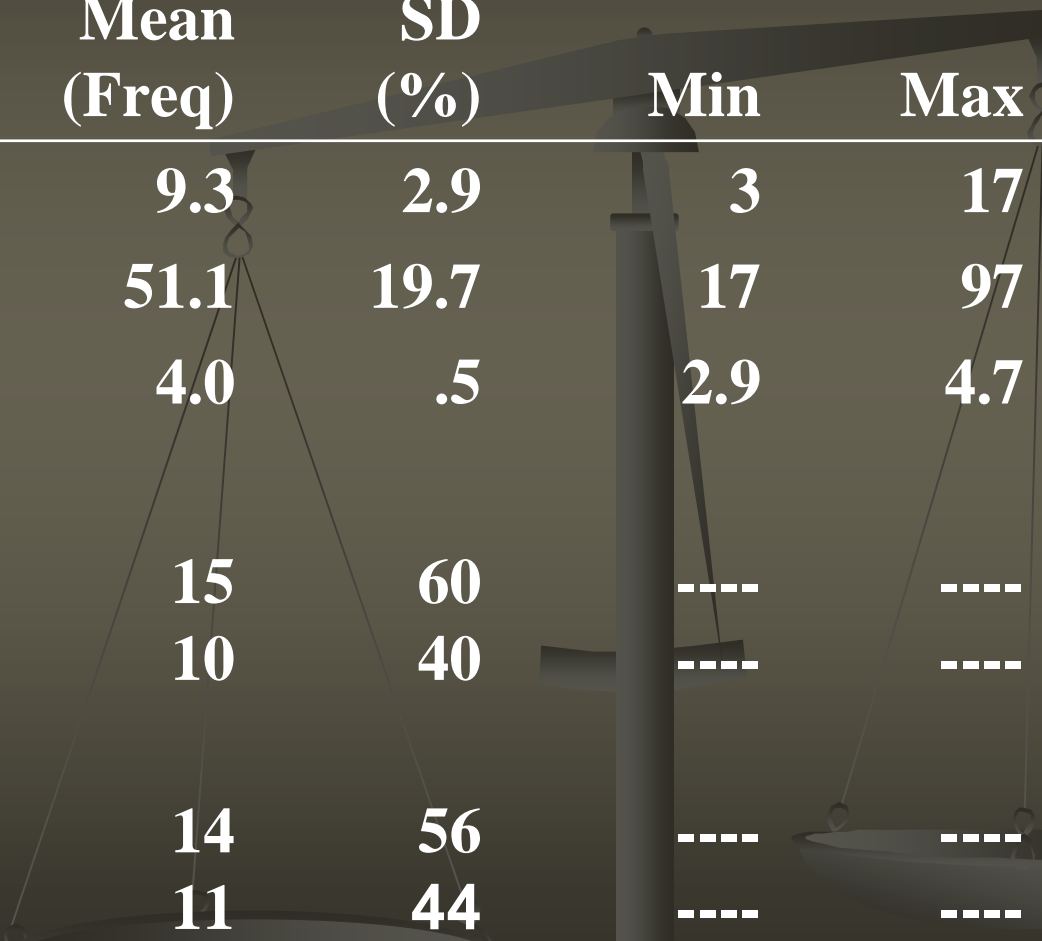
Teams

- Report either active implementation of ACT or presence of an intensive case management team
- One team per agency
- Delivering services for ≥ 6 months
- ≥ 3 members

Practitioners

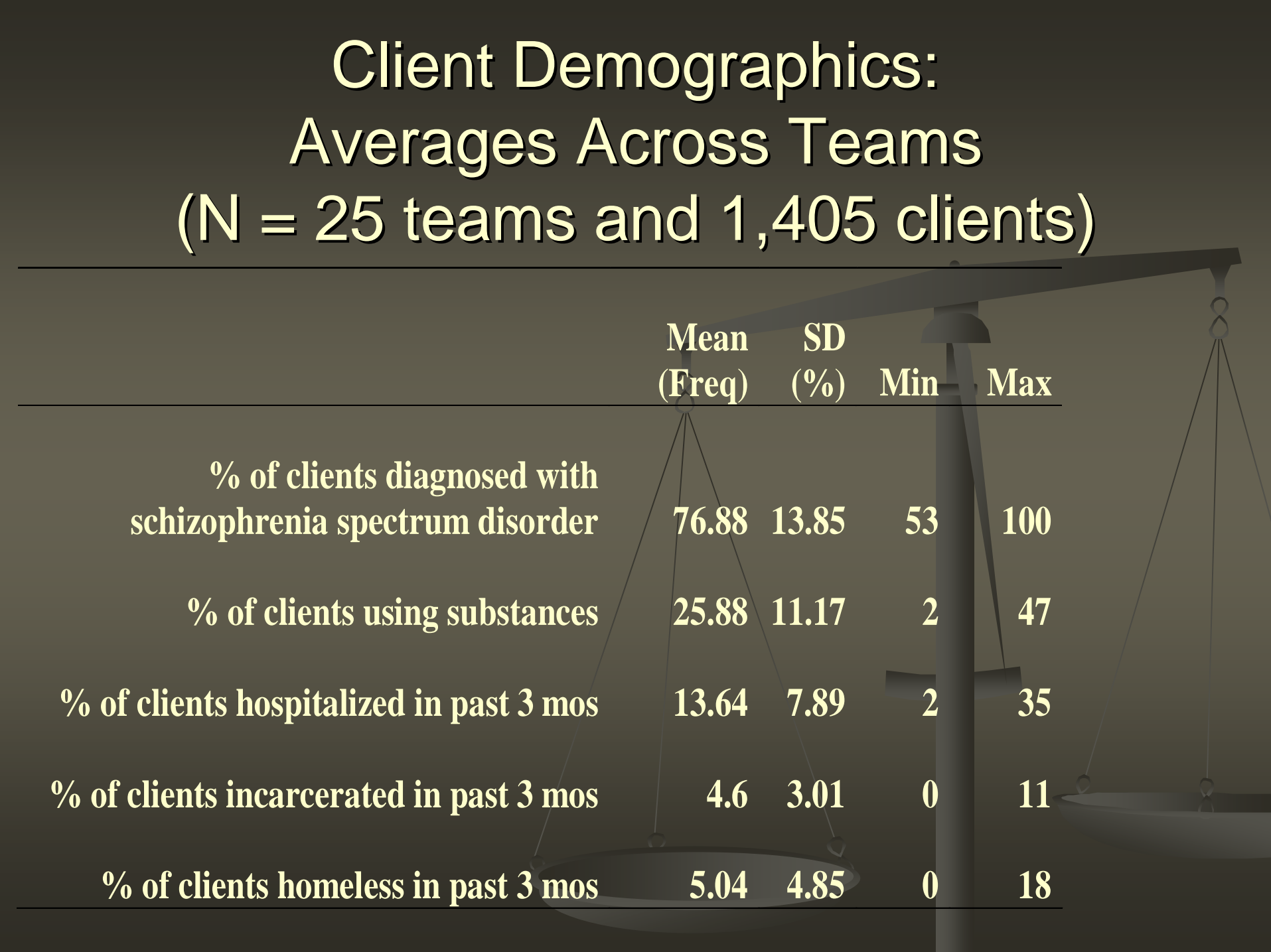
- ≥ 2 months experience with team

Team Demographics (N = 25)



	Mean (Freq)	SD (%)	Min	Max
Team Size	9.3	2.9	3	17
# of Clients Served	51.1	19.7	17	97
Program Fidelity (N = 24)	4.0	.5	2.9	4.7
Location				
Urban	15	60	----	----
Rural	10	40	----	----
Tenure				
< 3 years	14	56	----	----
≥ 3 years	11	44	----	----

Client Demographics: Averages Across Teams (N = 25 teams and 1,405 clients)



	Mean (Freq)	SD (%)	Min	Max
% of clients diagnosed with schizophrenia spectrum disorder	76.88	13.85	53	100
% of clients using substances	25.88	11.17	2	47
% of clients hospitalized in past 3 mos	13.64	7.89	2	35
% of clients incarcerated in past 3 mos	4.6	3.01	0	11
% of clients homeless in past 3 mos	5.04	4.85	0	18

