THE BENEFITS OF MEDICATION OUTREACH FOR THE SEVERELY MENTALLY ILL IN A RURAL CALIFORNIA COUNTY

A Project

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by

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Division of Social Work
Abstract

of

THE BENEFITS OF MEDICATION OUTREACH FOR THE SEVERELY MENTALLY ILL IN A RURAL CALIFORNIA COUNTY

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This descriptive study was conducted to provide insight into medication outreach services and the benefits for an individual diagnosed with severe mental illness. Difficulties surrounding the use of multiple medications, or polypharmacy, are amplified in adult's labeled schizophrenic, bipolar, and schizoaffective. The independent variable, in this study, is the medication outreach with the dependent variable being the societal impact of that action on the individual.

The incorporation of medication outreach services combined with therapy correlates to a self-defined better quality of life. The review of the literature reflects the high rate of incarceration, hospitalization, and homelessness directly affecting the individual as well as the community. Turning Point Providence Center (TPPC) professionally based opinions regarding clients receiving medication outreach services were sought during this project. Secondary data measured consistency of a 36-month criterion and participation verses non-participation in the medication outreach program. The combined results of the questionnaire in conjunction with those of the archival data retrieved indicated a positive
correlation between participation in the program and lowered rates of incarceration and homelessness. Furthermore, the results indicated an improved amount of community involvement and desire to participate in therapy. The intention of the research was both testing hypotheses and formulating more specific questions for future studies.

_______________________, Committee Chair
Dr. Francis Yuen, DSW, Professor

_______________________
Date
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Chapter 1

INTRODUCTION

Mental health care professionals agree that a consistent medication regime increases the well-being of clients diagnosed with schizophrenia, bipolar, and schizoaffective disorder. The Mayo Clinic website states, "Although psychiatric medications don't cure mental illness, they can often significantly improve symptoms. Psychiatric medications can also help make other treatments, such as psychotherapy, more effective" ("Treatment and Drugs" website, 2012).

This chapter is divided into six sections that introduce the study the researchers conducted. The first section introduces the background of the problem. The second section presents the purpose of the study. The third section describes the theoretical framework of the study. The forth section address the definition of terms. The justification is discussed in the fifth section followed by the statement of collaboration.

Background of Problem

The researchers postulate that medication, although effective, fails to address stigma, social connection, relationship building and involvement for these individuals in the mental health community prescribed daily medication. While many studies regarding symptom management and medication have been conducted surrounding those diagnosed with a severe mental illness, there is no one answers for every individual. This makes it difficult for medical professionals to prescribe the right medication for the right person and often discovering the right medication combination becomes a "guessing game". There are limited statistics indicating that medication outreach decreases unnecessary
hospitalization, incarceration and homelessness. The current literature lacks an association between the decrease in relapse or suicide.

A study that depicts the cost, risk, and benefits of medication outreach has not been established. Very few programs provide daily medication outreach to their clients. As a front-runner in the mental health arena, Turning Point Providence Center, California provides access to this resource for their clients diagnosed with a severe mental illness. The current medication outreach program is designed to support clients who have requested assistance in maintaining a consistent medication plan. Some of the side effects of severe mental illness are confusion, lack of capacity due to previous experience in locked facilities, or in some instances are required by law to take their medication daily.

**Purpose of the Study**

The primary purpose of this study was to explore the risk and benefits for individuals diagnosed with a severe mental illness who are on medication outreach with Turning Point Providence Center (TPPC). The researchers examined the effectiveness of medication outreach, the correlation for the client between the service provided, and the well-being of an individual diagnosed with schizophrenia, bipolar, and schizoaffective disorder through more involvement with the Turning Point Community. The researchers sought information from the service providers at TPPC and client medical records, surrounding quality of life for these individuals who are labeled severely mentally ill, and whether or not medication outreach helps to meet the client’s needs.

Essential components of medication outreach include building resiliency within the client through medication compliance, social interaction based on social work principles
and values, and community involvement. With these components in place, the client/professional relationship gains strength through rapport building, whilst stigma and disenfranchisement are supplanted by client empowerment and community connection. All of these things are more possible when a client is less symptomatic through the consistent use of their medication and provides an opportunity for maintenance of fragile client/provider relationship. The symptoms ascribed to severe mental illness, that make it more difficult for clients to handle their own medication on a daily basis, often include paranoia, fugue, transportation issues, and lack of insight when clients are symptomatic.

The secondary purpose of this study is to provide more literature on the importance of medication outreach when combined with best practices in the mental health arena. Some of these best practices include clinical case management, recovery model, harm reduction model, and quality of life as theoretical frameworks. Social workers are the ideal candidates to perform this task due to their curriculum, which focuses on biopsychosocial theory.

**Theoretical Framework**

This thesis project draws from a plethora of theoretical orientations. The recovery model upholds the social work *Code of Ethics* encompassing the number one social work value, which is upholding and advocating for the dignity and worth of a person. The harm reduction model eschewed by TPPC illuminates the need to address substance abuse and the interactions that occur between severe mental illness and recovery. Clinical case management addresses the client’s needs regarding access to resources and services in the community. The theory surrounding quality of life directly addresses individuality,
dignity, and self-worth. Empowerment must always be included to address gender, diversity, economics, age, ability, religion, race, and ethnicity issues. The researchers were mindful to write with a strength-based focus, which creates authenticity and transparency throughout the study.

Clinical Model in Regards to Case Management

Walsh (2000) suggests clinical case management is a form of, ...

...help-giving in which a socially sanctioned healer (the case manager) tries to relieve a sufferer’s distress (the client with mental illness) by facilitating changes in his feelings (e.g., anxiety), attitudes (e.g., paranoia), and behavior (levels of independent living skills) through the performance of certain activities with him or her (relationship-building, assessment, planning, linking, etc.), often with the participation of a group (other service providers in the case management network).

(p. 16)

Clinical case management benefits mental health professionals as well as their clients helping to build personal relationships, which has great potential for therapeutic impact. The client’s symptoms effect their environment and can create complication regarding housing, hospitalization, incarceration and isolation. Contact with the personal service coordinator helps to promote environmental stability resulting in less displacement for the client and more positive fiscal outcomes for the community. "Case managers need to understand that clients may not perceive their own communities as stable, supportive areas where many personal needs can be met" (Walsh, 2000, p. 60).
**Recovery Model**

The Recovery model builds on the clinical case model in regards to rapport building but adds the essential component of identifying the client as the expert concerning their mental health. Clossey and Rowlett (2008), use of the recovery model further emphasizes the importance of a self-defined meaningful life. The consumer determines their own needs, wants, and desires and the clinician provides the necessary support to access resources and services that correlate with the clients goals. This empowering and culturally sensitive approach contributes to lessening social stigma surrounding mental health and creates positive integration into the community based on respect of all individuals.

**Harm Reduction Model**

Harm reduction, developed in the 1960s and is based on the principal of prevention rather than the deficit-based abstinence principle used by many self-help groups and Alcoholics Anonymous. Denning and Little state, “The focus of harm reduction is on helping people to reduce drug-related harm while also addressing co-occurring psychological and emotional difficulties—all in a manner that is respectful, welcoming and client centered” (Denning & Little, 2012, book jacket). The incorporation of harm reduction is essential when providing support for a client who is suffering with the detrimental effects of depression and isolation that can occur in those individuals who live with severe mental illness and may have a co-occurring addiction.
**Quality of Life**

“When people list the key characteristics of a good life, they are likely to include happiness, health, and longevity. Similarly, scholars such as Edgerton (1992) define good cultures as those in which health and happiness flourish” (as cited in Diener & Chan, 2011, p.1). When measuring the quality of life for individuals with severe mental illness often the topics include psychological well-being, social and emotional functioning, functional performance, life satisfaction, and social support; which correlates, specifically, with social work values. Knapp and Parrish (2011) state, “Quality of Life is the paramount concern in the recovery and wellness model, and instead of focusing on a cure, it focuses on a multidimensional and individualized journey of personal growth” (p. 17).

**Definition of Terms**

*Medication outreach.* The personal in home assistance and support of daily medications, to the clients, diagnosed with severe mental illness conducted by a mental health professional. The clinician assures the correct dose of daily medication to the client. The client chooses to open the daily packet and self-administer their specific medication as directed by the doctor. The interaction that takes place between the clinician and the client supports the recovery model and social work values practiced in the home setting. Medication outreach is thoroughly client-centered practice.

*Severe mental illness.* According to the American Psychiatric Association (APA) current policy completed by Task Force on Serious Mental Illness and Severe Emotional Disturbance (2009),
…a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified by DSM-IV-TR, and that has resulted in functional impairments which substantially interfere with or limit one or more major life activities… functional impairment is defined as difficulties that substantially interfere with or limit role functioning in one or more major life activities including basic daily living skills (e.g., eating, bathing, dressing), instrumental living skills (e.g., managing money, maintaining a household, taking prescribed medication, or functioning in social, family and vocational/educational contexts) and that adults who would have met the functional impairment criteria during the year without the benefit of treatment or other support services are considered to have a serious mental illness… ("Resolution on APA Endorsement of the Concept of Recovery For People With Serious Mental Illness", website, 2009)

**Justification**

This study is congruent with the *Social Work Code of Ethics*, which is to honor the dignity and worth of a person. Diagnoses and institutions such as prisons and hospitals reinforce the stigma attached to severe mental illness through deficit-based practice and the balance of power attached to the provider with less emphasis surrounding power of the client. This research will help provide empirical evidence regarding daily medication outreach for this population as a form of therapy to incorporate self-respect, empowerment, and raise esteem, promoting independence for these individuals. The daily contact with a mental health professional educated with a social work bio-psycho-social emphasis in the client’s own environment is beneficial to the client. When this daily
support is provided in conjunction with medication adherence, medication outreach aids in the promotion of a quality of life for those living with symptoms of severe mental illness and are unable to maintain medication compliance.

The descriptive research will describe quantitatively connected outcomes. Other agencies, practitioners, and policy makers may use this study to justify implementation of a medication outreach program, provided by TPPC. This provides empirical evidence to promote fewer stigmas, easier funding, and community integration for those diagnosed with severe mental illness.

