



Corrections & Mental Health

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Book Review

New Studies Assess Consequences of Assertive Community Treatment and Assisted Outpatient Treatment in New York and Oklahoma

By Russ Immarigeon

Introduction

Assertive Community Treatment (ACT), like many measures stressing deinstitutionalization, is over three decades old. The original ACT teams, first developed in Wisconsin, consisted of psychiatrists, nurses, social workers, drug addiction specialists, and vocational counselors, among other intervention professionals. Sandra J. Johnson describes the work of these teams:

After receiving a comprehensive assessment, each client is provided whatever services he or she requires: medication, housing, food and clothing, substance abuse treatment, and/ or support. Additionally, ACT strives to lessen or eliminate the debilitating symptoms of mental illness every individual client experiences and to minimize or prevent recurrent acute episodes of the illness. ACT also seeks to enhance each client's quality of life, improve functioning in adult social and employment roles, promote independence, and alleviate the client's family's burden of providing care.

In Johnson's new book, *Assertive Community Treatment: Evidence-based Practice or Managed Recovery*, she conducts a qualitative examination of recent developments in the growth of ACT in the states of New York and Oklahoma. At the center of this research is a "case study" of recent innovations in state-level, mental health-related policymaking.

Johnson takes a well-grounded approach to her study:

Quantitative studies alone do not answer how ideas are articulated onto government agendas, but qualitative research tries to capture the meaning of what goes on through the perceptions of those who are interviewed. Furthermore, when data are quantified, the ability to link policy with practice is limited because the goal of understanding a phenomenon from the point of view of the participants and the particular social and institutional context being examined is fundamentally lost.

For this study, Johnson looks at two states - New York and Oklahoma. Johnson is unclear on her selection of these states. Both are as perplexing as they are interesting. At one point, Johnson mentions "chain sampling," but she quickly backs off, leaving no clear indicators of why she actually selected these states. Johnson teaches at the State University of New York, Delhi in upstate New York, so that may be sufficient reason for one of her

Sandra J. Johnson (2010). *Assertive Community Treatment: Evidence-based Practice or Managed Recovery*. New Brunswick, NJ: Transaction Books, 178 pp., \$39.95 (hardcover).

Marvin S. Swartz, ed. (2010). Special Section on Assisted Outpatient Treatment in New York. *Psychiatric Services*, 61(10), 967-1005.

choices. Oklahoma, on the other hand, is still a matter of guesswork.

More explicitly, Johnson interviewed a total of 53 “policy entrepreneurs” and “street-level bureaucrats” (33 in New York and 20 in Oklahoma), namely state officials, mental health care providers, mental health advocates, and consumer advocates. She also interviewed 12 national academics, advocates, and researchers. Sixteen of these interviews, all in New York, were done in person, while the rest were done over the telephone. As suggested through her 21-page bibliography, she also made significant use of published newspaper coverage, journal articles, and research and policy reports.

Johnson is a political scientist. As she suggests, policy entrepreneurs, as John Kingdon has outlined in *Agenda, Alternatives, and Public Choices*, are those persons “who seek to encourage a policy’s wider diffusion via their time, expertise, reputation, energy, and/or money by pushing policies onto the agenda where it is hoped the problem, the proposal, and the political receptivity will converge and provide a periodic window of opportunity for political change.” But in this volume Johnson argues that street-level bureaucrats, to use Michael Lipsky’s phrase, not only implement ACT policies and practices, but do so “in spite of the legislative, political, and economic ambiguities.” Moreover, despite recent emphasis on evidence-based practice, she finds that “there is a disconnect separating policy design – or legislative intent – and the actual policy implementation of ACT in Oklahoma and New York. In both states, the initial stages of policy formulation ignored the actual implementation of policy, and those responsible for implementing the programs are inevitably blamed for their shortcomings, rather than the flawed policy itself.”

New York and Oklahoma

One of the more difficult aspects of assessing initiatives or interventions that are implemented, in one form or another, across the United States is the diversity of those community-based or otherwise-placed settings where pre-established policy turns into day-to-day practice. In this context, national reforms can be put into operation in over 50 places, with an equal number of outcomes, and many more consequences. Johnson narrows her sample to two states, but, not surprisingly, these two states differ.

According to Johnson, “mental health policy has evolved through four cycles of reform: the era

of moral treatment in asylums, the era of mental hygiene, the era of deinstitutionalization, and the current era of community mental health support.” For Johnson, a review of these historical periods demonstrates that previous reforms, much like current efforts, were implemented “without taking into consideration the challenging economic and political restrictions directly affecting policy goals,” most notably mental health funding and support. That said, however, these periods of reform have been successful in expanding the focus of new reform initiatives.