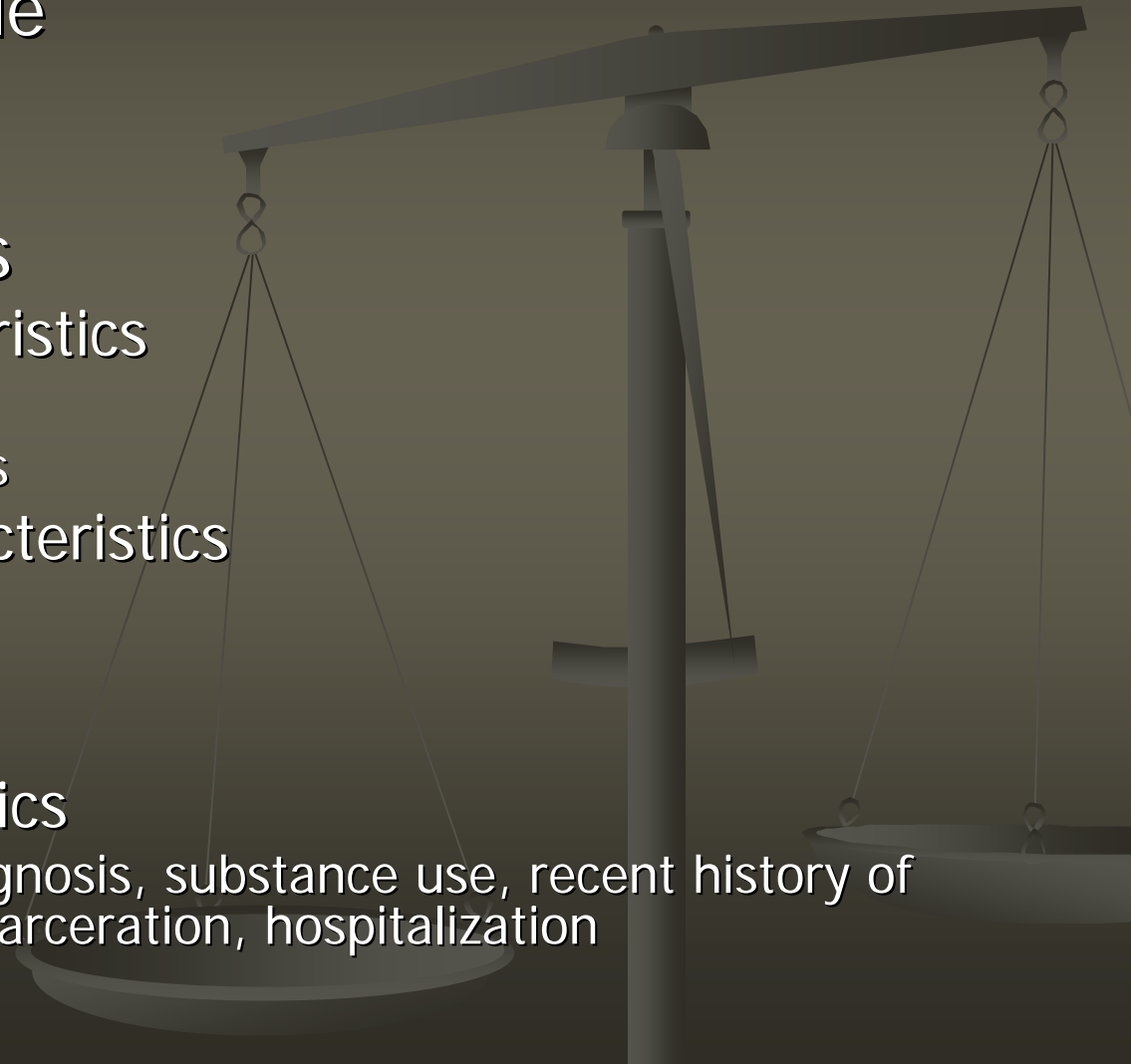
Measures



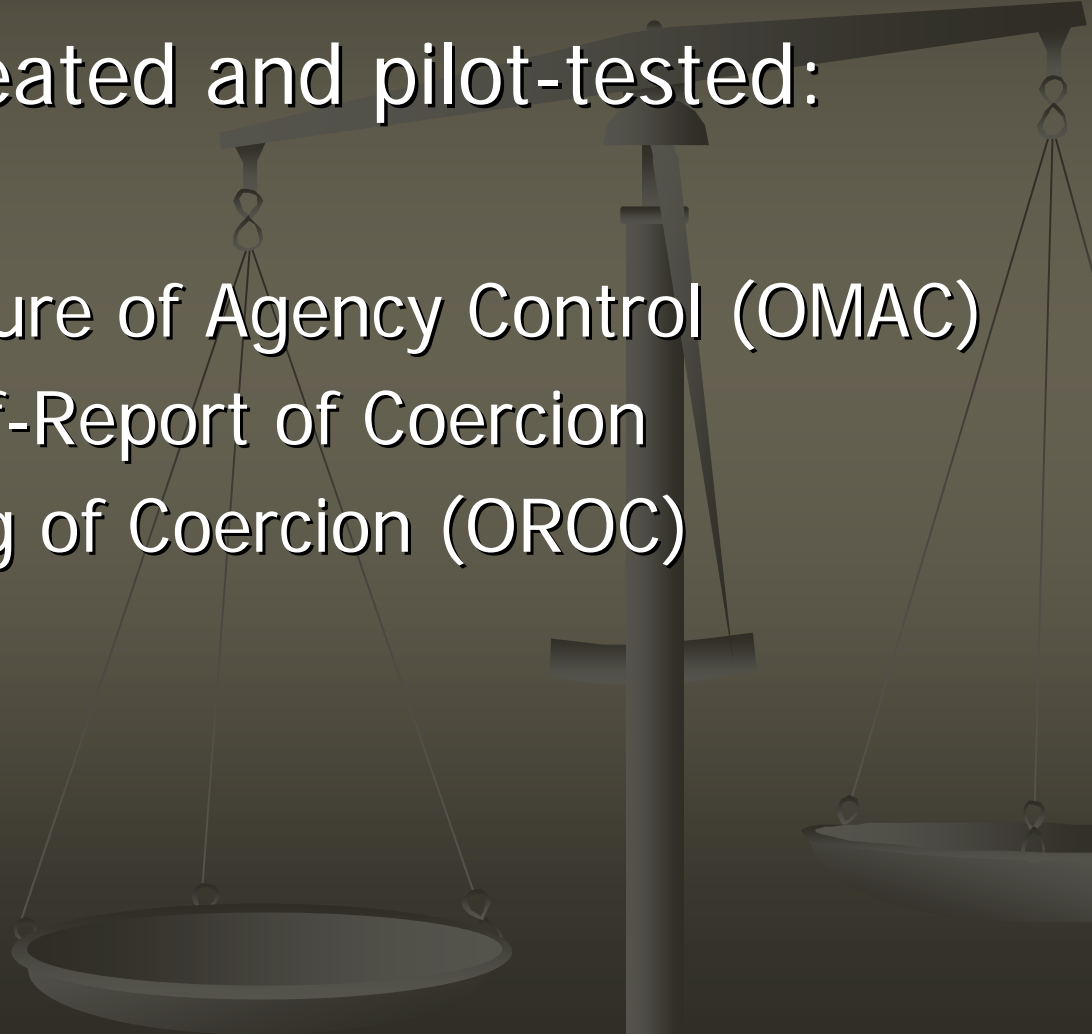
Measurement

- Dependent variable
 - Coercion

- Predictor variables
 - Program characteristics
 - ACT Fidelity
 - Quality of Services
 - Practitioner characteristics
 - Training
 - Attitudes
 - Supervision
 - Client characteristics
 - Schizophrenia diagnosis, substance use, recent history of homelessness, incarceration, hospitalization



Coercion

- Three scales created and pilot-tested:
 - Objective Measure of Agency Control (OMAC)
 - Practitioner Self-Report of Coercion
 - Observer Rating of Coercion (OROC)
- 

Objective Measure of Agency Control (OMAC)

- Percent of clients served by team who are currently:
 - On an involuntary inpatient commitment (Inv. Inpt)
 - On an involuntary outpatient commitment (IOC)
 - Have agency assigned as representative payee (Money)
 - Receiving depot (IM) shot and/or daily medication monitoring by team (Meds)
 - (Of clients with a dual diagnosis) receive urine screenings or breathalyzers at least monthly (SA monitoring)
 - Live in an agency-owned/leased residence (Housing)

Practitioner Self-Report of Coercion

- Named “Mental Health Practitioner Self-Report of Clinical Practices”
 - 11 items reflect general clinical practices
 - 5 items intended to capture social desirability response bias
 - 14 items that reflect coercive practices
 - Items reflect four areas indicative of coercion:
 - use of involuntary commitment
 - withholding of valued resources
 - medication and substance abuse monitoring
 - withholding of information
 - Response options: 5-point Likert scale reflecting frequency of practice (never, rarely, occasionally, frequently, always)

Observer Rating of Coercion (OROC)

Staff refer to clients in a negative and disrespectful manner (e.g., during team meeting).
Number of staff this is true for:

Overall impact of those who are negative and disrespectful:


The team does not make attempts to employ the least coercive interventions (e.g., persuasion, behavioral contracting) before resorting to more coercive interventions (e.g., withholding of valuable resources, involuntary commitment).

Staff do not appear to honor choices that clients make and tend to instead micromanage them (e.g., directing clients in a very detailed manner or providing feedback or giving direction for relatively small day-to-day decisions). Number of staff this is true for:

Overall impact of those who micromanage:

The team fails to systematically review whether clients can receive less intensive services (e.g., less frequent medication monitoring) in an effort to promote client independence. Thus, clients appear to receive a level of intensity of services that is inconsistent with their level of functioning.

Program Characteristics: ACT Fidelity

- Dartmouth Assertive Community Treatment Scale (DACTS)
 - 28 items
 - 3 dimensions:
 - human resources
 - organizational boundaries
 - nature of services
 - 5-point anchors, with 5 indicating high fidelity
 - Total scale score (mean) is used to index fidelity
- 

Program Characteristics: Quality of Fundamental Services

- General Organizational Index (GOI)
 - Four items selected from GOI:
 - Assessment
 - Individualized treatment plan
 - Individualized treatment
 - Outcome monitoring
 - Items measured on a 5-point scale of behavioral anchors, with 5 indicating high quality practice

Practitioner Characteristics



- Training
 - Highest level of education, as reported on a demographic questionnaire
- Pessimistic and Paternalistic Attitudes
 - Adaptation of The Clinician Optimism Scale (Grusky et al., 1989)
 - 8 items measured on a 5-point Likert scale
 - **Low scores** represent greater paternalistic and pessimistic attitudes

Client Centered Supervision

Supervision can be either client-centered (e.g., focusing on client strengths, problems, and strategies to overcome problems) or logistical (e.g., focusing on paperwork, productivity, and other policy-driven topics). Thinking about the client-centered supervision that you receive, please assess the degree to which you are satisfied with each of the following aspects, using the scale below:

- Frequency
 - Scheduled individual sessions
- Quality
 - Adaptation of Satisfaction with my Supervisor Scale (Scarpello & Vandenberg, 1987)

Client Characteristics

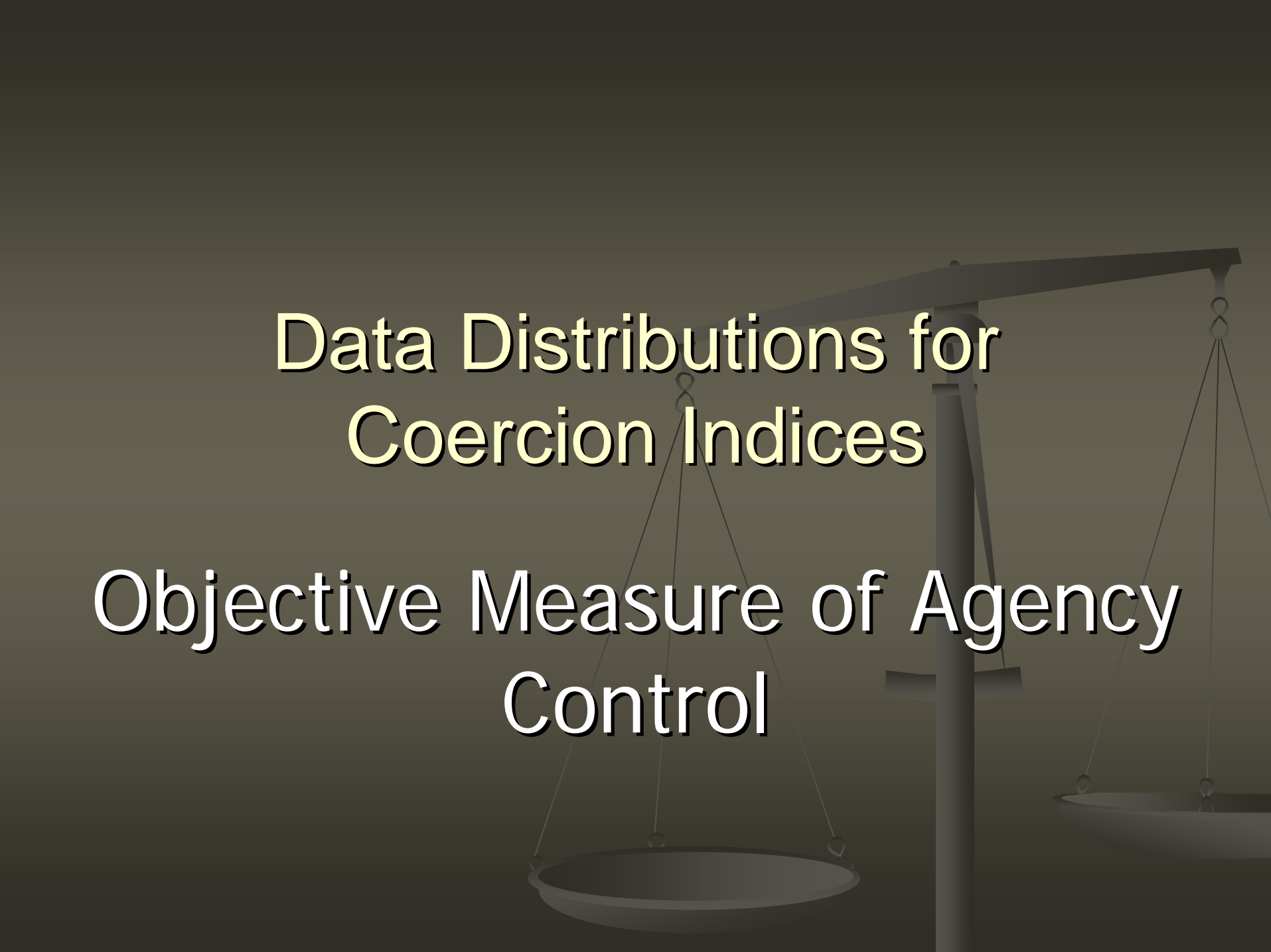


- Client percentages:
 - Schizophrenia spectrum diagnosis
 - Homelessness*
 - Incarceration*
 - Hospitalizations*
 - Substance abuse
- Interview or reliance on Consumer Outcome Monitoring Package (COMP) data
 - Data is collected monthly and reported quarterly to the ACT Center of Indiana