**Statement of Collaboration**

Brittany Morgan Fagundes and Melissa Anne Forbyn-Willett worked together as joint authors on this project. Both researchers worked collectively during the process of this study. Topic selection, data analysis, writing, and formatting were completed congruently throughout the research project.
Chapter 2

REVIEW OF THE LITERATURE

This review of the literature is divided into five sections that address the needs of individuals who are living with Severe Mental Illness (SMI) and how medication outreach may improve/increase their quality of life. The first section presents the history of mental illness. The second section introduces Turning Point Providence Center, California and their work with the severely mentally ill. The third section addresses the strength and challenges surrounding those living with symptoms related to schizophrenia, schizoaffective, and bipolar disorder. These three mental health disorders represent the American Psychiatric Association (APA) definition of severe mental illness, based on longevity and severity of symptoms. Treatments, laws, policies, and practices in the fourth section followed by a summary of the reviewed literature.

Prevalence and Effects of Severe Mental Health

According to National Alliance on Mental Illness (NAMI, 2012), three of the most serious mental illnesses are schizophrenia, schizoaffective, and bipolar disorder. NAMI’s website (2012) state,

A mental illness is a medical condition that disrupts a person's thinking, feeling, mood, ability to relate to others and daily functioning. Just as diabetes is a disorder of the pancreas, mental illnesses are medical conditions that often result in a diminished capacity for coping with the ordinary demands of life. ("What is Mental Illness" website, 2012)
Those who are qualified to diagnose an individual with a mental health disorder must be educationally and professionally qualified. The National Institute of Mental Health (2005) reminds us, “To be diagnosed with a mental illness, a person must be evaluated by a qualified professional who has expertise in mental health. Mental health professionals include psychiatrists, psychologists, psychiatric nurses, social workers, and mental health counselors” ("Information about Mental Illness and the Brain" website, 2012).

**Schizophrenia Disorder**

Schizophrenia affects more the 2.4 million adults in the United States of America (NAMI, 2012); this accounts for approximately 1% of the US population. Schizophrenia is characterized by five major symptoms in the Diagnostic and Statistical Manual of Mental Disorder- Forth Edition- Text Revision (DSM-IV-TR, 2000) which include hallucinations, delusions, disorganized speech, grossly disorganized or catatonic behavior, and negative symptoms including; affective flattening, avolition, and alogia.

Symptoms of schizophrenia often interfere with a person's ability to critically think, connect with others, construct decisions, and govern emotions. Torrey postulates that individuals diagnosed with schizophrenia 6% are homeless, 6% are incarcerated, 5-6% are hospitalized, 10% live in nursing homes, 25% live with a member of their family, 20% live in supervised housing and 28% live independently (as cited in Knapp & Parrish, 2011). This accounts for 48% of the population who may benefit from daily medication outreach. The high risk associated with individuals diagnosed with schizophrenia is
essential to be aware of; this population is eight times more likely to commit suicide compared to individuals without a diagnosis of schizophrenia (Pompili et al., 2007).

**Bipolar Disorder**

Bipolar disorder causes both physical and psychological symptoms. Physical symptoms can include impairment in concentration, energy levels, appetite and sleep; whereas thoughts, feelings and behaviors are psychological symptoms. Bipolar II and I differentiate with the cyclic fluctuations of mania and depression (Basco, 2006). A study completed by National Institute of Mental Health (NIMH, 2012) suggests that approximately 5.7 million individuals in the United States of America, which averages out to 2.6 percent, are diagnosed with bipolar disorder. In a survey conducted by the Epidemiologic Catchment Area in 2004, approximately 60% of individuals with bipolar disorder abuse alcohol and drugs during their history of illness (as cited in Rowland, 2008). Furthermore, NAMI (2004) reports a high rate of alcohol consumption in women.

**Schizoaffective Disorder**

Those diagnosed with schizoaffective disorder experience all of the symptoms of schizophrenia with the added symptoms of depression and mania. NAMI suggest that of those individuals with schizophrenia, approximately a third of those factions also receive a diagnosis of schizoaffective disorder (NAMI, 2012).

**Turning Point Providence Center**

Turning Point Providence Center (TPPC) is a non-profit mental health agency located in a small rural community in Nevada County, California. The passing of the Mental Health Services Act, Proposition 63, in 2004 was a 1% tax on personal income in
excess of $1 million. The tax was designed to fund the transformation of the mental health care system in California; because of this, TPPC was able to receive some of their funding from the Mental Health Services Act (MHSA; Cameron, et al, 2008). Turning Point clients that are at a high risk receive a referral to this agency through Nevada County Behavioral Health as well as Nevada County Mental Health Court through the implementation of Laura's Law, Assembly Bill (AB) 1421.

Mental Illness Policy Org. states,

Laura's Law allows courts--after extensive due process, to order a small subset of people with serious mental illness who meet very narrowly defined criteria to accept treatment as a condition of living in the community. It also allows courts to order the recalcitrant mental health system to provide treatment. Counties have the option to implement Laura's Law and most have not. Mental health directors prefer not to use their MHSA funds to focus on the most seriously ill because it can be a difficult to treat population. Instead, mental health directors transfer the seriously ill to jails, prisons, shelters and morgues. ("Laura's Law and other California Mental Illness Policy Info" website, 2013)

The statistics are astounding when looking at Nevada County and it is enactment of Laura's Law in 2010. Since that time, the county has managed to reduce hospitalization by 46%, incarceration by 65%, homelessness by 61%, and emergency contact reduced by 44%. Mental Illness Org. suggest a savings of "$1.81-$2.52 for every dollar spent as result of reducing incarceration, arrest, and hospitalization" (Laura's Law and other California Mental Illness Policy Info" website, 2013).
TPPC incorporates recovery-oriented rehabilitation that focuses on consumer empowerment, identifies, and changes any element of care that undermines the worth of the individual. This agency integrates culturally competent services, promotes community collaboration, and fosters resiliency in their clients. TPPC provides a variety of services that incorporates the multidimensional elements for those who are in the recovery process after receiving a diagnosis of severe mental illness. One of the innovative services that TPPC provides is twice daily medication outreach for those clients who request assistance with taking the multitude of medications that the client feels will provide them with a better quality of life.

As Chief Officer of Operations at TPPC Al Rowlett (2008) states,

...the foundation for understanding what an effective recovery-model-oriented mental health organization must aspire to... A recovery-oriented agency is empowering, offering hope, healing, and sense of community--elements that are intangible and difficult to measure. A recovery model agency appreciates the many ways in which consumers of agency services have suffered social marginalization and responds by offering significant resources that can tangibly change lives. Such resources include real venues for consumer participation in important agency decisions and resources improve the quality of life, such as monetary resources, job training, and placement assistance, and safe and desirable housing. A recovery model oriented agency seeks to empower consumers and integrate them into their communities as viable, contributing members. (p. 318)
Case Management

Case managers must buy into TPPC philosophy based on the recovery model. This philosophy includes advocating for clients, assisting the client with meeting tangible needs, and facilitating a consumer-defined quality of life. These agents of change must appreciate the consumers need for basic material resources, which allows them to live comfortably in their communities, and the clients desire to recover, and cope well with their diagnoses. Davidson, et al (2006), conveys the need for Personal Service Coordinators (PSC), at TPPC, to provide aid and access to "accommodations and support that enable people with psychiatric disabilities to lead safe, dignified, and full lives in the community" (as cited in Clossey & Rowlett, 2008, p. 319).

Case managers offer access to resources such as safe and affordable housing. The PSC collaborates with the member supporting access to income support such as Social Security Disability Insurance, food stamps, Medicare, and Medicaid. Education and employment assistance are both essential tools in this process. Clossey and Rowlett refer to this as, "whatever it takes" (2008, p. 326).

An integral part of PSC’s job will always reflect a commitment to the members of the community through recovery services that utilize the 'whatever it takes' approach (Clossey & Rowlett, 2008). This indicates a need for case managers to be more aware that individuals need more time, attention and collaboration between agencies.

Medication Outreach

Medication outreach is an innovative part of TPPC therapy. The focus of this particular service is supported by the recovery models recognition of meeting the clients
were they are at. This service is provided twice daily and promotes an independent quality for individuals living on their own in the community with a severe mental health diagnosis. This program is unlike all other medication outreach programs in that it is not a delivery service through the post office, it is not administering and controlling drugs as in a hospital setting; but instead it provides the necessary interaction to establish stability in an individual's mental health care.

Medication outreach supports the individual with their daily medication. Often clients need multiple doses or they have difficulties being able to obtain their medication due to financial and/or transportation issues. This creates a deterrent for the client when they are unable to adhere to their specific medication regimen. The clinical model traditionally prescribes medications not knowing exactly what combination will work for the individual. Often times the doctor will switch medication depending upon what the client reports regarding their symptom management and how effective these medications are for them. This ongoing process requires accurate monitoring. The daily contact helps provide more information to the therapist, so that the right combination for the right person is optimal. The importance of consistency is a key element to the effectiveness of these medications. This service promotes growth and autonomy while a person adjusts to their living situation and integrates back into the community.

The service that TPPC provides is unique in that it models the necessary behaviors and provides positive outcomes with the collateral contact. It increases the understanding and importance of self-administered medication along with social
interaction, which helps to provide a safe learning environment for the individual living in their home.

**Strengths and Challenges of Severe Mental Health**

There are many strengths and challenges for those dealing with symptoms of severe mental illnesses. Institutional practices include hospitalization and incarceration, which are traditional methods for individuals diagnosed with severe mental health disorders. Homelessness is a commonality that many in the mental health community share. Often time’s clients will report that they feel a sense of autonomy due to their ability to come and go as they please from the TPPC. There is no requirement to socialize with others even though it is encouraged, and the feeling of being free to make their own choices within the TPPC community provides empowerment and creates stabilization when outside of the community.

