Journal of Sociology and Social Work
June 2017, Vol. 5, No. 1, pp. 31-37
ISSN: 2333-5807 (Print), 2333-5815 (Online)

Published by American Research Institute for Policy Development
DOI: 10.15640/jssw.v5n1a4
URL: https://doi.org/10.15640/jssw.v5n1a4

The Crisis in Crisis Intervention: An Analysis of Crisis Care and Community Mental Health in Northwest Ohio

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Abstract

Lack of collaboration between Crisis Intervention Care and Community Mental Health Centers or fragmentation of services cause poor follow up care and lower quality of care for clients. These two mental health care delivery systems are a fundamental part for those struggling from mental health issues. This study explored benefits of collaboration between these two systems. The objective was to identify the crucial needs of these particular mental health systems. We surveyed seven agencies, including four crisis intervention centers and three community mental health facilities with semi-structured interviews. Findings emphasized a holistic view of crisis intervention that may speed up client care, decrease the revolving door and reduce the need for inpatient crisis care. For the best practice in crisis intervention, social workers should advocate for this beneficial collaboration. By raising standards of care in crisis intervention and community mental health, as a profession, we can improve services for our clients.

Keywords: crisis intervention, community mental health, collaboration, mental health

Introduction

Serious mental illness can have a detrimental impact on an individual's everyday life, often leaving one unable to work, perform daily tasks and ultimately not being able to fill their expected role. "One in twenty-five adults in the United States experience a mental illness that interferes or limits one or more major life activities"(NAMI, 2013 p. 1). Individual's suffering from severe mental illness, often have periods of psychiatric crisis, resulting in the need for more intensive care. During these episodes of mental crisis, patients initially seek out crisis intervention services (Burns, 2007; Silverman, 1997).Patients seeking crisis intervention for severe psychiatric crisis are often admitted to an inpatient facility for three to five days in order to stabilize the individual and to determine the most effective regiment of medication. After the individual is discharged from the hospital they are often times given a follow up plan, such as a referral to a therapist or other mental health providers(Roberts & Ottens, 2005).Although this situation impacts the patients' quality of care, often times the discharging facility does not follow up with the patient to ensure proper services are being provided. Without the correct follow up care, individuals are at risk to repeatedly face crisis because they have not been given the tools and skills needed for a proper recovery. As a consequence, this leads patients to experience the "revolving door effect" which is the repetitive occurrence of the same individuals seeking crisis care. (Ginnis, 2015; Lauer & Brownstein, 2008).

In order to meet the needs of patients with acute mental health diagnoses, community mental health care has been on the rise. Community mental health centers are agencies that are located in the neighborhood that they serve. It often functions as a "one stop shop" for community mental health needs. There is strong evidence proving that mental health services are most effectively delivered in the community of the clients its serving. (Abdulmalik, 2016).

These services can include therapy, psychiatrist, socialization, emergency evaluation, case management as well as physical health services. Physical health services typically involve a doctor or nurse practitioner as well as nurses, who examine physical health concerns such as high blood pressure, diabetes and hypertension. Community mental health centers are all slightly different, but they all strive to address and assist individuals with physical and mental health. The collaboration between crisis intervention centers and community mental health centers is essential in forming a holistic care plan for individuals suffering from mental illness, however little research has been done on the collaboration between the two. Collaboration allows both agencies to communicate, utilize services and work together on patient follow up plans that are specific to the client. In other words, the lack of collaboration between crisis intervention and community mental health centers can have a detrimental impact on the clients utilizing these facilities because they are not being educated on all the treatment options available in the community.

The purpose of this study is to examine the level of collaboration and communication between community mental health centers and crisis intervention centers in Northwest Ohio. As the healthcare system changes and adapts to the modern world, integrated community mental health care is emerging. This begs the questions: how do these two important components, crisis care and community mental health work together for successful continuous care? Improving this collaboration would increase the speed, efficiency and success of the patient's mental health care. These two types of agencies working together would allow patient follow-up plans to be individualized, holistic, and conducive to recovery. These collaborated service delivery systems allow for improved supervision of follow-up plan as well.

