A DESCRIPTIVE STUDY OF THE UTILIZERS OF A PRIORITY ACCESS SYSTEM IN A COMMUNITY MENTAL HEALTH CENTER

by

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Chapter I

Introduction

Community mental health centers were originally conceived as having the capability of providing timely services to all members of their local communities (Caplan, 1964). However, over the past twenty years, the demand for services has become greater than the resources available. This excess demand has resulted in waiting time for services ranging from one day to three months (Hochstudt & Trybula, 1980; Folkins, Hersch, & Dahlen, 1980; Craig, Huffine, & Broaken, 1974; Wolkon, 1972).

Realizing that a prologned delay in services may be detrimental to some client's mental health, community mental health centers established priority populations for which limited resources would be allocated first. The state legislature of Oregon, provider of most of the funding for community mental health centers in the state, established that the priority population of these centers should be those individuals who are at immediate risk of hospitalization due to a mental or emotional disturbance and those individuals in need of continuing services to avoid hospitalization. The chronically mentally ill and people in active crisis have been identified as the most in need of services from community mental health centers by many authors in the literature (Bloom, 1984; Craig, Huffine, & Broaken, 1974; Schwartz, 1971).

The problem community mental health centers now face is identifying and providing timely services to their priority

population, clients in active crisis and the chronically mentally ill. Centers must have organizational arrangements to assure rapid accessibility to treatment for these groups of individuals (Rossi & Freeman, 1982).

The purpose of this descriptive retrospective study was to examine whether one community mental health center was effective in identifying and providing rapid access to treatment for its priority population. Evaluation is an important component of a community mental health center and is one of the twelve essential services mandated by the federal legislature which indirectly finances most centers (Andrulis & Mazade, 1983).

Review of the Literature

Crisis Theory

The center under study based their program on a crisis theory framework. Therefore, the literature review will begin with an exploration of the key concepts of crisis theory. Next, the focus will turn on how crisis theory can be operationalized in the organizational structure of a community mental health center and provide criteria to measure program effectiveness.

Lindemann (1944) is credited with the foundation of crisis theory in his article in which he described the psychological effects of the fatal Coconut Grove night club fire on the survivors and relatives of the victims. Lindemann realized that proper counseling during the initial period of grief may prevent the later occurrence of prolonged mental health problems. Many authors have since elaborated on

Lindemann's basic concepts. A review of these author's ideas will be presented in order to provide a clear conceptual picture of crisis theory.

Definition of crisis. Webster's Third New International Dictionary (1971) defines crisis as "an emotionally significant event or radical change of status in a person's life; a psychological or social condition characterized by unusual instability caused by excess stress and either endangering or felt to endanger the continuity of the individual or his group" (p. 538). Parad and Caplan (1965) define crisis as "a state of disequalibrium overpowering the individual's moseostasis mechanisms" (p. 56).

The crisis period is characterized by an increase in tension, anxiety, and unpleasant emotional feelings (Jacobson, 1983). If a crisis continues without resolution, the individual may experience a general disorganization of functioning (Caplan, 1961). Lindemann (1944) described this dysfunctional state in his description of individuals who were preoccupied with the precipitating event, complained of physical distress, verbalized feelings of guilt, displayed hostile behavior, and experienced a change in their usual pattern of conduct.

Development of a crisis. The concept of crisis is grounded in the theory of emotional homeostasis (Parad & Caplan, 1965). The concept begins with a person being faced with a "change" in their life situation (Burgess & Lazare, 1976). This change is caused by an unavoidable development or situational event (Bloom, 1984). Examples

of major life change events are divorce, unemployment, the death of a spouse, and retirement.

The life change event may present the individual with a loss of the fulfillment of psychological needs (sense of love and belonging) resulting in increasing levels of anxiety (Strickler & La Sor, 1970). The event may threaten the individual's basic security needs: love, a sense of identity, and body integrity (Parad, Resnick, Ruben, Zusman, & Ruben, 1975). Caplan (1961) describes this as an emotionally hazardous situation.

Three variables interact to determine the outcome of an emotionally hazardous situation: the magnitude of the event, the perception of the event as stressful or a threat to them or their life goals, and the strength of the family's coping abilities (Hill, 1965). Hill developed his model in working with families, not individuals. However, the same variables can be used in evaluating an individual's response to a life change event. If the individual does not perceive the life event as a threat or has the coping abilities to adjust to the change, then the individual will remain in emotional homeostasis and a crisis will not develop (Taplin, 1971).

However, if the individual perceives the event as a threat and usual coping methods are not successful in dealing with change arising from the event, then the event becomes stressful (Burgess & Lazare, 1976; Eastham, Coates, & Allodi, 1970). As the individual's problem solving methods fail, the problem overtaxes the individual's psychological resources (Parad & Caplan, 1965).

Individuals may attempt to cope by utilizing their social networks, if available, as a means of support. However, the social network may be inadquate or ineffectual in assisting the individual in coping with the change from the life event. When internal and external resources fail to resolve the individual's problem, increased feelings of helplessness and behavioral disorganization may result, and the person may feel overwhelmed by the stress (Parad, Resnick, Ruben, Zusman, & Ruben, 1975; Walkup, 1974).

When there is failure to cope with change from a life event, an emotional crisis develops (Burgess & Baldwin, 1981). The individual's emotional homeostasis or equalibrium is disrupted, and the person is considered to be in active crisis (Burgess & Lazare, 1976).

Crisis resolution. A crisis is considered self-limited in a temporal sense (Rapoport, 1965). The crisis period will usually last from one to three weeks (Caplan, 1964). The individual cannot remain in disequilibrium for any greater length of time without sustaining psychological or physiological damage (Lukton, 1974). Adaptive or maladaptive, the individual will cope in order to reestablish equilibrium (Caplan, 1964).

The crisis state is both a danger to and an opportunity for ego integration (Kardener, 1975; Eastham, Coates, & Allodi, 1970). Through successful resolution of the crisis, the person may obtain new insights and problem-solving skills (Parad & Resnick, 1975). However, unsuccessful attempts at resolving the crisis may lead to continued internal turmoil and ultimately to mental illness (Parad & Resnick,

1975).

If the individual's usual problem-solving skills have failed and anxiety has built to a high level, there are three ways through which the individual may resolve the crisis and thus reestablish emotional equilibrium. The first way is through the individual's ego defense mechanisms (Strupp & Blackwood, 1980; Rusk, 1971; Sifneos, 1960). Emotional responses to the life change event are repressed into the unconscious part of the mind. Through the use of denial, the individual is "rid of the problem" and can thus return to emotional equilibrium. However, since the individual has repressed instead of dealing with the emotions stirred up by the problem, there is a potential for mental health problems to develop later in the individual's life (Sifneos, 1980; Kardener, 1975). Therefore, this method of resolving a crisis is considered by many to be maladaptive (Strupp & Blackwood, 1980; Sifneos, 1980; Kardener, 1975; Rusk, 1971).

The second way individuals may resolve a crisis is by obtaining emotional support from their social network (Narayan & Joslin, 1980; Baldwin, 1977; Kardener, 1975). However, the social network may not be effective in helping the person cope with the problem. If the social network can support the individual through a crisis, then that has to be viewed as adaptive. However, some writers (Narayan & Joslin, 1980; Kardener, 1975) express concern about what will happen the next time the person is faced with a life change event. Must the individual continue to rely on external support to survive crisis periods?

Kardener (1975) viewed total reliance on an external support system as fostering dependent behavior. Narayan and Joslin (1980) described the reliance on external support as regressive behavior. This writer's concern is what may happen the next time the individual is faced with a life crisis. An external support system should be viewed as a positive factor for individuals. However, it does not preclude the necessity of the need to be an autonomous individual. A support system may not always be there for the individual to fall back on during a crisis.

Another method by which an individual may resolve a crisis is through crisis intervention therapy. Many writers view this method as providing the best opportunity for growth by the individual (Murphy & Fawcett, 1983; Strupp & Blackwood, 1980; Sifneos, 1980; Kardener, 1975; Parad, Resnick, Ruben, Zusman, & Ruben, 1975; Rusk, 1971; Caplan, 1961). Crisis intervention therapy involves supporting individuals during a crisis, helping them identify and deal with their feelings, helping them change their perception of the event so that it is no longer viewed as a threat, helping them change their life situation, helping them to learn new behaviors, and assisting them in solving their current problems through teaching of new problem solving skills that they can also use in the future (Parad, Resnick, Ruben, Zusman, & Ruben, 1975). With effective crisis intervention, the individual returns to emotional equilibrium at a higher level of functioning than before the occurrence of the crisis (Murphy & Fawcett, 1983; Strickler & La Sor, 1970; Morley, Messick, & Aquilera,

1967). Through the teaching of adaptive means of coping, crisis intervention therapy can be viewed as preventing maladaptive means of coping which might lead to or foster mental health problems (Narayan & Joslin, 1980).

To summarize the concepts of crisis theory, a conceptual model is presented in Figure 1 on page 9. Included in the model are the variables identified by Hill (1965) as determining the outcome of an emotionally hazardous situation and the means by which the individual can reestablish emotional equilibrium or homeostasis.

Crisis Theory and the Community Mental Health Center

Crisis theory provides some important intervention strategies for community mental health centers to incorporate into their program planning. An individual who is unable to resolve a problem with usual coping methods will be in a state of disequilibrium for a period lasting from one to six weeks. During this period of time, the individual may turn to friends, relatives, or other sources of social support. If these sources are unavailable or unable to help with the problem, contact may be made with the mental health system.

Due to unfamiliarity with the mental health system, contact may be made with a number of agencies within the community such as hospital emergency rooms or the county health department. Coordination between agencies within a community is essential to assure that individuals receive services when needed (Craig, Huffine, & Broaken, 1974). A community mental health center must provide access to the system, have a process for identifying individuals requiring immediate services,

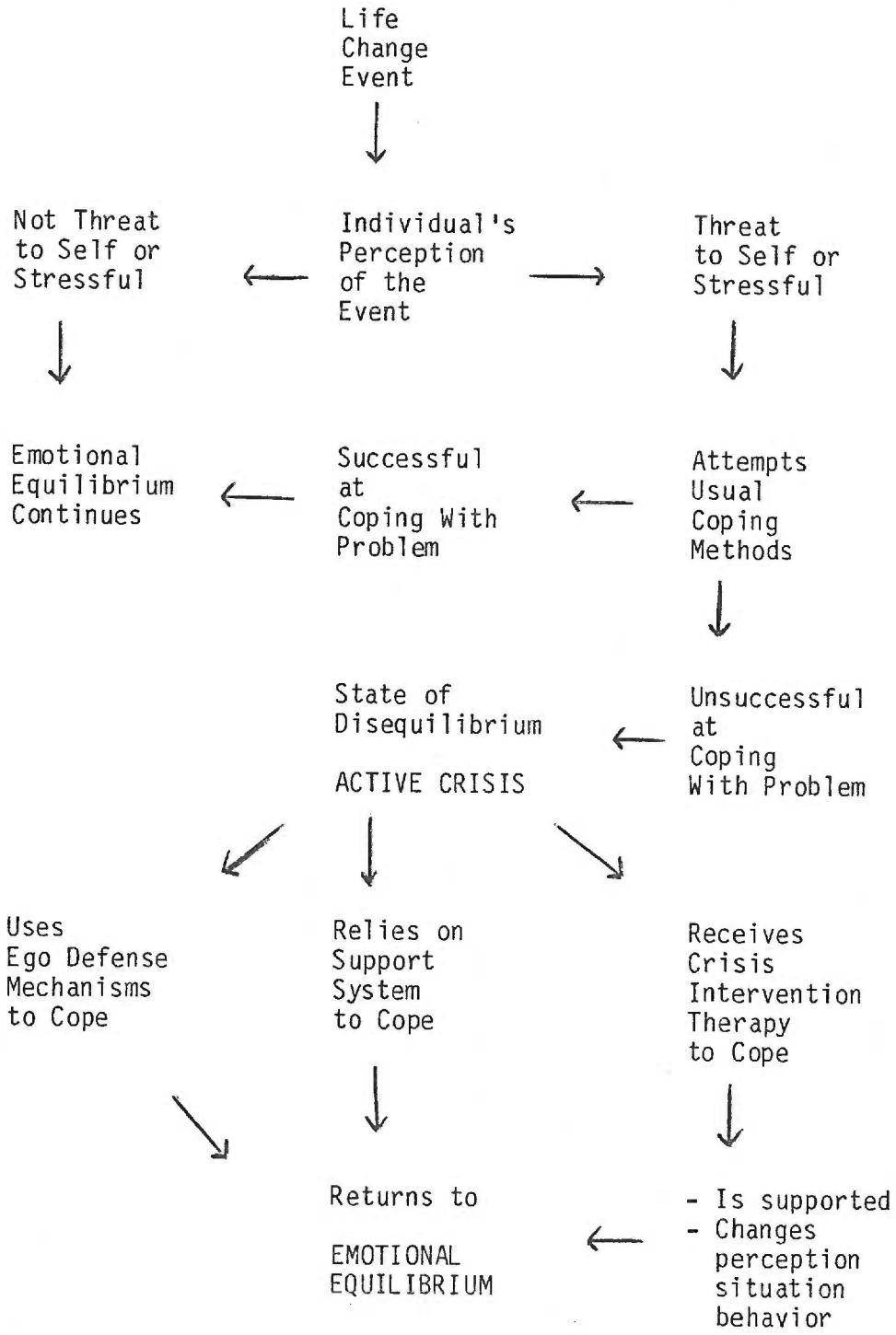

Figure 1. Conceptual Model of Crisis

and have a program for providing these services (Bloom, 1984).