Historically people with severe mental illness where often treated harshly and viewed as an individual possessed by demons. In Ancient Greece mental illness was considered admirable and a blessing from the Gods; however, this did not last long. In medieval times, the Catholic Church defined the mentally ill as witches and had them immolated. Whitaker (2002) explores the moral treatment of people dealing with symptoms of severe mental illness in the 1800's; including expelling them from their community, locking them up in prisons, and physical abuse (as cited in Knapp & Parrish, 2011). Whereas, in the 1800's the French treated the mentally ill as if they were animals, placing them in asylums for the public to come stare at their antics, as if animals in the Zoo (Thio, 2001; as cited in Rowland, 2008).
The decline of moral treatment during the 1850's was partially due to the increase in immigration of Chinese and Irish as well as the freeing of slaves (Jansson, 1997). With the influx of these ethnicities, there was a natural occurrence of more mental illness leading to these individuals viewed as less than human. By 1880, the asylums became a place to warehouse people with mental illness, segregating them from the white population. This then led to widespread contempt of asylums and the people who lived there; especially because the public institutions were funded by taxpayer dollars (Whitaker, 2002). These atrocities lessened in the late 1800's when the Quakers introduced a more enlightened approach of moral treatment. The Quakers envisioned the asylum as a place of refuge and not suffering for individuals living with mental illness.

**Hospitalization**

Torrey (1988) stated, "Most institutionalized mentally ill individuals were living in 'concentration camp' like conditions during the mid-1940's in the United States of America" (as cited in Perera, 1998, p. 3). When *Life* magazine did an expose on mental health institutions, in 1946, it depicted the inhuman treatment of the severely mentally ill living in asylums. *Life* magazine printed pictures of individuals lying on the floor living like animals (Perera, 1998). For many American’s who witnessed the lives of these individuals living in such harsh and inhuman conditions, deinstitutionalization seemed to be a logical conclusion.

“Asylums which started out as great philanthropic enterprises in the mid-19th century morphed into uncontrollable monsters that were finally slayed in 1963 with the passing of the Mental Retardation Facilities and Community Mental Health Center
The signing of the MRFCMHCCA of 1963 deinstitutionalized state run hospitals, no longer would the mentally ill be kept hidden and locked away for life in these asylums. Instead, 75% of the population diagnosed mentally ill were released out into the communities (Humphers, 1996; as cited in Perera 1998). According to Torrey (1988), the whereabouts of 58% of the severely mentally ill released from these asylums are unknown. “The chronic mentally ill patient had his locus of living in care transferred from a single lousy institution to multiple retched ones” (Torrey, 1988, p. 4). Upon release, many of those labeled severely mentally ill ended up living in and out of shelters, in the bushes, on the streets, board and cares, and prison. “The chronically mentally ill were freed from asylums but they were not free from misery, for they no longer had a stable place to live, many are not receiving treatment, and nobody is willing to take full responsibility for their condition” (Perera, 1998, p. 12).

Presently, counties in the state of California are only able to treat a small population of the mentally ill. Those individuals who meet the criteria have a better chance of getting into state hospitals. With a lack of funding many mental health programs are impacted in California and throughout the United States of America. Thus, many of the severely mentally ill are not currently receiving services at psychiatric hospitals. However, these individuals are often being treated at local emergency rooms that are ill equipped and without adequate specific education about treating those who are diagnosed with severe mental illness.
Incarceration

Incarceration has taken the place of the asylum of the chronically mentally ill who are labeled as a danger to others. Baillargeon et al (2009), suggest approximately 10-20% of the incarcerated inmates in the United States have a severe mental illness. Fellner (2006) proposes that 200,000, or as many as 300,000, incarcerated inmates struggle with severe mental health symptoms, and this number is increasing proportionately. Fellner postulates that there are three times more mentally ill individuals incarcerated than in mental health hospitals. With the mental health system fragmented, chronically underfunded, and with continuously limited abilities to access resources, it has created a crisis in the United States; this has significantly contributed to the number of mentally ill-incarcerated individuals. "As a result, too many people who need publicly financed mental health services cannot obtain them until they are in an acute psychotic state are found to be a danger to themselves or others" (Fellner, 2006, p. 393).

The Council of State Governments (2003) asserts:

...if many of the people with mental illness received the services they needed, they would not end up under arrest, in jail, or facing charges in court... The ideal mechanism to prevent people with mental illness from entering the criminal justice system is the mental health system itself—if it can be counted on to function effectively. (p. 26)

Prisons are not equipped to provide the quality and quantity of services necessary for those who are severally mentally ill. The scarcity of qualified mental health professionals, a lack of treatment planning and development, as well as the lack of monitoring these
individuals conditions combined with poorly administered medication creates suffering of painful symptoms and the deterioration of the client. These conditions lead to what is perceived as behavioral issues, when in fact they are symptoms of severe mental illness. Unfortunately, the prison system treats behavior issues such as delusional behaviors, and paranoid thoughts and actions as acts of defiance and non-compliance. These behaviors are often treated with punishment. Behaviors may include but are not limited to "...beat[ing] their heads against cell walls, smear themselves with feces, self-mutilate, and attempt suicide (sometimes succeeding). In short they may-and often do-behave in ways that prison systems consider punishable misconduct" (Fellner, 2006, p.395).

The Health Care Act of 1963 recognizes the dignity and strength of an individual by deinstitutionalizing the mentally ill. Unfortunately, this merely switched the location and limited human rights for the severely mentally ill living in the United States of America. Perera (1998) asserts that the only difference between placement in prison and placement in an asylum is the uniform and the societal belief that these individuals deserve punishment. This merely removed these individuals from the public eye once again.

**Homelessness**

The Recovery Model suggests, "Home is where recovery may begin" (Ashcraft, Anthony & Martin, 2008). In addition, researchers claim that housing services, if required, need to flexibly involve people and to build on individuals' personal visions and strengths, instead of "placing" and potentially "re-institutionalizing” people. Morse (1994) cites “Approximately 20-40% of the homeless population is believed to be...
mentally ill.” With minimal funding and housing needs, housing the mentally ill has become more and more difficult. These statistics are merely a rough estimate because of the difficulty mental health professionals have accessing those that are currently homeless or transient. Society (1994) states, "'Radical' forces have estimated the number of homeless to be in the range of 8.5 million people while 'conservative' forces set the mark at approximately five to six hundred thousand homeless" (as cited in Perera, 1998, p. 13). While neither of these extremes give us an accurate figure, it is easy to believe that one third of the homeless population is suffering from mental illness.

According to Mental Illness Policy Org. (2011) website states, "Numerous studies have reported that approximately one-third of homeless persons have a serious mental illness, mostly schizophrenia or bipolar disorder. The percentage is higher among those who are chronically homeless and among homeless women and is lower among homeless families. If overall one-third of homeless persons are seriously mentally ill, that means that there are approximately 250,000 out of 744,000 homeless persons with serious mental illnesses in the United States." Homelessness directly affects a person's quality of life specifically those diagnosed with schizophrenia or bipolar illness due to the difficulty of obtaining their basic needs. "The majority of homeless individuals with untreated psychiatric illnesses regularly forage through garbage cans and dumpsters for their food" ("250,000 Mentally Ill are Homeless. The Number is Increasing" website, 2011).

According to Walsh (2000), federal initiatives passed in 1963, embraced the idea of community care and freedom from incarceration for those who are mentally ill. These initiatives shifted the responsibility for the care of those with mental illness from the state
and federal level to the community level. The belief valued by many was that this would result in lower cost and value patient's rights. By taking individuals out of a locked facility and deinstitutionalizing them, the community would serve in normalizing the lives of clients and provide support in securing employment, housing, socialization opportunities, and access to medical care.

Deinstitutionalization has left the severely mentally ill on the streets, in and out of shelters, in our prisons, and hospitals with their needs unaddressed. These individuals are in serious need of assistance. In light of the current threats to social services, it is imperative for mental health agencies to determine how to successfully serve the needs of this population who face hospitalization, incarceration, and homelessness. For agencies to be more proficient in assisting the severely mentally ill, they will need to be able to identify systems that will assist an individualized plan of action.

**Treatment**

Treatments of severe mental illness often include medication, individual, and group therapy. These treatments have evolved over time. Medication has developed throughout the years and is typically broken down into old school and new school types of drugs. In order to distinguish two eras of the use of medication for mental health treatment, we have divided them into old school and new school. The old school drugs while effective in many ways also had strong, long lasting side effects. Whereas, new school drugs are created to counteract side effects and offer different ways of taking medication including injections, meltables, inhalants, and pills. Some of these new school
drugs have extended release and the ability to remain in the system for up to three months rather than daily pill consumptions.

There are positive and negatives aspects for each individual regarding both old and new school drugs. Health care professionals agree that there is no one perfect combination for everyone and it often takes a lot of time to find the right combination for each individual that works best for them. This trial and error approach to finding the right medication can often create instability for the client. The side effects can be off-putting or unhelpful which may lead to problems with compliance.

**Medication**

There are many viewpoints among health care professionals regarding drug treatment associated with the benefits and harms of psychotropic medications as being one of the contributing factors to a client's degree of compliance with these medications (Rowland, 2008). As part of the clinical model foundation, many clinicians' agree that medication is an integral part of treatment of severe mental illness. This is not the only tactic that is useful when treating those diagnosed with schizophrenia, bipolar, and schizoaffective disorder. Medication may seem a simple solution however, there are several disparities that may make it difficult to trivialize. "Adherence to antipsychotic medications continues to be a significant and challenging question in terms of its prevalence as well as its significant impact on the rate of relapse and resource utilization" (Awad, 2002, p. 75). He further goes on to state that "filling a prescription does not necessarily mean that the prescription is actually taken" (p. 75).
Old school. Whitaker (2002), suggest that 1952 changed the course of psychiatric intervention. The medical model was moving away from tooth extraction, organ removal, frontal lobotomy, and electric shock therapy, which were some of the treatments used in the early years. By the early 1960s, treatments for schizophrenia had markedly shifted from the physical to the pharmaceutical (as cited in Knapp & Parrish, 2012, p. 16). Old school antipsychotic medications Haldol, Navane, Mellaril and Thorazine helped alleviate many positive symptoms such as delusion, hallucinations, and disorganized speech and behavior.

