MINNESOTA DEPARTMENT OF HUMAN SERVICES

MENTAL HEALTH

AND

STATE OPERATED SERVICES DIVISION

LEGISLATIVE REPORT ON

EMERGENCY MENTAL HEALTH SERVICES:

A REVIEW OF THREE COUNTY SYSTEMS

JANUARY 1996

Pursuant to 1994 Minn. Laws Chap. 515 Subd. 2

Estimation of Report Costs:

Category	Cost
Staff Time Total	$5,185.00
Printing/Mailing/Distribution (est.)	$630.00
Mileage and other reimbursement for committee members (est.)	$500.00
Total	$6,315.00

DEPARTMENT OF HUMAN SERVICES REPORT TO THE LEGISLATURE ON EMERGENCY MENTAL HEALTH SERVICES: A REVIEW OF THREE COUNTY SYSTEMS

Executive Summary

In response to legislation passed in Spring 1994, the emergency mental health services in Ramsey, Olmsted and Washington Counties were monitored and evaluated from August 1994 to July 1995 by county advisory committees made up of nine members including at least five people who were family members, consumers or advocates. The committees found that the emergency mental health services specifically identified in the Minnesota Statutes, Section 245.269, subdivisions 1 and 2 are being delivered in each county and that consumers of the services are largely satisfied with them. Each committee, however, identified several emergency mental health needs in their communities such as specialized services for people who are deaf or non-English speaking, voluntary crisis respite, and psychiatric inpatient units, which were lacking or needed improvement. The committees expressed concern about the level of need which must be exhibited before intervention can occur. As a result of the frequent and significant role of law enforcement agencies in mental health crises, the committees recommended that law enforcement officers receive further education about mental illness and the available community resources to assist them in dealing with mental health emergencies/crises. Development of a universal crisis response system which allows appropriate intervention regardless of the type of health care coverage was also recommended.

TABLE OF CONTENTS

EXECUTIVE SUMMARY

BACKGROUND 1
Review of Legislation 1
County Selection 1
Committee Member Selection 1
Process Used by Each Committee 2
Study Limitations 2

FINDINGS AND RECOMMENDATIONS OF THE COMMITTEES
Task # 1: Presence of Emergency Mental Health Services 3
Task # 2: Quality and Sufficiency of Emergency Mental Health Services 7
Task # 3: Effectiveness of Consumer, Family and Advocates Input in the Provision of Emergency Mental Health Services 10

OVERALL RECOMMENDATIONS FROM THE COMMITTEE . . . 11
Changes in Rule or Statute 11
Changes in Funding 11

STATEWIDE INFORMATION REGARDING EMERGENCY MENTAL HEALTH SERVICES 12
Emergency Mental Health Services Survey, 1994 12
Crisis Mental Health Services Survey, 1995 13

CONCLUSION 15
REFERENCES 16
APPENDICES

BACKGROUND

Review of Legislation:
The 1994 legislature required the Commissioner of Human Services to monitor and evaluate emergency mental health services as decreed in Minnesota Statutes, Section 245.469 (Minnesota Comprehensive Mental Health Act), subdivisions 1 and 2. Emergency services are defined in the Mental Health Act as "an immediate response service available on a 24-hour, seven-day-a-week basis for persons having a psychiatric crisis, mental health crisis or emergency." Emergency services "must: 1) promote the safety and emotional stability of adults with mental illness or emotional crises; 2) minimize further deteriorization of adults with mental illness or emotional crises; 3) help adults with mental illness or emotional crises to obtain ongoing care and treatment and 4) prevent placement in settings that are more intensive, costly, or restrictive than necessary and appropriate to meet client needs."

County Selection:
The 1994 legislation required that three counties in the state be the focus of the study and identified attributes that the three counties must meet. One was to be a metropolitan county as defined by Minnesota Statutes, Section 473.121 subdivision 4 (Anoka, Carver, Dakota, Hennepin, Ramsey, Scott or Washington), with a city of the first class (Minneapolis or St. Paul), one a metropolitan county other than Hennepin or Ramsey Counties and one located outside the metropolitan area.

On June 15, 1994, a memo was sent to each county social services director in the state requesting volunteers to participate in the study. Olmsted County volunteered. The remaining two counties, Washington and Ramsey, were selected at random based upon the legislative criteria. The respective Social Services Directors were notified of their respective county's selection.

Committee member selection:
Legislation required that a nine-member advisory committee be developed in each selected county. Each committee was to be composed of nine county residents. In addition, five of the nine member committee must be chosen from persons who are advocates for persons with mental illness, family members of persons with mental illness and persons who have received emergency services.

The county chapter of the Alliance for the Mentally Ill and the Local Mental Health Advisory Council in each county were invited to submit member recommendations. From these recommendations, a nine-member committee was selected for each county (See Appendix A).

Tasks:
Each committee was charged with three tasks:

1. To determine whether the emergency services required by Minnesota Statutes, Section 245. 469 are being provided for persons in each of the selected counties;
2. To evaluate the sufficiency and quality of services for adult persons with mental illness who are in crisis; and
3. To assess the effectiveness of consumer advocates in monitoring the availability of emergency mental health services.

Process used by each committee:
Each committee began by discussing members' personal experiences with the emergency mental health services in their county. The committees all identified the providers/agencies who provide these services and looked at the various ways of accessing the system. All three groups also made use of satisfaction surveys to further evaluate the emergency mental health services in their respective county. The committees experienced significant attrition among members. In particular, consumers and family members (all of whom were volunteering their time) seemed to find it difficult to continue their involvement.

Study Limitations:

* These committees, due to limited time and resources were not able to assess emergency services to the extent that they might have liked to. As one of the committees indicated " an adequate assessment of the quality and sufficiency of emergency services would take more extensive resources of time and money than was provided for." (Appendix C)

* Difficulties in gaining information from persons with mental illness is sometimes difficult due to the illness itself. One county reported that "many of the surveys received were difficult to understand because spelling, sentence structure and grammar were confused." Other means of including consumer input such as focus groups may be more effective.

* Consumers, family members and advocate participation diminished as the project progressed. This could be the result of this group volunteering their time and other commitments becoming more pressing.

* Because of the diversity of available emergency mental health services across the state, this study or any study of only three counties would not adequately represent a picture of the emergency mental health services statewide. Emergency services vary from county to county. Consequently, these results must be viewed with some reserve.

FINDINGS AND RECOMMENDATIONS OF THE COMMITTEES

TASK # 1: PRESENCE OF EMERGENCY MENTAL HEALTH SERVICES

Task # 1 Finding:
The National Institute of Mental Health, in a 1993 study entitled "Psychiatric Crisis Response Systems: A Descriptive Study," identified five major components of a system of crisis services: crisis telephone services, walk-in crisis services, mobile crisis teams, crisis residential services and acute psychiatric inpatient services. All three county committees found some of these components within their county. For instance, all found 24-hour, seven-day-a-week emergency mental health hotlines exist in their county. This is the only service, however, that is provided 24-hours per day, seven days per week in all three study counties.

The committees also found that some of the other major service components were provided in each county. These services are available in varying configurations and time periods.

Each of the counties has walk-in services available in some form. In each situation, some of the walk-in services are provided by the county social service agency. The walk-in services in Ramsey County are provided by a number of vendors, including Ramsey County Mental Health Center, and the Ramsey Medical Center. The various county- and state-funded community support programs such as the Apollo Center in Ramsey County and Circle Center Clubhouse, in Olmsted County also fulfill some of this function. Washington County Social Services provides walk-in services during usual business hours and has staff on call after hours. Human Services, Inc.(HSI) (also in Washington County) provides a daily walk-in clinic from 9 a.m. until 11 a.m. 365 days per year.

Some type of mobile crisis service is also available. Olmsted County has an identified staff person who provides mobile crisis services after hours. Ramsey County has developed an intake and crisis intervention team based at the Ramsey County Mental Health Center. This team is available during business hours and their availability is in the process of being extended to evenings. In Washington County, a county mental health professional is on call 24 hours per day, and provides some mobile crisis services. HSI also has the capability to provide mobile services. The HSI emergency services workers frequently do outreach to the jail when an inmate is professing suicidal ideation or other mental health concerns.

All three counties identified some crisis residential services available to them. The Crisis Receiving Unit, a locked unit which serves as a detoxification center and a mental health crisis center is available to Olmsted County Residents. Washington County has a newly developed crisis foster home. Ramsey County's crisis residential service is Hewitt House, a former Rule 36 facility which now serves as a crisis respite service.

All three also have available acute psychiatric inpatient services. However, accessing

these services sometimes means that the consumer must be transported out of the county. This is always the case in Washington County, which has no psychiatric inpatient hospital beds available within its borders and predominately uses hospitals in Ramsey County. In Olmsted County, St. Mary's Hospital is commonly used, with St. Peter Regional Treatment Center as a backup. Ramsey County residents have access to a number of hospitals (as determined and limited by their insurance plan).

All three committees identified an additional player in their crisis response system: law enforcement agencies. Police officers are often the first interveners or are called upon to assist with transportation of the individual in need of mental health service. Communication between law enforcement and agencies providing mental health crisis services was cited as being essential. At the present time, the level of sophistication regarding mental illness and available resources to assist a person in a crisis varies from one law enforcement agency to another and likely from one officer to another.

Table 1 identifies some of the major mental health emergency services in each county.

TABLE 1

MENTAL HEALTH CRISIS SERVICE PROVIDERS
by County and Service Component Provided

Component of Services	Providers in Olmsted County	Providers in Ramsey County	Providers in Washington County
Hotline	Crisis Receiving Unit	Ramsey County Mental Health Center, Ramsey Medical Center	Human Services, Inc.
Mobile Crisis Services	Olmsted County Crisis Worker; Olmsted County Public Health Department--Medication Monitoring Program	Ramsey County Mental Health Center	Human Services, Inc.; Washington County Social Services
Walk-in Crisis Services	Crisis Receiving Unit; St. Mary's Hospital Emergency Room; Mayo Clinic Urgent Care; Zumbro Valley Psychological Services	Ramsey County Mental Health Center; Ramsey Medical Center	Human Services, Inc.; Washington County Social Services
Crisis Residential Services	Crisis Receiving Unit	Hewitt House	Crisis Foster Home
Acute Inpatient Services	St. Mary's Hospital--Psychiatric Unit; St. Peter Regional Treatment Center	Ramsey Medical Center; United and Children's Hospital	Ramsey Medical Center

Task #1 PRESENCE OF EMERGENCY MENTAL HEALTH SERVICES RECOMMENDATIONS:

County Specific Recommendations:

Olmsted County

* develop/enhance deaf crisis services
* develop/enhance multilingual crisis services
* add additional inpatient crisis beds
* develop voluntary crisis residential services
* develop crisis adult foster care
* separate detoxification and mental health crisis beds
* provide psychiatric coverage in the St. Mary's emergency department
* increase the amount of psychiatric time at the Crisis Receiving Unit

Washington County

* develop an in-patient psychiatric unit or other residential alternatives such as residential crisis beds or hospital observation beds within the county
* provide evening mobile crisis coverage
* increase appropriate services to minority populations

Ramsey County

* develop a simplified system with a single access point
* provide evening and weekend mobile crisis coverage
* provide psychiatric coverage in the emergency department
* enhance/expand telephone emergency/crisis services

General Recommendations (agreement from all three study counties):

* provide ongoing training to and communication with law enforcement agencies.

