PSYCHIATRIC EMERGENCY SERVICES
IN SELECTED OREGON COUNTIES

by

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CHAPTER I

INTRODUCTION

Psychiatric emergency services are recognized as an essential component in the provision of mental health care and are often the point of entry for persons seeking mental health services. Within most communities there has been an increase in the number of agencies that provide services to persons experiencing psychiatric emergencies. Some of these agencies may provide a highly specialized portion of services, such as telephone counseling or psychiatric evaluation. Other organizations such as law enforcement agencies intervene with persons in an emergency, but are not designed as a psychiatric emergency service. The increased number of agencies in the community and the diversity of services offered by particular agencies have contributed to the development of a complex network of psychiatric emergency services.

This study provides a description of existing psychiatric emergency services in selected communities in Oregon. Three components of these services are described: 1) the kinds of psychiatric emergency services provided and types of staff who provide them, 2) the characteristics of people who have used the services and the care they received, and 3) direct service providers' opinions regarding the operation of psychiatric emergency services. Finally, the conclusions drawn from these three components provide a framework from which recommendations are made to improve existing psychiatric emergency service delivery.

SURVEY OF MENTAL HEALTH PROGRAMS

To further define the area of study, the researchers gathered information from two types of sources. These sources were the mental health divisions of other states and the county mental health program directors in Oregon. The purpose was to learn what psychiatric emergency services are available in Oregon and other states. The researchers were also interested in learning what information from the study would be most useful to the county mental health programs in Oregon.

Survey of State Mental Health Programs

Letters were sent to the mental health divisions of all fifty states (Appendix A), asking for information regarding the psychiatric emergency services offered in each state. Nineteen states responded and seven states provided detailed descriptions of a particular emergency service in operation. The following types of services were described:

1. Mental Health Clinics. Several of these agencies offer telephone counseling and walk-in services during regular working hours to persons in need of emergency psychiatric care. They may also provide emergency consultation and/or direct psychiatric emergency service to other agencies. Many of the mental health clinics offer after-hours telephone service which is provided by an answering service or by on-call clinic professionals.

2. Hot Lines. These agencies may be available 24 hours or only during the nights and weekends when mental health clinics are closed. They are often staffed by volunteers who are trained and supervised by mental health professionals.

3. General Hospital Emergency Rooms. Several programs referred

to the local general hospital emergency room as a resource to emergency psychiatric clients during non-clinic hours. No states provided detailed information concerning the availability of mental health staff in these emergency rooms.

4. Psychiatric Services. These services were generally reported to be part of a larger agency such as a general hospital with a psychiatric unit or a comprehensive mental health center. Several staff members are trained to work with emergency psychiatric clients and are usually available 24 hours a day.

5. Other Services. Other psychiatric emergency services might be provided by rescue squads, general hospital switchboards, and information/referral services.

Survey of County Mental Health Programs

In order to determine the psychiatric emergency services available in each county, a questionnaire (Appendix A) was mailed to 32 county mental health program directors in Oregon. The directors of programs in Clackamas, Columbia, Multnomah and Washington Counties were interviewed directly by the researchers. Fifteen program directors returned their questionnaires and the responses indicated that:

1. The 24-hour psychiatric emergency services most commonly available are local general hospitals, county mental health clinics, and hot lines.

2. The problems most commonly identified in the delivery of psychiatric emergency services were lack of funds, lack of staff, lack of cooperation/coordination between agencies, and lack of holding rooms or temporary hospitalization.

3. Thetypes of information identified as must useful to the local mental health clinics were statistics on emergency events, models for rural communities, funding sources and the development of delivery systems.

PROBLEM STATEMENT

The researchers decided to study the delivery of psychiatric emergency services in Oregon. This was in response to a request by the Oregon State Mental Health Division for information facilitating the planning of emergency mental health services in local facilities throughout the state. The study was also in response to the knowledge that psychiatric emergency service delivery is of increasing concern to local communities.

MAIN CONCEPTS

The researchers found it necessary to define the terms "psychiatric emergency," "crisis," and "psychiatric emergency service" because there exists no common definition for each term.

Definitions for the terms psychiatric emergency, crisis and psychiatric emergency service vary widely in the literature. Swartz, Weiss and Miner (1972) and Parad and Resnik (1975) present a compilation of definitions of a psychiatric emergency. The interpretation advanced by some professionals is that a psychiatric emergency is a person who is suicidal, homocidal or gravely disabled. Authors with a broader view described a psychiatric emergency as a situation in which any person believes he/she needs to be seen immediately. The researchers developed a definition of a pyschiatric emergency using elements of several definitions reviewed in the literature. For the purposes of this study, a

psychiatric emergency was defined as "an acute onset of symptoms that require immediate intervention within 24 hours. If unattended, the situation may result in harm to self or others.

Darbonne (1967) reviewed the literature on crisis theory and included several definitions. The most frequently mentioned is a situation in which a person faces an obstacle to important life goals and is unable to use customary methods of problem-solving. A crisis is usually resolved for better or worse in 4 to 6 weeks. Parad and Resnik (1975) describe a crisis more specifically as a situation that occurs "in a psychological setting that has been previously identified and has been gathering momentum over some time. If attended to immediately, it can usually be 'dealt with' over the following 12 to 24 hours." (p.5)

The researchers developed the following definition of a crisis: "a situation in which a person or significant other makes a request for immediate service. This situation may be the result of a prolonged period of disequilibrium in which many abortive attempts at solution are made. A crisis situation is less acute than the psychiatric emergency and may not require an intensive therapeutic response within 24 hours."

In his article on emergency services, James Atkins (1976) defined a psychiatric emergency service specifically as a function of the mental health clinic. He stated that psychiatric emergency service is "treatment, evaluation or consultation provided, immediately, before or outside of the normal appointment, intake and treatment contract processes because the client, consultee, or petitioner (in the case of commitments) indicates he is in crisis." (p. 29)

Due to the various types of agencies providing psychiatric intervention, which may or may not include a formal psychiatric intake procedure, a more general definition of a psychiatric emergency service was developed by the researchers and is described as "any service that an agency provides to persons in a psychiatric emergency."

CHAPTER II

THEORETICAL FRAMEWORK

INTRODUCTION

The theoretical framework is composed of concepts from three theories. The researchers developed this framework in order to conceptualize several aspects of psychiatric emergency events. These aspects include:

1. The development of a psychiatric emergency, from the perspective of the individual experiencing it, is described using concepts of crisis theory.

2. The process by which an individual's behavior is identified by others as a psychiatric emergency is considered using the concept of social deviance.

3. The elements of health care systems that provide psychiatric emergency services to people requesting aid are discussed using concepts of general systems theory.

4. A review of several ideal models of service delivery in health and mental health systems.

These theories were not considered to be inclusive, but were used to guide the researchers in developing a format in which to study the problem area.

CRISIS THEORY

The impetus for the development of crisis theory was provided by Erich Lindeman's classic study of acute grief (Lindeman, 1944). After the Cocoanut Grove nightclub fire in Boston in 1942, Dr. Lindeman played a major role in the active psychological treatment of the surviving family members of the fire victims. Due to the nature of the disaster, the type of psychotherapy that would quickly reach the most people was sought. From his clinical analysis of the grief process, crisis theory was born.

Lindeman (1944) describes crisis as a turning point in a person's life which can have negative or positive future life effects. Lindeman (1944) states the major obstacle to grief resolution is reluctance to express the intense, unpleasant emotions associated with the loss of a loved one. The avoidance of this expression is dramatic. He also found that if the bereaved person could be persuaded toward emotional expression of grief, a relief from tension would follow rapidly, accompanied by the desire and ability to plan constructively for the future. (Bloom, 1973). However, if a person is not able to resolve the crisis properly, significant psychiatric illness may result.

This notion led Gerald Caplan, another major theoretician, to describe crisis as a major upset in an individual's normal homeostatic state (Caplan, 1974). This is the first major characteristic of crisis to be presented in this section. An individual's state of balanced emotional functioning is maintained by learning coping techniques used to solve common daily problems. When a problem is magnified or the previous coping techniques are not suited to meet the situation, a person moves into a crisis state. The crisis is the person's emotional

response to the hazardous situation, not the situation itself (Darbonne, 1967).

Caplan (1974) states that these variations from homeostasis are short periods of psychological upset which are the results of problems beyond the person's normal ability to cope. Crises are defined by the breadth and number of each individual's coping mechanisms.

As a result of a crisis situation, new problem solving behaviors may be developed which aid in meeting future crises. Conversely, a poor solution may have the opposite effect and create an inability to deal with future problems (Halpern, 1973). When there is an imbalance in emotional functioning, there is potential for both adaptive and maladaptive crisis resolution.

Lydia Rapoport (1962) views crisis as a situation with growth promoting potential. She states "a crisis is a new call to action requiring the discovery of new, strengthening, coping mechanisms increasing individual potential for mental health" (p. 23). James Tyhurst (1957) supports this notion that crisis is an opportunity for personal growth and establishes that a state of crisis is not itself a sign of mental illness. He says although a person may have chronic symptomatology, the crisis must be evaluated separately.

Julain Taplin (1971) feels Caplan's homeostatic answer to the definition of crisis is restrictive. He feels the concept carries "medical respectability because of its legitimacy in physiology yet it deems man a reactor only" (p. 14). He adds that the homeostatic definition does not cover the range of human change through growth, development, and actualization nor does it comment on personality through feelings, ideas and relationships. Bartolucci (1973) agrees that a dimension is missing

from Caplan's idea of homeostasis. He feels crisis should not be considered just a removal of a predicament and a return to the status quo, but rather an arrival at a new homeostasis.

A second major characteristic of crisis theory was formulated by Caplan (]974) who stated that crises are events that occur in the normal maturational developmental learning process. These events can be the result of internal physiological or psychological changes in an individual's experience such as adolescence or old age, or the result of a change in environmental factors affecting physical or psychosocial well-being through loss of basic needs, the threat of such loss or a challenge.

Behaviorally, a person who is in crisis feels emotionally distraught, confused and ineffective. She/he may exhibit anger, anxiety or depression; frustration at not solving the problem is evident. Characteristically, a threat to a person's integrity or instinctual needs is met with anxiety; a loss, actual or perceived, is met with depression; and a challenge is generally met with a mobilization of energy toward problem solving (Rapoport, 1965).

The third major characteristic of crisis is that it is time-limited. (Taplin, 1971; Bloom, 1973). Both Lindeman (1944) and Caplan (1964) state that crises are normal processes of discomfort that are generally resolvable in 4 to 6 weeks or 8 to 10 counseling interviews. And if the crises are not resolved, major disorganization may result.

Caplan (1964) identifies four phases of the crisis period. First, is the initial rise in tension precipitated by a stressful event. This triggers the utilization of familiar coping methods in order to reduce the tension. The stressful event may be developmental (beginning school, adolescence, getting married, first child or old age) or situational (illness,

hospitalization, death of a family member, loss of work). Second, is the failure of habitual problem solving techniques which increases the feeling of tension, disorganization and ineffectuality. The event is now being perceived as stressful, and the impact of the stimulus continues.

Third, emergency problem solving approaches are sought including internal and external resources. At this time, a person is mobilized to seek help due to the overwhelming nature of the situation. At these times, individuals are extremely amenable to treatment (Caplan, 1964; Taplin, 1971) and can be maximally influenced by another person (Morley, 1964). Howard Halpern's (1973) definitional study of crisis theory found evidence that individuals are less defensive in crisis, validating Caplan's notion that it is easier to help individual's in crisis than at other times. The fourth phase follows if the problem is not solved or accepted and is characterized by major disorganization and carries with it the threat of chronicity (Darbonne, 1967; James, 1972).

In conclusion, a crisis is a state of distress that occurs occasionally in a person's normal emotional life. It may be precipitated by passage into a new developmental stage such as old age, or by an environmental change such as loss of a significant other. A person in crisis is experiencing a temporary emotional imbalance in which all avenues of interpersonal support have failed. Motivated by the pain of the imbalance and the social alienation, a person may seek treatment and is generally more amenable to resolution of the crisis. The availability of mental health facilities at this time is important if intervention is to be made at the optimum time since a crisis is a time-limited situation that can be resolved positively in a 4 to 6 week period. If treatment is

not received during that period or it is unsuccessful, a psychiatric illness may occur.

Crisis theory has been examined to provide insight into the dynamics of the process by which individuals may come to experience a psychological upset of emergent proportion. This theory has also been used to provide rationale for the importance of mental health intervention during a crisis situation. Crisis theory is descriptive of an individual's response to a stressful emotional event with the crisis being defined by the failure of the individual's coping mechanisms. In the following section, the theory of social deviance is used to describe the social definition of maladaptive behavior.

SOCIAL DEVIANCE

One method of analyzing mental illness is to consider it in terms of deviance from the "normal." In this study, the emphasis is not the psychological factors contributing to the psychiatric emergency, but is the degree that an individual breaks social norms. Schur (1971) suggests that individuals continually label the behavior of others and their re-action depends on the tolerance level, the type of behavior, and the social power of the deviant individual. If an individual's behavior is considered deviant and intervention is necessary, that intervention might include some form of punishment or treatment. Scheff (1966) speaks of residual deviance, or deviant behaviors which have no definitive label and which may lead to the label of mental illness. He also suggests that there is a great amount of rule-breaking in this society, but it is often unnoticed or ignored. Those who are brought to the attention of psychiatric emergency services might then be considered to be indi-

viduals who have broken a group norm, or have exhibited a behavior which is considered to be deviant but which has no explicit label.

The question of who defines deviant behavior is addressed by Mechanic (1968). He has determined that these definitions may come from the deviant individual, his/her primary groups, or the professional evaluating him/her. Evaluations of deviant behavior and the consequent decisions about what action is to be taken are most frequently made by individuals in the community. As a result, intervention is dependent on the degree of visibility of the deviant behavior. In accordance with this theory, Gibbs (1962) suggests that mental hospitalization rates do not indicate the amount of mental illness in a population, but rather the societal reaction to deviant behavior.

A contrasting point of view to the labeling perspective is that the community does not label deviant behavior, but denies it until it is intolerable (Gove, 1975). In this study, the question of whether or not labeling of mental illness occurs is not as important as the determination of social factors which influence the number of psychiatric emergencies and how they are treated.

A number of studies have examined social variables which might affect psychiatric hospitalization. Research by Hollingshead and Redlich (1958) and Dohrenweed and Chon-Shong (1967) report more tolerance of deviant behavior among lower socio-economic classes and lower status groups. Other researchers have found relationships between demographic data and mental hospitalization (Scheff, 1964; Wanklin, Fleming, Buch and Hobbs, 1968; Linsky, 1970). Scheff found that rural courts have more time for investigation in commitment proceedings, while the urban court is more ceremonial and dependent on laypersons' opinions. Wanklin, et al found that people

with certain characteristics (urban residency; single, divorced, or separated marital status; 8 years or less of schooling; or recent immigration) had higher rates of first admissions to mental hospitals. Linsky studied community homogeneity and found that homogeneous communities have higher hospitalization rates and that this may be partly due to patients accepting the community definition of mental illness and voluntarily entering a treatment program.

As a group, these studies provide some evidence of the social factors involved in determining when behaviors will be considered deviant. Until an individual's behavior deviates from what is expected, it is not likely to be judged as mental illness; and what is considered to be deviant in one setting, will not necessarily be considered deviant in another setting.

Another factor affecting the determination of deviant behavior is the profession of the gatekeeper (Coie, Costanzo, and Cox, 1975). Five community agents and professionals who act as gatekeepers in the referral process of clients to mental health professionals were asked what behaviors they would categorize as mental illness. The five groups included clergy, public health nurses, social welfare workers, police and physicians. The findings suggest that the groups of gatekeepers have similar opinions of what constitutes mental illness, but their reactions are different. For instance, the two groups who had more familiarity with deviance (police and social welfare workers) had more tolerance for it.

Therefore, a number of factors will influence what individuals eventually arrive at psychiatric emergency service including: the type of behavior the individual exhibits; whether or not the individual or his/her primary group determines the behavior to be deviant in some way (depending on the population and social composition of the community);

the type of gatekeeper who might bring the individual to the attention of the mental health professional; and the mental health professional (or paraprofessional) who evaluates the individual.

The process by which an individual's behavior is identified by others as a psychiatric emergency has been considered using the concept of social deviance. Several factors have been identified that influence the process by which consumers of mental health services arrive at a psychiatric emergency facility. The following section discusses the operations of systems that provide intervention to persons who arrive at a psychiatric emergency service.

GENERAL SYSTEMS THEORY

General systems theory was used as a theoretical base to examine psychiatric emergency services. Every agency that comes in contact with persons in a mental health emergency, requesting help, has a set of services that it can offer. The services that an agency provides to persons in psychiatric emergencies are considered the psychiatric emergency service. An agency that has a psychiatric emergency service may have other services that it provides. The theoretical review of literature describes the psychiatric emergency services of health and mental health organizations as operating at the boundary of an open system. The boundary functions of a psychiatric emergency service are similar to the boundary functions of an open system.

The application of general systems theory to agencies providing mental health services is based on two assumptions. The first is that the delivery of mental health care has been provided within the context of a health organization since the state hospital movement in the 1840's (Bloom, 1973).

Therefore, the concepts of organizational theory will be useful to the description of psychiatric emergency services. The second assumption is that the ideological focus on delivery of mental health services in the community has opened the organization to influence from the community or environment. It is therefore possible to apply concepts of open systems to the delivery of psychiatric emergency services.

A major premise of general systems theory is that systems exist in hierarchal relationship to each other (Pierce, 1972). The hierarchy advances from levels of non-living systems to levels of living systems. Living systems differ from non-living systems in being open to the environment as opposed to the relatively closed nature of non-living systems. An open system is defined as "one into which there is a continuous flow of resources from the environment and a continuous outflow of products of the system's action back to the environment" (Baker & Schulberg, 1970, p. 184).

The conceptualization of an organization as an open system assumes that it engages in continuous transactions with the environment. In order to do this the system must differentiate itself from the surrounding environment. This differentiation occurs at the boundary of the system. The boundary of a system serves two functions. The first is to maintain separation from the environment in order to exist. The first function is evident in that the services of one program are different in nature, timing or purpose from other agencies in the community. The second function of the boundary is to allow the system to interact with the environment. This interaction is described using the terms input, output and throughput (Baker & Schulberg, 1970). Mental health systems obtain from the environment inputs that are essential to the viability of the organi-

zation, such as persons, ideas and resources. The work of the system is with the throughput. For health and mental health organizations the major throughput is the client population. Persons enter the system in some state of distress or impaired functioning. They receive services that either promote them to a higher state of wellness or the degree of impairment is reduced and then they are terminated or discharged to the environment.

The term entry system, is used to describe the boundary function of that portion of the system that receives input from the environment. Levinson and Astrachan (1974) coined this term to describe the intake procedure of a community mental health clinic. Any system that comes into contact with persons requesting service must screen the applicants, then select some persons as patients and reject others. The psychiatric emergency service of health and mental health organizations is a means for clients to enter treatment,either at the time of the emergency or sometime later. The issues presented by Levinson and Astrachan (1974) are pertinent to the functional description of psychiatric emergency services.

The first task of the entry system is to deal with the applicant population. The function to be carried out is the processing of prospective patients by exploring and negotiating with various parties. For psychiatric emergency services these parties may include clients, families, police or social service agencies, psychiatrists and mental health personnel. The decision to be made is whether the applicant will become a patient at the agency or will do something else. The possible outcomes are: 1. The client enters treatment at the agency; 2. The client receives limited services at the entry system and resolves the crisis without further intervention; 3. The client is referred elsewhere; 4. After brief contact the

request for services is terminated.

The second task of the entry system is to provide a link between the entering patient and the treatment system. The entry system or psychiatric emergency service is the point at which the client makes clear his/her help-seeking behavior by crossing boundaries to the environment of the mental health system. The admission process is divided into two stages; the first involves the decision that the client shall receive service at the agency. The second is the particular treatment that the client will receive and who will provide the treatment.

General systems theory has been used to describe the delivery of emergency mental health services within an open system. An open system is one that is in continual interaction with the environment. This interaction occurs at the boundary of the system. Persons who come into contact with a psychiatric emergency service do so at the boundary between the system and the environment.

The interaction between the system and the environment is carried out by several sets of people or components. Cipolla (1976) has conceptualized these components as being consumers and providers. Braden and Herban (1976) and Caplan (1974) have identified a third component in the delivery of health services, the gatekeeper. Each of these roles will be discussed as they relate to the provision of psychiatric emergency services.

Consumers

Prior to 1950, psychiatric treatment generally took place in large, geographically isolated state mental hospitals. These hospitals were built in the late 18th and early 19th century in response to the poor

care that mentally ill persons received in jails, poorhouses and boarding facilities. During the 19th century the financial needs of these institutions could not be met so the mental hospitals began a period of deterioration that ultimately resulted in the involvement of the federal government (Bloom, 1973).

During the 1950's the use of psychotropic medications and the "therapeutic community" were found to be effective treatments in the care of the mentally ill (Bloom, 1973). As psychiatric treatment in mental hospitals became more effective, the mental health care delivery system moved into the community. Previously hospitalized persons were discharged and maintained in their communities. During the 1950's and 1960's the Federal Government passed legislation that established the provision of comprehensive community care by mental health programs. Comprehensive community care indicates that all mental health services be available to all persons in the community (Bloom, 1973).

Comprehensive community care emphasizes direct treatment services as well as consultation, education and prevention programs. As a result of the federal mandate for comprehensive services, there has been an increase in the numbers of persons requesting mental health services and in the types of services being requested. Not only are there persons with long standing mental illnesses in the community seeking service, there are persons described as: a minority, and socially disadvantaged creating a need for mental health services. For facilities providing psychiatric emergency services, this has meant that each facility now sees a wide range of persons, from those persons brought to emergency services by the police to those persons suffering mild psychological discomfort. The demands for service

and the numbers of consumers requesting services have increased during the last 20 years (Bloom, 1973). Because health care delivery is considered an open system, the demands for service have created the need for a more diverse group of providers.

Providers

Community mental health legislation passed in 1963 and 1965 provided federal money for the construction and staffing of community mental health centers. An initial concern was that there would not be enough persons to staff the newly created mental health centers (Bloom, 1973). The response reflecting this concern was the preparation of more mental health professionals through the provision of training grants to professional schools. Besides training more professionals, schools began to specialize in their program sequences. Professional schools of psychiatry, psychology, social work, nursing and others developed specialty programs with a community mental health focus.

New sources of mental health personnel were also developed. In an effort to provide more relevant services to underserved populations, community mental health centers began to train persons without formal education in the field of mental health. The use of paraprofessionals in the delivery of direct services and in the development of new services geared to specific population groups is considered an effective adjunct to the professional staff (Brown, 1974; Bloom, 1973).

While greater numbers and variety of providers have been developed to deliver mental health services, there are fewer mental health programs in operation than the federal government envisioned in the 1960's. The geographic distribution of mental health providers is uneven in the United States. Rural areas have reported difficulty in recruiting well-trained

staff of all disciplines (Bloom, 1973). Other geographic areas, especially urban university locations, have reported no difficulty recruiting and retaining staff (Feldman, 1971).

Historically providers have responded to the movement of mental health care delivery from a more closed system to a more open system by increasing in numbers and specialization or diversification. One of these specialized roles applicable to psychiatric emergency services is that of the boundary spanner.

Agencies providing psychiatric emergency services must engage in multiple interactions with the environment. Consultation by a mental health professional with a physician regarding a patient in the emergency room who may need psychiatric inpatient care is an example of this type of interaction. This interaction occurs at the boundary region of the organization. Organizations that engage in frequent transactions across the boundary develop a specialized role to meet the demands of this form of interaction. This role has been called the boundary spanner (Baker & Schulberg, 1970). The person filling the boundary spanner role is considered the representative of the agency in these transactions.

Persons functioning in the boundary regions of a system are subject to increasing amounts of strain that may become difficult to handle over time. A case study at a regional psychiatric hospital described this phenomena (Dolgoff, 1972). The admissions officer functioned on the boundary of the hospital and the environment. In order to admit someone to the hospital, the admissions officer had to meet several conditions, such as the availability of staff, beds and resources. The director of the hospital expected the admissions officer to maintain

the census by admitting optimal numbers of patients. The clinical staff expected the admissions officer to produce the "right" patient at the "right" time. The admissions officer was exposed to considerable conflict arising from the incompatible expectations of several persons.

A review of studies researching the decision to admit psychiatric patients from emergency rooms to psychiatric units in general hospitals suggested that the decision to admit may often precede the diagnostic determination (Bartolucci, Goodman, & Streiner, 1975). The diagnosis is then formulated as a rationale for the need to admit the person to the hospital. The authors suggest that this finding represents a conflict-resolving strategy. The admissions officers emphasized the psychopathological characteristics of the clients when the admission was actually necessary because of other client characteristics or situational variables. Individuals who operate in the boundary regions often become "the person in the middle" (Baker & Schulberg, 1970). The consequences of this role conflict are tension and anxiety. These stresses often result in withdrawal from or hostility toward those creating conflict. These two studies have demonstrated the effects on persons functioning in the boundary spanner role and some of the behaviors that develop out of a need to meet expectations from different sources. Systems with many different tasks, such as the admission unit or hospital emergency room and the clinical sections, tend to acquire different characteristics, norms and values consistent with their tasks. Conflict occurs when the tasks of the admitting unit conflict with the tasks of the receiving unit. Levinson and Astrachan state that in mult-purpose service systems, the person in the boundary spanner role at the admission unit must have the authority to commit the treatment resources of the agency (1974. p. 9).

Gatekeepers

The third set of components which effect interaction between the agency and the environment are the gatekeepers. The gatekeeper is a person who serves as the intermediary between the client or the family and/or friends of a potential client and the mental health agencies in the community. It has been suggested that gatekeepers play a key role in referring patients to particular agencies and in the decision whether someone will seek mental health services.

Gatekeepers are typically agents who provide health and welfare services or are enforcers of moral, legal and social norms in particular communities. Identified gatekeepers are public health nurses, social workers, clergy and police (Coie et al, 1975). Caplan (1974) has identified solo practitioners, such as physicians, as the first point of contact for many clients and so they are considered gatekeepers also.

A study carried out in an urban and a rural community in North Carolina compared five gatekeeper professions (Coie et al, 1975). The five professions studied were public health nurses, social workers, clergy, police and physicians. Professionals in the sample were asked to complete a questionnaire rating 190 behavioral descriptions on whether they would be alerted to a psychiatric problem and how concerned they would be about the problem. The results of the study indicated that professionals generally agreed on ratings of extreme behavioral descriptions (definite psychiatric problem of much concern versus no psychiatric problem). Behavioral descriptions in the middle range of social deviance and distress showed more variation in ratings among professionals.

The police differed most from the other professions in expressing greatest concern for overt antisocial behavior. Physicians and public

health nurses expressed strongest concern for behavior indicative of internal disruption and distress. The researchers concluded that professional training and experience account for differences between the perceptions of these groups of gatekeepers (Coie et al, 1975). The differences in sensitivity to psychiatric problems among gatekeeper groups will affect the types of persons each professional refers to mental health agencies. The gatekeeper determines if a person will be referred to a mental health agency or to a hospital emergency room before he/she actually arrives at the agency and requests service.

Consideration of gatekeepers in a community is essential because they are frequently the first professional group contacted by persons seeking help. Gatekeepers express different degrees of recognition and concern for certain types of behaviors. The differences among gatekeeper groups appears to be a function of the value orientations developed during professional training and experience. The gatekeeper professional makes a determination of the problem and then makes a referral accordingly. In the course of a psychiatric emergency, the gatekeeper's determination, evaluation and decision affects which persons are selected and the timing of their contact with a particular mental health facility.

The psychiatric emergency service has been conceptualized as a boundary function of an open system. The components of a psychiatric emergency service that interact at the interface of the boundary and the system's environment have been identified. A final concept in the description of a psychiatric emergency service is that open systems are interdependent.

Interdependence is described as the extent that one system is dependent upon another for resources (Baker & Schulberg, 1970). Braden and Herban

(1976) suggest that no one service can provide comprehensive services and so must develop interinstitutional networks. This is an expression of the concept of interdependence between open systems in the health care field. In the area of mental health services, Levinson and Astrachan have said that "no community mental health center can cover the full spectrum of direct and indirect services" (1974, p. 7). In order to focus on the community-based delivery of psychiatric emergency service, it is necessary to shift from the level of services provided by a single system to that of the delivery of service by a network of systems. The relationships between agencies in a health care system have been the subject of increasing attention by organizational systems theorists and researchers since the 1960's (Baker and Schulberg, 1970). Baker and O'Brien (1971) use the term inter-system analysis to refer to the interaction that occurs between a network of agencies that are interdependent.

Interdependency of systems in a particular community environment may be classified as cooperative or competitive. Cooperative strategies involve direct interaction among organizations that increase the degree of influence that the environment has on a single system (Thompson and McEwan, 1958). Systems also engage in non-facilitative interaction or competition. Competition among systems in the community is increased when resources are scarce, when the independence of a system is threatened and when systems have similar but unclarified roles in the delivery of service (Baker & Schulberg, 1970).

Since 1960 federal legislation has emphasized the importance of inter-agency cooperation in the coordination of all parts of a community mental health care delivery system (Baker & Schulberg, 1970). Psychiatric emergency services have been considered one of the several services offered by agencies in a community. All agencies providing service to persons in a psychiatric

emergency should coordinate efforts in order to prevent duplication or gaps in the service delivery system (Baker & O'Brien, 1971).

Baker and Schulberg (1970) have identified several issues that present barriers to coordination of services. The first is the number and complexity of agencies in the system. The second is the lack of a unitary authority structure with responsibility to guide coordination in the overall system. Third, there has been an increase in the number of specialty services to the exclusion of general services. The fourth is the stereotyped beliefs that single agencies or service providers hold about other agencies or service providers in the system. This leads to a decrease in facilitative communication between agencies. Finally, each agency has multiple tasks and goals which contribute to complex relations between agencies in the community.

A systems framework has been used to analyze the delivery of psychiatric emergency services at three conceptual levels. The first was the description of the operation of a psychiatric emergency service using concepts of an open system. The second was the identification of the components that interact at the interface between the system and the environment. Thirdly, issues relating to interdependence in a network of agencies delivering psychiatric emergency services has been considered using the approach of intersystem analysis. The following section reviews several ideal models of service delivery in health and mental health systems.

IDEAL MODELS

Cipolla (1976) advocates the designation of community agencies as providers of primary, secondary or tertiary care. The primary care facility is the first point of contact between the client and service provider. The

primary care facility offers a range of services to meet the majority of mental health needs and is available to persons in the community within 30 minutes. Secondary mental health care is provided in institutions, clinics or hospital settings. This type of facility is characterized by the ability to provide long-term mental health care. The facilities designated as providing tertiary care are characterized by the provision of highly specialized services in teaching institutions, medical complexes, or research institutions.

The conceptualization of comprehensive mental health services by Cipolla (1976) designates the community mental health center as the facility to maintain responsibility for clients as they move through the mental health care system. In order to provide this type of continuity, the mental health professional has the responsibility to develop linkages or reciprocal relationships with other community treatment and support systems. Another recommendation made by Cipolla (1976) is that agencies providing mental health services develop program plans that consider all elements in the community that impact on the provision of service. Cipolla (1976) lists possible elements as including environmental, economic, educational, physical and social factors. Comprehensive mental health services are geared to provide preventive services to all consumers as well as the care and treatment of the ill consumer.

Leininger (1973) proposes a client-centered model of health care with several elements similar to Cipolla's model. The client-centered model emphasizes the relationship between the client and his/her community rather than the relationship between the client and the health care system. The second provision of this model is a broad based assessment system which provides screening, counseling and referral services similar to Cipolla's

primary care facility. Leininger (1973) specifies this system as using a greater variety of professionals, both generalists and specialists, than the traditional health care system. The client chooses the professional he/she wishes to receive services from. It is this professional who maintains primary responsibility for the client throughout the health care system. This model differs from the first, in that Leininger (1973) proposes increasing the variety of professionals and types of agencies which maintain primary responsibility for clients. Cipolla (1976) advocates the designation of one type of agency with responsibility for continuity of care. Leininger's (1973) argument for this variety is that accessibility to services is increased.

Caplan (1974) conceptualizes a population-oriented service delivery system. He advocates first, a one-door entry system because consumers should not be expected to pre-categorize themselves. The model also emphasizes greater utilization of the resources of all caregivers in the community as does Leininger's (1973) model. Caplan's (1974) model of a mental health care system relies on the role of the primary practitioner, a generalist, who is designated with continued client responsibility. The concept of a front line echelon of primary practitioners who are responsible for triage is emphasized. Caplan (1974) states that whichever professional (including law enforcement personnel) is in first contact with an individual or family requesting aid is responsible for the triage function and for mobilizing the relevant caseworkers.

The last element in Caplan's (1974) model is the provision for continuity of care by agency consortium. A consortium is formed by the relevant help-giving systems in a legal contract that guarantees free movement of clients among agencies. Fundamental information about clients is shared among agencies according to the provisions of confidentiality

developed by the consortium. The development of an agency consortium is a means by which clients have access to adequate health and welfare services without the problems of negotiating referrals.

There is some discussion in the literature relating to the inappropriateness of models developed to provide comprehensive mental health services for rural areas (Kinzie, Shore & Patterson, 1972). An alternative to the provision of direct services is a model of indirect services that has been proposed as more appropriate to rural areas (Daniels, 1967; Mahoney & Hodges, 1969). The elements of an indirect services model relating to the provision of psychiatric emergency services is the utilization and coordination of existing resources and the use of mobile teams made up of professionals and paraprofessionals. Mahoney and Hodges (1969) suggest that the development of a particular model of services in rural areas is not as important as the flexibility of a mental health professionals in responding to particular community needs.

The last ideal model to be presented is a set of criteria developed by several experts in the field of mental health services for 24-hour emergency services (National Institute of Mental Health, 1971).

1. Neither ability to pay nor place of residence shall determine a patient's eligibility for emergency treatment, and emergency care shall never be denied, nor abridged nor unduly delayed for these reasons.
2. The three basic components of an emergency service - a telephone service, and face-to-face extra-mural and intra-mural care - shall operate seven days a week, twenty-four hours a day, and be readily available and accessible to the population of the Center's catchment area.
3. Face-to-face emergency services shall be integrated with all of the other services of the Center:
   a. Staff of the emergency face-to-face services shall be classed as members of Center staff and shall receive their rights and prerogatives as well as accept the duties and responsibilities assigned Center staff.
   b. Unless contraindicated, a member of the emergency staff who made the original face-to-face contact with an emergency patient shall be able to continue treatment of that patient in all parts of the Center until such time as that patient may be safely referred.

4. Emergency staff shall be specially screened and trained to meet the exigencies of crises and the particulars of the emergency service's record system.
5. A few beds permitting overnight or 24 hour use should be available at all times to the emergency service for use in its immediate treatment of the patient, for evaluation and for the development of suitable treatment programs. Such a crisis resource provides a capability for handling most emergencies without a referral for inpatient care.
6. The exigencies of crises make the emergency service particularly dependent upon a comprehensive and current listing of care giving agencies and other emergency units in the Center's catchment area. It shall be one of the responsibilities of the emergency service to see to it that the Center maintains such a directory which includes description of services, eligibility requirements and hours of operation of each such agency and unit.
7. The emergency service shall develop reciprocal working arrangements with other agencies that deal with individuals in crisis so that their respective services are mutually supportive and the impact upon the patient potentiated. Particular attention shall be paid to developing specific agreements for the delivery of emergency medical care.
8. Both as a means of familiarizing themselves with the operations of those agencies and evaluating their services as well as making known the capabilities of the Center's own operations it shall be the responsibility of emergency workers to maintain liaison with these agencies through periodic meetings.
9. The emergency service shall institute and maintain an efficient and effective follow-up system which asserts that the service maintain responsibility for the patient until his referral is accepted, and responsibility for him asserted, by the recipient agency.
10. All workers on the emergency service shall go through a practicum in order to acquire at least the following knowledge and skills:
    a. Basic instruction in crisis intervention techniques.
    b. Learning by direct exposure to crisis situations (both telephone calls and face-to-face), first under supervision, then under observation, and finally with consultative support, of individuals experienced in these situations.
    c. Referral resources and referral procedures.
    d. Follow-up procedures.
    e. Record system.
11. The emergency service should maintain telephone coverage 24 hours a day, seven days a week with a well publicized number available to both the public and community caretakers. Since telephone accessibility varies, where necessary there should be a tie in with other frequently used emergency communication networks such as short-wave, police radio, or the 911 emergency call number.

12. Telephone service shall be manned by trained personnel (see 10 above).
13. A trained mental health professional shall be available at all times to back up the telephone operator.
14. The telephone service shall have direct access to all center services, and to other care services in the community.
15. The emergency telephone operators shall, without exception, record all calls (including, wherever possible, identifying information about the patient) as well as the actions taken.
16. All logs shall be transmitted daily to the emergency service for daily review and necessary follow-up.
17. A current directory of all mental health and other care giving services in the community (see 6 above) shall be at the hand of the mental health worker.
18. The number of the emergency service should be made widely known throughout the entire community, and the feasibility of establishing a "hot" or "open" line discussed with the telephone company. Orientation courses for telephone company operators on the disposition of crisis should be offered.
19. Various characteristics of persons in crisis situations-unmanageability, unwillingness, inaccessibility, physiological incapacity, lack of transportation-make it necessary that the emergency service be so organized that its staff be able to render care in the community at any time of the day or night.
20. The emergency service shall maintain facilities and staff adequate to meet the needs of walk-in patients for face-to-face assistance on their immediate problems, on a 24 hour a day, seven days a week basis. Inpatient beds shall be made available for use by the emergency service.
21. All extra-mural and all intra-mural services to patients shall be logged without exception, and include, wherever possible, identifying information about the patient, a statement as to the problem, the assistance provided, the results of this contact, what further assistance is indicated, and the emergency worker's disposition of the case.
22. The logs of both the telephone service and face-to-face contacts shall be reviewed daily to permit determination of whether referrals to (a) other services, and/or (b) other community services, were completed (See 9 above). Referrals found to be incomplete shall be recorded for further follow-up and disposition (pp. 5-7).

Three theories have been used to provide a framework to guide the researchers in considering several aspects of psychiatric emergency events. The perspective of the individual experiencing a psychiatric

emergency has been examined using concepts of crisis theory. Some of the social factors that influence the process by which certain individuals come to a psychiatric emergency service have been identified using concepts of social deviance. General systems theory was used to describe the operations of agencies that provide psychiatric emergency services. The theoretical framework also included a comparison of several models of ideal delivery of service.

CHAPTER III

LITERATURE REVIEW

INTRODUCTION

The purpose of the literature review is to outline the research relating to psychiatric emergency services. The review emphasizes three main areas. They are:

1. A description of programs providing psychiatric emergency services. This section is organized according to types of facilities, including general teaching hospitals with psychiatric units, general hospitals without psychiatric units, psychiatric hospitals, walk-in clinics, mobile crisis units, other settings, and law enforcement agencies. A review of general trends in the delivery of psychiatric emergency services is also included.

2. A description of the characteristics of those who use psychiatric emergency services. These characteristics include demographic variables, diagnostic variables, source of referral, treatment received, and disposition.

3. The roles of direct service providers in psychiatric emergency services. This section is organized according to four types of direct service roles, including professional roles, paraprofessional roles, interdisciplinary teams, and law enforcement roles.

The division into these three areas was made in order to examine

broad aspects of psychiatric emergency services comprehensively and independently. The studies reviewed in this chapter represent a portion of the existing literature and do not represent a complete examination of all the research available in the area of psychiatric emergency services.

DESCRIPTION OF EXISTING PSYCHIATRIC EMERGENCY SERVICES

This section presents the current literature describing the existing psychiatric emergency services programs. The following review is organized according to the program settings: general teaching hospitals with psychiatric units, general hospitals without psychiatric units, psychiatric hospitals, walk-in clinics, mobile crisis units and law enforcement agencies. The category entitled Other Settings is included to represent psychiatric emergency service programs which do not fit into the settings mentioned. Each of the programs is described according to the type of facility, staffing patterns and training, types of services offered, hours the service is available and the availability of professional mental health back-up staff. The next category in this section describes general trends in psychiatric emergency services and the section concludes with the summary of the review of the literature on psychiatric emergency services programs.

General Teaching Hospital with Psychiatric Unit

The literature on psychiatric emergency services appears to cluster around services offered in hospital emergency rooms. This is due in part to the well-documented increase in the number of patients coming to the medical-surgical emergency rooms since 1945 (Chafetz, Blane and Muller,

1966; O'Regan, 1965; Trier and Levy, 1969; Robert Atkins, 1967).