Criteria for identifying people in crisis. It could be argued that everyone calling a community mental health center is in a state of crisis to at least some degree. It can be assumed that the individual's usual coping skills and social support system have been unsuccessful in helping them cope with their problem. By calling the center, clients are signaling their need for help to the environment (Schwartz, 1971). Community mental health centers should provide services to clients at the time their need is the greatest and they are receptive to assistance (Harris & McCarthy, 1981). A person's motivation for change is greatest at the height of the problem (Perlman, 1965).

Unfortunately, the ideal, providing services in a timely manner to all clients requesting services is not always financially feasible. Therefore, it is important for the center to identify those clients who are in active crisis and provide priority services to them (Bloom, 1984; Rapoport, 1965; Ginatt, 1961).

A judgment must be made as to which individuals are most likely to be in ghe greatest state of crisis and therefore require rapid access to treatment. The literature provides two criteria for evaluating whether or not a person is in crisis; the presence of a major precipitating event and the person's general functioning ability.

Precipitating Event

The presence of a precipitating event is the one most common

element of a crisis situation (Bloom, 1984; Hoff, 1978). In asking a group of professionals to judge whether or not a person was in crisis, Bloom (1965) found that a precipitating event was the most common single element necessary for a person to be judged in the crisis. Halpern, in 1973, found that clients in an outpatient mental health center had been exposed to many more life events than a control group from the general population.

The research literature provides supporting evidence for an association between the recent occurrence of stressful life events and mental and physical health problems. Many studies used either the Social Readjustment Rating Scale as developed by Holmes and Rahe (1967) or a modified version of the instrument to evaluate for recent stressful life events. Using the scale, a number of researchers (Aneshensel & Stone, 1982; Block & Zautra, 1981; Wilcox, 1981; Pearlin, Lieberman, Menaghan, & Mullan, 1981; Papa, 1980; Vinokur & Selzer, 1975; Holmes & Masuda, 1973; Hudgens, 1973; Paykel, 1973; Markush & Favero, 1973; Myers, Lindenthal, & Pepper, 1973; Paykel, Myers, Dienelt, Klerman, Lindenthal, & Pepper, 1969) reported a positive correlation between scores on the scale and physical and mental health problems (defined by various measures).

Holmes and Rahe (1967) based the Social Readjustment Rating Scale on the assumption that major changes in life require adjustment by the individual and that this adjustment is stressful for the individual. They included 43 life events on their scale. Holmes and Rahe validated the instrument by having a variety of different

populations rate the stressfulness of the events. Consistently judged the most stressful events were the death of a spouse, divorce, separation, jail term, death of a close family member, personal illness or injury, marriage, being fired at work, marital reconciliation, and retirement. Noticeably missing from Holmes and Rahe's Scale, which was written back in 1967, is any mention of family violence or incest. The recent literature contains articles by many authors (Chesnay, 1984; Germain, 1984; Pfouts, Schopler, & Henley, 1982; Geiser, 1981) that suggest that incest and family violence is both physically and psychologically damaging not only to the victim but to the family members who witness or have knowledge of the abuse.

Holmes and Rahe included positive as well as negative events on their Scale as they believed that both required adjustment by an individual, and that it was the degree of adjustment that was correlated with the amount of stress the individual would incur. However, there is evidence in the literature that it is the negative events that are correlated with increased mental and physical health problems. In analyzing what events psychiatric inpatients had been exposed to in comparison to a control group from the community, Paykel, Myers, Dienelt, and Klerman (1969) found that the control group had actually been exposed to more positive events recently (such as job promotion or marriage). Similar findings were reported by other researchers (Block & Zautra, 1981; Vinokur & Selzer, 1975; Myers, Lindenthal, & Pepper, 1973; Paykel, 1973; Mueller, Edwards, &

Yarvis, 1977 & 1978).

Lazarus (1966) makes the point that the effects of life events cannot be generalized as always stressful or not stressful because stress is a transaction between the individual and the situation. Parad and Caplan (1965) individualized life events as stressful if the event has a basic importance to the individual and if it is difficult to handle by usual coping methods.

While acknowledging the individualization of life events, certain major negative life events can be assumed to place an individual in what Caplan (1961) termed an emotionally hazardous situation. These life events as identified in the literature and on the Holmes and Rahe Scale are as follows: death of a spouse, death of a close family member, death of a close friend, major personal injury or illness, change in health status of a close family member, divorce, marital separation, a jail term or arrest, being fired or laid off work, worsening financial status, being physically or sexually abused, close family member being physically or sexually abused. The knowledge of what major life events are usually stressful is helpful in identifying what population is at risk for developing mental and physical health problems and thus should be given rapid access to treatment at a community mental health center.

Functional Ability of Individual

The second criteria a community mental health center can use in evaluating a potential client's need for rapid access to treatment is the individual's functional ability. In crisis, normal behavioral

patterns are disrupted (Lindemann, 1944). Walkup (1974) described the active crisis state, if not resolved, as leading to behavioral disruption. Sifneos (1980) spoke of decompensating behavior including insomnia, loss of appetite, and a general inability to function in his definition of a psychological crisis. An individual in a dysfunctional state may be a danger to themselves either through neglect of basic needs or suicidal ideation (Zusman, 1975). Similar symptoms or behavioral changes were reported in research studies by Markush (1974), and Myers, Lindenthal, and Pepper (1973).

A visible behavioral disorganization was the second most common criteria used by a group of professionals in determining if an individual was in crisis in a study by Bloom (1965). As mentioned earlier, the presence of a precipitating event was the most frequent criteria used in that study.

Rationale for centers using a crisis framework. There is a need for rapid access to treatment for individuals in crisis. The literature provides evidence of the effects of waiting on the follow-through of potential crisis clients. A positive correlation has been found between the amount of waiting time until the first appointment and missed first appointments (no-shows) in research studies on community mental health center clients by Hochstudt and Trybula (1980), Folkins, Hersch, and Dahlen (1980), Craig, Huffine, and Brooks (1974), Wolkon (1972), and Perlman (1965). The longer people in the community have to wait for an appointment, the greater the likelihood that they will not keep the appointment.

The literature provides no clear answers as to what happens to

individuals who turn to the local community mental health center for help only to be placed on a waiting list. Perlman (1965) speculated that these individuals may turn to other mental health professionals for help. However, a study of the utilizers of a community mental health center in another Oregon county indicated that the majority were poor and unemployed (Gavin, 1983). It is unlikely that these individuals are obtaining professional services elsewhere due to the high cost of mental health care in the private sector.

The individual may turn to other sources of social support such as a family doctor, minister, or friend. However, it could be assumed that if these sources of support were available and effective in helping the individual deal with the problem, the person would not have sought assistance from the mental health center in the first place.

The final rationale for community mental health centers using a crisis theory framework is that clients do benefit from timely crisis intervention therapy. This conclusion is supported by the research literature although there is conflicting evidence as to whether crisis intervention therapy is more effective than not receiving any professional help.

Lindemann (1944) described greater improvement for the bereaved victims who received grief counseling than the individuals who did not receive such counseling. He used observation of symptomatology as the basis for evaluating the impact on the victims. His study cannot be considered a controlled research study but it does suggest that

crisis intervention therapy is beneficial to bereavement victims.

Many studies have been performed under more controlled conditions which provide evidence that clients have benefited from crisis intervention therapy (Maris & Conner, 1973; L. Parad & H. Parad, 1968; Gottschalk, Mayerson, & Gottlieb, 1967; Jacobson, 1965; Muench, 1965). Supporting both the benefit of crisis intervention therapy and the need of timely intervention were studies by Uhlenhuth and Duncan (1968), Roth et al. (1964), and Gordon & Cartwright (1954). Methods used in these studies to measure improvement or benefit included subjective symptom checklists filled out by the clients, symptom checklists filled out by the therapists, a psychiatric morbidity scale, a self-other attitude scale, and a depression and self-esteem scale. Each of these studies included both pre and post test scores. Unfortunately, a major methodological weakness of all these studies was the absence of a control group for comparison.

A search of the literature provided four studies which utilized a control group of "no treatment" individuals for comparison with the group receiving crisis intervention therapy. Both Roskin (1982) and Raphael (1977) reported a statistically significant difference in degree of improvement (measured by Symptom Checklist and Index of Health) between the two groups with the group receiving crisis intervention therapy improving the most.

In contrast, Liberman and Mullan (1978) and Polak, Egan, Vandenbergh, and Williams (1975) reported no statistically significant differences in degree of improvement between the group

receiving crisis intervention therapy and a "no treatment" group. A variety of measures were used by these researchers to measure improvement including the Index of Health and the Beck Depression Scale.

In reviewing the literature on the effects of crisis intervention therapy, both Auerbach and Kilmann (1977) and Bergin (1971) concluded that none of the studies were able to provide a "no treatment" group for comparison. In each study, the "no treatment" group had non-specific contact with a researcher who expressed interest in the individual's recent stressful life events and their health. Also, individuals within these groups may have benefited from contact with their support system.

The research literature supports a conclusion that clients generally benefit from crisis intervention therapy. There were no indications of harm or worsening of symptoms after crisis intervention in the studies. A complete model of crisis theory as it applies to the community mental health center is illustrated in Figure 2 on page 18.

Summary. There are five important conclusions to be drawn from the review of the literature. First, crisis intervention therapy is assumed to be beneficial to individuals in crisis. Second, individuals in crisis have usually been exposed to a stressful precipitating event which is perceived as negative. Third, individuals in a state of crisis usually demonstrate a decrease in their normal ability to function. Fourth, potential crisis clients

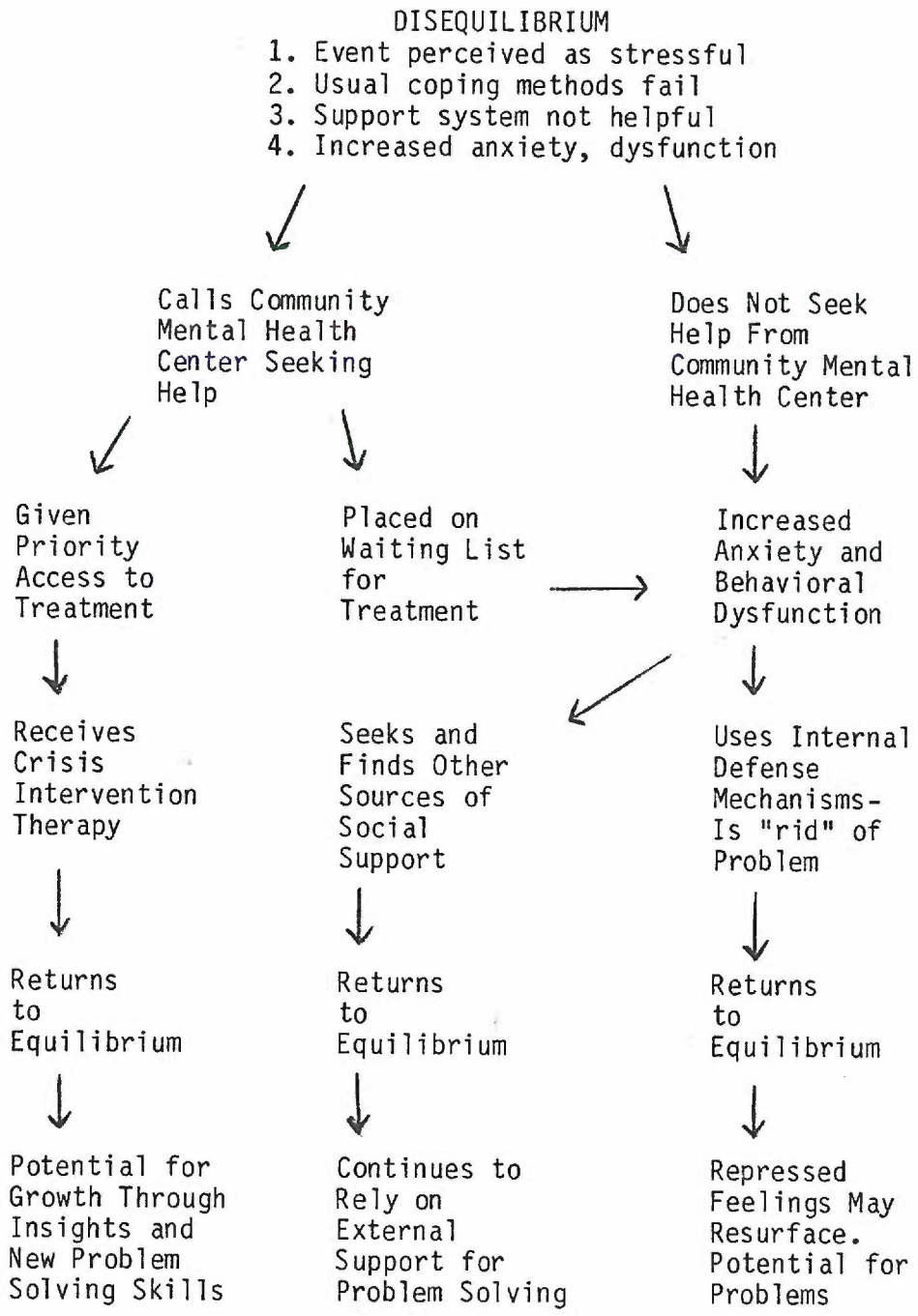

Figure 2. Crisis Theory and the Community Mental Health Center.

are most likely to follow through and benefit from treatment if given an appointment within a couple of days of their request for assistance. This is especially true for the lower socio-economic group and those clients being referred from another agency. The final conclusion is that community mental health centers can use the preceding four conclusions to identify people in crisis and for planning services for them.