However, the side effects from these drugs have created some of the stigma and stereotypes surrounding old school medication. Shaking, tics, and stiffness in walking is described as the Thorazine shuffle, which is actually the visible description of Tardive Dyskinesia (Alptekin et al., 2009). "Side-effects of anti-psychotic medication can be mild to severe and some of these side-effects are called Extra Pyramidal Symptoms and they are characterized by slow movements, depressed facial expressions, tremors usually noticed in the hands and lips, muscle stiffness, and shuffling gait" (Person, 2007, p.104).

Akathesisa is a side effect with the intense feeling of restlessness and presents as an inability to sit still or as pacing or hand flapping. Other more common side effects are constipation, blurred vision, sedation, difficulty urinating, sexual function and dry mouth. At times, these side effects are professionally treated with other medications including stool softeners and anti-anxiety medications, but some research includes alternatives, which incorporate vitamin regimens, physical exercise, and diet changes such as the reduction of caffeine.
The old school drugs while effective in many ways also had strong long lasting side effects. Whereas, new school drugs counteract side effects and offer different ways of taking medication including shots that will last up to three months rather than daily pill consumptions. There are positive and negatives for each individual regarding both old and new school drugs; however, there is not one perfect combination and it often takes a lot of time to find the right combination for each individual that works best for them. This trial and error approach to finding the right medication can often create instability for the client. The side effects can be off-putting or unhelpful which creates problems with compliance.

Due to the chronic nature that inherently defines severe mental illness there are often perceptions taken on by the client or their family surrounding medication they may have been prescribed in the past. Side effects of the old school antipsychotics are cited as reasoning for not taking medication. Some of these side effects are diabetes, heart damage, shuffling, memory loss, and loss of sexual drive. While the old school medications are still a part of TPPC medication outreach they are used less frequently and need consistent monitoring for things such as bladder/urinary tract infections. Urinary tract infections are commonly unnoticed by the client but are indicated by subtle behavioral changes and somatic symptoms. These subtle changes are easier to note with daily contact that medication outreach provides.

**New school.** New school antipsychotic medications including Risperidone, Olanzapine, and Quetiapine promote adherence to medication. "Overall the new antipsychotics were significantly better tolerated and had a positive impact on treatment
adherence, psychosocial functioning and quality of life" (Awad, 2004, p. 78). New school medication has advanced rapidly over the last few years with new medication coming out that offers fewer side effects and can make some of the medication longer lasting. The beneficial lessening of newer antipsychotic medications side effects, influences the decision making process for many clients. Often clients are more inclined to adhere to a more scheduled medicine regime when they do not feel worse than when they did before taking the medications.

TPPC uses both old and new types of medication to treat some of the symptoms that occur naturally with severe mental illness. Information is a powerful tool and training is provided by the agency for their staff, which allows for honest interactions when discussing medication with clients. Knowledge is power, and TPPC tries to empower the client in every way possible creating a better quality of life through education regarding treatment options.

**Compliance.** Many published reports confirm the significance of attitudes towards treatment and its impact on adherence/compliance and clinical outcomes. Awad (2004) posits negative critical attitudes can be enduring and oft require the clinician or agency to use specific targeted behavioral interventions in addition to expansion of medication-based treatment. Haynes et al (1979) defines adherence "the extent to which the patients' behavior, in terms of taking medications, following diets, executing life style changes, coincide with the clinical prescription" (as cited in Awad, 2004, p. 75). This supports the position that TPPC practices by providing the twice-daily medication outreach for the clients who feel they would benefit from consistent support.
When the DSM-IV-TR (2000) defines schizophrenia and other psychotic disorders it states:

A mental disorder was termed "psychotic" if it resulted in "impairment that grossly interferes with the capacity to meet ordinary demand of life." The term has also previously been defined as a "loss of ego" boundaries or a "gross impairment in reality testing." (p. 297)

According to Awad (2004), there are consistent findings regarding the lack of impact of approaches based solely on psychoeducation, without the additional behavioral, family and economic support. When TPPC provides medication outreach this helps to support the behavioral change the client is seeking along with the reinforcement of the thought process change by providing this daily personal contact as well as the medication. The access to medication is often cited as a challenge for clients as well as the lack of transportation. These are not the only challenges presented as issues. The need for assistance in remembering to take the medication may appear simple if a family member or health care professional is able to administer medication. Unfortunately, this places a different role for the caregiver who becomes the authority and takes away the autonomy of the client when resistance occurs, which can create conflict in the home. Medication outreach promotes change in the quality of life through consistent daily exposure to cognitive behavioral therapy and the recovery model; reinforced with harm reduction as the foundation for practice.

Non-Compliance. Non-compliance refers to those individuals who are not taking their medication regularly. "The best medications are of little value unless they are taken"
(Awad, 2004, p. 75). In 2004, NAMI informs us that the lack of compliance is an issue for psychiatric clients. Furthermore, they list side effects of psychotropic medication are often considered barriers to medication compliance. Awad (2004), suggest reasons for a lack of compliance is motivated by the following factors including negative family or individual attitudes, complex regimens, weight gain, feeling and mood changes, cultural issues, lack of insight, and substance use.

Previous researchers recognize the need to improve medication compliance; however, knowledge on improving medication compliance continues to be limited at best. The paucity of well-designed studies has been limited. Awad (2004), suggest that there is no benefit to psycho educational interventions without adding the accompanying behavioral components and supportive services. TPPC recognizes the need for empirical research emphasizing the positive benefits of symptom management. The focus on supportive service to the clients directly empowers client attitudes and behaviors regarding their choice to comply with a consistent medication regime. With the autonomy attached to the decision-making factors involved with allowing medication outreach in their daily lives, the client is buying in to the idea of creating their own ability to provide themselves with a better quality of life. "Concrete problem solving or motivational techniques were common features of successful programs" (Awad, 2004, p.77).

**Self-medication.** There is strong evidence that supports the prevalence of co-occurring substance abuse in the mental health community. Rowland (2008, p. 40) stated, "In 2002, the National Household Survey on Drug Abuse reports that among the seriously mentally ill, 20% were either abusing or dependent on alcohol/drugs." Miller
(2005) expounds on the letter at Harvard Mental Health, in 2003, which states almost one-half of individuals who profess to addictive behaviors with opiates struggle with depression and 80% of them had a psychiatric disorder.

TPPC encourages the staff and clients to create educated dialogue surrounding self-medication in the mental health community individually as well as in group settings. TPPC is aware of the research regarding the detrimental effects of substance abuse, combined with severe mental illness. Taking the perspective that education, acceptance of the client and where they are at, with no judgment, TPPC creates a neutral environment where it is safe for an individual to practice behaviors that reflect their vision of a quality of life. This may start as a seed, with the idea that possibly self-medication might not provide the quality of life that the client desires. When placed in a nurturing environment the cognitive seed grows and bears fruit with behavioral changes.

Medication outreach may provide an alternative for the client who is trying to regulate their medication by working with small daily doses. Thus, it is self-administered, which creates autonomy and behavioral change that the client seeks, not the practitioner. Conversely, treating co-occurring substance abuse and mental health diagnoses has just begun to evolve surrounding this issue; however, many practices fail to address individuals who are dealing with co-occurring disorders.

These dual disorder individuals are more prone than other people with severe mental illness to experience a number of other negative outcomes, including higher relapse rates, hospitalizations that are more frequent, more physical health problems; greater violence, higher incarceration rates, and more homelessness (Drake et al., 2001).
Theoretical Models used at Turning Point Providence Center

Several theoretical models are incorporated in the assistance and support of TPPC clients. A few of these models used within this agency are harm reduction, recovery, and quality of life, which emphasize the strength based aspect of Turning Point philosophy.

Harm reduction model. According to Denning and Little (2012), the primary developers of Harm Reduction Therapy (HRT), harm reduction provides a common sense approach to preventing harm while not eliminating behaviors. As a movement to reduce harm caused by drug use without mandating giving up the drugs, harm reduction promotes risk reduction and counseling to develop different cognitive behavioral and psychodynamic changes while the client is still addicted. Harm reduction theory honors the social work value of dignity and worth of a person empowering them to choose what works best for them. HRT specifically addresses duel diagnoses. HRT works as prevention, as stated by Denning and Little, "We American's continue to spend vastly more money on the drug war than on treatment--$121.4 billion from 2000-2006 in domestic spending alone compare to only about $5 billion on treatment each year" (p. x).

HRT facilitates gradual behavior change using many techniques such as motivational interviewing, relational psychotherapy and substance use management. HRT principles are "respect, collaboration, incremental client driven change, and offering a menu of options for behavioral change all support an individualized approach" (Denning & Little, 2012, p. 235). Another key point that Denning & Little stress is adapting the treatment to the individual client with the basic principle being that the therapist learns to tolerate and understand the client’s behavior rather than control it. With the help of a
therapist a client explores behavioral change, learns to refrain, adapt and understand their behavioral choices.

HRT is client centered and therapists are encouraged to use assessment as treatment. Denning and Little (2012) promote "...therapist's continual curiosity, observation, and inquiry into the client's experience, past and present, that never stops throughout the course of treatment" (p. 243). Sessions are encouraged to focus on current crisis and involve evaluation, problem solving, and de-escalation. Implementing HRT requires radical acceptance as the most important ingredient of HRT. The therapist attitude will promote building client relationships through interaction with the client, building and maintaining a respectful relationship, and provide space and time for people to invite the clinician into their lives in their own time. The therapist must model radical inclusion of all people and behaviors because this behavior communicates essential information about the therapist. These behaviors encourage the ability to listen and be present in the moment as well as the opportunity to practice neutrality, which promotes trust and respect between client and therapist.