The increase in hospital emergency room admissions may be due to several factors: (1) hospitals are convenient and available twenty-four hours a day, (2) there is little negotiation needed to receive service, (3) there is lower cost to the patient than with a private practitioner (Chafetz et al., 1966), and (4) there is disenchantment with the long waiting lists of private practitioners and outpatient clinics (Perlman, 1963; Blais and Georges, 1969; Robert Atkins, 1967). Massachusetts General Hospital in Boston experienced an increase of 120 percent between 1945 and 1958; and from 1955 to 1965 reported that admissions doubled. Random sampling of admissions indicated high concentrations of people from lower socio-economic levels. In all emergency services reported, psychiatric visits constitute 3-11 percent of the total (Spitz, 1970). Coleman (1961) states patients may seek admission to a medical-surgical hospital emergency room because physical complaints may be the last avenue open to help before behavior fails completely.

Many patients seeking general medical help may have emotional problems. It is on this assumption the Elmhurst City Hospital in Queens, New York developed its Troubleshooting Clinic (Bellak, 1964; Blane, Muller and Chafetz, 1967). It is a 24 hour walk-in clinic service located outside the emergency room and staffed by psychiatric residents, psychiatrists, psychologists and social workers who provide crisis intervention, brief treatment of three to five visits and referral services. There was no mention of psychiatric nurses on the staff in the Troubleshooting Clinic. Additionally, these staff screen all patients admitted to the medical-surgical emergency room on a 24-hour basis.

The Bronx Municipal Hospital, which is similar to Elmhurst, is a teaching hospital with a psychiatric unit. It has two services providing psychiatric emergency care (Blane et al., 1967). In the emergency room, psychiatric patients are seen by first- and second-year psychiatric residents on a 24-hour basis upon referral from the admitting physician. The emergency clinic or psychiatric walk-in clinic is traditionally oriented with the additional capacity to provide crisis intervention. The clinic operates from 8:00 A.M. to 5:00 P.M. In the evening hours, the patients go through the emergency room which works cooperatively with the walk-in clinic. Social workers and psychologists are available in the clinic. There is no reference made to psychiatric nurses.

San Mateo County General Hospital has 24-hour psychiatric coverage of the emergency room. This is provided by residents who utilize an intake screening device to increase dispositional accuracy on psychiatric patients (Trier and Levy, 1969). It is not clear if the residents are psychiatric residents. Sixty percent of the annual caseload in 1962-63 were hospitalized. There is no mention of services provided beyond screening and apparently social work, psychiatric nursing and psychological services are not available (Blane et al., 1967).

The Grace-New Haven Community Hospital (Coleman and Errera, 1963; Errera, Wyshak and Jarecki, 1963; Swartz and Errera, 1963, Blane et al., 1967; Trier and Levy, 1969) emergency room has consultation services available to the admitting physician provided by second- and third-year psychiatric residents. There are daily teaching conferences for psychiatric residents and social workers to discuss the management of

difficult cases. Psychiatric nurses are not mentioned. The consultation is provided on an on-call basis and accounts for three percent of the total emergency room admissions.

Massachusetts General Hospital (Blane et al., 1967) has psychiatric personnel on-duty 24 hours a day. The staff consists of psychiatrists, first- and third-year psychiatric residents, psychiatric social workers, a social work assistant, research personnel and clerical staff. Psychiatric nurses do not appear to be included in the psychiatric staff. The social worker generally has the first contact with the patient for social history gathering and problem assessment. The psychiatric resident then sees the patient and the social worker is free to see the family or person accompanying the patient. After these contacts, the resident and social worker act as a team to establish an immediate and long-term disposition. A social work aide provides needed social services such as placement, freeing the social worker to provide therapy. Every day a staff psychiatrist reviews records of all patients seen in the emergency room in the previous 24 hours, allowing him/her to evaluate and modify, if necessary, treatment planning.

An adjunct service in the Massachusetts General Hospital is an arrangement in which a social worker works both in the acute psychiatric service in the emergency room and in the local mental hospital with patients referred from the emergency room service. This service was established to enhance continuity of care and prevent further emergency room visits by ex-hospital patients.

At Massachusetts General Hospital, 16 percent of the total patients seen in the emergency room were hospitalized for psychiatric reasons.

Comparable percentages for Grace-New Haven and San Mateo County General Hospital were 32 percent and 60 percent, respectively (Blane et al., 1967).

The University of Saskatoon is a teaching hospital with a psychiatric unit. It has a psychiatrist, psychiatric resident and a medical student on-duty in the emergency room from 8:00 A.M. to 5:00 P.M. Monday through Friday and 8:00 A.M. to 12:00 M. on Saturday (O'Regan, 1965). After hours emergencies are handled by an on-call psychiatric resident with a psychiatrist as back-up staff. Brief treatment (up to six visits) is available through the emergency service, with three beds available for emergency inpatient service. Emergency patients are also seen in the outpatient clinic, the two other hospitals in Saskatoon, or at home if the emergent condition necessitates outreach into the community. The article does not state which staff provide the mobile service to the home. If longer treatment is indicated, regular inpatient hospitalization or referral to another agency may occur.

The Orange County Medical Center is the teaching hospital for University of California at Irvine College of Medicine. It has a psychiatric unit and an emergency admitting unit (EAU) for psychiatric emergencies (Swartz, Weiss and Miner, 1972; Swartz, 1971). The EAU is seen as the semipermeable membrane of the community mental health system. Its major mission is to make the best possible disposition. Particular emphasis is placed upon returning patients to the community and avoiding hospitalization. The 24-hour emergency admitting unit backs up a service network including mobile emergency teams, crisis intervention center and cooperative private practitioners in the community. Orange County Medical Center is comparable to Colorado Psychopathic Hospital

and Provincial Psychiatric Facility in Toronto, Canada, in its commitment to brief treatment in order to reduce stigma of long-term psychiatric hospitalization.

The University of Colorado Medical Center operates an emergency psychiatric service (EPS) in the emergency room of Colorado General Hospital (Rhine and Mayerson, 1971). It provides a 24-hour walk-in service, offers consultation to the general medical-surgical emergency room and evaluates all admissions to the Colorado Psychiatric Hospital. Teams of psychiatric residents, social workers and psychiatric nurses are utilized, although residents are the primary therapists. Individual, conjoint and family therapy are available, and patients are seen in the emergency psychiatric service follow-up clinic and in their homes.

Edward J. Meyer Memorial Hospital in Buffalo, New York, has psychiatric staff on duty in the emergency room on a 24-hour basis (Beahan, 1970). These staff include psychiatric nurses, social workers and psychiatric residents. The emergency room has a liaison with the local volunteer suicide telephone center which refers calls to the hospital emergency room. The staff are available for telephone or walk-in intervention. There are four emergency psychiatric beds in the emergency room area that can be used for observation and evaluation up to 24 hours.

Edward J. Meyer Memorial Hospital also has both traditional out-patient clinic in the psychiatric department and a short-term crisis clinic which operates from 8:00 A.M. to 5:00 P.M. The short-term clinic is staffed by hospital psychiatrists and a full-time social

worker. When patients do not come to the crisis clinic appointments, psychiatrically trained public health nurses provide home visits.

General Hospitals without Psychiatric Unit

There are few general hospitals without psychiatric units providing psychiatric emergency services documented in the literature. It is noted by Garetz (1960) that though physicians are willing to relinquish personal time to attend to emergencies they tend to categorize emergencies into two groups: "true" emergencies and "pseudo" emergencies. This tendency is especially strong in small hospitals with limited staffs, who may have little training in psychiatric matters. Often the service consists of consultation on an on-call basis with a determination of "true" or "pseudo" emergency being made by staff untrained in psychiatric emergencies. This can be misleading and unrealistic. Few general hospitals appear to have interest in serving psychiatric patients (Coleman, 1961).

In Escambia County, Florida (Blane et al., 1967; Glasscote, Cummings, Hammersley, Ozarin and Smith, 1966), a cooperative of six psychiatrists provided acute psychiatric services to three local general hospitals on a rotating basis. The services were not available to those lacking funds, so that the indigent were often jailed rather than hospitalized.

A second general hospital without a psychiatric unit is Memorial Hospital in North Conway, New Hampshire (Blane et al., 1967). What began as a demonstration project to offer comprehensive services to persons with alcohol problems in a rural area expanded to provide similar services to persons with other psychosocial emergencies. The 24-hour hour on-call service provided through the emergency room is run by an internist and a social worker with consultation from a psychiatrist

and psychologist. It is linked to the Massachusetts General Hospital for consultation and teaching purposes.

Reding and Maguire (1973) describe the use of three general hospitals in Franklin County, New York, for admissions of acute psychiatric patients to non-segregated general hospital units. Any patient coming to these hospitals in an acute state of psychiatric disturbance was medicated and admitted within one-half hour of his/her arrival. During the acute phase, the patient's bed remained in the corridor in full view of the nurses' station. A psychiatrist was part of the Hospital Board and provided psychiatric consultations as well as on-the-job training and inservice teaching to nurses and physicians. Of the 344 psychiatric patients admitted over a four-year period, 148 were admitted by the county psychiatrist and 198 by non-psychiatric physicians who requested psychiatric consultations. Readmission rate was 18 percent. A follow-up study on a sample of 38 showed that three persons were admitted to the State Hospital.

Psychiatric Hospitals

Two psychiatric hospitals noted in the literature provide innovative approaches to psychiatric hospitalization; Colorado Psychopathic Hospital (Kritzer and Pittman, 1968) and the Provincial Psychiatric Facility in Toronto, Canada (Voineskos, Morrison and Jain, 1974). They both provide brief hospitalization, 24-hour and 72-hour maximum stay respectively. The Colorado Psychopathic Hospital service functions as an evaluation service to prevent unnecessary hospitalizations. The focus of the Canadian psychiatric facility is short-term treatment, including

crisis intervention and a day care crisis therapy program provided by a multidisciplinary team. Another emphasis is establishing contact with the patient's family to maximize their involvement in the treatment. During the 72-hour stay, the following services may be rendered: physical exam; psychological testing; individual and group work; family therapy; home visits; interview with employer; referral to housing, welfare, etc.

The program at Colorado Psychopathic Hospital provides the patient who may be chronically ill and in an acute state of crisis, a brief respite from environmental forces. However, the 24-hour span is not so excessively long as to disrupt support systems. This allows a chronically ill person to remain in his community despite occasional acute outbreaks. Both programs strongly aim toward reducing the sick role created by long stays in mental hospitals, which avoids institutionalization and deculturization and most of all, stigma.

Malcolm Bliss Mental Health Center is a non-federally funded psychiatric hospital located in St. Louis, Missouri, and is across the street from St. Louis City Hospital. The St. Louis City Hospital emergency room has an on-call consultation liaison with Malcolm Bliss. Psychiatric residents from Malcolm Bliss come upon referral and evaluate psychiatric emergencies (Glasscote et al., 1966). Ten beds are reserved at Malcolm Bliss for prisoners suspected of being mentally ill.

Walk-In Clinics

There are very few free-standing psychiatric clinics providing psychiatric emergency services documented in the literature. The walk-

in clinics that provide psychiatric emergency services mentioned in this review are outpatient clinics of general hospitals with psychiatric units and none are free standing clinics. These include: Bronx Municipal Hospital, Elmhurst City Hospital, Massachusetts Mental Health Center (Blane et al., 1967) and Edward J. Meyer Memorial (Beahan, 1970).

Langsley, Machotka and Flomenhaft (1971) briefly describe a service called family crisis therapy (FCT) which was a program developed by a group of Denver mental health professionals to provide outpatient crisis therapy as an alternative to psychiatric hospitalization. They accepted only patients for whom hospitalization was imminent and gave them outpatient crisis treatment. More information describing the service was not available.

The Northwest Psychiatric Clinic in Eau Claire, Wisconsin (Glasscote et al., 1966) was a brainchild of mental health professionals in the community. Ten professionals including psychiatrists, social workers, psychologists and a speech therapist organized to provide a 24-hour psychiatric service which includes psychological and neurological testing, individual treatment, research, teaching seminars, etc. Psychiatric nurses were not mentioned in the article. Inpatient care is provided by two local hospitals. The Northwest Clinic also owns and operates a halfway house for ex-hospital patients. No one is turned away for lack of funds; and home visits are made when necessary.

Strickler, Bassin, Malbin and Jacobson (1965) state that long waiting lists are not eliminated at outpatient clinics offering short term treatment, since these clinics often utilize the traditional

system of scheduled appointments. And the psychiatric emergency facilities that exist in hospitals often limit intake to clinical emergencies such as suicide, homicide and acute psychosis. Based on these assumptions the Benjamin Rush Center for Problems in Living was designed. It is a community based walk-in clinic in Los Angeles which provides brief treatment to all persons above the age of 17 and 1/2 years. It attempts to reach a population that is under-represented in traditional outpatient treatment centers. The center serves persons with a full range of psychiatric problems. The staff are multidisciplinary mental health professionals who utilize crisis theory. The hours of availability are not stated though applicants are treated on the day of application if possible, and there is a maximum of six visits. A flat fee of $4 for each visit is charged for those who can pay. There is an attempt to reduce the stigma for the person seeking treatment through the use of a nonspecific name like the Benjamin Rush Center for Problems in Living, similar in nature to the Troubleshooting Clinic described by Bellak (1964). The term "consultee" is used instead of "patient."

The Suicide Prevention Center in Los Angeles is a walk-in emergency clinic which operates from 8:00 A.M. to 5:00 P.M. Monday through Friday and has a 24-hour telephone crisis service. Its major purposes are evaluation, referral, treatment, follow-up and prevention of suicidal behavior. However, crisis intervention for a wider range of psychiatric problems is provided. It is staffed by a professional team of psychiatrists, psychologists, psychiatric social workers, psychiatric nurses and volunteers. There are no age restrictions, as well

as no charges for diagnostic or evaluative services. If treatment is necessary, fees are charged on a sliding scale. Treatment may consist of individual interviews, testing and casework which usually involves significant others. There was no mention of how the center was funded.

Training is another important function of the Suicide Prevention Center. The staff provides formal training to students in the helping professions, post-doctoral training, training of volunteers and community education.

Perhaps the best known part of the Los Angeles Suicide Prevention Center is the telephone "hot line." It was developed out of the belief that many people in crisis need help and may not be able or care to physically present themselves to a psychiatric emergency service. Geographic and personal barriers are bridged and anonymity preserved when the telephone is used (Lester and Brockopp, 1973). Volunteers, trained in crisis intervention, are used to staff the telephones. Other hot lines will not be mentioned in this literature review since they provide similar services.

Mobile Crisis Units

A 24-hour mobile psychiatric emergency service was the answer to the increased rate of psychiatric hospitalization for Tulare and Kings Counties in California (Carter, 1973). For these two rural counties some outreach was necessary to bridge the geographic obstacles. Prior to the establishment of the Emergency and Aftercare Department of Tulare View Hospital, of which the mobile unit is a part, there was no psychiatric emergency service after hours which compelled the local police to assume the burden of mental health care.

The mobile team functions on an on-call beeper system and has

psychiatric nurses, psychiatric technicians and mental health workers on staff. Licensed staff carry locked bags of stock drugs and can administer medications in the field with a telephone order from the consulting M.D. on a 24-hour basis. In 1971, Emergency Services handled 2,060 emergency calls with 75% of them occurring after normal working hours.

There is a mobile emergency ambulance service in Leningrad, USSR (Torrey, 1973). The ambulance is staffed with a psychiatrist. A patient dials code 03 and an operator forwards the call to a regional station. This service is unique in that a psychiatrist takes the call and makes the ambulance outreach visit. If it is an emergency, an ambulance is dispatched within three minutes. The police are rarely used in Leningrad for psychiatric emergencies. The psychiatrists involved in this program receive more remuneration and longer vacations than general medical staff.

A county health department in a thinly populated part of Maryland provides a 24-hour on call, home visit team that will respond to psychiatric emergencies (Blane et al., 1967). The original aim of the service was to reduce the number of disturbed people jailed while awaiting involuntary mental hospitalization. The level and numbers of staff involved is not mentioned in the article.

Police

Law enforcement agencies have traditionally provided 24-hour mobile emergency assistance including a whole range of psychiatric and interpersonal problems for which their police training often leaves

them unprepared (Bard and Berkowitz, 1969). The emotionally ill persons who are not treated by the police at the sight of the emergency are frequently brought to hospital emergency rooms (Beck, 1974). The hospital emergency room is the arena where two helping professions, mental health and law enforcement, meet. From this interface, a consultation program with the police was begun at Cambridge Hospital to acquaint psychiatrists with police functions and police personnel with information about psychiatric functions in order to improve working relationships. An outside psychiatrist was the consultant.

The program described by Bard and Berkowitz (1969) is more comprehensive and oriented to training police to intervene in family disturbances effectively, subscribing to the idea that greater therapeutic effect occurs in time of crisis. The project was instituted by the Psychology Department of The City College of New York to prepare 18 selected policeman as mental health paraprofessionals. They were selected on the basis of interest, experience, aptitude and motivation from the Thirtieth Precinct in Manhattan's Upper West Side. The population of the area is 85,000 poor black and Latin-American families. The 18 men were racially balanced. The Family Crisis Intervention motor patrol operated 24 hours a day, and they patrolled in teams of two.

The three implications for this program are: (1) the trained men referred clients to social welfare and mental health agencies more frequently than untrained men, (2) this program provided early detection of mental health cases, and (3) police and mental health consultants worked together well, breaking down stereotypes of both professions.

Other Settings

The following category consists of a review of psychiatric emergency services that do not fit into the settings previously mentioned. The first example to be discussed is a research project in Wisconsin entitled "Training in Community Living." It is a 24-hour program designed to eliminate psychiatric hospitalization and intervene with the patient, his family and the community. It is based on the philosophy that the psychiatric hospital is useful only in treating the acute psychotic episode and beyond that has a negative effect on patients (Stein and Test, 1974). Stein and Test also believe that all types of walk-in centers and day treatment centers have generally been unsuccessful in limiting the movement of patients between the community and the hospital, because there are no organized assertive outreach efforts if the patient stops coming to treatment. Ex-hospital patients often do not function well in the community and rely on the psychiatric hospital to be the coping mechanism which Stein and Test (1973) see as maladaptive and encourages chronic dependence.

The patients involved in the program including the experimental group and the control group are randomly sampled from those adults who present themselves for treatment at the Mendota State Hospital. They are accepted regardless of symptomatology or social support systems. The patients in the control group are usually admitted to the hospital. The patient in the experimental group is in the community. He/she has a full schedule of activities and instruction in community living, such as cooking or job finding, in which staff provides assistance and encouragement. The staff may have hourly contact with a

newly-admitted patient which will taper off as treatment progresses. Staff are available twenty-four hours a day to a patient, family or community person or facility. Medications are used when appropriate.

The staff consists of a psychiatrist, psychologist, social worker, occupational therapist, nurses and aides who are all retrained mental hospital ward staff. The staff is dispersed throughout the community. They gather twice a day, at shift change, to share information and plan. There are two well-staffed shifts from 7:00 A.M. to 11:00 P.M. After those hours a member of the professional staff is available on call.

From the experimental group 18 percent were hospitalized compared with 89 percent of the control group. Out of the 89 percent of the control group, 37 percent were rehospitalized in the first year. The experimental group was maintained in the community without increased burden to their families.

A second example of psychiatric emergency service with a unique setting is the crisis hostel (Brook, 1973). Fort Logan Mental Health Center utilizes a transitional living facility as an alternative to psychiatric hospitalization. Occupants were persons who would normally have been admitted to Fort Logan Crisis Unit. The maximum stay at the hostel is 7 days. The rationale for the hostel is that it minimizes disruption in the patient's environment by placing him in a living situation that is similar to his own and does not promote sickness. Staff from Fort Logan Crisis Unit are available for crises, but the hostel is not formally staffed, relying on the neighbors to fix meals and supervise the residents. The facility is the home of a fully employed nurse who dispenses medications on her off hours. The patients

are admitted through Fort Logan Mental Health Center after physical and diagnostic evaluations.

General Trends

There appears to be an increase in the number of psychiatric emergency services available over the last few years (Jacobson, 1974). This seems to be influenced by some recent legislation including the Federal Community Mental Health Services Act of 1963. The Emergency Medical Services Systems Act of 1973 (PL 93-154), under which emergency medical services programs in the United States are to be funded, specifically includes psychological emergencies. And certainly the rising incidence of suicide in the United States has provided impetus to the increase of psychiatric emergency service provision (Stat. Bulletin, 1976). Perhaps the best illustration of the general trends of psychiatric emergency services offered is found in Department of Health, Education and Welfare (HEW) publication (Witkin, 1976) called "Emergency Services in Psychiatric Facilities." One drawback in the report is that it does not survey university health facilities; and according to the literature, the general teaching hospitals have the majority of the psychiatric emergency services.

Mental health facilities vary widely in their provision of types of psychiatric emergency service. Sixty-one percent of general hospitals with separate psychiatric units provided service, while only three percent of residential treatment centers provided service. However, the hospitals without emergency mental health programs were not included in the report. Emergency mental health services were

more often available in community based programs, i.e., general hospitals and clinics, than in psychiatric hospitals. In Region X of HEW, which includes Oregon, no psychiatric hospital reported that it provides psychiatric emergency services (Witkin, 1976).

Witkin (1976) states that the predominant psychiatric emergency mode of service delivery was walk-in, and the least offered psychiatric emergency service was home visits. When home visits were provided at all, it was only for part of a 24 hour period.

In the Community Mental Health Services Act of 1963, PL 88-164 requires the provision of 24 hour emergency mental health services by each community mental health center. These are to include: 24 hour walk-in, telephone, suicide prevention and home visit services. In Oregon, there are only two comprehensive community mental health centers, one in Eastern Oregon and one in the Willamette Valley, both of which do not provide 24 hour emergency psychiatric services. The United States survey conducted by the National Institute of Mental Health (NIMH) in January 1974 showed that the emergency services offered by the comprehensive community mental health centers outside regular working hours were provided by persons on-call. Of the free-standing outpatient psychiatric clinics, 59% in Region X (including Oregon, Washington, Alaska and Idaho) reported providing some type of psychiatric emergency service.

Summary

The literature suggests that increasing numbers of people are seeking psychiatric emergency care from general medical hospital emergency rooms. The hospital emergency rooms are open 24 hours

a day and are accessible to people seeking treatment. Many persons may seek medical help even in a psychiatric emergency.

General hospitals with psychiatric units appear to have the most psychiatric emergency services available; they tend to be teaching hospitals that have psychiatric residents on staff. The psychiatric emergency services seem to center in or near the medical-surgical emergency room with adjunct services like brief inpatient treatment, short-term 24-hour walk-in clinics, observation or holding rooms and mobile emergency units.

General hospitals without psychiatric units usually have a less sophisticated psychiatric emergency system than the teaching hospitals, with service being provided in the emergency room by collaboration and cooperation of medical and psychiatric personnel in the community on an on-call basis. There are few examples of psychiatric hospitals providing psychiatric emergency services.

Outpatient clinics are the traditional mode to reach psychia- clients, though few operate on a 24-hour basis. Walk-in psychiatric emergency services are most routinely provided during the hours of 8:00 A.M. and 5:00 P.M., except in the hospital emergency rooms which are open 24 hours a day. But the most common 24 hour emergency services are telephone hot lines.

Mobile crisis units provide services to persons in crisis by going to the scene of the emergency. They have the capability of dealing with the emergency on site or transporting a patient in an acute state of crisis to further care. This is a service that the police have rendered

for years. Recognizing the fundamental role police have played in psychiatric emergencies, especially with the advent of involuntary commitment legislation involving police holds, consultation by mental health personnel with the police is developing. The review also included two programs which are alternative types of psychiatric emergency services, including a crisis hostel and a community based hospital unit staff dealing with persons who presented themselves for psychiatric hospitalization and received treatment in the community.

CHARACTERISTICS OF THOSE WHO USE PSYCHIATRIC EMERGENCY SERVICES

The first section of the literature review provided descriptions of different kinds of emergency facilities, the psychiatric services provided in emergencies, educational preparation of those who staff these services, and the trends in service patterns nationwide.

The second section of the review considers the people who are consumers of psychiatric emergency services. Several questions are asked in an attempt to identify the variables that affect the delivery of psychiatric emergency services from initial contact with the consumer to the disposition and referral. What are the general characteristics of the people who come to psychiatric emergency services? Are there any distinctive subgroups? What problems cause these people to seek psychiatric aid? How are these problems dealt with, and do these people get further help after the crisis?

Demographic Variables

Demographic data is often routinely collected and is frequently used to determine the types of people who are using services. Exami-

nation of demographic data will also reveal any distinctive subgroups that use the service more frequently than other subgroups. The demographic variables that will be reviewed are those of age, sex and marital status. Research reporting data on race and income appears to be specific to the geographic area that the data was collected from (Huffine and Craig, 1974), and so will not be reported on here. The relevant research reports are reviewed for each of these characteristics separately.

Sex. The first variable to be considered in this section of the literature review is that of gender. Seven of the 13 studies surveyed, report males to be more frequent users of psychiatric emergency services. Blais and Georges (1969) report the highest ratio of females to males (2.2:1) on a sample of 350 persons being seen in the emergency room of a general hospital. Other studies reporting high percentages of women in psychiatric emergency services are Huffine and Craig (1974), Ungerleider (1960) and Robert Atkins (1967). Studies reporting slightly higher percentages of females than males in psychiatric emergency service populations are Swartz et al. (1972) and James Atkins (1976).

A program in Connecticut which utilizes brief (3-day) intensive hospitalization and 30 days of outpatient follow-up as an alternative to longer-term hospitalization for patients experiencing a psychiatric crisis has reported a high percentage of females (63 percent) in the population who are admitted to the unit (Weisman, Feirstein, Thomas, 1969). Follow-up studies on this same sample one year after discharge found that men were re-hospitalized significantly more than women. It was thought that coming to the hospital for help might represent a more complete and catastrophic breakdown in social roles for men than for

women. If so, then the return to the community would be more difficult to maintain and result in higher rates of re-hospitalization for men.

Four of the 13 studies reviewed, reported a higher percentage of males using psychiatric emergency services. The highest percentage was reported by Voineskos (1974). The percentage of males in the two samples studied who were admitted to psychiatric units in a regional mental hospital in Canada was 65 percent. Other studies reporting a higher proportion of males than females in psychiatric emergency services are Watson (1969), Tally (1977) and O'Regan (1965).

Trier and Levy (1969) defined visits to a general hospital psychiatric service as emergent (immediate attention required), urgent (could have waited up to 24 hours for intervention) and elective (could have waited longer than 24 hours). An analysis of each of the three groups found that there were no statistically significant differences in the composition of the groups by sex.

Muller, Chafetz and Blane (1967) summarized previously published data on acute psychiatric patients from several general hospitals. They compared these findings with the data they were keeping at Massachusetts General Hospital. The investigation at Massachusetts General Hospital found no overall difference in admission rates between men and women which confirmed findings reported by Fisch, Gruenberg and Banfield on data collected at Bellevue Psychiatric Hospital in New York (Muller et al., 1967).

Further examination of the sample of data from Massachusetts General Hospital was undertaken to determine if subgroups might have distinctively different characteristics. The analysis of data revealed that patients with a primary medical problem and a secondary psychiatric component were

represented equally by members of both sexes. Among alcoholic patients with related psychiatric problems there was a 4.1 ratio of males to females in the study population. The third group, those with psychiatric problems without either medical or alcohol components, were represented by more females (600) than males (548), but as age advanced toward the middle years the female majority diminished.

Of the studies reviewed here,more report higher percentages of women in the population using psychiatric emergency services. Several studies were reviewed in more detail, as they presented some of the variables that can interact with that of gender. These included: the number of previous hospitalizations, the type of service provided and the type of psychiatric problem.

Age. Six studies reported the highest population utilizing psychiatric emergency services were persons under the age of 30 years. Two studies showed that there was a clear majority of persons between the ages of 30 and 50, and six studies reported no clear majority in any one age category.

Researchers who have reported heavier utilization of psychiatric emergency services by those persons under 30 years of age are Rhine and Mayerson (1971), Tally (1977), Spitz (1976), Weisman et al. (1969), James Atkins (1976) and Huffine and Craig (1974). Two of the 12 studies reported clear majorities of persons in an older age category. Considering the two age categories with the highest percentage of admissions, the San Mateo County General Hospital shows an older population using the psychiatric emergency service (Trier and Levy, 1969). For the ages 31 to 40 years and 41 to 50 years, the combined percentages are 56 percent of the emergent

admissions, 46 percent of the urgent admissions and 49 percent of the elective admissions. Another general hospital (Blais and Georges, 1969) reported larger percentages of the population of 350 persons seen in the emergency room of a general hospital were between the ages of 30 to 39 years of age. The studies reviewed that used consistent age intervals suggest that between 45 and 60 percent of any population utilizing psychiatric emergency services will be between the ages of 20 and 40 years. Sixty to 75 percent of the population will be between 20 and 50 years.

Data from Massachusetts General Hospital (Muller et al., 1967) indicate that there is a high incidence of young adults using the psychiatric emergency service compared to their distribution of age in the general population and a low incidence of the elderly. Bellevue Psychiatric Hospital in New York (Fisch, Gruenberg, Bandfield, 1964) reports a higher proportion of older persons in the population that used that facility than the proportion of younger persons. James Atkins (1976) found that persons 65 years of age and older used psychiatric emergency services provided by mental health clinics in eastern Oregon more than they used other mental health clinic services. Those persons under 18 years of age were being seen with less frequency in the psychiatric emergency service population than in the general clinic population.

Nearly all studies of psychiatric emergency services report data on age although not always in comparable or equal interval categories. From those studies reviewed here, a large number report the greatest utilization of psychiatric emergency services by those under the age of

30 years. An equally large number report no one age category as being more common. By combining those age categories with the highest percentages it can be said that the majority of persons using psychiatric emergency services will be between the ages of 20 and 40 years. Finally, examination of specific studies in greater detail suggests that other variables, such as sex, may interact with the variable of age (Voineskos, 1974). Consideration of subgroups such as the elderly or the very young may also reveal specific utilization trends.

Marital Status. The variable marital status itself is practically meaningless in today's society but it is a variable that is consistently reported on because the data is discrete and objective (Muller et al., 1967). Marital status takes on an importance when such factors as the status of the relationship, the value placed on the marriage, the events precipitating the seeking of psychiatric emergency services and the client's resources can be effectively documented and evaluated.

The literature reviewed reports that the majority of clients for all studies reporting marital status are either single or married rather than widowed, divorced or separated. Four of 11 studies (Weisman et al., 1969; Spitz, 1976; Rhine and Mayerson, 1971; Muller et al., 1967) reported higher percentages of single persons than married persons used psychiatric emergency services. Six studies (Huffine and Craig, 1974; Ungerleider, 1960; Swartz et al., 1972; Blais and Georges, 1969; Robert Atkins, 1967; Blane et al., 1967) reported higher percentages of married persons in the populations utilizing psychiatric emergency services. It is not clear what other variables might be affecting this finding. As pointed out in the previous section on age,

the population utilizing psychiatric emergency services is a young one and it is possible that this is a factor in the predominance of either married or single persons rather than those who are divorced, separated or widowed. The married or single majority tends to be between 40 and 55 percent of all other samples. The categories, separated, divorced and widowed tend to fall within 15-30 percent of each study population.

Data collected by Voineskos (1974) was divided into categories for both marital status and sex. As with age, marital status differs with sex. Sixty-three percent of 569 males were single. The next largest group consisted of men who reported being separated--21 percent of the total population for men. This is the only study where those who are separated, widowed or divorced receive any majority. Married men in this study compose eight percent of the entire sample. For women the trend in marital status is similar to other studies reported in the literature. Single women rank first in frequency of occurrence--36 percent; married females rank second--30 percent; and women who are separated, divorced or widowed make up 33 percent of the sample.

Diagnostic Variables

Traditional psychiatric nomenclature is often used when researchers report on the diagnoses of persons using psychiatric emergency services. Muller et al., comment that "The consistency of diagnostic practices within an institution or among different institutions has frequently been questioned, but it is possible to take a broad view of the diagnoses of patients that are reported in the literature " (1967, p. 51). In addition to the data reported on diagnosis, this portion of the review considers literature reporting data on symptomatology, the

duration of the presenting complaint, psychiatric history, the time that the client arrived at the service and what treatment clients received while at the psychiatric emergency service.

Diagnosis. Portions of 17 studies were reviewed. In 14 of these the psychoses were reported as the diagnostic category that was either the highest or next highest percentage of persons seen. These percentages range from 20-50 percent of all populations except two. The diagnostic category of the neuroses was either first or second in the frequency with which persons received this diagnosis in ten of the studies reviewed. These percentages range from 22-68 percent.

In seven studies the character disorders were reported as the category with either the highest or next highest percentage of the population seen. These percentages range from 21-34 percent of the populations studied. The alcoholic diagnoses were reported in three studies as constituting higher percentages of the population studied and two studies reported situational reactions as composing large percentages of the population. These percentages range from 16-25 percent for the alcoholic diagnoses and 21-22 percent for the situational reactions. Two final studies reported that large percentages (30 percent and 40 percent) of the populations studied received no diagnoses at all.

The studies reporting larger percentages of persons with psychoses represent several different types of therapeutic institutions. Louise Hopkins (1976) investigated the use of involuntary hospitalization at a general hospital psychiatric unit in Jackson County, Oregon, and reported that 40 percent of those admitted received a diagnosis of

psychoses. The next largest diagnostic category in this study was that of character disorders, which constituted 21 percent of those admitted. In another study of 350 psychiatric patients seen at a general hospital emergency room, 45 percent received diagnoses of psychosis (Blais and Georges, 1969).

The Grace-New Haven Hospital in Connecticut (Blane et al., 1967) reports that 32 percent of the population seen in the 24 hour psychiatric emergency service receive diagnoses of psychosis. The diagnostic category with the next highest percentage is neurosis, comprising 27 percent of the population. A study conducted at the Emergency Treatment Unit of the Connecticut Mental Health Center (Weisman et al., 1969) reports that 48 percent of the population seen are diagnosed as psychotic (32 percent received the diagnosis of schizophrenia).

Three studies reported distinctively high percentages of persons being diagnosed as neurotic. Data collected at the Cincinnati General Hospital emergency room reported that 68.3 percent of the population seen during a representative month were diagnosed as neurotic (Spitz, 1976). The Cleveland University Hospital (Ungerleider, 1960) reported that 40.5 percent of the population seen at the 24 hour psychiatric service were diagnosed as neurotic. The next largest diagnostic category was that of the psychoses (20 percent).

Seven of the studies reviewed reported less distinctive differences between percentages on two or more diagnostic categories. At the University of Oregon Health Sciences Center (Tally, 1977), 12,220 psychiatric patients were seen at the emergency room over a 5 month

period. Twenty-one percent of these patients were undergoing a transient situational reaction and another 20 percent were diagnosed as psychotic. The diagnostic group with the next highest percentage were the neuroses (15 percent). The University Hospital at Saskatoon, Saskatchewan (O'Regan, 1965) reports data on two diagnostic categories, neurosis and psychosis. The diagnostic category of neurosis represented 35 percent of the same population.

Strong Memorial Hospital in Rochester, New York (Robert Atkins, 1967) reports data on three diagnostic categories. The character disorders and neuroses are considered together and represent 46 percent of the population seen during the years 1964-65. Those persons receiving diagnoses of psychosis constituted 44 percent of the same population and those with diagnoses of organic brain syndrome (acute and chronic), 9 percent.

Studies at two hospitals in Boston, Massachusetts report on diagnostic categories. Researchers at Massachusetts General Hospital (Muller et al., 1967) reported that 25.6 percent of all persons seen at the 24-hour psychiatric emergency service between March and August 1965 received the diagnosis of alcoholism. The categories with the next two highest percentages were the neuroses (22.4 percent) and the psychoses (21.9 percent). A study conducted at Boston City Hospital reported on 460 patients seen in the emergency room of this university associated general hospital. The diagnostic category of neurosis constituted 28.2 percent of this population and the psychoses 25.7 percent (Muller et al., 1967).

Trier and Levy's (1969) research at San Mateo County General

Hospital reported high percentages of the population seen during December, 1967, received diagnoses of personality disorders for all three groups: emergent, 32 percent; urgent, 34 percent; and elective as 32 percent. Those receiving diagnoses of psychotic constitute the next highest percentage for both the emergent group (29 percent) and the urgent group (28 percent). In the elective group the category of neurosis was the next highest percentage, 31 percent. For this same population, Trier and Levy (1969) report consistently high percentages of persons who also have problems with alcohol: the emergent group--39 percent, the urgent group--34 percent, and the elective group--31 percent.

The Benjamin Rush Center Walk-In Psychiatric Clinic (Strickler et al., 1965) reports nearly equal percentages of persons seen receiving diagnoses of character disorder (27 percent) and neurosis (28 percent). The diagnostic category with the next highest percentages is psychosis (18 percent) and those with situational reaction (16 percent). The Orange County Medical Center (Swartz et al., 1972) reports diagnostic categories in relation to those who have been admitted to the service once and those who had multiple admissions between March 2 and June 30, 1970. Persons with single admissions were more likely to be diagnosed as experiencing transient situational disorders (22 percent). Those persons with multiple admissions were more likely to be diagnosed with one of the personality disorders including alcoholism and drug dependence (29 percent).

The Emergency Psychiatric Service at the University of Colorado Medical Center (Rhine and Mayerson, 1971) studied diagnosis in relation

to duration of hospitalization. Nearly all persons admitted who were diagnosed as having a transient situational reaction and alcoholism were discharged within 7 days. Those persons admitted with diagnoses of character disorder and neurosis were discharged within 14 days. Of those persons diagnosed as psychotic there was a tendency toward longer hospitalization (21 days) and substantial numbers had to be transferred to longer care facilities. The authors report that half of all persons admitted could be discharged within a week.

At Kings College Hospital in England (Watson, 1969) data was collected on a sample of psychiatric patients seen in the accident and emergency department during 1965. Forty percent of persons seen at this service received no diagnosis at all. The reason for this is that 53 percent of all persons presenting themselves to this service have either made a suicide attempt, are threatening suicide or exhibit suicidal ideation. These persons are usually admitted to the hospital without a diagnostic determination being made at the time they were seen in the emergency department. The diagnostic categories with highest percentages of those persons who received diagnoses were acute crisis (14 percent), alcoholism (12 percent) and the psychosis (11 percent).

Of the studies reviewed the psychoses were the only diagnostic categories reflecting distinctively higher percentages among populations using psychiatric emergency services. A smaller group of studies found the neuroses as being a larger percentage of all diagnostic categories. The largest group of studies reported less distinctive differences in percentages between two or more diagnostic categories. It

appears that psychiatric emergencies can occur in all diagnostic groups. Persons entering a psychiatric emergency service may be more likely to receive a diagnosis of psychosis, neurosis, or character disorder, but this seems to depend somewhat upon the practices of particular institutions. It is not clear whether this tendency is because persons in a psychiatric emergency are psychotic or neurotic or if the symptoms are momentarily florid enough to convince the diagnostician.

Kenyon and Rutter (1963) suggest that the majority of patients seen in a psychiatric emergency service present behavioral management problems that are distinct from diagnostic issues. Muller et al. (1967) tested the hypothesis that diagnosis interacted with symptomatology by ranking symptoms within diagnosis and computing a coefficient of correlation. They did not find any significant relationship between diagnosis and symptoms and question whether it may be due to the unreliability of diagnostic judgments. Blais and Georges also report that based on their 8-month study of a general hospital emergency room, "diagnosis is a minor factor in the mobilization of a patient to the emergency department." (1968, p. 127)

Symptomatology. The preceding section has indicated that a psychiatric emergency can occur in any diagnostic category. It has been proposed that symptomatology may be the critical factor in treatment decisions. The review of literature with regard to the symptomatology of persons experiencing a psychiatric emergency suggests that a negligible amount of actual violence is reported to be associated with persons who enter a psychiatric emergency service at hospitals, clinics, or telephone hot lines, except that associated with suicide. Some form of

self-destructive behavior is present in the majority of persons in the form of suicidal thoughts or behavior, agitation, and alcohol or drug abuse. Depression and/or anxiety characterize the chief complaints of another large group of persons seen at psychiatric emergency services.

Weisman et al. (1969) report that potential for suicide is a factor in 50 percent of all admissions to the Emergency Treatment Unit at the Connecticut Mental Health Center. In breaking this category down further he reports that 7 percent of this group had made a suicide attempt, 13 percent had made a suicide gesture and 29 percent had suicidal ideation. Acute and chronic alcohol and drug problems were present in 14 percent of this population. Trier and Levy (1967) used three categories to distinguish between degrees of psychiatric emergencies found that suicide risks and attempts were significantly higher in emergent admissions than non-emergent admissions. Suicidal tendencies were present in 1 out of 2 emergent admissions; 1 out of 6 urgent admissions; 1 out of 12 elective admissions.