* Calculated from number of individuals in past 3 months

Psychometric Properties of Scales

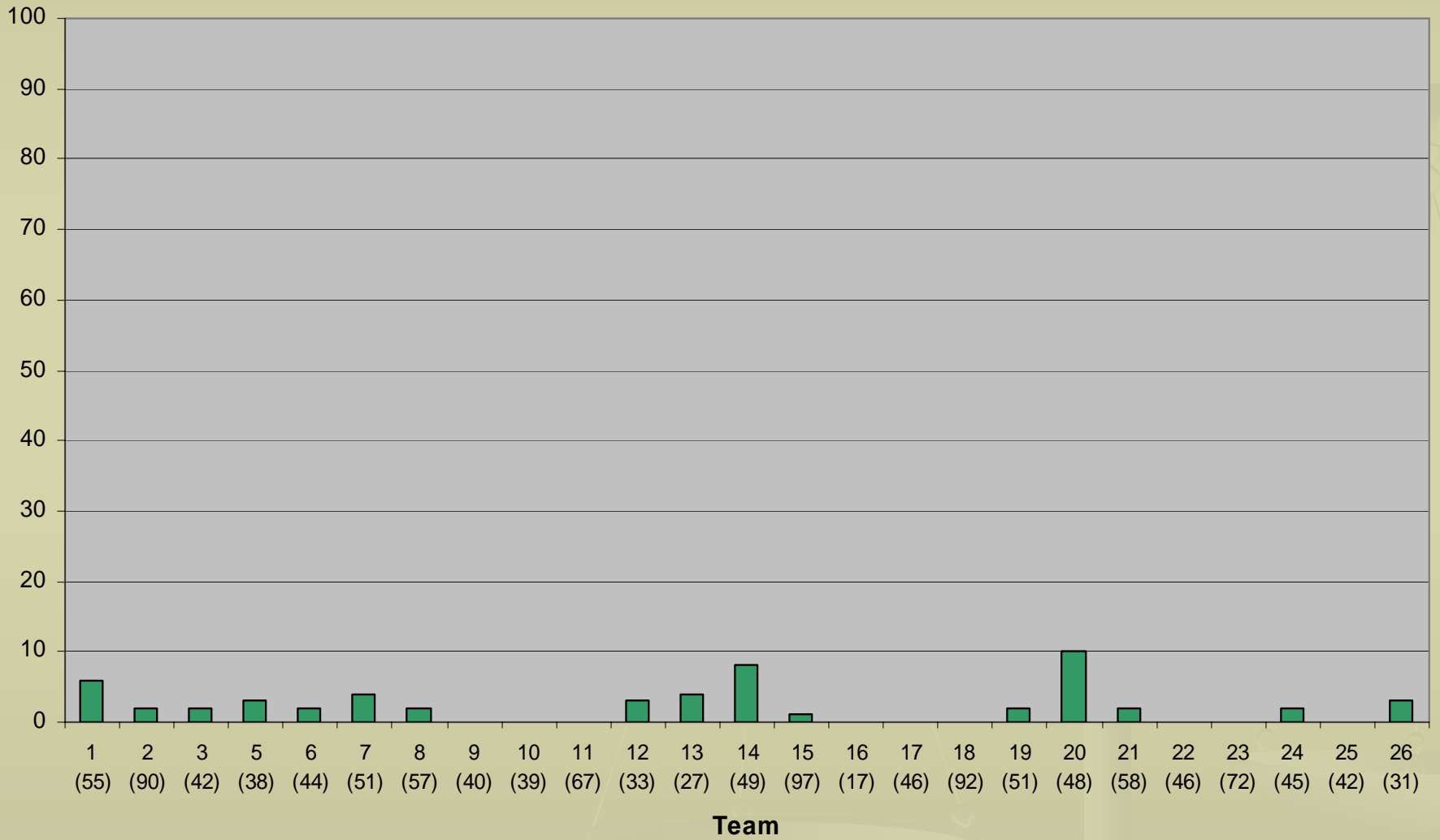
Scale	# of items	# of participants	Cronbach's alpha coefficient
Practitioner Self-Report of Coercion	*13	188 practitioners	0.82
Observer Rating of Coercion	6	19 sites	0.92
Quality of Client-Centered Supervision	11	158 practitioners	0.94
Clinician Optimism Scale	8	192 practitioners	0.77



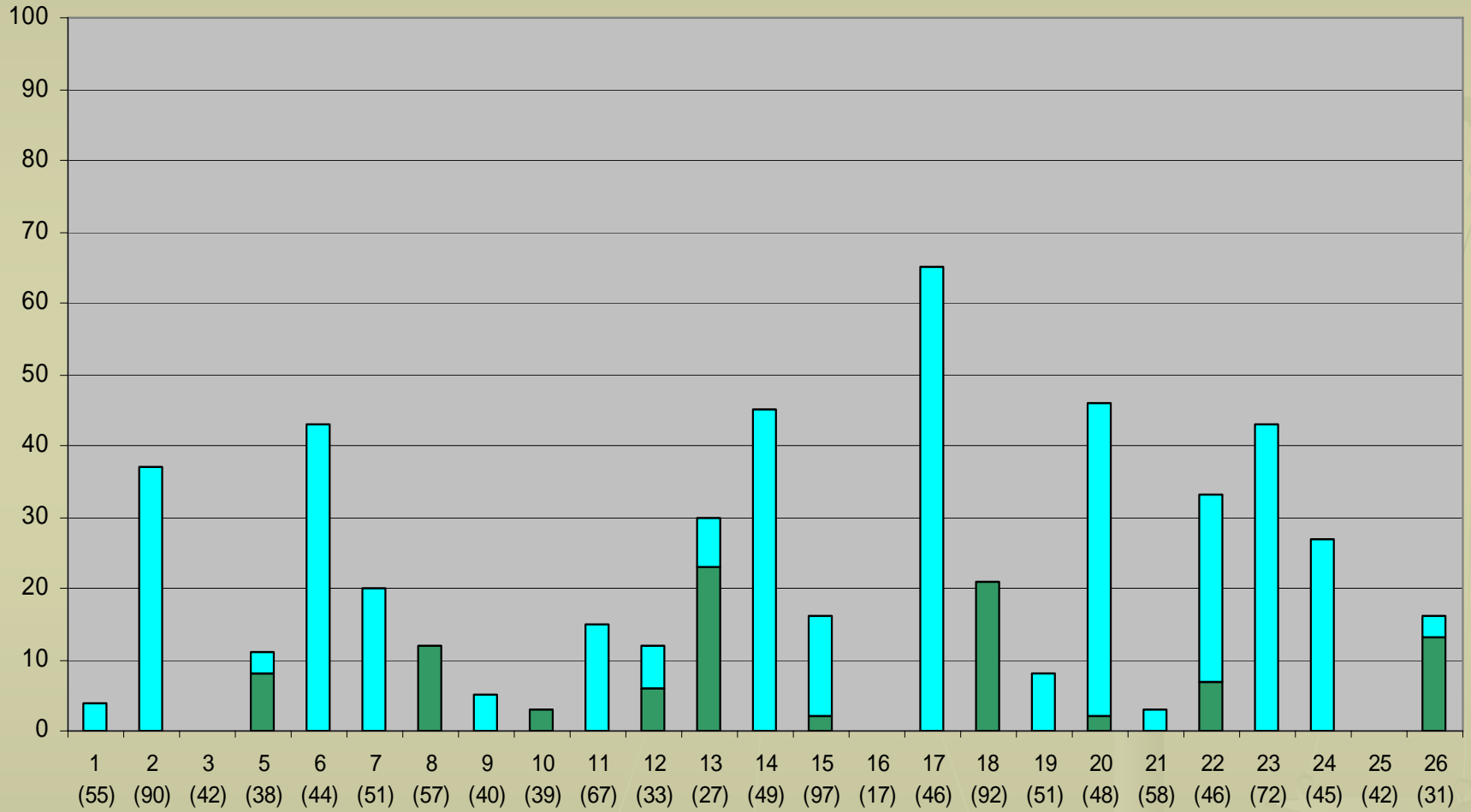
Data Distributions for Coercion Indices

Objective Measure of Agency Control

Percent of Clients on Inpatient Commitment



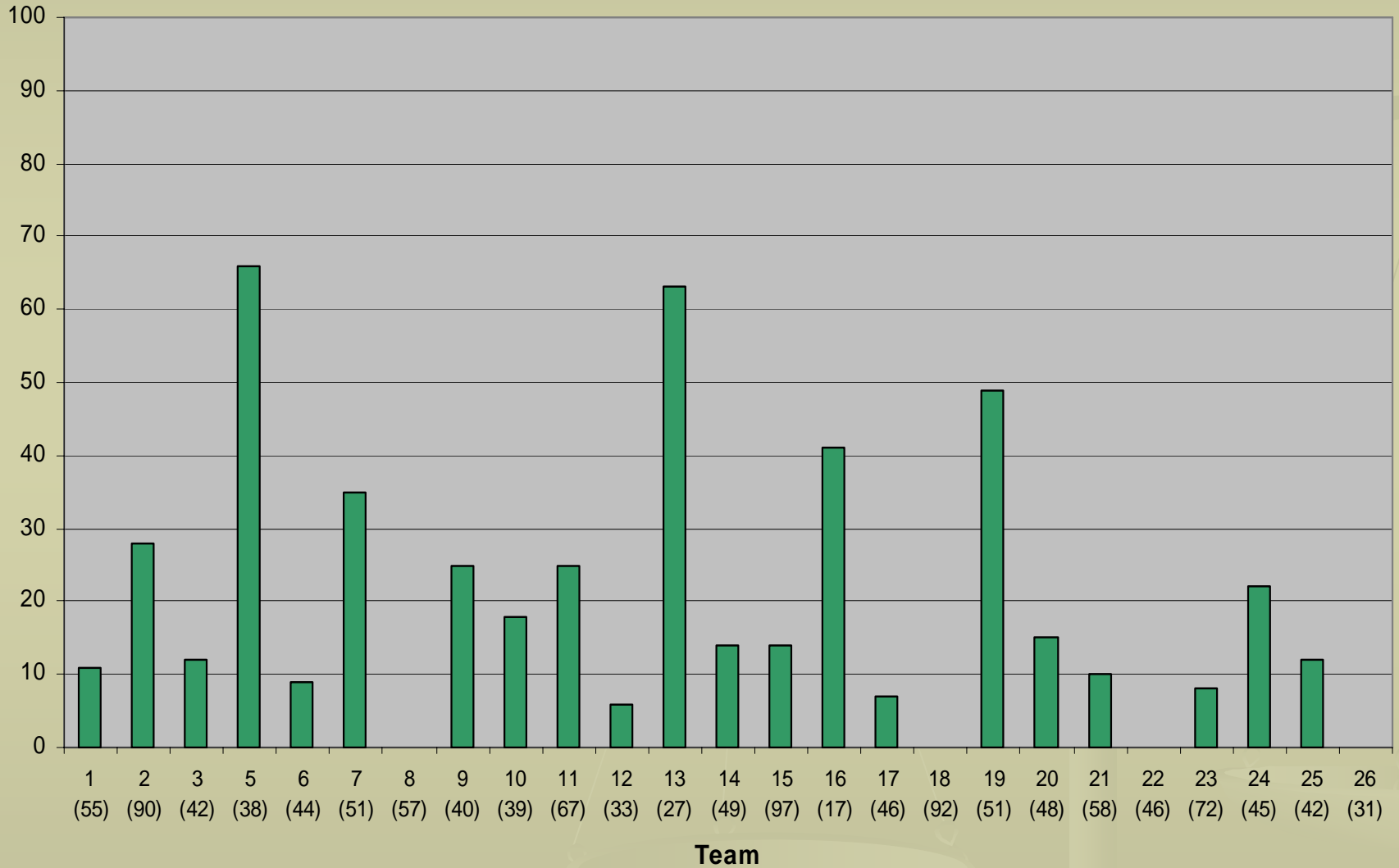
Percent of Clients on an Involuntary Outpatient Commitment