TASK # 2: QUALITY AND SUFFICIENCY OF EMERGENCY MENTAL HEALTH SERVICES

Task # 2 Finding:

All of the committees relied at least partly on surveys of consumer satisfaction to determine the quality and sufficiency of services. The Olmsted and Ramsey Committees used a satisfaction survey which the Olmsted group developed and the Ramsey group modified to address their system. (Please see individual committee reports, Appendices B, C, and D, for more information on the satisfaction surveys.) The Washington County Committee chose to review the results of the continuing survey of Crisis Clinic consumers and to review other indicators of effectiveness such as commitment rates.

General Results:

* The overall results of the surveys indicated that people who use the services in each of these three counties are largely satisfied with both the quality and sufficiency of emergency mental health services.

Olmsted County Satisfaction Survey Results:

* Eighty-four percent of Olmsted respondents indicated that they felt that 24-hour emergency services are available easily.
* Eighty-three percent indicated knowledge of how to get emergency help if needed
* Forty-six would contact 911 in a mental health emergency; Forty-nine percent would not
* Seventy-four percent would contact the Crisis Receiving Unit
* Seventy percent feel that they know what emergency services are available and who to call
* Fifty-five percent indicated that the Crisis Unit met their needs during non-business hours. Twenty-nine percent indicated they did not contact the unit during non-business hours.
* Seventy percent indicated that a crisis worker or other mental health professional has been available for consultation in person or by telephone within 30 minutes or less.
* Sixty-six percent indicated that follow-up services met their needs
* Forty-eight percent indicated that the crisis staff was willing to listen to family input and concerns; thirty-three responded that this question was not applicable to their circumstances
* Fifty-three percent reported that emergency services meet their specific cultural, religious or ethnic needs; thirty-one percent indicated that this question was not applicable to their circumstances
* Sixty-six percent indicated that services are accessible to them despite any physical disabilities or limitations that they may have; twenty-eight percent reported this was not applicable
* Seventy-one percent reported that they had no problems getting the services they needed
* Forty-four reported that they felt that the police understood their needs in a mental health emergency

* Satisfaction with quality of services was identified as a 3.98 on a 1-5 scale with 1 being no at all satisfied and 5 being very satisfied.
* Satisfaction with availability of services was identified as 3.83 on a 1-5 scale with one being not at all satisfied and 5 being very satisfied.

Ramsey County Satisfaction Survey Results:
(Responses of Case Management Clients)

* Sixty-seven percent of Ramsey respondents indicated that they felt that 24-hour emergency services are available easily.
* Sixty percent indicated knowledge of how to get emergency help if needed
* Fifty-four percent would contact 911 in a mental health emergency; Forty-two percent would not
* Fifty-three percent feel that they know what emergency services are available and who to call, however, forty-two percent indicated they did not
* The largest majority of respondents (sixty-nine percent) indicated that they would contact their case manager in a crisis situation. Fifty-six percent would contact their mental health professional and fifty-six percent would contact Ramsey Medical Center. Other contacts included Mental Health Intake/Crisis Program (24%), United Hospital (23%), Crisis Connection (22%) Hewitt House (19%), Law Enforcement (19%), and St. Joseph's Hospital (17%).
* Forty-six percent indicated that a crisis worker or other mental health professional has been available for consultation in person or by telephone within 30 minutes or less.
* Sixty-two percent indicated that follow-up services met their needs
* Forty-six percent indicated that the crisis staff was willing to listen to family input and concerns; thirty-three responded that this question was not applicable to their circumstances
* Twenty-four percent reported that emergency services meet their specific cultural, religious or ethnic needs;
* Twenty-one percent indicated that services are accessible to them despite any disabilities or limitations that they may have; Seventy-six percent reported this was not applicable
* Sixty-eight percent reported that they had no problems getting the services they needed
* Fifty-five percent indicated they had access to adequate service outside of usual business hours
* Seventy-four percent reported their mental health professional was available to them during business hours but only twenty-seven percent reported access to their mental health professional after business hours
* Forty reported that they felt that the police understood their needs in a mental health emergency
* Satisfaction with quality of services was identified as a 3.63 on a 1-5 scale with 1 being no at all satisfied and 5 being very satisfied.

* Satisfaction with availability of services was identified as 3.57 on a 1-5 scale with one being not at all satisfied and 5 being very satisfied.

Washington County
(Crisis clinic consumer follow-up survey)

* Ninety percent of respondents were satisfied with how quickly they were seen
* Ninety percent were satisfied with the recommendations made by the crisis worker
* Eighty-five percent of those responding indicated that the service was helpful in resolving their concerns
* Ninety-two and a half percent indicated that they would use the service again or refer others

(Hospitalization and commitments)

* Commitment was avoided in 20 of 92(80%) referrals for commitment.
* Of the 208 people seen at the HSI Crisis Clinic, only 15(7.2%) were referred for hospitalization.

Individual comments identified some concerns including dissatisfaction with the way that law enforcement has handled situations involving people in need of mental health services. Specific complaints included rudeness, and inappropriate overnight placement in a jail rather than a hospital. However, there were also some positive comments about law enforcement involvement. As one respondent noted, it "varies with the officer".

TASK # 2 QUALITY AND SUFFICIENCY OF EMERGENCY MENTAL HEALTH SERVICES RECOMMENDATION:

* **A focus on training and education of law enforcement personnel was noted in each of the reports.**
* **The Ramsey County report identified the need to a more centralized access to the whole array of services.**

TASK # 3 EFFECTIVENESS OF CONSUMER, FAMILY AND ADVOCATES INPUT IN THE PROVISION OF EMERGENCY MENTAL HEALTH SERVICES

Task # 3 Finding:
The Olmsted and Washington County committees identified the role that the local advisory council played in the development and changes made in emergency mental health services. They also mentioned the role of advocacy groups, such as the Alliance for the Mentally Ill, in bringing complaints to the attention of the county and/or service provider. However, neither county reported direct consumer involvement in monitoring emergency mental health services.

The Ramsey County report indicated that there is "no known group of consumers who are monitoring availability of emergency mental health services, therefore it is impossible to comment on their effectiveness."

Individual providers of service sometimes conduct satisfaction surveys of people who use their services on a regular basis; however, this is not a standard practice from provider to provider within the same county and is definitely not a standardized practice across county lines.

None of the committees noted the involvement of consumers, advocates or family members in decision-making for the actual development and day-to-day management of crisis services.

TASK # 3 EFFECTIVENESS OF CONSUMER, FAMILY AND ADVOCATES INPUT IN THE PROVISION OF EMERGENCY MENTAL HEALTH SERVICES RECOMMENDATION:

None of the committees made specific recommendations on this point; however, an increase in consumer, family and advocate involvement in decisions regarding the development and provision of crisis/emergency services would be positive.

OVERALL RECOMMENDATIONS FROM THE COMMITTEES

Changes in rule or statute:

* The stringency of the current standard for dangerousness in the commitment process was noted to be of concern to the Washington County Committee. This degree of stringency makes it difficult to provide needed and appropriate crisis intervention in a timely way. There is little room for intervention with a person who is exhibiting neglect in critical self-care until this neglect puts them at risk of harm. This issue also applies to the ability to access early intervention and support which would avert an emergency. The Ramsey County committee reported: "The current health care system requires that an individual exhibit dramatic and intense symptoms in order to receive medical attention."

Changes in funding:

The committees were concerned with the "difficult and complex problem of cost shifting." They recommended:

* Inclusion of requirements and safeguards that would assure that emergency services provided by the public system to individuals covered by health plans be reasonably reimbursed by those plans.
* Exploration by the Department of Human Services of ways to assure consistency among health plans for the coverage of appropriate and necessary services, such as hospital care, regardless of commitment status.

As we move toward a system in which more of the people who have a mental illness are insured by managed care organizations, the need to address the traditional "public safety net" though which we treat community crisis i.e. fires, crimes, injuries accidents, in relationship to their (Managed Care Organizations) positions on responding to mental health crisis /emergencies is accentuated. If each insurer operates independently, there may not be a large enough pool of people to provide top-notch services, and the public system will be dealing only with those persons who are uninsured and would otherwise fall through the cracks."

The Ramsey County Committee reported that "A universal crisis response system would alleviate a great deal of the confusion. It is impractical to ask someone who is about to jump from a bridge what health insurance they have prior to intervening. Therefore, it makes sense to have a universal crisis response system that can intervene regardless of insurance status."

STATEWIDE INFORMATION ABOUT EMERGENCY MENTAL HEALTH SERVICES

Other efforts have been made at the Department of Human Services to understand, monitor and evaluate the emergency and crisis mental health services which are available in the state. The following information comes from studies conducted by the Department in 1994 and 1995. These studies are not directly related to this legislation but give a more statewide perspective to the county committees' findings.

Emergency Mental Health Services Survey

In July and August of 1994, the Mental Health Division and the Deaf and Hard of Hearing Services Division of the Department of Human Services conducted a survey/test of the 24-hour mental health emergency services phone system (See Appendix E). The objectives of this survey were to determine:

1. the accessibility of this service throughout the state:
2. the availability of consultation with mental health professional within the prescribed 30 minutes:
3. the accessibility of this service to people who are deaf;
4. the level of orientation/training of the "first responder" (the person who first answers the phone line);
5. the mental health professional's skills in assessing suicide potential of a hypothetical caller; and
6. if the provider had specified (but not mandated) policies and procedures in place to provide emergency services.

Briefly, the survey results suggested that:

1. emergency mental health services were accessible to voice callers across the state.
2. almost all of the consulting mental health professionals responded within 30 minutes with an average response time of 8.4 minutes.
3. only half the providers contacted answered TTY calls.
4. slightly less than 2/3 of the first responders had some training in mental health/emergency intervention during the past year.
5. the surveyors thought that the mental health professionals did an adequate job of accessing for suicide risk.
6. approximately half those contacted indicated their agency has formal lethality assessment and forced intervention protocols.

The following are major observations of this study:

* Mental health professionals are available and responsive if needed.
* The mental health system continues to rely on law

enforcement agencies to directly intervene in a crisis within the community.

* The TTY system for callers who are deaf is not working adequately.

Recommendations based on this survey include:

- provide statewide training on suicide assessment, interpreter services resources, deaf services resources, forced intervention and interagency coordination agreements, and lethality assessment tools.

- study the feasibility of a statewide 800 TTY number for callers who are deaf.

- review and make recommendations on whether a waiver of the mental health professional qualifications is appropriate in some individual situations given some staff are well-trained and specialize in crisis work.

As a result of this survey, five two-day training sessions were sponsored by the Department. These sessions were held in various areas of the state (Marshall, Austin, Bemidji, Duluth and the Twin Cities) to make them more accessible. The focus of the sessions was based on the recommendations which came out of the survey (suicide and lethality assessment, intervention protocol development and cultural considerations).

In addition, a statewide 800 TTY number for callers who are deaf is currently being developed by People, Inc., a service provider which has extensive experience providing services to people who are both deaf and have a mental illness.