Watson (1969) collected data on psychiatric patients seen in the emergency room of Kings College Hospital in England and reported that suicide problems presented in 47 percent of the cases seen. In 53 percent of the cases suicide potential was a relevant factor but that in 82 percent of the cases little medical danger was present. Ungerleider (1960) and Spitz (1976) reported smaller percentages of persons at risk of suicide. Spitz (1976) states that 11.3 percent of all persons seen at Cincinnati General Hospital have made a serious suicide attempt and 12.7 percent have made a moderate suicide attempt. Suicide potential is present in approximately one-fourth of all persons seen. Ungerleider

(1960) reports that 20 percent of all persons seen either had made a suicide attempt or exhibited suicidal ideation.

O'Regan (1965) found that 66 percent of the patients seen at the University Hospital at Saskatoon, Saskatchewan, complained of depression and/or anxiety. The next most frequently complained of symptoms were those of insomnia and loss of concentration. Underleider (1969) reports that following suicidal symptomatology, depression is the next most frequent complaint (18 percent). Anxiety and somatic complaints follow, each occurring in 7 percent of the population studied.

Several studies use unique, non-comparable or undefined categories for symptomatic complaints and portions of these will be reported separately. The study on the psychiatric emergency service at Massachusetts General Hospital (Muller et al., 1967) concluded that agitation was the symptom ranked most frequently for all diagnostic groups. Suicide potential, drinking and withdrawal were the symptoms next most frequently ranked. Only 10 percent of the sample included phobias, compulsions, assaultive and violent behavior. Watson (1969) found that after complaints of suicidal thoughts the next most frequent complaints were collapse (21 percent), symptoms of unspecified mental illness (16 percent), alcohol (9 percent), and social/emotional stress (7 percent). Collapse and alcohol problems were more frequent for males.

In Oregon two studies report on data collected relating to symptomology. The Benton County Hotline (Woodward, 1976) reports marital difficulties as precipitating 21 percent of all calls between January and March, 1975, along with considerable percentages for the

categories depression, suicide and alcohol. The compilation of data on 1,152 persons seen at one of the six mental health programs in eastern Oregon (James Atkins, 1976) showed that the symptom of psychiatric discomfort was ranked as severe or extreme for 41.6 percent of this population. Problems with interpersonal relations constituted 30.8 percent of symptomatic complaints ranked as severe or extreme for 1,152 persons.

In summary, some form of self-destructive behavior is present in the majority of persons utilizing psychiatric emergency services. Complaints of depression and/or anxiety characterize another large group of persons who request service. The variation between researchers' methods of reporting symptomatology and the complex interrelation between symptoms and diagnoses prevent strong generalizations from being made.

Previous History. Six studies report on the previous psychiatric history of persons seen at the facility. Weisman et al. (1969) studied persons seen during the first 2 years the Connecticut Mental Health Center was in operation and reported that 39 percent of all patients seen had a previous admission. O'Regan's (1965) study of the University Hospital psychiatric emergency service in Saskatoon, Saskatchewan, reports that 20 percent of all persons seen have a positive family history for mental disorders and that 50 percent of all 133 persons seen reported previous psychiatric treatment.

Ungerleider (1960) found that 11 percent of 378 persons seen by the emergency psychiatric consultation service at University Hospital in Cleveland gave a positive though non-specific history and that an additional 23 percent of the persons in the sample gave a positive and

specific psychiatric history. For a substantial portion of the total population, 58 percent, there were no data on previous psychiatric history. Data relating to the use of a hospital emergency room by persons with a history of previous psychiatric hospitalization and/or a psychiatric history experiencing a psychiatric emergency is inconclusive.

Hopkins (1976) studied the use of involuntary holds at a general hospital for persons awaiting commitment hearings and reported that 178 or 90 percent of the total population were admitted once during the study period and that 10 percent were admitted to the general hospital two or more times. The data collected at Orange County Medical Center emergency admissions unit (Swartz et al., 1972) reported that 87 percent of 2,252 patients were seen once from March through June and that 13 percent were seen two or more times. Voineskos' (1974) two samples of emergency admissions to a psychiatric hospital show a higher percentage of persons who had been hospitalized two or more times, as compared to those who were admitted for the first time. Voineskos (1974) suggests that persons who have been treated once at a mental hospital may return directly to that hospital in times of stress or decompensation more often than to a general hospital.

Duration of the Presenting Problem. Two studies report contradictory data on the duration of the presenting problem for populations using psychiatric emergency services. The University Hospital psychiatric emergency service (O'Regan, 1965) in Saskatchewan, Canada, reports that 40 percent of 133 persons treated during a period beginning January 1, 1964, had suffered from the presenting complaint for 2 years or more. One-half of this group were seen because the family or general practitioner was concerned rather than there being any recent change. The

other half were referred to the emergency service because of a recent deterioration in a chronic course of illness. A final 10 percent were referred to the emergency service because of some problem with a sudden onset.

In contrast, the psychiatric emergency consultation service at University Hospitals in Cleveland (Ungerleider, 1960) report that 36 percent of the 378 consultations during a 6 month period represented an acute problem arising on the same day the patient was seen. The next largest group (19 percent) were persons with a semiacute problem, which had existed from 20 hours to 1 week. Only 7 percent of this population had a presenting problem of 1 year or more in duration.

These contrasting findings may represent differences in the particular population or service, the presence or absence of other resources in the community, or differences in the health care systems of the two countries.

Client Arrival Time. Seven studies report a greater percentage of clients seen during regular working hours: James Atkins (1976); O'Regan (1965); Ungerleider (1960); Trier and Levy (1969); Huffine and Craig (1974); Spitz (1976); and Woodward (1976). Ungerleider (1960) also reports a greater percentage of clients seen during weekdays rather than weekends. The other studies provide no evidence as to the day of the week clients are more likely to be seen. Explanations as to why clients utilize a service at one time or another, include the availability of personnel and differences in referral sources (James Atkins, 1976).

Treatment Received. The treatment received by clients while at the psychiatric emergency service is not always reported in the studies

reviewed here. In many cases it must be assumed that clients receive a minimum of an evaluation and referral. Some agencies perhaps offer counseling or crisis intervention as well. Most reports in the literature will describe services provided to clients, but the collection of data does not consistently reflect who receives what services.

Trier and Levy (1969) looked at several treatment variables with regard to the degree of emergency. This study is included in the literature review because it describes the types of equipment and personnel commonly used in the provision of psychiatric emergency services at the San Mateo General Hospital. For the emergent group 1 out of every 3 persons required nursing care and 1 out of every 2 persons required the use of a locked room. Medication was administered to about 66 percent of the persons seen. For the urgent group, 1 out of every 4 persons needed nursing care, 21 percent required the use of a locked room and 56 percent of all persons seen in this category either were given medication or received a prescription. Thirty-six percent of all persons in the elective category were given medication or received a prescription. Nursing care was required in only 9 percent of these cases.

Social work services were required in 2 percent of the emergent cases, 8 percent of the urgent cases and 6 percent of the elective cases. The police were involved in 18 percent of the emergent cases, 4 percent of the urgent cases and none of the elective cases. Medical services were provided to 16 percent of the emergent cases, 8 percent of the urgent cases, and 5 percent of the elective cases. Trier and Levy (1969)

do not define the nature of nursing and medical care, social work services or police involvement, so it is not possible to generate the implications of these findings beyond what is reported.

Watson noted that 40 percent of the persons seen at Kings College Hospital, England, during 1965 were provided consultation and/or advice. Another 60 percent of this population were treated with a combination of chemotherapy and psychotherapy. Ungerleider (1960) reports less use of medications in the sample studied at Cleveland General Hospital. Of 378 persons in the sample only 18 percent received medications.

The data from the Eastern Oregon Comprehensive Community Mental Health Center (James Atkins, 1976) indicates that 3.4 percent of 1319 persons whose problems were rated as severe or extreme were provided with medications. Caseworking and counseling were the actions taken in 25 percent of those cases. An evaluation was performed in 8.2 percent of the cases and consultation provided in 7.9 percent. Commitment arrangements composed 3.2 percent of all the cases.

Source of Referral

Eleven of the studies reviewed reported data on who referred the persons utilizing psychiatric emergency services. The categories of referral break down into those who refer themselves or those whose families or friends refer them, those who are referred by specific groups of professionals (the police and/or ambulance, physicians or psychiatrists, social workers or private therapists), and those who are referred by specific agencies such as the courts or an outpatient clinic. Three studies have included data on who accompanied the

client to the service.

There appears to be a reciprocal relationship between the proportion of self-referred persons or persons referred by family or friends and persons referred by professionals. Those studies with high percentages of persons referred by professionals usually show a correspondingly low percentage of family, friend or self referrals. Persons referred by other agencies show a consistently low percentage of the total. It appears that some of the factors that might affect the referral pattern are the protocol of the agency for referral, the publicity a facility receives, the type of clientele served, and the type of emergency.

In the studies reviewed the percentages of persons who are self-referred or have been referred by family or friends range from 90 percent to 10 percent. The highest percentage reported for this type of referral is from the Benton County Hotline (Woodward, 1976). Seventy-eight percent of 120 telephone calls received between January and March, 1975, were from persons calling in regard to themselves. An additional 12 percent of the calls were from family or friends. This agency reports receiving no calls from professionals or agencies with regard to specific individuals.

Self referrals or referrals from family or friends constitute 75 percent of the total sample population that was studied at Massachusetts General Hospital (Muller et al., 1967). There was a correspondingly low percentage of referrals received from law enforcement personnel, physicians and agencies for this same study population. In a pilot study of 350 persons experiencing a psychiatric emergency

seen at a general hospital emergency room, Blais and Georges (1969) also found high percentages of self referrals (32 percent) and referrals from family or friends (47 percent). Two other studies report the percentage of self referrals and referrals from family or friends to be more than 50 percent of the populations studied (Spitz, 1976; James Atkins, 1976). O'Regan (1965) reports the lowest percentage of self referrals of the studies reviewed (10 percent) with a correspondingly high percentage of referrals received from physicians.

Professionals most often cited as making referrals to psychiatric emergency services are the police and local physicians. The percentages of referrals from the police to a psychiatric emergency service range from a low of 6 percent to a high of 40 percent. Referrals from physicians account for a high of 80 percent to a low of 5 percent.

Of the studies reviewed the University of Oregon Health Sciences Center emergency room (Tally, 1977) reports the highest percentage of all referrals from law enforcement agencies (40 percent). Police referrals in Blais' and Georges' (1969) sample of 350 persons seen at a general hospital emergency room constituted 31 percent of that study population. Low percentages of referrals received from law enforcement agencies range from 8.6 percent to 6 percent (Spitz, 1976; Robert Atkins, 1967; Muller et al., 1967).

For referrals from physicians O'Regan (1965) reports the highest percentage (80 percent) of all the studies reviewed in this section. This psychiatric emergency service was developed to provide screening services and consultation to local general physicians. Upon evaluation by the psychiatric emergency team the patient was referred back to the physician who was responsible for ongoing treatment. The author of the

research article (O'Regan, 1965) suggests that in this way unnecessary admissions to psychiatric inpatient treatment units were avoided. The second largest source of referrals at the Eastern Oregon Mental Health Clinics are physicians (James Atkins, 1976) and Cincinnati General Hospital (Spitz, 1976) reports its second largest source of referrals to be physicians also; 24 percent of the population studies were referred by physicians. The lowest percentage of physician referrals (5 percent) is reported at Massachusetts General Hospital (Muller et al., 1967).

Referrals from social workers constitute 3 percent of the referrals in the study population at Cleveland University Hospitals (Ungerleider, 1960). Spitz (1976) mentions referrals from private therapists or other professionals as 1.8 percent of all referrals for 495 clients seen at the Cincinnati General Hospital. Referrals from private professionals constitute 8 percent of 745 clients referred to the Benjamin Rush Center for Problems in Living (Strickler et al., 1965).

Referrals from other agencies, chiefly the courts, social agencies and outpatient clinics compose a small percentage of the total referrals received from for nearly all studies reviewed. The only study that received more than 10 percent of its referrals from other agencies was the walk-in clinic at the Benjamin Rush Center for Problems in Living.

The second largest referral source during the clinic's first eighteen months of operation were referrals from other agencies (Strickler et al., 1965). This study reduced the referral pattern to three 6 month sections for closer study. In the first 6 months after the

Center opened, two-thirds of the clientele were self-referred and one-fifth were referred through professional channels. The authors suggested that those who were self-referred were attracted by the visibility of the clinic's opening and the resultant publicity. In succeeding months the numbers of self-referrals steadily declined as the professional or agency referrals increased. By the third 6 month period the total number of persons who were self-referred was reduced by half. The number of agency referrals increased by approximately 50 percent from the first time period to the third time period.

At the San Mateo (California) General Hospital, Trier and Levy (1969) collected data on the source of referral in relation to the degree of severity of the psychiatric problem. Persons having psychiatric problems requiring immediate attention (emergent), were referred by the police or by family and friends the majority of the time. People with psychiatric problems that needed to be dealt with in 24 hours (urgent) were either self-referred of referred by family or friends. People with psychiatric problems that did not require attention within 24 hours (elective), were predominantly self-referred.

These researchers also collected data on the client's manner of arrival in relation to the three categories of urgency. People in the emergent category were most likely to be brought by the police or ambulance. In the urgent category people more often arrived alone or with family or friends.

Two other studies collected data on the arrival of clients at psychiatric emergency services. Watson (1969) reports that at

Kings College Hospital Emergency and Accident room, 69 percent of the population seen are brought by the police or ambulance. Watson (1969) suggests that this mode of arrival was more frequent because of the high proportion of suicide attempts in the sample. Ungerleider (1960) reports that at Cleveland General Hospital the majority of persons arrive accompanied by relatives (50 percent) followed by those who arrive alone (27 percent). The police (13 percent) and other friends or neighbors (10 percent) accompanied clients with less frequency.

In the review of literature by Muller et al. (1967), two comments were made regarding referral patterns. One comment is that data on referral sources was difficult to obtain from a retrospective chart search because this information is usually not recorded. The other comment was that "the decision to seek help is the result of a complex interplay of psychological, social and cultural factors only indirectly related to symptomatology" (1967, p. 54). Once the decision to seek help is made, other individuals or agencies may become involved in this help-seeking behavior. By the time the client reaches the psychiatric emergency service a complex set of factors are in operation. Some of these factors are the individual's decision to seek help, the norms and procedures of other agencies, the hospital system and the care providers. These factors not only interact with the client but with each other and will ultimately affect the disposition and treatment. Muller et al. (1967) conclude that the pattern of referral will become the critical element in the diagnosis of psychiatric emergencies.

Disposition

One of the primary goals of most psychiatric emergency services is to develop an adequate solution to the client's problem or disposition upon completion of the evaluation and immediate treatment. There is wide variation in the classification of disposition among the reports in the literature. When information about dispositions is recorded it may be as simple as the percent of admissions to inpatient units and the number of persons referred for outpatient treatment. Or it may be as complex as a list of facilities that persons were referred to in a specific community.

The review of literature describing the types of disposition will consider first those facilities that report a higher proportion of people being admitted for inpatient treatment. The facilities that report a higher proportion of persons being referred for outpatient treatment will be considered next. Finally, those facilities that present unique or distinctive patterns of disposition will be considered.

Researchers collecting data at three psychiatric emergency services connected with teaching hospitals report higher percentages of persons admitted to inpatient facilities (Ungerleider, 1960; Blais and Georges, 1969; Swartz et al., 1972). The percentages of persons admitted to inpatient units in these studies range between 40-50 percent. Swartz et al. (1972) reports that persons with multiple admissions to the Emergency Admitting Unit at the Orange County Medical Center were admitted to an inpatient unit more often than they were referred for outpatient treatment.

Two university hospitals report high proportions of referrals to outpatient treatment. This seems to be related to the provision of expanded services by the emergency room staff. The first hospital emergency room in Saskatoon, Saskatchewan (O'Regan, 1965) functions primarily as a screening facility and relies heavily on the use of family physicians both as referral sources and treatment resources. In addition brief therapy (6 visits) can be provided by the emergency service and there are three beds available for short-term inpatient treatment in the unit. Data was collected on 133 consecutive cases during 1974. Twenty-one percent of this population were referred for treatment at an outpatient facility and 39 percent were referred to private physicians. Thirty-eight percent of these emergency patients were admitted, half to be transferred to a state mental hospital. The other half were treated in the emergency service's three beds and discharged home.

Massachusetts General Hospital (Muller et al., 1967) also uses return appointments to the emergency service for follow-up. The staff of the emergency service felt that the patients using the return appointments were a component of marginal cases who could easily be hospitalized. Sixty-five percent of the 1,792 patients seen between March and August, 1965, were seen for follow-up by the psychiatric emergency service or were referred for outpatient treatment compared to 26 percent who were admitted to an inpatient facility.

Trier and Levy (1969) considered dispositions made in relation to the type of emergency. Persons judged to be in an emergent psychiatric crisis were most often admitted to an inpatient unit (84 percent) for

treatment. Persons judged to be experiencing a psychiatric emergency of an urgent nature were also more likely to be hospitalized (54 percent). Greater numbers of persons in the urgent category were referred for outpatient treatment (39 percent) than those persons in the emergent category (15 percent). The majority of persons in the elective category were referred for outpatient treatment (44 percent) as compared to those who were hospitalized (28 percent) and those who returned home (29 percent).

Watson (1969) considered disposition in relation to different diagnostic groups. Forty-three percent of the population seen at King's College Hospital in England during 1965 were hospitalized. Those who were admitted were more likely to have attempted suicide or to have made a suicidal gesture. Twelve percent of the population were referred for outpatient treatment and 11 percent were referred to a general practitioner. Those who were referred to either of these resources were diagnosed as neurotic more often than persons for whom other plans were made. Alcoholics comprised a majority of the 25 percent of the population who were allowed to return home without a referral.

It appears from the review of literature regarding dispositions developed for persons seen at psychiatric emergency services that several factors are crucial to this determination. The types of problems that clientele bring to a psychiatric emergency service as well as the acuteness of the problem or situation will affect the types of dispositions made. The particular services that are available at the facility at the time of the emergency will determine whether further

treatment is deemed necessary. Finally, the types of resources that are available in the community will affect the type and complexity of the disposition. Two studies describe facilities providing brief treatment and follow-up services by psychiatric emergency services. These facilities have been instrumental in linking clients to resources in the community for outpatient treatment and more extensive follow-up services. Both of these facilities admit fewer persons to inpatient facilities. Other studies describing psychiatric emergency services show proportionately more persons being admitted to inpatient units for treatment than those who are maintained as outpatients.

Summary

Studies that have researched the characteristics of consumers of psychiatric emergency services have been reviewed in relation to 11 variables. Generalizations that result from this review of recent literature and the factors that have been identified as affecting the findings for each of these variables are presented.

Research examining three demographic variables were reviewed. More studies report higher percentages of women in the population using psychiatric emergency services. Factors that interact with this variable are the number of previous hospitalizations, the type of psychiatric problem, the type of facility and service provided. Although the majority of persons using psychiatric emergency services are between 20 and 40 years of age, examination of data by population subgroups may reveal important utilization trends for specific facilities. Finally, the majority of clients using psychiatric emergency services are either single or married rather than divorced, widowed or separated.

Less conclusive findings are reported for other variables reviewed. The literature reviewed in this section suggests that psychiatric emergencies occur within all diagnostic categories. Psychoses were the only diagnostic category reflected by distinctively higher percentages among populations using psychiatric emergency services. The factors that affect diagnostic determinations are the practices of the particular institution, the patient's psychiatric history and the acuteness of the emergency. There is wide variation among researchers' methods of reporting symptomatology, but it is evident that self destructive behavior and the complaints of depression and/or anxiety are common to populations using psychiatric emergency services.

The results of research reporting data on the prevalence of previous psychiatric history among persons experiencing a psychiatric emergency and the duration of the presenting complaint among this population are inconclusive. No particular findings were generated about the types of service clients received at agencies that provide psychiatric emergency services. The review of current research reveals that the majority of clients arrive at a psychiatric emergency service during regular working hours on weekdays. The factors that are suggested which affect this finding are the availability of personnel and differences among referral sources.

The majority of clients coming to psychiatric emergency services were either self-referred (including referrals from family or friends) or were referred by professionals. The professionals most commonly cited as referring persons to psychiatric emergency services were law enforcement personnel and private physicians. Factors that interact

with data on referrals are the particular facility's protocol for referral, the publicity an agency receives, the type of clientele and the acuteness of the emergency.

The dispositions developed for clients fall into three general categories: to admit the client for inpatient treatment, to refer the client for outpatient treatment or to provide the client with no referral at all. Two university hospital emergency rooms that provide brief treatment and follow-up services reported low percentages of clients who were admitted to inpatient facilities compared to other university hospital emergency rooms. The factors that affect the types of dispositions developed for clients are the type and acuteness of the client's problem, the particular services available at the facility and the resources in the community that are available to the client.

THE ROLES OF DIRECT SERVICE PROVIDERS IN PSYCHIATRIC EMERGENCY SERVICES

This section reviews the roles of various direct service providers in psychiatric emergency services. Throughout this section the distinction is made between mental health professionals, paraprofessionals and law enforcement personnel. Professionals are those who have had graduate or postgraduate training, i.e., psychologists, psychiatric nurses, physicians, social workers and psychiatrists. Paraprofessionals are those who hold a bachelor's degree or who have had specialized training in the mental health field, i.e., mental health aides, registered nurses, social work aides or bachelor's degree social workers, trained volunteers, and bachelor's level counselors. These distinctions have been made purely

on the basis of training and it is recognized that many of those classified as paraprofessionals consider themselves to be professionals. For the same reason we have placed law enforcement personnel in a separate category. They have had a particular type of training, but it is also recognized that it is common for law enforcement personnel to hold bachelor's or master's degrees in related fields.

According to these delineations the roles of workers in psychiatric emergency services are reviewed in terms of the specific services they provide. Additionally, various reports describing interdisciplinary teams are reviewed; teams comprised of professionals and paraprofessionals from a variety of disciplines.

All agencies define the roles of service providers in particular ways, but usually according to the amount and type of training they have had. The literature on psychiatric emergency services is often unspecific about the exact roles and training of the personnel within these services. An effort is made here to distinguish between professional and paraprofessional roles when it is possible to do so.

Professional Roles

Typically, the professional whose role is most often defined in literature on psychiatric emergency services, is that of the psychiatrist. Blane et al. (1967) review emergency services in general hospitals and the staffing patterns and some role descriptions of these agencies. The authors report that the roles of psychiatrists and psychiatric residents may include consultant to other professionals and paraprofessionals, clinical teacher, supervisor, and direct service provider. Robert Atkins (1967), in addition to mentioning those roles listed

above, reports that the third-year resident at Strong Memorial Hospital in Rochester, New York, is on-call to the second-year residents, certifies involuntary patients, and runs a follow-up clinic.

The specific roles of other professionals in psychiatric emergency services is often not described. It is common for nurses to be reported as part of the personnel, but it is difficult to know whether the nurse is a paraprofessional or a professional (holds a graduate degree). One might assume that the term social worker would entail having a graduate degree, but this is not always so, since it is now possible for one to receive a bachelor's degree in this field. Ytrehus (1973), in discussion of the professional nursing role, states that "the tendency to specialize in different kinds of nursing, has given the nursing staff possibilities of working more independently on a higher professional level" (p. 29). In a discussion of an investigation on the role of the nurse in a psychiatric outpatient clinic, Ytrehus reports that

> 50% of the nurses said they took part in initial interviews, functioned as co-therapists, went home visiting, and acted as a link between their special institution and other institutions working in the same field (1973, p. 30).

The important role that the nurse (the level of training is not mentioned here) plays in the diagnosis and reshaping of suicidal and depressive behavior is reported by Frederick (1973).

The role of the social worker may involve consultation, collaboration, direct service to the patient, coordinating services and teaching (Ytrehus, 1973). Robert Atkins (1967) also refers to the teaching role of the social worker in the instruction of the matters of collateral visits and referrals to other agencies. Blane et al. (1967) refer to various general hospitals who utilize social workers in their psychia-

tric emergency services, but only refer to the specific role of the social worker in one facility, Massachusetts General Hospital. There, the social worker is the first to see the patient and is responsible for gathering information and assessing the patient's psychosocial context.

Paraprofessional Roles

The number of mental health professionals available to provide direct services is limited and most facilities depend on paraprofessionals to provide a large amount of this direct service. Brown (1974) and Carkhuff (1968) propose the need for more controlled studies of the effectiveness of paraprofessionals. Brown states that "collectively the studies over the past fifteen years provide compelling evidence as to the effectiveness of paraprofessional counseling" (1974, p. 258). Brown goes on to explain the effectiveness of paraprofessional counselors in terms of the selection process:

> Paraprofessional training programs carefully select psychologically healthy persons, while professional training programs emphasize selection on intellectual factors that may or may not correlate with effective interpersonal functioning (1974, p. 261).

Carkhuff (1968) points out the differences in training and treatment procedures to explain the differential results of lay and professional programs.

Paraprofessionals are often utilized by hot lines, and an example of such a service is the Alexandria Hot Line in Virginia (Preston, Schoenfeld and Adams, 1975). The hot line has a staff of volunteers responsible for the direct service, with professionals providing supervision and inservice training. Getz, Fujita and Allen (1975) studied

the use of paraprofessionals in a single-session crisis service which is part of a hospital's emergency room service. The crisis counselors (graduate students and community volunteers) were rated as helpful to very helpful by 85 percent of the follow-up respondents. The results of the study point out that intervention by paraprofessionals may have long-lasting effects in specific problem areas (depression, anxiety, family discord, suicide proneness).

Paraprofessionals such as nurses (without graduate degrees) and social work assistants, are now trained to provide psychiatric emergency services which previously have been provided by professionals. The use of social work assistants (Blane et al., 1967) in the emergency psychiatric service of Massachusetts General Hospital frees the social workers for more casework while a trained paraprofessional takes care of the details of placements, calls to other agencies and financial arrangements. The significant roles that nurses play in any psychiatric service is acknowledged by Wittington (1970) and Frederick (1973). Trier and Levy (1969) report that in the San Mateo County General Hospital emergency room nurses are needed for two-thirds of the emergent admissions (needed immediate attention) and one-fourth of the urgent admissions (could wait up to 24 hours for intervention). The authors do not define the educational level of nurses at this particular facility. Wittington (1970) describes the role of baccalaureate psychiatric nurses in Denver General Hospital's psychiatric emergency service. The nurses are referred to as nurse practitioners and are responsible for interviewing patients, providing disposition, referrals, follow-up, suicide telephone service, and crisis therapy. The hospital's use of the term "nurse practitioner" appears to be its own definition

and not the general term for registered nurses who have had advanced training in a particular area. It is Wittington's opinion that "the use of mental health nurse practitioners has much to commend it as a solution to the psychiatric needs of the general hospital emergency service" (1970, p. 54).

Conflicts may arise in any psychiatric emergency service regarding the roles of the service providers. Biegel (1972) recognizes the territoriality that exists between the various levels of personnel and makes several recommendations as possible solutions to this problem. They include inservice training in the management of psychiatric patients, follow-up reports on patients who were seen, and ready availability of crisis interventionists. Another solution might be the program described by Spitz (1976) where the distinction between roles of medical and non-medical staff in the psychiatric services of a general hospital have been dropped for the most part, with all workers performing similar tasks.

Interdisciplinary Teams

An alternative to relying on one type of professional or para-professional in psychiatric emergencies would be the development of an interdisciplinary team comprised of nurses of all educational levels, physicians, social workers, psychiatrists, psychologists, aides, etc., who would all participate in the evaluation and treatment of emergency clients. In a discussion of suicidal patients who need psychiatric intervention, Watson (1969) suggests that such a team is needed to do a full psychosocial assessment. An interdisciplinary team need not be limited to suicidal patients, but could also work with all psychiatric emergencies.

Rhine and Mayerson (1971) in their report of the emergency

psychiatric service (EPS) in the emergency room of Colorado General Hospital, discuss a permanent team on the service. The team is comprised of nurses (education level not specified), technicians, occupational therapists, psychiatric residents, social workers and a psychologist. The team does the initial evaluation, follows the patient through hospitalization and subsequent outpatient crisis therapy. The members of a similar team in a Canadian general hospital (Voineskos et al., 1974) are all called therapists and their roles are those of planner, coordinator, treater, and expediter. Additionally, the interdisciplinary team on the Emergency Treatment Unit at the Connecticut Mental Health Center was formed in an effort to de-emphasize traditional role definitions (Weisman et al., 1969). There is an emphasis on training and supervision in order that ETU nurses or aides can do therapy and interview patients.

The crisis team at the Temple Follow-up Service at Eastern Pennsylvania Psychiatric Institute provides a comprehensive service (Rubenstein, 1972). The team, consisting of a social worker, a psychiatric nurse, a psychiatric resident and a psychiatric staff doctor, is available for crisis referrals and home visits. The nurse's home visits often become the front line of service in helping families find solutions other than hospitalization for the patient. In describing the team relationship, Rubenstein writes that:

> We have established that treatment team members must have open and constant communication with each other in order to pursue an intensive and consistent intervention during crisis. This points up the essence of the team relationship in such a program, in which various professional disciplines must interact as equal participants with complete disregard of traditional status or hierarchy (1972, p. 719).

Law Enforcement Roles

Another important role in the management of psychiatric emergencies is that of the law enforcement officer. She/he is often the first one called to the scene of the emergency and therefore determines the disposition of the client. Hoffman and Fosterling (1975) state that

> In a very real sense the police officers are the community social workers; they are the ones who are called when someone has just attempted suicide, or when a family is having a shattering argument, or when a psychotic is directing traffic with no clothes on (p. 6).

A person in crisis may not get to a mental health clinic or an emergency room for a variety of reasons, but the knowledge that law enforcement personnel are available 24 hours a day, 7 days a week, may provide the needed link to those services. Lack of other resources is identified as the major reason why people call on the police in a psychiatric emergency (Bittner, 1967; Liberman, 1969). Bittner reports that in a 1 year period, the police referred 1,600 patients to a San Francisco public hospital's psychiatric service. Liberman reported that in Baltimore, 50 percent of mentally ill clients and their families use the police as a resource in getting to the state hospital.

Although they play a large role in the management of psychiatric emergencies, law enforcement personnel may have minimal training in this area. The Los Angeles Police Department instructs its officers on ways of working with the mentally ill for a total of 8 hours out of 840 hours of training (Snibbe, 1973). Jacobsen, Craven and Kushner (1973) questioned police officers who brought in mentally ill persons to the Los Angeles County University of Southern California Medical Center, and discovered that three-quarters of the officers had no

have been proposed. These resolutions are based on education and the development of communication between the various levels of providers. It has been pointed out that the level of training of service providers is often excluded in studies of psychiatric emergency services and the roles within these services. Reports on several services reveal that paraprofessionals are now providing many mental health services, which in the past were only provided by professionals. In these instances professionals are utilized as consultants and teachers. The roles of law enforcement personnel are also discussed and as indicated in the review they are often the front line service deliverers in psychiatric emergency services, although they may not have training in this area.

PURPOSE OF THE STUDY

The purpose of the study is to describe the delivery of psychiatric emergency services in selected Oregon counties, to identify variables that determine the nature of psychiatric emergency services provided, and to develop recommendations for existing psychiatric emergency services.

Objectives of the Study

1. To describe the existing agencies delivering psychiatric emergency services within selected counties in Oregon according to:

    a. type of facility

    b. staffing patterns and training

    c. types of services offered

    d. hours that the service is available

    e. availability of professional back-up

f. general trends

2. To describe the people who use a psychiatric emergency service during a specified period of study according to:

a. demographic data

b. diagnostic data

c. treatment received

d. disposition and referral

3. To obtain impressions from persons who deliver direct service in psychiatric emergencies according to:

a. respondent's role within the delivery of psychiatric emergency services

b. what types of personnel should deliver psychiatric emergency services

c. what types of facilities should deliver psychiatric emergency services

d. aspects of the psychiatric emergency service that are positive according to:

(1) staffing

(2) delivery of services

(3) facility

(4) coordination

e. aspects of the psychiatric emergency service needing improvement

f. descriptive comments regarding the major impediments to psychiatric emergency service delivery.

CHAPTER IV

METHODOLOGY

DEVELOPMENT OF METHODOLOGY

The methodology for this study was developed from: (1) preliminary interviews with major organizations involved in mental health planning and service delivery; (2) the compilation of responses to a questionnaire sent to community mental health program directors in Oregon identifying components of psychiatric emergency systems; (3) interviews with other persons who conducted research on psychiatric emergency services in Oregon; and (4) reading of the county mental health plans.

Preliminary interviews were conducted with organizations in the Metropolitan Tri-County area which are involved in mental health planning. These interviews were designed to gather background information describing the network of agencies that are linked to provide mental health services. The planning agencies interviewed were: Mental Health Association of Oregon, Tri-County Community Council, and Northwest Oregon Health Systems.

Interviews were also conducted with the directors of mental health programs in Clackamas, Columbia, Multnomah, and Washington counties. The purpose of these interviews was to obtain information in three areas: first, to determine the nature of psychiatric emergency services provided by mental health programs; second, to discern what information was routinely kept by mental health programs that would be accessible to the researchers for data collection; finally, the program director was

asked to indicate which areas in the delivery of psychiatric mental health services would provide useful data if researched. A questionnaire was designed to gather information similar to that obtained from the interviews conducted with the directors of mental health programs in the Tri-County area. The questionnaire was sent to the clinic directors of the remaining thirty-two counties. A summary of these responses was presented in the introduction and a copy of the questionnaire is included in Appendix A.

A third area of investigation in the development of the methodology was examination of other existing studies in Oregon on psychiatric emergency services. Interviews were conducted with persons who had researched similar problems and copies of the studies were obtained. These studies are: (1) "Emergency Services 1975," Eastern Oregon Comprehensive Community Mental Health Center, by James Atkins, Ph.D.; (2) "End of the Oregon Trail: Suicides 1894 through 1974," by James Shore, M.D. and Betty Arvidson, M.Ed.; (3) "Emergency Services," Jackson and Benton County, by Melinda Woodward (1976); (4) "Evaluation of the Involuntary Commitment Program Including Recommendations for the Future (Multnomah County)," by Charles Fosterling, MSW and Susan Hoffman, MSW; These studies were examined for potential data collection tools, problems that the researcher identified in the data gathering procedures and findings that could be substantiated or supported by additional research.

A fourth area of exploration in the development of the methodology was reading of the available county mental health plans. The purpose was to identify existing psychiatric services and assess county priorities for psychiatric emergency service systems in future county mental health planning. The plans were made available by the Program Office of the State Mental Health Division.

On the basis of these efforts to assess the current status of information available on psychiatric emergency services two conclusions were reached. The first was that mental health programs had access to data collected at their own agency but had no indication of the volume of service provided by other agencies in the same community. The other conclusion was that personnel in mental health programs had knowledge regarding psychiatric emergency services utilized in their community but had little information available to them about psychiatric emergency services available in other counties. Therefore, there was little information that documented the scope of psychiatric emergency service delivery in Oregon.

GENERAL DESIGN

The preliminary interviews and investigations provided a general overview of the psychiatric emergency service delivery system in the state of Oregon. The researchers developed more specific knowledge of existing resources and identified areas that would benefit from further study. In order to provide the most useful and comprehensive type of data the researchers chose to conduct a non-experimental descriptive field study. The purposes in formulating this design were that the research be statewide in scope, that it utilize existing mechanisms of data collection and retrieval, and that it include the major public agencies providing psychiatric emergency services. The study design provides a description of psychiatric emergency services offered by a selection of agencies and the characteristics of people who used the services. The design also includes a compilation of opinions held by direct service providers about the effectiveness of the psychiatric emergency service system.

SETTING

The setting of the study is described in two sections. The first section presents the criteria used to select counties for study and the general rationale for the selection of agencies studied within each county. The second section describes each county and each of the agencies studied within that county.

Selection of Counties

Five counties in the State of Oregon were chosen for the setting of the study. Counties were chosen for study on the basis of several criteria developed by the researchers to provide a representative picture of the characteristics of the state. The criteria for selection were that the counties represent:

(1) Varying population sizes

(2) Areas of increasing geographical size

(3) Urban and rural composition

(4) Increasing numbers of potential service resources

(5) The three regions of the Mental Health Division and admissions to the three state mental hospitals

(6) The different geographical regions of the state (N, S, E & W)

(7) Willingness to participate and convenience for the researchers

Within each county three agencies were studied: (1) the county mental health program, (2) the local hospital emergency room, and (3) the police department and/or county sheriff. The review of current research and the responses to questions in the interviews and on the survey questionnaire identified these three types of agencies as delivering the greatest volume of psychiatric emergency services. Additional agencies were chosen for study in Klamath County, Multnomah County and Washington County

because these agencies provide unique types of psychiatric emergency service.

Description of Counties

Klamath County. Klamath County is located in south-central Oregon, east of the Cascade summit and includes an area of 5,970 square miles. Douglas and Jackson Counties are located to the west. Deschutes County is located to the north and the State of California borders on the south. Klamath County is bounded on the west by Lake County.

The latest population count for Klamath County is 54,400 persons. Klamath Falls, with a population of 16,300, is the only community within Klamath County with a population over 1,000 persons. Eighty percent or 43,000 persons in Klamath County live within a five-mile radius of Klamath Falls.

Klamath County was chosen for study because large portions of the county are rural. It is geographically the largest county studies and served by one mental health program. This county is the only one studied in the southern portion of the state and has a population in the mid-range of all counties in Oregon. Persons from this county are admitted to the Oregon State Hospital in Salem for psychiatric treatment.

Two problems in delivery of service have been identified for this county (Klamath County Mental Health Plan, 1976-77). The first is that the size of the county makes access to mental health services difficult for approximately 20 percent of the population. The second is that because of the proximity to northern California the county is subject to significant migrations from the south. Many of these people are unemployed and transient which creates problems in providing service to those who lack adequate finances and a stable living situation.

Psychiatric patients may be directly admitted to the hospital by their attending physician or they may be seen in the emergency room and admitted by the physician who has seen them there. At the present time persons with psychiatric problems are admitted to a room on a general medical floor. Upon completion of the new psychiatric unit, patients may be admitted to the unit which will include a holding room.

There are 20 physicians who have staff privileges at the Presbyterian Intercommunity Hospital including two psychiatrists and one child psychiatrist. There are no psychiatric nurses available to nursing staff on the general medical-surgical floors or in the emergency room. Consultation is provided by the psychiatrists or staff from the mental health program.

(3) Law Enforcement Agency. The Klamath Falls Police Department maintains a 24 hour dispatch system. All emergency calls coming in to the department go through the dispatcher who determines which patrol units to notify and if more than one unit should be dispatched. The police also maintain a detention unit that is used for detoxification if the person refuses voluntary treatment or if the alcohol treatment center is full. The Klamath Falls Police Department and Sheriff's Office provide transportation for psychiatric patients from one facility to another. The Klamath Falls Police were instrumental in developing a coordinated protocol between agencies for the management of psychiatric emergencies that involve involuntary commitment proceedings.

(4) Hot Line and Crisis Service. The Hope in Crisis Hot Line and crisis service was chosen for study because it is available to community residents 24 hours a day, 7 days a week. The service is

staffed by trained volunteers and receives operating funds from United Way.

The hot line provides three services: (1) resource and referral, (2) crisis intervention, and (3) supportive listening. All volunteers who staff the hot line have completed an eight-session training sequence.

In addition, persons who call the hot line and require a personal response will be responded to by a team from the crisis service. This service is also staffed by volunteers who have participated in the telephone counseling service and have received an additional training course designed for the crisis service.

(5) Other. There are other agencies in Klamath County providing emergency or crisis services that were not the subjects of this study. Among these agencies are: Klamath Work Activity Center, Inc., Klamath Council on Alcohol, Klamath Alcohol and Drug Abuse, Inc., Children's Services Division, Public Welfare, Senior Citizens Council and counselors in the school system. In addition there is 1 psychiatrist, 2 psychiatric social workers, 1 counselor, and 1 clergyman who have private practices and provide emergency mental health services to clients.

Multnomah County. Multnomah County is the most populated county in the state with 556,667 residents, 384,000 of whom live in Portland (Multnomah County Mental Health Plan, 1976-77). This county is bounded on the west by Washington County, on the north by the Columbia River, on the east by Hood River County, and on the south by Clackamas County. Multnomah County was chosen for the study because of its highly urbanized and populated nature and because it offers a wide variety of psychiatric emergency services.