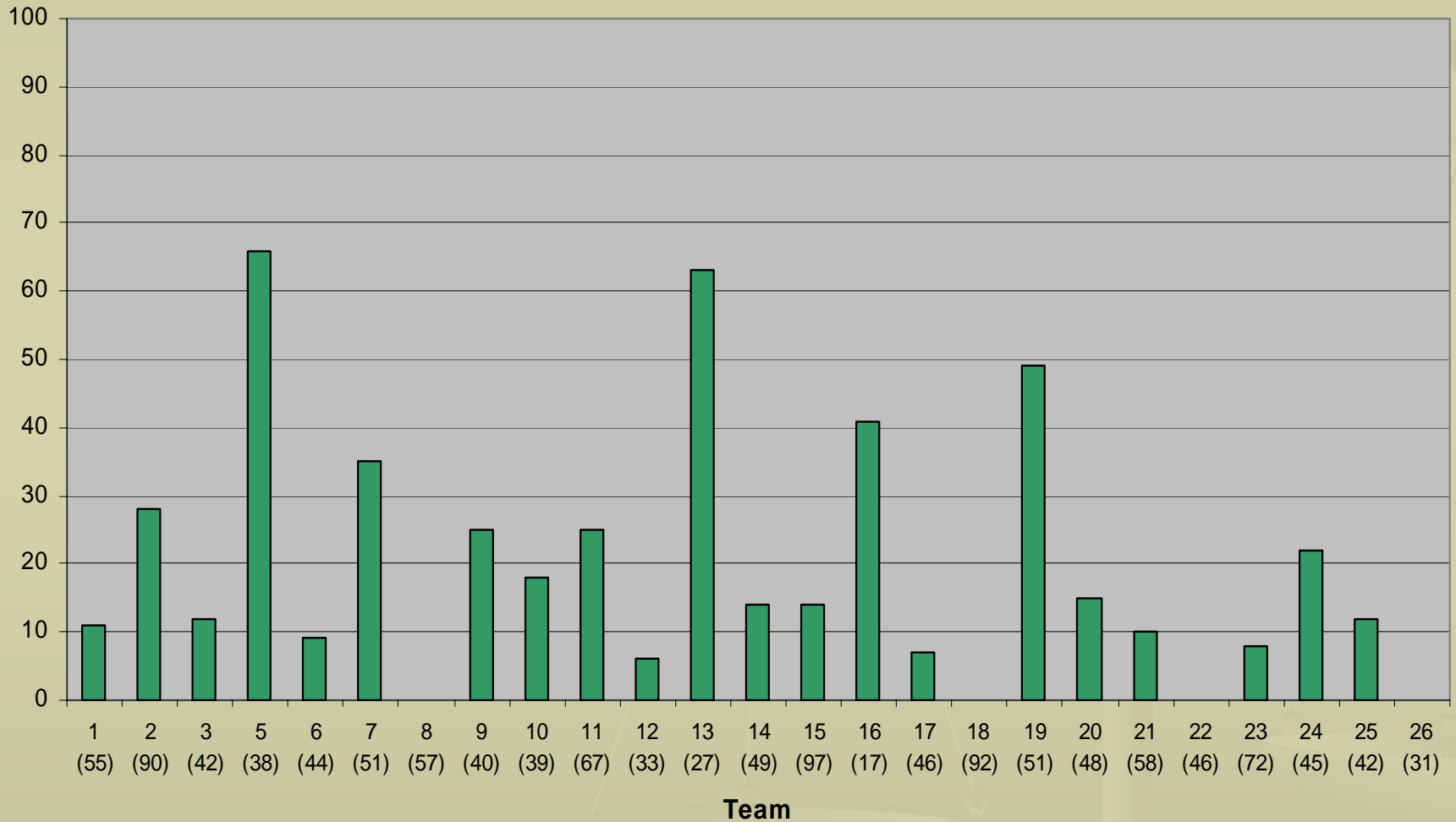
■ outpatient_not team initiated

■ outpt_team initiated

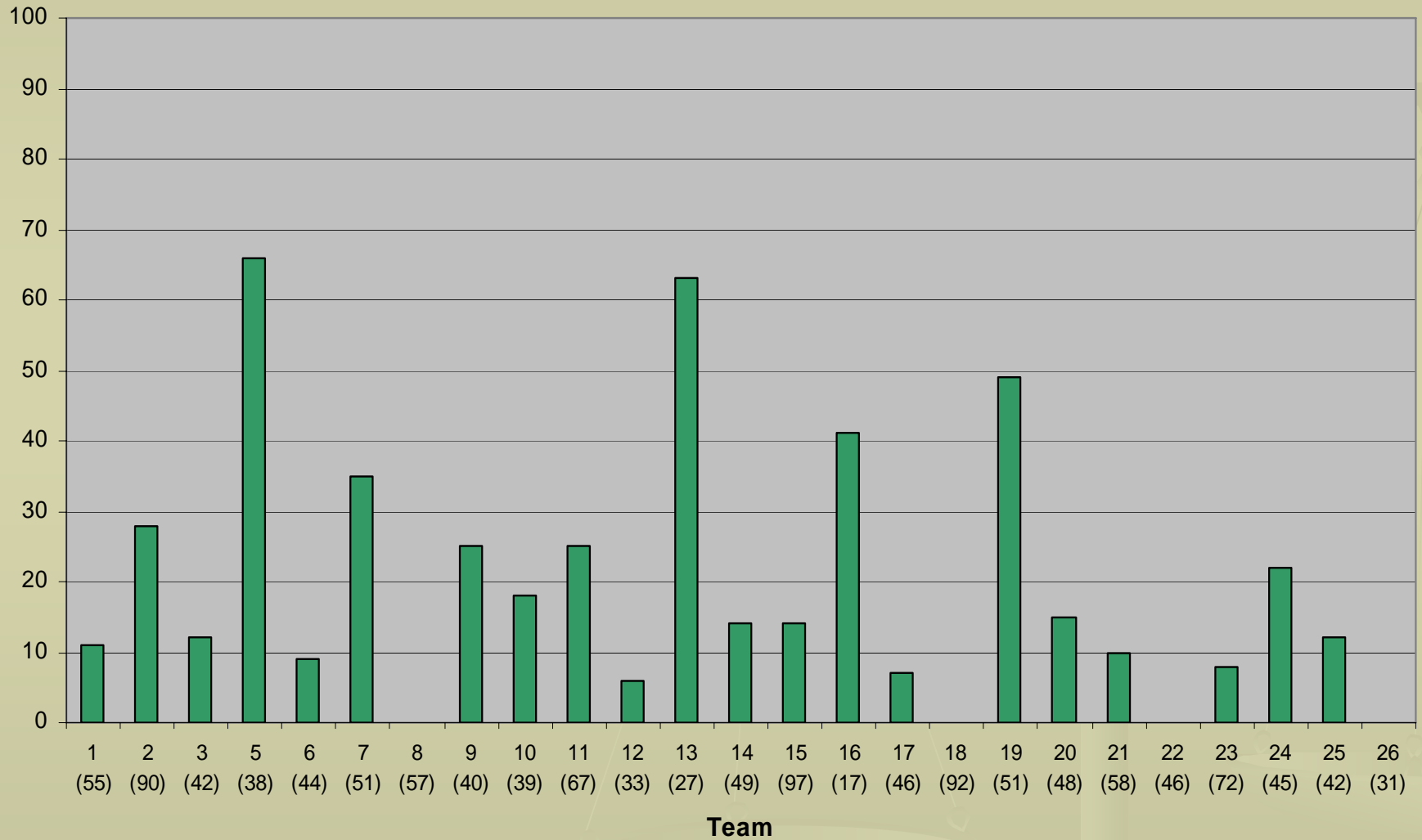
Percent of Clients with Agency Assigned as Rep Payee



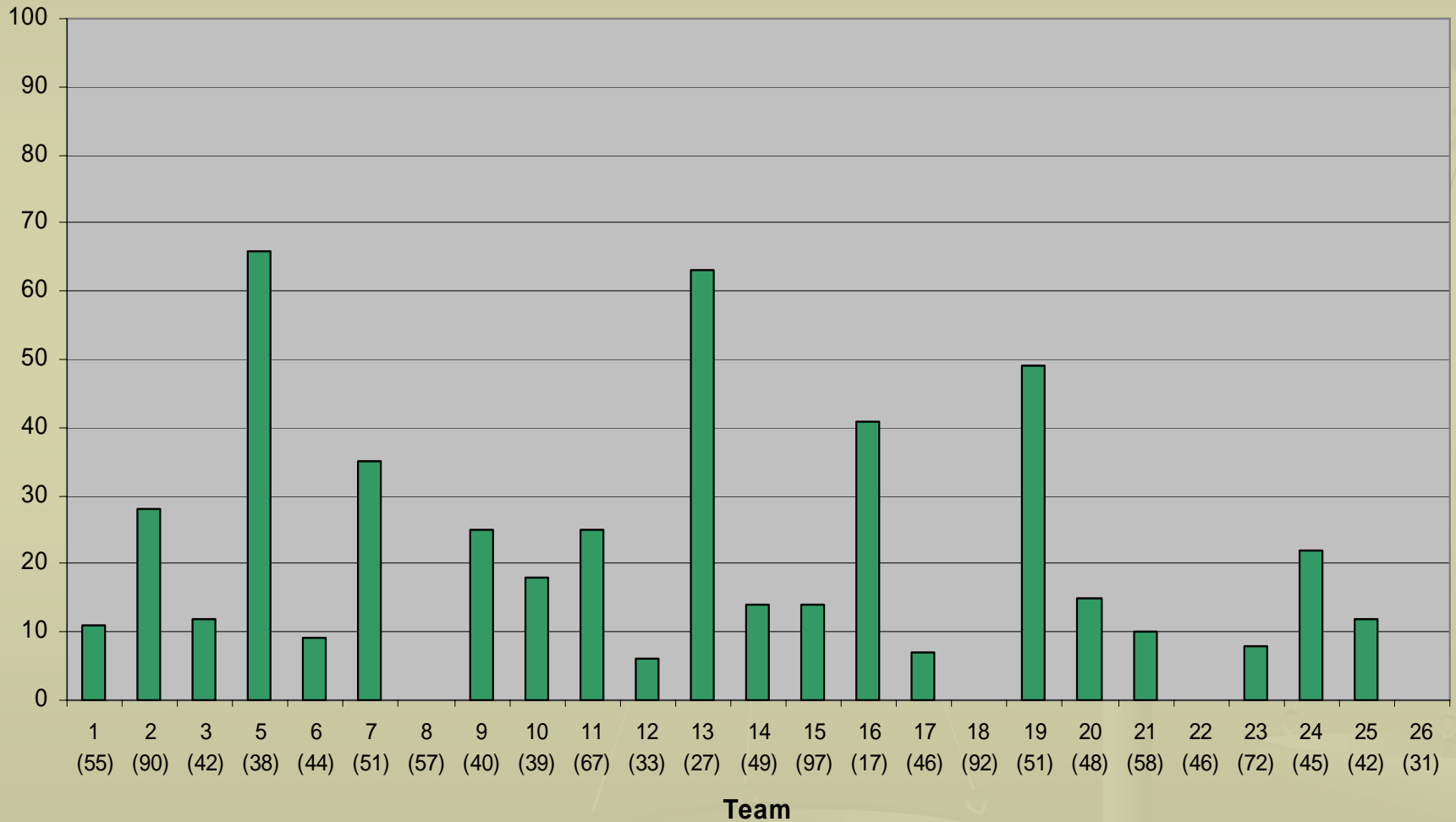
Percent of Clients Living in Agency Owned or Leased Housing



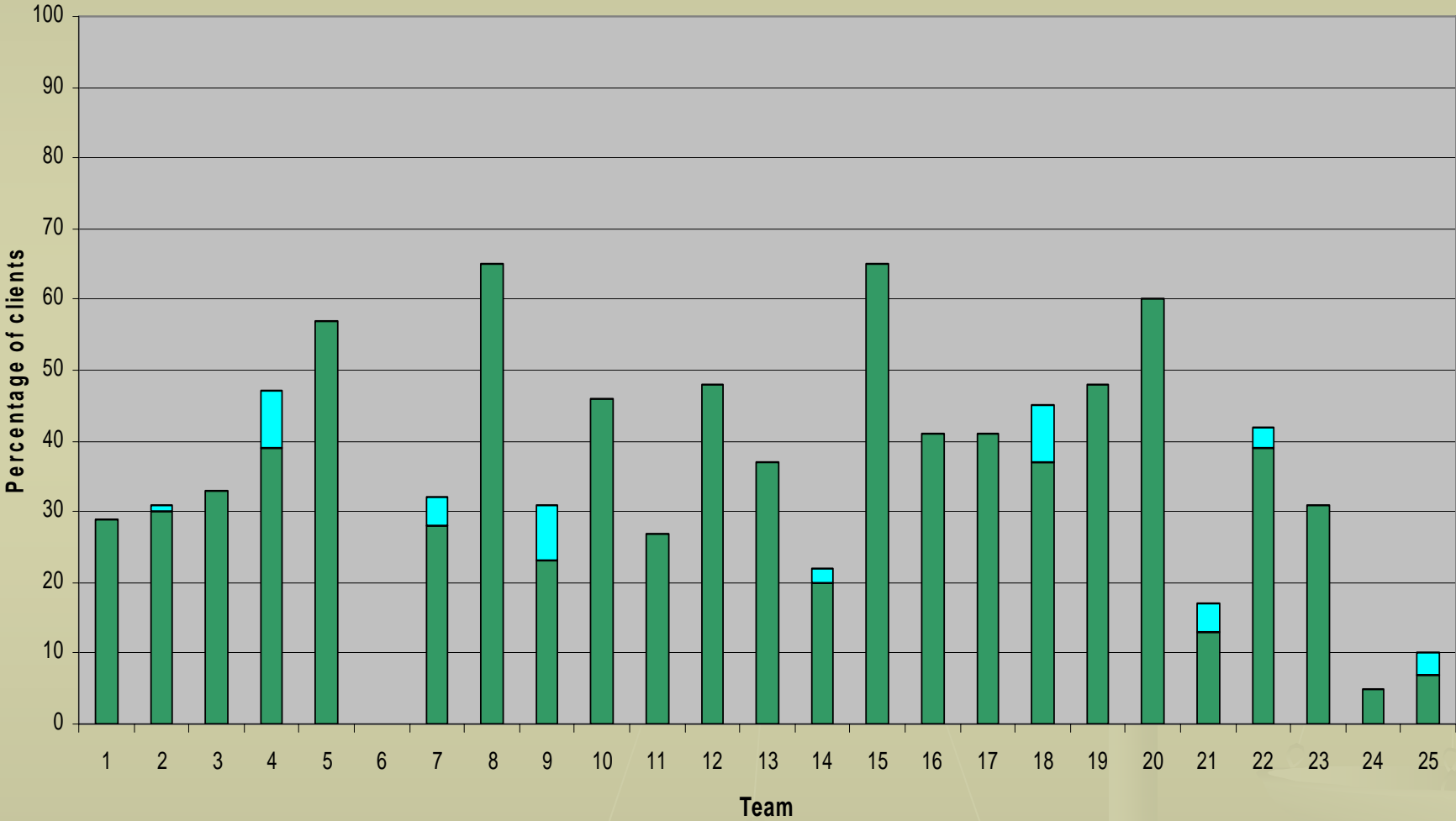
Percent of Clients Receiving Depot Injection