Conceptual Framework

This study is designed to examine the extent to which the Center under study was effective in identifying and providing priority access to treatment for potential clients in crisis. Therefore, the framework for this study is based on the Center's intake procedure.

Individuals who requested services were screened by the Center's intake worker for the presence of a precipitating event, and the intake screener assessed the functional level of the potential client. Precipitating events included recent negative life events with which the potential client had difficulty coping. The functional level of the potential client was judged in relation to ability to carry on daily functioning, maintain social relationships, and meet basic health and safety needs.

A decision was made as to whether the potential client was in crisis as judged by the intake worker based on the functional level and the presence of a precipitating event.

If the potential client was judged by the Center's intake worker to be in crisis, then the individual was given an appointment in the Priority Access System (PAS) clinic, usually within two days. If

judged not to be in crisis, potential clients were given an appointment in the appropriate Center program. However, the waiting time for these programs was up to three months. The center's intake procedure is explored in more detail in the methods section. Refer to Figure 3 for an illustration of the conceptual framework for this study. This conceptual framework provides the basis for this study's research questions, which involve the description and comparison of the two groups.

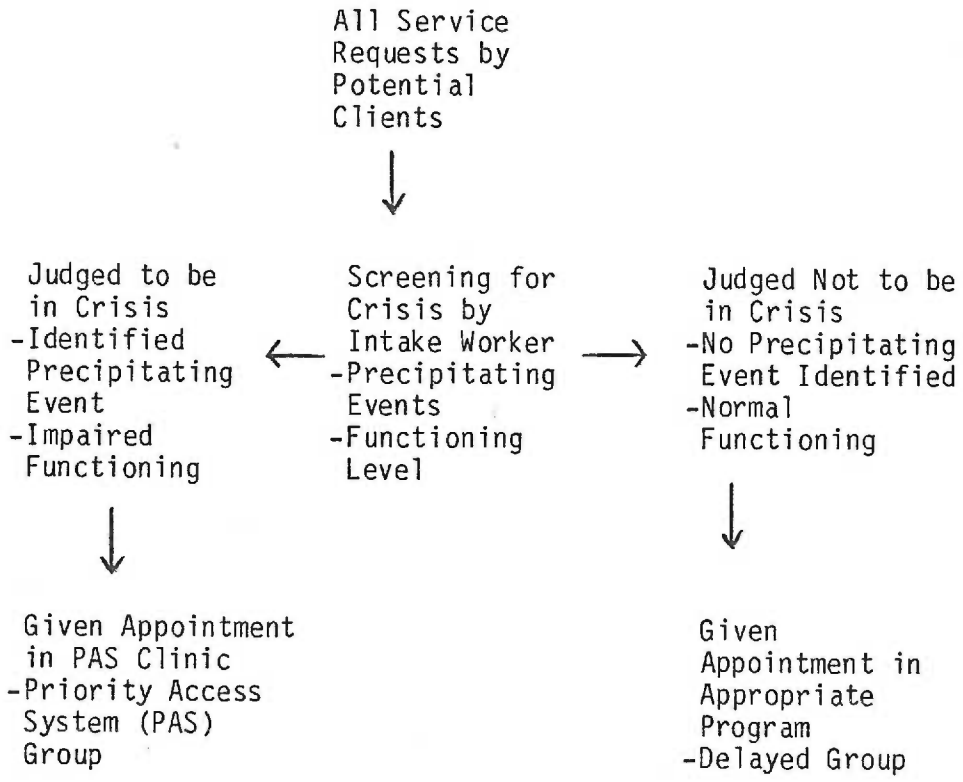

Figure 3. Conceptual Framework for Study

Research Questions

The purpose of this study was to describe and compare the following two groups: clients screened and given an appointment in the PAS clinic and clients screened and given an appointment in the appropriate Center program which may have a waiting time up to three months. Specifically, the groups were compared in terms of functional level and recent exposure to major negative life events. It can be concluded from the literature review that the PAS group should have demonstrated a lower functional level and a higher exposure to recent major negative life events if the PAS screening process worked effectively. To determine if this was indeed the case, the following research questions were addressed in this study.

1. What major negative life events did the clients in the PAS and delayed groups experience in the preceding six months?

2. Comparing group means, was either group exposed to more major negative life events over the preceding six months?

3. What was the functional level of the clients in the PAS and delayed groups?

4. Comparing group means, did either group demonstrate a higher functional level?

5. What was the mean length of time in days between requests for services and the first appointment for the PAS and delayed groups?

6. What was the rate of attendance at the first appointment for the PAS and delayed groups?

7. Comparing group means, did either group have a shorter length

of time between request for services and the first appointment?

The following questions were asked to gather data as to who utilizes a community mental health center. Specifically, was there any difference in the socio-demographic characteristics of individuals who utilized the PAS system in comparison to the delayed group.

8. What were the ages of the clients in the PAS and delayed groups? What was the mean age of each group?

9. What percentage of the clients in the PAS and delayed groups were Caucasian, Hispanic, Asian, Black, American Indian, Eskimo?

10. What percentage of the clients in the PAS and delayed groups were female and male?

11. What percentage of the clients in the PAS and delayed groups were married, separated, divorced, widowed, never married?

12. What percentage of the clients in the PAS and delayed groups were employed at the time of services?

13. What were the monthly incomes of the clients in the PAS and delayed groups? What was the median monthly income for each group?

Chapter II

Methods

Design and Procedure

The purpose of this study is to evaluate the PAS screening system of a community mental health center by describing the clients in terms of their recent major negative life events, functional ability, and socio-demographic characteristics. Retrospective record review was used to collect the data. The individual data collected was grouped for the purpose of comparison and analysis of the PAS and delayed groups.

Setting

The setting for this study was a private, non-profit community mental health center located in the state of Oregon. The Center was partially funded by county and state funds. The Center had an adult program, an adolescent day-treatment program, an elderly program, a child and family program, and an alcohol program. Treatment modalities included individual and group therapy as well as a medication monitoring program.

Client Entry System

Individuals requested services by either telephoning or walking into the Center. A receptionist elicited the potential client's presenting problem and recorded it on a Service Request Form (Refer to Appendix A). Callers who presented as an imminent danger to self or others were transferred immediately to a therapist on-call for emergencies. Otherwise, a crisis worker was designated to determine

need for rapid access to treatment returned the potential client's call. The return telephone call normally occurred the same or next day.

The crisis worker did a brief assessment over the telephone which included the following: presenting problem, general functional ability of the individual, and any precipitating events. Based on the information obtained, the crisis worker judged whether the client was in crisis. If clients were judged to be in crisis, they were given an appointment in the PAS clinic, usually within two days. If the crisis worker judged the individual not to be in crisis, the potential client was given the next available appointment in the appropriate program. The waiting time for these programs ranged from one week to three months.

The Center developed a follow-through system which got them back in contact with 98% of potential clients. The crisis worker attempted to recontact the potential client over the telephone daily for six days. If no contact was made, a letter was sent to the individual asking them to contact the Center if they were still interested in receiving services.

Another way potential clients entered the Center's system was through referral from another community agency. The Center had a contract with fourteen area agencies (Refer to Appendix B for list) to provide rapid access to treatment through the PAS clinic for clients who, in the judgment of the staff of the referring agency, were in crisis and in need of outpatient services as soon as

possible.

The goal of the PAS clinic was to provide clients in crisis with timely (within two days) brief intervention, stabilization, and medication monitoring as needed. The PAS clinic was staffed by a master's-prepared psychiatric nurse practitioner with prescription privileges. She was well experienced in assessment and crisis intervention therapy. Clients in crisis were closely monitored on an outpatient basis through the PAS clinic. However, if emergency inpatient hospitalization was needed, appropriate referral and supervised transportation were immediately arranged. Clients were monitored in the PAS clinic with both face-to-face and telephone contact until the client was picked up by a therapist in the appropriate center program. The time frame for this process was usually one to two weeks. The Center intake process is illustrated in Figure 4 on page 26.

Description of the Population From Which the Clients Come

The Center provided outpatient mental health services to the citizens of an Oregon county which, according to the 1980 census data, had a population of 245,808 (Bureau of the Census, 1983). The county is located near a large metropolitan city. However, there is not one single large city within the county itself. The population is spread out over the 725 square miles of the county which means some individuals had to travel some distance to get to the Center as it was located in the northern portion of the county. A branch office was recently opened in the southern portion of the county to

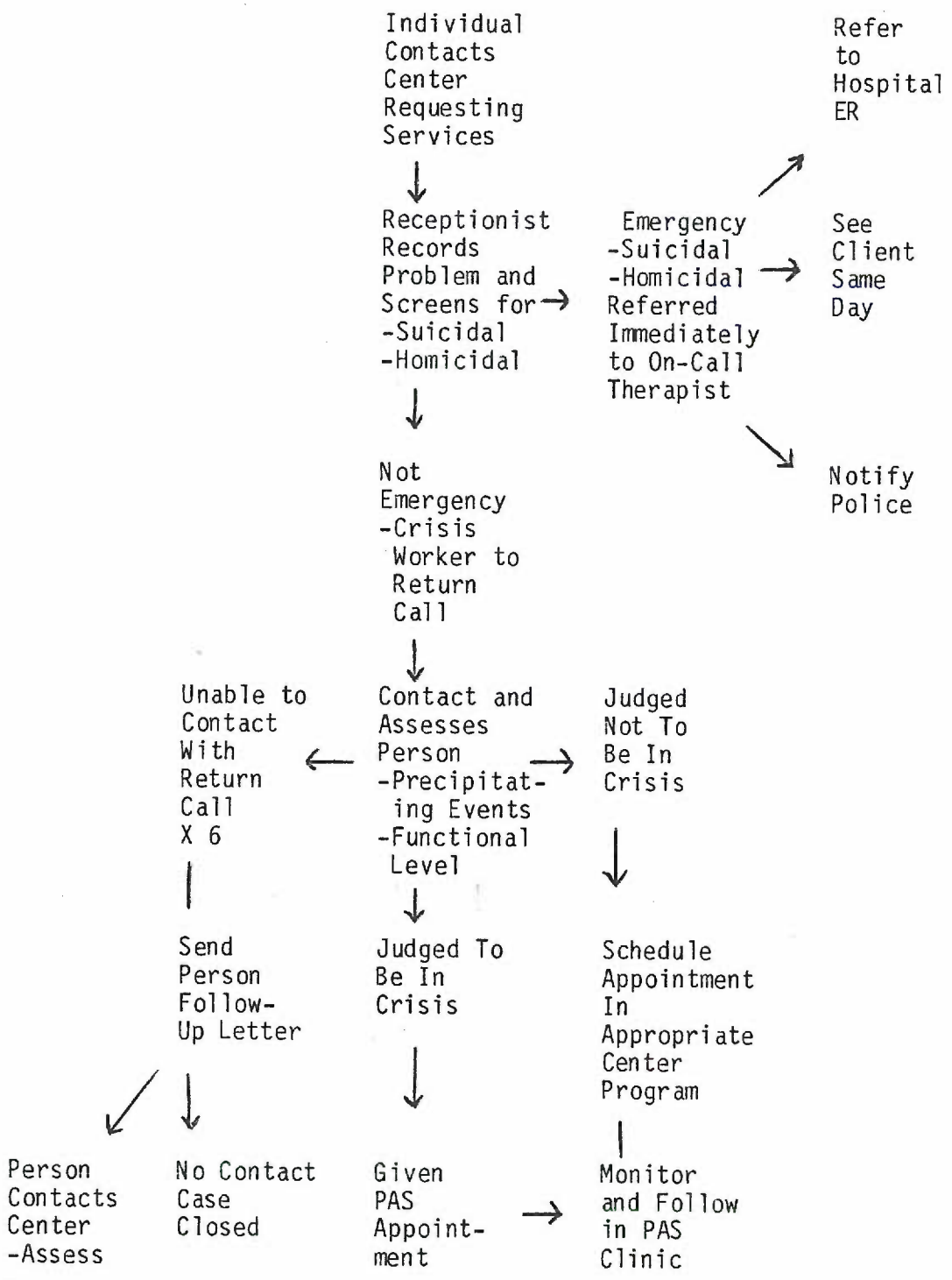

Figure 4. Center Intake System

alleviate this problem.

The population of the county was growing as evidenced by a 55.7% increase in population from 1970 to 1980 (Bureau of the Census, 1983). The population was 50.9% female and 49.1% male. Individuals of the caucasian race made up 94.5% of the population, Asian 2.1%, Black 0.4%, Indian-Eskimo 0.4%, and Spanish-origin 2.6%. The median age was 29.2 years. The marital status of individuals 15 years and older was as follows: 61.6% married, 23.5% single, 8.2% divorced, 5.0% widowed, and 1.7% separated. The median household income in 1979 was $21,572. The unemployment rate was 5.3% in 1983 (Bureau of the Census, 1984).