TPPC affords the opportunity to provide limited but sincere daily interactions through medication outreach. The consistency maintained through this daily contact with the provider is essential to create true change, which then leads to the client's definition of a better quality of life through self-determined goals. Once again, this promotes change in the quality of life through consistent daily exposure to cognitive behavioral therapy and the recovery model.
Recovery and wellness model. According to Carpenter (2002),

The recovery model is the name given to a conceptual model that has arisen in reaction to the traditional medical model of mental health practice... For some who struggle with psychiatric disability, recovery can mean genuine and complete remission of symptoms. For others it may mean the symptoms do more than remit; instead, the symptoms actually go away never to return and a complete recovery is achieved. For some, recovery refers to living well with their ongoing symptoms. The path of recovery means simply the ability to live a meaningful life, where coping skills are employed as needed to manage symptoms, and individuals feel empowered as contributing members of their communities in whatever ways, large and small, that complement their circumstance." (as cited in Clossey & Rowlett, 2008, p. 317)

The contrast Carpenter refers to when one observes that the medical model approach has received some criticism for stigmatizing, dehumanizing, and labeling the client. Whereas, recovery expects that clients will be seen as unique in their individuality and circumstance, and encourages treatment that is non-stigmatizing and holistic. The medical model emphasize medication and compliance to treatment and it places the therapist as the experts and the consumer as a patient with no real function or control in their individual recovery process.

The recovery and wellness model emphasizes the quality of life over symptom reduction (Knapp & Parish, 2011, p. 17). Repper and Perkins (2006) agree that finding and nurturing hope is a key to recovery. Furthermore, it includes not just optimism but a
sustainable belief in oneself and a willingness to persevere through uncertainty and setbacks. Hope can start at a certain turning point, or come forth more gradually as a small and fragile feeling, and may fluctuate with despair. Karow and Neber (2002), assert treatment outcomes are becoming more consumer driven as the client's perspective is being considered more often. The medical model promotes symptom reduction as its primary focus, which is less empowering coming from a deficit-based model. When the focus for a client with severe mental health concerns is more about what is wrong with them than that of what is right with them, there is less likelihood of personal growth and recovery.

The recovery and wellness model sheds light on the benefit of a multidimensional focus and the individual's journey as well as personal growth. TPPC encourages clients to view their diagnoses, not as a deficit, but as an asset that makes them the unique individuals that they are. TPPC encourages their staff to help clients and their families build on their strengths. The agency's goal is to provide the individual with access to more services and resources within their community. Individuals living independently may need encouragement and support that is not just financial but also nurtures a better quality of life through promotion of self-determined goals, is essential to better outcomes.

**Quality of life.** According to Katsching article in the October 2006 *Journal of the World Psychiatric Association*,

Psychiatric patients have the specific problem of being stigmatized when they declare themselves as being mentally ill, which seems necessary if they want to obtain the means for survival, including their additional needs for treatment
(drugs, social security benefits, etc.). Such stigma jeopardizes autonomy, since patients are excluded from society, while they want to be "one of us", as qualitative research shows. Many psychiatric patients are thus in a no-win situation as far as the fulfillment of their needs is concerned, and many give up some of their expectations and "cut their coat to their cloth. (p.141)

Since the 1990's, the discussion surrounding quality of life has risen to include nearly all fields of medicine. The quality of life concept, more efficiently addresses the psychosocial aspects when addressing the needs of those diagnosed severely mentally ill. The deficit based biomedical model, of the past, does not address quality of life as thoroughly and takes on a more negative approach to helping.

When measuring the quality of life for individuals with severe mental illness often the topics include psychological well-being, social and emotional functioning, functional performance, life satisfaction, and social support. Addressing these topics with the client allows mental health professionals to create a discourse surrounding the areas the client feels needs to be targeted on their path towards recovery. TPPC uses the Milestone of Recovery (MOR) survey in a monthly meeting between team leaders and staff that is based on the information given by the client through quality of life questions; this is delivered to the Personal Service Coordinators (PSC) throughout the patient-client relationship. The MOR survey uses a 7-point Likert Scale to define these quality of life measurements for TPPC members.
Katsching (2006) postulates,

Today, in clinical trials and health services research, Qol measures are often included in order to describe effects of treatments or of special ways of delivering these treatments; but, as a rule, they are not themselves a target of intervention. In this respect some new developments are under way which may have long reaching consequences for the whole health field, including not only treatment and rehabilitation, but also prevention, and finally also promotion of health. (p. 142)

**Group Therapy**

Group therapy is an important aspect of the recovery and harm reduction models. The socialization skills that are promoted in a group setting are often as beneficial as the information the group is sharing. Group work is community building for individuals with like life experiences. This can be a resource for the individual who might be new to the community or individual who is trying to incorporate more socialization in their lives.

Group therapy when performed in a community based setting makes the change and the effort to do so more of a resource vs. an intrusion or punishment (Denning & Little, 2012). Using several therapeutic approaches based on the client's hierarchy of needs creates a more cohesive learning experience. If one were considering integration into a community this would be a form of immersion. Group therapy often provides a setting with which to practice new behaviors and thoughts. The client can then practice these ideas as they come up naturally linking them to a stronger recovery.
TPPC provides their clients with several group therapy options such as art therapy, fitness therapy, anger management therapy, grief therapy, moral recognition therapy, and activity groups. Through participation in group interactions the client is able to integrate into the larger community through interaction and participation in daily activities. TPPC encourages all interactions as motivational moments of learning. These gradual life exposures, along with the consistent daily medication outreach service, reinforce the learned behaviors when at home. With the ability to check in with the staff member, while in their home environment medication outreach creates a sense of stability during the changing process. Furthermore, this consistency of care creates a safe and nurturing environment for the client to learn and grow. Thus generating a confidence based on respect for the clients choices that promote their quality of life.

**Summary of the Review of the Literature**

In conclusion, the review of this literature indicates the need to study the outcome when combining the current best practice for social workers in the mental health community with daily medication outreach and the study results. There is currently a gap in the literature regarding the effects that daily medication outreach may have on the quality of life for the mental health community, specifically for those who are diagnosed as having schizophrenia, bipolar, or schizoaffective disorders. In the following chapter, research methodology will be explored.

J. Belcher (personal communication, December 10, 2012) states,

It appears necessary that an efficient medical regimen, personal interaction and a feeling of accomplishment is needed to provide the best outcome for clients at
hand. This research should provide the necessary elements of consistency between medication and socialization with follow-up responsibilities, which will provide a healthier outcome. This study should be able to take all of the aforementioned ‘arrows’ of healing and contain them in a holistic quiver for better outcomes for the clients. Each client deserves respect, fellowship, opportunities to learn, socialization, safety, and the best medical model that can be afforded in order to optimize the current situation.
Chapter 3

METHODOLOGY

This study was designed to gather experienced-based opinions of employees at Turning Point Providence Center (TPPC) who work with clients that have been diagnosed with a severe mental illness. Participants in this study were picked through a convenience sample. During the course of this study, TPPC employees were asked to use their expertise and experiences to evaluate the medication outreach program. This agency was also asked to provide the researchers with access to archival data, over the last 36 months. This archival retrieval of secondary data is divided into two separate groups. The first group, group A, consisted of those who were consistently receiving medication outreach for 36 months. The second group, group B, was comprised of those clients who chose not to receive assistance with their medications over the same 36-month period. The researchers used purposive sampling when retrieving archival data from TPPC. A human subject's protection committee, at California State University, Sacramento, approved all procedures before any data was collected.

This chapter is divided into six sections that address the researcher's methodology during the course of this study. The first section presents the design of the study. The second section describes the researchers sampling procedures. The third section addresses the data collection procedures. The fourth section discusses the instruments used for this study. The data analysis is discussed in the fifth section followed by the protection of the human subjects.
Study Design

This is a descriptive study involving the analysis of existing client service records, for clients in the medication outreach program, and a questionnaire of service providers at TPPC. The existing secondary data consists of two sets of client's, those that have chosen to participate in medication outreach and those who have declined this service. The first set of client's, those individuals who have chosen to participate in medication outreach over the past 36 months, are currently TPPC clients and receiving daily medication support. This group is designated group A. The second set of TPPC clients are comprised of those individuals who have declined medication outreach over the same 36-month period. This is group B. These two data sets, group A and group B, provide a description and comparison of individuals diagnosed with a severe mental illness.

The third set of data collected was the service provider questionnaire, which depicts the experienced-based opinions of TPPC professionals working with clients diagnosed with a severe mental illness. The survey consisted of 23 five-point Likert Scale questions and 5 demographic questions. The five questions surrounding demographics provided background and educational information pertaining to the service provider at TPPC. Rubin and Babbie (2008) stated, "Quantitative research is empirical in that it …utilizes experiences and observations as a route to knowledge” (as citied in Rowland, 2008, p. 57).

The initial goal of this study was to describe TPPC daily medication outreach and its possible relations with hospitalization, social connections to the community and recidivism for individuals diagnosed with severe mental illness. The second goal of this
study was to illuminate possible interconnections between medication outreach service and the client's quality of life.

**Sampling Procedures**

Twenty-five TPPC employees were asked to participate in this study. These participants are experienced and knowledgeable in working with individuals diagnosed with a severe mental illness. The study population includes, but was not limited to, males and females with various ethnicities, ages, sexual preference, experience, and educational background. All participants, of this study, were voluntary and include, but are not limited to, psychiatrist, psychologist, nurses, licensed clinical social workers, social workers, therapist, and other mental health professionals within this agency, TPPC.

Participants were asked if they were willing to complete an approximately fifteen minute survey of the medication outreach program. In gratitude for their participation in this study, the researchers offered thank you gifts in the form of homemade cookies, which were placed in a common area at TPPC. All participants in this study work at TPPC, making this a sample of convenience. Informed consent was provided, in the form of a letter (Appendix A), to each participant before the surveys were administered. Returning a completed questionnaire implied that each participant read and consented to participate in this study.

The researchers also explored secondary data collected by TPPC over a 36-month period, which consisted of the years 2010, 2011, and 2012. A portion of the secondary data collected targeted approximately thirty clients in the medication outreach program at TPPC. The researchers identified this portion of clients as group A. The difficulty
surrounding this archival research pertains to the newness of medication outreach service and finding those clients who consistently received support with their medication over the designated 36-month period. Group B is comprised of TPPC clients who chose not to participate in the voluntary medication outreach program over the same 36-month period.