Crisis Services Survey

In an effort to develop a statewide directory of mental health crisis services, a survey of these services was conducted by the Mental Health Crisis Provider Network and the Department of Human Services in July and August of 1995. The results of this survey seem to indicate that there is a telephone emergency service available in all 87 counties, and that there are 34 mobile crisis services, 74 walk-in services, 41 inpatient crisis services and 28 crisis residential services in Minnesota.

The configuration of services varies throughout the state and does not show a rural versus urban distinction in the array of services available. In some parts of the state, every component of emergency and crisis psychiatric service is represented. In other areas, services are limited by hours, location and kinds of services available. It is common in many parts of the state for the telephone hotline and an inpatient hospital (sometimes in another county) to be the only crisis service available on a 24-hour basis. When this is the situation, transportation becomes a major issue for people in need of services more intensive than phone intervention.

Commonly, law enforcement officers are called on to provide this transportation. In several counties (Cass, Faribault, Martin, Meeker, Morrison, Sibley, and Wadena) the local law enforcement agency is the designated "after-hours" emergency/crisis mental health telephone line.

CONCLUSION:

Emergency mental health services are available to citizens of Minnesota. There is, however, room for improvement. Several recommendation made by the three emergency service monitoring committees are applicable on a statewide basis:

1. Assure that the emergency mental health response system can deal with mental health emergencies regardless of insurance coverage or payment sources.

2. Assure consistency among health plans for the coverage of appropriate and necessary services, such as hospital care and crisis intervention regardless of commitment or hold status.

3. Reduce the stringency of the standard for dangerousness to self or others which is required to be met prior to intervention while protecting individuals' rights.

4. Encourage communication, cooperation, and education between law enforcement agencies and those agencies which provide mental health emergency or crisis services. Clarify the roles of each.

5. Encourage more emphasis on prevention through education and supportive services.

Ideally, an array of crisis/emergency mental health services, from prevention to hospitalization, would be available in an appropriate, responsive, respectful, cost-effective manner to meet the needs of every Minnesotan experiencing an emotional or mental health crisis.

References

1. Stroul, B: *Psychiatric Crisis Response System: A Descriptive Study.* National Institute of Mental Health, Community Support Program, 1993.

2. *Minnesota Comprehensive Adult and Children's Mental Health Act.*

3. Olmsted County Advisory Committee: *Emergency Services Monitoring Report.* (Appendix B)

4. Ramsey County Emergency Services Monitoring Committee: *Report of Ramsey County Emergency Services Monitoring Committee, 1994-1995.* (Appendix C)

5. Washington County Emergency Services Monitoring Committee: *Washington County Emergency Services Report.* (Appendix D)

6. Minnesota Department of Human Services, Mental Health Division: Internal report. *Mental Health Emergency Service Phone Survey Summary, 1994.* (Appendix E)

APPENDIX A

PARTICIPANT RECOMMENDATIONS FOR THE EMERGENCY SERVICES MONITORING PROJECT

County	Participant	Recommending Agency
Washington	Cindy Rupp Mental Health Supervisor Washington County Social Services 14900 - 61st Street North P.O. Box 30 Stillwater, MN 55082-0030	Washington County Community Services Department
	Doug Flory Deputy Sheriff Washington County Government Center 14900 - 61st Street North Stillwater, MN 55082	Washington LAC
	Will Hale 10532 Southeast Point Douglas Road Cottage Grove, MN 55016	
	Eileen Herbert 7079 Irwin Avenue South Cottage Grove, MN 55016	
	Gloria Knoblach 9181 West 31st Street Lake Elmo, MN 55042	
	Diane Marcon Program Director Beeman Place 3819 Luverne Avenue North Lake Elmo, MN 55042	
	David Olsen 3124 North Layton Court Lake Elmo, MN 55042	
	Teresa DeVine 8665 South 81st Street Cottage Grove, MN 55016	
	John Kaul 15500 South 42nd Street Afton, MN 55001	

County	Participant	Recommending Agency
Ramsey	Dawn Holmen 218 East 7th Stree #304 Saint Paul, MN 55105	Mental Health Association of Minnesota
	Patty Tennant 1163 Edmund Avenue St. Paul, MN 55104	Ramsey County LAC
	Dr. Steve Herman Department of Psychiatry 640 Jackson St. Paul, MN 55101	
	Tom Larson 850 Dayton Avenue St. Paul, MN 55104	
	Kris Flaten 1043 Haugue St. Paul, MN 55104 649-0838	
	William Conley 114 Mackubin Street St. Paul, Mn 55102	
	Barbara Simonson 9 W. Delos St. Paul MN 55107	
	Lorene Magnuson Ramsey County Human Services 160 East Kellogg Boulevard St. Paul, MN 55101	Ramsey County Social Services
	Dr. Steve Pratt Ramsey County Human Services 160 East Kellogg Boulevard St. Paul, MN 55101	

County	Participant	Recommending Agency
Olmsted County	Joan Scott	Olmsted County Social Services
	Brad Bjorngaard 1545 2nd Ave NE #7 Rochester, Mn 55906	Olmsted AMI
	Cheryl Shoop 3607 10th Lane NW Rochester, MN 55901	
	Elaine White 1134 6th St. SW Rochester, MN 55902	
	Bart Brown 430 5th St. SW #4 Rochester, MN 55902	
	Rev. Robert Schroeder 1502 9th Av. NE Rochester, MN 55906	
	Ms. Bonnie Thompson 912 14th Av. SW Rochester, MN 55902	
	Bob Nelson 1931 Greenfield Ln SW, Unit C Rochester, MN 55902	
	Ms. Terry Kaufman 435 4th Ave SE #3 Rochester, MN 55904	

APPENDIX B

To: Lorraine Felland
Re: Adult Mental Health Task Force
Olmsted County Report

From: Olmsted County Advisory Committee
Emergency Services Monitoring Committee

Goal: To determine whether emergency services in Olmsted County are being provided for persons in this area, to evaluate the sufficiency and quality of services available, and to assess the effectiveness of consumer advocates in monitoring the availability of services. For our purposes, quality of services is defined as positive outcome based on consumer satisfaction. Sufficiency of service is defined as having access to the services needed, when they are needed.

Method: This committee first attempted to identified through personal knowledge, local listings, and community contacts what emergency services are available in Olmsted County; and then, through a "24-Hour Emergency Mental Health Services Survey" to determine the quality and sufficiency of those services. The survey was distributed to various adult mental health agencies such as the Crisis Receiving Unit, Zumbro Valley programs, local psychological services, county social workers, and local advocate organizations with the request that they have as many clients as possible complete the survey (but only at one agency). A copy of the survey that was used is attached to this report.

Results: The following emergency services were identified as being available in the Olmsted County area:

Crisis Receiving Unit
St. Mary's Hospital Emergency Room
Mayo Clinic Urgent Care
St. Mary's Hospital Psychiatric Unit
Olmsted County Crisis Worker (24 hours)
Olmsted County Public Health Department
    Medication Monitoring Program
Zumbro Valley Psychological Services
    Partial Hospitalization Program
    Circle Center Club House
    Recovery Partners
    Housing Options Program

Outreach Services
Medication Monitoring Program
THOMAS House halfway house
Transitional Housing
Carillian Halfway House for MI/CD
Law Enforcement
RAAMI

The Crisis Receiving Unit (CRU) provides a sense of security, a place for people in crisis to feel and be safe. (Concerns that detox people in same area can be scary to mentally ill persons in crisis.) Admission to CRU is available 24 hours per day. If CRU is full, patients may be able to go to St. Mary's locked psychiatric unit. If that too is full, patients would be transported to St. Peter Regional Treatment Center by Law Enforcement.

St. Mary's Hospital Emergency Room is available 24 hours per day. If the hospital unit is full and admission is required, they can transfer to CRU or if that is full, to St. Peter Regional Treatment Center. Nurses there treat mentally ill patients well, but on duty residents who are doing M.I. rotation but specialize in other areas sometimes don't know what to do.

Olmsted County Crisis Worker is on duty evenings when regular staff is not available. They can do assessments, answer crisis calls, admit clients to ER or CRU on involuntary holds if required. They also have access to client's case manager if additional information is required.

Law Enforcement officers are generally professional and courteous, but could still benefit from training about mental illness.

The committee identified that consumers, their families, and professionals do have opportunities to impact how services are being provided through service organizations such as RAAMI, committees such as this one, serving on local advisory boards, and through social services and other mental health professionals.

Survey: The overall outcome of the survey conducted by this committee was quite positive. Response breakdown sheet is attached to report. Responses to specific questions were as follows:

1. **Do you feel that 24-hour emergency services are available to you easily?** 84% responded YES
2. **Do you know how to get this emergency help if you need it?** 83% responded YES
3. **In a mental health emergency would you call 911?** 46% responded YES; 49% responded NO
4. **In a mental health emergency would you call the Crisis Unit number?** 74% responded YES
5. **Do you know what emergency services are available and whom to call?** 70% responded YES

7. **When you call the Crisis Unit outside of usual business hours, does the staff meet your needs?** 55% responded YES; 29% responded Not Applicable

8. **In the past, has a crisis worker or other mental health professional been available for consultation in person or by telephone within 30 minutes?** 70% responded YES

10. **Did you feel the follow-up services you received met your needs?** 66% responded YES

11. **Was the Crisis staff willing to listen to your family's input and concerns?** 48% responded YES; 33% responded NA

12. **Have emergency services been able to meet any specific cultural/religious/ethnic/language requirements you may have?** 53% responded YES; 31% responded NA

13. **If you have any disabilities such as hearing impairment, visual impairment, or physical limitations, are emergency mental health services accessible to you?** 66% responded NA; 28% responded YES

14. **Have you had any problems getting the services you need?** 71% responded NO (meaning NO PROBLEMS)

15. **Do you feel the police are understanding of your needs in a mental health emergency?** 44% responded YES

For the scaled response to 16. **How satisfied are you with the QUALITY of emergency services in Olmsted County?** on a scale of 1 through 5 (one being not at all satisfied and 5 being very satisfied) the average was 3.98 which is excellent.

For the scaled response to 17. **How satisfied are you with the AVAILABILITY of emergency services in Olmsted County?** on a scale of 1 through 5 (one being not at all satisfied and 5 being very satisfied) the average was 3.83 which is excellent.

A random sample of comments to questions from this survey include:

7. They were very kind and help me until I felt better and thinking better before we hung up.

But sometime they don't have the information I need or don't provide the services I'd like.

8. Not at Mayo Clinic but at Crisis Center they were.

They are there for job, but not to listen to you all the time.

10. I have trouble with my mental illness at times and they are there. Especially when I feel it could feel it is emergency.

I have not been disappointed in the quality of care I received for follow-up.

I've had great difficulty finding a therapist - though I found one in Red Wing.

11. They were ready to listen, but I wasn't willing to talk.

Not necessarily, they overrule family who knows best from experience.

12. I don't feel I needed any of these meds.

They understand my religious background. It really makes me feel really good inside.

They treated whole person except in ER at St. Mary's, who treated me with no respect.