Percent of Clients Receiving Daily Med Monitoring From Team



Substance Use Monitoring



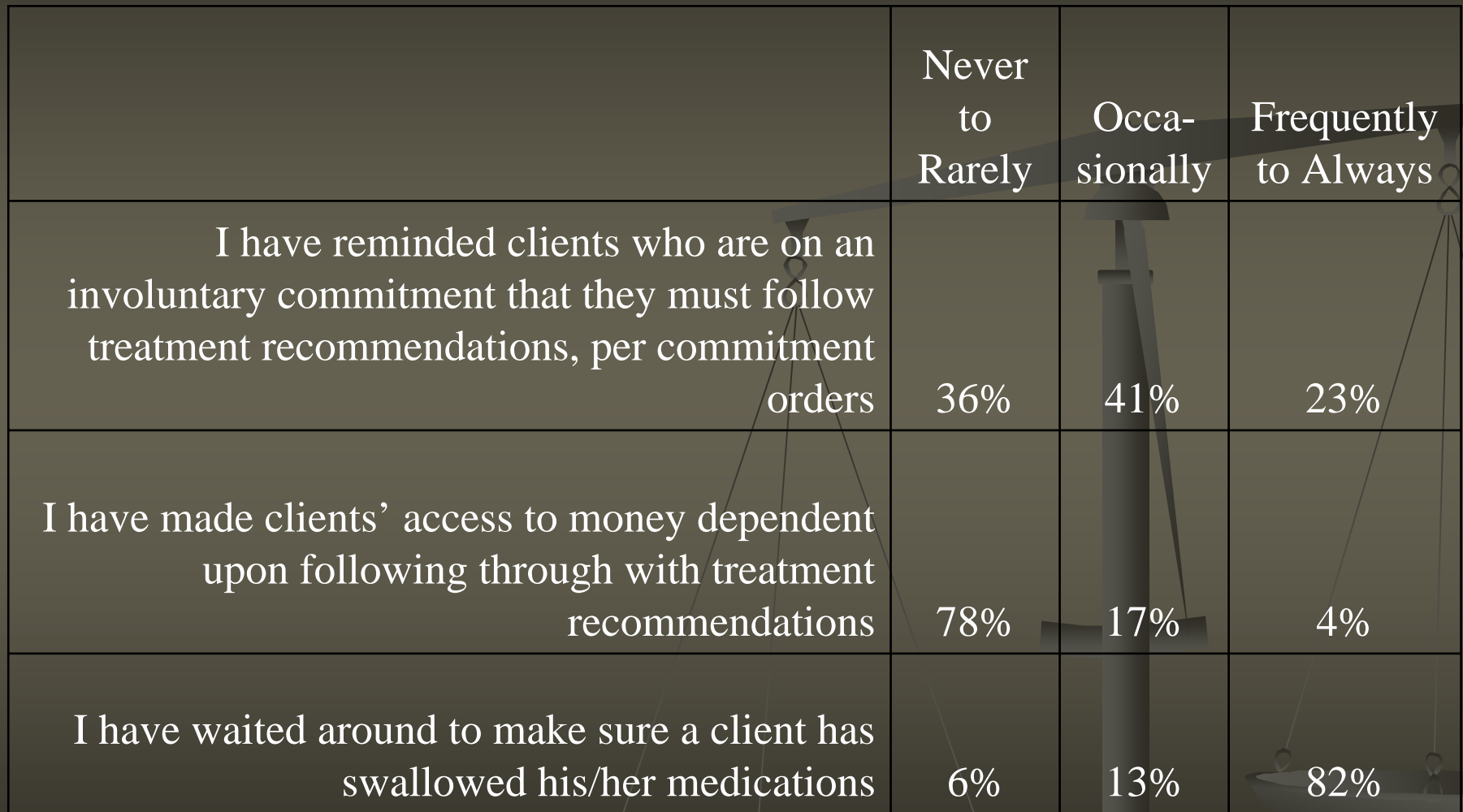
■ DD cls with no SA screen ■ DD cls with SA screen



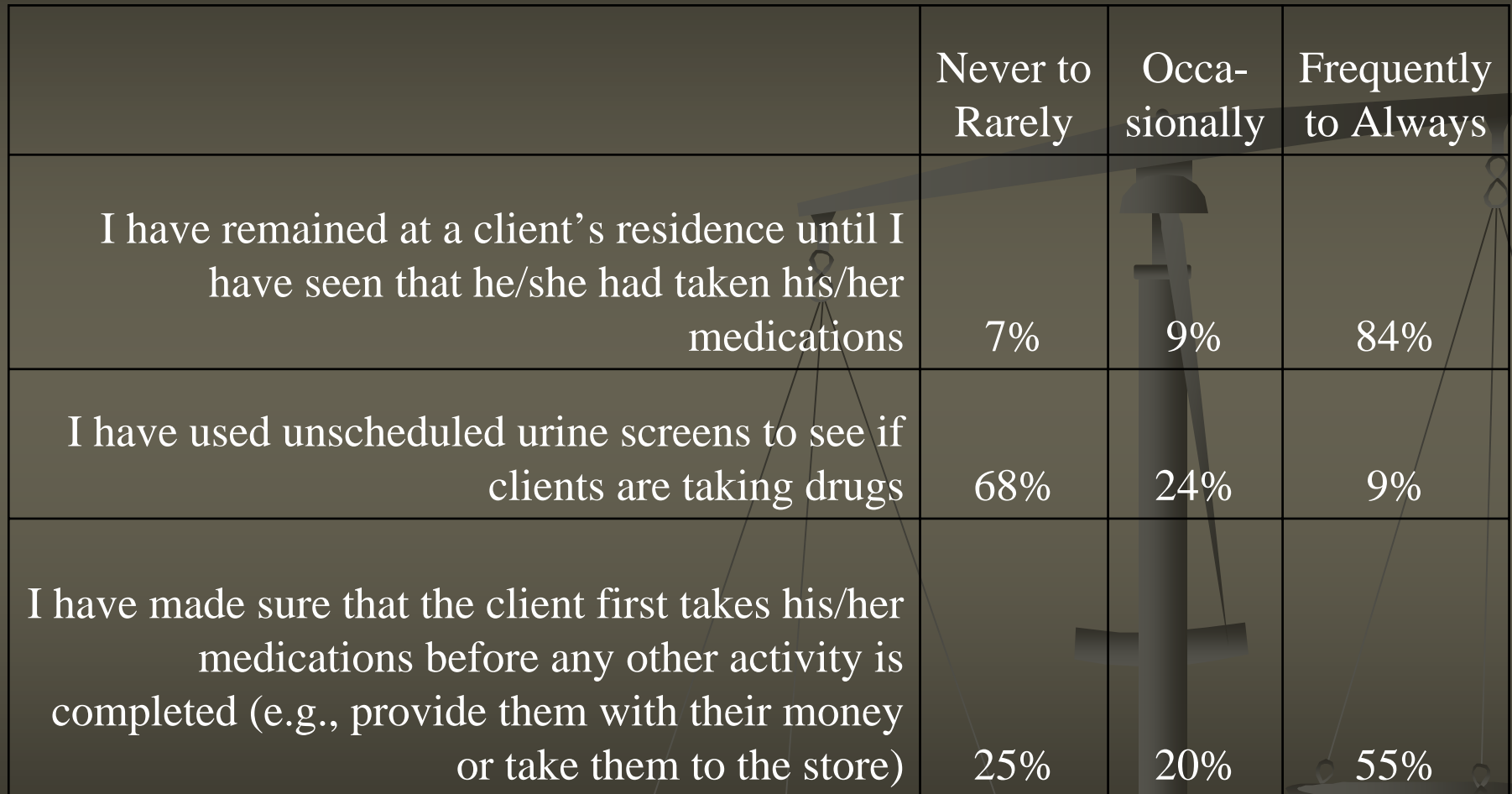
Data Distributions for Coercion Indices

Practitioner Self-Report of
Coercion

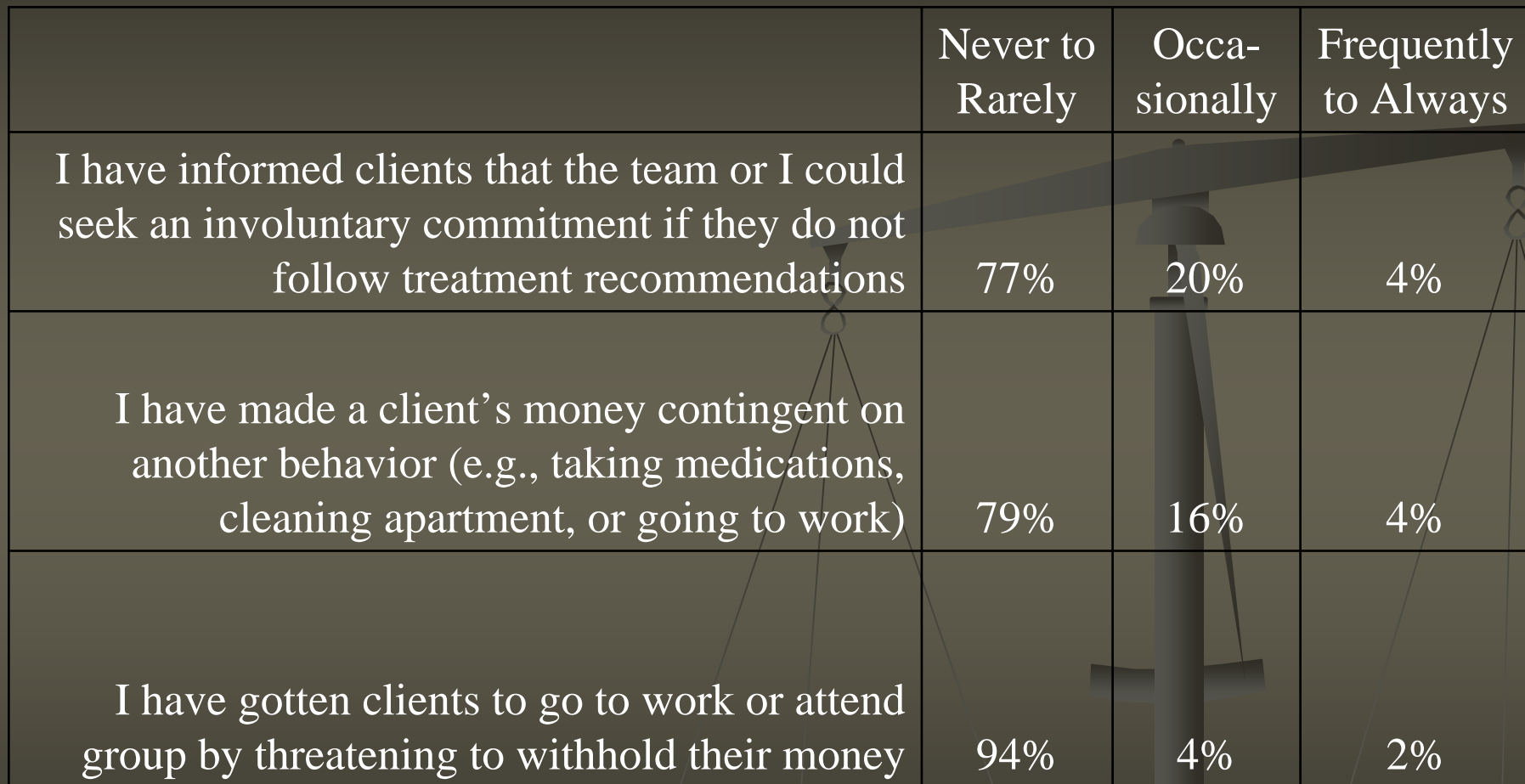
	Never to Rarely	Occasionally	Frequently to Always
I have told clients that I will assist them (e.g., find a job or help move to a new residence) when they change a behavior (e.g., stop drinking or start taking medications)	60%	17%	23%
I have told clients that I may have to stop working with them if they behave in a certain way	84%	11%	5%
I have reminded clients that they must follow through with treatment recommendations if they are to remain in their current residence	52%	30%	18%
I have purposely withheld information from clients because I believed it to be in their best interest	77%	19%	4%



