A DESCRIPTION AND EVALUATION OF A COMMUNITY MENTAL HEALTH CENTER'S TWENTY FOUR HOUR EMERGENCY SERVICE

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ABSTRACT

A DESCRIPTION AND EVALUATION OF
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TWENTY FOUR HOUR EMERGENCY SERVICE

By

Cynthia Mae Cole

This study attempted to describe the population using Ingham Medical Community Mental Health Center's Emergency Service in March 1972. It also attempted to evaluate client perception of the emergency service during this month.

Demographic data (age, sex, marital status, type of contact, presenting problem) were analyzed for all 121 contacts during the month and a telephone questionnaire was administered to 34 of these clients. The results of this analysis indicate that, though the emergency service is designed on a crisis model, to a large extent the clients do not represent a classic crisis population. The 34 respondents to the telephone questionnaire had quite positive opinions of the service and seemed to find it useful to them.

This study was viewed as exploratory and areas which might prove fruitful for further research were outlined.

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CHAPTER I

INTRODUCTION

It has become a generally accepted notion in the last ten to fifteen years that psychological assistance provided to a person or family during a time of emotional crisis may have a large effect with a relatively small expenditure of effort (Caplan, 1964). Following this theory, it has become a requirement that a community mental health center provide emergency services as one of the five services necessary if a center is to receive a federal staffing grant. The Ingham Medical Community Mental Health Center received a federal staffing grant in July 1971 and instituted its twenty four hour emergency service October 15, 1971.

This study is intended to investigate some characteristics of the population which is being reached, and to assess how the user population perceives emergency services. The study was not intended to assess in objective terms whether the intervention by the crisis counselor improved psychological functioning, though this would certainly be a worthwhile but lengthy undertaking.

Some of the specific items of interest in this study were: 1) demographic characteristics of clients (age, sex, marital status, income); 2) a rough assessment of the "presenting problem" of clients (e.g. depression, anxiety, etc.);

3) a look at whether marital-family upsets and job instability are highly represented in a crisis population; 4) a look at one or two counselor characteristics. None of these was conceived as a full-blown hypothesis, but rather meant to outline the area of study. The results of this study can properly be viewed as a guidepost which points the way to further research. The implications and suggestions for further work will be discussed in Chapter 5.

Definition of Terms

For the purposes of the emergency service discussed in this paper, a crisis is defined by the individual user of the service, particularly initially. This means that a counselor does not attempt an objective appraisal of whether or not a client "should" be using the service unless it becomes clear that it is not to the client's advantage to continue using the service. Examples of this situation occur when: 1) the emergency service involvement is undermining an existing outpatient relationship; and 2) the client would get better or more appropriate service by a referral to another program. This policy means that many of the persons served by this particular service are not in the category defined by crisis theory as ideally appropriate to crisis intervention. It is obvious, however, that it would require too much time, effort and loss of clients to certify each one as a bona fide crisis before serving him. Also, it is certainly true that it is a real service to the community to provide a twenty

four hour point of contact for the seriously disturbed who are trying to function without hospitalization.

For the purposes of this emergency service, a crisis counselor is a person who, by aptitude and/or training, is functioning in that capacity. Thus, the staff represents a wide variety of background both with respect to discipline and with respect to years of formal training.

A "natural" caregiver as referred to in this study is one who has not been specifically trained as a mental health worker but whose work has significant mental health overtones. Teachers, ministers, policemen, and physicians are some of the most frequently observed individuals in this class.

CHAPTER II

REVIEW OF LITERATURE

Crisis Theory

Though there have been a small number of psychiatrists who have reportedly used brief psychotherapy in the treatment of certain emotional disorders, Erich Lindemann's 1944 study of grief reactions is widely acknowledged to be the first attempt to explore crisis theory which has resulted in the development of a new field of crisis intervention therapy. Lindemann's study involved 101 persons who had suffered one of the following: 1) psychoneurotic patients who lost a relative during the course of treatment; 2) relatives of patients who died in the hospital; 3) bereaved disaster victims (of the Cocoanut Grove fire in Boston) and their close relatives; 4) relatives of members of the armed forces. Lindemann felt that the picture shown by those suffering grief reactions is remarkably uniform. Some common features are: sensations of somatic distress occurring in waves lasting from 20 minutes to an hour at a time, a feeling of tightness in the throat, choking with shortness of breath, need for sighing, an empty feeling in the abdomen, lack of muscular power, and an intense subjective distress described as tension or mental pain. In addition, there is a sense of unreality, feelings of guilt,

loss of warmth in relationship to other people, and loss of accustomed patterns of action. In addition, some who border on a pathological reaction may take on characteristics of the deceased.