13. I have a bad back and seeing a doctor for my back and have learning disability and also have a mental illness and C.D. issue.

I let them know I am hearing impaired and they or most adapt to it.

14. Not enough education/experience dealing with my particular problem of a dissociative disorder.

Crisis unit doesn't let me stay with them because I'm suicidal.

Sometimes it seems more often that CRU is full.

15. I was taken to jail overnight instead of a mental health facility.

Varies with officer.

Very rude to me and my family. Counter productive. Scared me a lot.

When they transported me they were very gentle and understanding.

19. If you don't have any assistance and no income it's hard to pay for services a lot like no services.

20. Separate more the mentally ill from the alcoholics.

Have more than one psychiatrist on staff.

Recommendations: This committee identified the following areas of remaining need for emergency services in Olmsted County:

Deaf Crisis Services
Multi-lingual Crisis Services
Additional in-patient crisis beds
Crisis respite beds (voluntary)
Crisis adult foster care

Additionally the committee identified the following areas of concern:

Would like to see detox separated from mental health crisis beds.

Would like to see on-duty psychiatric staff at St. Mary's Emergency Room instead of Residents staffing it.

Would like to see psychiatric consultant at CRU twice a day instead of only once a day.

Would like to see regional training for emergency services providers, police, etc. Focus on calmness in crisis.

At St. Mary's ER, recommend staff doctor and resident see patient together. It presents a serious problem with waiting and seeing doctors one after another and each one asks the same questions of a patient who is in crisis and possibly psychotic. Need doctors to be more available so the wait is not so long for clients in crisis.

Community needs more board and care beds for mentally ill persons and also crisis beds and crisis respite beds. Twin Cities has a pilot project in this vein that Olmsted County could take a look at.

Additional community awareness and information on mental illness continues to be needed.

Conclusion:

In summary, the committee feels that although there are still areas that could use improvement and additional services needed that would more completely meet the needs of the community, overall, the services available in Olmsted County meet the needs of the adult mental health community both in quality and in sufficiency.

Respectfully submitted,

Joan Scott

Olmsted County Advisory Committee
Emergency Services Monitoring Committee
Joan Scott

24-Hour Emergency Mental Health Services Survey

****Please fill out only one survey.**

1. Do you feel that 24-hour emergency services are available to you easily? Yes No

2. Do you know how to get this emergency help if you need it? Yes No

3. In a mental health emergency would you call 911? Yes No

4. In a mental health emergency would you call 281-6248, the Crisis Unit number? Yes No

5. Do you know what emergency services are available and whom to call? Yes No

6. If you needed to be seen immediately, which of these services would you use?
   (*Check all that you might use.*)
   Crisis Unit? _____
   Emergency Room? _____
   Law Enforcement? _____
   Your mental health professional? _____

7. When you call the Crisis Unit outside of usual business hours, does the staff meet your needs?
   Yes No Please comment:

8. In the past has a crisis worker or other mental health professional been available for consultation in person or by telephone within 30 minutes? Yes No Please Comment:

9. How did you learn about these emergency mental health services?

10. Did you feel the follow-up services you received met your needs? Yes No
    Please comment:

11. Was the crisis staff willing to listen to your family's input and concerns? Yes No
    Please comment:

12. Have emergency services been able to meet any specific cultural/religious/ethnic/language requirements you may have? Yes No Please comment:

24 HOUR EMERGENCY MENTAL HEALTH SERVICES SURVEY
OLMSTED COUNTY
TOTAL RESPONSES = 80

QUESTION	Percent of All Respondents Yes	No	Blank or Not Applicable	# WITH COMMENTS
1	84%	11%	5%	0
2	83%	13%	5%	0
3	46%	49%	5%	0
4	74%	20%	6%	0
5	70%	24%	6%	0
6 Crisis Unit*	68%	33%	0%	0
Emergency Room*	61%	39%	0%	0
Law Enforcement*	20%	80%	0%	0
MH Professional*	60%	40%	0%	0
7	55%	16%	29%	41
8	70%	14%	16%	23
9	0%	0%	0%	72
10	66%	16%	18%	29
11	48%	20%	33%	34
12	53%	16%	31%	31
13	28%	6%	66%	13
14	19%	71%	0%	16
15	44%	18%	0%	34
18				14
19				9
20				3

Q 16 Rating Scale	1	1.5	2	2.5	3	3.5	4	4.5	5
16 (% of Ratings)	3%	0%	1%	1%	5%	1%	12%	1%	13%
# of Comments	9		AVERAGE=3.98						

Q 17 Rating Scale	1	1.5	2	2.5	3	3.5	4	4.5	5
17 (% of Ratings)	0%	0%	2%	0%	6%	1%	22%	1%	22%
# of Comments	7		AVERAGE=3.83						

*Note: On Question 6, if the item was not checked it was counted as a "No".
Any comment was included in the "# with Comments" column, even "No Comment".

Prepared by the Mental Health Division based on Olmsted Survey.

APPENDIX C

Report of Ramsey County Emergency Services Monitoring Committee. 1994-1995

INTRODUCTION:

The 1993 Minnesota Legislature required the Minnesota Department of Human Services to monitor countys' compliance with the emergency services provision of the Comprehensive Adult Mental Health Act of 1987, stipulating that three counties (at least one rural/outstate) participate in the study and submit reports to DHS which addressed the following three points:

1) whether the emergency services (required by MN statutes, section 245.469, are being provided;

2) evaluate the sufficiency and quality of services for adult persons with mental illness who are in crisis; and

3) assess the [current] effectiveness of consumer advocates in monitoring the availability of emergency mental health services.*

The legislation also specified that of the 9 members of each county's committee, at least 5 must be mental health advocates, family members, and/or persons who had received emergency mental health services.

INITIAL RESPONSES TO THE THREE POINTS.

The Ramsey County Committee was quickly able to respond, just through discussion, to the three points posed by the legislation, particularly in regards to subdivision 2 of MN Statutes, Section 245.469:

1: Yes.
2: On par with other counties and programs.
3: None of us knew of a group of consumer advocates who are monitoring availability of emergency mental health services, therefore it is impossible to comment on their effectiveness.

In regards to subdivision 1 of MN Statutes, Section 245.469, responses were less clear (the statute itself is written more broadly, so it is more difficult to ascertain compliance).

WHO WE WERE: [include names, addresses, phone #s].

---

* paraphrased from legislation.

COMMITTEE PROCESS:

We decided to focus on subd.1 of the statute (245.469) which emphasizes that emergency services must:

1. promote the safety and emotional stability of adults with mental illness or emotional crises;
2. minimize further deterioration of adults with mental illness or emotional crises;
3. help adults with mental illness or emotional crises to obtain ongoing care and treatment; and
4. prevent placement in settings that are more intensive, costly or restrictive than necessary and appropriate to meet client needs.*

We started by looking at the current system for receiving preventive, emergency, and follow-up mental health services in Ramsey County. We then mapped entry, exit and transfer points. We looked for the points which were likely to be the most stressed (i.e. most stressful for the person requiring services and/or person(s) intervening)**. We identified the following five points:

entry and transfer via police
entry via emergency room
entry/transfer to/from detox
transfer to/from ER & Hewitt
transfer to/from mental health intake/crisis

DISCUSSION ABOUT THE SYSTEM

We also agreed that the current system (again, see map) is unwieldy, confusing, and inefficient. Attempts to perform outcome evaluations and check accountability are almost impossible. We worked at developing and mapping a more workable system,*** especially in light of anticipated organizational and funding changes.

The current crisis response system is complicated. There are a variety of ways in which a person can access the system. There is often confusion among ancillary parts of the system, such as the police, about how to access services. Many providers don't know what services are available. There is a great deal of variability in the services available at different times of the day and different days of the week. Pending changes in health care coverage may complicate the matter even more as consumers will need to be aware of the crisis services available with the particular Integrated Service Networks of their health coverage.

A universal crisis response system would alleviate a great deal of the confusion. It is impractical to ask someone who is about to jump from a bridge the kind of health insurance they have before pulling them back from the edge. It makes sense to have a universal crisis response system that can intervene regardless of insurance status. It also makes sense for trained crisis

---

* from Comprehensive Adult Mental Health Act, 1987, 245.469.
** see map, Attachment 1-A.
*** see Attachment 1-B.

professionals to provide intervention rather than police officers, who often have little training in mental health services.

INFORMATION GATHERING

We started the information gathering process with contacting (by letter and in person) each of the ten police and sheriff departments in Ramsey county. We asked them what difficulties they experience in dealing with people with mental illnesses in the community. We met with an officer and representative of the St. Paul police department to hear their perspective.

We looked at completed evaluation forms from Hewitt House (3-7 day residential crisis).

We conducted three different surveys:

1. **Brief Non-Random Survey**

This was a short, 5 question pick-up survey that was available in a variety of settings for persons with mental illnesses and/or their family members to complete. It was available at community support programs, Rule 36 programs (half-way houses), Hewitt House, and was enclosed with the Minnesota Mental Health Consumer/Survivor Network newsletter and submitted to the Ramsey County Alliance for the Mentally Ill newsletter.

This survey asked open ended questions about the kinds of emergency services respondents had used and their experiences (positive? negative?). Forty-three (43) surveys were completed*.

2. **Case Management Client Survey--Random Sample.**

This survey was sent to a random sample of 500 of the approximately 2,000 clients who receive case management services. Questions were posed in a Yes/No/Continuum format, with space available for written comments. Seventy-eight (78) surveys were returned**.

3. **Survey of Service Providers.**

This was a survey sent to a variety of mental health programs including case management, community support, Rule 36, outpatient and crisis residential services. The questions were similar to the questions on the case management client survey. Thirteen (13) surveys were returned***.

---

* Attachment 2 includes a copy of this survey.

** see Attachment 3.

*** see Attachment 4. Please note: "Provider" in this case refers to community mental health workers with widely varying degrees of education and experience. Psychiatrists, psychotherapists and nurses in private practice (that is, those who actually provide medical treatment) were not included (there may have been some exceptions).

RESULTS:

CASE MANAGEMENT CLIENT SURVEY AND PROVIDER SURVEY

Please refer to attachments 3 and 4 which provide the survey questions and the results for each specific question. The following are highlights of those results:

1. Access to emergency mental health services (easily):

Clients:	67%
Providers:	46%

2. Top three sources for help in crisis:

Clients:	Case manager (69%) Mental health professional i.e. doctor, psychotherapist. (56%) Ramsey Medical Center (56%).
Providers:	Ramsey Medical Center (92%) Hewitt House (69%) Intake/Crisis Program (62%).

3. Interactions with police:

Clients:	positive = 40%; negative = 28%.
Providers:	positive = 38%; negative = 31%

4. Satisfaction with quality of emergency mental health services:

Clients:	84% rated #3,4, or 5 (3.63 avg)
Providers:	100% rated #3,4, or 5(3.73 avg)

5. Satisfaction with availability of emergency services:

Clients:	75% rated #3,4, or 5(3.57)
Providers:	69% rated #3,4, or 5(3.38)

6. Slightly over half (53%) of the clients know the emergency services available to them and whom to call.

Feedback from the police were fairly consistent:

1. Frustration with the lack of emergency/crisis mental health services/resources available during nights and weekends.

2. Need for additional and ongoing education and training about mental illnesses and available resources. (Some police departments did not realize the Mental Health Intake/Crisis unit was available.