Nine agencies within Multnomah County were chosen for the study; Providence Hospital Emergency Room, Good Samaritan Hospital Emergency

Room, University of Oregon Health Sciences Center Emergency Room, Multnomah County Sheriff's Department, Portland Police Department, Outside-In, Suicide and Personal Crisis Service, Kaiser Mental Health Clinic, and Northeast Multnomah County Mental Health Clinic.

In addition to these services, there exist many other agencies that may provide some portion of psychiatric emergency services. These agencies include hospitals, hot lines, private practitioners, social service programs and volunteer programs.

(1) Mental Health Clinic or Program. The Northeast Multnomah County Mental Health Clinic provides outpatient mental health services to north and northeast Portland. It was chosen to represent a mental health clinic because of the diverse population it serves and because the director was in favor of permitting the clinic to be used in the study. The clinic is open during week days and persons with psychiatric emergencies can be served on a walk-in basis, or provided with telephone counseling and referral services. The staff includes a psychologist, psychiatrists, a mental health nurse and an aide, social workers and a guidance counselor who rotate on emergency duty.

Another mental health clinic that was studied is the Kaiser Mental Health Clinic which is part of a larger prepaid medical care system--Kaiser Permanente Health Plan. It is a non-county government facility. The Mental Health Clinic's staff consists of 3 physicians, 2 psychologists, 3 doctoral social workers, 3 master's social workers, 3 mental health assistants and 2 social work students. Bess Kaiser Hospital and Sunnyside Hospital are the general hospitals in the Kaiser System. Neither has a psychiatric unit, so psychiatric beds are contracted from Woodland Park Hospital. During working hours any of the therapists may do crisis intervention and after hours all calls go through

the main Kaiser switchboard. The operator can then telephone a master's or doctoral prepared staff member who is on call and will see the patient at the hospital emergency room if it is appropriate.

(2) General Hospital. The University of Oregon Health Sciences Center is the most widely utilized public hospital for psychiatric emergencies. Multnomah County contracts with this agency to provide 58 client visits per month to the emergency room. It is staffed by a psychiatric nurse, graduate nursing students and psychiatric residents. The hospital also offers an inpatient psychiatric unit and a psychiatric crisis unit. An outreach team, staffed by the psychiatric nurse and the graduate nursing students, provides follow-up on emergency room clients. The police and sheriff most often use the emergency room when they are dealing with someone who is in need of emergency psychiatric service.

The second general hospital studied in Multnomah County is Providence Hospital, located in northeast Portland. Providence Hospital is a private institution with a psychiatric unit and a recently developed social work service in the emergency room. Social workers serve as consultants to the emergency room Monday through Friday from 8:00 A.M. to 5:00 P.M. and from 6:00 P.M. to 11:00 P.M. Wednesday through Saturday. A psychiatrist is on call at any hour. Providence Hospital was chosen to represent a hospital with a psychiatric ward and because it offers the emergency room social work service.

The third general hospital studied in Multnomah County is Good Samartan Hospital, located in northwest Portland, an area with a large transient population and a large number of young adults. It was chosen to represent a hospital without a psychiatric unit, although it is utilized in psychiatric emergencies because of its accessibility to the northwest area. Its

psychiatric service consists of doctors from outside the hospital who serve as consultants. There are no psychiatrists on call in the emergency room and the physicians, nurses or aides who staff it have not received specialized instruction in the management of psychiatric emergencies.

(3) Law Enforcement Agency. The Multnomah County Sheriff's Department is the law enforcement agency responsible for the county, with the exception of incorporated areas of Portland and Gresham. The law enforcement officers in this agency typically become involved in psychiatric emergencies when someone is reported to be dangerous to himself/herself or to others. If the problem is not resolved at the scene of the call, the officer will take the person to the emergency room at the Medical School. If it is deemed necessary, the officer will also take the client to Dammasch.

(4) Hot line and crisis service. Outside-In was chosen to represent a mobile crisis intervention team and hot line. Of its staff the majority are volunteers and only a few are paid. It is the only mobile crisis intervention team in the county and has been in operation since 1968. The team is called the crash crew and it works from 10:00 P.M. to 9:00 A.M. Monday through Friday and 24 hours on Saturday and Sunday. Outside-In also provides a counseling center which operates from 7:00 P.M. to 9:00 P.M. Monday through Thursday. Medical services are offered during week days and will respond to walk-in emergencies and take emergency calls. Outside-In receives most of its donations from the Unitarian Church and Multnomah County Mental Health gives matching funds in return for contracted services. There are no charges to the clients for any psychiatric emergency services received. The staff receives

ongoing crisis intervention training and also provides a training program to the community.

Another agency of this type that was studied in Multnomah County is Suicide and Personal Crisis Services, a 24 hour telephone crisis service staffed by a half-time director and volunteers. It has been in operation since 1965 and is primarily funded by United Way. Volunteers must have at least a bachelor's degree or training in the behavioral sciences and are then trained in suicidology. All calls go through the Doctor's Exchange of Multnomah County and are then patched through to a volunteer on call who provides crisis intervention or referral. Twenty-five percent of the calls are suicide calls.

Tillamook County. Tillamook County, located on the northwest coast of Oregon, is approximately 50 miles long and an average of 25 miles in width. The county is bordered by Clatsop County to the north, Washington, Yamhill and Polk Counties to the east and Lincoln County to the south. The county covers a land mass of 1,115 square miles, much of which is located in the rugged coast range mountains. Approximately two-thirds of the east portion of Tillamook County is virtually uninhabitable due to rough mountainous terrain and poor primary and secondary roads.

Tillamook County has a population of approximately 18,500 persons. The population density of the county is 16 persons per square mile. This compares to 35.4 persons per square mile in Clatsop County which borders Tillamook County on the north. Seventy-five percent of the total population live within a 15 mile radius of the city of Tillamook. The remaining portion of the population is widely dispersed in small farmland communities and residential areas.

Tillamook County was chosen for study because of its rural nature. It was also chosen because of its location in the western portion of the state and because it could be compared to Union County which is of similar population size in the eastern portion of the state. Persons from this county are admitted to Dammasch State Hospital for psychiatric treatment.

Two potential problems in the area of service delivery have been identified (Tillamook County Mental Health Plan 1976-77). The first is that the population is scattered throughout the county and that transportation between small towns is limited. The second is that there is a large group of persons present in the county who are not residents but may require the delivery of mental health services.

The four agencies studied that deliver psychiatric emergency services in Tillamook County are the Tillamook County Mental Health Program, the Tillamook County General Hospital, the City of Tillamook Police, and the Tillamook County Sheriff.

(1) Mental Health Clinic. The Tillamook County Mental Health Program offers a variety of services in the program areas of mental emotional disturbances, mental retardation, developmental disability, and alcohol and drug problems.

Psychiatric emergency services are provided on an "on-call" basis, 24 hours a day, 7 days a week. The hospital and law enforcement agencies have the names and home phone numbers of the clinic staff. The staff are called for emergencies that arise after regular clinic hours. Specific staff members have been designated to deal with emergencies that involve potential involuntary commitment and alcohol and/or drug abuse.

The mental health program has been concerned about the delivery of psychiatric emergency services for some time. This program spearheaded a conference on crisis or emergency services in May 1975 for all social service agencies in the county. The purpose of the conference was to upgrade and coordinate services provided by a multitude of agencies.

(2) General Hospital. The Tillamook County Hospital is a facility which has recently undergone administrative and structural changes. The Portland Adventist Church became involved in operating the Tillamook County Hospital during 1975-1976.

Shortly thereafter construction was begun to enlarge and improve the facility. The plans include a new and larger emergency room. The present emergency room has a two- to four-bed capacity which is generally staffed by one registered nurse. The hospital also has a holding room for psychiatric patients but because of construction it has not been available for use much of the time.

Psychiatric patients who are admitted through the emergency room are placed in the holding room or, if available, one of the rooms used for medical-surgical patients. Persons who are admitted involuntarily are placed in the holding room until transportation can be arranged to Dammasch State Hospital.

There are three to four physicians and several osteopaths who practice in Tillamook County with staff privileges at the hospital. There are no psychiatric nurses available to nursing staff on the general medical-surgical floor or to the nurses in the emergency room. The part-time psychiatrist or other staff from the mental health clinic are available to the hospital for consultation and training. Individual physicians and nurses have been cooperative in regard to providing

services to psychiatric patients but the general attitude of medical and nursing personnel is that they do not have the skills or facility to manage this type of patient.

(3) Law Enforcement Agencies. The Tillamook County Sheriff's Department and the City of Tillamook Police Department were the two law enforcement agencies studied. The majority of psychiatric emergencies in the county are handled by these two agencies rather than the State Police.

The City Police Department maintains a dispatch system during the day and evening. The Sheriff's Department maintains a 24 hour dispatch system. This system is used by the Police Department during the early morning hours and by the Mental Health Program after 5:00 P.M. on week days and on weekends.

Persons calling the police or Sheriff's Department speak with the dispatcher first, who then notifies the nearest patrol car, or begins to locate the person "on-call" at the Mental Health Program. Officers who are in the field also report their activities to the dispatcher. The dispatch system appears to be a key element in service delivery for this community.

The County Sheriff's Department also houses the jail which is used by both law enforcement agencies. The jail is used for alcohol detoxification in addition to criminal detainment.

The County Sheriff also will provide transportation for psychiatric patients from Tillamook County to Dammasch State Hospital since no other adequate means of transportation exists. This has created staffing problems for a small law enforcement agency.

The City Police report that they have been asked to provide assistance to hospital personnel when psychiatric patients have been admitted

involuntarily and are considered threatening or unmanageable. This practice also creates staffing problems for the Police Department.

(4) Other. There are other agencies in Tillamook County that provide emergency or crisis relief in Tillamook County, that were not the subjects of this study. They include Public Welfare, Children's Services Division, the Alcohol and Drug Center, Food Stamp Office, and the Juvenile Department, and the clergy and counselors in the school system. The county mental health plan states that some Tillamook County residents have been known to obtain mental health services in Beaverton, McMinnville and Salem (1976-77).

Union County. Union County is located in the northeast portion of the state of Oregon. It is approximately 60 miles from north to south and 50 miles east to west. The county is bounded by Baker County on the south.

Union County was chosen for study because it is primarily rural and is located in the eastern portion of the state. It is similar in population size to Tillamook County and both are in the lower population range. In addition Union County participated in another study (James, 1976) on psychiatric emergency services and had data that was readily available. This county admits psychiatric patients to the Eastern Oregon State Hospital.

The population of the county is estimated at 20,900 people who are located primarily in the county seat, La Grande, and 13 other small towns. The city of La Grande has an estimated population of 10,000 people. Union County appears to have significant portions of community life involved in agricultural pursuits while another large proportion are represented by corporate industry, a liberal arts college, and small business.

The geographical size of the community has been identified as a problem in the delivery of service (Union County Mental Health Plan, 1976-77). Because the population appears to be so widely dispersed active outreach and transportation services have been developed for persons requiring mental health services.

There were three agencies studied in Union County, the Union County Mental Health Program, Grande Ronde Hospital, and the La Grande City Police Department.

(1) Mental Health Clinic. The Union County mental health program is located several blocks out of the downtown area and is situated adjacent to the hospital. The clinic provides a full range of services for the programs area's mental emotional disturbances, mental retardation, development disabilities and alcohol and drug problems. This clinic is also a member of the Eastern Oregon Comprehensive Community Mental Health Center and receives federal funds.

Twenty-four hour emergency psychiatric services are provided 7 days a week by clinic staff who rotate responsibility for the on-call service. Service is generally provided over the telephone although staff may choose to provide face-to-face intervention. The clinic staff may also be called by the hospital or Police Department to provide an evaluation or assistance in psychiatric emergencies. The clinic is also able to provide mental health services to persons who walk in and request them. The person on emergency call is usually the one who will see the person.

The program utilizes the services of a part-time psychiatrist who provides both direct service, including home visits, and back-up to the clinic staff. The psychiatrist also is on the staff at Grande Ronde Hospital and is often consulted regarding psychiatric patients who are being seen in the emergency room.

(2) General Hospital. Grande Ronde Hospital is located several blocks from downtown La Grande, and is located in a building adjacent to the mental health program. The hospital is a privately funded facility that is undergoing construction and expanding services.

The emergency room is a two- to four-bed facility staffed by a registered nurse or licensed practical nurse. Psychiatric patients who are admitted to the hospital either directly or through the emergency room are placed in a room on a general medical-surgical floor. The hospital is remodeling the one holding room so it has not always been available for use by psychiatric patients.

There are approximately 40 physicians who have staff privileges at the Grande Ronde Hospital, one of whom is a psychiatrist. The nursing service has used the psychiatrist (and a graduate student in psychiatric mental health nursing) to provide inservice training to the nurses in the hospital. In addition, the staff at the mental health program provide consultation to nursing staff for any clients of the program who are admitted to the hospital. The mental health program staff also provide psychiatric consultation and evaluation services to the hospital for patients being seen in the emergency room or who have been admitted.

(3) Law Enforcement. The La Grande City Police Department is located in the downtown area and is reported to manage the majority of psychiatric emergencies that come to the attention of law enforcement agencies in the area. The Police Department maintains a 24 hour dispatch system 7 days a week. Any emergency calls coming to the police go through the dispatcher who then notifies a patrol car. The activities of patrolmen are also coordinated through the dispatcher.

Persons in a psychiatric emergency who first come in contact with the La Grande City Police may be transported or are urged to transport

themselves to the Grande Ronde Hospital. The police maintain an active consultation agreement with the Union County Mental Health Program. Staff from the mental health program may be asked to meet the police officer to provide evaluation and intervention with psychiatric emergencies. The City Police Department maintains a detention facility that is used for detoxification in addition to criminal detainment.

(4) Other. There are other agencies in Union County that provide emergency or crisis services that were not the subjects of this study. They are Children's Services Division, Public Welfare Department, the Union County Alcohol and Drug Unit and the Juvenile Department. In addition, one psychiatrist has a part-time private practice and several clergymen provide mental health counseling.

Washington County. Washington County is located west of Portland and is bordered by Columbia, Clatsop, Tillamook, Yamhill, Clackamas and Multnomah Counties. There are 716 square miles in Washington County and the population is 190,900, the third largest in the state. The east end of Washington County is mostly suburban. It is oriented to light industry and considered a bedroom community of urban Multnomah County. Many Washington County residents work in Multnomah County and therefore do utilize the resources there. The west end of Washington County is rural and agricultural.

Washington County was chosen for study because of its suburban/rural nature, and because its population is in the upper two-thirds of the population range of all counties in the state. The Mental Health Program in this county admits psychiatric patients to Dammasch State Hospital. Community agencies which provide unique types of services to persons in a psychiatric emergency expressed strong interest in participating in the study.

Four agencies were chosen for study in Washington County. They were Tuality Community General Hospital, Washington County Sheriff's Department, Washington County Mental Health Program, and Tualatin Valley Guidance Clinic.

(1) Mental Health Clinic or Program. Washington County Mental Health Program was chosen because it is the county mental health agency. The Washington County Mental Health Plan (1976-77) was developed from this office and lists psychiatric emergency service as first priority. The Washington County Mental Health Program has the ability to serve walk-in emergencies from the hours of 8:00 A.M. to 5:00 P.M. After 5:00 P.M. there is an answering service which refers the caller to the Sheriff dispatcher. The mental health worker on call carries a beeper through which the dispatcher can locate the worker. The worker then can respond appropriately to the crisis.

Washington County Mental Health Program has a commitment-diversion program that can respond to persons defined as psychiatric emergencies, who are dangerous to self or others, by telephone, walk-in or by outreach during 8:00 A.M. to 5:00 P.M. There is also an alcohol and drug program that has staff to respond to emergencies from 8:00 A.M. to 5:00 P.M. The same staff are responsible for all on-call coverage. The Mental Health Program does not operate as a direct service clinic since it is not set up primarily for individual, group and family therapy although it fulfills direct service functions.

The second mental health clinic or program studied in Washington County is the Tualatin Valley Guidance Clinic. It is one of five subcontract agencies of Washington County Mental Health Program including Lutheran Family Services, Metropolitan Family Services, Cedar Hills

Psychiatric Hospital and Tualatin Valley Workshop. It was chosen because it was the first mental health clinic in the county. Prior to the creation of Washington County Mental Health Program, the director of Tualatin Valley Guidance Clinic was also the director of Washington County Mental Health Program. Tualatin Valley Guidance Clinic is a private non-profit corporation and no longer is responsible for the county mental health program. Washington County is unique in that the mental health program is not defined as a clinic, and the clinics are not a county facility.

Tualatin Valley Guidance Clinic has the capability to respond to psychiatric emergency by telephone or walk-in during clinic hours. The clinic has no provision for psychiatric emergency services after 5:00 P.M. on Mondays, Wednesdays, and Fridays, and after 9:00 P.M. Tuesdays and Thursdays.

(2) General Hospital. Tuality Community General Hospital is located in the city of Hillsboro. The emergency room is staffed by one registered nurse, aides and on-call physicians. The staff in the emergency room see an average of 10 psychiatric emergency cases per month. A private psychiatrist serves as a consultant to the hospital staff. Tuality Community General Hospital has one holding room for use by psychiatric patients. The holding room is also used as an additional room for non-psychiatric patients, in which case it is not available for psychiatric emergency use. In the spring of 1976 the staff at this hospital participated in an 8 week course designed to teach the principles of managing psychiatric emergencies.

(3) Law Enforcement Agency. The Washington County Sheriff's Department is on duty 24 hours per day. The researchers consider

law enforcement agency as a primary emergency care giver since it has traditionally been available 24 hours a day and has always had the capability of meeting a person in crisis face-to-face. Often people in crisis call the police or sheriff. Washington County Sheriff's Department has a unique 24 hour dispatch system which connects, if necessary, to the Washington County Mental Health Program employee on-call. Due to this linkage Washington County residents have availability of a mental health worker by telephone 24 hours a day.

(4) Other. There are other agencies in Washington County that provide emergency or crisis services that were not the subjects of this study. There is an information and referral telephone service funded by Tri-County Community Council. This telephone service refers psychiatric emergencies to one of the three Washington County Mental Health Clinics during the daytime hours. After 5:00 P.M. the Washington County telephone number is responded to by the Portland branch of Tri-County Information and Referral Service. These psychiatric emergencies are referred to available agencies in Multnomah County.

POPULATION AND SAMPLE

Four sample populations are described including: (1) individual counties, (2) individual agencies in each county, (3) individuals utilizing the psychiatric emergency service, and (4) individual direct service providers.

Counties

Of the 36 Oregon counties, five counties were selected and met the criteria discussed in the previous section. Since this selection

was not randomized, the sample is considered the population, and the results from this sample are not generalized to other counties.

Agencies

Within each of the five counties selected, a minimum of three agencies were chosen to provide data. They were the mental health clinic, a general hospital, and law enforcement agency. These three types of agencies were studied in Tillamook and Union counties. Additional agencies were selected for data collection in Klamath, Washington and Multnomah counties. Again, the sample of the agencies is also the population since no randomization occurred.

Individuals Utilizing the Psychiatric Emergency Service

At each agency a sample of client records or charts was randomly selected from the population of clients who received psychiatric emergency services during the months of July, August, and September, 1976. The following procedures were used to select the sample:

(1) If the population was less than 10, all the records were selected as the sample used for data collection.

(2) If the population was between 10 and 20, a random numbers table was used to select a sample of ten.

(3) If the population was greater than 20 but less than 30, a random numbers table was used to select a sample of 30.

(4) If the population was 30 or greater but less than 100, a systematic sample from a random start was used to yield a sample of 20.

(5) If the population was greater than 100, a sample of 20 was selected systematically from a random start.

The sampling procedure determined that the size of the sample selected would be between 1 and 20 depending upon the size of the population. A random sample was selected when the population was greater than 10 and a 100 percent sample was used when the population was less than 10.

Direct Service Providers

A maximum of 15 direct service providers at each agency were asked to fill out the subjective questionnaire. The contact person distributed the questionnaire to the personnel of his/her choice with the instructions that they be given to direct service providers with different educational and experiential backgrounds.

RESEARCH INSTRUMENTS

Services Interview

The first research instrument used in this study was the Services Interview. This tool was developed by the researchers as a compilation of the responses to key questions collected in the preliminary open-ended interviews. The services interview was designed to be administered in a variety of agencies including police/sheriff departments, hot lines, hospitals and clinics. A structured interview was the format for the administration of this tool. This format was chosen because it controls the volume of response and standardizes the interview procedure.

Purpose. The purposes of the tool were:

(1) To describe the available psychiatric emergency services, including telephone, walk-in, outreach, transportation, consultation and referral.

(2) To identify the staffing of these services.

(3) To identify the educational preparation of staff involved in psychiatric emergency situations.

(4) To investigate the availability of inservice training in the management of psychiatric emergency.

(5) To obtain from the interviewee estimates of the utilization of the services per typical month.

Rationale. The structured interview method was chosen for several reasons:

(1) To limit the time involvement of the interviewee which increases the probability of obtaining consent to conduct the interview.

(2) To increase the degree of consistency between the three interviewers.

(3) To allow for computerization of responses.

Procedures. The interview was conducted with the contact person or other person designated by the contact person at each agency. At the beginning of the interview, the researcher explained the purpose of the information being requested. At the termination of the interview a final open-ended question was asked to obtain any additional information not included in the questionnaire. A list of definitions were compiled by the researchers to provide clarification of the terminology used in the interview. The primary definitions were explained prior to the interview.

Validity and Reliability. The Services Interview was reviewed by a group of experts in the mental health field (both researchers and professors). They judged the instrument to be appropriate to the focus of the study, and recommended changes which would facilitate administration of the instrument. The interview was administered to a group of four mental health professionals (including two of the researchers) and the reliability coefficient between raters was 1.0.

Client Data Sheet

The second research tool used in this study was the Client Data Sheet. This tool was developed by the researchers from a combination of existing instruments. The instruments that were used in the development of this tool are: (1) The Emergency Service Record developed by James Atkins, Ph.D. Program Evaluation and Research Specialist, to gather data on emergency events at the clinics in the catchment area of the Eastern Oregon Comprehensive Community Mental Health Center. (2) The Emergency Services form developed by Melinda Woodward, who was requested by the State Mental Health Division to gather data in Benton and Jackson Counties. These studies and the results were discussed in the review of literature. (3) The Multi-State Information System forms were used as a guideline to develop similar service and referral information. The researchers used portions of previously developed data collection tools in the formation of the client data sheet to allow for inter-study comparison, to augment data already collected and to benefit from other researchers' revisions of data collection tools.

The format for this instrument was the collection of existing data in the form of a retrospective chart search. The existing data was considered to be in raw form because clients' charts or records were used, which were not designed as research instruments but as administrative documents. Therefore, tabulations of the client data were made by the researchers. A limitation of using this form of data is that there is a high degree of variability between individual records and between the types of information in the records at each agency.

Purpose. The purpose of the client data sheet was to obtain descriptions of the people who use the service. This information was gathered in four areas:

(1) Demographic data.

(2) Diagnostic data and elements of the problem situation.

(3) The types of services each person received at the agency.

(4) The disposition and referral of the case.

Rationale. This method of collecting data from existing sources was preferred to client interviews or observations for several reasons:

(1) To limit the time involvement.

(2) To protect the client experiencing a psychiatric emergency from additional trauma associated with a research interview.

(3) To gain information about the crisis and the types of services recorded at the time of occurrence rather than at a later time.

(4) Some information being requested could not be obtained from the client in the most accurate fashion.

Procedure. A list of all clients' names or chart number who received service during the months of July, August, and September 1976 was obtained by the researcher from the service log, appointment sheet, record file, or computer printout. All clients received a number and from this list a random or 100 percent sample was taken depending on the size of the total population. The selected charts or records were then reviewed by the researchers at the agency and appropriate information was transferred to the client data sheet. Client confidentiality was insured by giving each client data sheet a consecutive number without utilizing names or any identifying information. This list of clients' names or record numbers was then destroyed by the researchers in the presence of someone from the agency.

Validity and Reliability. The procedure to establish the validity of the Client Data Sheet was identical to that used with the Services

Interview. The Client Data Sheet was reviewed by the same group of experts in the mental health field (both researchers and professors). They judged the instrument to be appropriate to the focus of the study and recommended changes which would facilitate more reliable sampling of the client charts. Five mental health professionals (including the three researchers) independently completed Client Data Sheets, using a sample client chart provided by the researchers. The reliability coefficient between raters was .98.

Psychiatric Emergency Services Questionnaire

The third research instrument used in this study is the Psychiatric Emergency Services Questionnaire. During the preliminary interviews, many interviewees expressed a concern that there was an inconsistency between how the mental health program is designed to operate and how it actually functions.

This tool was developed to examine this concern and survey the care givers' opinions in terms of the most positive aspects and the aspects most in need of improvement in the psychiatric emergency service system. This tool was designed not only to be given to a variety of persons with varied educational and professional backgrounds, but also a variety of agencies.

With the exception of the final question which was open-ended, the format for this instrument was a closed form, self-administered questionnaire. Persons filling out the questionnaire were asked to check appropriate response choices from six or more alternatives. The closed form limits the scope and depth of responses but permits a standardization of possible responses. An open-ended "Other" category was included to allow for the lack of possible appropriate answers. This category was provided

to consider various settings, unique experiences and special circumstances that are not reflected in the tool. Ten of the 16 items utilized a rank order method of rating which required the ordering of three aspects of the psychiatric emergency service in order of importance. There were a minimum of nine available choices per question.

A cover letter was attached to the questionnaire which explained the purpose of the questionnaire and the study and asked for the response, help and cooperation in completing and returning the instrument. The researchers felt the cover letter improved the likelihood that the questionnaire would be completed. Enclosed was a self-addressed stamped envelope in which the questionnaire was to be returned.

Purpose. The major purpose of the tool was to determine how individual care givers viewed the effectiveness of psychiatric emergency service delivery. Effort was made to include service providers with a variety of educational backgrounds and experiences.

Rationale. The closed form, self-administered questionnaire was chosen for several reasons:

(1) To obtain valuable information without time commitment of the researcher.

(2) To provide an instrument which would elicit subjective information not obtainable by interview, that also protected the individuals confidentiality.

(3) To facilitate the tabulation and analysis of the data by limiting the possible choices on each question.

The ranking method was included in the questionnaire in order to reduce the length of the questionnaire; to cite the individual's opinion of the most important aspects of the psychiatric emergency service within

a select number of choices; to be able to compare anonymous answers within an agency and to facilitate the compilation of data.

Procedure. At the time of the services interview with the contact person, the Psychiatric Emergency Services Questionnaire was explained by the researcher. The contact person was given copies to distribute among a variety of interested staff who provide service to persons in a mental health emergency.

In agencies with less than 10 staff, all staff were given questionnaires. In larger agencies 10 to 15 were distributed, to increase the return yet still limit the volume of data received. The directions to the questionnaire were self-explanatory. It required approximately 20 to 30 minutes to complete. Having been provided with a stamped, self-addressed envelope, the respondent could then mail the completed questionnaire to the researchers and maintain anonymity.

Validity and Reliability. The procedure to establish the validity of the Psychiatric Emergency Services Questionnaire was identical to that used for the other instruments. A group of experts in the mental health field (both researchers and professors) judged the instrument to be appropriate to the focus of the study. They recommended changes which would facilitate completion of the questionnaire by direct service providers. The reliability was not checked on this instrument.

PRETESTING THE RESEARCH INSTRUMENTS

Two of the research tools, the Services Interview and the Client Data Sheet, were pretested at the Columbia County Mental Health Program (Columbia County Adult and Child Guidance Clinic). The Services Inter-

view was conducted with the director of the program and his responses to each question in the interview were recorded independently by the researchers. The Client Data Sheet was used to collect data from four client records and the researchers collaborated when either the client record or the tool was unclear. The recorded responses were compared, the terminology was clarified to improve reliability between interviewers, and revisions were made on both data collection tools. The Psychiatric Emergency Services Questionnaire was distributed to the staff but their responses were not received by the researchers prior to the time that further data gathering occurred.

PILOT STUDY

The research methodology was piloted at four agencies in Tillamook County. The researchers conducted the pilot study to identify problems in the administration of the revised data collection tools and the procedure for selecting a sample of client records. The Psychiatric Emergency Services Questionnaire was evaluated according to the number of questionnaires that were returned and the number of questionnaires that were usable.

There were no problems identified in the use of the revised Services Interview or the Client Data Sheet. A client sample was obtained at each agency according to the sampling procedure. It was found that each agency used a different method of identifying the population of clients who received psychiatric emergency services. No changes were made in the sampling procedure because the researchers' definition was used to identify the population of psychiatric emergencies that the client sample was taken from and not the agency's definition.

The evaluation of the Psychiatric Emergency Services Questionnaire resulted in minor revisions to clarify the directions for filling out the questionnaire. A total of 37 questionnaires were distributed to personnel in the four agencies participating in the pilot study. The number of questionnaires that were returned was 24, or 65% of the total number distributed. Each questionnaire was evaluated to determine the responses that were usable from those that were not completed correctly. Questionnaires with two or more categories not completed were considered unusable. Of the 24 returned questionnaires 19, or 70% were completed correctly. Eight questionnaires were considered unusable. The examination of responses to the questionnaires indicated that no individual item was consistantly left blank or completed incorrectly. No particular type of direct service provider returned fewer questionnaires or completed fewer numbers of questionnaires correctly.

STATISTICAL PROCEDURES

The three research tools were designed with a coding system that could be computerized to ease tabulation. When the data collection was complete it was keypunched and programmed for frequency tallies and percentages. Each research instrument was separately tabulated. The keypunched cards for the Service Interview and the Client Data Sheet were sorted by individual counties surveyed and by types of facilities surveyed. The keypunched cards for the Psychiatric Emergency Services Questionnaire were sorted by individual counties, by type of facilities and by occupational roles of the service providers in the facilities. Percentages and frequencies were computed for individual items on each research instrument. These figures were then used to compare and describe the variables studied.

CHAPTER V

ANALYSIS AND INTERPRETATION OF DATA

INTRODUCTION

The analysis and interpretation of data is presented in three sections, coinciding with the three research instruments: the Service Interview, the Client Data Sheet, and the Psychiatric Emergency Services Questionnaire. Twenty-four agencies which provide psychiatric emergency services were studied. The analysis of the Service Interview includes descriptions of who provides psychiatric emergency services in these facilities, what special types of services are offered, and the estimates of the number of psychiatric emergency contact that each agency has per typical month.

The next section is the analysis of the Client Data Sheet. Data were collected from 19 of the 24 agencies and this sample totaled 224 clients seen during the months of July, August, and September, 1976. This section describes the demographic characteristics, the types of services received, and dispositions of the client sample.

The last section of the chapter is the analysis of the Psychiatric Emergency Services Questionnaire. In each agency approximately 10 questionnaires were distributed to personnel who provide psychiatric emergency services. The data are described according to the occupational roles of those who filled out the questionnaire and their opinions of who should deliver psychiatric emergency services, who delivers the

majority of psychiatric emergency services in their agency, and what prevents personnel from delivering psychiatric emergency services. This section also describes the direct service providers' opinions of the most important positive aspects of their psychiatric emergency service and those aspects most in need of improvement.

SERVICE INTERVIEW

The results of the service interview provide a description of what psychiatric emergency services exist in the 24 facilities studied, and what types of staff are available to provide these services. The 24 facilities include the emergency rooms of 2 general hospitals with psychiatric units, the emergency rooms of 5 general hospitals without psychiatric units, 3 hot lines, 7 mental health clinics and 7 law enforcement agencies.

Number of Staff

Tables XXXIV through XXXVIII (Appendix C) show the numbers and types of staff providing psychiatric emergency services in each facility. Table I, below, presents the total number of staff in each type of facility.

General Hospitals with Psychiatric Units. In this category, two emergency rooms were studied and both are located in Multnomah County. Providence Hospital's emergency room has the greater number of staff who work with psychiatric emergencies in all categories but one (physician). The University of Oregon Health Science Center's emergency room has six physicians who provide psychiatric emergency services, while Providence Hospital has five.

TABLE I

NUMBER OF STAFF PROVIDING PSYCHIATRIC EMERGENCY SERVICES IN ALL FACILITIES

Type of Staff	Type of Facility						
	Gen.* Hosp. With	Gen. Hosp. W/out	Hot Lines	Mental Health Clinic	Law Enf.	TOTAL	%
Volunteers	0	0	157	0	0	157	12%
Parapro-fessionals	27	40	4	15	19	105	8%
Master's Prepared	13	0	1	25	0	39	3%
Doctoral Prepared	1	0	0	14	0	15	1%
Physicians	21	95	0	1	0	117	9%
Psychia-trists	43	4	0	10	0	57	5%
Law Enf. Pers.**	6	0	0	0	780	786	62%
TOTALS	111	139	162	65	799	1276	100%

* Gen. Hosp. With is General Hospitals with Psychiatric Units
Gen. Hosp. W/out is General Hospitals without Psychiatric Units
Law Enf. is Law Enforcement Agencies
**Law Enf. Pers. is Law Enforcement Personnel

General Hospitals Without Psychiatric Units. The type of personnel in the emergency rooms of the five general hospitals without psychiatric units is quite different than the personnel in the two hospitals with psychiatric units. In the former case, there are no master's or doctoral prepared personnel to work with psychiatric emergencies in any of the five hospitals. These emergency rooms depend on nurses without advanced education in the area of mental health and non-psychiatric physicians to care for the majority of psychiatric emergencies, with psychiatrists normally on an on-call basis. The 95 physicians providing psychiatric emergency services in the emergency rooms of hospitals without psychiatric units do not usually work in the emergency room, but are on-call to any emergency cases brought to the

emergency room.

Hot Lines. The greatest number of psychiatric emergency service providers in the three hot lines studied are volunteers. Outside-In is the only hot line which has paid paraprofessionals (four) and Hope in Crisis Hot Line has the only paid master's prepared person. The volunteers in all three agencies have a variety of backgrounds, from that of a high school degree to a psychiatrist. In order to delineate between volunteer and paid staff, all volunteers have been placed in the same category. The hot lines are the only agencies of the total 24 which have volunteers providing psychiatric emergency services.

Mental Health Clinics. In the seven mental health clinics studied, there are more master's prepared professionals providing psychiatric emergency services than any other type of staff. Kaiser Mental Health Clinic (the only noncounty or noncontract clinic studied) has the highest number of professionals in all categories (master's, doctoral, physician, psychiatrist) of the seven clinics. The total number of staff varies little between the seven clinics (six clinics have between 8 and 11 staff members providing psychiatric emergency services), although Union County Mental Health Clinic does have a smaller number (6). Washington County Mental Health Program is the only mental health clinic with a physician available for psychiatric emergencies.

Law Enforcement Agencies. This category has the largest number of personnel available to provide psychiatric emergency services. For convenience in comparing law enforcement personnel between counties, all personnel with law enforcement training (i.e., dispatchers and patrolmen/women) are in one category, while the secretaries (paraprofession-

als) are in a separate category. In all counties, the law enforcement personnel have varied educational backgrounds, and it is common for officers to have one or more bachelor's or master's degrees. As would be expected, the urban counties have larger numbers of law enforcement personnel (Portland Police, 385; Multnomah County Sheriff, 184; and Washington County Sheriff, 150). Klamath Falls City Police, Multnomah County Sheriff and Washington County Sheriff are the only law enforcement agencies which report that secretaries provide some form of psychiatric emergency service. The only other type of agency which has law enforcement personnel providing psychiatric emergency services is the general hospital with a psychiatric ward. The emergency rooms in both Providence Hospital and the University of Oregon Health Sciences Center have security guards who will assist with violent psychiatric clients.

Totals. Table I provides the total number of personnel according to type of training and the percentages of these categories. Of the 1,276 personnel in 24 facilities, 62% are law enforcement personnel, the greatest percentage of all types of personnel. The smallest percentage is the category of doctoral prepared professionals. Excluding law enforcement personnel, volunteers comprise the greatest percentage of the remaining personnel. The percentage of physicians (9%) is inflated by the large number of doctors in emergency rooms of hospitals without psychiatric units who are generally on-call for psychiatric emergencies.

Type of Services Offered

The 24 facilities were asked what types of psychiatric emergency services they provide (Table II). These services are divided into

TABLE II

TYPES OF PSYCHIATRIC EMERGENCY SERVICES PROVIDED
ACCORDING TO NUMBER OF FACILITIES

	Number of Facilities					
Type of Service	G.H.* With N=2	G.H. W/out N=5	Hot Lines N=3	M.H. Clinic N=7	Law Enf. N=7	FACILITY TOTAL N=24
Telephone 1-8 hours	0	0	0	1	0	1
Telephone 1-16 hours	0	0	0	1	0	1
Telephone 1-24 hours	2	5	3	5	7	22
Walk-in 1-8 hours	0	0	1	6	0	7
Walk-in 1-16 hours	0	0	1	1	0	2
Walk-in 1-24 hours	2	5	1	0	5	13
Outreach 1-8 hours	1	0	0	3	0	3
Outreach 1-16 hours	0	0	0	0	0	0
Outreach 1-24 hours	0	1	2	1	7	11
Trans. home/** agency	1	0	3	3	5	12
Trans. agency/ agency	1	0	3	2	5	11
Trans. comm./ agency	1	0	3	2	6	12
Referral 1-8 hours	0	0	0	1	0	1
Referral 1-16 hours	0	0	0	1	0	1
Referral 1-24 hours	2	5	3	5	7	22
Answering Service	0	1	2	3	1	7
Consultation Services	2	3	2	7	1	15

* G.H. With is General Hospitals with Psychiatric Units
G.H. W/out is General Hospitals without Psychiatric Units
M.H. Clinic is Mental Health Clinics
Law Enf. is Law Enforcement Agencies (Sheriff and Police)

**Trans. home/agency is Nonambulance Transportation from client's home to an agency
Trans. agency/agency is Nonambulance Transportation from your agency to another agency
Trans. comm./agency is Nonambulance Transportation from the community to another agency

seven general categories: telephone, walk-in, outreach, nonambulance transportation, referral, answering service and consultation. The definitions of these terms are provided in Appendix B.

General Hospitals with Psychiatric Units. The emergency rooms in the two general hospitals with psychiatric units both provide 24 hour telephone, referral, and walk-in psychiatric emergency services, plus consultation services. Providence Hospital's emergency room will provide transportation for clients (nonroutinely) by taxi or by the professional staff. The emergency room at the University of Oregon Health Sciences Center will provide limited outreach during regular working hours to clients who need psychiatric services in an emergency situation.

General Hospitals without Psychiatric Units. The emergency rooms of hospitals without psychiatric units provide the same 24 hour psychiatric emergency services as those hospitals with psychiatric wards: telephone, referral, and walk-in services. Tillamook County Hospital has the only emergency room which provides outreach 24 hours a day (by its own ambulance service). Three of the emergency rooms in hospitals without psychiatric wards provide consultation services in psychiatric emergencies.

Hot Lines. All three hot lines provide 24 hour telephone services and referral services for psychiatric emergencies. Outside-In (Multnomah County) and Hope in Crisis (Klamath County) also provide 24 hour psychiatric emergency outreach service. All three hot lines will provide nonambulance transportation to clients.

Mental Health Clinics. Excluding Tualatin Valley Guidance Clinic, the other mental health clinics are available 8 hours per day, 5

days a week. Three of the clinics provide an answering service when they are closed, and two clinics rely on a beeper system. Tualatin Valley Guidance Clinic is available for walk-in and telephone psychiatric emergency service during the evenings of regular working days. Northeast Multnomah County Mental Health has no answering service which is able to contact mental health personnel during non-working hours. It is not common for the mental health clinics to provide outreach or nonambulance transportation to those experiencing a psychiatric emergency, but all clinics provide consultation services.

Law Enforcement Agencies. The seven law enforcement agencies all provide 24 hour telephone, referral, and outreach psychiatric emergency services. The majority also provide 24 hour walk-in services and nonambulance transportation services. Law enforcement agencies provide more types of 24 hour psychiatric emergency services than the other facilities studied.

Who Has First Contact With Clients

Table XXXIX (Appendix C) describes the staff who have the first telephone contact with clients according to the type of facility. Secretaries have the first contact with clients in most types of facilities, although in the evening this will change to an answering service in some clinics. Volunteers, answering service personnel and paraprofessionals have the first telephone contact with clients in hot lines during all periods of the day. In all but one law enforcement agency, law enforcement personnel (usually dispatchers) rather than secretaries have the first telephone contact with clients. Master's and doctoral prepared professionals have been combined into one category (professionals) and neither they or psychiatrists have the first telephone

contact with clients in any facility.