The major theoretical contribution of Lindemann's paper seems to be his realization of the necessity for a bereaved person to do his "grief work" if he is to avoid unhealthy psychological consequences. This means that a person who has suffered the loss of a loved one must go through the pain of realizing and accepting his loss. If the bereaved person does not achieve this, his grief may be either delayed or distorted. In both cases the person is prevented to a greater or lesser degree from a healthy readjustment.

Following the early lead of Lindemann, Gerald Caplan studied families in which the crisis was the birth of a premature baby and discovered certain patterns of coping which were associated with healthy and unhealthy outcomes. Caplan discusses three areas and the ways in which they can predict future family adjustment: cognitive, handling of feelings and seeking of help. In the cognitive area, healthy outcome is predicted if the crisis is met with aggressive information gathering and reality, while unhealthy outcome often accompanies a great deal of fantasy or hope based on wishful thinking, but not in fact. In the area of handling feelings, desirable behaviors include open expression of positive and negative feelings, occasional use of defensiveness, denial,

etc. which quickly passes, and minimal scapegoating of others either in or outside of the family. Unhealthy outcome in this area is prognosticated by much denial and repression of feelings, and blaming of others accompanied by continuous signs of tension leakage into inappropriate areas. With regard to provision of help, those who achieved a healthy outcome actively sought and accepted help, had good extended family support. In these families, husband and wife alternated being "the strong one" so that each one was able to experience both giving and receiving. Any unhealthy behaviors were stopped by the other spouse before they became harmful. On the other hand in families which never adjusted adequately to the stress of prematurity, help was either not sought, not available, not accepted or regarded as competition and belittled. In addition, it was often found that the helper would support the parents in denial, repression or scapegoating.

In 1948 Lindemann and Klein initiated a 5 year project in Wellesley, Masachusetts which attempted to examine Lindemann's premise that there are adaptive and maladaptive ways of meeting a range of emotional hazards during the life cycle. By offering both service and research components they reached the conclusion that help with common crises can help prevent major illness and that mental health services can be used most effectively when concentrated upon those most likely to be in crisis (Klein and Lindemann, 1961).

From the results of these and other studies, Caplan

developed his own crisis theory (Caplan, 1964) which has influenced the current thinking concerning the etiology and handling of emotional crises. As he defines it, "...crisis involves a relatively short period of psychological disequilibrium in a person who confronts a hazardous circumstance that for him constitutes an important problem which he can for the time being neither escape nor solve with his customary problem-solving resources." (Caplan, 1964, p. 53). During this crisis as Caplan sees it, the individual devises new ways of reacting--they may be healthy or not--which then becomes his new, relatively persistent modus operandi. Caplan also notes that while the person in crisis may emerge healthier than before, someone in his family may be forced to adjust in a maladaptive way and thus be less healthy. A less healthy state for either may involve manifest mental disorder (the adaptive pattern adopted is non-reality based in his culture). If the crisis has been evaded, it will continue to press on the individual and hamper his freedom. On the other hand, if the crisis is met head on and solved with reality-based methods, it will provide an indispensible opportunity for growth rather than deterioration.

The three aspects of crisis which have caused much of the current interest in crisis intervention are:

1) The outcome is not determined by antecedent factors even though these factors may influence the outcome. The outcome depends on the interplay of endogenous and exogenous forces.

2) During crisis an individual experiences a heightened desire for help and the signs of his distress evoke a helping response from those around him.

3) During the disequilibrium of crisis, a person is more susceptible to influence by others than during periods of stable functioning. Thus, a relatively minor intervention at this period will have a major impact whether for bad or for good. The resultant steady state will then be relatively stable.