To ensure the privacy of clients at TPPC, the researchers did not list any identifiable information in this project. The data collection tool consisted of information surrounding age, gender, diagnoses, months in program, number of hospitalizations, number of incarcerations, employment status, conservatorship, involvement in therapy, and involvement in the community. The researchers designed this form to measure quality of life and the effect of medication outreach service. Please see Appendix C for a blank copy of the form used in the retrieval of archival data.

**Data Collection Procedures**

This voluntary confidential questionnaire and information sheet was provided to twenty-five TPPC staff members who have direct face-to-face contact with clients receiving medication outreach daily. The researchers only asked questions regarding staff member’s professional, experienced-based opinions regarding working with individuals diagnosed with a severe mental illness. The researchers provided a typed survey to each participant, which took approximately fifteen minutes to complete. The participants were given two weeks to complete and return the survey to the researchers. To ensure anonymity the researchers placed a manila envelope in the mailroom at TPPC for all completed questionnaires; therefore, there was no risk of discomfort or harm to any of the participants. By returning the completed questionnaire, the participants implied that they
read the information sheet and consented to participating in this survey. In order to avoid any real or perceived conflict of interest, as a researcher, Melissa Anne Forbyn-Willett did not participate in this study. Please see Appendix B for the specific questionnaire provided to the participants.

Participants were asked to review an information sheet that detailed all ethical considerations. This form encouraged all participants to answer the questions honestly and emphasized that there is no right or wrong answers. The researchers protected the participant’s unbiased views and stated this clearly in the information sheet that the participants received before the survey was distributed. No one should have felt obligated to participate in this study. See Appendix A for a copy of the information sheet provided to each participant in this study.

The researchers obtained permission from the supervisor at TPPC to retrieve archival data with the condition that researchers would not use any identifiable data of an individual member. This data consisted of TPPC case notes. The researchers selected only information pertaining to those clients who met the criteria of Group A or Group B. No identifiable information was extracted from the archive, thus confidentiality was maintained.

The researchers extracted data from the archives at TPPC regarding two different groups. Group A are those participants in the medication outreach program for over three years consecutively. Group B are those participants offered the medication outreach program and refused. Both groups are current members of TPPC and the only criteria that differed were whether they participated in the medication outreach program or not. The
data form used when collecting information on both groups was the same. Please see Appendix C for a blank copy of this data sheet used by the researchers.

**Instruments**

This survey intended to acquire feedback regarding the medication outreach program at TPPC. The questionnaire contained twenty-eight close-ended questions, which focused on the participant’s experience-based opinions with medication outreach for clients diagnosed with bipolar, schizophrenia, and schizoaffective disorder. The researchers used the Table of Specifications (Yuen, Terao & Schmidt, 2009) as a guide to developing the questionnaire. As a result, the content validity of the questionnaire was established, thus reflecting the current knowledge, practice experience, and focus of the study. The development of items was guided by the research question and grounded in the theoretical framework of this study. Marlow (2005), suggest that by utilizing close-ended questions researchers are better able to analyze gathered data. Unfortunately, close-ended questions do not encompass questions that the researcher’s did not think of ahead of time.

The secondary data intended to acquire documentation regarding clients at TPPC who are currently receiving medication outreach services. The desired outcome was to discover if there is a correlation between the medication outreach program and a better quality of life. However, the researchers were unable to access as many participants in the medication outreach program for the desired 36-month criteria resulting in a small study group. Consequently, the researchers were advised to search for a group that had not chosen medication outreach to create a comparison. Longevity was considered an
important factor to support the idea that individuals who have been diagnosed with a severe mental illness, living independently and consistently maintain their medication outreach services fared a better quality of life. The content validity of the secondary data collected was not threatened due to it reflecting TPPC records over a 36-month period, 2010-2012.

**Data Analysis**

The data that the researchers gathered was input and analyzed by Statistical Package for the Social Sciences 20 (SPSS, IBM, 2012), a computer program. Frequency distribution and variable correlation were all measures of central tendencies used when considering responses to each question. The researchers analyzed the frequency regarding the independent and dependent variables before deciding which two variables to cross tabulate in SPSS. The independent variable, in this study, is the medication outreach with the dependent variable being the societal impact of that action on the individual. Repeated responses were given a higher ranking when analyzing surveys. Fisher's Test and cross-tabulations were used to compare the independent and dependent variables.

The secondary data retrieved from the archives at TPPC was analyzed by comparing and contrasting the difference in the two groups. The frequency of hospitalization, incarcerations, and homelessness between the two groups, A and B, were compared to help determine the significance, if any, medication outreach made on an individual's quality of life. All variables were given equal importance when analyzing secondary data.
Protection of Human Subjects

The Human Subjects Application was submitted for approval to the California State University, Sacramento, Division of Social Work, Committee for the Protection of Human Subjects, prior to the administration of this survey. This study was approved and determined to be an “exempt” study; even though, this research studied a population that is considered high risk (see Appendix D). Only mental health professionals and not TPPC members participated in this study. Due to this exemption, participants were informed, in writing that their completion of this survey implied their consent to participate. Participants were asked to review an information sheet that details all ethical considerations. This information sheet ensures the protection, privacy and opinions of each participant in regards to the medication outreach program offered at TPPC, as seen in Appendix A. The researchers were able to uphold anonymity by not collecting names or other identifying information. See Appendix A for a copy of the information sheet provided to each participant in this study.

The access to the secondary data collected for this study was provided to the researchers by TPPC. The researchers provided TPPC with a data sheet asking for specific information on clients in the medication outreach program, as seen in Appendix C. In order to ensure the privacy of clients during the collection of secondary data, all data collected from TPPC had no identifiable specifiers (see Appendix C). The chapter that follows will analyze the secondary data and questionnaire surveys, collected by the researchers, to display their findings of this research project.
Chapter 4

STUDY FINDINGS AND DISCUSSIONS

This chapter discusses the findings from the secondary data, retrieved from Turning Point Providence Center (TPPC) archive, and the questionnaire surveys completed by experienced based professionals at TPPC in the spring of 2013. The first section of this chapter discusses background. The second section presents an overall finding of the data collected. The third section displays tables and charts from the analyzed data collected from both secondary and questionnaire surveys. The fourth section explores specific findings that the researchers discovered. Any additional findings that the researchers believed relevant to this study are discussed in the fifth section, followed by the summary of the chapter.

Background

This study explored the benefits of Turning Point Providence Center (TPPC) medication outreach program for individuals diagnosed with a severe mental illness. The researchers examined the effectiveness of medication outreach, the correlation for the client between the service provided, and the well-being of an individual diagnosed with schizophrenia, bipolar, and schizoaffective disorder through more involvement with the Turning Point Community. Furthermore, the researchers explored the quality of life for these individuals diagnosed with a severe mental illness. The researchers wanted to evaluate whether an individual's quality of life improved due to being actively involved with the medication outreach program at TPPC.
Overall Findings

The survey was distributed to 25 TPPC employees, with 16 surveys returned to the researchers. The 16 surveys returned indicated that overall the mental health professionals suggested that quality of life improved due to the client's participation in the medication outreach program. Groups A and B indicated that there may be a correlation between voluntary participation in this program and improved community involvement and enhanced participation in therapy. The overall findings were more clinically based than statistically based due to the small sample size of mental health professionals and cliental who met the researcher's criteria available at this rural agency. Furthermore, this is a newer service offered, narrowing the opportunity for a larger population to sample.

Specific Findings

The finding of the surveys amongst the mental health professionals at TPPC illuminated several areas that were notable unilaterally. The survey showed a high level of agreement in the areas of the medication outreach program and the relation to improved physical wellbeing, improved emotional wellbeing, decrease in incarceration, decrease in the possibility of homelessness, and improved desire for therapy, activity, and community involvement. The findings showed the results in these areas are not statistically significant with a critical value (p) set at .10. However, positive correlations are presented with critical values (p) between .10 and .24. The survey also indicated that there is a lack of correlation between the medication outreach program and an individual's improved wellbeing as well as offered services to clients in hospitalized
settings. Furthermore, the participants in this survey overwhelmingly agreed that there was a correlation between the medication outreach program and the improved wellbeing of the individual; the Fisher's Exact Test indicated no statistical findings.

Among the respondents, 15 (94%) replied improved physical wellbeing is highly correlated to improve community integration (Fisher Exact Test, \( p= .18 \)). The respondents, 15 (94%), also indicated frequent improvement in emotional wellbeing of the clients with their participation in the medication outreach program (Fisher Exact Test, \( p= .18 \)). Seventy-three percent of the mental health professionals noted a decrease in incarcerations while 27% felt that there was occasionally a decrease in incarceration when a client was participating in the medication outreach program (Fisher Exact Test, \( p=.15 \)). Sixty-seven percent (2/3) of the respondents indicated a frequent correlation between a client’s coping skill while living independently and a decreases in their risk of homelessness while receiving medication outreach services (Fisher Exact Test, \( p=.24 \)). Replies indicated an occasional increase in the desire to participation in therapy and a frequent increase in desire to participate in activities (Fisher Exact Test, \( p=.15 \)).

Among the TPPC employees, 10 (63%) postulated that medication outreach frequently improved the client's mental. While 14 (93%) responded that they rarely were required to provide medication outreach service in a hospital setting. Please see Table 1 for a summary of the Fisher's Exact Test results.
Table 1

*Summary Table of Cross Tabulations of Variables*

<table>
<thead>
<tr>
<th>Variables</th>
<th>Fisher's Exact Test, p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication outreach improve coping skills within the community/Improved Physical wellbeing</td>
<td>.18</td>
</tr>
<tr>
<td>Medication outreach improve coping skills within the community/Improved Emotional wellbeing</td>
<td>.18</td>
</tr>
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<td>Medication outreach improve coping skills within the community/Improved Mental wellbeing</td>
<td>.70</td>
</tr>
<tr>
<td>Medication outreach improve coping skills within the community/Deliver Medication to Clients Hospitalized</td>
<td>.80</td>
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<tr>
<td>Medication outreach improve coping skills within the community/Decrease the number of Incarcerations</td>
<td>.15</td>
</tr>
<tr>
<td>Medication outreach improve coping skills within the community/Decrease the possibility of Homelessness</td>
<td>.24</td>
</tr>
<tr>
<td>Improved Activity/Improved desire for Therapy</td>
<td>.15</td>
</tr>
</tbody>
</table>

Incarceration, hospitalization and homelessness were directly addressed in the retrieval of archival data. The data tools used included length of housing, length of employment status, conservatorship, therapy, community involvement, and demographic makeup of gender, age and diagnoses. The data was collected for two different groups Group A consisting of five individuals who received voluntary medication outreach services from TPPC for 36 consecutive months, 2010-2012. Group B was comprised of five individuals who declined medication outreach services when offered by TPPC over
the same 36-month period. The archival data retrieved for Group B was identical to that of Group A’s.