Who Provides Telephone Counseling/ Referral and Walk-In Services

The facilities were asked to describe what types of personnel provide telephone counseling/referral services and walk-in services (Tables XL and XLI, Appendix C). They were also asked if back-up was provided by other staff members. More agencies have professionals, paraprofessionals and secretaries providing telephone counseling/referral services for psychiatric emergencies than any other type of personnel. This is also true for walk-in psychiatric emergencies. The majority of the personnel described in Tables XXXIV through XXXVIII provide both telephone counseling/referral and walk-in psychiatric emergency services. With the exception of law enforcement agencies, all facilities provide back-up personnel to their staff, ranging from paraprofessionals at Outside-In to psychiatrists in the clinics and hospitals. Two mental health clinics and the two hospitals with psychiatric wards have inter-disciplinary teams who work with walk-in psychiatric clients.

Number of Staff Providing Referral Services

In addition to telephone counseling/referral being a source of referral services, most facilities offer referrals to walk-in and outreach clients. The 24 facilities were asked to describe the number of staff providing referral services and Table XLII (Appendix C) identifies the total number of such personnel in the five categories of facilities. In general, most of the staff in all facilities who provide psychiatric emergency services provide referral services as part of their work. This is shown by the little difference between the number of staff

providing referral services (1266) and the total number of staff in Table I (1276).

Types and Number of Staff Providing Outreach

Fourteen facilities provide psychiatric emergency outreach services, meaning that their staff deliver the service in the field rather than in the agency. The facilities were asked what types of personnel provide these services and what types of personnel might provide back-up to these people if they needed additional help (Table XLIII Appendix C).

Of the 14 facilities which provide outreach services, law enforcement agencies make up nearly half of the total. Law enforcement personnel are the only type of personnel in these seven police or sheriff's departments who provide outreach services. The three mental health clinics utilize paraprofessionals, professionals, psychiatrists and, in one instance, an interdisciplinary team (Washington County Mental Health Program). These clinics provide professional and psychiatrist back-up to their outreach personnel. Two hot lines have outreach services provided by volunteers and at Outside-In one paid bachelor-level paraprofessional.

Klamath County provides no paraprofessional or professional back-up to its outreach volunteers. Professionals with professional and psychiatrist back-up provide outreach services at the University of Oregon Health Sciences Center. An ambulance service staffed by paraprofessionals with professional back-up provides outreach services at Tillamook General Hospital. Excluding law enforcement agencies, of the remaining 7 agencies offering outreach services in psychiatric emer-

gencies, 5 have paraprofessionals providing outreach, 4 have professionals, 2 have volunteers and 2 have psychiatrists. As in the case of telephone counseling/referral and walk-in services, those agencies offering outreach services (excluding law enforcement) have more professionals and paraprofessionals providing this service than any other type of personnel.

Table III describes the number of staff providing outreach in psychiatric emergencies in all agencies. Law enforcement personnel make up 91% of the 752 personnel in the 14 agencies which provide outreach services. The 42 volunteers in the two hot lines which provide outreach services make up 6% of the total. The five professionals which provide outreach services at the University of Oregon Health Sciences Center's emergency room are psychiatric nurses (four of which are graduate nursing students). The only other facilities which have professionals providing psychiatric emergency service outreach are Klamath County Mental Health and Washington County Mental Health Program.

Types of Personnel Providing Consultation

Table IV reports the types of personnel providing consultation services. Consultation would include any information given to other individuals or agencies concerning the management of clients experiencing psychiatric crises.

Of 16 facilities providing consultation services, 12 have psychiatrists providing consultations for psychiatric emergencies and 11 agencies have professionals (master's and doctoral prepared) providing this service. All mental health clinics and both general hospitals with psychiatric units offer consultation services provided mainly by pro-

TABLE III

NUMBER OF STAFF PROVIDING PSYCHIATRIC EMERGENCY OUTREACH SERVICES IN ALL FACILITIES

Type of Staff	Type of Facility						
	Gen.* Hosp. With	Gen. Hosp. W/out	Hot Lines	Mental Health Clinic	Law Enf.	TOTAL	%
Volunteers	0	0	42	0	0	42	6%
Parapro-fessionals	0	2	1	4	0	7	1%
Profes-sionals**	5	0	0	11	0	16	2%
Psychia-trists	0	0	0	1	0	1	.3%
Law Enf. Pers.	0	0	0	0	687	687	91%
TOTALS	5	2	43	16	687	753	100.3%

* Gen. Hosp. With is General Hospitals with Psychiatric Units
Gen. Hosp. W/out is General Hospitals without Psychiatric Units
Law Enf. is Law Enforcement Agencies

**Both Master's Prepared and Doctoral Prepared staff persons are included in the "Professional" category.

fessionals and psychiatrists. Two law enforcement agencies report that they provide consultation service (La Grande City Police Department and the Washington County Sheriff's Department). There may have been some confusion over the meaning of consultation when the service interview was administered to the law enforcement agencies. Law enforcement personnel might not provide the same type of consultation as that given by mental health personnel, but it is conceivable that they would consult over matters concerning violent clients, legal aspects of commitment, etc. For this reason it is difficult to know if the number of law enforcement agencies reported in Table IV as providing psychiatric emergency consultation is accurate.

Types of Agencies Providing In-Service Training

All facilities were asked if they offer in-service training con-

TABLE IV

TYPE OF STAFF PROVIDING PSYCHIATRIC EMERGENCY CONSULTATION ACCORDING TO NUMBER OF FACILITIES

	Number of Facilities					
Type of Staff	G.H.* With N=2	G.H. W/out N=5	Hot Lines N=3	M.H. Clinic N=7	Law Enf. N=7	AGENCY TOTAL N=24
Volunteers	0	0	2	0	0	2
Parapro-fessionals	0	1	1	4	0	6
Profes-sionals**	2	0	0	7	0	9
Psychia-trists	2	3	0	7	0	12
Law Enf. Pers.	0	0	0	0	2	2

* G.H. With is General Hospitals with Psychiatric Units
G.H. W/out is General Hospitals without Psychiatric Units
M.H. Clinic is Mental Health Clinics
Law Enf. is Law Enforcement Agencies

**Both Master's Prepared and Doctoral Prepared staff persons are included in the "Professional" category

cerning the management of psychiatric emergencies to personnel who provide psychiatric emergency services. Table V gives the results of this question.

Of the 24 facilities, 11 report that they offer in-service training on a nonroutine basis, nine offer it on a routine basis and four do not offer it. Both emergency rooms in general hospitals with psychiatric units and all three hot lines provide in-service training routinely. Two of the emergency rooms in hospitals without psychiatric units do not offer it (Good Samaritan Hospital and Tuality Community Hospital), and the other three hospitals offer in-service training nonroutinely. The mental health clinics offer in-service training in the management of psychiatric emergencies, but more often on a nonroutine basis. One clinic (Northeast Multnomah County Mental Health) does not offer in-service training. The number of law enforcement agencies which

TABLE V

NUMBER OF FACILITIES PROVIDING IN-SERVICE TRAINING

	Number of Facilities					
Response	G.H.* With N=2	G.H. W/out N=5	Hot Lines N=3	M.H. Clinic N=7	Law Enf. N=7	FACILITY TOTAL N=24
Yes, Routinely	2	0	3	2	2	9
Yes, Nonroutinely	0	3	0	4	4	11
No	0	2	0	1	1	4

* G.H. With is General Hospitals with Psychiatric Units
G.H. W/out is General Hospitals without Psychiatric Units
M.H. Clinic is Mental Health Clinics
Law Enf. is Law Enforcement Agencies

offer in-service training is similar to that of the clinics, with the City of Tillamook Police Department reporting that it does not offer such training.

Number of Psychiatric Emergency Contacts

All facilities were asked to make estimates of the number of psychiatric emergency contact they have with clients per typical month. Most of the agencies in rural counties were able to make more accurate estimations, because of the smaller number of psychiatric emergencies they see each month. Estimations of the number of contacts each agency has are in Tables XLIV through XLVIII (Appendix C). The estimated total number of psychiatric emergency contacts according to types of agencies are in Table VI.

General Hospitals with Psychiatric Units. These two hospital emergency rooms have approximately 370 psychiatric emergency telephone calls per month, 70 at Providence Hospital's emergency room and 300 at the emergency room of the University of Oregon Health Sciences Center.

TABLE VI

ESTIMATED NUMBER OF PSYCHIATRIC EMERGENCY CONTACTS PER TYPICAL MONTH IN ALL FACILITIES

Type of Contact	Type of Facility: Gen.* Hosp. With	Gen. Hosp. W/out	Hot Lines	Mental Health Clinic	Law Enf.	TOTAL	%
Telephone	370	204	705	174	207	1660	39%
Walk-in	285	54	32	68	42	481	11%
Outreach	10	2	29	14	433	488	11%
Referral	171	88	469	64	169	961	23%
Answering Service	0	5	30	37	400	472	11%
Consulta-tions	34	3	65	109	1	212	5%
TOTALS	870	356	1330	466	1252	4274	100%
%	20%	8%	31%	11%	29%	99%	

* Gen. Hosp. With is General Hospitals with Psychiatric Units
Gen. Hosp. W/out is General Hospitals without Psychiatric Units
Law Enf. is Law Enforcement Agencies

Of the estimated 285 psychiatric emergency walk-in clients to these emergency rooms per month, 35 are seen at Providence and 250 are seen at the University. Approximately 10 outreach visits are done per typical month by the University. One hundred seventy-one psychiatric emergency referrals are estimated per month, 85 by Providence emergency room and 86 by University of Oregon Health Sciences Center emergency room. Approximately 34 consultations are made, 18 by Providence emergency room and 16 by University of Oregon Health Sciences Center emergency room. Adding these categories together, approximately 870 psychiatric emergency contacts are made per typical month in the emergency rooms of the two hospitals, 208 at Providence Hospital and 562 at the University of Oregon Health Sciences Center.

General Hospitals Without Psychiatric Wards. In this category,

approximately 204 psychiatric emergency telephone contacts are made per typical month, the most originating from Good Samaritan Hospital (180). Approximately 54 psychiatric emergency walk-in contacts are made, with Good Samaritan seeing the most (N=30). Grande Ronde Hospital has the smallest number of estimated psychiatric emergency walk-in contacts, a total of three in a typical month. Tillamook County General Hospital's ambulance service provides approximately two emergency outreach contacts per typical month. The hospitals in this category make few psychiatric emergency referrals (between one and three) per typical month, with the exception of the emergency room at Good Samaritan Hospital, which makes about 80 referrals in the same time period. Tuality Community Hospital is the only hospital without a psychiatric ward which has an answering service, and this service has about five psychiatric emergency contacts per typical month. Tuality Community Hospital, Grande Ronde Hospital and Presbyterian Inter-Community Hospital emergency rooms each provide about one psychiatric emergency consultation per typical month. The other two hospitals do not provide this service. The estimated total number of psychiatric emergency contacts per typical month for emergency rooms in hospitals without psychiatric wards is about 356. Two hundred ninety (81%) of these estimated contacts are made in the emergency room of Good Samaritan Hospital.

Hot Lines. Approximately 705 psychiatric telephone contacts are made to the three hot lines per typical month. Four hundred (55%) originate at Suicide and Personal Crisis Service, 175 (25%) at Outside-In, and 130 (20%) at the Hope in Crisis Hot Line. All three agencies see a similar number of walk-in clients (N=10-12). Of the two hot lines that provide outreach services, 20 are provided by Hope in

Crisis and nine are provided by Outside-In. Approximately 469 psychiatric emergency referrals are provided per typical month in the three hot lines, 200 at Suicide and Personal Crisis Service, 139 at Outside-In, and 130 at Hope in Crisis. Two hot line agencies, Suicide and Personal Crisis Service and Hope in Crisis have an answering service. Hope in Crisis' answering service receives approximately 30 telephone calls per typical month. The answering service at Suicide and Personal Crisis Service answers all incoming calls, rather than being designed to answer calls when regular personnel are not available. For this reason, all calls at Suicide and Personal Crisis Service are included in the category of "telephone contacts." Suicide and Personal Crisis Service and Outside-In both provide psychiatric emergency consultation, about 25 at Suicide and Personal Crisis Service and about 40 at Outside-In per typical month. Those three hot lines provide approximately 1,330 psychiatric emergency contacts per typical month. Three hundred twenty-two originate at Hope in Crisis, 373 originate from Outside-In and 635 originate from Suicide and Personal Crisis Service.

Mental Health Clinics. The seven mental health clinics respond to approximately 174 psychiatric emergency telephone contact per typical month, with Kaiser Mental Health Clinic providing the most (N=100). Approximately 68 emergency walk-in clients are seen per typical month (Kaiser sees 25 of these). An estimated 14 outreach visits are made per typical month (all four clinics providing similar numbers of contacts). Of the estimated 64 total psychiatric emergency referrals made per typical month among the seven clinics, 25 are made by Kaiser Mental Health Clinic and 37 answering service contacts are made in three clinics. About 109 psychiatric emergency consultations are provided

per typical month among the seven clinics--50 from Kaiser Mental Health Clinic and 30 from Washington County Mental Health program. Of the estimated 466 psychiatric total emergency contacts, nearly half (46%) are provided by Kaiser Mental Health Clinic.

Law Enforcement Agencies. The estimated number of psychiatric emergency contacts per typical month in the total number of law enforcement agencies is incomplete because most of this data were unavailable to the researchers in the largest agency (Portland Police Department). About 207 psychiatric emergency telephone contacts are made per typical month in five agencies (Portland Police and Multnomah County Sheriff's Department had no statistics). The largest numbers are from Klamath Falls City Police (100) and from Washington County Sheriff's Department (75). Four of the law enforcement agencies see relatively few walk-in psychiatric emergencies, Tillamook (city and county) sees none, and data from the Portland Police Department were unavailable to the researchers. The estimated number of outreach visits per typical month varies from six in Tillamook city and county to 124 in the Portland Police Department. The approximate number of psychiatric emergency referrals made by these agencies is also varied, 1 per month by Tillamook County Sheriff's Department, 3 in La Grande, 70 in Klamath Falls, 75 by the Multnomah County Sheriff's Department and 20 by the Washington County Sheriff's Department. There are about 400 psychiatric emergency contacts made per typical month through the answering service provided by the Washington County Sheriff's Department. This is a beeper service which patches calls to mental health personnel at the Washington County Mental Health program. La Grande City Police make about one psychiatric emergency consultation per typical month, and Washington County Sheriff

makes less than one. This number might be greater because of possible confusion over the meaning of consultation. The estimated 1,252 psychiatric emergency contacts per typical month in the seven law enforcement agencies is not an accurate estimate of the actual contact made. The absence of data on contacts in the Portland Police Department (the largest law enforcement agency studied) certainly skews the results. When the percentages of the estimated total 4,274 psychiatric emergency contacts across all 24 facilities were computed, those 1,252 law enforcement contacts account for only 29% of the total. Hot lines provide the greatest percentage of contacts (31%), general hospitals with psychiatric wards provide 20%, mental health clinics provide 11%, and hospitals without psychiatric wards provide 8% of all contacts. Table VI also provides the numbers and percentages of the types of psychiatric emergency contacts. Of the estimated 4,274 contacts per typical month, 39% were telephone, 23% were referral, 11% were answering service contacts, 11% were outreach, 11% were walk-in and 5% were consultations.

<u>Summary</u>

This section of the data analysis reported the results of the Service Interview which was administered to 24 facilities. Although each facility offers particular types of services, delivered by particular types of staff, several conclusions can be drawn from the data collected at the 24 facilities.

It was found that the types of staff providing psychiatric emergency services is related to the type of facility in which they work. Facilities which are designed to provide mental health services (emergency rooms of general hospitals with psychiatric units and mental health clinics) have mental health professionals and paraprofessionals

on staff. Other facilities such as emergency rooms of general hospitals without psychiatric units and law enforcement agencies, are not designed to provide mental health services, but in fact do provide psychiatric emergency services. These facilities depend on non-mental health staff to offer psychiatric emergency care.

Although the types of personnel vary between the types of facilities studied, the number of psychiatric emergency services offered do not vary significantly between types of facilities. For instance, law enforcement agencies and emergency rooms of general hospitals without psychiatric units provide nearly the same types of psychiatric emergency services as mental health clinics and emergency rooms of general hospitals with psychiatric units. Hot lines, which depend on volunteers to provide psychiatric emergency services, also offer the same types of services as those facilities with paid mental health workers.

Law enforcement agencies provide more 24-hour psychiatric emergency services than any other type of facility studied. They also have the greatest number of staff providing these services. The staff in these agencies is composed of patrolmen/women and dispatchers, not mental health professionals. It was also found that law enforcement agencies are the only facilities studied that do not have mental health staff available to back-up their personnel in the event of a psychiatric emergency.

In all types of facilities studied, secretaries generally have the first telephone contact with emergency clients, with the exception of law enforcement agencies where dispatchers usually have the first telephone contact. Secretaries also have contact with emergency clients who walk in to the facility. It is known that secretaries do have con-

tact with psychiatric emergency clients, but it is not known if they have had training in the management of psychiatric emergencies. The researchers found that the facilities studied (including mental health clinics) generally offer in-service training in the management of psychiatric emergencies on a non-routine basis. All three hot lines offer this type of training routinely.

The estimate of psychiatric emergency contacts per typical month is low because the data from the Multnomah County law enforcement agencies are incomplete. It has been concluded that if the data were available, the category of law enforcement agencies would have the largest number of psychiatric emergency contacts per typical month. Hot lines have the largest number of psychiatric emergency telephone contacts and law enforcement agencies provide the greatest number of psychiatric emergency outreach visits per typical month. The emergency room in the University of Oregon Health Sciences Center sees more psychiatric emergency walk-in clients than any other facility studied. Mental health clinics provide the largest estimated number of psychiatric emergency consultations per typical month.

The facilities in counties with smaller population sizes have fewer psychiatric emergency contacts, but normally have fewer staff providing services to clients. Psychiatric emergency telephone contacts appear to be the most frequently provided psychiatric emergency service in all types of facilities, except in law enforcement agencies where these data are incomplete.

The facilities participating in this study provide a large number of psychiatric emergency services. It was found that not only mental health facilities offer these services, but that a considerable propor-

tion are provided by facilities which are not specifically designed to deliver such care. Law enforcement agencies in particular play a significant role in the provision of psychiatric emergency services because they offer outreach and are available 24 hours a day.

These findings provide a clearer picture of the roles that mental health facilities and non-mental health facilities play in the psychiatric emergency service delivery system. The following section describes the types of persons using these facilities and the care they received.

CLIENT DATA

The second section of data analysis considers the characteristics of persons who use psychiatric emergency services. This section also describes the types of services received by persons in a psychiatric emergency and the dispositions that are commonly made by agencies which provide psychiatric emergency services.

Data were collected using a retrospective chart search of a random sample of clients who were seen at each agency. The population that the sample was taken from included clients over the age of 18 years, who were considered a mental health emergency by either themselves or others and who received service from the agencies being studied during the months of July, August and September 1976.

Client data were collected from a minimum of a mental health clinic, law enforcement agency and general hospital with an emergency room in four counties. In Klamath County, Multnomah County and Washington County additional agencies provided access to client records. The list of agencies from which client data were obtained and the sample sizes are presented in Table XLIX Appendix C. Client data were not collected at

mental health clinics in Multnomah County because there was no means of retrieving the records of clients who were seen on an unscheduled basis. Client data were not collected at the law enforcement agencies in Multnomah County because the researchers felt that it would not be possible to obtain a meaningful but manageable sample, given the high number of law enforcement interventions in a given month.

The total client sample is composed of 224 clients over the age of 18, who received services during the months of July, August and September, 1976. Table L Appendix C displays an equal distribution of the number of clients in the sample who were seen by the agencies studied during each of the three months.

The data analysis for this section will consider first the demographic variables. The variables of the emergency situation, such as the type and duration of the problem will be presented next. The services that the client received and the disposition made for the client will be considered last. The data have been analyzed by tabulating the frequencies for each item and computing a percentage. The findings of the analysis will be presented first as they relate to all the counties studied and then according to the types of facilities that were studied. Findings relating to individual counties or facilities within counties will not be presented except in those instances where there is a major deviation from the trend established by the other counties.

Demographic Variables

The demographic variables considered by the researchers were those of age, sex, marital status, dependent status and county of residence.

Age. In the data analysis, the demographic variable, age, was considered in 10 year categories. Table VII displays the breakdown of the client sample by age. Over all counties and facilities, the age category with the highest percentage was that of 20-29 years. Persons in this age category represented 34% (76 persons) of the total client sample. The age category with the next highest percentage was those persons aged 30-39 years, making up another 20% (44) of the total sample. Approximately half of all the clients in the sample were between the ages of 20 and 39 years. Two thirds of the persons in the sample were between 20 and 50 years.

TABLE VII

DISTRIBUTION OF AGE FOR CLIENTS IN THE SAMPLE

	Type of Facility									
	General Hospital		Hot Line		Mental Health Clinic		Law Enforcement Agency		TOTAL	
	N=93		N=15		N=60		N=56		N=224	
Age of Client	N	%	N	%	N	%	N	%	N	%
18-19 years	8	9	0	0	4	7	3	5	15	7%
20-29 years	30	32	4	27	23	38	18	32	76	34%
30-39 years	17	18	4	27	11	18	12	21	44	20%
40-49 years	15	16	2	13	9	10	5	9	31	14%
50-59 years	7	8	1	7	4	7	1	2	13	6%
60-69 years	9	10	1	7	4	7	1	2	15	7%
70 - over	7	8	0	0	3	5	2	4	12	5%

There are differences among the agencies studied in the age majorities of the clientele in the samples. The largest group of persons in the client sample who received services from general hospitals and men-

tal health clinics were between the ages of 20 and 29 years. The largest percentage of persons in the sample who were seen by law enforcement agencies were between 30 and 39 years of age. Persons over the age of 60 receive psychiatric services at general hospitals more than at any other type of facility studied.

Sex. Referring to Table VIII, the tabulation of frequencies on the variable sex reveal that 122 (54%) of the total sample of 224 clients were female. There were 102 (46%) men in the same sample. The client sample obtained from the hospitals, mental health clinics, and hot lines was composed of more females than males. The client sample from law enforcement agencies was represented by more men than women. Mental health clinics and hot lines displayed the largest difference between the numbers of men and women in the sample.

TABLE VIII

DISTRIBUTION OF CLIENTS IN THE SAMPLE BY SEX

	Type of Facility									
	General Hospital		Hot Line		Mental Health Clinic		Law Enforcement Agency		TOTAL	
	N=93		N=15		N=60		N=56		N=224	
Sex of Clients	N	%	N	%	N	%	N	%	N	%
Male	43	46	6	40	24	40	29	52	102	46%
Female	50	53	9	60	36	60	27	48	122	54%

Among individual counties, the sample from Union County was the only one to contain more males (56%) than females (43%). The samples from the other four counties were all represented by more women than men. The percentage of females in the county samples ranged from 42% to 46%, and the range for males was from 54% to 58% (See Table LI, Appendix C).

Marital Status. The researchers defined marital status according to two categories, single and married. Those persons who reported being widowed, divorced or legally separated were recorded as being single. Those persons who reported being separated from their spouse were recorded by the researcher in the category married. This definition was developed to reflect the status of the marital relationship and not other living or interpersonal relations between persons.

Marital status was recorded in 186 of the 224 client records. Percentages computed on the basis of the 186 client records are presented in Table IX and reveal that 59% (110) of the clients were married and 41% (76) were single. Of the client samples obtained at the mental health clinics and law enforcement agencies, the majority of clients were reported to be married. This trend is reversed for the client samples from general hospitals with the majority of clients reporting single status.

TABLE IX

MARITAL STATUS OF CLIENTS IN THE SAMPLE

	Type of Facility									
	General Hospital		Hot Line		Mental Health Clinic		Law Enforcement Agency		TOTAL	
	N=93		N=15		N=60		N=56		N=224	
Marital Status	N	%	N	%	N	%	N	%	N	%
Single	41	53	3	25	23	39	9	24	76	34%
Married	37	41	9	75	36	61	28	76	110	49%
Unavailable	15	16	3	20	1	2	19	34	38	17%

Among individual counties, the samples obtained from the agencies studied in Tillamook, Union and Washington counties are represented by more persons reporting a married status than those persons of single

status. Klamath and Multnomah counties report higher proportions of single persons using the psychiatric emergency services that were the subjects of study (see Table LII Appendix C). The client's marital status was not recorded in 38 (17%) of the 224 records that were sampled. There were more records obtained from law enforcement agencies that did not include a notation of the client's marital status than the other agencies studied. This finding suggests that there is a difference in the record keeping practices among the different agencies.

Dependent Status. Data were collected by the investigators to indicate those persons in the sample who received financial support from public welfare programs. Of the 224 records that were reviewed, 83 records (37%) contained no information on the client's current financial status. One hundred and five (47%) of the records indicated that the client was employed and either would pay for the service received or had an insurance policy that covered the cost of care rendered. For 36 persons (16%) in the client sample, the records indicated the client to be receiving financial support from public welfare programs.

The presented data indicates that information on the dependent status of clients using psychiatric emergency services is not consistently included and updated in the client's record. In some instances, the client's financial status had been indicated,at the time of a previous request for service,in the record several months to a year or more earlier at the time of a previous request for service. Because the client's financial status may have changed during this extended period of time, the information was considered unreliable. No generalizations have been made about the dependent status of the sample of clients who

used psychiatric emergency services during the period of study because of the unreliable nature of the information collected.

County of Residence. Data were collected to indicate the frequency with which county agencies provide service to persons not living in the county. Of the total client sample of 224 clients, 186 (83%) persons resided in the same county as the agency from which they received psychiatric emergency services (see Table LIII Appendix C). Twenty-two persons (10%) in the sample were not residents of the same county as the agency that delivered the service. For 16 clients it was not possible to discern from the record the client's county of residence. There is no particular type of agency that intervenes with more persons who are not residents of the same county.

TABLE X

COUNTY OF RESIDENCE FOR CLIENTS IN THE SAMPLE

	County Studied											
	Klamath County N=41		Multnomah County N=66		Tillamook County N=38		Union County N=30		Washington County N=49		TOTAL N=224	
County of Residence	N	%	N	%	N	%	N	%	N	%	N	%
In County	36	88	47	71	31	81	27	90	39	80	186	83%
Out of County	4	9	10	15	3	8	3	10	8	16	22	10%
Unavailable	1	2	9	14	4	11	0	0	2	4	16	7%

Data presented in Table X shows that the agencies studied in Washington and Multnomah counties show higher percentages of persons seen in a psychiatric emergency who do not reside in that county. The agencies in the other counties studied appear to provide service to smaller percentages of persons living outside the county.

Variables of the Emergency Event

The client data in this section consider the day and time that the clients were seen. Also considered is the duration of the client's problem, the acuteness of the emergency situation and the legal status of the client.

Day of Week the Client Was Seen. The researchers sought an indication of which day or days of the week were characterized by the highest rate of use. The frequencies with which the clients in the sample were seen each day of the week were fairly evenly distributed across all 7 days (see Table LIV Appendix C). The range is from 26 persons (12%) seen on Mondays to 42 persons (19%) seen on Thursdays. There do not appear to be any outstanding days that more persons are likely to be seen by a psychiatric emergency service.

TABLE XI

NUMBER OF CLIENTS WHO WERE SEEN ON WEEKDAYS AND WEEKENDS

	Type of Facility									
	General Hospital		Hot Line		Mental Health Clinic		Law Enforcement Agency		TOTAL	
	N=93		N=15		N=60		N=56		N=224	
Clients seen on	N	%	N	%	N	%	N	%		%
Weekends	45	48	8	53	14	23	20	36	87	39%
Weekdays	48	52	7	47	46	77	36	64	137	61%

The days of the week were separated into weekdays and weekends so that the numbers of persons in the sample who were seen by a psychiatric emergency service at these times could be compared. Friday, Saturday and Sunday were considered weekend days. Referring to Table XI, 137 persons (61%) in the sample of 224 clients were seen during the week

and 87 persons (39%) were seen during the weekend.

Time of Day the Client Was Seen. The variable, time of day that the client was seen, consists of three categories. The categories are: during the daytime hours (8 a.m. - 5 p.m.), during the evening hours (5 p.m. - 12 a.m.), and during the early morning hours (12 a.m. - 8 a.m.). Table XII displays greater percentages of clients in the sample who were seen during the daytime hours than during the evening and early morning hours. On four records the time that the client was seen could not be determined by the researchers.

TABLE XII

TIME OF DAY CLIENTS WERE SEEN

	Type of Facility									
	General Hospital		Hot Line		Mental Health Clinic		Law Enforcement Agency		TOTAL	
	N=93		N=15		N=60		N=56		N=224	
Time of Day Client Seen	N	%	N	%	N	%	N	%	N	%
Day (8am-5pm)	42	45	5	33	41	68	16	28.5	104	46%
Evening (5pm-12am)	33	35	3	20	10	17	24	43	70	31%
Early Morning (12am-8am)	18	19	5	33	7	12	16	28.5	46	21%

The records reviewed at six mental health clinics indicate that greater numbers of persons in the sample were seen between the hours of 8 a.m. and 5 p.m. Progressively fewer persons were seen by clinics during the evening and early morning. Law enforcement agencies saw the majority of the clients (43%) in the sample during evening hours. Law enforcement agencies saw clients during the early morning hours more frequently than any other type of agency studied. General hospital emergency rooms were the most similar to the overall frequencies for

counties and facilities studied.

Duration of the Problem. The variable, duration of the presenting problem, was divided into six categories ranging from 1 day or less to 2 years or more. The first finding is that for a substantial number of persons in the sample, the duration of the presenting problem was not indicated in the record (see Table LV, Appendix C). Of the 224 records reviewed, 86 (38%) gave no indication of the problem duration. Records sampled at law enforcement agencies and general hospitals less frequently included an indication of the duration of the problem.

TABLE XIII

DURATION OF CLIENT'S PROBLEM

	Type of Facility									
	General Hospital		Hot Line		Mental Health Clinic		Law Enforcement Agency		TOTAL	
	N=55		N=9		N=44		N=30		N=138	
Duration of the Client's Problem	N	%*	N	%	N	%	N	%	N	%
One day or less	10	18	1	11	2	4.5	21	70	34	25%
Less than one week	9	16	0	0	2	4.5	0	0	11	8%
Less than one month	13	24	0	0	4	11	3	10	20	14%
Less than one year	10	18	2	22	10	22	2	7	24	17%
Less than two years	1	2	1	11	4	9	0	0	6	4%
Two years or more	12	22	5	55	22	50	4	13	43	31%

*All percentages are computed on the basis of the 138 records that indicated the duration of the client's problem.

The data presented in Table XIII indicate that of the 138 records that contained data on the duration of the client's problem, the majority fell into one of two categories, either 1 day or less or 2 years or

more. The facilities studied show different trends in the problem duration of clients who use the service.

The law enforcement agencies tend to serve clients whose problem occurred during the last 24 hours. Of the 30 case records that were reviewed, 70% (21) indicated that the problem duration was 1 day or less. The mental health clinic showed the opposite trend: Of the 44 records reviewed, 22 (50%) indicated that the problem had been in existence 2 years or more. It appears that mental health clinics serve a population of whose problems are long standing and the law enforcement agency intervenes with persons whose problems appear to be of an acute onset. The general hospitals appear to provide service to nearly equal numbers of persons with problems of varying duration.

Type of Emergency. The variable, type of emergency, was developed by the researchers to indicate the urgency of the situation and consists of two categories, a psychiatric emergency and a crisis situation.

A psychiatric emergency indicated that the symptoms and distress of the client were of acute onset. The situation requires immediate intervention in order to prevent further physical or psychological damage.

A crisis situation is of less acute onset, usually involving a degree of distress related to a current problem situation. The distress has usually been increasing over time until it mounts to a degree where relief is sought by a client. Intervention should take place within 24 hours.

The trend over all counties shows almost equal percentages for psychiatric emergencies (46%) and crisis situations (52%). In all but three records, it was possible to determine the urgency of the problem.

It was more difficult to determine whether the onset of the problem was acute or occurred over a period of time. Because the onset of the client's problem was difficult to determine, the investigators operationalized these terms again. A person was judged to be in a psychiatric emergency if the record reflected the urgency of the situation and if the person was admitted to a hospital for inpatient care. A person was considered to be experiencing a crisis if the record indicated that the situation did not require immediate intervention and the person was not hospitalized. Because of the difficulty in operationalizing these terms satisfactorily, only general interpretation of the collected data can be made.

The records sampled at general hospitals and mental health clinics indicated equal percentages of clients who were considered to be in a crisis situation (57% and 56% respectively) and a psychiatric emergency (43%). According to the record review, those clients who received services from law enforcement agencies were considered a psychiatric emergency more often than a crisis situation.

TABLE XIV

TYPE OF EMERGENCY FOR CLIENTS IN THE SAMPLE

	County Studied											
	Klamath County		Multnomah County		Tillamook County		Union County		Washington County		TOTAL	
	N=41		N=66		N=38		N=30		N=49		N=224	
Type of Emergency	N	%	N	%	N	%	N	%	N	%	N	%
Crisis Situation	21	51	33	50	18	47	22	73	23	47	117	52%
Psychiatric Emergency	20	49	33	50	20	53	6	20	25	51	104	46%

Data presented in Table XIV shows that of the agencies studied

in Klamath, Multnomah, Tillamook and Washington counties, the samples were composed of nearly equal percentages of persons considered to be a psychiatric emergency and a crisis situation. The sample of client records obtained from agencies studied in Union County displayed higher proportions of persons considered to be in a crisis situation than those in a psychiatric emergency.

Legal Status. The variable legal status consists of two categories, voluntary and involuntary. Persons categorized as involuntary are those for whom commitment or detention is sought. Persons who are brought to a psychiatric emergency service by relatives, friends, or other agencies for whom commitment or detention is not being sought are categorized as voluntary, even though the client is not seeking help directly.

TABLE XV

CLIENTS' LEGAL STATUS BY FACILITY

	Type of Facility									
	General Hospital		Hot Line		Mental Health Clinic		Law Enforcement Agency		TOTAL	
	N=93		N=15		N=60		N=56		N=224	
Legal Status	N	%	N	%	N	%	N	%	N	%
Voluntary	75	81	13	87	39	65	35	63	162	72%
Involuntary	14	15	0	0	20	33	16	29	50	22%

The data in Table XV show that 50 persons (22%) in the sample were considered by the investigators as involuntary patients. Seventy-two percent of the sample (162) were persons seeking help voluntarily. The percentage of voluntary clients ranged from 81% (75) of the 93 clients in the sample from general hospital emergency rooms to 63% (35) of the 56 persons in the sample seen by law enforcement agencies. The

percentage of voluntary clients ranged from 33% (20) of the 60 clients in the sample from mental health clinics to 15% (14) of the 93 clients in the sample from general hospital emergency rooms.

Evaluation and Treatment of Clients and Their Families

The data analysis considers three variables in the area of the problem presented by the client's emergency and the treatment rendered to the client. Consideration is given to the variables of diagnosis, which persons were seen by the direct service provider, and the types of services received by clients.

Diagnosis. The review of literature commented on the difficulties in making interpretations from data using traditional psychiatric nomenclature. The researchers collected data using the diagnostic categories of the DSM II, since it is most frequently used as a means of problem identification by mental health clinics and hospitals. Two additional categories, family dispute and harrassment, were added to reflect the law enforcement agency's means of identifying problems. A final category was added to separate suicide attempts and overdose from other categories.

The data that are reported here reflects the agency's determination of the nature of the client's problem and does not indicate the reliability between different types of agencies in making diagnostic determinations. Therefore, generalizations cannot be made about the diagnoses of clients who receive psychiatric emergency services from different agencies.

For all counties, suicide attempts and/or overdose was the problem diagnosis received by the most persons seen by agencies providing

psychiatric emergency intervention. Neuroses were the second largest category. Thirty-six persons or 16% of the sample of 224 were diagnoses as neurotic. Sixteen of these were diagnosed with anxiety neurosis and 15 persons were diagnosed with depressive neurosis. The category of alcohol and drug abuse and the category of psychosis each composed 12% of the total case sample. Other problem categories composed smaller proportions of the total client sample as illustrated in Table XVI.

TABLE XVI

DIAGNOSES MADE FOR CLIENTS IN THE SAMPLE

	Type of Facility											
	Gen.* Hosp. With		Gen. Hosp. W/out		Hot Line		Mental Health Clinic		Law Enf. Agencies		TOTAL	
	N=31		N=62		N=15		N=60		N=56		N=224	
Diagnoses	N	%	N	%	N	%	N	%	N	%	N	%
Organic Brain Syndrome	2	6	3	5	0	0	4	7	0	0	9	4%
Psychosis	8	26	3	5	0	0	15	25	1	2	27	12%
Neurosis	8	26	14	23	7	47	7	12	0	0	36	16%
Alcohol/ Drug Abuse	4	13	14	23	1	7	5	8	2	4	26	12%
Personality Disorders	1	3	1	2	0	0	2	3	0	0	4	2%
Transient Situational Reaction	2	6	5	8	0	0	9	15	0	0	16	7%
Social/Marital Maladjustment	0	0	0	0	0	0	6	10	0	0	6	3%
Suicide Attempt/Overdose	3	10	9	15	3	33	1	2	24	43	40	18%
Family Dispute	0	0	0	0	0	0	2	3	18	32	20	9%
Harrassment	0	0	0	0	0	0	0	0	4	7	4	2%
No Mental Disorder	1	3	2	3	0	0	1	2	0	0	4	2%
Other	1	3	5	8	0	0	3	5	1	2	11	5%
Unavailable	1	3	5	8	4	27	4	7	5	9	17	8%

*=General Hospitals with Psychiatric Units. W/out = Without Psy. Units.

There are differences between the types of facilities studied and the frequency with which the various diagnostic categories were used. Hospitals with and without psychiatric units were examined separately in the data analysis. Of the 31 case records reviewed at two general hospitals with psychiatric units, more persons were diagnosed as either psychotic or neurotic than any of the other diagnoses received by persons in the sample. The sample of clients who received services at general hospitals without psychiatric units were more often diagnosed as either neurotic or as having an alcohol or drug problem. Nine persons (15%) in the client sample were suicidal or had taken an overdose. The general hospitals without psychiatric units had the second highest frequency of all facilities studied for this category.

Fifteen records were reviewed at the telephone hot line and seven of these clients were diagnosed as neurotic. Five of the seven persons received the diagnosis depressive neurosis. Three persons were suicidal or had taken an overdose and one person was considered to have an alcohol problem.

Of the records reviewed at mental health clinics, more clients in the sample were diagnosed as psychotic than the numbers of persons who received other diagnoses. The mental health clinics also provided services to more persons considered to be experiencing a transient situational reaction or exhibiting social or marital maladjustment than any other type of facility. This finding may reflect preferences in diagnostic practices that are different from other facilities which use the same classification system.

Fifty-six records were reviewed at law enforcement agencies in four counties. In general, the psychiatric classifications were not

used. Forty-three percent (24) of the sample of 56 records involved a law enforcement officer who dealt with a suicide attempt or with a person having taken an overdose. Thirty-two percent (18) of the sample involved law enforcement intervention in family dispute situations.

During the 3 months from which the client sample was taken (July, August and September), law enforcement personnel were involved in a number of other situations for which a police record is not usually made. Only those cases where a record could be obtained were included in the sample. In the city of Klamath Falls, 18 records were made out by the city police during the three months of study, involving situations with people who have mental health problems. In addition, the law enforcement officers intervened in 166 cases of persons with alcohol or drug abuse problems, 52 family disturbances and four reported overdoses. All of these situations were recorded in the police complaint log and indicate the involvement of law enforcement agencies in the mental health problems of a given community.

Who Was Seen at the Time of the Emergency. This categorization was developed to describe the variety of persons who may accompany the client and are included by the service provider in the evaluation and intervention. The client was seen by the service provider in 85% (190) of all the situations where intervention was requested. Examples of situations where the client was not seen include successful suicide attempts or persons who were seeking treatment for someone else. The law enforcement agencies saw the client in all but nine out of 56 cases, and mental health clinics either saw the client (or spoke to the client by phone) in all but nine out of 60 cases.

Other persons or family members significant to the client were

seen by service providers at the time of help seeking in 51% (114) of the cases in the total sample. Personnel at law enforcement agencies indicated that they interviewed other persons in the client's social mileau in 86% of the 56 records reviewed. This finding may reflect the type of service provided by law enforcement agencies in situations of family dispute and harrassment or that law enforcement personnel are more likely to indicate this type of information on the record.

The staff at general hospitals with psychiatric units reported interviewing other persons in the client's mileau in 65% (20) of the 31 client records in the sample of persons seen in the emergency room. In contrast, the staff at general hospitals without psychiatric units recorded that they interviewed other persons in addition to the client in 29% (18) of the 62 records of clients who had sought service at the emergency room. Forty-seven percent (28) of the 60 client records reviewed at mental health clinics indicated that the staff interviewed persons in addition to the client.