Literature Review

Crisis intervention is short term treatment responding to trauma, suicidal thoughts or behaviors, behavior that is harmful to oneself or others, and other mental health struggles when an individual needs emergency care for a psychological issue. Crisis intervention had its first notable start in World War II. In order to help soldiers with the trauma from "battle fatigue" short term stabilization services were established (Teed, 2007). The main goal of crisis intervention is to stabilize the patient and allow them to return to everyday life. However, in general the public does not understand how common crisis intervention cases are. This can take place at a mental health center, an emergency room, hospital, or psychiatric ward (Silverman, 1997). In 2007, about 12 million visits to the emergency department were due to a mental disorder, a substance abuse problem, or both. (Harris, 2016). A lower capacity of beds for a patient in crisis can result in a practitioner scrambling to find a spot for a patient in crisis (Amirsadri, 2015; Abdulmalik & Thornicroft, 2016).

Community mental health is a model of community care to provide appropriate and relevant mental health care in a community setting, reducing the need for hospitalization. The Community Mental Health Care population is often defined as a group of individuals suffering from moderate to severe mental health diagnoses (McCormick, 2009).In 1965 the Community Mental Health Care Act was passed, providing at least five essential services with the idea of the "least restrictive environment" for the clients, started to gain popularity. These essential services included access to inpatient, outpatient, and partial hospitalization care, emergency care, and consultation and education for the surrounding community (Feldman, 2004;Minkoff, 2015). Although deinstitutionalization was considered humane, some individuals were released without adequate preparation (Teed, 2007). Murphy and Rigg's research tells us that service delivery should always be community based, and follow these ideas, but that is not always the case. Client participation is important to community mental health as this allows treatment to be transparent and relevant. Additionally, it should be multidisciplinary, culturally pertinent, and the staff members should represent the community, and have a connection to the neighborhood (Murphy& Rigg, 2014; Wakefield, 2011).

With these ideas of crisis intervention and community mental health, how can these two crucial areas of mental health work together to help their clients reduce hospitalization and improve the ease of service? Previous research stressed the importance of an interdisciplinary team due to the fact that those suffering from mental health typically have a number of physical health problems such as obesity, hypertension, and diabetes (McCormick, 2009).An inter-disciplinary team would allow practitioners to communicate with each other about the progress of the patient's mental and physical illness, producing a more holistic view of care for the patient.

This type of team also allows for better relationships with patients because the practitioner is able to better understand their social history, medical history and the environment they live in. Patients often described feeling un-supported by emergency department staff (Harris, 2016).

For instance, Emergency room physicians in the Amirsadri study often stated their goal was to get psychiatric patients out quickly and to avoid the substance abuse cases (Amirsadri, 2015). Collaboration with community mental health organizations would allow the patient to receive the necessary follow-up care after a crisis and create more personable relationships with their community mental healthcare provider. Patients report that hospital type settings are often not positive or helpful during or after a crisis, which is where collaboration comes into play (Harris,2016). As emergency room doctors frequently feel unprepared to diagnose mental illness, collaborating with community mental health agencies would allow them to get a second opinion, receive training, and have community liaisons (Amirsadri, 2015).

Methods

Participants

Eight service providers (seven women and one man) from seven community mental health and crisis intervention centers in Northwest Ohio volunteered to participate in the study. Of these seven agencies, three were community mental health centers, two were hospital emergency rooms and two were crisis intervention centers.

Procedure

A recruitment script and informed consent form were sent to potential participants introducing them to the study. The recruitment script explained the purpose of the study and how to get a hold of the principal investigators if they chose to participate. Informed consent forms further explained the study; objectives, benefits, risks, the researchers contact information and that participation is completely voluntary. Two sets of questions were used; one for Community Mental Health and one for Crisis intervention. The question sets contained the same demographic questions, and slightly different questions about the collaboration of Community mental health and crisis intervention. In addition, each participant was given the same set of six scaling questions. Participants used the scale (1 strongly disagree- 5 strongly agree) to indicate their opinion on specific statements related to collaboration between community mental health centers and crisis intervention centers.