3. Many departments experience repeat calls from individuals who report the occurrence of incidents which cannot be substantiated. Police suspect some of these people may have mental illnesses, are not receiving services and would benefit from some kind of community outreach. As these calls take a great deal of police time, they would welcome a way to collaborate with mental health intake/crises services.

4. Tangential, though related, was the often voiced concern that the detox center is frequently full.

GENERAL CONCLUSIONS

After reviewing the surveys, the committee came to several general conclusions:

1. Written surveys are not a reliable means of gaining information from persons with mental illnesses due to

1. the illness itself interferes with the person's ability to stay on track with responding to the written question
2. Many of the surveys we received were difficult to understand because spelling, sentence structure and grammar were confused (this seems to indicate that many people with serious and persistent mental illnesses had difficulties during their school years so are functionally illiterate).
3. Besides the general cynicism with which the public greets surveys as a class people with mental illnesses entrenched in the system do not believe their contributions will make any difference at all and so don't respond to surveys.

2. An adequate assessment of the quality and sufficiency of emergency services would take more extensive resources of time and money than was provided for. (It is very difficult to locate important target groups, such as family members or even psychiatrists practicing in Ramsey County).

3. There is a need for expanded evening and weekend coverage. People generally felt that access to and availability of emergency services was good during business hours but lacking during evening and weekend hours.

This is consistent with the direction the county has been working on for several years. In 1991 the "crisis work group" recommended four top priorities for changes in services. One of those recommendations was to restructure existing county staff in order to provide one central mental health crisis/intake phone number and service (Mental Health Intake/Crisis Unit). That restructuring was completed and hours have been expanded but the county has not been able to expand as much as desired.

The crisis/intake unit is seen by providers as providing excellent and needed services. Though, in general, the case management clients responding to our survey, did not identify the crisis/intake unit as a service that they use.

4. A second recommendation of the 1991 crisis work group was to develop non-hospital crisis beds and to provide and integrate psychiatric services into the crisis program. In response to that recommendation the county developed the Hewitt House non-hospital crisis bed program and hired a psychiatrist to work with the crisis program. Hewitt House has received many positive comments.

5. There is a need for more telephone emergency/crisis services available and accessible. There were many reports about people repeatedly getting a busy signal.

6. Clients often turn to their therapists and case managers for crisis services. Many only use identified crisis providers when they cannot gain access to their therapists or case managers (often evenings and weekends).

OTHER INFORMATION:

1. Emergency Room physicians are not prepared to deal with persons in acute emotional crises and so it seems wise to separate psychiatric emergency services from physical/medical emergency services.

2. Within committee discussions, we began to realize that negative experiences during crises continue to haunt and affect the choices people make about where and how they will seek help/intervention. One woman said, "What do they think? That just because I'm in crisis I can't see or hear or feel? Even if I can't interact with them, can't talk, I'm still watching. And I remember it later on."

COMMENTS:

The chief concern with providing crisis services to people with mental illnesses is to provide services which encourage and support the person's recovery process. As part of their recovery, people learn their warning signs and learn to seek appropriate medical attention, starting with the least intensive (perhaps a change in medication) and moving towards more intensive intervention only as needed. Emergency/crisis services need to be available prophylactically: services need to respond to the person's individual needs and individual ability and commitment to ascertaining those needs.

This approach is not only the best approach for the client but is also, particularly in the long run, the least expensive. Trauma to both the individual and their family and community will decrease.

Currently, the health care system most often requires that an individual exhibit dramatic and intense symptoms in order to receive medical attention. It is rather like forcing a person with a history of cardiac arrest to wait until they are in the middle of a full-blown heart attack before entering the ER.

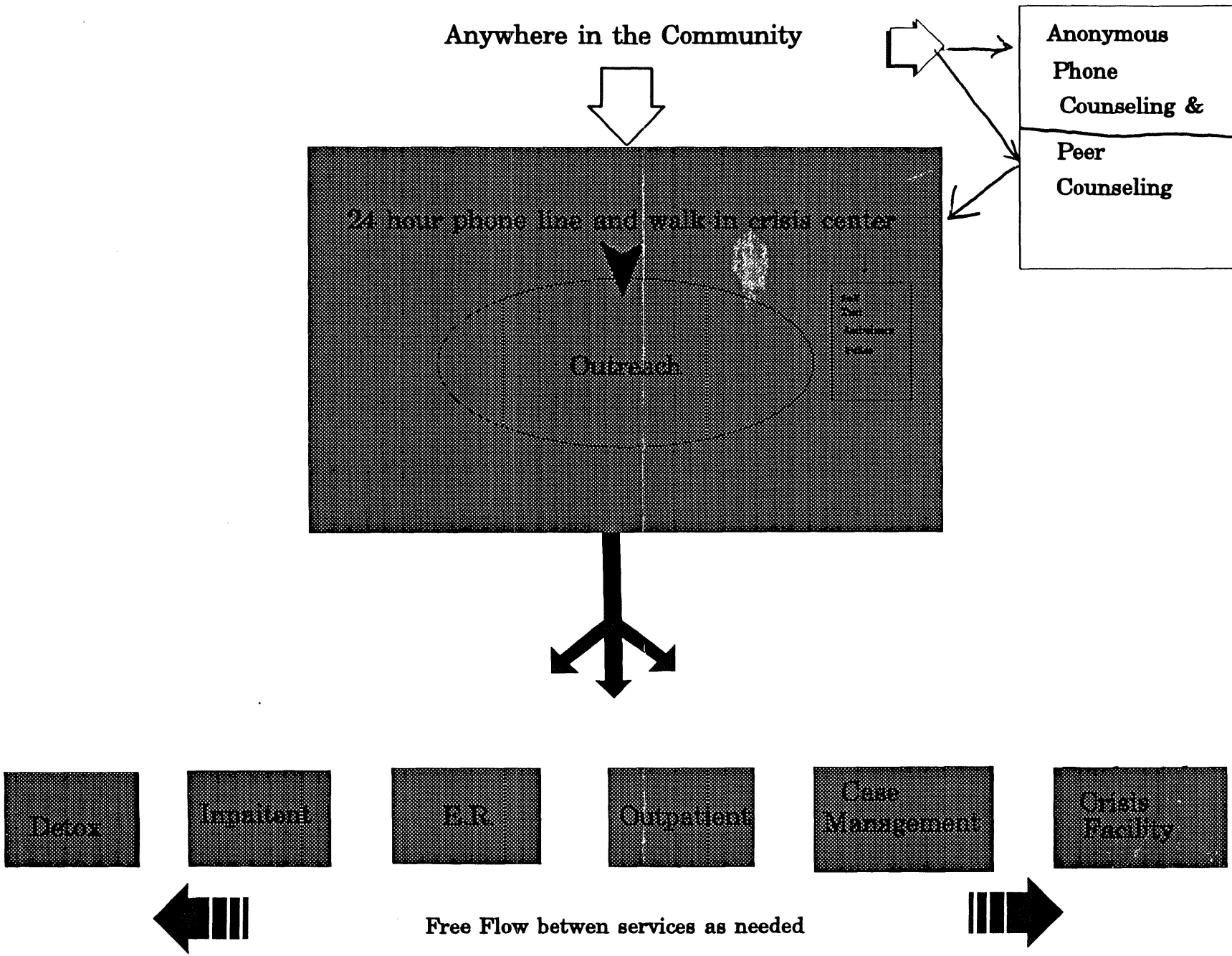
RECOMMENDATIONS:

This committee recommends that Ramsey County vigorously pursue meeting with major health care providers (Allina, etc.) to discuss their coverage of emergency/crisis mental health services. The traditional "public safety net" through which the community responds to crises: fires, crimes, injuries, accidents, medical emergencies, depends upon a fairly large pool of people in order to provide cost-effective and quality services. It is doubtful that each major insurer will have a large enough pool of people to provide top-notch services. And, if Ramsey County only deals with those persons who would otherwise fall through the cracks, that pool of people in Ramsey County would also most likely be too small to sustain quality accessible crisis/emergency services.

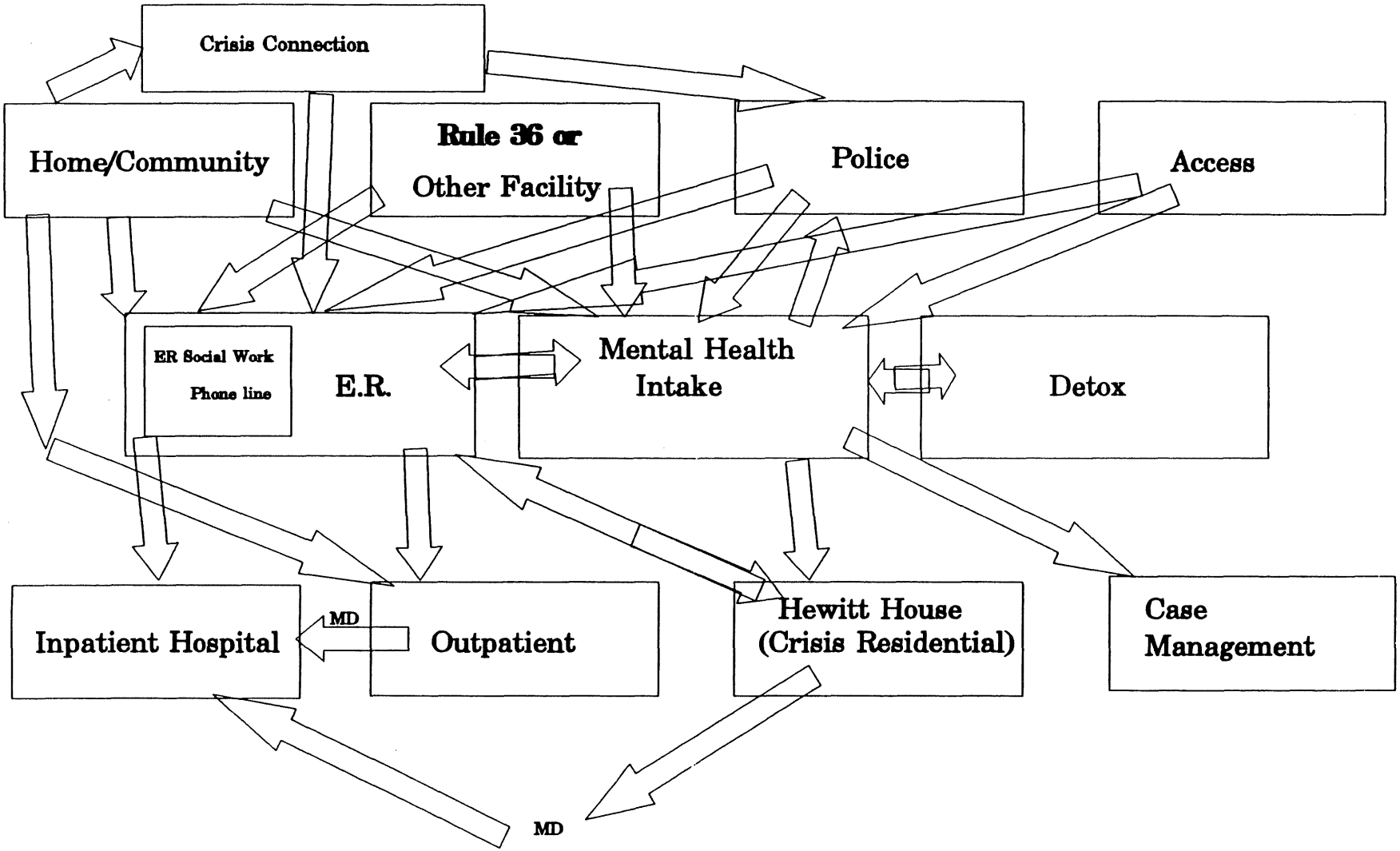
It is our recommendation that Ramsey County (or the metro counties, working collaboratively) develop and operate a universal crisis response system 24 hours per day, 365 days per year (similar to the 911 system). This system could use a single 7 digit phone number staffed by professionals capable of providing phone counseling, walk-in crisis counseling, and community outreach. Staff would be able to respond directly to clients, family members, neighbors,

others in the community, and police. Staff would be able to place people directly into community crisis beds, detox, hospital (Emergency Department and/or inpatient beds), and would arrange for case management services and outpatient follow-up as needed.