Johnson states that ACT works best with voluntary clients who have severe and persistent mental illness. Andrew Goldstein, a 29-year-old diagnosed with schizophrenia, was one such client. Despite his repeated requests for treatment, Goldstein was out on the streets without treatment. In January 1999, Goldstein pushed 32-year-old Kendra Webdale off a New York City subway platform, killing her. Goldstein was subsequently convicted of second-degree murder in March 2000. And in the meanwhile, angry advocates and citizens convinced the New York State legislature to pass “Kendra’s Law,” a well-meaning act that established procedures for obtaining court orders for the assisted outpatient treatment (AOT) of certain mentally ill persons. Ironically, Andrew Goldstein would not have been subject to this law. Moreover, Johnson argues, Kendra’s Law was underfunded, and it forced practitioners to work with clients who did not fit the profile of those likely to succeed according to available evidence-based research.

Johnson observes that ACT differs from AOT, as the former is evidence-based and the latter is court-ordered. In New York, the two were merged and inhibited. As she elaborates, “The language of Kendra’s Law focused on increasing the number of severely mentally ill that would be assigned to AOT and be forced to accept treatment. Under the law, each assisted outpatient becomes an obligation of the local and state governments, which are responsible for the client regardless of the limited budgetary resources allocated. Although (an) enormous infusion of money for ACT and case management helped improve the state’s mental health infrastructure, it failed to provide the counties, the local governmental units, with any additional money to implement and monitor cases in compliance with AOT regulations. This underfunded mandate simultaneously jeopardizes New York’s community mental health system and contradicts the voluntary philosophy supporting ACT, which originally was not created to be a monitoring service. Rather, it was designed to work with people with schizo-

phrenia and engage clients on a voluntary basis.”

In Oklahoma, as in New York, reforms were being forged at various levels. Unlike New York, however, mental health was not a state policy priority. So, in Oklahoma, the National Alliance for the Mentally Ill (NAMI) played a greater role in advocating and spelling out particular reforms. Specifically, NAMI developed good working relationships with state legislators, many of whom had family members or friends who suffered one form or another of mental illness. Forging these working coalitions was not necessarily easy. As Johnson observes, “Those advocating for NAMI had to convince the legislators that people with serious mental illnesses had needs that could not be met if they were treated like criminals and that not addressing their needs was wasting taxpayers’ money.”

NAMI worked effectively through organizing, “networking across state lines,” and evidence. In Oklahoma, a window of opportunity appeared because of the closing of the Eastern State Hospital, a large psychiatric facility, and the 2001 hiring of a new forward-thinking, professional state mental health commissioner. In this context, NAMI helped build “a political opportunity for pro-change policy direction.” In Oklahoma, this was the Program for Assertive Community Treatment (PACT). Johnson provides the following timeline for PACT development in Oklahoma: PACT programs started in the state’s two largest cities in 2001; evidence of program success were disseminated and four new initiatives were started in 2002; and the teams in Norman, Tulsa and Oklahoma City were expanded in 2004, while additional teams were added in 2005 and 2006. A key factor in NAMI’s organizing was gaining the support of rural counties. Interestingly, PACT also seemed to fit nicely with some of the state’s service-delivery vacuums.

Implications

Johnson’s case studies or “reform histories” of mental health policy development in Oklahoma and New York are valuable presentations. In one chapter in particular, she notably observes “how model fidelity, Medicaid, and legislative ambiguity influence inconsistent policy outcomes in New York and Oklahoma.” These inconsistencies include limiting the range of essential services such as employment and housing support or peer counseling, emphasizing cost efficiency to the detriment of recovery-oriented services, the lessened role of psychiatric need in program eligibility criteria, and unbalanced prefer-

ences for research in an ideal world versus practice in the real world. Johnson notes, “Programs such as ACT have demonstrated strong evidence-based results within carefully controlled research settings, but implementation in ‘real world’ settings does not confirm that the evidence-based practice is positively improving outcomes in the lives of severely mentally ill individuals.”

Johnson concludes that ACT is largely a cost-driven program, not a recovery-oriented approach to seriously mentally ill. The program has drifted from its original mooring. Johnson reports that “clinicians from both states stressed that the original ACT teams were meant to provide services in the community to prevent hospitalization and emergency use for severely mentally ill individuals who are unable to access the traditional services to them.” She adds that ACT appears a suitable model for a small number of clients.