In order to ensure the credibility of our study, before we began collecting data we applied for approval from the Institutional Review Board, and received it. The purpose of the Institutional Review Board is to ensure that research being conducted is done in an ethical way without bias. Principle Investigators emailed participants containing the recruitment script and informed consent form. It informed potential participants about the deductive study examining the impact of collaboration between community mental health and crisis intervention centers. Those interested in volunteering for the study reached out to the principle investigator stating they were interested and when they were available for an interview. The framework we used for the interview process was a semi-structured interview which allowed for question flexibility during each individual interview. The duration of each interview was between twenty minutes to an hour depending on the length of the participant's response. Each interview was recorded and began with a summary of the research followed by the participant reading and signing the consent form. Although there was some room for people to share their thoughts, we achieved good internal validity by asking the same set of questions for community mental health and for crisis intervention. Participants employed at a crisis intervention center were given the seventeen question 'Crisis Intervention' question set catered to their field, while community mental health employees answered a twenty-one question set.

After the completion of all seven interviews, each recording was transcribed onto a researcher's personal, password protected laptop where they were stored. This transcription was another safeguard to the research's internal validity. In the process of our study all participants and their associated agencies have not been named. In order to protect their identity, we replaced their names with Agency 1, Agency 2 and so on. Each interview was reviewed to determine the common themes, ideas, and issues discussed by the participating providers. The results of both the interview and scaling questions were then compared to find the common issues, strengths and further program development determined by participants' responses.

Findings

Characteristics of Participants

The practitioners interviewed had been working in the field for as little as two years to as many as thirty-five years. They had degrees ranging from bachelors or masters in social work or psychology. Clients they served were adults ages 18 and older with severe and often persistent mental illness. Generalized anxiety disorder, and major depressive disorder are two of the most common diagnoses seen. There was also a reported increase in gambling disorders, transgender clients, substance abuse, and post-traumatic stress disorder. The agencies also often served clients on the autism spectrum and individuals with other cognitive deficiencies. Many of the clients utilized Medicaid and Medicare, and were of a lower social economic status.

Common Themes

***Level of collaboration*:** Participants were asked a variety of questions about their views on collaboration between other mental health agencies and their working relationships. They were also asked how collaboration, or the lack thereof, effects their speed of service, efficiency and resources offered. All three community mental health centers providers interviewed stated that collaboration between crisis intervention and other mental health agencies has a positive effect on their organization. Each agency seemed to have a strong relationship with at least one crisis intervention center or emergency room. Two of the three community mental health agencies reported that they work closely with crisis intervention centers on a weekly basis. These two agencies send liaisons to hospitals and crisis intervention centers to meet the client before they have been discharged or released from their current program. This allows the community mental health liaisons to set up a follow-up plan with the client before they have even left the hospital. Participants explained how this initial meeting with the client has helped tremendously in preventing future crisis situations.

A common theme that emerged in our interviews with both community mental health and crisis intervention providers was the issue of the 'revolving door.' This is when the same client continuously returns for crisis intervention services. Participants from both fields agreed that there is a causal relationship between collaboration and the decrease of ‘revolving door' cases. This is due to the increased support a client receives when these agencies are working together. Participants were also asked if they believed that an increase in collaboration would lead to a decrease in crisis intervention cases and all seven agencies answered yes. Collaboration between the two agencies allows for better follow-care for the client resulting in more support and options for the client. Finally, participants were asked what helps and hinders collaboration between different mental health and social service agencies. The most common response for what helps collaboration is regular communication between agencies and service providers and ongoing professional relationships. All agencies reported that time, staff and resources are the most common factors that hinders collaboration.