Subjects

The client population of the Center was estimated to be approximately 1400 for the calendar year 1984. This system was unique for a community mental health center in that it did not serve the chronically mentally ill population which was served at another clinic within the county. Therefore the population served by the Center was composed of individuals with acute problems in their activities of daily living. Most of this population had not had any psychiatric hospitalizations. This point is important when considering life events and crisis. It is generally believed that even small changes in a daily schedule may precipitate a crisis for the chronically mentally ill. However, this should not have been the case for the population served by this Center.

The PAS clinic served 278 clients in the calendar year 1984. A sample size of 150 cases was examined. For the purpose of comparison,

an equal number of clients from a non-PAS or delayed group was included in the study. Therefore, the sample size of this study totalled 300 clients. The non-PAS or delayed group was comprised of those individuals requesting services at the Center who were given an appointment in any Center program other than the PAS clinic. This population was estimated to be approximately 1,100 for the calendar year 1984. A systematic random sampling of every Kth case was conducted to derive the sample for the PAS and delayed groups.

A sample size of 150 was chosen for each group since a portion was expected not to attend their first appointment at the Center. This factor was important in analyzing the effects of waiting on the non-attendance rates of the PAS and delayed groups. The sample size utilized for the other purposes of this study was decreased by the clients who cancelled or did not show up for their appointment. Therefore, a sample size of 150 was selected with an attrition rate of 10 to 20% expected.

Protection of Human Services

For the purpose of this study, the researcher had no direct contact with the clients of the Center. Individual data collected are reported only in group statistics with a sample size large enough that facts regarding individual cases are not identifiable. Approval for data collection was obtained from the Administrator of the Center. Refer to Appendix C for a copy of the agreement to conduct archival research and the conditions to be applied to protect the privacy of the Center and its clients. This researcher was guided in

all practices by the Ethical Principles in the Conduct of Research with Human Participants published by the American Psychological Association (1982).

Data Collection

The data for this study was collected from the records of clients seen at the Center during calendar year 1984. Specifically, data was collected from the Service Request Form (Appendix A), the Client-Process Monitoring System Form (Appendix D) which includes socio-demographic information, and the intake interview which includes the presenting problem, a psychosocial history, a mental status examination, the therapist's impressions, and an initial treatment plan.

In order to assess whether a client was in crisis and therefore appropriately placed in the PAS group, data was collected retrospectively by this researcher from the client's clinical record and focused on the following two variables: precipitating events and functional level.

Precipitating events. The researcher reviewed the client's record to determine the recorded occurrence over the preceding six months of any of the following major negative life events:

1. Death of a spouse
2. Divorce
3. Marital separation
4. Jail term or arrest
5. Death of a close family member

6. Being fired or laid off work

7. Major personal injury or illness

8. Death of a close friend

9. Retirement

10. Major change in the health of a close family member

11. Worsening financial status

12. Being physically or sexually abused

13. Close family member physically or sexually abused

The selection of these major life events for including in this study was supported by the fact that the first eleven events on the above list are included in the top 17 in terms of stressfulness on the Holmes and Rahe scale. The inclusion of the final two events on the above list was supported by recent literature. The exclusion of any major positive life event was also supported in the review of the literature.

It is acknowledged that a combination of small stressors can place an individual in a state of crisis. However, for the purpose of this study, the inclusion of small stressors was not warranted. The telephone screening process used to determine need for rapid access to treatment through PAS is brief and does not allow time to assist the caller in identifying a number of small stressors in their life.

Level of function. The overall functioning ability of the client was assessed by this researcher based on information in the clinical record. The functioning ability of the client was scored using the Global Assessment Scale as developed by Endicott, Spitzer, Fleiss,

and Cohen (1976). Refer to Appendix E for a copy of this scale. The scores on the scale range from 1 to 100 with 1 being an individual who hypothetically is not functioning at all and 100 being an individual who demonstrates superior functioning (Endicott, Spitzer, Fleiss, & Cohen, 1976). A "normal" range on the Global Assessment Scale (GAS) is 70-80. The scale is divided into ten equal intervals with behavioral descriptions for each level. After assessing an individual, a judgment is made as to which behavioral description best describes that person's general functioning ability.

Most outpatients of community mental health centers score between 31 and 70 on the GAS (Endicott, Spitzer, Fleiss, & Cohen, 1976). Individuals scoring 20 or below on the scale are in need of hospitalization as they are currently unable to function without supervision or case. A score of 50 or below indicates a major impairment in the individual's functioning ability.

The inter-rater reliability of the GAS has been reported by Endicott, Spitizer, Fleiss, and Cohen (1976) as between .76 and .91 when the assessment was based on actually interviewing the client, and between .69 and .85 when a score was obtained by reviewing the client's clinical record. Gully and Harris (1982) reported an inter-rater reliability of .90 for the GAS. Endicott, Spitzner, Fleiss, and Cohen (1976) concluded that the information needed to make an accurate rating on the GAS could be obtained from any source including a direct interview of the client or from the client's clinical record.

The GAS has been utilized as an assessment tool by researchers conducting studies on both psychiatric inpatients (Herz, Endicott, & Spitzer, 1977 & 1975) and outpatients of community mental health centers (Bassuk, Winter, & Apsler, 1983; Kass, Charles, Walsh, & Barsa, 1983; Gully & Harris, 1982; Battista, 1982).

The inter-rater and intra-rater reliability of the GAS was tested with the Center's population. Ten randomly selected charts were independently reviewed by this researcher and a staff member of the Center with each judging the functional level of the client by assigning a GAS score. The information needed to make an accurate GAS rating was obtained by each scorer from the instructions on the GAS Scale (Appendix E) and by reading the article on the GAS by Endicott, Spitzer, Fleiss, and Cohen (1976). The correlational coefficient as measured by the Pearson R was .93. Intra-rater reliability was tested by this researcher who reviewed ten randomly selected charts one week apart. Functional level was assessed using the GAS and a correlation coefficient for the scores using the Pearson R was .95. It was concluded that the GAS is a reliable tool with the population used in this study.

Effects of a waiting list. The following data was retrospectively collected by this researcher for the purpose of comparing the PAS and delayed groups and assessing the effects of waiting on attendance at the first appointment.

1. The length of time in days between the request for services and the first appointment. Clients seen on the same day services are

requested were judged to have 0 waiting time in terms of days. The waiting time was calculated for all other clients by counting the number of days from the date of request for service to the date of the first appointment.

2. Did the client show up for the first appointment? Recorded "yes" or "no" as indicated on the Center's records.

Socio-demographic variables. In order to assess the comparability of the PAS and delayed groups, the following socio-demographic data was collected from the Client Process Monitoring System form which is filled out by all clients seen at the Center. The data will also be useful in future program planning by providing data as to who uses a community mental health center.

1. Age
2. Sex
3. Ethnic Group
4. Marital Status
5. Employment Status
6. Monthly Income

Data Analysis

Data analysis included frequency distributions for comparison of the PAS and delayed groups in terms of socio-demographic characteristics, functional level, and major negative life events. For further group analysis, percentages were obtained for research questions number 6, 9, 10, 11, and 12. Chi-square analysis was conducted to analyze proportional differences between groups. Group means were obtained for research questions 2, 3, 5, 7, 8, and 13. These group means were used to compare the PAS and delayed groups for statistically significant differences in the variables through t-test

analysis. The *t*-test results were used to answer research questions numbers 2, 4, and 7.

Chapter III

Results

The findings from the retrospective record review of the clients in the PAS and delayed groups are reported in this section as they relate to this study's research questions. After attrition, the number of clients was 121 in the PAS group and 105 in the delayed group.

Findings Regarding Research Question One

What major negative life events had the clients in the PAS and delayed groups experienced over the preceding six months?

The major negative life events experienced over the preceding six months by the clients in the PAS and delayed groups are summarized in Table 1 on page 37. For the PAS group, worsening financial status (32.2%) was the most frequently experienced event followed by being fired or laid off work (22.3%), jail term or arrest (14.9%), and major personal injury or illness (11.6%). There was no documentation that any of the clients in the PAS group had experienced any of the following events over the preceding six months: death of a spouse, death of a close friend, retirement, and major change in the health of a close family member.

For the delayed group, the most frequently experienced event was jail term or arrest (19.0%) followed by worsening financial status (9.5%), being physically or sexually abused (8.6%), and being fired or laid off work (7.6%). There was no documentation that any of the clients in the delayed group had experienced any of the following

events over the preceding six months: death of a spouse, death of a close friend, retirement, or a major change in the health of a close family member.

When compared to the delayed group, more of the clients in the PAS group had experienced a major personal injury or illness (chi square=14.9, $p<.001$, 1 df), worsening financial status (chi square=17.6, $p<.001$, 1 df), and being fired or laid off work (chi square=9.0, $p<.001$, 1 df). The differences were statistically significant. There was no statistically significant difference between groups in clients experiencing a divorce (chi square=0.4), marital separation (chi square=0.8), a jail term or arrest (chi square=0.4), a close family member being physically or sexually abused (chi square=0.0), or being physically or sexually abused (chi square=0.5).

Finings Regarding Research Question Two

Comparing group means, had either group been exposed to more major negative life events over the preceding six months?

The mean number of major negative life events experienced over the preceding six months by the clients in the PAS group was 1.1 event (standard deviation of 1.23) compared to 0.6 events (standard deviation of 0.69) for the clients in the delayed group. The difference in group means was statistically significant ($t=3.85$, $p<001$, two-tailed, 224 df).

The number of clients identified in the clinical records as experiencing at least one of the thirteen major negative life events

Table 1

Major Negative Life Events Experienced Over the Preceding Six Months by Users of Center, 1984

Event	PAS Group		Delayed Group	
	Number	Percent	Number	Percent
Death of a spouse	0	0.0	0	0.0
Divorce	5	4.1	4	3.8
Marital separation	12	9.9	7	6.7
Jail term or arrest	18	14.9	20	19.0
Death of a close family member	3	2.5	1	0.9
Being fired or laid off work	27	22.3	8	7.6
Major personal injury or illness	14	11.6	0	0.0
Death of a close friend	0	0.0	0	0.0
Retirement	0	0.0	0	0.0
Major change in the health of a close family member	0	0.0	0	0.0
Worsening financial status	39	32.2	10	9.5
Being physically or sexually abused	13	10.7	9	8.6
Close family member physically or sexually abused	3	2.5	3	2.9

on this study's list over the preceding six months was 72 (59.5%) of the PAS group and 50 (47.6%) for the delayed group. The proportional difference between groups in respect to experiencing at least one event was non-significant (chi-square=3.19).

Findings Regarding Research Question Three

What were the functional levels of the clients in the PAS and delayed groups?

The functional level of the clients in the PAS group as judged by this researcher using the Global Assessment Scale (GAS) ranged from 30 to 70b with a mean score of 50.0 and a standard deviation of 8.54. The model score for the PAS group was 50 (31.4%) and the median was 50.

The GAS scores for the delayed group ranged from 40 to 80 with a mean of 62.6 and a standard deviation of 7.91. The model score for the delayed group was 60 (26.7%) while the median was 65. Refer to Table 2 on page 39 for a complete breakdown of the GAS scores for the PAS and delayed groups.

Findings Regarding Research Question Four

Comparing group means, did either group demonstrate a higher functional level?

The difference in group means between the PAS (50.0) and delayed (62.6) groups is 12.6. This difference was found to be statistically significant using a two-tailed t-test (t=11.67, p<.001, 224 df).

Findings Regarding Research Question Five

What was the mean length of time in days between request for

Table 2

Functional Level of Users of Center, 1984,

as Rated by Global Assessment Scale (GAS)

	PAS Group		Delayed Group	
GAS Score	Number	Percent	Number	Percent
80	0	0.0	0	1.9
75	0	0.0	0	5.7
70	3	2.5	25	23.8
65	4	3.3	20	19.0
60	20	16.5	28	26.7
55	14	11.6	10	9.5
50	38	31.4	12	11.4
45	15	12.4	1	1.0
40	20	16.5	1	1.0
35	5	4.1	0	0.0
30	2	1.7	0	0.0
TOTALS	121	100.0	105	100.0

services and the first appointment for the PAS and delayed groups?

The mean length of time in days between request for services and the scheduled first appointment was 2.8 days for the PAS group and 21.3 days for the delayed group.

Findings Regarding Research Question Six

What was the rate of attendance at the first appointment for the PAS and delayed groups?

Of the 150 clients in the PAS group, 121 (80.7%) actually attended the first appointment while 29 clients (19.3%) either cancelled or did not show up for their appointment. Of the 150 clients in the delayed group, 105 (70.0%) actually attended the first appointment while 45 clients (30%) either cancelled or did not show up for their appointment.

Findings Regarding Research Question Seven

Comparing group means, does either group have a shorter length of time between request for services and the scheduled first appointment?

The mean length of time between request for services and the first appointment of 2.8 days for the PAS group is shorter than the 21.3 days for the delayed group. The difference in the group means of 18.5 days was found to be statistically significant using a two-tailed t-test (t=10.88, p<.001, 133 df).

Findings Regarding Research Question Eight

What are the ages of the clients in the PAS and delayed groups? What is the mean age of each group?