	Never to Rarely	Occa- sionally	Frequently to Always
I have reminded clients who are on an involuntary commitment that they must follow treatment recommendations, per commitment orders	36%	41%	23%
I have made clients' access to money dependent upon following through with treatment recommendations	78%	17%	4%
I have waited around to make sure a client has swallowed his/her medications	6%	13%	82%



	Never to Rarely	Occasionally	Frequently to Always
I have remained at a client's residence until I have seen that he/she had taken his/her medications	7%	9%	84%
I have used unscheduled urine screens to see if clients are taking drugs	68%	24%	9%
I have made sure that the client first takes his/her medications before any other activity is completed (e.g., provide them with their money or take them to the store)	25%	20%	55%



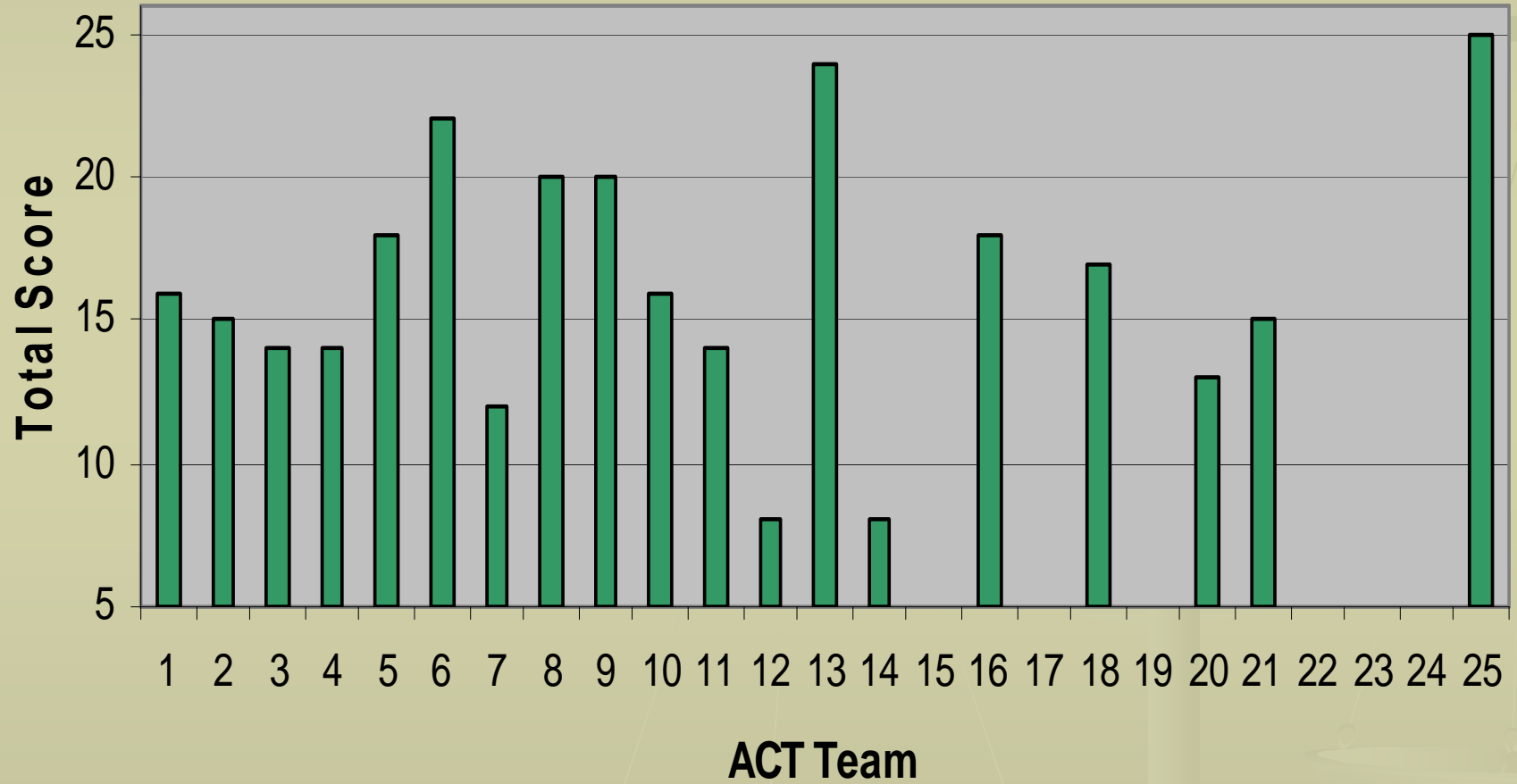
	Never to Rarely	Occasionally	Frequently to Always
I have informed clients that the team or I could seek an involuntary commitment if they do not follow treatment recommendations	77%	20%	4%
I have made a client's money contingent on another behavior (e.g., taking medications, cleaning apartment, or going to work)	79%	16%	4%
I have gotten clients to go to work or attend group by threatening to withhold their money	94%	4%	2%



Data Distributions for Coercion Indices

Observer Rating of Coercion

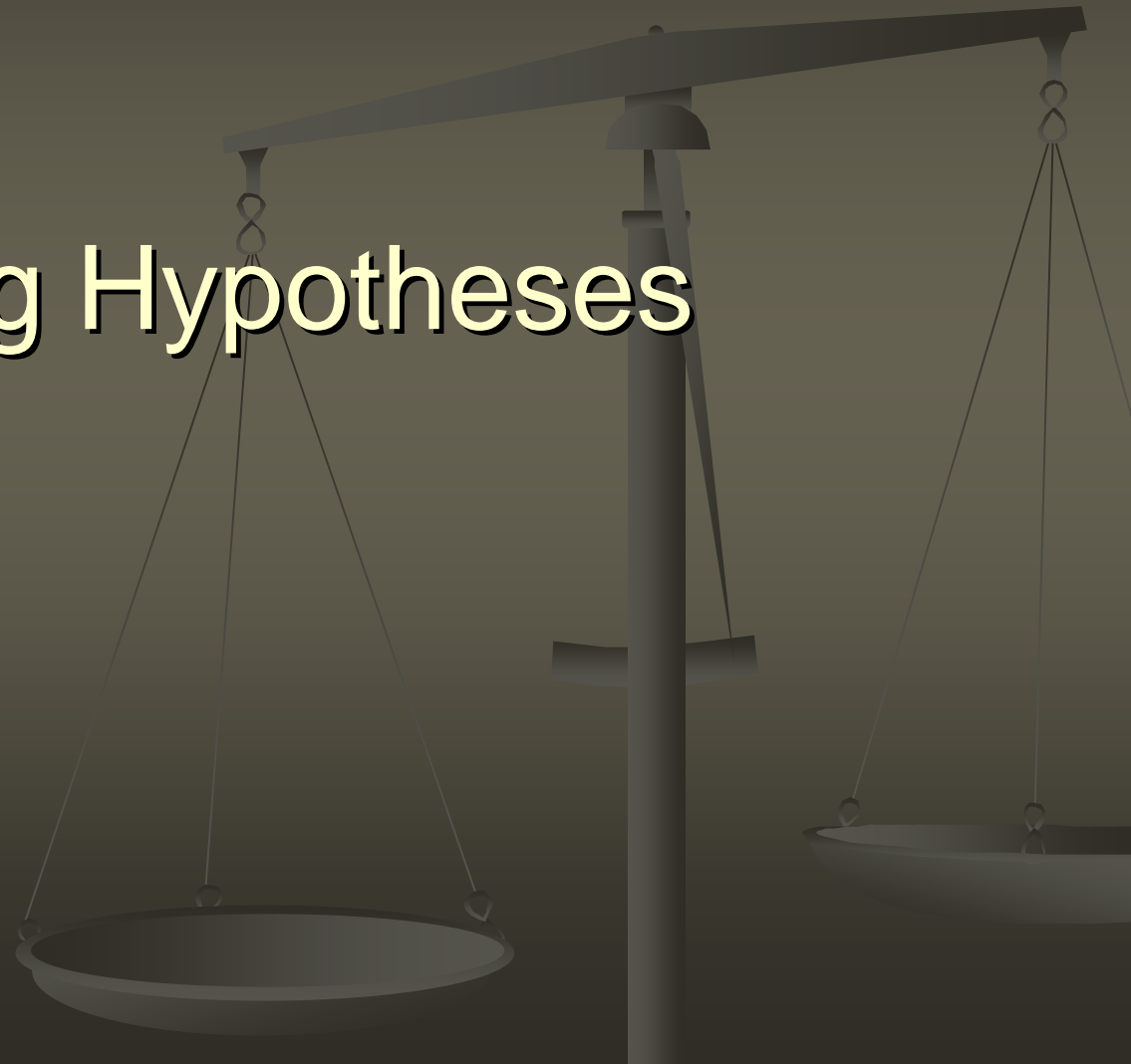
Observer Rating of Coercion



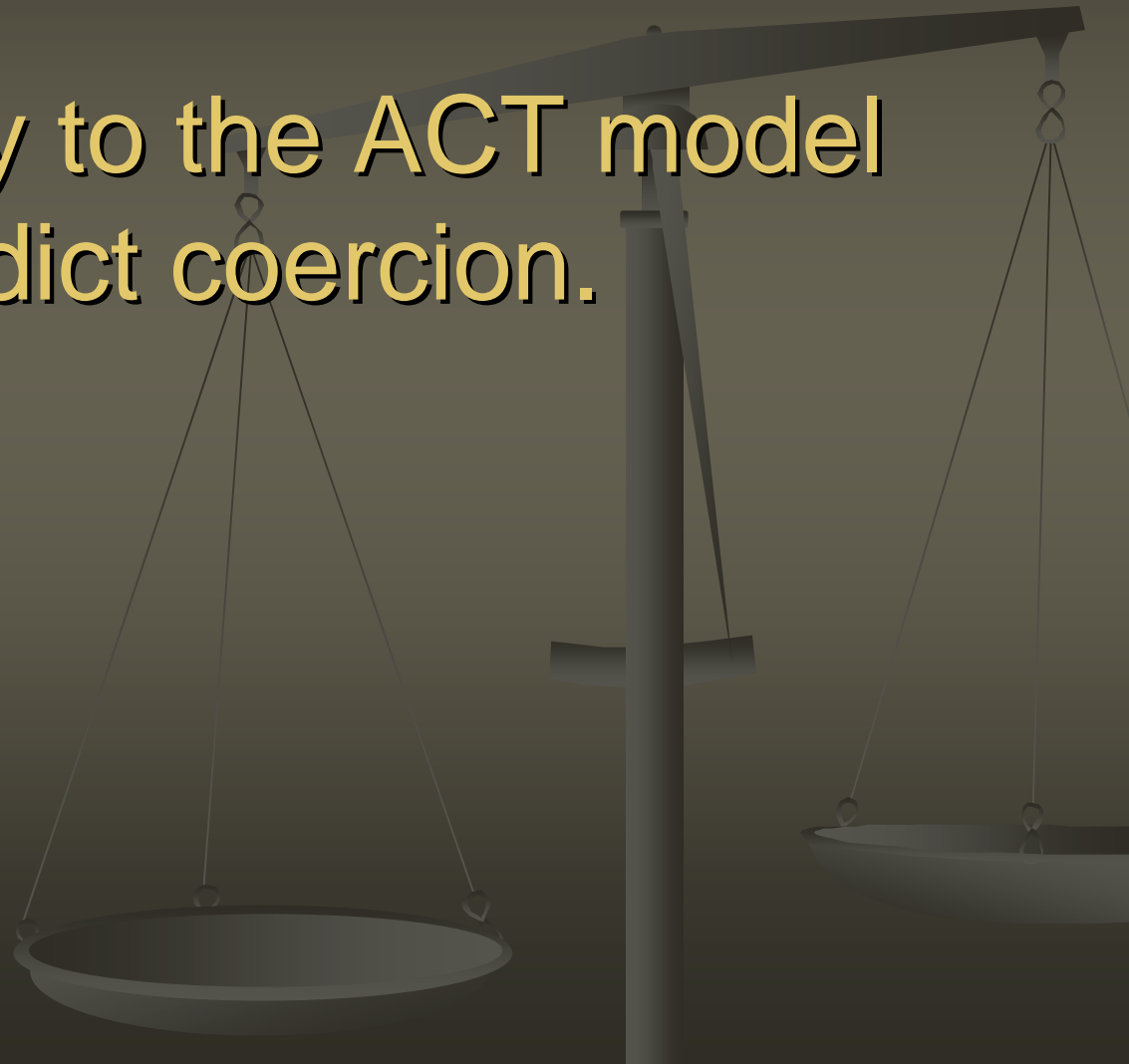
Relationships Between Coercion Indices

- Significant bivariate relationships among coercion indices:
 - OROC (n = 19) and Practitioner Self-Report of Coercion (using the most coercive team member's score) are moderately correlated ($r = .43, p = .07$)
 - Teams serving a greater percentage of clients who receive intensive med monitoring are reporting *less* frequent coercive practices**
 - Greater percentage of clients receiving intensive med monitoring associated with greater percentage of clients with agency as representative payee