Type of Service the Client Received at the Agency. Data were collected by the researchers on 10 types of services that a client might receive at an agency. These categories were not considered exclusive of one another. If a client received more than one type of service, the researchers indicated on the data collection tool, all of the services.

The types of services may be divided into three general areas:

1. Those that are provided by anyone with a minimal amount of training in mental health skills.

2. Those that require specialized knowledge in medical or psychiatric fields.

3. Those services that require the client to be admitted to an

The data analysis for all counties indicates that 83% of all 224 persons seen at the various agencies received crisis intervention. The use of the term crisis intervention by the investigators is distinctly different from the short-term, problem-oriented counseling that is designed to return the client to his/her pre-crisis style of coping. For this study, crisis intervention was defined as the provision of direct service to persons at the time of the crisis or psychiatric emergency. The provision of direct service may have been intervention or physical contact in order to prevent further behavioral deterioration or a brief telephone contact urging the client to seek further psychiatric treatment. Direct service may also have been the provision of sophisticated problem-oriented counseling. The definition of this term was developed to reflect the nature of services provided to persons in a psychiatric emergency by a variety of agencies, many of which have no mental health personnel who provide service. All agencies that supplied client data provided crisis intervention to 75% to 90% of all persons in the sample seen by the agency.

The second area of service includes medication administration, psychiatric, medical and neurological evaluations. The delivery of these services requires specialized training or knowledge in medical or psychiatric fields. In only one case at a law enforcement agency were any of these services delivered (one person received medication and a psychiatric evaluation). No person received these services from the telephone hot line. Therefore, only hospitals and mental health clinics will be featured in this portion of data analysis.

Psychiatric evaluations were made on 42% (N=95) of the total client sample. Psychiatric evaluation was defined as documentation in

the record of the results of, at least, a mental status examination. The two general hospitals with psychiatric units and the mental health clinics provided psychiatric evaluations to more persons in the client sample than the general hospitals without psychiatric units.

Medications were either prescribed or administered to 35% (N=79) of the total client sample while the person was being seen by the agency. There was no major difference in the rate at which medications were prescribed or administered by general hospitals, either with or without psychiatric units. Medications were prescribed or administered to 60 (65%) of the 93 clients who received psychiatric services from the emergency rooms at these facilities. According to the 60 records reviewed, mental health clinics provided or administered medication to 30% (N=18) of the client sample.

A physical exam was provided to 72 (32%) of the 224 clients in the sample. This term was defined as documentation in the record of the results of a general physical exam. General hospitals performed a physical exam on between 65 to 76% of the clients in these two samples. In contrast, a physical exam was provided to 5 persons (8%) in the sample of 60 clients who received psychiatric emergency services from mental health clinics.

Neurological evaluations were provided for 12% (N=27) of the total client sample. A neurological evaluation was defined as specific tests or evaluation procedures which are used with the client to assess neurological status beyond that of the mental status examination. General hospitals with psychiatric units provided neurological examinations to a slightly higher percentage of clients in the sample than general hospitals without psychiatric units. Neurological examinations were not

generally provided by the staff at mental health clinics. This finding is probably due to the particular training of persons who staff the various facilities studied than to the type of problem that clients are requesting services for.

The third area of service is the admission of the client for inpatient care or for a period of observation. Service was noted by the researchers as being provided by an agency until such a time as one service provider was relieved of all responsibility for a client.

Twenty-four percent (N=54) of the total client sample were admitted to hospitals for inpatient care. Inpatient care was defined as specific treatment received by the client in a hospital setting other than the emergency room and not limited to psychiatric treatment. General hospitals without psychiatric units admitted almost twice as many clients for inpatient care as general hospitals with psychiatric units and mental health clinics.

A client was considered admitted for observation when he/she was observed for an unspecified period of time in order for the service providers to either determine the problem and necessary treatment or to allow the client to recover and return to his/her living situation. A smaller proportion of the client sample was admitted to a facility for observation. The data that were collected from the sample of client records indicated that general hospitals without psychiatric units admitted twice as many clients in the sample for observation as the general hospitals with psychiatric units and the mental health clinics.

There are two possible reasons for the high rate of admissions for inpatient treatment and observation from the emergency rooms of general hospitals without psychiatric units. The first possible reason is that

these hospitals are primarily in rural areas that are some distance from the state mental hospitals. In these communities, the general hospital may often serve as the psychiatric facility for persons needing inpatient care. The two general hospitals with psychiatric units are located in metropolitan Portland and the lower admission rate may reflect a greater number of resources that patients can be referred to. The other possible reason is that the general hospitals without psychiatric units are generally not staffed by professionals with specialized training in mental health. Persons without psychiatric training are often more likely to seek admission for persons with psychiatric problems.

Law enforcement agencies are indicated in the data presented on Table XL as admitting the client for inpatient care or for observation. These data reflect situations when an officer transports a client to a hospital emergency room and waits until the nature of the client's problem is determined and a disposition is made.

Disposition

The disposition or result of each client's contact with an agency providing service to persons experiencing a psychiatric emergency is divided into two broad categories. The first category was those persons who received no further treatment or intervention after the service that was provided at the time of the emergency. The second category included those persons who were invited or required to participate in continued treatment.

Those Who Received No Further Treatment. Sixty-four (28.5%) of the 224 clients in the sample received no further treatment after that provided at the time of the psychiatric emergency. Clients received no further service because the client withdrew from further contact with

the agency or the client was terminated by the agency.

Thirteen persons, or 6% of the total client sample (N=224) withdrew from further treatment. Four (2%) of these people were successful suicides and seven of the 13 persons withdrew for unspecified reasons (see Table LVI, Appendix C).

The data presented in Table LVII (Appendix C) indicates 51 persons (23%) in the total client sample were terminated without a referral. The telephone hot line terminated without referral approximately one half of the clients in the sample obtained from that agency. Law enforcement agencies and general hospitals without psychiatric units each terminated without a referral approximately 30% of the clients in the sample. The samples obtained from general hospitals with psychiatric units and mental health clinics appeared to terminate fewer clients from treatment without a referral. Thirty-seven of the total 51 clients were terminated without referral because it was determined that the client needed no further care or that the client was unresponsive to further treatment.

Referrals. The second type of disposition is for those persons who were either continued in treatment at the original facility and/or received a referral to another agency for service. Of the total sample of 224 clients, approximately 160 persons (71%) either received a referral or continued in treatment at the agency that provided service at the time of the mental health emergency.

The referral categories are not exclusive. One person may have received several referrals that were each marked by the researchers. The purpose of this section of data analysis is to consider the types of referrals and the frequency with which these referrals are made. A total of 182 referrals were made for clients in the sample. The percent-

ages for each type of referral are based upon the 182 referrals made and not the number of clients.

Table XVIII displays the data collected on referrals made to facilities providing inpatient care. Table XIX includes the data relating to referrals made for outpatient treatment. Table LVIII Appendix C may be referred to for a tabulation of the other types of referrals that were made for the clients in this sample.

TABLE XVIII

CLIENTS WHO RECEIVED INPATIENT TREATMENT

	Type of Facility						
	Gen.* Hosp. With	Gen. Hosp. W/out	Hot Line	Mental Health Clinic	Law Enf. Agencies	TOTAL	
	N=31	N=62	N=15	N=60	N=56	N=182	
Clients Referred for Inpatient Care						N	%
to a mental hospital	4	1	0	10	4	19	10%
to a general hospital psychiatric unit	4	1	2	0	0	7	4%
to a general hospital/other unit (not ER)	3	18	0	0	0	21	12%
to a Veterans Administration Hospital	1	0	0	4	0	5	3%
TOTAL	12	20	2	14	4	52	28.5%

*Gen. Hosp. With is General Hospitals with Psychiatric Units
Gen. Hosp. W/out is General Hospitals without Psychiatric Units

Fifty-two (29%) of the 182 referrals made were for inpatient care. The mental health clinic and general hospitals made more referrals to inpatient facilities than law enforcement agencies or the hot line. Another 52 (29%) referrals were made to other agencies for outpatient treatment. An additional 16 persons were continued in outpatient treat-

ment at mental health clinics after the resolution of the crisis. Twenty-three (13%) of these referrals were to mental health clinics. Sixteen referrals (9%) were made to professionals other than psychiatrists in private practice. Thirty-four referrals (21%) were made to the emergency rooms of general hospitals. One half of all referrals made by law enforcement agencies were to the emergency rooms of general hospitals.

TABLE XIX

CLIENTS WHO RECEIVED OUTPATIENT TREATMENT

	Type of Facility						
	Gen.* Hosp. With	Gen. Hosp. W/out	Hot Line	Mental Health Clinic	Law Enf. Agencies	TOTAL	
	N=31	N=62	N=15	N=60	N=56	N=182	
Clients referred for Oupatient Treatment						N	%
to a mental health clinic	2	11	7	0	3	23	13%
to a day treatment center	0	0	0	1	0	1	n.s.
to a psychiatric clinic	4	0	0	0	1	5	3%
to a private psychiatrist	2	4	0	0	0	6	3%
to another private professional	3	10	0	3	0	16	9%
to a clergy person	0	0	0	0	1	1	n.s.
TOTAL	11	25	7	4	5	52	28.5%

*Gen. Hosp. With is General Hospitals with Psychiatric Units
Gen. Hosp. W/out is General Hospitals without Psychiatric Units

The emergency rooms of general hospitals without psychiatric units made a total of 65 referrals for the clients in the sample, 20 of these were to inpatient facilities and 25 were to facilities which provide outpatient treatment. More of the referrals for inpatient care were to units within the same hospital as the emergency room. Most of the

referrals for outpatient care were to mental health clinics and professionals in private practices.

The emergency rooms of general hospitals with psychiatric units made a total of 25 referrals for the client sample. Twelve referrals were for inpatient care and 11 referrals were to facilities which provide outpatient treatment. This type of facility made a variety of referrals for inpatient care. Four referrals for inpatient care were to psychiatric units and three were to other units in the hospital. Another four referrals were made to state mental hospitals. Outpatient referrals were made to a variety of resources. This type of facility made fewer referrals to mental health clinics than the other facilities studied.

Mental health clinics made a total of 60 referrals, 14 to facilities providing inpatient care and 20 referrals were for outpatient treatment. The mental health clinic made most of the referrals for inpatient care to state mental hospitals and most of the persons receiving an outpatient referral were continued in treatment at the same mental health clinic that provided the psychiatric emergency service. The mental health clinic also made 12 referrals to the emergency room of a general hospital.

Law enforcement agencies made 37 referrals, the majority of these were to the emergency rooms of general hospitals; fewer referrals were made to other resources. The telephone hot line made seven referrals to mental health clinics and five referrals were made to various facilities providing inpatient care.

There were several types of referrals that were not used at all or used infrequently according to the review of client records. Only one referral was made for day treatment, even though four of the counties have these programs. Only two referrals were made to a hostel or halfway

house. Two referrals were made to public health or welfare agencies and no referrals were made to mental retardation facilities or programs.

Summary

The second section of data analysis focused on the characteristics of 224 clients who used the psychiatric emergency services provided by the 18 agencies studied.

The majority of clients in the sample from all agencies were between 20 and 39 years old. The general hospitals also provide the majority of psychiatric emergency services for the geriatric population. The clientele using emergency services appear to be nearly equal percentages of men and women. The law enforcement agencies tend to provide services to more men than women and the mental health clinics provide service to more women than men. Those clients for whom marital status was recorded were more often married than single. General hospital emergency rooms provided service to more single persons in the sample.

Approximately 80-85% of the clients in the sample resided in the same county as the agency providing service. Ten to 15% of the client sample were persons who did not reside in the same county as the agency providing service. Psychiatric emergency services were provided to 40% of the total client population on a weekend. It appeared that more of these persons are being seen in the emergency rooms of general hospitals than other facilities studied. The majority of clients in the sample were seen during normal working hours. There were fewer clients seen during the evening and the lowest number were seen during the early morning hours. The law enforcement agencies saw greater numbers of clients in the sample during the evening hours.

It appeared from the data analysis that the problems people

brought to psychiatric emergency services had either arisen during the previous 24 hours or were over 2 years in duration. The split findings with regard to this variable appear to be related to the type of agency and service provided by the agency.

There were more clients in the sample requesting voluntary treatment than those clients who were receiving treatment involuntarily. There were nearly equal percentages of psychiatric emergencies and crisis situations. Law enforcement agencies tended to deal with more persons in psychiatric emergencies of an acute nature (such as suicide). The mental health clinics generally provided service to more persons considered to be in a crisis situation.

With regard to diagnosis, suicide attempts and depression appear to be the most common complaints of persons who use a psychiatric emergency service. Law enforcement agencies were most often involved with persons making a suicide attempt or having taken an overdose.

From the standpoint of the consumer, it appears that the type of service and disposition that one receives is determined by the type of agency that provides the psychiatric emergency service. Nearly all patients seen by mental health clinic staff were given a mental status examination, and yet few clients received a physical exam. The general hospitals more often provided for physical exams and less often performed a mental status examination.

The referrals made by law enforcement agencies were often to general hospital emergency rooms. General hospitals appeared to be more likely to terminate clients without a referral or to admit clients to an inpatient facility. Mental health clinics more often continued the client in treatment at the clinic.

From the analysis of data, it appears that the type of service and disposition received by clients in a psychiatric emergency was not necessarily in relation to the client's problem, but may be more closely related to the service bias of the agency, or the service resources available.

The analysis of client data has used the demographic variables to describe the characteristics of the people who use psychiatric emergency services. The elements of the situation surrounding a psychiatric emergency have been considered. The trends in service delivery, including the assessment and evaluation of the problem, have been identified. Finally, the dispositions and referrals that are most frequently made for clients seen by a psychiatric emergency service were described. The following section describes direct service providers' opinions about psychiatric emergency service delivery.

PSYCHIATRIC EMERGENCY SERVICES QUESTIONNAIRE

The psychiatric emergency services questionnaire was designed to gather subjective data on psychiatric emergency services from direct service providers in each of the agencies studied. Approximately ten copies of the questionnaire were given to each agency contact person to be distributed among his/her staff, including personnel in all occupational roles who deliver psychiatric emergency services in that agency. Self-addressed stamped envelopes were included to encourage return of the questionnaires.

The results reported in this section represent the questionnaires returned that were correctly and fully completed. If two or more items were not answered, the questionnaires were not used. Other question-

naires not used were those that were not returned prior to the processing of the data or those that were not returned. Approximately 237 questionnaires were distributed and 101 of the total were used. The percent of usable returned questionnaires was 43%. The information collected is either considered by the occupational roles of all the persons responding, by the county in which they work, or by the type of facility in which they work such as a mental health clinic or hot line. The subheading will represent items taken directly from the questionnaire.

In the psychiatric emergency services questionnaire, the first question on the questionnaire identified the occupational role of the respondent (Appendix B). The next four questions were designed to obtain a general idea of the respondent's opinions concerning: what kind of facilities should deliver psychiatric emergency services, what personnel deliver the majority of psychiatric emergency services, what personnel should deliver the services and what prevents these personnel from delivering effective services. The first part of the data analysis of the psychiatric emergency services questionnaire will focus on these general questions.

The second part of the questionnaire consisted of items asking the respondent to rank in order of importance three variables of their psychiatric emergency service according to the positive and negative aspects of the staffing, delivery, facility and coordination of the service. In each of these questions, the three ranked variables were selected from 10 possible choices. Each respondent was also asked to choose the one most positive aspect of their agency's psychiatric emergency service from the 12 items they had already ranked. For example, out of the 12 positive variables already ranked in importance, one

variable which was the most important was chosen. The same was done for negative aspects.

General Question: Respondent's Occupational Roles in Psychiatric Emergency Services

This question identifies the respondent's occupational role in psychiatric emergency service delivery. There are two categories of professionals including: 'bachelor's prepared professional or registered nurse,' and 'professional' which includes any master's or doctoral level professional with specialized mental health training or non-psychiatrist medical doctor. In the remaining items, the two professional categories are collapsed.

TABLE XX

RESPONDENT'S OCCUPATIONAL ROLES REPRESENTED IN PSYCHIATRIC EMERGENCY SERVICES IN FIVE COUNTIES

	County Studied						
	Klamath County	Multnomah County	Tillamook County	Union County	Washington County	TOTAL Counties	
Roles	N	N	N	N	N	N	%*
Volunteer	3	5	0	0	1	9	9%
Para-professional	2	1	0	1	2	6	6%
B.A. Prof. or R.N.	1	5	2	3	3	14	14%
Professional	5	14	6	2	4	31	31%
Psychiatrist	0	5	0	0	1	6	6%
Law Enforcement	4	9	9	6	7	35	35%
TOTAL	15	39	17	12	18	101	101%
TOTAL %	15	39	17	12	18	101	

*Percentages rounded

By County. Table XX represents the occupational roles of the per-

sonnel involved in the delivery of psychiatric emergency services in Klamath, Multnomah, Tillamook, Union, and Washington counties who filled out the Psychiatric Emergency Services Questionnaires. No responses by certain categories of personnel indicates only that questionnaire were not received or utilized from these personnel in the particular facility, not that those personnel are not present in those facilities. Because more facilities were surveyed in Multnomah County, that county has the largest number of staff responding to the questionnaire. Law enforcement represents the largest percentage (35%) of the total respondents. Professionals (31%) are the second highest percentage. Paraprofessionals (6%) and psychiatrists (6%) were the occupational roles least represented.

By Facility. Table XXI represents the occupational roles in the various facilities that provide psychiatric emergency services who filled out Psychiatric Emergency Services Questionnaires.

TABLE XXI

RESPONDENT'S OCCUPATIONAL ROLES REPRESENTED IN PSYCHIATRIC EMERGENCY SERVICE DELIVERY BY FACILITY

	Type of Facility						
	Gen. Hosp. With	Gen. Hosp. W/out	Hot Line	Mental Health Clinic	Law Enf. Agencies	TOTAL	
Roles	N	N	N	N	N	N	%*
Volunteer	0	0	7	1	0	8	8%
Para-professional	0	2	1	2	0	5	5%
B.A. Prof. or R.N.	3	8	1	2	0	14	14%
Professional	5	0	0	24	0	29	30%
Psychiatrist	4	0	0	2	0	6	6%
Law Enforcement	0	2	0	0	33	35	36%
TOTAL	12	12	9	31	33	97	99%

Gen. Hosp. With is General Hospitals with Psychiatric Units
Gen. Hosp. W/out is General Hospitals without Psychiatric Units
*Percentages rounded

No response by certain categories of personnel does not necessarily indicate the lack of a particular role within a facility. It does indicate that a particular role in a particular facility (i.e., no volunteers in general hospitals) is not represented by a completed questionnaire. The largest percentage is reported below.

(1) General Hospital. Sixty-six percent of personnel who completed Psychiatric Emergency Services Questionnaire are bachelor's prepared professionals or registered nurses.

(2) General Hospital with Psychiatric Unit. Forty-two percent of persons completing the questionnaire are professionals.

(3) Mental Health Clinic. Seventy-seven percent of the respondents are professionals.

(4) Hot Line. Seventy-eight percent of respondents are volunteers.

(5) Law Enforcement. Law enforcement personnel were considered only as law enforcement regardless of their education, since a master's may not represent special education in mental health. Two law enforcement people showed in the general hospital tally. It could be the responses of two guards since they are not part of a law enforcement agency per se.

(6) Total by Facility. Of all respondents across all facilities, law enforcement has the largest percent of total responses (36%). Paraprofessionals have the smallest (5%).

It appears that occupational roles dealing with psychiatric emergency services are not evenly distributed within different facilities, since there are many occupational roles which were not represented in certain facilities; i.e., no paraprofessional in a general hospital with psychiatric unit.

General Question: Facilities That Should Deliver Psychiatric Emergency Services

This is the second item on the questionnaire. Respondent's answered this question by checking any or all of the 10 facility choices that they felt should deliver psychiatric emergency services. Table XXII represents the number of times a person in a particular occupational role chose a particular facility that should deliver psychiatric emergency services.

TABLE XXII

FACILITIES THAT SHOULD BE DELIVERING PSYCHIATRIC EMERGENCY SERVICES ACCORDING TO OCCUPATIONAL ROLE

	OCCUPATIONAL ROLE							
	Volun.	Para-P.	B.A. Prepared or R.N.	Prof.	Psych.	Law Enf.	TOTAL	
Facility	N	N	N	N	N	N	N	%*
Mental Health Clinic	18	5	11	31	5	22	82	15%
Psychiatric Hospital	7	5	13	28	5	16	74	13%
Gen. Hosp. W/out Psych. Unit	2	2	7	23	4	2	40	7%
Gen. Hosp. W/ Psych. Unit	8	5	14	28	6	29	90	16%
State Hospital	5	3	10	23	5	10	56	10%
Law Enforcement	3	1	8	19	2	11	44	8%
Hot Lines	9	4	10	22	4	10	59	10%
Private Psychiatrists	5	2	8	20	5	9	49	9%
Private Mental Health Professionals	5	2	8	22	3	12	52	9%
Other	2	1	2	6	1	4	16	3%
TOTAL	54	30	91	222	40	125	562	100%

*Percentages rounded

By Occupational Role. The following results are represented in Table XXII. All volunteers felt hot lines should deliver psychiatric emergency services. Paraprofessionals chose mental health clinics, psychiatric hospitals and general hospitals with psychiatric units as the facilities that should deliver psychiatric emergency services. Professionals chose mental health clinics most often as the facility that should deliver these services. Bachelor's prepared professionals or registered nurses, psychiatrists and law enforcement selected the general hospital with psychiatric unit most frequently as the facility that should deliver psychiatric emergency services. Of the total responses to the questionnaire across roles, the respondents felt that the facilities that should be delivery psychiatric emergency services are: general hospitals with psychiatric units (16%), mental health clinics (15%) and psychiatric hospitals (13%). The least picked facilities were the general hospitals without psychiatric units (7%) and law enforcement (8%).

By County. General hospitals with psychiatric unit was the most often picked facility that should deliver psychiatric emergency services including: Multnomah (92%), Tillamook (71%), Union (92%) and Washington (100%).

Ninety-three percent of the Klamath County personnel selected mental health clinics as the facility which should deliver the majority of psychiatric emergency services.

General hospital with psychiatric units (89%) and mental health clinics (82%) were the two facilities chosen most often by all counties to deliver these services.

General Question: Who Delivers the Majority of Psychiatric Emergency Services

This is the third item on the questionnaire and respondent's only selected one response. Who delivers the majority of psychiatric emergency services according to the respondent's role is reported in Table XXIII.

TABLE XXIII

THE OCCUPATIONAL ROLE THAT DELIVERS MAJORITY OF PSYCHIATRIC EMERGENCY SERVICES BY ACTUAL ROLE

Occupational Role Delivering Most Services	Occupational Roles of Respondents							
	Volun.	Para-P.	B.A. Prepared or R.N.	Prof.	Psych.	Law Enf.	TOTAL	
	N	N	N	N	N	N	N	%*
Volunteer	8	0	0	0	0	0	8	9%
Para-Professional	0	2	2	0	0	2	6	6%
Professional	0	3	7	22	3	3	38	41%
Psychiatrist	0	0	0	2	3	2	7	8%
Law Enforcement	0	0	0	2	1	22	25	26%
Interdisciplinary Team	0	0	2	5	1	1	9	10%
Other	0	0	0	0	0	1	1	1%
TOTAL	8	5	11	31	8	31	94	101

*Percentages rounded

By Occupational Role. The majority of paraprofessionals bachelor's prepared professionals or registered nurses, and professionals felt that professional mental health workers deliver the majority of services. Psychiatrists felt psychiatrists and other professionals delivered the majority of these services. Law enforcement and volunteers both chose themselves as delivering the majority of emergency mental health services. Of the 94 total responses, professionals were chosen 41% of the time as delivering the majority of psychiatric emergency services, law

enforcement was second with 26%, and paraprofessionals (6%) were selected least often.

By County. Professionals were most often picked as delivering the majority of psychiatric emergency services by Klamath (33%), Multnomah (28%), Tillamook (44%), Union (42%), and Washington (60%) counties. Union County also selected law enforcement 42% of the time. Psychiatrists were not selected by Klamath, Tillamook, Union or Washington counties. Across total counties, professionals prevailed as delivering the majority of psychiatric emergency services in 38% of responses. Psychiatrists (7%) and paraprofessionals (7%) were chosen least often.

General Question: Ideally Who Should Deliver Psychiatric Emergency Services According to Occupational Role

This is the fourth item on the Psychiatric Emergency Services Questionnaire, and the respondents could select one choice only. The results are reported in Table XXIV.

TABLE XXIV

WHO SHOULD BE DELIVERING PSYCHIATRIC EMERGENCY SERVICES ACCORDING TO OCCUPATIONAL ROLE

	Respondent's Occupational Role							
	Volun.	Para-P.	B.A. Prepared or R.N.	Prof.	Psych.	Law Enf.	TOTAL	
Ideal Occupational Role	N	N	N	N	N	N	N	%*
Volunteer	0	0	0	0	0	0	0	0%
Para-Prof.	2	1	0	1	0	6	10	11%
Professional	3	4	3	13	3	10	36	38%
Psychiatrists	1	1	3	1	1	10	17	17%
Law Enforcement	0	0	0	0	0	1	1	1%
Inter. Disc. Team	2	0	6	15	4	2	29	31%
Other	0	0	0	0	0	1	1	1%
TOTAL	8	6	12	30	8	30	94	100%

*Percentages rounded

By Occupational Role. Volunteers and paraprofessionals stated that professionals should be delivering psychiatric emergency services in an ideal delivery system. Law enforcement agreed that professionals should deliver the majority of these services but also felt that psychiatrists should be the primary deliverers of mental health emergency services. Bachelor's prepared professionals or registered nurses, professionals and psychiatrists most often chose interdisciplinary teams to deliver the majority of psychiatric emergency services. Professionals and psychiatrists also felt professionals should be direct service deliverers of these services. Of the 94 total responses from all occupational roles it was apparent that professionals (38%) and interdisciplinary teams (31%) were chosen as the personnel that should deliver the majority of psychiatric emergency services. As shown in Table XXIII, professionals do deliver the services which is congruent with who it was felt by the respondents should deliver these emergency services. However, law enforcement was chosen second most often as the occupational role delivering the majority of services and was one of the least selected categories for personnel who should deliver the services. Volunteers were not chosen at all as persons who should deliver psychiatric emergency services, yet they deliver hot line telephone emergency services almost exclusively.

By County. Respondents from Tillamook (56%), Union (50%), and Washington (38%) counties all felt that professionals should be the major deliverers of psychiatric emergency services. Respondent's from Klamath County (33%) selected psychiatrists to deliver the majority of services, and in Multnomah County (51%) interdisciplinary teams were the personnel of choice to deliver mental health emergency services. Of the total

responses to this item, professionals (36%) were the personnel chosen most frequently who should deliver psychiatric emergency services. Next was the interdisciplinary teams with 31%.

General Question: What Prevents Personnel from Delivering Psychiatric Emergency Services

This is the fifth item on the questionnaire and the last general question. Respondents could choose from 10 possible choices and could select any of all of them.

TABLE XXV

WHAT PREVENTS PERSONNEL FROM DELIVERING PSYCHIATRIC EMERGENCY SERVICES BY COUNTY

	Counties						
	Klamath County	Multnomah County	Tillamook County	Union County	Washington County	TOTAL	
Problem	N	N	N	N	N	N	%*
Need More Funds	24	11	11	5	16	67	24%
Need more Volunteers	6	2	0	0	1	9	3%
Need more Para-Prof.	12	2	3	0	4	21	8%
Need more Professionals	24	7	5	5	9	50	18%
Need more Psychiatrists	10	5	5	2	4	26	9%
Need More Interest	9	6	4	1	6	26	9%
Need More Collaboration	13	5	5	4	5	32	12%
Need More Training	10	6	3	0	7	26	9%
Other	12	2	3	1	3	21	8%
TOTAL	120	46	39	18	55	278	100

*Percentages rounded

By County. As shown in Table XXV, respondents from Multnomah and Union counties felt 'need for funds' and 'need for more professionals' prevented service delivery. Washington, Klamath and Tillamook

County respondents stated they were inhibited from delivering service most often due to 'lack of funds.' Of the 278 total choice selected, the counties registered agreement in selecting the 'need for more professionals' and the 'need for more funds' as the factors that prevent psychiatric emergency services delivery.

By Facility. General hospitals with psychiatric units (92%) and general hospitals without psychiatric units (69%) agree that the 'need for more professionals' is the factor inhibiting psychiatric emergency services delivery.

While general hospitals with psychiatric units (83%), mental health clinics (65%) and law enforcement agencies (69%) feel the lack of funds prevents personnel from delivering psychiatric emergency services.

Ranking Question: Most Positive and Negative Aspects of Psychiatric Emergency Services

The second part of the questionnaire consisted of items which ranked in order of importance the three most positive aspects of the staffing, delivery, facility and coordination of the agency in which the respondent works. The same was done for the three aspects needing improvement. For example, each ranking question has the potential of having a first choice item, a second choice item and a third choice item. All the totals of the first choice items for each ranking question will be reported in the analysis and will appear in the remaining tables. Since the respondents noted some difficulty in choosing whether a choice would be most appropriate as a first, second or third choice, the researchers determined it was important that a more general picture of the aspects of psychiatric emergency services could be presented. This was accomplished by combining all the first, second and third choices, item

by item. This is called the combined choice total and will also be presented in the following tables.

When the ranking data from the questionnaire was tallied by the computer, it was computed according to: the respondent's occupational role and the facility in which the respondent worked. This was done by the researchers to learn if there were any major differences in the responses of respondents in different occupational roles (i.e., professional or psychiatrist) or in different types of facilities (i.e., general hospitals with psychiatric units and mental health clinics). All totals are reported by total facilities (including all general hospitals, general hospitals with psychiatric unit, mental health clinic, hot line and law enforcement agencies), and by total roles (including volunteers, paraprofessionals, bachelor's prepared professionals, registered nurses, professionals, psychiatrists and law enforcement personnel). So in each of the following table there will be four columns of total figures: the first choice totals and the combined choice totals by occupational role and by facility.

The responses to the "other" categories have not been presented since they do not represent any one category and are not conclusive to the rest of the data. Tables XXVI-XXIX represent the positive aspects of staffing, delivery, facility and coordination of psychiatric emergency services by role and by facility. Tables XXX-XXXIII represent the elements needing improvement of the same aspects. Each of the choices representing items of a positive nature are simply reworded to provide a negative counterpart choice. For example, from the positive item 'sufficient number of waiting rooms,' the negative counterpart item 'need for more waiting rooms' was developed in order that the positive

and negative aspects could be easily compared.

The next four questions to be presented will be the positive aspects of the psychiatric emergency service staffing, delivery, facility and coordination, with a fifth concluding question reporting the overall choice from the twelve previously ranked aspects which represents the one most important positive aspect of the agency in which the respondent works.

TABLE XXVI

MOST IMPORTANT POSITIVE ASPECT OF STAFFING

	FACILITY				ROLE			
	First Choice TOTALS		Combined Choice TOTALS		First Choice TOTALS		Combined Choice TOTALS	
Categories	N	%	N	%	N	%	N	%
Sufficient Mental Health Personnel On-duty	16	16*	33	11	16	16	33	11%
Sufficient Mental Health Personnel On-call	13	13	42	14	14	14	43	14%
Responsive Mental Health Personnel	37	37	64	22	38	38	65	22%
Sufficient Cooperation and Coordination	11	11	48	16	10	10	49	16%
Appropriate Internal Referrals	1	1	14	5	1	1	14	5%
Recognition of Psychiatric Problems by Medical Staff	10	10	28	10	10	10	28	9%
Sufficient Administrative Support	1	1	24	8	1	1	24	8%
Sufficient Crisis Intervention Training	8	8	36	12	8	8	36	12%
Other	2	2	4	1	2	2	4	1%
TOTAL	99	99	293	99	100	100	302	98%

*Percentages rounded

Ranking Question: Most Important Postive Aspect of Staffing

First Choice Total. The most frequently chosen first choice as the most important aspect of the staffing of all psychiatric emergency

services agencies was 'responsive mental health personnel' by facility (37%) and by role (38%), as shown in Table XXVI. There is little numerical difference between these totals. In the subtotals, only hot lines diverged from the majority by selecting 'sufficient coordination and cooperation among staff' most often.

The least chosen categories were 'sufficient administrative support' (1%) and 'appropriate internal referrals from general medical staff' (1%). The latter category would less likely be used by hot lines and law enforcement agencies since they don't have medical personnel on their staffs.

Combined Choice Total. The combined totals also reflected 'responsive mental health personnel' by facility (22%) and by role (22%) as the most important positive aspect of their psychiatric emergency services.

TABLE XXVII

MOST IMPORTANT POSITIVE ASPECT OF DELIVERY

	FACILITY				ROLE			
	First Choice TOTALS		Combined Choice TOTALS		First Choice TOTALS		Combined Choice TOTALS	
Categories	N	%	N	%	N	%	N	%
Appropriate Self-referrals	14	14*	33	12	15	15	32	12%
Appropr. Waiting Period	7	7	27	10	7	7	28	10%
Routine Medical Exams	4	4	24	9	4	4	24	9%
Sufficient Social Service Support	6	6	31	11	6	6	32	12%
Sufficient Follow-up	13	13	46	16	13	13	46	16%
Appropriate Service Not Ability to Pay	41	42	71	25	41	42	70	25%
Ability to Administer Standing Order Meds	2	2	12	4	2	2	12	4%
Appropriate Time Span Referral to Appointment	6	6	26	9	5	5	21	8%
Other	4	4	12	4	4	4	12	4%
TOTAL	97	98	282	100	97	98	277	100

*Percentages rounded

Ranking Question: Most Important
Postive Aspect of Delivery

First Choice Totals. In Table XXVII these totals show that the most frequently chosen category was 'appropriate service regardless of ability to pay' by facility (42%) and by role (42%). The least chosen category was the 'ability to give standing order medications' (2%) by role and facility.

Combined Choice Total. These totals are consistent with the first choice totals, selecting most often 'appropriate service regardless of ability to pay' by facility (25%) and by role (25%). The least chosen category is 'ability to give standing order medications' by role (4%) and by facility (4%); this is also consistent with the first choice totals.

TABLE XXVIII

MOST IMPORTANT POSITIVE ASPECT OF FACILITY

	FACILITY				ROLE			
	First Choice TOTALS		Combined Choice TOTALS		First Choice TOTALS		Combined Choice TOTALS	
Categories	N	%	N	%	N	%	N	%
Sufficient Interview Rooms	6	6*	21	8	6	6	21	8%
Sufficient Holding Rooms	6	6	13	5	6	6	12	4%
Sufficient Observation Rooms	0	0	2	1	0	0	3	1%
Adequate Telephone Coverage	21	22	52	19	22	23	49	18%
Good Proximity to Medical Facility	26	27	66	24	26	27	68	26%
Facility Physically Available to Client	30	30	66	24	30	31	69	26%
Sufficient Transportation to Facility	3	3	30	11	3	3	28	10%
Other	3	3	16	6	3	3	15	6%
TOTAL	95	99	270	99	96	99	268	100%

*Percentages rounded

Ranking Question: Most Important
Aspect of the Facility

First Choice Totals. The most frequently chosen category is the 'facility is physically available' by role (30%) and by facility (31%) reported in Table XXVIII.

The least chosen category is 'sufficient transportation to agency' by role and by facility (3%). Results of the "other" category were not conclusive. 'Sufficient number of observation rooms' and 'sufficient number of private waiting rooms' were not chosen at all.

Combined Choice Total. There were two categories selected most often by role (24%) and by facility (24%) including 'good proximity to medical facility' and 'facility physically available.' The latter substantiates the findings in the first choice total categories. The least chosen categories were 'sufficient number of observation rooms' and 'sufficient number of private waiting rooms.'

Ranking Question: Most Important
Aspect of Coordination

First Choice Totals and Combined Totals show that 'sufficient coordination with law enforcement' is the category selected most often: first choice by facility is 27% and by role is 24%; combined total is 22% by facility and 20% by role as shown in Table XXIX.

The least often picked category, 'sufficient community education,' is the same across totals: first choice totals by facility (3%), by role (2%); combined choice total by facility (4%), by role (3%).

TABLE XXIX

MOST IMPORTANT POSITIVE ASPECT OF COORDINATION

	FACILITY				ROLE			
	First Choice TOTALS		Combined Choice TOTALS		First Choice TOTALS		Combined Choice TOTALS	
Categories	N	%	N	%	N	%	N	%
Provision of Transportation to Referral	6	7*	20	8	6	6	19	7%
Appropriate Referrals from other Agencies	8	10	37	14	12	12	44	15%
Sufficient Coordination with Law Enforcement	21	27	58	22	23	24	59	20%
Sufficient Coordination with other M.H. Agencies	10	13	34	13	16	16	45	15%
Sufficient Number of Referral Sources	4	5	20	8	8	8	28	10%
Community Support for Mental Health	3	4	20	8	6	6	21	7%
Sufficient Community Education	2	3	10	4	2	2	9	3%
Sufficient Coordination with Social Agencies	8	10	33	13	9	9	37	13%
Ability for Non-M.D. to admit to Local Hospital	12	16	21	8	12	12	22	8%
Other	3	4	8	3	3	3	7	2%
TOTAL	77	99	261	101	97	98	291	100

*Percentages rounded

Summary of Positive Aspects of the Psychiatric Emergency Services

Questionnaire results showed that the most often selected positive aspects of psychiatric emergency service staffing and delivery were 'responsive mental health personnel' and 'appropriate service regardless of ability to pay' respectively. This represents both first and combined choice totals. The positive aspect of the facility reported in the first choice totals most often was 'facility physically available.' This was also reflected in the combined choice totals as well as 'good proximity to general medical facility.' The most important factor aiding coordination with law enforcement.' The most important positive

aspect of the respondent's psychiatric emergency service agency was 'responsive mental health personnel.'

The following four items to be presented in the data analysis are the aspects of the staffing, delivery, facility, and coordination of psychiatric emergency services that need improvement. A fifth item represents the overall factor that the respondents felt was most in need of improvement. This will be followed by a summary of the aspects needing improvement. Finally, a summary of all the data collected from the psychiatric emergency services questionnaire will conclude this section of the data analysis.

Ranking Question: Most Important Aspect of Staffing Needing Improvement

First Choice Totals. The most often selected category needing improvement in the staffing was 'need more personel on-duty' by facility (26%) and by role (26%). The least often selected categories were: (a) 'need for more coordination and cooperation among staff' by facility (4%) and by role (4%) which is consistent with the findings in Table XXX, where this category was chosen second most frequently as a positive aspect of staffing; and (b) 'need more appropriate internal referrals' by facility (4%) and by role (4%).

Combined Choice Totals. These totals showed the most frequently chosen category was 'need for more crisis training' by facility (17%) and by role (17%). Second was the 'need for more personnel on-duty' by facility (16%) and by role (17%).

The least chosen category, 'need more appropriate internal referrals,' is the same as for the first choice totals by facility (4%) and by role (4%).

TABLE XXX

MOST IMPORTANT AREA OF STAFFING NEEDING IMPROVEMENT

	FACILITY				ROLE			
	First Choice TOTAL		Combined Choice TOTAL		First Choice TOTAL		Combined Choice TOTAL	
Categories	N	%	N	%	N	%	N	%
Need more personnel on-duty	26	26*	46	16	26	26	50	17%
Need more personnel on-call	15	15	38	13	15	15	37	13%
Need more responsive personnel	12	12	32	11	12	12	29	10%
Need more cooperation and coordination	4	4	28	10	4	4	28	9%
Need more appropriate internal referrals	4	4	13	4	4	4	12	4%
Need more recognition from medical staff	8	8	45	15	10	10	46	16%
Need more administrative support	8	8	24	8	9	9	25	8%
Need for more crisis intervention training	17	17	50	17	16	16	51	17%
Other	5	5	15	5	5	5	17	6%
TOTAL	99	99	291	99	101	101	295	100

*Percentages rounded

Ranking Question: Most Important Aspect of Delivery Needing Improvement

First Choice Total. By facility, the most frequently selected category was the 'need for more follow-up' (21%). By role, most often selected was 'need for more service regardless of ability to pay' (22%); 'need for more follow-up' is second (18%).

The least chosen category is the 'need to administer standing order medications' by facility (3%) and by role (5%). Also least selected by role is 'need for better self-referrals' (5%).

Combined Choice Totals. There is agreement by facility (20%) and by role (20%) that 'need for more follow-up' is the most often selected aspect of delivery needing improvement.

The least chosen category, 'need to administer standing order medications,' is consistent with the first choice totals by facility (4%) and by role (6%). This may reflect the lack of medical personnel in the hot line and law enforcement agencies.