Our committee considered the merits of an additional fully anonymous phone counseling line. Our committee also discussed the merits of peer counseling and there was some consensus that both services should be considered further.


Anywhere in the Community
Anonymous
Phone
Counseling &
Peer
Counseling
24 hour phone line and walk in crisis center
Outreach
Detox
Inpatient
E.R.
Outpatient
Case
Management
Crisis
Facility
Free Flow betwen services as needed

Current Mental Health Crisis "System"



Attachment 1

Please Help Us!
We want to hear from you...

We are interested in finding out about the quality and availality of crisis/emergency services in Ramsey County. Please help us by using this form (plus additional pages as needed) to describe your experiences.

1. Have you used Crisis/Emergency Mental Health Services in the past two years?

2. Which of the following services have you used?

Ramsey Medical Center ____

St. Joseph's Hospital ____

United Hospital ____

Hewitt House ____

Mental Health Intake/Crisis Program (298-4545) ____

Crisis Connection (phone counseling) (379-6363) ____

Crisis Program (Walk-in)(221-8922) ____

Crisis Intervention Center (347-2222) ____

Your Mental Health Professional (Dr., Therapist) ____

Your Case Manager ____

Your CSP Program Crisis Number ____

Other_____

RAMSEY COUNTY EMERGENCY/CRISIS MENTAL HEALTH
MONITORING COMMITTEE

3. If you have a therapist, psychiatrist or case manager, are they available to you during business hours? After business hours?

4. Have you had positive experiences with Crisis/Emergency Mental Health Services? Have you had negative experiences? Please tell us about them.

5. When you've used Crisis/Emergency Mental Heaith Services, have you been treated with respect and dignity? Please comment.

Thank you, Thank you, Thank you
for taking time to fill this out!

Please drop this in the box near the place you picked this up or mail it to
Mental Health Division
444 Lafayette Road
St. Paul, MN 55155-3828

RAMSEY COUNTY CRISIS/EMERGENCY
MENTAL HEALTH SERVICES MONITORING COMMITTEE

Case Management Clients (78) Attachment 2

24-Hour Emergency Mental Health Services Survey

	YES	NO	Blank or NA
1. Do you feel that 24-hour emergency mental health services are available to you easily? Yes No	67%	26%	8%
2. Do you know how to get this emergency help if you need it? Yes No	60%	33%	6%
3. In a mental health emergency would you call 911? Yes No	54%	42%	4%
4. Do you know what emergency services are available and whom to call? Yes No	53%	42%	5%

5. If you needed help immediately, which of these services would you use? (Check all that apply.)

	YES	NO		YES	NO
A) Ramsey Medical Center	56%	44%	B) St. Joseph's Hospital	17%	83%
C) United Hospital	23%	77%	D) Hewitt House	19%	81%
F) Mental Health Intake/ Crisis Program (298-4545)	24%	76%	G) Crisis Connection (phone counseling) (379-6363)	22%	78%
H) Crisis Program (Walk-in)(221-8922)	9%	91%	J) Crisis Intervention Center (347-2222)	9%	91%
K) Your Mental Health Professional (Dr., Therapist)	56%	44%	L) Your Case Manager	69%	31%
M) Your CSP Program Crisis Number	3%	97%	N) Law Enforcement	19%	81%

O) Other 13% yes 87% no

6. Are you able to get adequate service outside of usual business hours? Yes No Please comment.

55% yes 28% no

7. If you have a therapist, psychiatrist or case manager, are they available during business hours? Yes No NA 74% yes 5% no
After business hours? Yes No NA 27% yes 38% no

8. In the past has a crisis worker or other mental health professional been available for consultation in person or by telephone within 30 minutes? Yes No Please comment.

46% yes 35% no

9. How did you learn about these emergency mental health services?

10. Did you feel the follow-up services you received met your needs? Yes No Please comment.

62% yes 17% no

11. Was the crisis staff willing to listen to your family's or friend's input and concerns? Yes No Please Comment

46% yes 17% no

12. Have emergency services been able to meet any specific cultural/religious/ethnic/language requirements you may have including interpreter services? Yes No Please comment.

24% yes 24% no

13. If you have any disabilities such as hearing impairment, visual impairment, or physical limitations, are emergency mental health services accessible to you? Yes No Not Applicable 21% yes 4% no 76% NA

14. Have you had any problems getting the services you need? Yes No If yes, please explain the problem:

18% yes 68% no

15. Do you feel the police are understanding of your needs in a mental health emergency? Yes No Please comment.

40% yes 28% no

16. How satisfied are you with the quality of emergency mental health services in Ramsey County?

1 _____ 2 _____ 3 ___*___ 4 _____ 5

Not at all Satisfied Very Satisfied

Average = 3.63

Comments:

2% 3% 3% 9% 22% 17% 16% 16% 13%

17. How satisfied are you with the availability of emergency services in Ramsey County?

1 _____ 2 _____ 3 ___*___ 4 _____ 5

Not at all Satisfied Very Satisfied

Average = 3.57

Comments:

3% 3% 9% 11% 16% 16% 11% 19% 13%

18. If you are on Medical Assistance, does that affect your access to emergency mental health services?

1% yes 3% no 10% NA or Blank

19. If you have no health insurance, does that affect your access to emergency mental health services?

0% yes 0% no 0% NA or Blank

20. If you could make one improvement in emergency mental health services, what would it be?

1% yes 2% no 6% NA

Please return this survey to
Larraine Felland
Emergency Services Monitoring Project
444 Lafayette Road
St. Paul, MN 55155-3828

Note:
If you have additional comments, please add another sheet.

Providers (13) Attachment 3

24-Hour Emergency Mental Health Services Survey

	YES	NO	NA
1. Do you feel that 24-hour emergency mental health services are available to your clients easily? Yes No	46%	31%	23%
2. Do you know how to get this emergency help for your clients? Yes No	92%	0%	8%
3. In a mental health emergency would you call 911? Yes No	69%	15%	15%
4. Do you know what emergency services are available and whom to call? Yes No	92%	0%	8%

5. If your client needed help immediately, which of these services would you use? (Check all that apply)

	YES	NO		YES	NO
A) Ramsey Medical Center	92%	8%	B) St. Joseph's Hospital	54%	46%
C) United Hospital	54%	46%	D) Hewitt House	69%	31%
F) Mental Health Intake/ Crisis Program (298-4545)	62%	38%	G) Crisis Program (Walk-in)(221-8922)	23%	77%
H) Their Mental Health Professional (Dr., Therapist)	46%	54%	I) Their CSP Program Crisis Number	8%	92%
J) Law Enforcement	46%	54%			
K) Other	31%	69%			

6. Are you able to contact your clients' mental health professional? Yes No Please comment.

69% yes 8% no 23% Blank

7. In the past has a crisis worker or other mental health professional been available for consultation in person or by telephone within 30 minutes? Yes No Please comment.

62% yes 15% no 23% Blank

8. Do follow-up services meet your clients' needs? Yes No Please comment.

31% yes 31% no 38% Blank or NA

9. Was the crisis staff willing to listen to your input and concerns? Yes No Please Comment

62% yes 15% no 23% Blank

11. Have emergency services been able to meet any specific cultural/religious/ethnic/language requirements your clients may have (including interpreter services)? Yes No Please comment.

23% yes 8% no 69% Blank or NA

12. If your clients have any disabilities such as hearing impairment, visual impairment, or physical limitations, are emergency mental health services accessible to them? Yes No NA

31% yes 31% no 38% NA

13. Have you had any problems getting the services your clients need? Yes No If yes, please explain the problem:

46% yes 38% no 15% Blank or NA

14. Do you feel the police are understanding of your clients' needs in a mental health emergency? Yes No Please comment.

38% yes 31% no 31% Blank or NA

15. How satisfied are you with the quality of emergency mental health services available to your clients in Ramsey County?

1 _____ 2 _____ 3 _____ 4 _____ 5

Not at all Satisfied Very Satisfied Average = 3.73

Comments:

0% 0% 0% 0% 31% 15% 38% 8% 8%

16. How satisfied are you with the availability of emergency services available to your clients in Ramsey County?

1 _____ 2 _____ 3 _____ 4 _____ 5

Not at all Satisfied Very Satisfied Average = 3.38

Comments:

8% 0% 23% 0% 23% 0% 38% 8% 0%

17. If your clients are on Medical Assistance, does that affect your ability to help them get emergency mental health services?

18. If your clients do not have health insurance, does that affect your ability to help them get emergency mental health services?

19. If you could make one improvement in emergency mental health services, what would it be?

Please return this survey to
Larraine Felland
444 Lafayette Road
St. Paul, MN 55155-3828

Note:
If you have additional comments, please add another sheet.

APPENDIX D

WASHINGTON COUNTY

COMMUNITY SERVICES DEPARTMENT

Social Services Division

GOVERNMENT CENTER

14900 61ST STREET NORTH, P.O. BOX 30 - STILLWATER, MINNESOTA 55082-0030

Office (612) 439-6901 Facsimile Machine: (612) 430-6605

Daniel J. Papin
Director

Richard C. Backman
Division Manager

July 14, 1995

Larraine Felland
Mental Health Specialist
Department of Human Services
444 Lafayette Road
St. Paul, MN 55155-3828

Dear Larraine:

RE: Washington County Emergency Services Report

Enclosed is a copy of the Washington County pilot study report regarding emergency services. The report follows the outline you provided dated January 10, 1995. The county portion of the report on the outline starts with Roman Numeral II.

If you have any questions, please contact me at 430-6562.

Sincerely,

Cynthia A. Rupp, LSW
Social Services Supervisor
Adult Mental Health Case Management

EMERGENCY SERVICES MONITORING PROJECT

WASHINGTON COUNTY PILOT STUDY

I. BACKGROUND

The Department of Human Services will provide this information.