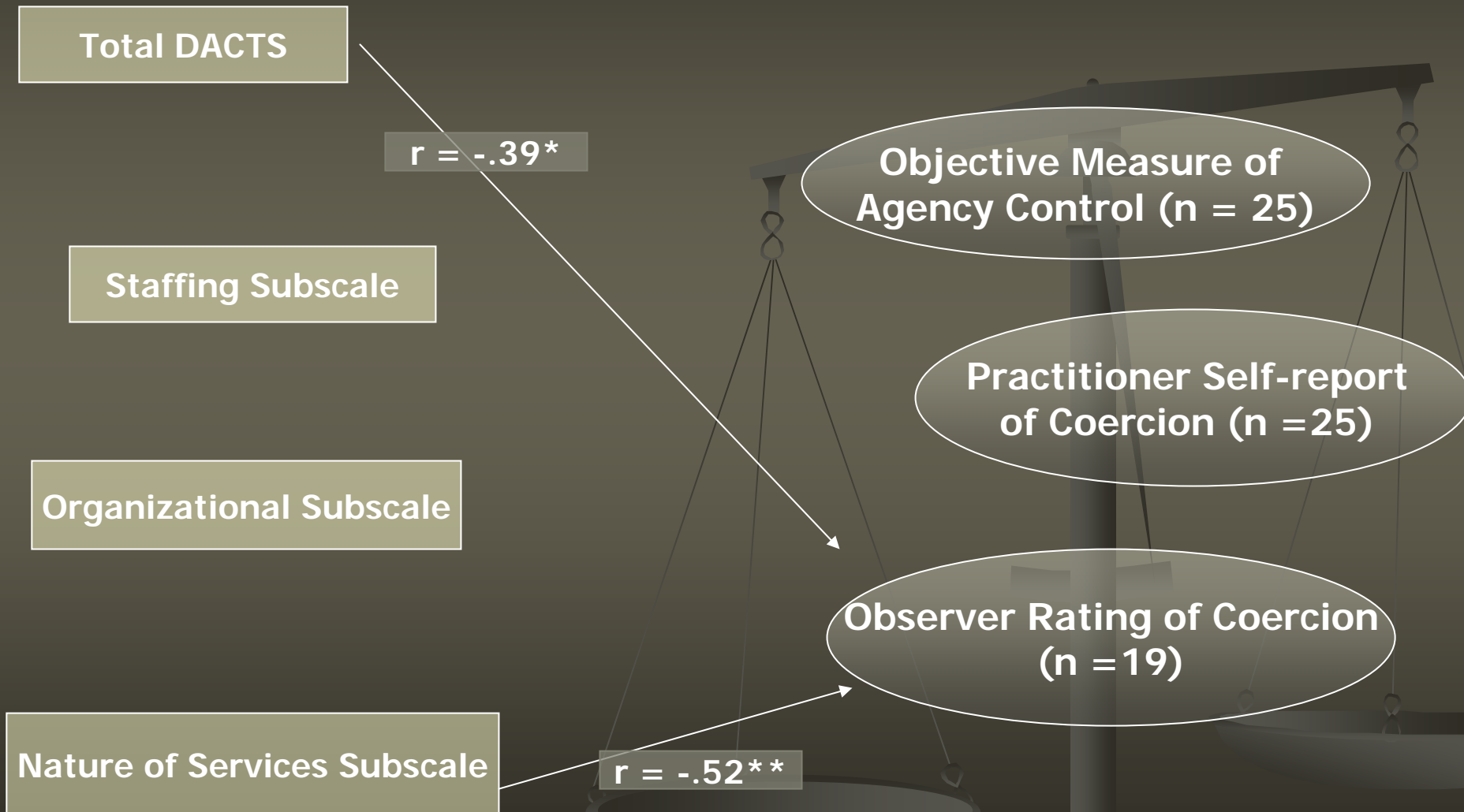
Testing Hypotheses



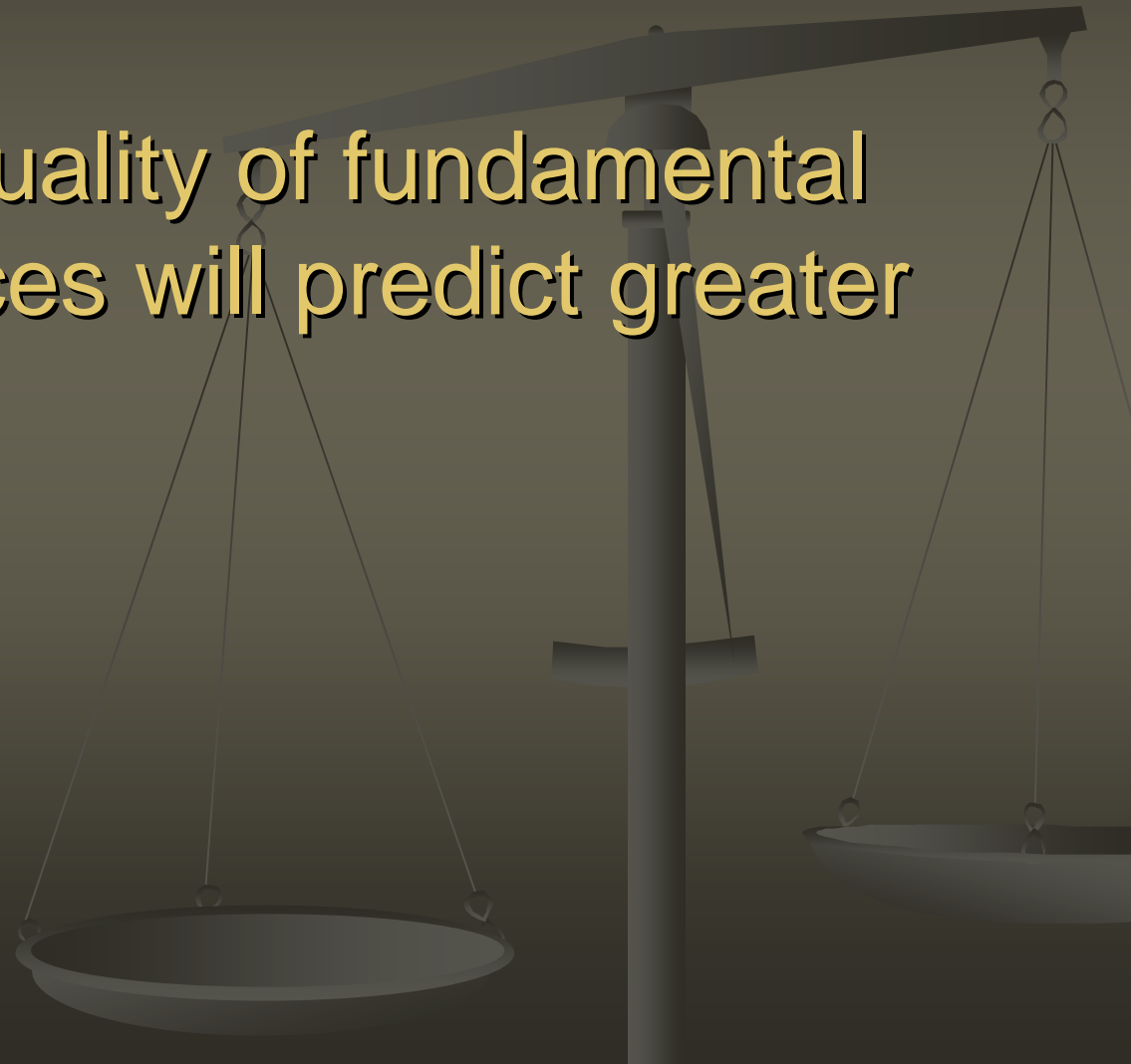
H1: Fidelity to the ACT model
will not predict coercion.