The age levels of the clients in the PAS and delayed groups are described in Table 3 on Page 42. A majority of the clients for both the PAS (52.9%) and delayed (54.3%) groups were in the 18-33 year old category. In contrast, the 65 year old and over category contained only one client for each group (0.8% for PAS and 0.9% for the delayed group).

The mean age was 32.3 years for the PAS group and 29.4 years for the delayed group. The difference of 2.9 years between the mean age of the two groups was found to be statistically non-significant using a two-tailed t-test analysis (t=1.97).

Findings Regarding Research Question Nine

What percentage of the clients in the PAS and delayed groups are Caucasian, Hispanic, Asian, Black, American Indian, and Eskimo?

The ethnicity of the clients in the PAS and delayed groups are summarized in Table 4 on page 42. A large majority of the PAS (93.5%) and delayed (98.1%) groups were Caucasian. For the PAS group, the only other ethnic groups represented were the American Indian (4.1%), Hispanic (1.6%), and Asian (0.8%). The Hispanic group (1.9%) was the only ethnic group besides Caucasian represented in the delayed group. Neither the PAS or delayed groups were represented by any Blacks or Alaskan Natives.

The proportional difference between the PAS and delayed groups in regards to race was found to be non-significant at the $p<.05$ level using chi-square analysis (chi-square=5.18).

Table 3

Age Level of Users of Center, 1984

Age Level (in years)	PAS Group		Delayed Group	
	Number	Percent	Number	Percent
1-17	10	8.3	12	11.4
18-33	64	52.9	57	54.3
34-49	35	28.9	32	30.5
50-64	11	9.1	3	2.9
65+	1	0.8	1	0.9
TOTALS	121	100.0	105	100.0
	Mean age - 32.3		Mean age - 29.4	

Table 4
Ethnicity of Users of Center, 1984

Ethnic Group	PAS Group		Delayed Group	
	Number	Percent	Number	Percent
White	113	93.5	103	98.1
Black	0	0.0	0	0.0
American Indian	5	4.1	0	0.0
Alaskan Native	0	0.0	0	0.0
Asian	1	0.8	0	0.0
Hispanic	2	1.6	2	1.9
TOTALS	121	100.0	105	100.0

Findings Regarding Research Question Ten

What percentage of the clients in the PAS and delayed groups are male and female?

The clients in the PAS group were 56.2% female and 43.8% male. The delayed group was composed of 46.7% females and 53.3% males. The proportional differences between the PAS and delayed group in regards to sex was found to be non-significant using chi-square analysis (chi-square=2.05).

Findings Regarding Research Question Eleven

What percentage of the clients in the PAS and delayed groups are married, separated, divorced, widowed, and never married?

A complete breakdown of the marital status of the clients in the PAS and delayed groups is in Table 5 on page 45. The divorced category contained the most PAS clients (29.3%) while the married category contained the most delayed group clients (43.8%). A majority of both the PAS (74.1%) and delayed (51.4%) groups clients were in a non-married category of never married, widowed, divorced, or separated. The proportional difference between the PAS and delayed groups regarding clients who were married was found to be statistically significant at the $p<.01$ level using chi-square analysis (chi-square=10.47, 1 df).

Findings Regarding Research Question Twelve

What percentage of the clients in the PAS and delayed groups are currently employed?

The unemployment rate for the PAS group was 56.4% while 43.6%

were employed on either a part or full time basis. In comparison, 24.8% of the clients in the delayed group were unemployed and 75.2% were employed either part or full time. The proportional difference between the PAS and delayed groups regarding employment status was found to be statistically significant at the $p<.001$ level using chi-square analysis (chi-square=20.04, 1 df).

Findings Regarding Research Question Thirteen

What are the monthly incomes of the clients in the PAS and delayed groups. What is the median income for each group?

The monthly incomes of the clients in the PAS and delayed groups are summarized in Table 6 on page 45. The median monthly income for clients in the PAS group was $400 compared to a median income level of $1,000 for the delayed group clients. Of the PAS group clients, 57.0% made $499 or less a month in contrast to 27.0% of the delayed group clients. On the other end of the income levels, only 5.2% of the clients in the PAS group made $2,000 or more a month compared to 28.1% of the clients in the delayed group.

The difference in the group medians in regard to monthly income was found to be statistically significant at the $p<.001$ level using median test analysis (chi-square=24.11, 1 df). The median income of the two groups combined was $600. This median was exceeded by 31.6% of the PAS group clients and 65.6% of the clients in the delayed group.

Table 3

Age Level of Users of Center, 1984

Marital Status	PAS Group Number	PAS Group Percent	Delayed Group Number	Delayed Group Percent
MARRIED				
Married	27	23.3	46	43.8
Living as married	3	2.6	5	4.8
Total	30	25.9	51	48.6
NON-MARRIED				
Never married	32	27.6	24	22.8
Widowed	2	1.7	1	1.0
Divorced	34	29.3	24	22.8
Separated	18	15.5	5	4.8
Total	86	74.1	54	51.4
UNKNOWN	6	--	0	--
TOTALS	121	100.0	105	100.0

Table 6

Monthly Income Level of Users of Center, 1984

Monthly Income (In Dollars)	PAS Group Number	PAS Group Percent	Delayed Group Number	Delayed Group Percent
0-499	65	57.0	26	27.0
500-749	17	15.0	11	11.5
750-999	7	6.1	9	9.4
1000-1499	9	7.9	16	16.7
1500-1999	10	8.8	7	7.3
2000-2499	3	2.6	10	10.4
2500+	3	2.6	17	17.7
Unknown	7	--	9	--
TOTALS	121	100.0	105	100.0

Chapter IV

Discussion

The purpose of this study was to describe and compare the PAS and delayed groups in terms of recent exposure to major negative life events, functional level, socio-demographic data, and attendance rates. It was hypothesized that the PAS group would demonstrate a lower functional level and a higher exposure to recent major negative life events if the PAS screening process of the Center were working effectively. Relevant findings from this study regarding recent exposure to major negative life events, functional level, attendance rates, and socio-demographic data would be discussed in terms of practical and theoretical implications. Relationships between this study's findings and previous studies will also be identified.

Major Negative Life Events

The presence of a recent major negative life event was one criteria used by the Center's crisis screener to determine the need for rapid access to treatment through the PAS clinic. More of the clients in the PAS group (59.5%) had experienced at least one of the major negative life events on this study's list than the clients in the delayed group (47.6%). However, the proportional difference between the two groups was not found to be statistically significant. Therefore, no conclusions can be drawn regarding the percentage of clients exposed to specific recent major negative life events. However, the presence of a recent major negative life event in the lives of a majority of the Center's clients supports the concept that

crisis is precipitated by a life change event as proposed by Bloom (1985, 1964), Huff (1978), and Hill (1965). The percentage of clients judged to have experienced a precipitating event was reduced greatly by the restricted list used in this study. It does not take a major event to precipitate a crisis. This methodological weakness makes it difficult to adequately assess this variable.

There was a statistically significant difference between the PAS and delayed groups in the mean number of major negative life events experienced over the preceding six months. A larger percentage of the clients in the PAS group (33%) than the delayed group (10%) had experienced two or more major negative life events. This combination of stressors can be viewed as particularly stressful and increases the likelihood of a crisis occurring. The effectiveness of the PAS screening process is supported by the fact that clients in the PAS group had experienced more multiple stressors.

An apparent weakness of the life events list used in this study was that a job loss will always result in worsening financial status. Therefore, these accounted for two events and may have affected the group means. However, further analysis provides evidence that this is not the case. Although lowering the group means to 1.0 for the PAS and 0.5 for the delayed group, the difference in group means remained statistically significant ($t=3.85$, $p<.001$, 224 df).

The types of major negative life events most frequently experienced by the Center's clients appear related to the age level of the clients (85% 18-49 years old). A worsening financial status

was the most frequently experienced event for the clients in the PAS group (32.2%). Being fired or laid off work was second (22.3%). In contrast, 9.5% of the delayed group clients reported worsening financial status and 7.6% reported being fired or laid off work. Fired at work ranked eighth and a change in financial status sixteenth in terms of stressfulness on the Social Readjustment Rating Scale (Holmes & Rahe, 1967). Job loss will usually result in worsening financial status. Therefore, exposure to this event results in the individual having not only to deal with the psychological effects of losing a job but also the financial hardships. A lower functional level for the PAS group compared to the delayed group (50.0 to 62.6 on GAS) may have precipitated a portion of the PAS group losing their jobs. This speculation is based on a review of the client's clinical records. Many of the PAS clients' records described a chronic below normal level of functioning with frequent job changes and few long term social relationships. In contrast, the delayed group clients appeared to usually function at a "normal" level with steady jobs and long term social relationships. This was not the case for all clients in these groups and there was no formal way to measure the clients usual functioning level.

A jail term or arrest was the most frequently experienced event for the delayed group clients (19.0%). Fifteen percent of the PAS group also reported experiencing an arrest or jail term in the preceeding six months. This event is ranked fourth on the Social Readjustment Rating Scale (Holmes & Rahe, 1967) and therefore should

be considered a very stressful event. Most of the cases of jail term or arrest in this study involved driving under the influence of alcohol. Alcohol treatment at the Center was an alternative to jail or loss of driver's license for many of these clients.

That 10.7% of the PAS group and 8.6% of the delayed group reported being physically or sexually abused by a family member over the preceding six months supports conclusion by many authors (Chesnay, 1984; Germain, 1984; Pfouts, Schopler, & Henley, 1982; Geiser, 1981) in the recent literature that domestic violence and incest can lead to mental health problems. The incidence of domestic violence and incest as a precipitating event to mental health problems could be high considering that 10% of the Center's clients in this study reported what is considered taboo to disclose to anyone outside the family unit. Although physical and sexual abuse can be viewed as extremely stressful, it is not included on the Social Readjustment Rating Scale.

A major personal injury or illness was recently experienced by 11.6% of the PAS clients while none of the clients in the delayed group reported experiencing this event. Personal injury or illness is ranked sixth in terms of stressfulness on the Social Readjustment Rating Scale (Holmes & Rahe, 1967). The high degree of stressfulness of this event may have precipitated mental health problems which lead to the inclusion of these clients in the PAS group.

Ten percent of the PAS clients reported experiencing a recent marital separation while 4.1% reported a divorce. In comparison, 6.7%

of the delayed group had experienced a marital separation while 3.8% reported a divorce. These two events are ranked third and second on the Social Readjustment Scale (Holmes & Rahe, 1967) in terms of stressfulness. The commonality of these events may be the result of age levels of the clients.

The absence of death of a spouse (ranked first on Social Readjustment Rating Scale), death of a close friend (ranked seventeenth), retirement (ranked tenth), and a major change in the health of a close family member (ranked eleventh) from the experiences of any of the clients in this study also appears related to the age levels of the clients. These are all infrequent events in the lives of the 18-49 year old age group which represents 85% of the Center's clients.

Functional Level of Clients

The functional level of potential clients is the second criteria used by the Center's crisis screener in judging need for rapid access to treatment through the PAS clinic. An individual with a lowered or below normal functioning level is viewed by the Center as needing timely treatment.

There was a statistically significant difference in the functional level of the clients in the PAS (50.0 mean) and delayed (62.6 mean) groups as judged by this researcher using the Global Assessment Rating Scale (GAS). The significance of this finding is that it supports the effectiveness of the PAS screening process in identifying individuals with lowered functional levels and providing

them with rapid access to treatment through the PAS clinic.

The GAS scores for the clients in the PAS group ranged from 30 to 70 with a mean of 50. These GAS scores indicate that the clients' functional levels ranged from "being unable to function in almost all areas" to "functioning pretty well with some mild symptoms" (Endicott, Spitzer, Fleiss, & Cohen, 1976). A score of 50 or below on the GAS is considered an indication that the individual is not functioning well and is in need of timely treatment. A majority (57.8%) of the clients in the PAS group were judged to be functioning at 50 or below on the GAS.

If a score of 50 on the GAS were taken as an absolute in judging need for priority access to treatment, then the 42.2% of the PAS group who scored about 50 would represent inappropriate group placement. However, the GAS scores are not absolute and a margin of score variance should be allowed for clinical judgment. Almost all (94.2%) of the PAS clients were judged to be functioning at 60 or below on the GAS. With a built-in 20% margin of variance or error, the results support the effectiveness of the PAS screening process. It is also important to realize that the clinician also used the presence or absence of recent negative life events in deciding group placement. Therefore, it is difficult to draw definite conclusions without both of these variables known. Unfortunately, these data were not correlated in this study.

The functional level of the delayed group clients was judged to be between 40 and 80 on the GAS. These GAS scores indicate that the

functional levels of the clients ranged from "a major impairment in several areas of functioning" to "no more than a slight impairment in functioning" (Endicott, Spitzer, Fleiss, & Cohen, 1976). Few (13.4%) of the clients in the delayed group were judged to be functioning at 50 or below on the GAS. Scoring 60 or below on the GAS was 49.4% of the clients in the delayed group.

In terms of clients who demonstrated a major impairment in several areas of functioning (40 or below on GAS), the PAS group had a much larger percentage than the delayed group (22.3% to 1.0%). These scores are outside any margin of error and indicate a definite need for rapid access to treatment. The effectiveness of the PAS screening process is supported in that 27 out of 28 clients functioning at this low level were identified and placed in the PAS group. This is especially impressive considering that the Center's screener relies on a telephone interview to judge the functioning levels of the potential clients.