Lack of Resources: A common theme that emerged when interviewing community mental health and crisis intervention service providers was the lack of resources in the community. If the community does not have the proper resources needed, community mental health workers are not able to collaborate with these services. Throughout the interviewing process the participants indicated a lack in services and resources that are greatly needed for the population of clients they serve. Participants reported a trend in homelessness, drug addiction, and chronic mental illness within their client base. This increase is due to a decrease in employment opportunities, an increase in drug trafficking in the area, and increasing economic disparities. Not only do Community mental health agencies collaborate with crisis intervention centers but they also work with other service providers within the community. A large portion of the population seeking mental health treatment is struggling with addiction. The most common addictions reported by participants were alcohol and opiates. Each interviewee described opiate addiction as an epidemic as they continue to see a rise in the rate of opiate addiction cases. One of the largest barriers in serving this population is the lack of programs and services dedicated to addiction. Participants described countless situations where a client struggling with addiction would come into their agency looking for detoxification help, but unfortunately they do not have a specific program dedicated to detoxification and rehabilitation. Each participant expressed the need for more beds in hospitals for individuals struggling with detoxification and the need for addiction rehabilitation programs. Another barrier when serving those struggling with mental illness is homelessness.

A large portion of the population served by community mental health centers is either homeless or has a low socioeconomic status. These individuals are not only struggling with mental illness but they also do not have

consistent shelter, food and health insurance coverage. Participants expressed their concern for the lack of public resources when it comes to housing and food insecurity. There are not enough programs in the community to help with the homeless population so that service providers in the community mental health field are not able to refer their clients to programs that will help clients find a stable living situation.

Finally, the third most common trend in the population of clients seeking services are those suffering with chronic mental illness. Individuals suffering from chronic mental illness, such as schizophrenia, rely more heavily on mental health services than those with less severe mental illness. These individuals require more intensive treatment. The barrier to this is that there are not enough long term beds in the hospital. Individuals suffering from chronic mental illness are more likely to return for crisis intervention services. Participants expressed the need for more options for their clients with chronic mental illness. Some of these options include longer hospitalizations, partial hospitalization and group homes due to the need for more consistent care and supervision. Without these services the chronic, mentally ill do not receive the care and treatment needed to return to a more normal level of functioning.

Professional relationships*:* In order for an agency to successfully collaborate with other agencies, ongoing professional relationships must be built. One of the main barriers, indicated by the participants, when building a relationship is opposing views. Each agency has a model of care they use and it does not always match up with the collaborating agency. These differences in the way clients are served and the process of service delivery can deter agencies from working together. It is important to talk through the different viewpoints when trying to build collaboration between two agencies. Service providers must work together and put aside their differences to create a plan or program that each agency agrees on in order to provide their clients with the best services. Two of the three participating community mental health centers seemed to have a small rivalry as too who is the better service provider, which has had an impact on collaboration between them. One particular service provider from a community mental health center interviewed expressed that competition between community mental health centers should be eliminated. Rivalries between community mental health centers prevent these agencies from creating professional relationships with one another. Without relationships collaboration will not happen and can have a detrimental impact on the services one agency can provide. Throughout the interviewing process it was indicated that the best way for agencies to collaborate is by each agency specializing in a certain service. This allows each agency to have one service as their main focus instead of trying to provide a variety of strong services and programs. Agencies would be able to refer clients to another agency that is specialized in a particular service or program, which would improve speed of service, efficiency and the overall treatment process for the client.