II. FINDINGS AND RECOMMENDATIONS OF THE COMMITTEE

A. Process Used by the Committee

The Washington County Committee met once a month from October 1994 until April 1995. During the initial meeting the committee reviewed the legislation which required the pilot study of emergency services and determined the steps needed to be taken to accomplish the task during the time period. The committee decided the first step was to ask vendors of mental health emergency services to present information about how services are provided during the subsequent meetings.

These services were reviewed for compliance with mandated requirements for provision of emergency services as per Minnesota Statute 245.469. The committee also evaluated the sufficiency and quality of services for adult persons with mental illness who are in crisis, and assessed the effectiveness of consumer advocates in monitoring the availability of emergency mental health services.

The information from all providers was accumulated and the committee through discussion came to some conclusions about the provision of emergency services in Washington County. The following report reflects the thoughts and conclusions of the committee members who worked on this project.

B. Presence of Emergency Mental Health Services

The majority of formal mental health emergency services in Washington County are provided through Human Services, Inc., but there are a number of key components provided by county community services staff and law enforcement. There are four primary crisis lines available in Washington County. Washington County Community Services can be accessed 24 hours a day. -After hours, calls are handled through a contract with Emergency Social Services. This line might be used to contact mental health case management services in a crisis situation. Case managers are available during work hours via pagers. After work hours Emergency Social Services has the home numbers of all of the mental health case managers.

HSI's business lines are answered 24 hours a day. In crisis situations, a mental health professional is available via pager.

Medical back-up is also available through an on-call psychiatrist. The mental health professional and psychiatrist are also equipped with cellular phones to assure prompt response in crisis situations. HSI contracts with Crisis Connection to staff the "Washington County Crisis Line". This is a separate line from the regular Crisis Connection hotline. This system is also backed up by the on-call mental health professional and psychiatrist on call. Each morning HSI receives a report from Crisis Connection staff on all calls received through the Washington County Crisis Line. The head of Emergency Services at HSI is responsible to review all these calls and assure any necessary follow-up or communications. HSI also maintains crisis lines for chemical dependency crises, as well as for emergencies involving sexual assault.

Key gate keepers within the community are provided information so they can directly access when necessary the mental health professional on call. These gate keepers include local and county law enforcement personnel, mental health case managers, staff of agencies such as Family Services and others.

The mental health professional on call is responsible to triage calls. They may provide consultation to gate keepers managing crisis situations, provide counseling by phone to clients, enlist the assistance of the medical staff on call when required, make referrals for admission when required, etc. In situations which require immediate face-to-face intervention, usually situations involving some significant risk, the patients will typically be referred to an appropriate hospital mental health emergency service or may arrange for direct admission as appropriate. If the situation requires prompt follow-up but not immediate attention, the on-call professional will typically direct the patient to the appropriate provider service and system. Often the client will be referred to the Crisis Clinic offered at HSI.

HSI's Crisis Clinic is available 7 days a week, 365 days a year, between 9:00 and 11:00 a.m. This is a walk-in service. Police and others who may encounter urgent situations frequently direct clients to this service which requires no appointment. The management of crisis situations is not limited to the Crisis Clinic. Persons in crisis may be seen at anytime during business hours. HSI has mental health professionals on site from 8:00 a.m. to 9:00 p.m. Monday through Thursday and until 5:00 p.m. on Friday. The Crisis Clinic, as mentioned, is available all days, including weekends and holidays.

A large percentage of emergency contacts are managed by HSI's two primary crisis workers, the supervisor of Emergency Services who is a licensed psychologist and a clinical nurse specialist. The supervisor is responsible for the management of all crisis services, the crisis lines, the scheduling of on-call staff, the management of crisis clinics, etc. The role of the clinical nurse specialist is to assist particularly in those situations that involve medical complications or the need for medications. In the past a serious problem in the local emergency service system was access to psychiatry services. With the assistance of a crisis services grant, HSI was able to make some significant changes to its system, including the creation of the clinical nurse specialist's position. The nurse acts as a physician extender. She will medically assess situations and consult with the psychiatrist about appropriate intervention. If medications are required, the nurse and the psychiatrist can initiate them immediately, which was not possible in the past. The triage function provided by the nurse has proved to be extremely helpful in assuring that patients access a level of care required in a timely manner.

The Emergency Services supervisor and the clinical nurse specialist provide some limited mobile outreach in crisis situations. Although the frequency is currently low, they are available to provide off-site assessment of crisis situations within the community. Fairly frequent, however, are outreach contacts at the county's jail. These contacts frequently involve new inmates who have psychiatric histories, often serious and persistent mental illness. Not uncommonly, they entail some suicide risk. The Emergency Services staff will go to the jail to assess crisis intervention and direct needed care. When medical issues are involved, such as medications, HSI provides the necessary psychiatric services on site at the jail.

The Crisis Services staff works very closely with the county mental health case managers. The county case managers play a key role in managing many crisis situations. In fact, in many situations the county case managers are providing mobile crisis services. In Washington County the case managers also do pre-petition screening for commitment. Frequently the county's mental health unit will be contacted by a member of the community or an agency representative about a crisis situation which could potentially involve a commitment. This unit provides an immediate response to such requests. A case manager will make a direct assessment of the situation and arrange for services as necessary. Not infrequently, this intervention results in a stabilization of the situation and avoidance of a need for commitment. As other community agents, the case managers may rely upon the HSI crisis staff and services for back-up and additional needed interventions.

In some situations a case manager and a member of the Emergency Services staff may team to jointly assess a particularly difficult situation.

The pre-petition screening team in Washington County is a particularly important communications link for crisis services. The pre-petition team membership includes all of the county case managers, the HSI Emergency Services staff, HSI chemical dependency staff representatives, other HSI staff who may be commonly involved in crisis management, a county attorney, and representatives from law enforcement. Commitment cases and cases potentially involving commitment are reviewed by this team which meets monthly. This meeting is also an opportunity for joint training. All members of the pre-petition screening team have been trained in the use of health officer holds and other relevant matters.

The HSI Emergency Services staff and the county mental health unit have jointly shared responsibility for communications and linkages with other systems. The mental health unit has taken particular responsibility to establish relationships with law enforcement regarding the management of after-hour emergency situations which require face-to-face intervention which is not available through the mental health emergency services system. The HSI Emergency Services staff has taken particular responsibility for the training of law enforcement personnel and the personnel of other agencies on the assessment and management of crisis situations, services available, and how to access them. Frequently, members of the Emergency Services staff and the county's mental health unit will provide this training as a team.

The committee notes the high degree of cooperation and communication which occurs between county services and HSI. Washington County has established with HSI a collaborative relationship which may be unique in Minnesota. HSI has been given significant responsibility for the planning and management of mental health services in the county. The director of the HSI division responsible for adult services and all emergency services is provided office space at the county's Government Center and maintains daily contact with the county's mental health unit.

HSI staff and staff from the county's mental health unit are working on a number of enhancements to the current emergency services system. As detailed later, there are a number of desirable services not currently available within the Washington County system. One recent development has been the establishment of the first mental health crisis foster home in the county. Efforts have been made to establish this capability in the past but without success.

It has been apparently difficult to recruit and maintain crisis foster homes. We hope that this recent development is the beginning of the more substantial crisis foster home service.

C. Quality And Sufficiency of Emergency Mental Health Services

Quality

The committee struggled with a variety of definitions of quality. We decided that, at its most basic, quality is characterized largely by two characteristics: positive outcome and consumer satisfaction. Given limited resources, quality cannot be divorced from the issue of cost. The committee believes that value or cost benefit is an important variable to consider but chose not to focus on that issue due to its complexity and limitations of time and resources.

A number of possible outcome measures were considered. Suicide prevention appears to be a "common sense" outcome, and it is an issue that provides considerable concern and emotion. However, there appears to be no hard data to indicate that mental health emergency services actually reduce the incidence of suicide. The committee, therefore, chose not to pursue this issue but notes that the overall suicide rate in Washington County is lower than the overall rate found in the U.S., and lower than the Minnesota average.

There is statistical evidence to suggest that emergency services do reduce hospitalization rates. Data easily available to the committee was limited to the State Utilization Tables, but we assume that these figures represent a large enough portion of psychiatric hospitalization for county residents to be a useful indicator. In reviewing this data, we found very low rates of admission to acute care hospitals as well as to the regional treatment centers. Clearly, many factors affect admission rates, but we considered these favorable data to be at least a general indicator of positive system performance.

Another general measure of system performance we considered was the commitment rate. We assumed that a poorly performing mental health service system would cause an increase in the commitment rate. We were handicapped in assessing this measure because we lacked comparative data and could not determine the degree to which emergency services would affect that rate independent of other variables. Given an apparent low rate of hospitalization, we expected to find a comparable low rate of commitment in Washington County. Our "best guess" is that, in fact, the case. In 1994, there were 92 requests for commitment.

Actual commitment occurred in only 20 cases, however which is a rate of about 4.4 per 10,000 of the adult population in the county. Commitment was avoided in nearly 80% of cases.

A related measure considered was the rate of hospitalization among persons seen through the HSI Crisis Clinic. In 1994, 208 individuals were seen in this Crisis Clinic. Only 15 persons, or 7.2% were referred for hospitalization. If only individuals presenting with Major Depression or other serious and persistent mental illness are considered, the rate is about 12%. In a recent study conducted by ConnectiCare of a 24-hour, 7 day a week psychiatric in-home crisis intervention, triage and treatment program, the rate was 19.3%.

In the area of consumer satisfaction, the committee considered as consumers both the individual/family in crisis and the key gate keeping agencies within the community. HSI provided relevant data. HSI conducted telephone follow-up interviews with a 38% sample of Crisis Clinic consumers 4 to 6 weeks following the crisis contact. Ninety percent of respondents were satisfied with how quickly they were seen. Ninety percent expressed satisfaction with the recommendations made by the crisis worker. Eight-five percent of Crisis Clinic consumers reported that the service was helpful in resolving their concerns. Ninety-two and a half percent of the individuals surveyed indicated they would use the service again if needed or would refer others to the service who required it.

In 1994, HSI conducted written surveys of five agencies, with 4.4 persons responding per agency. All but one of these agency representatives rated the timeliness of crisis services satisfactory or better. Seventy-five percent rated the availability of crisis staff for consultation as satisfactory or better. Timeliness of reports and feedback to these agencies was rated as satisfactory or better by over 90% of respondents. The success of intervention in safety resolving the crisis was rated by 90% of respondents as satisfactory or better. Representatives of these five agencies rated competence in the crisis services as follows: 5% poor, 12% satisfactory, 55% good, and 28% excellent.

Sufficiency

We found "sufficiency" to be a particularly difficult parameter to define and assess. We determined it most useful to consider sufficiency on a continuum. At the low end, we considered sufficiency to be the availability of the essential services necessary and in such quantify to provide timely and safe disposition in mental health crisis situations. By this definition, we determined services in Washington County to be generally sufficient.

Data available to the committee suggests that services are provided by a competent staff who provide service based upon individual need and in a fashion which protects the rights and dignity of the consumer. Surveys of gate keeping agencies and consumers indicate a relatively high degree of satisfaction with the timeliness of services, and consumers find the system to be a respectful one. This does not suggest a perfect system. At the high end of the continuum, we considered sufficiency to mean the availability of a range, and quality of services to assure, not only safe disposition, but, also, minimum disruption in community life and services provided which are "least restrictive" and precisely targeted to the needs of the particular situation and the individual consumer.