A "normal" score on the GAS is considered to be between 70 and 80 (Endicott, Spitzer, Fleiss, & Cohen, 1976). The group means for both the PAS (50.0) and delayed (62.6) groups are both below the normal functioning level. Similar findings were reported in research studies by Markush (1974), and Myers, Lindenthal, and Pepper (1973).

Attendance Rates of Clients

The difference in the attendance rates of the PAS (81%) and delayed (70%) groups was statistically significant. The difference appears related to the waiting time between request for services and

the first appointment. The PAS group had a statistically significant shorter waiting time (2.8 days compared to 21.3 days for delayed group). The longer potential clients in the community must wait for initial appointments, the greater the likelihood that they will not attend the appointment. Similar research findings were reported by Hochstudt and Trybula (1980); Folkins, Hersch, and Dahlen (1980); Craig, Huffine, and Brock (1974); Wolkon (1972); and Perlman (1965).

The attendance rates for the PAS (81%) delayed (70%) groups are slightly higher than reported in other research studies. Folkins, Hersch, and Dahlen (1980) reported a 76% attendance rate for clients given an appointment within three days of their request and a 54% attendance rate for clients given an appointment within 16-19 days of their request. Hochstudt and Trybula (1980) reported a 68% attendance rate when clients were reminded of their appointment by telephone or letter within 3 days of their appointment and an attendance rate of 55% when clients were given no reminder of their appointment.

An explanation of the high rate of attendance (70%) for the delayed group even after a mean waiting time of 21 days might be that 19% had a recent arrest. These clients may have been motivated to attend their appointment to avoid jail or the loss of their driver's license as a large majority had been arrested for driving under the influence of alcohol.

A waiting time of 2.8 days for the PAS group supports a conclusion that the PAS system is effective in providing timely services to clients in crisis. This is especially significant when

compared to the longer waiting time (21.3 days) for the Center's other clients.

Socio-demographic Data

The clients in the PAS and delayed groups were compared in respect to age, race, sex, marital status, employment status, and monthly income level. There were statistically significant differences between the PAS and delayed groups in regards to marital status, employment status, and monthly income level. There were no statistically significant difference between the PAS and delayed groups in regards to age, race, or sex.

Age. The mean ages of 32.3 years for the PAS group and 29.4 years for the delayed group are only slightly higher than the mean age of 29.2 years for the population of the county served by the Center. Eighty-five percent of the Center's clients in this study were between 18 and 49 years old. This age group is associated with child-bearing and rearing and family and financial stressors.

Ethnicity. The PAS and delayed groups were similar in terms of race. Most of the clients (93.5% PAS; 98.1% delayed) were of the Caucasian race which is representative of the county population which the Center serves (94.5% Caucasian). Neither Blacks or Alaskan Natives were represented in this study's sample population. However, these ethnic groups compose less than one percent (0.8%) of the county's population.

Sex. The proportion of females in the PAS group (56.2%) was higher than the proportyion of females in the delayed group (46.7%).

However, this difference was not found to be statistically significant. The PAS and delayed groups combined are 50.9% female and 49.1% male. These proportions are representative of the county's population which is 50.9% female and 49.1% male.

Marital status. A majority of both the PAS (74.1%) and delayed (51.4%) groups were in a non-married category which includes never married, divorced, widowed, and separated. The difference between the PAS and delayed groups in proportion of non-married clients was found to be statistically significant. Therefore, this researcher concludes that a non-married status is associated with use of the PAS clinic. This is not to say that the non-married status had precipitated the individual's problem and the use of the PAS clinic. The specualtion that the utilizers of the PAS clinic may function at a "below normal" level on a daily basis may be a better explanation for their non-married status. They may be unable to maintain long term relationships. This is especially true in comparison to the general population of the country. Certainly, the absence of a spouse lessens these individuals' social and financial support. If this is the case, their need for assistance from the Center in handling their problem is greater than the married clients. Unfortunately, no further data was collected in this study regarding the clients' support systems or parental responsibilities. A change in marital status was experienced by 14% of the PAS group and 10.5% of the delayed group. The stressfulness of this event in addition to the loss of social and

financial support makes this group of clients especially vulnerable to developing mental health problems.

The non-married categories which includes individuals who have never been married, divorced, widowed, or separated was over represented by the Center's population when compared to the population from the county served by the Center. Non-married individuals represented 63.7% of the Center's clients compared to 35.4% of the county's population. Once again, a link between the lack of social support and the use of the community mental health center must be proposed.

Employment status. The unemployment rate was much higher for the PAS group (56.4%) than the delayed group (24.8%). The difference in the proportions of unemployed clients in the PAS and delayed groups was found to be statistically significant. Both groups had a much higher unemployment rate than the population of the county served by the Center (5.3% in 1983). There are three explanations offered by this researcher for the high unemployment rate among the Center's clients. First, the Center's sliding scale fee depending upon income attracts individuals with limited financial resources. Second, the stressfulness of unemployment may precipitate mental health problems which lead to use of the Center. Third, the Center's clients may have chronically been functioning at a below "normal" level which made them susceptible to losing their jobs. Other research studies (Paykel, Myers, Dienelt, & Klerman, 1969; Block & Zautra, 1981; Vinokur & Selzer, 1975; Myers, Lindenthal, & Pepper, 1973; Paykel,

1973; Mueller, Edwards, & Yarvis, 1977 & 1978) also reported that mental health clients had experienced negative events including job loss more often than a control group from the general population.

Monthly income level. The findings from this research study support a conclusion that the Center was used mainly by low income individuals. The median income for the PAS group was $400 while the median monthly income for the delayed group was $1,000. The difference in group median income was found to be statistically significant. Therefore, it is concluded that low income individuals utilized the PAS clinic more often than the delayed group. The group median incomes were affected by the high percentage of clients (56% for PAS, 24.8% for delayed) who were unemployed and without incomes. There were also some single mothers who were attempting to support their children and themselves on a low monthly welfare income (below $400). The median income level of $400 for the PAS group equates to $4,800 a year which is below the poverty level for single member households ($4,901). Gavin (1983) also reported a high level of use of a community mental health center by low income individuals.

What is not clear is whether the lack of financial security precipitates or is the result of mental health problems. After the retrospective record review of the clients' clinical records, this researcher is left with the impression that these individuals usually function at a below normal level which serves to maintain their inability to improve their income. Their histories indicated frequent job changes, poor interpersonal skills, few long term relationships,

and a tendency to rely on alcohol or drugs to cope with the problems of daily living.

Chapter V

Summary

The demand for services has become greater than the resources available at community mental health centers resulting in waiting time for services. A need arose for these centers to establish priorities and make organizational arrangements so that clients who were judged unable to wait prolonged periods of time for services were identified and given rapid access to treatment. The literature identified the chronically mentally ill and people in active crisis as the population most in need of timely services from community mental health centers.

The purpose of this descriptive retrospective study was to examine the effectiveness of one community mental health center in identifying and providing rapid access to treatment to its priority population, people in active crisis. Evaluation is an essential element of the nursing process and is necessary in order to judge whether goals have been met, and if not, analyze what adjustments should be made in terms of interventions or goals.

A review of crisis theory was undertaken since the Center under study based their program on crisis theory. The literature provided two important variables which are usually present in a crisis situation; a precipitating event and a decrease in the functional level of the individual. A conceptual framework for this study was built around these two variables which were also used in the Center's intake process.

Potential center clients were screened for the presence of major negative precipitating events and a lowered functional ability and those clients judged to be in crisis by the crisis screener were given rapid access to treatment through the Priority Access System (PAS).

It was proposed that if the Center's intake screening process worked effectively, then the clients in the PAS group should demonstrate a lower functional level and have experienced more recent major negative life events than a group of clients who were screened and judged able to wait for services (delayed group).

A random sample of 150 clients from the PAS group and 150 clients from the Center's other program were selected and their clinical records reviewed for the presence of recent major negative life events, functional level, and socio-demographic data. A list of thirteen major negative life events were drawn from the literature to use in this study. Most of the events were rated high on the Social Readjustment Rating Scale and included such events as the death of a spouse, friend, or close family member, divorce or marital separation, loss of a job, and being physically or sexually abused. Functional level was assessed using the Global Assessment Scale (GAS) as developed by Endicott, Spitzer, Fleiss, and Cohen (1976).

The PAS and delayed groups were found to be similar in regards to age, sex, and race (no statistically significant differences). There were statistically significant differences found between the PAS and delayed groups in regard to marital status, employment status, and

monthly income. In comparison to the delayed group, the clients in the PAS group were more likely to be in a non-married category including never married, separated, divorced, or widowed; unemployed; and have a low monthly income. Over one-half of the PAS group and one-fourth of the delayed group were unemployed. In addition, similar percentages for these groups reported an income of $499 or less a month. These findings are consistent with the literature in that a majority of the users of community mental health centers are poor and unemployed.

There was a wide discrepancy in the waiting time for the PAS (2.8 days) and delayed (21.3 days) groups. This finding supports the Center's effectiveness in providing timely treatment to the clients in the PAS group. The prologned waiting time for the delayed group was associated with a non-attendance rate at the first appointment (70%) which was found to be statistically significantly different from the PAS group (80.6%). This finding is similar to other results reported in the literature.

The clients in the PAS group had experienced a greater number of recent major negative life events than the delayed group. the difference in group means was found to be statistically significant. A majority of the clients had been exposed to at least one of the thirteen life events on this study's list. This finding supports the concept of crisis theory that crises are percipitated by stressful events. The most frequently occurring events for the Center's clients were job loss, a worsening financial status, and a jail term or

arrest.

The clients in the PAS group also demonstrated a lower functional level than the delayed group as judged from the documentation in the clinical records and scored using the Global Assessment Scale. The difference was statistically significant. Overall, the Center's clients were functioning at a level which can be considered "below normal" and requiring professional intervention.

It was concluded that the PAS screening system was effective in identifying potential clients in crisis and providing them with timely treatment based on the following findings from this study: the clients in the PAS group had experienced more major negative life events, demonstrated a lower functional level, and were seen at the Center within an average of 2.8 days of their request for service.

Limitations

The limitations of this study include the use of retrospective record review to collect data; the restricted list of life events, not including the intervening variables of clients' perception, coping ability, and support systems; and the attrition rate. Each limitation will be discussed briefly.

The use of retrospective record review depends upon adequate documentation and information which was not recorded with this study's needs in mind. The ability of the researcher to identify recent major negative life events and to make an accurate assessment of the functioning level of the client was dependent upon the quality of the documentation of the different Center therapists. Also, a bias

may have existed in that the therapist in the PAS clinic was more experienced in identifying and documenting recent major negative life events than some of the therapists in the other programs who provided the documentation for the delayed group clients.

The limiting of life events to thirteen and that they had to have occurred over the preceding six months proved too constricting. Many of the clinical records contained events which were quite stressful to that particular client. However, for the purpose of this study, they could not be counted as a major precipitating event. Also, some of the clients had experienced one of the thirteen events on this study's list but the event had occurred longer than six months ago. Once again, the event could not be considered as a precipitator for the purposes of this study regardless of whether the person had ever been able to deal with the problem. The Social Readjustment Rating Scale as developed by Holmes and Rahe (1967) may be outdated as an instrument for the 1980's as evidenced by the fact that incest or domestic violence was not included on their scale. One explanation for this might be that their scale contains "change" events and does not include stressful events unless they require an adjustment by the individual.

A weakness in this study was the assumption made regarding the intervening variables in the development of a crisis. First, it was assumed that clients requesting assistance from the Center were exposed to a precipitating event which they perceived as stressful. Second, if they were asking for the Center's help in dealing with a

problem, then they must lack the coping abilities and social support to deal with the problem. These assumptions are applied on a general basis and do not take individual differences and the degree of stressors into consideration.

The attrition rate decreased the sample size which could be studied for the other variables. The attrition was expected and a larger sample size selected. However, the clients who had external motivation to attend (DUI clients) affected the sample which was drawn from the Center's population. DUI clients were more likely to attend the first appointment and thus be included in this study's sample used to evaluate the other variables (functional level, precipitating events, and socio-demographic data). Thus, the conclusions drawn from this study cannot be considered based on a random sample.

Recommendations for Further Study

Evaluation of a community mental health center's programs is an important component of the overall treatment process and is therefore an encouraged undertaking for the staff of community mental health centers. Psychiatric nurses must take the responsibility for being accountable for the services they provide. When a target population has been identified as needing to receive services (people in crisis in this study), then the whole nursing process including evaluation needs to be conducted.

Precipitating events and functional level appears to be appropriate variables to use to judge crisis. However, measuring the

individual's social support and general coping abilities would provide a more detailed and accurate assessment as for the need for rapid access to treatment. The Global Assessment Scale proved a useful and reliable tool for measuring the functional level of the clients. As far as stressful life events, a questionnaire administered to the clients would provide a more detailed and accurate assessment of precipitating events which led up to the clients' request for services from the center. An exploration of what happens to the 20 to 30% of clients who fail to attend their appointment would provide useful information. Do they receive help from other agencies and friends, or does the problem just resolve itself?