Discussion

During this research there were many unexpected findings. First, many of the agencies stressed the importance of holistic health. Holistic health is the idea that in order for someone to be healthy, they need to address it in all parts of their life. Holistic health is important because it considers all of a person, including the health of a person socially, emotionally, physically, and other factors of managing your health. Many health professionals believe there is a link between all of these factors to achieve overall health. For example, what if a patient comes in for mental health care, but they are suffering from un-managed diabetes and are constantly sick? Until the symptoms of the diabetes are under control it is hard to expect the patient to be able to improve their mental health. Another way to think of holistic health is as an all-encompassing approach. To relate this to crisis care and community mental health in Northwest Ohio, many agencies are hiring doctors and nurses to help their patients, but patients often cannot enter inpatient care until they are in reasonable physical health. Many clinics have also started using nutritionists and yoga instructors. In addition, law enforcement and the criminal justice system came up many times, as agencies felt it would be important to work and collaborate with them. One way this already happens is through Crisis Intervention Training (CIT) officers. A crisis officer is a law enforcement officer, who is specially trained to handle potentially dangerous crisis care situations. These officers are usually the first to respond to a crisis call where the client is in danger of hurting themselves or others. It helps keep the patient safe, as well as the officers and other community members. The training the officers go through is meant to help them gain an understanding of this population.

They also learn about safely transporting someone, and de-escalation techniques, not all communities have this program, but many of the providers stated a need for this type of collaboration. Throughout the interviews participants revealed that the fastest growing issues in the Northwest Ohio area had to do with substance abuse.

Every agency interviewed reported a substantial lack or shortage of resources for this particular population. Due to this, community members were often coming to crisis care centers and community mental health for assistance in detoxification process. Often the practitioners had no resources to give them, and instead the client was put on a long waiting list for a detox bed. This was identified as one of the largest areas of need in Northwest Ohio. Another thing that was commonly reported was transportation and housing problems. There was a general consensus that clients struggling with one of these two areas had a harder time succeeding in crisis care or community mental health. Finally, many agencies in the area have seen the need for gerontological crisis care and community mental health. This need has been addressed in a few areas with special inpatient units for this population. Another program related to crisis care that is gaining momentum is partial hospitalization. Partial hospitalization is for clients who do not need inpatient hospitalization but have a serious need for intensive outpatient care. Oftentimes the patientcomes in during the day, and leaves at night.

In spite of profound, enriching findings in the study, there are a few limitations to be addressed. Firstly, due to the very busy schedules and understaffing of professionals in the field, it was difficult to contact some of them and schedule an interview. Secondly, sometimes the interviewees were slightly reserved about talking about our topic due to its sensitive nature and that we are critically analyzing the current system in place. Also due to limited time and research, we did not have enough interviews and data sets to make our results statistically significant in a quantitative sense. Lastly, these research findings indicate a need for more exploratory research. Our external validity is transferable to other areas of the Midwest with areas of small cities and rural towns. Although our scaling questions are not statistically significant, they do indicate a trend that professionals value and need collaboration.

Conclusion

This study stresses the need for collaboration between crisis care and community mental health. In addition, a dire need for collaboration in other avenues is needed as well, such as collaboration with Law Enforcement. This research shows a clear need for further exploration of the benefits of collaboration and how to best implement that between agencies. From our research it is very clear that conscious, intentional collaboration between crisis intervention and community mental health are needed. This could be done in various ways such as forming communities between the two services, or making more detailed follow up care plans for clients. Another solution would be finding ways to share patient data without breaking confidentiality. Collaboration between these two agencies has an impact on what services can be offered by social workers. Implications for social work practice and collaboration would be more efficient care, reduced boarding rates, and improved ease of service. Collaboration allows for more efficient care because providers from different organizations working with the same clients are able to come together and create a care plan working with all the services offered by both agencies. Boarding rates decrease with collaboration because social workers from community mental health centers are able to meet the client before they get out of the hospital to plan follow up services for when they are discharged. Overall, collaboration between community mental health and crisis intervention centers improves social work practice because it allows the worker to create professional relationships, utilize more services and have easier access to patient records (Minkoff, 2015). While there are many avenues to improve collaboration, the most important factor is practitioners putting long term care, and follow up care at a high priority. Additionally, further education about the benefits of the collaboration is needed for professionals in the field. This includes those in the mental health sector as well as other social service areas.

Acknowledgment

We would like to thank our participants whose input was invaluable for the understanding of this important topic. We would also like to thank the Center for Undergraduate Research at Bowling Green State University from who we received a generous grant. Their aid, and support fueled our research and made it what it could be.

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