TABLE XXXI

MOST IMPORTANT AREA OF DELIVERY NEEDING IMPROVEMENT

	FACILITY				ROLE			
	First Choice TOTAL		Combined Choice TOTAL		First Choice TOTAL		Combined Choice TOTAL	
Categories	N	%	N	%	N	%	N	%
Need for better self-referrals	6	6*	22	8	5	5	22	8%
Need to shorten waiting period for clients	13	13	29	10	9	10	26	10%
Need for more routine physical exams	11	12	25	9	9	10	20	7%
Need more social service support	11	12	34	12	9	10	32	12%
Need for more follow-up	20	21	56	20	17	18	55	20%
Need more service regardless of ability to pay	16	17	44	16	21	22	50	18%
Need to administer standing order meds	3	3	10	4	5	5	16	6%
Need to shorten time between refer. & appt.	10	11	45	16	14	15	44	16%
Other	5	5	12	4	5	5	11	4%
TOTAL	95	100	277	99	94	100	276	101

*Percentages rounded

Ranking Question: Most Important Aspect of Facility Needing Improvement

First Choice Totals. As shown in Table XXXII, the most often selected category was 'need more holding rooms' by facility (24%) and by role (24%). In the sub-totals by role, law enforcement personnel and mental health clinics especially favored this category. The second choice category was 'need for the facility to be physically available.' This is inconsistent with Table XXVIII, the positive counterpart to this

issue in which the 'facility is physically available' was the most often selected positive variable.

The least often selected category is the 'need for more telephone coverage' by facility (3%) and by role (3%).

Combined Choice Total: The most often selected category was 'need for transportation to facility' by facility (20%) and by role (18%). The least often selected categories by facility were 'need for more telephone coverage' (5%) and 'need for more proximity to general medical facility' (5%). The latter is also the least picked category by role (5%). This category was chosen most often by law enforcement and mental health clinic personnel.

TABLE XXXII

MOST IMPORTANT AREA OF FACILITY NEEDING IMPROVEMENT

	FACILITY				ROLE			
	First Choice TOTAL		Combined Choice TOTAL		First Choice TOTAL		Combined Choice TOTAL	
Categories	N	%	N	%	N	%	N	%
Need for more interview rooms	13	15*	40	16	13	15	37	15%
Need more holding rooms	21	24	40	16	21	24	41	16%
Need more observation rooms	4	4	26	10	4	4	26	10%
Need more private waiting rooms	6	7	29	12	7	8	27	11%
Need more telephone coverage	3	3	13	5	3	3	17	7%
Need more proximity to general medical facility	4	4	13	5	4	4	12	5%
Need for facility to be physically available	20	22	29	12	20	22	37	15%
Need for transportation to facility	13	15	50	20	14	16	44	18%
Other	5	6	10	4	4	4	10	4%
TOTAL	89	100	250	100	90	100	251	101

*Percentages rounded

Ranking Question: Most Important Aspect of Coordination Needing Improvement

First Choice Total. The most selected category was the 'need for community education' by facility (20%) and by role (21%). The second most selected category was the 'need for more community support' by facility (18%) and by role (18%).

TABLE XXXIII

MOST IMPORTANT AREA OF COORDINATION NEEDING IMPROVEMENT

	F A C I L I T Y				R O L E			
	First Choice TOTAL		Combined Choice TOTAL		First Choice TOTAL		Combined Choice TOTAL	
Categories	N	%	N	%	N	%	N	%
Need transportation to referral source	14	14*	32	11	13	13	31	11%
Need more appropriate referrals	3	3	18	6	3	3	16	6%
Need more coordination with law enforcement	10	10	29	10	10	10	25	9%
Need more coordination mental health agencies	8	8	35	12	8	8	32	11%
Need more referral sources	13	3	27	9	13	13	31	11%
Need for more community support	17	17	47	16	18	19	50	18%
Need for more community education	19	20	41	14	20	21	42	15%
Need for more coordination social agencies	7	7	34	12	6	6	31	11%
Need for non-M.D. to admit to local hospital	5	5	19	7	5	5	18	6%
Other	1	1	3	1	1	1	3	1%
TOTAL	97	99	285	98	97	99	279	99

*Percentages rounded

Combined Choice Total. The above findings are reversed in the combined choice totals with 'need for community support' first by facility (16%) and by role (18%), and 'need for more community education' by facility (14%) and by role (15%). All four totals in Table XXXIII showed 'need for more appropriate referrals' as the category least

chosen: first choice totals by facility (3%) and by role (3%); combined choice totals by facility (6%) and by role (6%).

Ranking Question: One Most Important Positive Aspect of Respondent's Agency

The two most important aspects needing improvement by facility were: 'need for more community support' and 'need for more community education,' both with 12%. The most important aspect needing improvement by role is the 'need for more community support' (17%) and 'need for more community education' (10%).

Summary of Aspects of Psychiatric Emergency Services Needing Improvement

'Need more personnel on-duty' was selected most often in the first choice totals as the factor needing improvement in the staffing of the psychiatric emergency services, while the combined choice totals reflected 'need for more crisis training' as the factor most in need of improvement.

Both first choice totals and combined choice totals reflected 'need for follow-up' as the aspect most in need of improvement in the delivery of psychiatric emergency services. The most important aspect of the facility needing improvement is the 'need for more holding rooms' according to the first choice totals and 'need for transportation to the facility' according to the combined choice totals.

In the first choice totals the most frequently selected aspect of coordination needing improvement was the 'need for community education.' And in the combined choice totals was the 'need for community support.' The 'need for community support' was also reflected in the most impor-

spondents are 'need for more professionals' and the 'need for more funds.'

In the area of staffing, as shown in Table XXVI, the most overwhelming positive aspect was 'responsive mental health personnel.' This may be indicative that service providers see themselves or their colleagues as responsive and caring. This is substantiated again by a high percentage in 'sufficient cooperation and coordination.' The aspect of staffing most in need of improvement was 'more personnel on duty' which respondents felt were necessary to provide better psychiatric emergency care. 'Need for more training' (Table XXX) is another aspect for improvement especially expressed by the volunteers and bachelor's level professionals and registered nurses. The more highly trained professionals appear not to feel the need for more training in crisis intervention as much as other needs.

In the area of delivery, the most important aspect of psychiatric emergency services (Table XXVII) is 'appropriate service regardless of ability to pay.' This may reflect the fact that many of the agencies are county and state funded and have a capacity to see clients on a sliding fee basis, or the services are free of charge to the person in crisis like the hot lines or law enforcement. 'Need more services regardless to pay' showed up as a needed area of improvement (Table XXXI). This may indicate generally the need for more services, which is not substantially indicated by 'need for more referral sources' in Table XXXI. The percentage of this category is in the mid-range.

One category in the delivery of psychiatric emergency services that was extremely low, both in positive (Table XXVII) and negative (Table XXXI) aspects, was the 'ability (or need) to administer standing order psychotropic medications.' This choice would not be chosen by a

telephone hot line that does not see clients in person. The professionals in the general hospitals with and without psychiatric units did not select this category often, which may suggest that there are physicians available in a crisis to prescribe medications if necessary. Law enforcement agencies appeared to be the facility most in need of giving psychotropic medications to persons in crisis. This may be because they go into people's homes and perhaps see more acute crisis episodes than hospital or clinic personnel.

The most positive aspect of the facility (Table XXVIII) is that it is 'physically available to persons seeking care.' However, this variable also was the second variable most needing improvement. One conclusion may be found in the subtotals. Law enforcement has chosen this category most often in both the negative and positive aspects. Perhaps this is due to the fact that law enforcement personnel are physically available due to their mobility, but closer geographic proximity to the actual psychiatric facilities would be helpful in getting the person in crisis to treatment. This corresponds to the relatively high percent response across totals in category 'need for more referral sources' (Table XXXIII). However, the second most important positive aspect of the facility across totals (Table XXVIII) was 'good proximity to medical facilities.' The results in the subtotals of the first choices indicated that mental health clinics desire 'closer proximity to medical facilities' but over all facilities across totals, it appeared that medical facilities were well within needed reach (Table XXXIII).

The first choice totals showed that the aspect of the facility needing most improvement was 'need for more holding rooms.' In the subtotals this reflects two facilities in particular: the clinics and law

enforcement. These personnel often deal with persons involved in the involuntary commitment process who are in danger to themselves or others. The service providers have no place to lodge these individuals prior to the court process. Both combined choice totals (Table XXXII)reflected that 'need for transportation to the facility' was the most important area needing improvement. In the subtotals, the mental health clinics expressed the most need in this area.

In the area of coordination of psychiatric emergency services, the most positive aspect of all the totals (Table XXIX) is that there is 'sufficient coordination with law enforcement agencies.' In the subtotals this seems to be particularly noted by general hospitals with psychiatric units and by law enforcement themselves. However, in the aspects needing improvement, law enforcement also reported needing more coordination. This may be indicative that coordination with law enforcement occurs, but could occur more frequently or be improved in other ways, especially in the minds of law enforcement personnel.

The two aspects of coordination most needing improvement (Table XXXIII) are the 'need for more community support' and the 'need for more community education.' While this removes the onus from the service deliverers, it may point to a desire for more preventative community mental health as a needed area of emphasis. This finding is confirmed in Table XXIX, in which the least often selected positive choice is 'community support for mental health' and 'sufficient community education.'

In Table XXXIII,'need for more coordination with social service agencies' and 'need for more coordination among mental health agencies' both fell in the mid-range of importance for improvement. The litera-

ture suggests that the interplay between these two types of agencies could be improved, especially in follow-up and referral. The inclusion of both categories could have created confusion since the respondents may not have seen the two as substantially different from each other. If considered together, 'coordination between agencies' would become the area most in need of improvement.

This concludes the data analysis of the psychiatric emergency services questionnaire which reflects the opinions and perceptions of individual direct service providers in each of the agencies studied. This data was the result of questions designed to elicit information concerning what facilities deliver psychiatric emergency services, who actually delivers these services, who should deliver such services, and what prevents personnel from delivering effective psychiatric emergency services. Also included were items which asked the respondents to rank in order of importance aspects of their individual agency's emergency mental health services. By compiling the responses from this questionnaire, the subjective impressions of the respondents were obtained.

CHAPTER VI

CONCLUSIONS AND RECOMMENDATIONS

INTRODUCTION

This chapter presents the major findings and conclusions of the study of psychiatric emergency services. Recommendations are made from the conclusions for the further development of psychiatric emergency services. The limitations of the study are discussed and recommendations made for future research.

SUMMARY

The purpose of this study was to describe the delivery of psychiatric emergency services in selected Oregon counties, to identify variables that determine the nature of psychiatric emergency services provided and to develop recommendations for existing psychiatric emergency services. In order to provide a comprehensive examination of this service delivery system, the researchers have approached the problem area from several perspectives.

The standpoint of the consumer of psychiatric emergency services was one perspective accounted for throughout the study. The theoretical literature was used to describe the process by which certain individuals experience a psychiatric emergency and to provide rationale for the provision of skilled mental health intervention at the time of the emergency situation. The review of literature outlined the research report-

ing the characteristics of clients who have used psychiatric emergency services and the data analysis took into account a sample of persons who received services at each of the agencies studied.

The sociological perspective was another that was used to examine the process of help-seeking. This framework also provided guidelines for the researchers to observe the interactions between individuals who request service and persons providing service. The review of literature catalogued the different types of agencies that provide psychiatric emergency services and the variation in approaches to the provision of specific services. The data collected by the researchers portrays the function and structure of different types of agencies and the variety of preparation and training among those who provide psychiatric emergency services.

The third perspective was an identification of the issues that are relevant to the delivery of psychiatric emergency services by a system of community agencies. The theoretical literature was used as a guide to the development of issues that promote or inhibit the function of a service network. In addition, the theoretical framework described the interaction patterns that develop between service providers and consumers and between service providers from other organizations. The review of literature contained mostly narrative material describing the provisions made by service providers for the delivery of comprehensive services within specific communities and the maintenance of open channels of communication between different agencies. The research methodology was developed to take into account the services provided by community agencies in relation to each other. The purpose of this format was to more accurately describe the role of several agencies in the

delivery of psychiatric emergency services in selected communities.

The final purpose of this study was to recommend areas of existing psychiatric emergency services that could be further developed. In preparation for this, the researchers sought out and evaluated several ideal models of service delivery proposed for health and mental health systems care systems. The comparison of these models produced a set of elements that were used to evaluate the findings of the study describing existing psychiatric emergency service delivery systems and that served as the premise on which recommendations were based.

MAJOR FINDINGS

The following section presents a summary of the findings resulting from the research project. These findings represent a composite of the results obtained from the separate sections of data analysis. The implications of these findings are discussed in relation to aspects of the theoretical and research material that the study was developed from.

The first finding is that the study established the volume of service provided to persons in a psychiatric emergency in specific communities. Previous research has established the volume of service provided by individual agencies or particular types of agencies but not in relation to the total services provided by different agencies in one community.

The volume of service provided by the agencies studied does not appear to be related to the staffing pattern or the level of training persons providing psychiatric emergency services have. A facility may have greater numbers of skilled personnel providing psychiatric emergency services and provide service to smaller proportions of the total number of persons in the system requesting service than a similar type of facility. It appears that the requests for psychiatric emergency

services are not distributed equally throughout the system and that this results in under and over utilization of specific services.

The researchers also found that non-mental health personnel provide substantial amounts of service to persons in a psychiatric emergency situation, without the provision of specialized training or professional mental health back-up. The theoretical and research material established the importance of skilled intervention at the time of a psychiatric emergency. This study documented the frequency of contact persons in a psychiatric emergency have with staff at local hospital emergency rooms and law enforcement personnel. If service providers have not received training in the management of persons in a psychiatric emergency, except informally, it is possible that consumers are not receiving the most appropriate services for the situation.

The theoretical literature also established the critical role played by gatekeepers in providing access for clients to appropriate services. If service providers in all agencies are considered gatekeepers, then the data collected on the services and referrals clients received, suggests that variation exists among gatekeepers in the ability to provide access to appropriate services.

This phenomena is especially evident in situations that require specialized services. The client who most appropriately requires medication or a period of supervised observation may involve the services of several agencies before access to such service is gained. The result is that the delivery of service to persons in a psychiatric emergency may require the negotiation of a complex maze of agencies, services and service providers. From the data, it would appear that consumers of psychiatric emergency services cannot be assured access to

complete problem-oriented evaluation, an array of treatment alternatives and resources for problem solving.

The theoretical literature also documented the necessity of cooperation among organizations to provide comprehensive health and mental health services. The opinions shared by direct service providers about the delivery of psychiatric emergency services suggests that service providers are not aware of the amount of service provided by other agencies in the same community. The theoretical material reviewed, suggests that direct service providers will not be able to provide access for clients to appropriate services if they lack information about available resources and do not develop satisfactory linkages with other agencies.

A general overview of the research process has been outlined including a synthesis of the major findings and a discussion of their hypothesized implications. The following section outlines the conclusions of this study and makes recommendations for the development of existing psychiatric emergency services.

CONCLUSIONS AND RECOMMENDATIONS

This section includes the conclusions resulting from the study of psychiatric emergency services and recommendations for systems delivering psychiatric emergency services. For the purpose of clarity, each conclusion is directly followed by a corresponding recommendation.

Conclusion

There appear to be gaps in psychiatric emergency services available within communities. It also appears that agencies provide similar

services. The treatment received seems to be determined by the particular service offered at an agency rather than determined by the nature of the psychiatric emergency.

Recommendation. Representatives from each agency providing aspects of psychiatric emergency service should meet together to discuss the components of psychiatric emergency service delivery. The purposes of this recommendation are:

1. To clarify agency roles in the delivery of psychiatric emergency services.

2. To develop a complimentary working network based on increased awareness by individual service providers of psychiatric emergency services available community-wide.

3. To develop cooperation among agencies to provide the most appropriate service to clients through referral if necessary.

4. To develop coordinated planning among all community psychiatric emergency service providers as a prerequisite for state and county funding for psychiatric emergency services.

5. To develop a workable network to provide transportation to clients seeking help in a psychiatric emergency.

6. To develop an inter-agency and intra-agency follow-up on clients who have experienced a psychiatric emergency or have been referred to another agency.

Conclusion

Each agency utilizes a different method of evaluation and record keeping for psychiatric emergencies.

Recommendation. A uniform method of recording demographic, diagnostic and dispositional information should be considered among agencies

for the following purposes:

1. To develop new referral services.

2. To evaluate service effectiveness.

3. To evaluate utilization of existing psychiatric emergency services.

4. To allow for comparison of services between agencies.

Conclusion

When referrals are made by direct service providers, they are most often made to facilities providing inpatient care or outpatient therapy.

Recommendation. There should be consideration by direct service providers to increase the number of referrals to existing alternative psychiatric resources such as day or night treatment, half-way houses, sheltered workshops, and public welfare. The purposes of this recommendation are:

1. To expand the services utilized by the psychiatric population at risk to include all types of social care-giving agencies.

2. To provide a more comprehensive service network in the community.

3. To encourage direct service providers to refer clients to the most appropriate service which may aid in the prevention of further psychiatric emergencies.

Conclusion

There is no 24-hour information and referral service that provides information concerning what resources exist, but also has the knowledge of what resources have openings during a particular hour of the day.

Recommendation. There should be consideration to develop a com-

plete 24-hour information and referral service community-wide. This service would provide information to clients and to direct service providers regarding availability of psychiatric emergency services daily. It could be staffed by volunteers who would call all community resources several times during the 24 hour period to determine the availability of services. The purposes of this recommendation are:

1. To reduce the amount of time direct service providers and clients spend in locating resources.

2. To provide the most appropriate available resource to direct service providers or clients at any point in time by making one phone call.

3. To patch a caller directly through to the identified resource.

4. To achieve rapid intervention which has the potential of preventing future psychiatric emergencies.

5. To have treatment available according to what a community can offer, not what an agency can offer.

Conclusion

Particular types of agencies give certain services consistently. For example, law enforcement personnel do the majority of outreach services and hospitals offer the majority the 24-hour walk-in services.

Recommendation. Each agency providing an aspect of psychiatric emergency services should be provided with a trained mental health professional designated to aid in the provision of the existing psychiatric emergency services. For example, law enforcement agencies could have a designated mental health professional to help provide existing outreach services in a psychiatric emergency. A general hospital without a psychiatric unit could have a designated mental health professional to

aid in the provision of walk-in services in a psychiatric emergency. The purposes of the recommendation are:

1. To increase the quality of services provided by agencies serving the population at risk.

2. To identify a responsible mental health professional in the event of a psychiatric emergency.

3. To reduce the number of agency staff initially involved in a psychiatric emergency.

4. To reduce the amount of time a client must wait to be served in a psychiatric emergency.

5. To provide a person in each agency representing the interests of psychiatric emergency services within the agency, between agencies and within the community.

6. To provide a mental health professional who could train or consult with volunteers, paraprofessionals or other professionals in the area of psychiatric emergency services.

7. To help support a community-wide psychiatric emergency service prevention and community education program.

Conclusion

The majority of direct service providers studied feel that community education is a major area needing improvement.

Recommendation. Each community should consider the development of a comprehensive community education program. The purposes of this recommentation are:

1. To emphasize the prevention of psychiatric emergencies.

2. To increase community awareness of the information and referral psychiatric emergency telephone number.

3. To increase public awareness of the availability of psychiatric emergency services.

4. To decrease public of fear of psychiatric emergencies.

Community education might be accomplished by:

1. Radio and television advertisements or public broadcasting.

2. Television interviews of mental health professionals involved in the delivery of psychiatric emergency services.

3. The development of a speakers bureau with capabilities to reach public schools, various types of support groups that may be at risk for a psychiatric emergency, or neighborhood associations.

LIMITATIONS

The results which were obtained from this research study must be placed in the context of certain limitations imposed by the research design and the implementation of the data collection process. The researchers have identified four areas of the study that limit the generalizability of the reported findings.

A descriptive, non-experimental design was chosen to study the area of psychiatric emergency services. The major limitation of this design is that is does not control for internal validity; therefore, the nature of relations between variables were not stated. Instead the study design allowed for the identification of variables that may serve as hypotheses for future study.

Other limitations were that the scope of the research effort was so large that within the time allotted for study, the potential extent of data analysis was not realized, although the data is available for further analysis. A final limitation of the design was the lack of

precise methods of measurement. The investigators evaluated the level of research in the area of psychiatric emergency services; found it to be descriptive in nature and characterized by the lack of precise methods of measuring the phenomena under study. In order to accommodate the complexity of the area studied, the researchers chose several types of data collection tools to obtain data from different perspectives.

The second area of study that places limitations on the generalizability of these findings relates to the selection of the population studied. Five counties were selected for study by the researchers on the basis of several criteria developed to provide a representative picture of the characteristics of the state of Oregon. The results describing the psychiatric emergency services within these counties do not allow the application of these findings to other counties in Oregon.

The types of agencies that were the subjects of study in each county were chosen on the basis of preliminary data collection and the review of literature. The findings that were reported cannot be generalized to the delivery of psychiatric emergency services by other types of agencies.

A sample of direct service providers was selected by the contact person at each agency to complete the psychiatric emergency services questionnaire. The researchers were not able to control the selection of the initial sample or those persons in the sample who completed and returned the questionnaire. Therefore, the data reported on the opinions of direct service providers reflects only those persons who completed the questionnaire and not the opinions of all direct service providers.

The choice of data collection tools places additional limitations

on the degree to which generalizations can be made. Although provisions were made to insure the inter-rater reliability and the validity of the tools used to collect data, extensive pretesting did not occur. Therefore, some of the data collected reflects a lack of definition clarity. Where the researchers had reason to question the validity of the data because of poorly defined terms, they indicated so in the data analysis. Collection of client data from existing records did not allow the researchers to control for the variation between persons completing the record or the variation in the types of information kept in the records at different agencies.

The researchers decided that the descriptive, non-experimental format was the most appropriate of the available methodologies to provide an initial exploration of the problem area. This decision followed an extensive process of identifying the key elements in the delivery of psychiatric emergency services and a review of the methods used by previous investigators to research this area. The researchers were aware of the limitations inherent in the choice of the descriptive design, sample selection and methods of data collection. In order to reduce the effects of these limitations, additional measures were built in to increase the generalizability of these findings. The results of this research study have provided the basis for several suggested areas of further study which are presented in the following section.

RECOMMENDATIONS FOR FURTHER STUDY

Little research has been carried out examining the effects of different types of emergency intervention. A potential area of study would be to conduct grounded research that examines the intervention

clients in a psychiatric emergency receive from the earliest possible point of identification. The purpose of such research would be to begin to define the behaviors of service providers and clients along the dimensions of changing environments and the passage of time, as well as to determine more accurately the nature of intervention strategies.

Another suggestion for further study would be to select one community, identify all the providers of psychiatric emergency services and carry out the same data collection procedures. The purpose of this study would be to revise the research tools so that more precise measurements are obtained and to determine if the services provided by other agencies are significantly different from those that were the subjects of this study.

Additional suggestions for further study would be to quantify the volume of service provided and compare these findings longitudinally to identify changes in patterns of requests for service. Another area for study would be to develop a means to measure an agency's ability to meet the demands for service and to document how services change as a result of increases or decreases in requests for service. Final suggestions for further study would be to take the theoretical material describing intersystem analysis and investigate the community-based relations between health and mental health organizations or to identify the theoretical framework of specific types of agencies and compare it to measures of actual service provided.

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APPENDIX A

CORRESPONDENCE
PROCEDURE FOR NEGOTIATION

MENTAL HEALTH DIVISION

DEPARTMENT OF HUMAN RESOURCES

2575 BITTERN STREET N.E. • • SALEM, OREGON • • 97310

ROBERT W. STRAUB
GOVERNOR

July 29, 1976

We are graduate students from the Portland State University School of Social Work working on a National Institute of Mental Health training project in community mental health.

We are studying the use of hospital and community based emergency services for mentally or emotionally disturbed persons, and the existence and inter-relationships of psychiatric services provided within medical facilities such as in emergency rooms, ambulance services and mobile crisis units. Our specific interest is emergency service delivery models for this population.

We are interested in any models of psychiatric emergency service delivery provided through a medical or community facility or agency you may have utilized in your state, including unit cost if available, or any studies you have done in this area. Any information and assistance you can provide will aid in our project. Please send any replies to the address below.

At your request, we would be glad to share with you the results of our compilation at the completion of our project.

Sincerely,

Karalee Kiser
Marnie Hersrud
Cathy Knox
4224 S.W. Condor Avenue
Portland, Oregon 97201

LETTER TO COUNTY MENTAL HEALTH
PROGRAM DIRECTORS

August 5, 1976

We are graduate students from Portland State University School of Social Work and the University of Oregon School of Nursing. We are studying emergency psychiatric services in Oregon. We are surveying available resources in Oregon and would like to know what emergency services you utilize in your facility and if you refer, what other resources you utilize. We are interested in all emergency services, including twenty-four hour.

We would greatly appreciate an appointment with you to discuss these issues and any other information you would feel important to our investigation. One of us will call you in the near future to discuss the possibility of us meeting with you. Thank you.

Sincerely,

Karalee Kiser, PSU, School of Social Work
Marnie Hersrud, PSU, School of Social Work
Cathy Knox, U of O, School of Nursing

LETTER TO COUNTY MENTAL HEALTH
PROGRAM DIRECTORS

September 16, 1976

Pursuant to our letter of August 5, 1976 regarding the study of psychiatric emergency services in the State of Oregon, we are concerned that we have not been able to make telephone contact with you. However, we are still very much interested in the services you provide in a psychiatric emergency.

Your completion of the enclosed questionnaire will be appreciated. We realize that this may involve some time on your part, but any information you can provide will assist us in developing our research proposal appropriate to existing needs and services, in the State.

A self-addressed, stamped envelope is enclosed for your convenience. Thank you for your cooperation.

Sincerely,

Karalee Kiser, PSU, School of Social Work
Marnie Hersrud, PSU, School of Social Work
Cathy Knox, U of O, School of Nursing

SURVEY OF COUNTY MENTAL HEALTH
PROGRAMS IN OREGON

1. In your clinic do you define psychiatric emergency as "danger to self or others"? YES_________ NO__________.

   If not would you indicate the definition you do use?____________

   ____

   ____

2. List the psychiatric emergency services in your county and indicate any that provide 24 hour coverage.

	24 hr.		24 hr.
a.______________________		d.______________________	
b.______________________		e.______________________	
c.______________________		f.______________________	

3. Briefly describe the program that provides the most comprehensive service to clients in your county. ______________________

   ____

   ____

4. Indicate if you have any statistics available in the following areas?

	YES	NO
a. Patients seen in mental health clinic in a crisis situation.		
b. Involuntary inpatient admissions.		
c. Voluntary inpatient admissions.		
d. Follow-up services including:		
1. post hospitalization		
2. suicide		
3. crises counseling		

5. Identify any problems in the delivery of psychiatric emergency services for your county.
   a. ____
   b. ____
   c. ____

6. What information related to development and/or use of psychiatric emergency services could you utilize?

   a.____
   b.____
   c.____

PROCEDURE FOR NEGOTIATION

The procedure for negotiating with each individual agency to be studied was as follows:

1. The agency director, administrator or person most directly involved with the service to be studied was contacted by telephone. The purpose of the study and data gathering instruments were described. The contact person was given some idea of the amount of time and effort that would be required by agency personnel and what the activities of the researchers would be while at the agency. During this initial contact the researcher gained permission to interview the contact person and discuss in more depth the details of the study.

2. The researcher met with the contact person to find out the types of psychiatric emergency services that the agency offered and how the requested data might be obtained. The contact person was shown a letter from Dr. Delbert Kole, Assistant Administrator, Mental Emotional Disturbances, introducing the researchers and the purpose of the study. Each contact person received a copy of the research proposal. The researchers reviewed two of the research tools, the Client Data Sheet and the Direct Service Questionnaire (Appendix A), so that the contact person would know the types of data that would be gathered at the agency. The arrangements for insuring confidentiality were discussed at this time. The Services Interview was not shown to the contact person because of the possibility of biasing responses, since the interview would in most cases be carried out with the contact person. If the contact person granted permission to initiate the study, arrangements were made for the dates that the data was to be collected. If permis-

sion was not granted arrangements were made between the researchers and contact person for any supplementary information that might be needed by the contact person in gaining permission to initiate the study at the agency. The researcher then established an agreeable time to re-contact the agency to further negotiate for permission to do the study.

3. When the negotiations between the researcher and the agency were complete the researcher called to confirm the dates that the data gathering would take place.

APPENDIX B

RESEARCH INSTRUMENTS

DEFINITIONS

Data Collection Tool: Service Interview
Page 1

Column	Item
	County
1 2	
	Type of Facility
3 4	
5	What type of facility is this? 1. Mental health clinic 2. Hot line 3. General hospital with emergency room 4. General hospital with emergency room with psychiatric service 5. General hospital with an emergency room, psychiatric service and psychiatric ward 6. City police department 7. County sheriff 8. Other ________________
6 7	How many volunteers are there in your facility who deliver psychiatric emergency services?
8 9	How many paraprofessionals are there in your facility who deliver psychiatric emergency services?
10 11	How many bachelors prepared professionals are there in your facility who deliver psychiatric emergency services?
12 13	How many masters prepared professionals are there in your facility who deliver psychiatric emergency services?
14 15	How many doctoral prepared, non-physicians are there in your facility who deliver psychiatric emergency services?
16 17	How many physicians (not psychiatrists) are there in your facility who deliver psychiatric emergency services?
18 19	How many psychiatrists are there in your facility who deliver psychiatric emergency services?
20 21 22	How many law enforcement personnel are there in your facility who deliver psychiatric emergency services?
	Is there anyone else who does not fit into the above categories and delivers psychiatric emergency services in your agency? ________________________________

Services Interview
Page 2

Do you provide the following psychiatric emergency services (1-yes, 0-no)

a. Telephone (1-8 Hours) — 23

b. Telephone (1-16 hours) — 24

c. Telephone (1-24 hours) — 25

d. Walk-in (1-8 hours) — 26

e. Walk-in (1-16 hours) — 27

f. Walk-in (1-24 hours) — 28

g. Outreach (1-8 hours) — 29

h. Outreach (1-16 hours) — 30

i. Outreach (1-24 hours) — 31

j. Non-ambulance transportation from client's home to an agency — 32

k. Non-ambulance transportation from your agency to another agency — 33

l. Non-ambulance transportation from the community to an agency — 34

m. Referral (1-8 Hours) — 35

n. Referral (1-16 hours) — 36

o. Referral (1-24 hours) — 37

p. Answering service — 38

q. Consultation services for psychiatric emergencies — 39

Which of the following types of personnel do you have in your telephone counseling and/or referral service? (1-yes, 0-no)

a. Secretary — 40

b. Volunteer — 41

Services Interview
Page 3

	c. Volunteer with paraprofessional back-up
___ 42	d. Volunteer with professional back-up
___ 43	e. Volunteer with psychiatrist back-up
___ 44	f. Paraprofessional
___ 45	g. Paraprofessional with professional back-up
___ 46	h. Paraprofessional with psychiatrist back-up
___ 47	i. Professional
___ 48	j. Professional with professional back-up
___ 49	k. Professional with psychiatrist back-up
___ 50	l. Psychiatrist
___ 51	m. Law enforcement personnel
___ 52	

___ 53

Generally, who has the first telephone contact with the client during the day?
1. Secretary
2. Answering service
3. Volunteer
4. Paraprofessional
5. Professional
6. Psychiatrist
7. Law enforcement personnel

___ 54

Generally, who has the first telephone contact with the client during the evening?
1. Secretary
2. Answering service
3. Volunteer
4. Paraprofessional
5. Professional
6. Psychiatrist
7. Law enforcement personnel

Services Interview
Page 4

__ 55

Generally, who has the first telephone contact with the client during the night (swing shift)?
1. Secretary
2. Answering service
3. Volunteer
4. Paraprofessional
5. Professional
6. Psychiatrist
7. Law enforcement personnel

Which of the following types of personnel do you have in your walk-in service? (1-yes, 0-no)

__ 56 a. Secretary

__ 57 b. Volunteer

__ 58 c. Volunteer with paraprofessional back-up

__ 59 d. Volunteer with professional back-up

__ 60 e. Volunteer with psychiatrist back-up

__ 61 f. Paraprofessional

__ 62 g. Paraprofessional with professional back-up

__ 63 h. Paraprofessional with psychiatrist back-up

__ 64 i. Professional

__ 65 j. Professional with professional back-up

__ 66 k. Professional with psychiatrist back-up

__ 67 l. Physician

__ 68 m. Physician with psychiatrist back-up

__ 69 n. Psychiatrist

__ 70 o. Law enforcement personnel

__ 71 p. Interdisciplinary team

Services Interview
Page 5

Column	Item
	Which of the following types of personnel do you have in your outreach service? (1-yes, 0-no)
___ 72	a. Volunteer
___ 73	b. Volunteer with paraprofessional back-up
___ 74	c. Volunteer with professional back-up
___ 75	d. Volunteer with psychiatrist back-up
___ 76	e. Paraprofessional
___ 77	f. Paraprofessional with professional back-up
___ 78	g. Paraprofessional with psychiatrist back-up
___ 79	h. Professional
___ 80	i. Professional with professional back-up
___ 1 ___ 2	County
___ 3 ___ 4	Type of Facility
___ 5	j. Professional with psychiatrist back-up
___ 6	k. Psychiatrist
___ 7	l. Law enforcement personnel
___ 8	m. Interdisciplinary team
___ 9 ___ 10	How many outreach teams are there in your facility?
___ 11 ___ 12	How many volunteers are there in your outreach team?
___ 13 ___ 14	How many paraprofessionals are there in your outreach team?
___ 15 ___ 16	How many professionals are there in your outreach team?
___ 17 ___ 18	How many psychiatrists are there in your outreach team?
___ 19 ___ 20	How many drivers are there in your outreach team?
___ 21 ___ 22 ___ 23	How many law enforcement personnel are there in your outreach team?

Services Interview
Page 6

24 25	On the average, how many members of the team go on an outreach visit?
26	If you are a mental health facility, do you utilize law enforcement personnel in your outreach team?
27 28	How many volunteers are there in your ____________ team?
29 30	How many paraprofessionals are there in your ___________ team?
31 32	How many professionals are there in your _______________ team?
33 34	How many psychiatrists are there in your _______________ team?
35 36	How many drivers are there in your ______________ team?
___ ___ ___	How many law enforcement personnel are there in your _______________ team?
40 41 42	On the average, how many members of the _______________ team go on an outreach visit?
43	Do you provide non-ambulance transportation, other than that provided by the outreach team? (1-yes, 0-no)
44 45	How many volunteers are there in your non-ambulance transportation service?
46 47	How many paraprofessionals are there in your non-ambulance transportation service?
48 49	How many professionals are there in your non-ambulance transportation service?
50 51	How many psychiatrists are there in your non-ambulance transportation service?
52 53	How many drivers are there in your non-ambulance transportation service?
54 55 56	How many law enforcement personnel are there in your non-ambulance transportation service?
57 58 59	On the average, how many members go on a non-ambulance transportation service call?

Services Interview
Page 7

__ __ 60 61	How many secretaries provide referral services?
__ __ 62 63	How many volunteers provide referral services?
__ __ 64 65	How many paraprofessionals provide referrel services?
__ __ 66 67	How many professionals provide referral services?
__ __ 68 69	How many psychiatrists provide referral services?
__ __ 70 71	How many physicians provide referral services?
__ __ 72 73	How many answering service personnel provide referral services?
__ __ __ 74 75 76	How many law enforcement personnel provide referral services?
	Which of the following types of personnel provide consultation services for psychiatric emergencies? a. Volunteer
__ 77	b. Paraprofessional
__ 78	c. Professional
__ 79	d. Psychiatrist
__ 80	County
__ __ 1 2	Type of facility
__ __ 3 4	e. Law enforcement personnel
__ 5	
__ 6	Is in-service training provided to staff who have the first contact with clients in the management of psychiatric emergencies? 1. Yes, routinely 2. Yes, non-routinely 3. No
__ __ __ __ 7 8 9 10	How many psychiatric emergency telephone contacts are there per typical month in your agency?
__ __ __ 11 12 13	How many walk-in emergency contacts are there per typical month in your agency?

Services Interview
Page 8

14 15 16	How many outreach emergency contacts are there per typical month in your agency?
17 18 19	How many _______________ team emergency contacts are there per typical month in your agency?
20 21 22	How many non-ambulance transportation emergency contacts are there per typical month in your agency?
23 24 25 26	How many referral of emergency cases to other agencies are there per typical month in your agency?
27 28 29	How many answering service emergency contacts are there per typical month in your agency?
30 31 32	How many consultations for psychiatric emergencies are there per typical month in your agency?

Data Collection Tool: Client Data Sheet
Page 1

Columns	Item
1 2	County
3 4	Type of Facility
5 6 7	Client consecutive number
8 9	Age 99 unavailable
10	Sex 1. male 2. female 3. unavailable
11	Marital Status (current) 1. single 2. married 3. unavailable
12	Dependent Status 1. welfare 2. non-welfare 3. unavailable
13 14	County of Residence 99 unavailable
15	Legal Status 1. voluntary 2. involuntary 3. unavailable
16 17 18 19	Diagnostic Category 290-319.3 DSM II 9999 unavailable
20	Duration of the presenting problem 1. one day or less 2. less than one week 3. less than one month 4. less than one year 5. less than two years 6. two years or more 7. unavailable
21	Type of Emergency 1. crisis situation 2. psychiatric emergency 3. unavailable

Client Data Sheet
Page 2

Type of service rendered in the emergency or crisis

__ 22

Was information given to the client or significant other?
1. yes
2. no
3. unavailable

If yes, what was the nature of information given?

____

____

__ 23

Was the client or significant other given a referral?
1. yes
2. no
3. unavailable

__ 24

Was the client or significant other counseled by telephone?
1. yes
2. no
3. unavailable

__ 25

Did the client or significant other receive crisis intervention?
1. yes
2. no
3. unavailable

__ 26

Did the client or significant other receive medication?
1. yes
2. no
3. unavailable

__ 27

Did the client receive a psychiatric evaluation?
1. yes
2. no
3. unavailable

__ 28

Did the client receive a physical evaluation?
1. yes
2. no
3. unavailable

__ 29

Did the client receive a neurological evaluation?
1. yes
2. no
3. unavailable

Client Data Sheet
Page 3

___ 30

Did the client receive inpatient care?
1. yes
2. no
3. unavailable

___ 31

Was the client admitted to the facility for observation?
1. yes
2. no
3. unavailable

___ 32

All data on psychiatric services rendered to the client is unavailable.
0. no
1. yes

___ 33

Was the client seen at the time of the emergency?
1. yes
2. no
3. unavailable

___ 34

Was the client's spouse seen at the time of the emergency?
1. yes
2. no
3. unavailable

___ 35

Were the client's parents seen at the time of the emergency?
1. yes
2. no
3. unavailable

___ 36

Were other members of the client's family seen at the time of the emergency?
1. yes
2. no
3. unavailable

___ 37

Were other persons, not family members, but significant to the client seen at the time of the emergency?
1. yes
2. no
3. unavailable

Client Data Sheet
Page 4

Disposition

The client withdrew and the facility

38
1. was notified because the client moved or was ill.
2. was notified because the client died.
3. was notified for reasons other than indicated above.
4. was NOT notified.

The client was terminated by the facility without referral

39
1. because no further care was indicated.
2. because further care was indicated but unavailable.
3. because the client was unresponsive.
4. for reasons other than those listed above.
5. no reason given.

The client was terminated by the facility with a referral to

40 41
42 43
44 45
46 47

1. a mental hospital.
2. a mental health center.
3. a general hospital psychiatric unit.
4. a general hospital other unit. Indicate which unit, if known ___________________.
5. a Veteran's Administration hospital.
6. an institution for the retarded.
7. other retardation facility
8. a hostel or halfway house.
9. a nursing home.
10. a residential treatment center.
11. partial hospitalization (day).
12. partial hospitalization (night).
13. psychiatric clinic.
14. day training center.
15. sheltered workshop.
16. vocational training.
17. a private psychiatrist.
18. other private professional.
19. court or correction agency.
20. public health or welfare agency.
21. voluntary agency.
22. clergy.
23. other.

Client Data Sheet
Page 6

61 — The client was referred for reasons other than any of those listed.
0. no
1. yes

62 — Data on the client disposition is unavailable.
0. no
1. yes

63 — Was the referral agency contacted by the referring agency?
0. no referral
1. yes
2. no
3. unavailable

64 — What hour of the day was the client seen?
1. During regular daytime hours (approximately 8 a.m. - 5 p.m.).
2. During the evening hours (approximately 5 p.m. - 12 midnight).
3. During the early morning hours (approximately 1 a.m. - 8 a.m.).
4. Unavailable.