Further studies to identify the socio-demographic characteristics of the people who use community mental health centers is also encouraged by this researcher. The need for special programs or groups can be identified through the identification of the characteristics of the users of the center. If a large percent of the clients are unemployed and poor, then job skills training and education on community services available for the poor would be appropriate.

References

American Psychological Association. (1982). Ethical principles in the conduct of research with human participants. Menasha, WI: Banta.

Andrulus, D. P., & Mazade, N. A. (1983). American mental health policy: Changing directions in the 80's. Hospital and Community Psychiatry, 34, 601-606.

Aneshensel, C. S., & Stone, J. D. (1982). Stress and depression. Archives General Psychiatry, 39, 1392-1397.

Auerbach, S. M., & Kilmann, P. R. (1977). Crisis intervention: A review of outcome research. Psychological Bulletin, 84, 1189-1217.

Baldwin, B. A. (1977). Crisis intervention in professional practice: Implications for clinical training. American Journal Orthopsychiatry, 47, 659-669.

Bassuk, E. L., Winter, R., & Apsler, R. (1983). Cross-culteral comparison of British and American psychiatric emergencies. American Journal Psychiatry, 140, 180-184.

Battista, J. R. (1982). Empirical test of Vaillant's hierarchy of ego functions. American Journal Psychiatry, 139, 356-357.

Bergin, A. E. (1971). The evaluation of therapeutic outcomes. In A. E. Bergin & S. L. Garfield (Eds.), Handbook of Psychotherapy and Behavior Change: An Empirical Analysis (pp. 217-270). New York: John Wiley & Sons.

Block, M., & Zautra, A. (1981). Satisfaction and distress in a community: A test of the effects of life events. American Journal of Community Psychology, 9, 165-177.

Bloom, B. L. (1965). Definitional aspects of the crisis concept. In H. J. Parad (Ed.), Crisis Intervention: Selected Readings (pp. 303-311). New York: Family Service.

Bloom, B. L. (1984). Community mental health: A general introduction. Monterey: Brooks-Cole.

Bureau of the Census. (1983, August). 1980 Census of Population and Housing. Washington, D. C.: U. S. Government Printing Office.

Burgess, A. W., & Baldwin, B. A. (19819). Crisis intervention theory and practice. Englewood Cliffs: Prentice-Hall.

Burgess, A. W., & Lazare, A. (1976). Community mental health target populations. Englewood Cliffs: Prentice Hall.

Caplan, G. (1964). Principles of preventive psychiatry. New York: Basic Books.

Craig, T. J., Huffine, C. L., & Brooks, M. (1974). Completion of referral to psychiatric services by inner city residents. Archives General Psychiatry, 31, 353- .

Eastham, K., Coates, D., & Allodi, F. (1970). The concept of crisis. Canadian Psychiatric Association Journal, 15, 463-472.

Endicott, J., Spitzer, R. L., Fleiss, & Cohen, J. (1976). The Global Assessment Scale. Archives General Psychiatry, 33, 766-771.

Folkins, C., Hersch, P., & Dahlen, D. (1980). Waiting time and no-show rate in a community mental health center. American Journal of Community Psychology, 8, 121-123.

Gavin, H. J. (1983). An analysis of the sociodemographic attributes of utilizers at a community mental health center's rural satellite clinics. Unpublished master's thesis, Oregon Health Sciences University, Portland, OR.

Germain, C. P. (1984). Sheltering abused women: A nursing perspective. Journal Psychosocial Nursing Mental Health Services, 22 (9), 24-31.

Ginatt, H. G. (1961). Group psychotherapy with children. New York: McGraw-Hill.

Gordon, T., & Cartwright, D. S. (1954). The effect of psychotherapy upon certain attitudes toward others. In C. R. Rogers (Ed.), Psychotherapy and Personality Change (pp. 196-195). Chicago: The University of Chicago Press.

Gottschalk, L. A., Mayerson, P., & Gottleib, A. A. (1967). Prediction and evaluation of outcome in an emergency brief psychotherapy clinic. The Journal of Nervous and Mental Disease, 144, 77-95.

Gully, K. J., & Harris, M. D. (1982). The impact of fee setting procedures in a mental health center setting. Community Mental Health Journal, 18, 210-218.

Halpern, H. A. (1973). Crisis theory: A definitional study. Community Mental Health Journal, 9, 342-349.

Harris, H. C., & McCarthy, K. (1981). Mental health practice for community nurses. New York: Springer.

Herz, M. I., Endicott, J., & Spitzer, R. L. (1975). Brief hospitalization of patients with families: Initial results. American Journal Psychiatry, 132, 413-418.

Herz, M. I., Endicott, J., & Spitzer, R. L. (1977). Brief hospitalization: A two-year follow-up. American Journal Psychiatry, 135, 502-507.

Hill, R. (1965). Generic features of families under stress. In H. J. Parad (Ed.), Crisis Intervention: Selected Readings (pp. 32-52). New York: Family Service.

Hochstadt, N. J., & Trybula, J. (1980). Reducing missed appointments in a community mental health center. Journal of Community Psychology, 8, 261-265.

Hoff, L. A. (1978). People in crisis: Understanding and helping. Menlo Park, CA: Addison-Wesley.

Holmes, T. H., & Masuda, M. (1973). Life changes and illness susceptibility. In B. S. Dohrenwend and B. P. Dohrenwend (Eds.), Stressful Life Events: Their Nature and Effects (pp. 45-72). New York: John Wiley & Sons.

Holmes, T. H., & Rahe, R. H. (1967). The social readjustment rating scale. Journal of Psychosomatic Research, II, 213-218.

Hudgens, R. W. (1973). Personal catastrophe and depression: A consideration of the subject with respect to medically ill adolescents, and a requiem for retrospective life-event studies. In B. S. Dohrenwend and B. P. Dohrenwend (Eds.), Stressful Life Events: Their Nature and Effects (pp. 119-134). New York: John Wiley & Sons.

Jacobson, G. F. (1965). Crisis theory and treatment strategy: Some sociocultural and psychodynamic considerations. The Journal of Nervous and Mental Disease, 141, 209-217.

Jacobson, G. F. (1983). The multiple crises of marital separation and divorce. New York: Grune & Stratton.

Kardener, S. H. (1975). A methodologic approach to crisis therapy. American Journal of Psychotherapy, 29, 4-13.

Kass, F., Charles, E., Walsh, T., & Barsa, J. (1983). Quality review of outpatient psychopharmacological practice with APA task force criteria. American Journal Psychiatry, 140, 221-224.

Lazarus, R. S. (1966) Psychological stress and the coping process. New York: McGraw-Hill.

Lieberman, M. A., & Mullan, J. T. (1978). Does help help? the adaptive consequences of obtaining help from professionals and social networks. American Journal of Community Psychology, 6, 499-517.

Lindemann, E. (1944). Symptomatology and management of acute grief. American Journal of Psychiatry, 101, 141-148.

Lukton, R. C. (1974). Crisis theory: Review and critique. Social Service Review, 48, 384-402.

Maris, R., & Conner, H. E. (1973). Do crisis services work? A follow-up of a psychiatric outpatient sample. Journal of Health and Social Behavior, 14, 311-322.

Markush, R. E., & Favero, R. V. (1973). Epidemiologic assessment of stressful life events, depressed mood, and psychophysiological symptons - a preliminary report. In B. S. Dohrenwend and B. P. Dohrenwend (Eds.), Stressful Life Events: Their Nature and Effects (pp. 171-190). New York: John Wiley & Sons.

Morley, W. E., Messick, J. M., & Aguilera, D. C. (1967). Crisis: Paradigms of intervention. Journal of Psychiatric Nursing, 5, 531-544.

Muellar, D. P., Edwards, D. W., & Yarvis, R. M. (1977). Stressful life events and psychiatric symptomatology: Change or undesirability. Journal of Health and Social Behavior, 18, 307-317.

Muellar, D. P., Edwards, D. W., & Yarvis, R. M. (1978). Stressful life events and community mental health center patients. The Journal of Nervous and Mental Disease, 166, 16-24.

Muench, G. A. (1965). An investigation of time-limited psychotherapy. Journal of Counseling Psychology, 12, 294-298.

Murphy, E., & Fawcett, J. (1983). The crisis theory framework. In M. B. White (Ed.), Curriculum Development from a Nursing Model: The Crisis Theory Framework (pp. 43-60). New York: Springer.

Myers, J. K., Lindenthal, J. J., & Pepper, M. P. (1973). Social class, life events, and psychiatric symptoms: A longitudinal study. In B. S. Dohrenwend and B. P. Dohrenwend (Eds.), Stressful Life Events: Their Nature and Effects (pp. 191-206). New York: John Wiley & Sons.

Narayan, S. M., & Joslin, D. J. (1980). Crisis theory and intervention: A critique of the medical model and proposal of a holistic nursing model. Advances Nursing Science, 3, 27-39.

Papa, L. L. (1980). Responses to life events as predictors of suicidal behavior. Nursing Research, 29, 362-369.

Parad, H. J., & Caplan, G. (1965). A framework for studying families in crisis. In H. J. Parad (Ed.), Crisis Intervention: Selected Readings (pp. 53-74). New York: Family Service.

Parad, L. G., & Parad, H. J. (1968). A study of crisis-oriented planned short-term treatment: Part II. Social Casework, 49, 418-426.

Parad, H. J., & Resnik, H. L. (1975). The practice of crisis intervention in emergency care. In H. L. Resnick, H. L. Ruben, and D. D. Ruben (Eds.), Emergency Psychiatric Care: The Management of Mental Health Crises (pp. 23-34). Bowie, MD: Charles Press.

Parad, H. J., Resnick, H. L., Ruben, H. L., Zusman, J., & Ruben, D. D. (1975). Crisis intervention and emergency health care: Concepts and principles. In H. L. Resnick, H. L. Ruben, and D. D. Ruben (Eds.). Emergency Psychiatric Care: The Management of Mental Health Crises (pp. 1-22). Bowie, MD: Charles Press.

Paykel, E. S. (1973). Life stress and psychiatric disorder: Applications of the clinical approach. In B. S. Dohrenwend and B. P. Dohrenwend (Eds.), Stressful Life Events: Their Nature and Effects (pp. 135-150). New York: John Wiley & Sons.

Paykel, E. S., Myers, J. K., Dienelt, M. N., Klerman, G. L., Lindenthal, J. J., & Pepper, M. P. (1969). Life events and depression. Archives General Psychiatry, 21, 753-760.

Pearlin, L. I., Lieberman, M. A., Menaghan, E. G., & Mullan, J. T. (1981). The stress process. Journal of Health and Social Behavior, 22, 337-356.

Perlman, H. H. (1965). Some notes on the waiting list. In H. J.. Parad (Ed.), Crisis Intervention: Selected Readings (pp. 193-201). New York: Family Service.

Polak, P. R., Egan, D., Vandenbergh, R. & Williams W. V. (1975). Prevention in mental health: A controlled study. American Journal Psychiatry, 132, 146-148.

Rahe, R. H. (1973). The pathway between subject's life changes and their near-future illness reports: Representative results and methodological issues. In B. S. Dohrenwend and B. P. Dohrenwend (Eds.), Stressful Life Events: Their Nature and Effects (pp. 73-86). New York: John Wiley & Sons.

Raphael, B. (1977). Preventive intervention with the recently bereaved. Archives General Psychiatry, 34, 1450-1454.

Rapoport, L. (1965). The state of crisis: Some theoretical considerations. In H. J. Parad (Ed.), Crisis Intervention: Selected Readings (pp. 22-31). New York: Family Service.

Roskin, M. (1982). Coping with life changes - A preventive social work approach. American Journal of Community Psychology, 10, 331-340.

Rossi, P. H., & Freeman, H. E. (1982). Evaluation: A systematic approach. Beverly Hills: Sage Publicatrions.

Roth, I., Rhudick, P. J., Shaskan, D. A., Slobin, M. S., Wilkinson, A. E., & Young, H. H. (1964). Long-term effects on psychotherapy of initial treatment conditions. Journal Psychiatric Research, 2, 283-297.

Rusk, T. N. (1971). Opportunity and technique in crisis psychiatry. Comprehensive Psychiatry, 12, 249-263.

Schwartz, S. L. (1971). A review of crisis intervention programs. Psychiatric Quarterly, 45, 498-508.

Sifneos, R. E. (1960). A concept of emotional crisis. Mental Hygiene, 44, 169-179.

Sifneos, P. O. (1980). Brief psychotherapy and crisis intervention. In H. I. Kaplan, A. M. Freedman, and B. J. Sadock (Eds.), Comprehensive Textbook of Psychiatry (pp. 2247-2256), Baltimore: Williams & Wilkins.

Skinner, H. A., & Lei, H. (1980). The multidimensional assessment of stressful life events. Journal of Nervous and Mental Disease, 196, 535-541.

Strickler, M., & La Sor, B. (1970). The concept of loss in crisis intervention. Mental Hygiene, 54, 301-305.

Strupp, H. H., & Blackwood, G. L. (1980). Recent methods of psychotherapy. In H. I. Kaplan, A. M. Freedman, and B. J. Sadock (Eds.), Comprehensive Textbook of Psychiatry (pp. 2233-2247). Baltimore: Williams & Wilkins.

Taplin, J. R. 1971). Crisis theory: Critique and reformulation. Community Mental Health Journal, 7, 13-24.