Members of the TPPC community program have all received a diagnosis of severe mental illness. There was no significant correlation between those diagnosed bipolar, schizophrenic, or schizoaffective and there was no indication of one diagnosis being more prominent than the other as far as medication compliance is concerned. The secondary data the researchers compiled and analyzed supports the idea that hospitalizations increase without a stable daily medication regimen. Those who are on medication outreach (Group A) had significantly fewer hospitalizations than those members who chose not to participate in this program (Group B). Group A reported seven days of hospitalization as their highest number whereas Group B reported 46 days hospitalized as their highest number of days of hospitalized. Another significant finding the researchers discovered was the number of incarcerations increased when comparing Group A and Group B. Furthermore, archival data suggest that housing was directly affected by a lack of support in maintaining stability with daily medication. Thus, the risk increases for these individuals becoming homelessness due to the aforementioned hospitalization and incarceration for those who choose not to receive support with their medication on a daily basis.

Group B data suggests that those who were not engaged in daily medication outreach were also not involved with therapy and very rarely involved within the community. The researchers discovered a significant correlation between those who consistently received medication outreach (Group A) and the desire to remain on medication outreach support
verses those who were either on it for a short amount of time or those who were not willing to participate at all (Group B). Another notable finding was that conservatorship often was removed or not needed for those clients who were maintaining daily medication (Group A) through this program verses those who were unwilling to participate in daily medication outreach services (Group B).

The increase in community involvement with those members who chose to participate in daily medication outreach (Group A) rose significantly as opposed to the lack of community involvement of those who chose to handle their own medication (Group B). Community involvement rose with length of time and exposure for those who chose to receive daily support with their medication. Those individuals in Group B displayed a lack of community involvement and difficulty remaining engaged with TPPC at all.

Therapy is an integral piece of TPPC client self-determined program. It is an essential component for effective treatment when diagnosed with a severe mental illness. Therapists provide a sounding board for the client and a professional gauge of symptom management. The therapist is also the person who directs and manages the medications including all changes whether an increase or decrease.

Group A results indicated that there was a higher level of consistency in attending and participating with the therapist. Group B results indicated that there was little or no attendance or participation with the therapist. While medication and therapy alone are less effective for clients diagnosed with a severe mental illness together these two components can create an effective component of treatment. Since Group A, as a
voluntary status, chose both medication and therapy consistently one could postulate that this could correlate with an improved quality of life.

**Additional Findings**

The researchers noted a consistency in several areas of the survey. All or most participants of the survey reported the same answers on several questions. Specifically, areas surrounding personal goal setting, improved coping skills within the community, and adherence to medication. Seventy-five percent (12 participants) of those who were surveyed report that personal goal setting frequently improved with participation in the medication outreach program (Table 2). All respondents agreed that medication outreach services improved the clients coping skills within the community (Table 3). With the exception of one participant, the majority of TPPC health care professionals agreed that adherence to the recommended medication regimen would rarely/occasionally be possible for individuals diagnosed with a severe mental illness (Table 4).

Table 2

**Medication Outreach Increases Personal Goals**

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
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</thead>
<tbody>
<tr>
<td>Occasionally</td>
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<td>25.0</td>
</tr>
<tr>
<td>Frequently</td>
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<td>3</td>
<td>18.8</td>
</tr>
<tr>
<td>Total</td>
<td>16</td>
<td>100.0</td>
</tr>
</tbody>
</table>
Table 3

**Medication Outreach Improving Coping Skills within Community**

<table>
<thead>
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<th>Frequency</th>
<th>Percent</th>
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</thead>
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<td>13</td>
</tr>
<tr>
<td>Very Frequently</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>16</td>
</tr>
</tbody>
</table>

Table 4

**Ability to Adhere to Medication Regimen Without Medication Outreach Services**

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Percent</th>
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<td>Rarely</td>
<td>8</td>
</tr>
<tr>
<td>Occasionally</td>
<td>7</td>
</tr>
<tr>
<td>Very Frequently</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>16</td>
</tr>
</tbody>
</table>

The archival data suggest that demographics may play a part in an individual’s choice to participate in the medication outreach program. It was noted in the data retrieved that gender might have significance as to who may choose to participate in medication outreach services. The findings showed more female participants involved in this program compared to those non-participants who were mostly male. Age was an identifiable component in the demographic information retrieved. All of those who were receiving medication outreach for over 36-months consistently were over the age of 60 years. Conversely, all those who declined to participate in the program were under the age of 60 years.
Summary

Some of the professional participants in the survey advised additional questions be addressed in further studies. The participants provided valuable quantitative insight about the medication outreach program and their client's involvement. The archival data retrieved provided historical qualitative insight to the client's changes in mental health status, environment and their quality of life. The collected demographic variables in Group A and B indicated age and gender played a small role in participation in the medication outreach program. However, demographic variables were irrelevant factors in the responses returned by the TPPC professionals. The proceeding chapter will provide further interpretation of the data collected and implications for future research will be discussed.
Chapter 5

CONCLUSION, SUMMARY, AND RECOMMENDATIONS

The literature review sustains the allegation that the use of a consistent daily medication regimen, therapy, and community involvement are effective supports in the treatment of those individuals diagnosed with schizophrenia, bipolar and schizoaffective disorder. The risk related with medication mismanagement has a strong correlation with an individual's quality of life. Therefore, pointing to a need for daily medication outreach services for individuals with severe mental illness, living independently within the community.

This chapter focuses on summarizing the purpose of this study. It will also discuss themes that emerged from the analyzed data in relation to the research discussed in Chapter 2, review of the literature. The implication for social work is presented in the second section. The third section focuses on recommendations. The limitations of the study are highlighted in the fourth section of this chapter followed by the conclusion.

Summary of Study

The aim of this descriptive study was to provide insight into medication outreach services and the benefits for an individual diagnosed with severe mental illness. The review of the literature reflects the high rate of incarceration, hospitalization, and homelessness directly affecting the individual as well as the community. The researchers sought professional opinion regarding clients receiving medication outreach services from Turning Point Providence Center (TPPC). Secondary data measured consistency of a 36-month criterion and participation verses non-participation in the medication outreach
program. The combined results of the questionnaire in coordination with those of the archival data retrieved indicated a positive correlation between participation in the program and lowered rates of incarceration and homelessness. Furthermore, the results indicated an improved amount of community involvement and desire to participate in therapy. The intention of the research was both testing hypotheses and formulating more specific questions for future studies.

**Implications for Social Work**

The Health Care Act of 1963 recognizes the dignity and strength of an individual by deinstitutionalizing the mentally ill. Unfortunately, this merely switched the location and limited human rights for the severely mentally ill living in the United States of America. Professional social workers focus on how life choices and environment influence individuals and society more effectively than other professions. Social workers continuously strive to protect and advocate for the oppressed, stigmatized and underrepresented on a macro, mezzo and micro level.

**Macro**

Current policies in the mental health arena are expanding and changing more rapidly. The passing of the Mental Health Services Act (MHSA), Proposition 63, in 2004 was a 1% tax on personal income in excess of $1 million designed to fund the transformation of the mental health care system in California. MHSA provided a larger amount of available funding for the government to allocate to the many different mental health agencies, counties and programs throughout the state. Furthermore, Laura's Law, Assembly Bill (AB) 1421, passed in California in 2002.
Laura's Law enabled the courts to legally require individuals meeting the specific criteria of schizophrenia, bipolar, and schizoaffective disorder to comply with treatment to live independently within the community. Part of that treatment includes maintaining a consistent medication regiment. Medication outreach has proven to be effective in helping this highly symptomatic group to comply with the court order and maintain their independence at a low cost to the county. Los Angeles County is in the process of implementing this legislation and New York is currently implementing similar legislation.

**Mezzo**

Caregivers, family, and community members are often strong supports for the severely mentally ill. Difficulty may arise for the caregiver when a person who is extremely paranoid or anosognosia, with little insight into their illness, resist taking their medication. This support can often be taxing for caregivers living with an individual who experiences symptoms of severe mental illness. Medication outreach is a voluntary program taking the caregiver out of the position of being the authoritarian and places the social worker in the position of encouraging medication compliance. This affords the social worker opportunities to create in-roads and build a stronger relationship with the client outside of the office setting. This creates a more comfortable living environment rather than a more institutionalized environment; thus creating a more cohesive environment within the community.
Micro

Medication outreach services uphold the social work edict to recognize the worth and dignity of every individual. The key to this program is the voluntary aspect even when the client is court ordered to participate in order to maintain their independence in the community. This client-centered approach is the essential component to the success of the program by supporting the clients self-defined goal to maintain their autonomy in the community. Due to the therapeutic aspect of the interaction between client and social worker, the inherent nature of medication outreach services administered in an individual's home is perfectly suited for a professional social worker. These professionals encourage empowerment within an individual and promote the development of a safe environment; decreasing stigma and advocating change in the community.