65 — What day of the week was the client seen?
1. Sunday
2. Monday
3. Tuesday
4. Wednesday
5. Thursday
6. Friday
7. Saturday
8. Unavailable

66 — What month of the year was the client seen?
1. July, 1976
2. August, 1976
3. September, 1976

Data Collection Tool: Cover Letter for Psychiatric Emergency Services Questionnaire

Dear Person:

The Oregon State Mental Health Division is sponsoring a study of psychiatric emergency services sampled from five counties in Oregon. The purpose of this study is to provide descriptive data about existing emergency services. The results of this research will be used to support requests of the Mental Health Division for funding of additional psychiatric emergency services to be presented to the Oregon State Legislature for the 1977-79 biennium.

This research is being carried out by Marnie Hersrud and Karalee Kiser, Social Work graduate students from Portland State University, and Catherine Knox, graduate student from the University of Oregon School of Nursing.

The following questionnaire is being given to you to get subjective impressions about the delivery of psychiatric emergency services. As a result of answering this questionnaire, you will not be identified by name or any other personal information. Please respond to all the questions that are asked and feel free to make any comments you wish. We would appreciate your response as soon as possible. The questionnaire may be returned in the enclosed self-addressed envelope.

The following definitions may aid you in responding to the questions:

1) Volunteer - any non-paid mental health service deliverer.

2) Paraprofessional - any paid service deliverer with specialized training in mental health and does not include bachelor's preparation.

3) Professional - any master's or doctoral degree with specialized training in mental health or M.D.

Thank you for your time and cooperation.

1 2

3 4

Data Collection Tool: Psychiatric Emergency
Services Questionnaire
Page 1

5

1. Which role in the delivery of psychiatric emergency services do you have? Check one.

1) ______ volunteer
2) ______ paraprofessional
3) ______ bachelor's prepared professional or R.N.
4) ______ professional
5) ______ psychiatrist
6) ______ law enforcement personnel

2. In your opinion, what kind of facilities should be delivering psychiatric emergency services? Check any that apply.

6 ______ mental health clinic

7 ______ psychiatric hospital

8 ______ general hospital with emergency room without a psychiatric unit

9 ______ general hospital with emergency room with a psychiatric unit

10 ______ state hospital

11 ______ police

12 ______ hotline

13 ______ private psychiatrists

14 ______ private mental health professionals

15 ______ other Please specify: ______________________________

Psychiatric Emergency Services Questionnaire
Page 2

16

3. In your opinion, who delivers the majority of direct services to clients in a psychiatric emergency within your agency? Check one.

1) _______ volunteer
2) _______ paraprofessional
3) _______ professional
4) _______ psychiatrist
5) _______ law enforcement personnel
6) _______ interdisciplinary team
7) _______ other Please specify: _______________

17

4. Given an ideal state, in your opinion, who should be delivering direct services in a psychiatric emergency? Check one.

1) _______ volunteer
2) _______ paraprofessional
3) _______ professional
4) _______ psychiatrist
5) _______ law enforcement personnel
6) _______ interdisciplinary team
7) _______ other Please specify: _______________

5. What prevents the personnel you have chosen above from delivering effective psychiatric emergency services? Check all that apply.

18 _______ need for more funds

19 _______ need for more volunteers

20 _______ need for more paraprofessionals

21 _______ need for more professionals

22 _______ need for more psychiatrists

23 _______ need for increased interest on the part of individual caregivers

24 _______ need for more collaboration between individual caregivers

Psychiatric Emergency Services Questionnaire
Page 3

25 ______ need for increased training

26 ______ other Please specify: ______________
____

27 28

29 30

31 32

6. In your opinion, rank in order of importance the three most positive aspects of the staffing in your psychiatric emergency service. Rank three.

1) ______ sufficient mental health personnel on duty in the agency

2) ______ sufficient mental health personnel on call in the agency

3) ______ responsive mental health personnel

4) ______ sufficient coordination and cooperation among personnel

5) ______ appropriate internal referrals from medical staff

6) ______ recognition of the importance of psychiatric problems by general medical staff

7) ______ sufficient administrative support

8) ______ sufficient training in crisis intervention for general staff

9) ______ other Please specify: ______________
____

33 34

35 36

37 38

7. In your opinion, rank in order of importance the three most positive aspects of the delivery of psychiatric emergency services in your agency. Rank three.

10) ______ appropriate self-referrals to agency

11) ______ appropriate waiting period for clients

12) ______ routine medical examinations for psychiatric patients

13) ______ sufficient social service support for non-psychiatric patients

14) ______ sufficient follow-up on referred clients

15) ______ appropriate services regardless of ability to pay

16) ______ ability to administer standing order psychotropic medications

17) ______ appropriate time span between referral and client's appointment at referral agency

18) ______ other Please specify: ______________________________

__ __ 39 40

__ __ 41 42

__ __ 43 44

8. In your opinion, rank in order of importance the three most positive aspects of your psychiatric emergency service facility. Rank three.

19) ______ sufficient number of interview rooms

20) ______ sufficient number of holding rooms

21) ______ sufficient number of observation rooms

22) ______ sufficient number of private waiting rooms

23) ______ adequate telephone coverage

24) ______ good proximity to general medical facility

25) ______ facility is physically available to persons seeking help

26) ______ sufficient transportation to the facility

27) ______ other Please specify: ______________________________

Psychiatric Emergency Services Questionnaire
Page 5

45 46

47 48 — 9. In your opinion, rank in order of importance the three most positive aspects of coordination in your psychiatric emergency service. Rank three.

49 50

28) ______ provision of transportation of client to referral source

29) ______ appropriate referrals from other agencies to this agency

30) ______ sufficient coordination with the police

31) ______ sufficient coordination with other mental health agencies

32) ______ sufficient number of referral sources

33) ______ community support for mental health services

34) ______ sufficient community education

35) ______ sufficient coordination with other social service agencies

36) ______ ability for non-physicians to admit clients for short term local hospitalization (Less than 72 hrs.)

37) ______ other Please specify: ________________

____

51 52 — 10. Of the twelve items you have ranked as positive aspects of your psychiatric emergency service, which one is the most important? Please specify:

____

Psychiatric Emergency Services Questionnaire
Page 6

__ __
53 54

__ __
55 56

__ __
57 58

11. In your opinion, rank the three areas most in need of improvement in the staffing of your psychiatric emergency service. Rank three.

39) ______ need for more mental health personnel on duty in the agency

40) ______ need for more mental health personnel on call in the agency

41) ______ need for more responsive mental health personnel

42) ______ need for more coordination and cooperation among personnel

43) ______ need for more appropriate internal referrals from medical staff

44) ______ need for more recognition of the importance of psychiatric problems by general medical staff

45) ______ need for more administrative support

46) ______ need for more training in crisis intervention for general staff

47) ______ other Please specify: ________________
____

__ __
59 60

__ __
61 62

__ __
63 64

12. In your opinion, rank the three areas most in need of improvement in the delivery of your psychiatric emergency service. Rank three.

48) ______ need for more appropriate self-referrals to agency

49) ______ need to shorten waiting period for clients

50) ______ need for routine medical examinations for psychiatric patients

Psychiatric Emergency Services Questionnaire
Page 7

51) ______ need for more social service support for non-psychiatric patients

52) ______ need for more follow-up on referred clients

53) ______ need for more appropriate services regardless of ability to pay

54) ______ need to be able to administer standing order psychotropic medications

55) ______ need to shorten time span between referral and client's appointment at referral agency

56) ______ other Please specify: ______________

__ __
65 66

__ __
67 68

__ __
69 70

13. In your opinion, rank the three areas most in need of improvement in your psychiatric emergency service facility. Rank three.

57) ______ need for more interview rooms

58) ______ need for more holding rooms

59) ______ need for more observation rooms

60) ______ need for more private waiting rooms

61) ______ need for more telephone coverage

62) ______ need for more proximity to general medical facility

63) ______ need for facility to be more physically available to persons seeking help

64) ______ need for transportation to the facility

65) ______ other Please specify: ______________

Psychiatric Emergency Services Questionnaire
Page 8

$\overline{71}\ \overline{72}$

$\overline{73}\ \overline{74}$

$\overline{75}\ \overline{76}$

14. In your opinion, rank the three areas most in need of improvement in the coordination of your psychiatric emergency service. Rank three.

66) ______ need for transportation of client to referral source

67) ______ need for more appropriate referrals from other agencies to this agency

68) ______ need for more coordination with the police

69) ______ need for more coordination with other mental health agencies

70) ______ need for more referral sources

71) ______ need for more community support for mental health services

72) ______ need for more community education

73) ______ need for more coordination with other social service agencies

74) ______ need for non-physicians to be able to admit clients for short term local hospitalization (less than 72 hours)

75) ______ other Please specify: ________________

____

$\overline{77}\ \overline{78}$

15. Of the twelve items you have ranked that need improvement in your psychiatric emergency service, which is the most important? Please specify:

____

Psychiatric Emergency Services Questionnaire
Page 9

$\overline{79}$ $\overline{80}$

16. In your opinion, why is the item you have ranked most important to the improvement of your psychiatric emergency service a major impediment to service delivery? Please esplain:

____

____

____

____

____

____

Definitions
Page 1

ANSWERING SERVICE - telephone service not delivering counseling at first contact.

CRISIS - a situation in which a person or significant other makes a request for immediate service. Crisis may be the result of a prolonged period of disequilibrium in which many abortive attempts at solution are made. The crisis situation is less acute than the psychiatric emergency and may not require an intensive therapeutic response within 24 hours.

DOCTORATE PREPARED NON-PHYSICIAN - Ph.D.

DRIVER - a non-mental health person providing transportation.

GENERAL HOSPITAL EMERGENCY ROOM - emergency room of a general medical facility without a psychiatric unit but which will see clients in psychiatric emergencies. Has ability to admit psychiatric patients to general medical/surgical wards.

GENERAL HOSPITAL EMERGENCY ROOM WITH PSYCHIATRIC UNIT - emergency room of a general medical facility with a psychiatric unit and a mental health professional on duty or on call.

HOLDING ROOM - room with availability of physical security in psychiatric emergency.

HOSTEL, BOARDING HOME OR HALFWAY HOUSE - protected living environment not necessarily providing mental health services.

HOTLINE - telephone counseling and/or referral service which may or may not serve walk in clients, which need not be a 24 hour service. Serves all persons who call.

INFORMATION - any information dispensed without suggestion of psychiatric emergency service referral.

INSERVICE - any specialized training provided by agency staff or outside consultant to agency staff in the area of crisis intervention of psychiatric emergency delivery.

INTERDISCIPLINARY TEAM - two or more persons in mental health role delivering psychiatric emergency services.

LAW ENFORCEMENT PERSONNEL - any person employed by a law enforcement agency.

LEGAL STATUS - INVOLUNTARY - at time seen anywhere in the involuntary process.

Definitions
Page 2

MARITAL STATUS:
single - divorced, unmarried or widowed
married - separated, married

MASTER'S PREPARED PROFESSIONAL - any professional Master's degree in mental health (M.Ed; MSW; MN; MS; MA)

MENTAL HEALTH CLINIC - county based and funded walk-in clinic with capacity to deal with unscheduled visits.

MENTAL HOSPITAL - Dammasch State Hospital, Oregon State Hospital, Eastern Oregon State Hospital or Cedar Hills Psychiatric Hospital.

NEUROLOGICAL EVALUATION - more extensive physical exam testing brain dysfunction.

NURSING HOME - residential treatment center for adults.

OBSERVATION - one to 72 hours.

OBSERVATION ROOM - availability of short term stay in facility with availability of mental health or medical staff.

ON-CALL - staff available for consultation or direct service by telephone within or outside the facility.

ON-DUTY - staff on site of emergency service.

OUTREACH - any psychiatric emergency service delivered by any mental health personnel in the field.

OUTREACH TEAM - the above delivering psychiatric emergency services in the field.

PARAPROFESSIONAL - paid service deliverer with specialized training in mental health. May include bachelor's level training.

PHYSICAL EVALUATION - Physical exam.

PHYSICIAN - non-psychiatrist M.D.

PRIVATE MENTAL HEALTH PROFESSIONAL - any mental health professional with own practice who may act as consultant or direct service provider to a particular facility.

PRIVATE PSYCHIATRIST - any M.D. with own practice who may admit clients to or may act as consultant to a particular facility.

Definitions
Page 3

PROFESSIONAL - any of above.

PSYCHIATRIC CLINIC - private clinic delivering outpatient psychiatric services with one or more mental health professionals.

PSYCHIATRIC EMERGENCY - an acute onset of symptoms that requires immediate intervention within 24 hours. If unattended may result in harm to self or others.

PSYCHIATRIC EVALUATION - mental status exam minimum.

PSYCHIATRIST - M.D. with speciality in psychiatry.

RECEIVING MEDICATION - medication prescribed or received.

APPENDIX C

TABLES

TABLE XXXIV

NUMBER OF STAFF IN EMERGENCY ROOMS
OF GENERAL HOSPITALS WITH
PSYCHIATRIC WARDS

Type of Staff	County of Study		
	M.C.[1*]	M.C.[2]	Total
Paraprofessional	23	4	27
Master's Prepared	8	5	13
Doctoral Prepared	1	0	1
Physician	5	6	11
Psychiatrist	27	16	43
Law Enforcement	5	1	6
Totals	69	32	101

*M.C.[1] is Providence Hospital (Multnomah County)
M.C.[2] is University of Oregon Health Sciences Center (Multnomah County)

TABLE XXXV

NUMBER OF STAFF IN EMERGENCY ROOMS
OF GENERAL HOSPITALS WITHOUT
PSYCHIATRIC WARDS

Type of Staff	County of Study					
	K.C.*	M.C.	T.C.	U.C.	W.C.	Total
Paraprofessional	11	14	6	9	2	42
Physician	10	8	8	19	50	95
Psychiatrist	2	0	0	1	1	4
Totals	23	22	14	29	53	141

*K.C. is Presbyterian Inter-Community Hospital (Klamath County)
M.C. is Good Samaritan Hospital (Multnomah County)
T.C. is Tillamook County Hospital
U.C. is Grande Ronde Hospital (Union County)
W.C. is Tuality Community Hospital (Washington County)

TABLE XXXVI

NUMBER OF STAFF IN HOT LINES

Type of Staff	County of Study			
	K.C.*	M.C.[1]	M.C.[2]	Total
Volunteer	40	27	90	157
Paraprofessional	0	4	0	4
Master's Prepared	1	0	0	1
Totals	41	31	90	162

*K.C. is Hope in Crisis Hot Line (Klamath County)
M.C.[1] is Outside-In (Multnomah County)
M.C.[2] is Suicide and Personal Crisis Service (Multnomah County)

TABLE XXXVII

NUMBER OF STAFF IN MENTAL HEALTH CLINICS

Type of Staff	County of Study							
	K.C.*	M.C.[1]	M.C.[2]	T.C.	U.C.	W.C.[1]	W.C.[2]	Total
Paraprofessional	4	2	0	2	1	3	3	15
Master's Prepared	5	5	2	4	3	3	3	25
Doctoral Prepared	1	1	5	1	1	4	1	14
Physician	0	0	1	0	0	0	0	1
Psychiatrist	1	2	3	1	1	1	1	10
Totals	11	10	11	8	6	11	8	65

*K.C. is Klamath County Mental Health Program
M.C.[1] is Northeast Multnomah County Mental Health
M.C.[2] is Kaiser Mental Health Clinic (Multnomah County)
T.C. is Tillamook County Mental Health Program
U.C. is Union County Mental Health Program
W.C.[1] is Tualatin Valley Guidance Clinic (Washington County)
W.C.[2] is Washington County Mental Health Program

TABLE XXXVIII

NUMBER OF STAFF IN LAW ENFORCEMENT AGENCIES

Type of Staff	County of Study							
	K.C.*	M.C.[1]	M.C.[2]	T.C.[1]	T.C.[2]	U.C.	W.C.	Total
Paraprofessional	9	2	0	0	0	0	8	19
Law Enforcement	19	184	385	13	9	20	150	780
Totals	28	186	385	13	9	20	158	799

*K.C. is Klamath Falls City Police (Klamath County)
M.C.[1] is Multnomah County Sheriff
M.C.[2] is Portland Police (Multnomah County)
T.C.[1] is Tillamook County Sheriff
T.C.[2] is City of Tillamook Police Department (Tillamook County)
U.C. is La Grande City Police (Union County)
W.C. is Washington County Sheriff

TABLE XXXIX

STAFF HAVING FIRST TELEPHONE CONTACT WITH CLIENTS ACCORDING TO NUMBER OF FACILITIES

Type of Staff	Number of Facilities: G.H.* with N=2	G.H. w/out N=5	Hot Lines N=3	M.H. Clinic N=7	Law Enf. N=7	Facility Total N=24
Secretary:Day	1	4	0	7	1	13
Secretary:Eve.**	1	4	0	2	1	8
Secretary:Nit.	1	4	0	1	1	7
Ans. Ser.:Day	0	1	1	0	0	2
Ans. Ser.:Eve.	0	1	1	3	0	5
Ans. Ser.:Nit.	0	0	2	3	0	5
Volunteer:Day	0	0	1	0	0	1
Volunteer:Eve.	0	0	1	0	0	1
Volunteer:Nit.	0	0	1	0	0	1
Paraprof.:Day	1	0	1	0	0	2
Paraprof.:Eve.	1	0	1	0	0	2
Paraprof.:Nit.	1	1	0	0	0	2
Law Enf. :Day	0	0	0	0	6	6
Law Enf. :Eve.	0	0	0	1	6	7
Law Enf. :Nit.	0	0	0	1	6	7

*G.H. with is General Hospitals with Psychiatric Units
G.H. w/out is General Hospitals without Psychiatric Units
M.H. Clinic is Mental Health Clinics
Law Enf. is Law Enforcement Agencies
**Eve. is Evening; Nit. is Night; Paraprof. is Paraprofessional; Law Enf. is Law Enforcement Personnel

TABLE XL

STAFF PROVIDING TELEPHONE COUNSELING/REFERRAL ACCORDING TO NUMBER OF FACILITIES

Type of Staff	G.H.* with N=2	G.H. w/out N=5	Hot Lines N=3	M.H. Clinic N=7	Law Enf. N=7	Facility Total N=24
	Number of Facilities					
Secretary	1	3	1	6	2	13
Volunteer	0	0	3	0	0	3
Vol. w/Para. back-up**	0	0	1	0	0	1
Vol. w/Prof. back-up	0	0	2	0	0	2
Vol. w/Psyc. back-up	0	0	2	0	0	2
Parapro-fessional	2	5	1	5	0	13
Para. w/Prof. back-up	2	5	0	5	0	12
Para. w/Psyc. back-up	2	3	0	4	0	9
Profes-sional	1	4	2	7	0	14
Prof. w/Prof. back-up	1	4	1	7	0	13
Prof. w/Psyc. back-up	1	3	1	6	0	11
Psychiatrist	1	2	1	6	0	10
Law Enforce-ment Pers.	0	0	0	0	7	7

*G.H. with is General Hospitals with Psychiatric Units
G.H. w/out is General Hospitals without Psychiatric Units
M.H. Clinic is Mental Health Clinic
Law Enf. is Law Enforcement Agencies
**Vol. is Volunteer; Para. is Paraprofessional; Prof. is Professional; Psyc. is Psychiatrist; Law Enforcements Pers. is Law Enforcement Personnel

TABLE XLI

STAFF PROVIDING WALK-IN SERVICE ACCORDING TO NUMBER OF FACILITIES

Type of Staff	G.H.* with N=2	G.H. w/out N=5	Hot Lines N=3	M.H. Clinic N=7	Law Enf. N=7	Facility Total N=24
	Number of Facilities					
Secretary	2	0	0	7	3	12
Volunteer	0	0	1	0	0	1
Vol. w/Para. back-up**	0	0	1	0	0	1
Vol. w/Prof. back-up	0	0	1	0	0	1
Vol. w/Psyc. back-up	0	0	0	0	0	0
Paraprofessional	5	2	1	6	0	14
Para. w/Prof. back-up	5	2	0	6	0	13
Para. w/Psyc. back-up	4	2	0	5	0	11
Professional	2	2	1	7	0	12
Prof. w/Prof. back-up	2	2	0	7	0	11
Prof. w/Psyc. back-up	2	2	0	7	0	11
Psysician	5	2	0	1	0	8
Phys. w/Psyc. back-up	4	2	0	1	0	7
Psychiatrist	1	2	0	6	0	9
Law Enforcement Pers.	0	0	0	0	5	5
Interdis. Team	0	2	0	2	0	4

*G.H. with is General Hospitals with Psychiatric Units
G.H. w/out is General Hospitals without Psychiatric Units
M.H. Clinic is Mental Health Clinics
Law Enf. is Law Enforcement Agencies

**Vol. is Volunteer; Para. is Paraprofessional; Prof. is Professional; Psyc. is Psychiatrist; Phys. is Physician; Law Enforcement Pers. is Law Enforcement Personnel; Interdis. Team is Interdisciplinary Team

TABLE XLII

NUMBER OF STAFF PROVIDING REFERRAL SERVICES ACCORDING TO TYPE OF FACILITY

Type of Staff	Type of Facility						
	G.H.* with	G.H. w/out	Hot Lines	Mental Health Clinic	Law Enf.	Total	%
Secretary	18	3	0	20	19	60	5%
Volunteer	0	0	157	0	0	157	12%
Paraprofessional	19	27	4	8	0	58	5%
Professional	13	0	1	39	0	53	4%
Physician	5	95	0	1	0	101	8%
Psychiatrist	43	4	0	10	0	57	5%
Law Enforcement Person.	0	0	0	0	780	780	61%
Totals	98	129	162	78	799	1266	100%

*G.H. with is General Hospitals with Psychiatric Units
G.H. w/out is General Hospitals without Psychiatric Units
Law Enf. is Law Enforcement Agencies

TABLE XLIII

STAFF PROVIDING OUTREACH SERVICES
ACCORDING TO NUMBER OF FACILITIES

Type of Staff	Number of Facilities: G.H.* with N=2	G.H. w/out N=5	Hot Lines N=3	M.H. Clinic N=7	Law Enf. N=7	Facility Total N=24
Volunteer	0	0	2	0	0	2
Vol. w/Para. back-up**	0	0	1	0	0	1
Vol. w/Prof. back-up	0	0	0	0	0	0
Vol. w/Psyc. back-up	0	0	0	0	0	0
Parapro-fessional	0	1	1	3	0	5
Para. w/Prof. back-up	0	1	0	3	0	4
Para. w/Psyc. back-up	0	0	0	3	0	3
Profes-sional	1	0	0	3	0	4
Prof. w/Prof. back-up	1	0	0	3	0	4
Prof. w/Psyc. back-up	1	0	0	3	0	4
Psychiatrist	0	0	0	2	0	2
Law Enforce-ment Pers.	0	0	0	0	7	7
Interdis. Team	0	0	0	1	0	1

*G.H. with is General Hospitals with Psychiatric Units
G.H. w/out is General Hospitals without Psychiatric Units
M.H. Clinic is Mental Health Clinics
Law Enf. is Law Enforcement Agencies

**Vol. is Volunteer; Para. is Paraprofessional; Prof. is Professional; Psyc. is Psychiatrist; Law Enforcement Pers. is Law Enforcement Personnel; Interdis. Team is Interdisciplinary Team

TABLE XLIV

ESTIMATED NUMBER OF PSYCHIATRIC EMERGENCY CONTACTS PER TYPICAL MONTH IN GENERAL HOSPITALS WITH PSYCHIATRIC WARDS

Type of Contact	County of Study		
	M.C.[1]*	M.C.[2]	Total
Telephone	70	300	370
Walk-in	35	250	285
Outreach	0	10	10
Referral	85	86	171
Answering Service	0	0	0
Consultation	18	16	34
Totals	208	662	870

*M.C.[1] is Providence Hospital (Multnomah County)
M.C.[2] is University of Oregon Health Sciences Center (Multnomah County)

TABLE XLV

ESTIMATED NUMBER OF PSYCHIATRIC EMERGENCY CONTACTS PER TYPICAL MONTH IN GENERAL HOSPITALS WITHOUT PSYCHIATRIC WARDS

Type of Contact	County of Study					
	K.C.*	M.C.	T.C.	U.C.	W.C.	Total
Telephone	4	180	10	5	5	204
Walk-in	4	30	7	3	10	54
Outreach	0	0	2	0	0	2
Referral	2	80	3	1	2	88
Answering Service	0	0	0	0	5	5
Consultation	1	0	0	1	1	3
Totals	11	290	22	10	23	356

*K.C. is Presbyterian Inter-Community Hospital (Klamath County)
M.C. is Good Samaritan Hospital (Multnomah County)
T.C. is Tillamook County Hospital
U.C. is Grande Ronde Hospital (Union County)
W.C. is Tuality Community Hospital (Washington County)

TABLE XLVI

ESTIMATED NUMBER OF PSYCHIATRIC EMERGENCY CONTACTS PER TYPICAL MONTH IN HOT LINES

Type of Contact	County of Study			
	K.C.*	M.C.[1]	M.C.[2]	Total
Telephone	130	175	400	705
Walk-in	12	10	10	32
Outreach	20	9	0	29
Referral	130	139	200	469
Answering Service	30	0	0	30
Consultation	0	40	25	65
Totals	322	373	635	1330

*K.C. is Hope in Crisis Hot Line (Klamath County)
M.C.[1] is Outside-In (Multnomah County)
M.C.[2] is Suicide and Personal Crisis Service (Multnomah County)

TABLE XLVII

ESTIMATED NUMBER OF PSYCHIATRIC EMERGENCY CONTACTS PER TYPICAL MONTH IN MENTAL HEALTH CLINICS

Type of Contact	County of Study							
	K.C.*	M.C.[1]	M.C.[2]	T.C.	U.C.	W.C.[1]	W.C.[2]	Total
Telephone	12	9	100	21	13	3	16	174
Walk-in	8	9	25	11	4	1	10	68
Outreach	4	3	0	0	3	0	4	14
Referral	4	3	25	6	10	4	12	64
Answering Service	15	0	12	0	0	0	10	37
Consultation	6	5	50	6	4	8	30	109
Totals	49	29	212	44	34	16	82	466

*K.C. is Klamath County Mental Health Program
M.C.[1] is Northeast Multnomah County Mental Health
M.C.[2] is Kaiser Mental Health Clinic (Multnomah County)
T.C. is Tillamook County Mental Health Program
U.C. is Union County Mental Health Program
W.C.[1] is Tualatin Valley Guidance Clinic (Washington County)
W.C.[2] is Washington County Mental Health Program

TABLE XLVIII

ESTIMATED NUMBER OF PSYCHIATRIC EMERGENCY CONTACTS PER TYPICAL MONTH IN LAW ENFORCEMENT AGENCIES

	County of Study							
Type of Contact	K.C.*	M.C.[1]	M.C.[2]	T.C.[1]	T.C.[2]	U.C.	W.C.	Total
Telephone	100	**	**	8	10	14	75	207
Walk-in	2	15	**	0	0	5	20	42
Outreach	80	120	124	6	6	12	85	433
Referral	70	75	**	1	0	3	20	169
Answering Service	0	0	0	0	0	0	400	400
Consultation	0	0	0	0	0	1	0	1
Totals	252	210	124	15	16	35	600	1252

*K.C. is Klamath Falls City Police (Klamath County)
M.C.[1] is Multnomah County Sheriff
M.C.[2] is Portland Police (Multnomah County)
T.C.[1] is Tillamook County Sheriff
T.C.[2] is City of Tillamook Police Department (Tillamook County)
U.C. is La Grande City Police (Union County)
W.C. is Washington County Sheriff
**Data is unavailable

TABLE XLIX

SIZE OF SAMPLE FOR EACH FACILITY FROM WHICH CLIENT DATA WAS OBTAINED

Facility by County	Sample
Klamath County	N= 41
Klamath County Mental Health Program	N= 12
Presbyterian Intercommunity Hospital	N= 19
City of Klamath Falls Police Department	N= 10
Multnomah County	N= 61
Kaiser Mental Health Clinic	N= 10
University of Oregon Health Sciences Center	N= 20
Providence Hospital	N= 11
Good Samaritan Hospital	N= 10
Suicide and Personal Crisis Hotline	N= 10
Tillamook County	N= 38
Tillamook County Mental Health Program	N= 10
Tillamook County General Hospital	N= 10
City of Tillamook Police Department	N= 8
Tillamook County Sheriff's Department	N= 10
Union County	N= 30
Union County Mental Health Program	N= 9
Grand Ronde Hospital	N= 13
La Grande City Police Department	N= 8
Washington County	N= 49
Washington County Mental Health Program	N= 9
Tualitan Valley Guidance Clinic	N= 10
Tuality Community Hospital	N= 10
Washington County Sheriff's Department	N= 20
Total Sample Size	N=224

TABLE L

NUMBER OF CLIENTS IN THE SAMPLE FOR EACH MONTH STUDIED

	Month of Study			
	July 1976	August 1976	September 1976	Total
Number of Clients	70	78	75	224
Percent	31.25%	34.82%	33.48%	99.55%

TABLE LI

DISTRIBUTION OF CLIENTS IN THE SAMPLE BY SEX

	County of Study											
	Klamath County N=41		Multnomah County N=66		Tillamook County N=38		Union County N=30		Washington County N=49		Total N=224	
Sex of Clients	N	%	N	%	N	%	N	%	N	%	N	%
Male	19	46	28	43	17	45	17	56	21	43	102	46
Female	22	54	38	58	21	55	13	43	28	57	122	54

TABLE LII

MARITAL STATUS OF CLIENTS IN THE SAMPLE

	County of Study											
	Klamath County N=41		Multnomah County N=66		Tillamook County N=38		Union County N=30		Washington County N=49		Total N=224	
Marital Status	N	%	N	%	N	%	N	%	N	%	N	%
Single	22	58	28	50	10	39	4	16	12	29	76	34
Married	16	42	28	50	16	61	21	84	29	71	110	49

TABLE LIII

COUNTY OF RESIDENCE FOR CLIENTS IN THE SAMPLE

	Type of Facility									
	General Hospital N=93		Hot Line N=15		Mental Health Clinic N=60		Law Enforcement Agency N=56		Total N=224	
County of Residence	N	%	N	%	N	%	N	%	N	%
In-County	76	82	11	73	55	92	44	79	186	83
Out of County	9	10	2	13	5	8	6	11	22	10
Unavailable	8	9	2	13	0	0	6	11	16	7

TABLE LIV

DAY OF WEEK CLIENTS WERE SEEN

Sunday		Monday		Tuesday		Wednesday		Thursday		Friday		Saturday		Total	
N	%	N	%	N	%	N	%	N	%	N	%	N	%	N	%
29	13	26	12	39	17	30	13	42	19	28	12.5	30	13	224	100

TABLE LV

DURATION OF THE CLIENTS' PROBLEM
BY FACILITY

Duration of the Clients' Problem	General Hospital N=93		Hot Line N=15		Mental Health Clinic N=60		Law Enforcement Agency N=56		Total N=224	
	N	%	N	%	N	%	N	%	N	%
One day or less	10	11	1	7	2	3	21	37.5	34	15
Less than one week	9	10	0	0	2	3	0	0	11	5
Less than one month	13	14	0	0	4	6.6	3	5	20	9
Less than one year	10	11	2	13	10	17	2	3.5	24	11
Less than two years	1	1	1	7	4	6.6	0	0	6	3
Two years or more	12	13	5	33	22	37	4	7	43	19
Unavailable	38	41	6	40	16	27	26	46	86	38

TABLE LVI

CLIENTS WHO RECEIVED NO FURTHER SERVICE

Client withdrew from further treatment because	Gen. Hosp. with a Psych. Unit N=31		Gen. Hosp. without a Psych. Unit N=62		Hot Line N=15		Mental Health Clinic N=60		Law Enforcement Agency N=56		Total N=224	
	N	%	N	%	N	%	N	%	N	%	N	%
client moved or was ill. Notified agency.	0	0	0	0	0	0	1	2	0	0	1	NS
client died. Agency notified.	0	0	0	0	1	7	0	0	3	5	4	2
of other reasons. Agency notified.	1	3	4	6	0	0	1	2	1	2	7	3
the agency was not notified.	0	0	0	0	0	0	1	2	0	0	1	NS
Totals	1	3	4	6	1	7	3	6	4	7	13	5

Type of Facility

TABLE LVII

CLIENTS WHO RECEIVED NO FURTHER SERVICE

Client was terminated by the facility without further treatment	Gen. Hosp. with a Psych. Unit N=31		Gen. Hosp. without a Psych. Unit N=62		Hot Line N=15		Mental Health Clinic N=60		Law Enforcement Agency N=56		Total N=224	
	N	%	N	%	N	%	N	%	N	%	N	%
because no further care was indicated	2	6	7	11	1	7	2	3	13	23	25	11
because care was indicated but unavailable	0	0	2	3	2	13	0	0	0	0	4	2
because the client was unresponsive	3	10	6	10	2	13	1	2	0	0	12	5
for other reasons	0	0	5	8	1	7	1	2	3	5	10	4
Totals	5	16	20	32	6	40	4	7	16	28.5	51	23

Type of Facility

TABLE LVIII

CLIENTS WHO WERE REFERRED ELSEWHERE

Type of Facility

Client referred to	General Hospital with a Psychiatric Unit N=31		General Hospital without a Psychiatric Unit N=62		Hot Line N=15		Mental Health Clinic N=60		Law Enforcement Agency N=56		Total N=182	
	N	%	N	%	N	%	N	%	N	%	N	%
a nursing home	0	0	3	5	0	0	1	2	0	0	4	2
for vocational training	0	0	1	2	0	0	1	2	0	0	2	1
to court or correction agency	1	3	3	5	2	13	2	3	4	7	12	5
to public health or welfare agency	0	0	0	0	0	0	2	3	0	0	2	1
to a voluntary agency	0	0	1	2	0	0	1	2	1	2	3	NS
other	1	3	4	6	1	7	1	2	4	7	11	5
Totals	2	6	12	19	3	20	8	13	9	16	34	19

APPENDIX D

SITUATIONAL VIGNETTES

FIVE CASE VIGNETTES DEVELOPED FROM THE RESEARCHERS' CLINICAL EXPERIENCE AND INTERVIEWS WITH OTHER DIRECT SERVICE PROVIDERS

CASE #1

It is 11:30 P.M. on Thursday and John Doe has been experiencing depressive and suicidal thoughts for the past day. His family decides that if he does not receive psychiatric help today, they may not be able to prevent John from killing himself. The family has no means of transportation, so they begin to look in the yellow pages for the telephone number of an agency who will provide some type of psychiatric outreach service. After several calls to various hospitals, clinics and hot lines the family learns that none of these agencies provide outreach services and they are advised to call an ambulance or the police. They learn from one hot line that there is another hot line that will provide outreach. They call, and within an hour two volunteers arrive and begin to assess the situation. The volunteers believe John's condition to be serious enough to warrant hospitalization, but after calling two hospitals with psychiatric units, they are told that the units are full and the hospitals are unable to admit the client. At this point, going to these hospital emergency rooms would not facilitate hospitalization. The volunteers must decide whether they will continue to try other hospital emergency rooms, take John to the state mental hospital which John is willing to do, or advise the family to watch him for the night and take him to a mental health clinic in the morning.

CASE #2

The local police have received a call from a grocery store owner who reports that a "strange" woman has been wandering in and out of his store for the past hour. When approached, she appears confused and disoriented. She cannot remember her name or where she lives and most of her words are incomprehensible. The dispatcher radios a patrolman, who drives immediately to the store. When he arrives he questions the woman and finds that she is unable to give him any information about herself. The police officer determines that she is a "mental case" and with great difficulty takes her to the emergency room of a local hospital. He describes the situation in which he found the woman to the nurse and then waits while the woman is seen by a psychiatrist. The woman is eventually admitted to the hospital and the police officer leaves, having spent a total of four hours on this case.

CASE #3

Mr. Adams, age 55, is in a panic. His wife has recently died and he feels desperately lonely and frightened. These feelings threaten to overwhelm him. After being unable to reach any of his close friends, and feeling extremely anxious, he calls the local mental health clinic where he had been seen several years before. Since it is 7:00 Friday evening, no one answers.

Feeling very shaky, alienated and anxious, Mr. Adams goes to the local general hospital emergency room. He is seen by the intern and is sent home.

The records for that emergency visit remain with the hospital and the mental health clinic where Mr. Adams had previously been seen is not contacted concerning his crisis or the intervention. A referral is not given to Mr. Adams.

CASE #4

A young man is brought to the emergency room by his girlfriend after taking an overdose of drugs. The physician examines the man while admonishing him for taking an overdose and then pumps his stomach out. The client, feeling overwhelmed by the experience, remains silent.

When the treatment is completed the man leaves with his girlfriend. No reference to the events surrounding the overdose are made in the chart and the client does not receive a referral.

CASE #5

It is eleven o'clock Tuesday morning. Jane Doe is a 35-year-old housewife who has become increasingly agitated and fearful. Her family doesn't know what is causing Mrs. Doe to be so distressed. Her husband decides to take his wife to the emergency room after she spent the night pacing the house and waking the children.

They go to the nearest emergency room and are seen by a psychiatric social worker who suggests to the husband that Mrs. Doe be admitted to a psychiatric unit. The social worker goes on to say that the hospital's psychiatric unit is full and thay they should go to another hospital that has some free beds.

If Mrs. Doe hadn't become more agitated while waiting to be seen, Mr. Doe would have just taken her home. Instead they go to the hospital that the social worker suggested.

It is 2:30 in the afternoon before they are seen by the admitting physician. By this time Mrs. Doe is very agitated and is accusing her husband of being unkind and trying to "put her away." The physician decides to admit Mrs. Doe to the psychiatric unit.

The attendant arrives to escort Mrs. Doe to her room. Mr. Doe it trying to say goodbye and reassure her. Mrs. Doe is shouting verbal abuse and does not respond to her husband's comfort.

Mr. Doe leaves feeling confused and distraught.

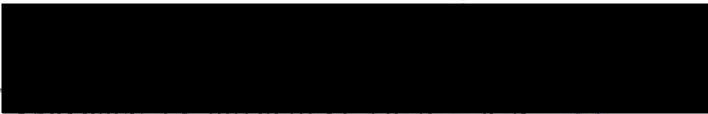
AN ABSTRACT OF THE THESIS OF

CATHERINE M. KNOX

For the: MASTER OF NURSING

Date of receiving this degree: June 11, 1977

Title: PSYCHIATRIC EMERGENCY SERVICES IN SELECTED OREGON COUNTIES

Approved: 
Advisor

Psychiatric emergency services are recognized as an essential component in the provision of mental health care. This study describes the delivery of psychiatric emergency services in selected Oregon communities. The theoretical framework was developed to consider the problem of psychiatric emergency service delivery from the perspective of the individual experiencing the emergency, the social milieu, and the health care system. The literature describing psychiatric emergency service programs, the characteristics of those who use these services and the roles of direct service providers was reviewed. On the basis of the review a study was undertaken to describe the delivery of psychiatric emergency services in selected Oregon counties, to identify variables that determine the nature of psychiatric emergency services provided and to develop recommendations for existing psychiatric emergency services.

Data was collected from the major public agencies providing psychiatric emergency services in each of the five counties chosen for study. These agencies included general hospital emergency rooms, mental

health clinics, law enforcement agencies, and hot lines. Three research tools were developed to study these agencies. A description of the psychiatric emergency services offered by each agency was obtained using a structured interview. Client data was collected using a retrospective chart search of a random sample of clients who were seen at each agency. The third research tool was used to elicit the opinions held by direct service providers about the effectiveness of the psychiatric emergency service delivery system.

The results of the study indicate the volume of services received by persons in a psychiatric emergency. This does not appear to be related to the staffing pattern or the level of training of persons delivering psychiatric emergency services. The results also showed that non-mental health personnel provide substantial amounts of service to persons in a psychiatric emergency situation, without the provision of specialized training or professional mental health back-up. The opinions shared by direct service providers about the delivery of psychiatric emergency services suggest that service providers are not aware of the amount of service provided by other agencies in the same community.

The researchers concluded that there are gaps in psychiatric emergency services available within communities and that particular types of agencies consistently give certain services. Another conclusion is that there is no 24-hour information and referral service that provides information concerning the availability of psychiatric emergency resources. When referrals are made by direct service providers, they are most often made to facilities providing inpatient care or outpatient therapy. It was noted that each agency utilizes a different method of evaluation and record keeping for psychiatric emergencies. The last

conclusion of the research was that the majority of direct service providers studied feel that community education is a major area needing improvement for comprehensive psychiatric emergency service delivery.