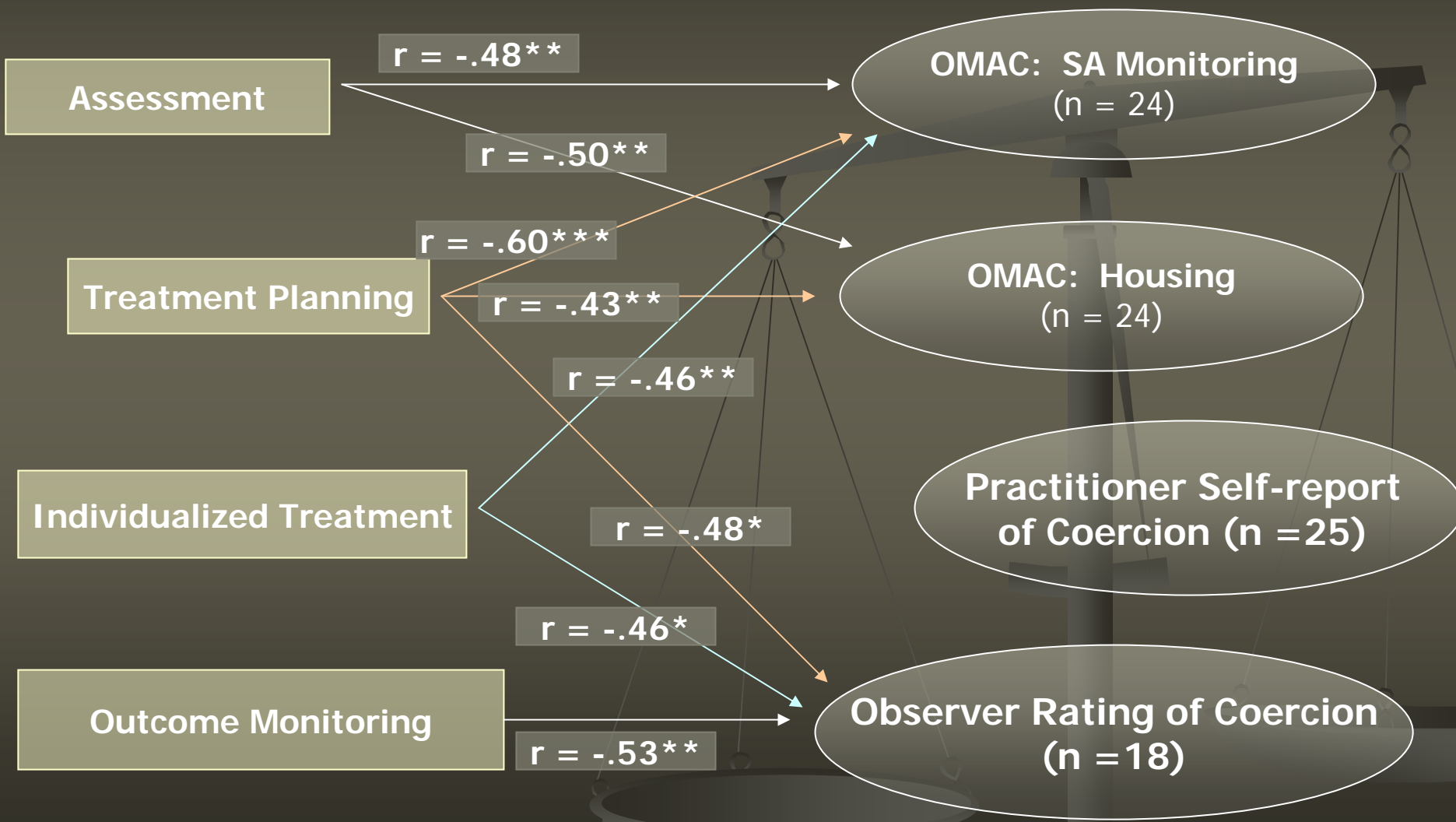
ACT Fidelity and Coercion Indices



H2: Lower quality of fundamental clinical services will predict greater coercion



Quality of Fundamental Clinical Services and Coercion Indices

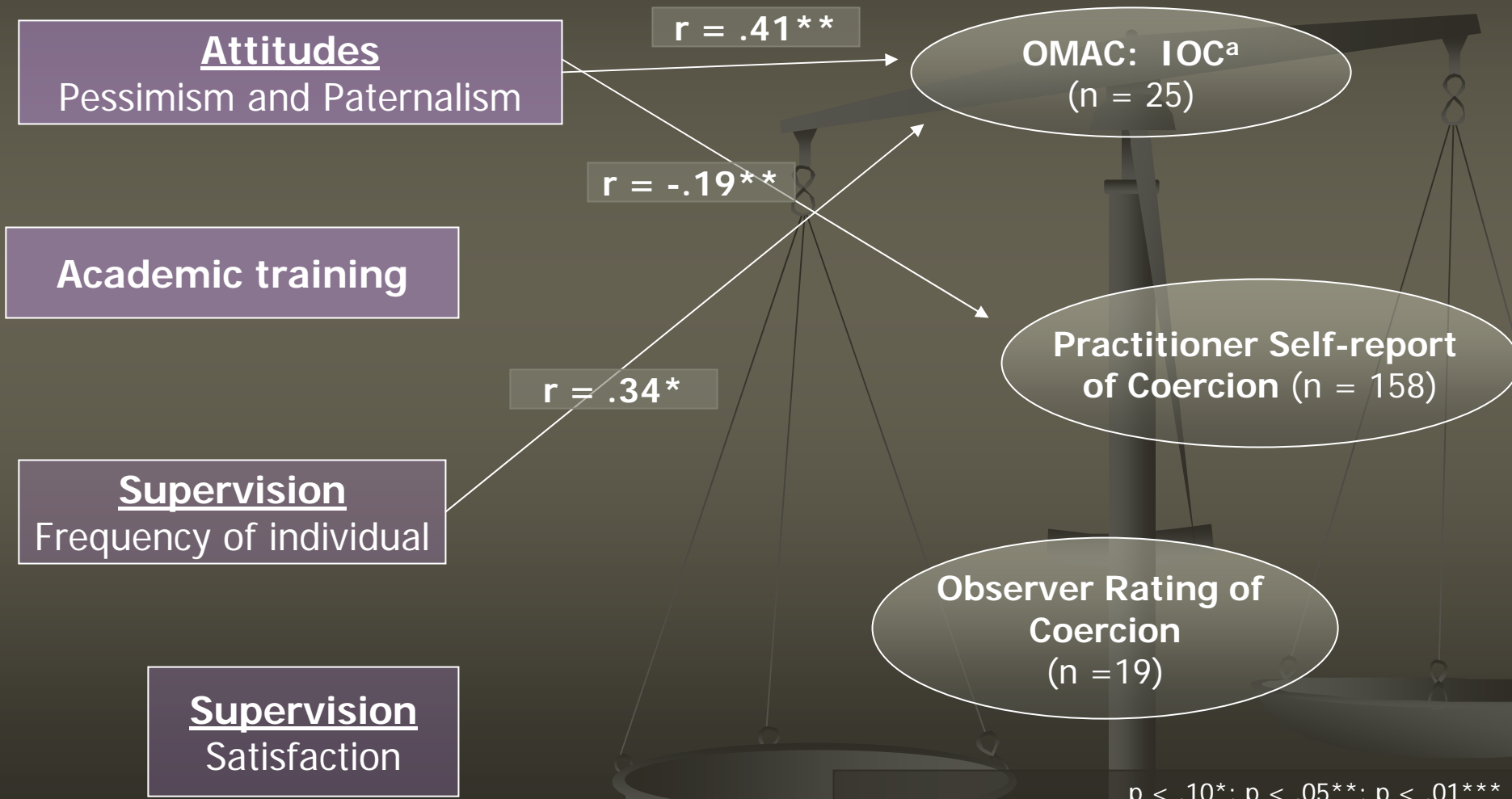


H3: Teams with practitioners with few advanced degrees will display greater coercion.

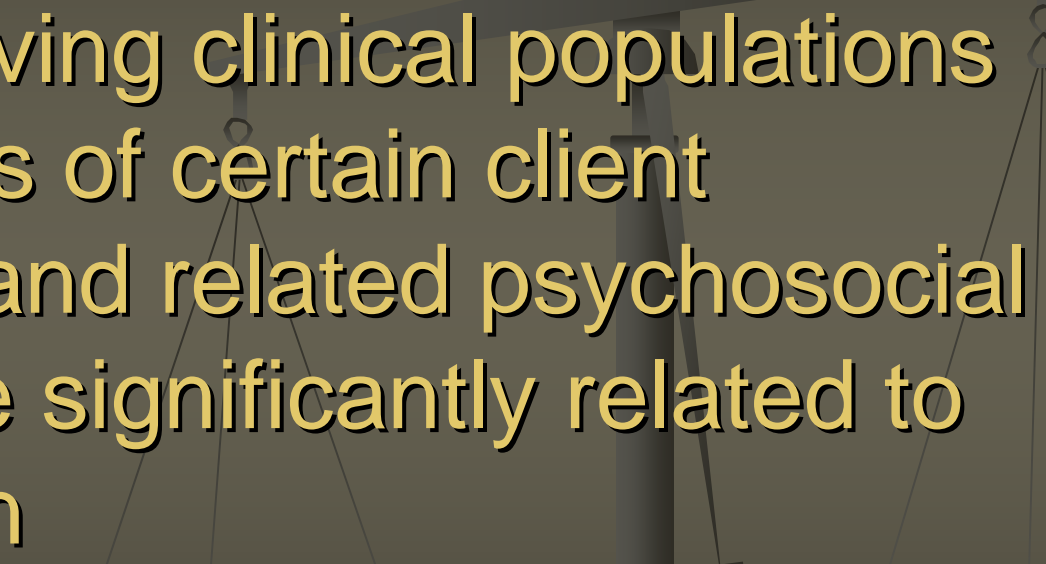
H4: Teams with practitioners who lack recovery-oriented attitudes (i.e., high paternalism and high pessimism) will predict greater coercion.

H5: Teams with practitioners who receive frequent client-centered supervision will be less coercive.

Practitioner Characteristics and Coercion Indices

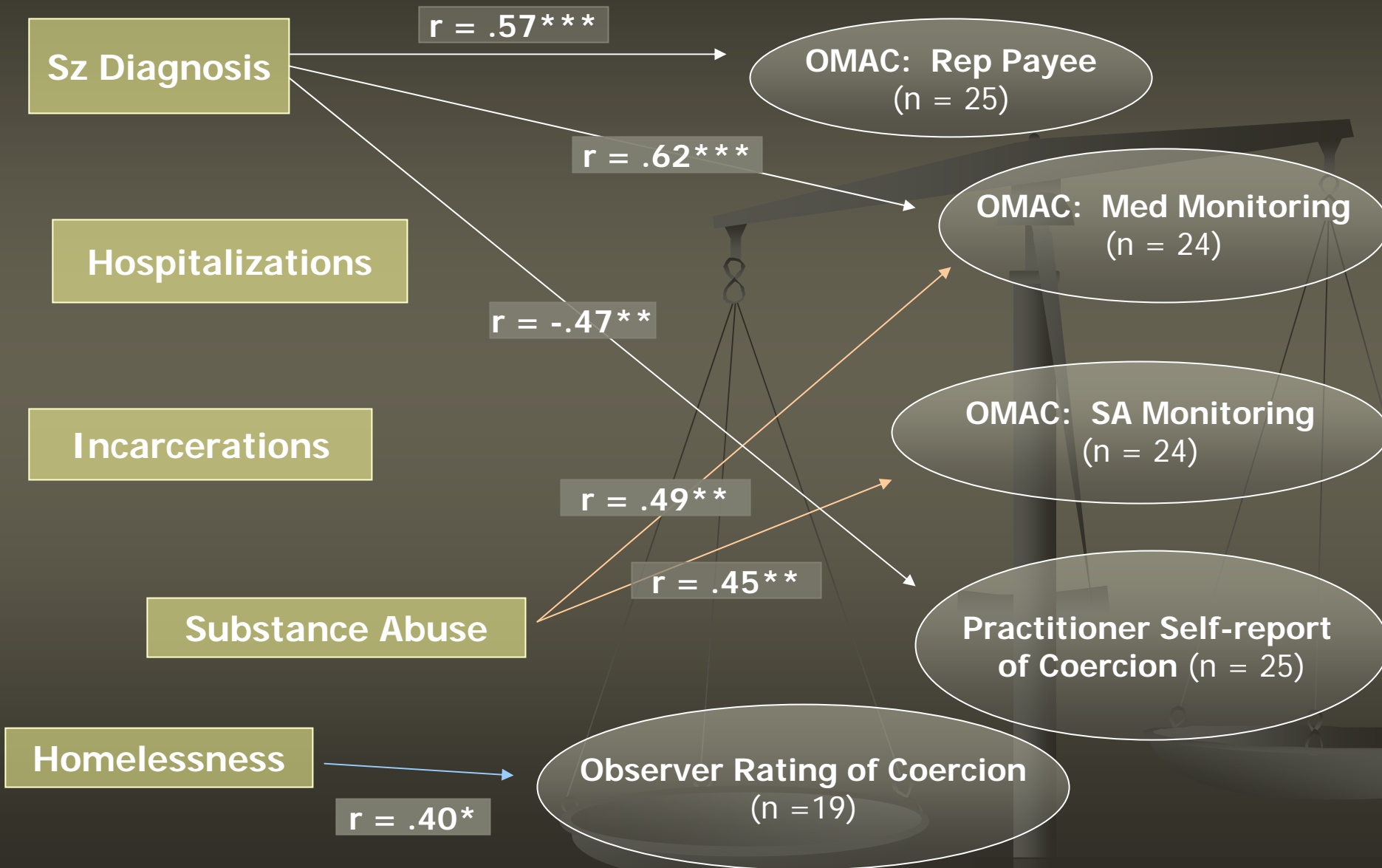


Note a: The significant relationship disappears when looking at only team-initiated IOCs



H6: Teams serving clinical populations with higher rates of certain client characteristics and related psychosocial sequelae will be significantly related to greater coercion

Client Characteristics and Coercion Indices



$p \leq .10^*$; $p \leq .05^{**}$; $p \leq .01^{***}$

Summary of Results

- Three measures of *coercion* not significantly correlated with one another.
 - Obj Measure of Agency Control a measure of power rather than coercion
 - Analyses preliminary and may need to consider how to statistically control for possible noise, as well as construct a more theoretically-sound model to test
- Clearly there are differences across teams and practitioners
 - In their position of power over client
 - In their use of more restrictive interventions
 - What is unclear is how to account for these differences
 - Staff attitudes appear to play a role
 - ACT Fidelity does NOT
 - Certain client characteristics (e.g., schizophrenia) lend to the use of more restrictive interventions

Study Limitations



- Construct Validity
 - Really assessing coercion?
 - How to account for negligence (which may lead to a team appearing less coercive on the OMAC and practitioner self-report scale, less so on the OROC)?
- Only show possible relationships; causality unknown
- Power
 - Sample size is a concern (esp. where team is the unit of analysis)
 - Problems with some measures
- Generalizability
 - Across state systems and different case management models