There are clearly services, partly or totally, lacking in Washington County which might be part of a comprehensive system. There is no psychiatric inpatient unit in Washington County, so situation requiring hospitalization entails a considerable disruption in the life of the consumer. The crisis worker and the client must deal with a hospital that is not routinely involved in the local system, which makes for some difficulties at times in communications, particularly regarding discharge planning. There are sometimes delays in admission and certainly some inconvenience.

While there is the beginnings of a crisis foster home service in Washington County, the currently available option is limited to mild to moderate crisis situations. There are no residential crisis beds in the county, nor any hospital based observation beds. When required, such services can be arranged in other counties but with some difficulty. Arranging for these services generally requires some assistance from the county case managers who must frequently interrupt routine service to other clients. The crisis worker and the case manager must develop a short-term plan for stabilization of the situation and the protection of the client until the option is created. Sometimes, if that is not possible, a brief hospitalization is required until the less restrictive option is available.

With the support of the Crisis Grant, mobile crisis outreach is now available in Washington County, but is limited to daytime hours. The low demand for this service makes it cost prohibitive to have a 24-hour capability, but the committee notes that there are times when situations arise "after hours" which result in a less desirable intervention, such as by the police because such a service is not available at all times.

While a Crisis Clinic is available 7 days per week and face-to-face crisis services are available much of the time, they are not available during nighttime hours.

The on-call mental health professionals provide assistance by telephone, and when face-to-face contact is required will refer clients in crisis to an emergency room. In most of these situations, such a referral is appropriate. Based upon the information provided to the committee, these situations usually involve some form of medical emergency, such as the need for an admission or consultation with a medical doctor about a serious medication problem. However, the committee believes that there likely are instances in which an emergency room contact could be avoided by the availability of a 24-hour face-to-face crisis service.

Finally, services to minority populations are not optimal. Washington County has only very small minority populations, and so minorities represent only a small number of crisis situations handled in the course of the year. Persons from a minority population in crisis are unlikely to find a similar person of race or culture in Washington County. If the person in crisis does not speak English, interpreter services will be required with few exceptions. The crisis staff managed by HSI has had some diversity training, but more would appear to be in order.

In summary, the committee assesses the crisis services in Washington County to be sufficient for the safe management of emergency situations but fall considerable short of being a fully comprehensive crisis service system.

D. Effectiveness of consumer, family and Advocates

Consumers, family members and advocates play a strong role in the Local Mental Health Advisory Council. There are currently 16 members to the Council. Membership currently includes three consumers, two family members and a position designated for the Alliance for the Mentally Ill, which is shared by two Alliance representatives.

The Local Mental Health Advisory Council also has a designated representative to the Counties Social Service Act committee. Biannually, the Local Mental Health Advisory Council and the CSSA committee hold public hearings during which testimony is taken from consumers, family members and other citizens. This information is used by the Local Mental Health Advisory Council as input for the development of recommendations for the biannual mental health plan.

Representatives from the Alliance for the Mentally Ill of Washington County work with the local mental health center on educational projects within the county and a local AMI member is a representative to an advisory committee to the local mental health center.

Periodically the Alliance for the Mentally Ill invites representatives of the county service staff and representatives of the local mental health center to present relevant information to the Alliance. Complaints have been rare. When encountered by members of the Alliance, the Alliance has been provided prompt, direct access to the management to the local mental health center. Above the county and the local mental health center have policies and procedures for handling complaints from consumers.

The committee has no specific recommendations with regard to the effectiveness of consumer input in the provision of emergency services. However, with regard to emergency services the consumer, family and advocate representatives would advise continuing periodic education of law enforcement personnel with regard to mental health issues and encourage greater law enforcement and mental health center collaboration.

III. Statewide information about emergency mental health services.

This information will be provided by the Department of Human Services.

IV. RECOMMENDATIONS

A. CHANGES IN STATUTE OR RULE

The committee has only two particular concerns in this area, both of which relate to the commitment process. The current standard for dangerousness is very stringent. It makes it difficult in many situations to provide needed and appropriate intervention in a timely way. In some situations, consumers who fall just short of the standard must be allowed to deteriorate to the point where the standard is met.

This increases, obviously, the risk that some harm will in fact occur which otherwise might have been avoided.
It often makes the process more complex and distressing for all concerned parties. Particularly difficult are those cases in which the risk of harm is driven not by clear homicidal or suicidal ideation, but is due to grave disability which results in neglect in critical self care. Finally, the committee believes it would be helpful if the Jarvis process was made simpler and integrated into the regular commitment process.

B. FUNDING

The committee would recommend that funding for successful crisis projects be continued. The committee has concerns about the difficult and complex problem of "cost shifting". The committee recommends that the Department access this issue carefully, particularly as it relates to emergency services.

In particular, the committee would like to see requirements and safeguards developed that would assure that emergency services provided by the "public" system to individual covered by health plans be reasonably reimbursed by those plans. The committee would also recommend that the Department explore ways to assure consistency among health plans for the coverage of appropriate and necessary services, such as hospital care, regardless of commitment status.

C. HEALTH CARE REFORM

If health care reform results in coverage for the currently uninsured, this would be the greatest benefit to persons in need of emergency mental health services. This would presumable assure access to inpatient services when required, as well as other behavioral health care services, lessening the burden on the "public" system. Large health care systems also may have the resources necessary to support diversion services, such as in-home triage, which hold the potential of reducing demand on costly services such as hospitalization, or providing an improved service to the consumer.

Because of the great differences from area to area in population density, demographics, clinical service availability, transportation services, and many others, it may not be possible to define an ideal system. There is no "one size fits all". The answer to the question is also dependent upon the definition of "emergency". If emergency is defined as a high risk, e.g., suicidal, homicidal situation which demands immediate action, a relatively narrow system of services might be required.

Perhaps, minimally, this would be a system which assures prompt 24-hour access to triage, possibly an emergency intervention team to assess situations on site, with good communications and rapid response among the key service components, such as the police, paramedics, and emergency rooms. If emergency is defined as an acute crisis that may be personally distressing but not necessarily entailing significant risk of harm to self or others, a more elaborate system would be required. Fewer than 10% of calls to "hotlines" are placed by very high risk individuals.

This is not to suggest that services based upon such a broad definition are not helpful. They can represent an important mental health resource for persons in distress. A system designed for this purpose must include a 24-hour crisis line, walk-in counseling services, mobile outreach, ideally with medical capability, and other services. The cost of such services would be prohibitive in some locales due to low population density and low demand, some form of regionalization would be necessary for the support of certain services.

Managing crisis with persons with special needs such as hearing or speech impairments, language barriers, and other complicating needs might also require regionalization if services designed specifically to meet the unique needs of certain minorities and persons with special needs are to be available. In any configuration, the idea posed earlier for the establishment of local crisis systems appears to be a vital component.

FINAL REMARKS

This report has been compiled and is being submitted to the Department of Human Services by the Washington County Pilot Study Committee for Emergency Services. The report has received the approval of the Local Mental Health Advisory Council at the June 20, 1995 meeting.

7/01/95

APPENDIX E

MENTAL HEALTH EMERGENCY SERVICE PHONE SURVEY SUMMARY
1994

In July and August of 1994, the Mental Health Division (MHD) and the Deaf and Hard of Hearing Services Division (DHHSD) conducted a survey/test of the 24-hour mental health emergency services phone system. At a randomly assigned time, staff of the MHD and DHHSD called (DHHSD staff called by TTY) the county-identified provider of the mental health emergency services to conduct the survey.

The objectives of this survey where to:

- determine the accessibility of this service throughout the state;
- determine the availability of consultation with a mental health professional within 30 minutes of the request to speak to the mental health professional;
- determine the accessibility of this services to people who are deaf;
- determine the level of orientation/training the "first responder" (the person who first answers the emergency services phone line) had;
- determine the mental health professional's skills in assessing suicide potential of a hypothetical caller; and
- determine if the provider had specified (but not mandated) policies and procedures in place to provide emergency services.

This information is used to provide county mental health authorities with feedback on these services, to determine the status of these services statewide, to determine needs and strengths of the system, and to help with targeted technical assistance and consultation and training to improve these services.

Results of the survey suggest that:

- emergency services did seem accessible to voice callers. Surveyors' found that we did have many inaccurate phone numbers; but once 800 number was known, services did exist.
- 19 of 34 first responders had some training in mental health/emergency intervention during the past year. Training varied significantly in hours and focus. Of note is that three providers subcontract with phone answering services during some hours to provide the initial response to callers. Staff of these three subcontracters report that they have had no training nor mental health service experience.

- in 33 of 34 surveys, a provider identified as the mental health professional on-call responded within the 30 minute statutory time frame. The other provider took 63 minutes. One additional provider's mental health professional on-call could not be reached. The average response time of the first 34 was 8.4 minutes. Of note, in 8 surveys, there was question if the education/training of the "on-call professional" met the qualifications of the mental health professional.
- in general, the surveyors thought the mental health professionals did an adequate job of accessing for suicide risk. The mental health professionals identified on average 5.3 of the 11 suicide assessment factors sought in the survey. This result may have been impacted negatively because of the survey design. In followup discussion, some providers communicated that it was not clear to them that they were being asked to demonstrate their suicide assessment knowledge. The skills of the mental health professionals seemed to vary. Some focused on "building rapport" with caller without clearly assessing the "suicide risk" of the caller.
- DHHSD surveyors found that half the providers did not answer the TTY calls. This was a concern two years ago when a similar survey was done. Infrequent calls on the TTY, limited provider staff training in use of TTY, and normal staff turnover seem to contribute to emergency services not being accessible to callers who are deaf.
- Counties continue to rely primarily on law enforcement to directly intervene if a direct in-home intervention is needed by the caller. Only 4 providers identified capacity to do outreach to callers if needed. Provider followup services to caller vary. Many providers will offer a followup appointment with the caller and/or followup call by a provider representative.
- 14 of 38 providers indicated they had access to interpreter services, 7 additional providers had access to limited interpreter services. 21 of 38 providers indicated they had the capacity to have a call traced if needed. Almost everyone (except two) indicated capacity to contact child protection services if needed. 15 of 31 providers indicated having forced intervention procedures in place. 18 of 35 providers indicated that they had lethality assessments tools to assist staff's assessments of callers situations.

The major observations from the survey are that:

- mental health professionals are available and responsive if needed;
- the mental health system continues to not have the capacity to directly intervene in the community; the system relies on law enforcement for this role; and
- the TTY system for callers who are deaf is not working adequately.

Recommendations include:

- provide statewide training on suicide assessment, interpreter services resources, deaf services resources, forced intervention and interagency coordination agreements, and lethality assessment tools. This training should be coordinated with the informal Emergency Services Provider Group.
- study the feasibility of a statewide 800 TTY number for callers who are deaf.
- review and recommend if a waiver of mental health professional qualifications is appropriate in some individual situations given some staff are well trained and specialize in crisis work.