Furthermore, “the successful implementation of ACT requires the recognition and knowledge of the implementers providing the actual treatment, not merely additional scientific research. Without knowledge input from those providing treatment in vivo, the researchers and scientists responsible for ACT’s ‘gold standard’ will continue to stifle innovation in their attempt to strategically brand ACT as a commodity for distribution while policy makers responsible for the dissemination of ACT in real-world settings will continue to ignore the unique economic and political realities challenging the program’s implementation process. As long as knowledge input from the street-level entrepreneurs providing the actual treatment remains scarce, flawed implementation, rather than flawed policy, will be blamed, much to the detriment of society’s most vulnerable population – the severely mentally ill.”

Assisted Outpatient Treatment

As Sandra Johnson notes in Assertive Community Treatment, the New York state legislature enacted Kendra’s Law in 1999, thus allowing preventive, court-ordered treatment for mentally disordered persons. In the October 2010 issue of *Psychiatric Services*, Dr Marvin S. Swartz of the Department of Psychiatry and Behavioral Sciences at the Duke University Medical Center has gathered a collection of six articles for a “Special Section on Assisted Outpatient Treatment in New York State.” In his introductory notes, he establishes the importance of Kendra’s Law, which fortified administrative and financial support for the use of Assisted Outpatient

Treatment: “The statute authorizes a preventive form of court-ordered treatment, which is designed to take effect in advance of an illness exacerbation that would likely trigger involuntary inpatient commitment. Only a handful of states take this approach. Indeed, 44 states have involuntary outpatient commitment statutes, but most are not preventive in this sense. They set identical thresholds for inpatient and outpatient commitment, which places clinicians in the difficult position of judging an individual ill enough to be committed to the hospital while recommending outpatient treatment.”

Kendra’s Law is the only involuntary outpatient commitment statute in the United States that is not permanent. So far, it has been statutorily put in place and extended over two five-year periods. Past and future extensions have been, and will be, contingent upon empirical outcomes, which are being measured through a research contract issued through the New York State Office of Mental Health to the Services Effectiveness Research Program in the Department of Psychiatry and Behavioral Sciences at the Duke University School of Medicine. A subcontract has also been awarded to Policy Research Associates, Inc. (PRA) a well-known and highly-regarded research group located in Delmar, New York, just outside the state capital of Albany. Funding for this research comes from the John D. and Catherine T. MacArthur Foundation Research Network on Mandated Community Treatment. Principle investigators include Jeffrey W. Swanson (Duke), Henry J. Steadman (PRA), Pamela Clark Robbins (PRA), and Marvin S. Swartz (Duke).

Learnings and Lessons

The articles in this issue of *Psychiatric Services* cover the following topics: different applications of Kendra’s Law in communities across New York State; improvements in outcome measures for persons under court-mandated treatment; outcomes for persons after their participation in Assisted Outpatient Treatment; the diversion of necessary services from seriously ill mental health patients to those with court orders for treatment but with less explicit needs; comparative arrest rates of persons receiving services because of court-ordered or voluntary treatment; and regional changes in possession of guideline-recommended medications by seriously mentally ill persons (information for this last article was not available in the 2005 final report).

Key findings of these studies include the following:

- Nearly 9,000 Assisted Outpatient Treatment

court orders were given between 1999 and 2007; regional differences were found in the AOT First and the Enhanced Voluntary Services First models; other regional differences were found in how AOT was implemented and administered, the continuity and interest of presiding judges, the attitudes of mental health legal service attorneys;

- Likelihood of psychiatric hospitalization was reduced by 25% during the first six-month court orders and by 33% over the second six-month order;
- Assisted Outpatient Treatment patients received improved psychotropic medication and intensive case management services;
- Sustained post-AOT improvements, such as receipt of psychotropic medications or length of hospital stays, were related to the length of time patients stayed in court-ordered treatment (assertive community treatment or intensive case management improved outcomes for those who were in AOT for six months or less);
- Expanded, enhanced services were more readily available for court-ordered persons for the three-year period following passage of Kendra’s Law, but these services were more routinely equitable after this three-year period;
- Voluntary treatment seekers were as likely as persons receiving treatment in neither voluntary nor court-ordered services to be arrested, but the odds of arrest for Assisted Outpatient Treatment patients was two-thirds less than those in voluntary treatment or no treatment at all;
- Court-ordered persons were more likely than persons receiving enhanced services to receive guideline-recommended medications.

Lessons learned from these findings include:

- Jurisdictions lacked guidance about how to implement Kendra’s Law;
- Assisted Outpatient Treatment-related program implementation eventually expanded the availability of enhanced services for both court-ordered and voluntary patients;

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- Assisted Outpatient Treatment appears to reduce the criminal justice system involvement of persons with serious mental illness;
 - Receipt of guideline-recommended medications was improved for all Medicaid eligible persons regardless of whether they were involved with court-ordered, voluntary, or enhanced community treatment.