Uhlenhath, E. H., & Duncan, D. B. (1968). Subjective change with medical student therapy. Archives General Psychiatry, 18, 532-540.

Vinokur, A., & Selzer, M. L. (1975). Desirable versus undesirable life events: Their relationship to stress and mental distress. Journal of Personality and Social Psychology, 32, 329-337.

Walkup, L. L. (1974). A concept of crisis. In J. E. Hall and B. R. Weaver (Eds.), Nursing of Families in Crisis (pp. 151-157). Philadelphia: J B. Lippincott.

Webster's Third New International Dictionary (1971). Chicago: Encyclopedia Brittanica.

Wilcox, B. L. (1981). Social support, life stress, and psychological adjustment: A test for the buffering hypothesis. American Journal of Community Psychology, 13, 371-386.

Wolkon, G. H. (1972). Crisis theory, the application for treatment, and dependence. Comprehensive Psychiatry, 459-464.

Zusman, J. (1975). Recognition and management of psychiatric emergencies. In H. L. Resnick, H. L. Ruben, and D. D. Ruben (Eds.), Emergency Psychiatric Care: The Management of Mental Health Crises (pp. 35-60). Bowie, MD: The Charles Press.

APPENDIX A

Service Request Form

Tualatin Valley Mental Health Center

File in Chart

File in Chart

* _____ Receptionist

___Cornell
___Tigard
___Open Gate

SERVICE REQUEST

Tualatin Valley Mental Health Center

* Call Received: Date:_____ Time:_____

Caller's Name: _____ DOB:____ Sex:____

Target Client's Name:_____ Age:____ Sex:____
(if other than caller)

- Relationship of target client to caller:_____
- Legal Guardian of Target Client (if child):_____

Referred By:_____ Relationship/Agency:_____

Presenting Problems: _____

_____

_____

* Caller's Daytime Phone:_____ Hours Available_____

Caller's Evening Phone:_____ Hours Available_____

Caller's Address: _____

City:_____ County_____ Zip_____

Insurance: ___ Yes ___ Blue Cross ___ Kaiser ___ Other Carrier (specify)_____

Group # or Employer:_____

___ No

___ Don't Know - Employer:_____

___ Title XIX

___ Title V

___ Other - Explain:_____

(over)

APPENDIX B

PAS Participating Agencies

Tualatin Valley Mental Health Center

PAS PARTICIPATING AGENCIES

Tualatin Valley Workshop

Juvenile Department

University Health Sciences University

George Rex, WCMHD

Children Services Division

Metro Crisis Service

St. Vincent Hospital

Riverside Psychiatric Hospital

Dammasch State Hospital

WCMH-MR/DD

Washington County Health Department

Cedar Hills Hospital

Washington County Comm. Corrections

Boys & Girls Aid Society

APPENDIX C

Agreement to Conduct Archival Research

Tualatin Valley Mental Health Center

TUALATIN VALLEY MENTAL HEALTH CENTER

GARY DOMBROFF, Ph.D.
EXECUTIVE DIRECTOR

14600 N.W. CORNELL ROAD, PORTLAND, OREGON 97229
(503) 645-3581

Agreement to Conduct Archival Research

In order to protect the safety and privacy of Center clients, the ollowing conditions are agreed to regarding records research:

A. Recorded data extracted from client files may never be attached to any client's name, or other identifying information (e.g., Birthdates, unique circumstnces, etc.)

B. Data must be coded for research and statistical purposes in such a way that individual elements may not be traced back to any specific client or client's chart.

C. Data must be grouped and summarized in such a way, and with a sufficiently large sample size, that individual's contributions to the data pool may not be isolated or identified.

D. The researcher shall hold in the strictest professional confidence any information learned about any individual center client, and shall refrain from ever discussing or divulging such information about individuals.

E. The researcher shall not review any client file wherein the name(s) of a client is in any personal way known to the researcher.

F. The study will be conducted and results utilized only in the ways specified in advance in the research proposal, and for no other purposes.

G. Evidence of procedures necessary to satisfy each of the prior conditions will be submit in advance for approval by the Center's Executive Director.

H. The Center retains the right to fully monitor the project and its operations, to discontinue the project at any time and for any reason, and to completely review and screen any information or results prior to their release from the Center to any third party or for preparation of a manuscript.

I. The researcher agrees to be guided in all practices by the Ethical Principles in the Conduct of Research with Human Participants (APA, 1982).

[redacted]
Signature of Researcher

OHSU
Affiliation

[redacted]
Gary Dombroff, ~~Ph.D.~~, Exec. Dir.
Tualatin Valley Center

1-8-85
Date

APPENDIX D

Client Process Monitoring System

Tualatin Valley Mental Health Center

State of Oregon
MENTAL HEALTH DIVISION
Department of Human Resources

CLIENT PROCESS MONITORING SYSTEM

WHITE-LOCAL COPY YELLOW-STATE COPY

M-ED or A-D ENROLLMENT

FORM USE

1 1 = ENROLLMENT 2 = RE-ENROLLMENT

2 This form corrects information from a previously submitted form. 1-YES 2-NO

CLINIC IDENTIFICATION

3 CMHP

4 PROVIDER

5 OPENING DATE — MONTH DAY YEAR

6 NAME (USE UPPER CASE BLOCK LETTERS)

LAST FIRST MAIDEN

7 CASE NUMBER

8 DATE OF BIRTH — 1 = Known 2 = Estimated — MONTH DAY YEAR

9 ENTRY CODE

10 ELIGIBILITY CODES

11 PROGRAM AREA ASSIGN. — 1 = ALCOHOL 3 = M-ED

12 SEX — F = FEMALE M = MALE

13 EDUCATION — HIGHEST GRADE COMPLETED

14 SCHOOL/TRNG. — ENROLLED IN SCHOOL OR TRAINING — 1 = YES 2 = NO

15 REFERRAL — LIST ON BACK OF FORM

16 CRISIS — 1 = YES 2 = NO

17 MONTHLY INCOME — 0001 = REFUSED 0002 = UNKNOWN 9999 = MORE THAN $9999

18 CLIENT RESIDENCE CODES

A. COUNTY, STATE, OR COUNTRY CODE (List on back of form)

B. TRACT OR DIVISION CODE (See CPMS Manual for Code List)

19 RACE/ETHNICITY

01-WHITE (Non-Hispanic)
02-BLACK (Non-Hispanic)
03-AMERICAN INDIAN
04-ALASKAN NATIVE
05-ASIAN, PACIFIC ISLANDER
06-HISPANIC (Mexican)
07-HISPANIC (Puerto Rican)
08-HISPANIC (Cuban)
09-OTHER HISPANIC
10-SOUTHEAST ASIAN
98-REFUSED
99-UNKNOWN

20 HEALTH INSURANCE — 1 = YES 2 = NO MAKE ENTRY FOR EACH

- MEDICARE
- MEDICAID
- BLUE CROSS/BLUE SHIELD
- C.H.A.M.P.U.S.
- V.A.
- OTHER PRIVATE
- OTHER PUBLIC

21 CURRENT MARITAL STATUS

1-NEVER MARRIED
2-MARRIED
3-WIDOWED
4-DIVORCED
5-SEPARATED
6-LIVING AS MARRIED
8-REFUSED
9-UNKNOWN

22 LIVING ARRANGEMENT

ENTER THE **FIRST** APPROPRIATE CODE

01-ALONE
02-SPOUSE
03-PARENTS, RELATIVES, CHILDREN
04-FOSTER PARENTS
05-INSTITUTION
06-FRIENDS OR OTHERS
98-REFUSED
99-UNKNOWN

Additional Codes on Back of Form

23 DEPENDENTS

ENTER THE TOTAL NUMBER OF PEOPLE IN EACH AGE GROUP THAT ARE DEPENDENT UPON THE INCOME INDICATED IN ITEM #17

INCLUDE THE CLIENT

YEARS OF AGE

UNDER 6 | 6-17 | 18-64 | OVER 65

24 SOURCE OF INCOME — 1 = YES 2 = NO MAKE ENTRY FOR EACH

- WAGES, SALARY
- SOCIAL SECURITY
- S.S.I.-FEDERAL
- O.S.I.P.-STATE
- PUBLIC ASST./WELFARE
- DIVIDENDS/INTEREST
- PENSION/UNEMP./VETS.
- ALIMONY/CHILD SUPPORT
- OTHER
- UNKNOWN

25 EMPLOYMENT STATUS

1-FULL TIME (35 hours or more)
2-PART TIME (17-34 hours)
3-IRREGULAR (less than 17 hours)
4-NOT EMPLOYED (but has sought employment)
5-NOT EMPLOYED (and has not sought employment)
8-REFUSED
9-UNKNOWN

26 IS EMPLOYMENT SUBSIDIZED? 1 = YES 2 = NO

29 AFS PRIME NUMBER

30 LOCAL OPTION — A B C D E

FORM NUMBER
MHD-ADMS-0189
REVISION NUMBER
1182

NOTE: FILL OUT THIS FORM FOR ANY CLIENT WHO IS TO RECEIVE SERVICES FROM THIS FACILITY.

APPENDIX E

Global Assessment Scale (GAS)

by Endicott, Spitzer, Fleiss, & Cohen

GLOBAL ASSESSMENT SCALE (GAS)
By Endicott, Spitzer, Fleiss, & Cohen (1976)

Ranges one through fifty should be used to determine Priority 1.

Rate the subject's lowest level of functioning in the last week by selecting the lowest range which describes his functioning on a hypothetical continuum of mental health-illness. For example, a subject whose "behavior is considerably influenced by delusions" (range 21-30) should be given a rating in that range even though he has "major impairment in several areas" (range 31-40). Use intermediary levels when appropriate (e.g., 35, 58, 63). Rate actual functioning independent of whether or not subject is receiving any may be helped by medication or some other form of treatment.

100 No symptoms, superior functioning in a wide range of activities, life's problems never seem to get out of hand, is sought out by
91 others because of his warmth and integrity.

90 Transient symptoms may occur, but good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, "everyday" worries
81 that only occasionally get out of hand.

80 Minimal symptoms may be present but no more than slight impairment in functioning, varying degrees of "everyday" worries
71 and problems that sometimes get out of hand.

70 Some mild symptoms (e.g., depressive mood and mild insomnia) or some difficulty in several areas of functioning, but generally functioning pretty well, has some meaningful interpersonal relationships and most untrained people would not consider him
61 "sick."

60 Moderate symptoms or generally functioning with some difficulty (e.g., few friends and flat affect, depressed mood, and pathological self-doubt, euphoric mood and pressure of speech,
51 moderately severe antisocial behavior).

50 Any serious symptomatology or impairment in functioning that most clinicians would think obviously requires treatment or attention (e.g., suicidal preoccupation or gesture, severe obsessional rituals, frequent anxiety attacks, serious
41 antisocial behavior, compulsive drinking).

40 Major impairment in several areas, such as work, family relations, judgment, thinking, or mood (e.g., depressed woman avoids friends, neglects family, unable to do housework), or some impairment in reality or communication (e.g., speech is at times obscure, illogical, or irrelevant), or single suicide
31 attempt.

30 Unable to function in almost all areas (e.g., stays in bed all day), or behavior is considerably influenced by either delusions or hallucinations, or serious impairment in communication (e.g., sometimes incoherent or unresponsive) or judgment (e.g., acts
21 grossly inappropriately).

20 Needs some supervision to prevent hurting self or others, or to maintain minimal personal hygiene (e.g., repeated suicide attempts, frequently violent, manic excitement, smears feces), or gross impairment in communication (e.g., largely incoherent
11 or mute).

10 Needs constant supervision for several days to prevent hurting self or others, or makes no attempt to maintain minimal personal
1 hygiene.

AN ABSTRACT OF THE THESIS OF

T. SCOTT CHURCH

for the Master of Nursing

Date of Receiving this Degree: June 14, 1985

Title: A DESCRIPTIVE STUDY OF THE UTILIZERS OF A PRIORITY ACCESS SYSTEM IN A COMMUNITY MENTAL HEALTH CENTER

Approved: _____
Florence Hardesty, R.N., Ph.D., Thesis Advisor

The purpose of this study was to examine the effectiveness of one community mental health center in identifying and providing priority access to treatment for clients in crisis. This is an important need since the demand for services have become greater than the resources available at community mental health centers. A sample of 150 clients who were judged by the Center's crisis screener to be in crisis and therefore placed in the Priority Access System (PAS) was studied along with a sample group of 150 clients who were judged by the Center's crisis screener not to be in crisis and therefore had to wait a longer period of time for services.

Precipitating events and functioning level were the two variables used by the Center's crisis screener and this study to judge whether a client was in crisis. Data was collected through retrospective record review. A list of 13 major negative life events

identified in the literature as very stressful was used to measure for a major precipitating event. Functional level of the clients were judged using the Global Assessment Scale.

The PAS group was found to have experienced a greater number of recent major negative life events and were functioning at a lower level than the delayed grup. Both group differences were statistically significant. Therefore, it was concluded that the Center was effective in identifying and providing rapid access to treatment to clients in crisis through the PAS system.

The PAS and delayed groups were similar in respect to age, sex, and race and were representative of the population of the county served by the Center. A greater percentage of the clients in the PAS group were non-married, unemployed, and low income. The differences between the groups were all statistically significant. The PAS group had a shorter waiting time for services and a higher rate of attendance than the delayed group. Both group differences were found to be statistically significant.