Recommendations

This project provided insight into the benefits of medication outreach services for the severely mentally ill at Turning Point Providence Center (TPPC). The researchers recommend a more in-depth study involving a larger population sample, due to the positive correlations found between medication outreach services and an improved quality of life. Further study would be beneficial including a mechanism that measures the effectiveness of medication outreach and risk of suicide associated with this population. The researchers advise further study to establish validity with the immanent growth, depth, and breadth of this program as more areas embrace medication outreach services. Furthermore, it would be beneficial to conduct a study that depicts the cost, risk, and benefits of medication outreach.
Limitations

Medication outreach services are a newer service offered to the specific clients who meet criterion at TPPC. While the benefits to the client and community are notable, a small homogenous group able to meet the 36-month criterion limited the researchers data from Group A (N=5) and Group B (N=5). Other limitations included the ability for program comparison. The quantitative questionnaire was created with consideration for the availability of the participants being surveyed resulting in a five-point Likert Scale design. A qualitative study would be an exploitative tool to illuminate in-depth professional opinions.

Conclusion

With changes in mental health growing daily and funding becoming more available, education and willingness are essential for professionals to embrace new ideas that promote individual and community health. The literature supports a correlation between symptom management and medication. Although effective, medication fails to address stigma, social connection, relationship building and involvement for these individuals within the community. Medication outreach services address this need to establish a self-determined quality of life for clients with severe mental health challenges. With professional social workers at the helm, this program has the ability to help transform how one approaches the client and how the client approaches society.
Appendix A

Information Sheet

You are being asked to provide information through a survey to assist in determining if medicine outreach helps clients with schizophrenia, schizoaffective, and bipolar by Brittany Morgan Fagundes and Melissa Anne Forbyn-Willett, graduate students in the Division of Social Work at California State University, Sacramento for their thesis study. The purpose of this project is to determine whether medicine outreach decreases clients with schizophrenia, schizoaffective, and bipolar disorder likelihood to be hospitalized; as well as if medicine outreach helps these clients become more active members in their community.

You will be asked to respond to questions about the current medicine outreach program at Turning Point Providence Center, California and its effectiveness in helping patients with schizophrenia, schizoaffective, and bipolar disorder maintain active roles within their community. The information obtained from the survey will be used to determine if other mental health agencies should adopt a medicine outreach program for their clients.

There is no risk associated with participating in this study. We will only be asking questions about your professional experiences with clients, and covering topics that you work with on a regular basis. After completing the interview your answers will be incorporated into helping bring awareness to the importance and effectiveness of medicine outreach to other mental health agencies throughout California.

Your participation in this survey as well as any personal identifying information obtained during the interview process will be kept confidential. In the final draft of the thesis only the key data collected and the effectiveness of the program will be published. As participants of this survey, you will be informed of the content of the survey questions prior to our meeting and may choose not to answer any questions that make you uncomfortable. By completing and returning this survey you are acknowledging to have read this consent form and have agreed to participate in this questionnaire study. Your questionnaire surveys will be kept in a separate locked box and stored at our own home. All of the materials will be shredded following the completion of this project. Your name will not be connected with the information you have provided, however the project as a whole will be shared as public information. If you have any question about this questionnaire survey please contact our thesis advisor Dr. Francis Yuen by e-mail at fyuen@saclink.csus.edu or by telephone at (xxx) xxx-xxxx. You may also contact either of the researchers if needed, Brittany Morgan Fagundes at xxxxxxxxxxxxxxxx@xxxxx.com or (xxx) xxx-xxxx and Melissa Anne Forbyn-Willett at xxxxxxxxxxxxxxxx@xxxxx.com or (xxx) xxx-xxxx.

You may decline to participate in the study without any consequences. You will receive a thank you lollipop in return for your participation in this study. Your completed and returned questionnaire survey is your agreement to participate in this study and implied consent to put any information provided into this project.

Sincerely,
Brittany Morgan Fagundes and Melissa Anne Forbyn-Willett
Appendix B

Questionnaire Survey

1) Approximately how long have you been employed with Turning Point Providence Center? _____
2) What is your position at Turning Point Providence Center? ________________
3) Do you have daily contact with clients? _____ Yes _____ No _____ N/A
4) Approximately your total years of experience working with those who are diagnosed with Schizophrenia, Schizoaffective and Bipolar Disorder. _______
5) On average, how many clients are on your case load? ____________
6) Do you have clients who are conserved by the state or other conservator?
   ____ Very Frequently ____ Frequently _____ Occasionally _____ Rarely _____ Never
7) Do you offer medicine outreach support to clients living in transitional housing?
   ____ Very Frequently ____ Frequently _____ Occasionally _____ Rarely _____ Never
8) Have you ever been required to support clients with medication outreach services if hospitalized?
   ____ Very Frequently ____ Frequently _____ Occasionally _____ Rarely _____ Never
9) Have you ever been required to support clients with medication outreach services if incarcerated?
   ____ Very Frequently ____ Frequently _____ Occasionally _____ Rarely _____ Never
10) Have you ever been required to support clients with medication outreach services living independently?
    ____ Very Frequently ____ Frequently _____ Occasionally _____ Rarely _____ Never
11) Have you ever been required to support clients with medication outreach services who are homeless?
    ____ Very Frequently ____ Frequently _____ Occasionally _____ Rarely _____ Never
12) Do you believe medication outreach improves the client's physical wellbeing?
    ____ Very Frequently ____ Frequently _____ Occasionally _____ Rarely _____ Never
13) Do you believe medication outreach improves the client's mental wellbeing?
    ____ Very Frequently ____ Frequently _____ Occasionally _____ Rarely _____ Never
14) Do you believe medication outreach improves the client's emotional wellbeing?
    ____ Very Frequently ____ Frequently _____ Occasionally _____ Rarely _____ Never
15) Do you believe if medication outreach were unavailable your client's would be able to adhere to their medication plan?
    ____ Very Frequently ____ Frequently _____ Occasionally _____ Rarely _____ Never
16) Do you consider medication outreach positively promotes the physiological outcomes such as breathing, food, water, sleep, homeostasis, and excretion for clients?
    ____ Very Frequently ____ Frequently _____ Occasionally _____ Rarely _____ Never
17) Is there an increase in the client's ability to cope with their mental health symptoms when receiving medication outreach services?
   ____ Very Frequently ____ Frequently _____ Occasionally ____ Rarely _____ Never

18) Has a client on your caseload ever requested medication outreach services?
   ____ Very Frequently ____ Frequently _____ Occasionally ____ Rarely _____ Never

19) Has a client's family ever requested medication outreach services?
   ____ Very Frequently ____ Frequently _____ Occasionally ____ Rarely _____ Never

20) Do clients report building easier relationships with their family, friends, and neighbors while receiving medication outreach services?
   ____ Very Frequently ____ Frequently _____ Occasionally ____ Rarely _____ Never

21) Does a medication outreach service help to improve a client's ability to pursue more independent activities such as shopping, banking, bill paying, etc.?
   ____ Very Frequently ____ Frequently _____ Occasionally ____ Rarely _____ Never

22) Does medication outreach service help to promote client's hygienic habits such as showering, brushing teeth, changing clothes, etc.?
   ____ Very Frequently ____ Frequently _____ Occasionally ____ Rarely _____ Never

23) Do you notice an increase in ability to set personal goals with client's who receive medication outreach services?
   ____ Very Frequently ____ Frequently _____ Occasionally ____ Rarely _____ Never

24) Does medication outreach service increase a client's desire to establish roles inside the Turning Point Providence Center community?
   ____ Very Frequently ____ Frequently _____ Occasionally ____ Rarely _____ Never

25) Does medication outreach service increase a client's desire to establish roles outside the Turning Point Providence Center community?
   ____ Very Frequently ____ Frequently _____ Occasionally ____ Rarely _____ Never

26) Does medication outreach service increase a client's desire to participate more readily in therapies at Turning Point Providence Center?
   ____ Very Frequently ____ Frequently _____ Occasionally ____ Rarely _____ Never

27) Does medication outreach service increase a client's desire to participate more readily in activities at Turning Point Providence Center?
   ____ Very Frequently ____ Frequently _____ Occasionally ____ Rarely _____ Never

28) Does medication outreach improve a client's coping skills in their interpersonal relationships within the community?
   ____ Very Frequently ____ Frequently _____ Occasionally ____ Rarely _____ Never
### Appendix C

Secondary Data: Data Collection Over 36 Months

<table>
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<tr>
<th>Case Number</th>
<th>Gender</th>
<th>Age</th>
<th>Diagnoses</th>
<th>Months in MO Program</th>
<th>Hospitalization Number of Hospitalization</th>
<th>Incarceration</th>
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<th>Housing</th>
<th>Employment Status</th>
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To: Brittany Fagundes & Melissa Forbes-Willett  Date:  11/5/2012

From: Committee for the Protection of Human Subjects

RE: YOUR RECENT HUMAN SUBJECTS APPLICATION

We are writing on behalf of the Committee for the Protection of Human Subjects from the Division of Social Work. Your proposed study, “Medication Outreach.”

_X_ approved as ____ X_EXEMPT ____ MINIMAL RISK _____

Your human subjects approval number is: 12-13-020. Please use this number in all official correspondence and written materials relative to your study. Your approval expires one year from this date. Approval carries with it that you will inform the Committee promptly should an adverse reaction occur, and that you will make no modification in the protocol without prior approval of the Committee.

The committee wishes you the best in your research.

Professors: Maria Dinis, Jude Antonyappan, Teiahsha Bankhead, Serge Lee, Kisun Nam, Maura O’Keefe, Dale Russell, Francis Yuen
Appendix E

Agency Letter: Turning Point Providence Center

October 3, 2012

To Whom It May Concern:

Melissa Willett and Brittany Fagundes have proposed to do a research project at Turning Point Providence Center for their Master of Social Work thesis regarding the effects of Medication Outreach for clients with severe and persistent mental illness (schizophrenia, severe bipolar disorder, or schizoaffective disorder). They will be canvassing Personal Service Coordinators about their clients using a survey they have developed, and will also be researching data about how TPPC client hospitalizations, arrests, education, and employment are affected by medication outreach.

This project has been reviewed and accepted by the Clinical Director, Trina Flentge, and Lynn Cameron, LCSW, Clinical Team Leader.

Sincerely,

Lynn Cameron, LCSW
References