Periods of crisis thus provide care-giving persons with a remarkable opportunity to deploy their efforts to maximum advantage. Additcnal steps to maximize professional functioning can be taken utilizing the knowledge that crises are basically of two types: developmental and accidental. Thus professional help can be made more available to those who are most at risk, e.g. honeymooners, new parents, surgical patients, those in mourning, etc. Much impact on the community can be had by training the natural caregivers (ministers, hospital personnel, funeral directors, etc.) to promote healthy adjustment while still retaining their own roles. All these caregivers need to do is to encourage people to choose effective, reality-based ways of handling their crisis tasks in order to be of great help.

Family Systems Theory

The next step after observing the individual as a psychological system is to observe how that individual in turn acts as a part of a larger system: his family. The work in applying systems theory to the family is just beginning and even less has been done in applying systems theory to the family in crisis. Some exploratory work has been done by Nancy Harries in an unpublished paper (1970) which outlines the differences to be expected from families in crisis depending on whether they are open or closed systems. Thus, according to this theory, a closed family system (with little provision for information unput from the outside or feedback among members) tends to experience increased entropy (disorganization) under normal operating conditions. When facing a crisis situation, this tendency becomes even more pronounced as change is occurring but information and feedback to the sustem are lacking. A more open family system, in contrast, tends to negentropy (organization) under stress because of the greater opportunities for new information and feedback. In principle, then, one could predict which families would tend to disintegrate during the crisis experience. In practice, however, family systems are not uniformly either open or closed but are selective about what types of information and feedback are admissible within the family system's rule structure.

These concepts have received some attention by family theorists, though they have been expressed in somewhat dif-

ferent terms. Lindemann (1944) noted that families who seek information and help survive crises better. Others (Caplan et al.) have related adaptability, the ability to discover more options, the ability to discuss feelings frankly and openly, with the ability to survive crises. It seems to me that systems theory can be useful in portraying symbolically and economically what family theorists have been describing about how a family system acts and reacts in a crisis state.

Crisis Intervention: Short Term Versus Emergency Therapy

The practice of formal crisis intervention which has arisen in the last ten to fifteen years is based on the theoretical formulations of individual and family systems in crisis which I have discussed in the first two sections. There seem to be three basic types of crisis intervention services available at this time: suicide prevention centers, family crisis centers such as the Family Treatment Unit in Denver, and twenty four hour personal emergency services for all types of personal crises. In this section I will discuss the theory and operation of all three types. Before I do this, however, I want to talk briefly about the differences and similarities between crisis intervention and early access short term psychotherapy. These two terms are rather consistently interchanged in the literature, but at least one writer (Bonstedt, 1970) emphasizes the differences between the two. In reviewing the literature, it appears that the two are functionally separate except in the case of the

Family Treatment Unit (Langsley and Kaplan, 1968). The impression one gets from the literature is that brief psychotherapy by the same therapist who intervened in a client's crisis could very profitably be the customary followup for crisis intervention. As the situation is typically handled now, the client is initially served by the specialized crisis interventionist, then referred for further therapy if he seems to need it. Caplan (1964) sees the period of crisis as lasting from one to five weeks while the brief psychotherapists describe a period of six weeks as the maximum time for brief psychotherapy. Bonstedt (1970) states that the differences between the two include crisis intervention's greater emphasis on the environment, its more optimistic view of the role of crisis and the opportunity to utilize "anticipatory guidance" through the training of other professionals. In his view, brief psychotherapy is based primarily on modifications of ego psychology with some attention to various aspects of social psychiatry. Jacobson (1970) basically agrees with Bonstedt in his emphasis on crisis intervention as a distinct mode of treatment, not a truncated psychotherapy nor a lesser treatment option.

Yet others have made somewhat different and conflicting claims concerning short term psychotherapy. Castelnuovo-Tedesco (1966) feels that it is important not to admit psychotic depressions, or cases where the whole personality is involved, or major character disorders to short term therapy.

He feels that the best criterion to use is a patient's ability to function in his accustomed social role despite the discomfort of his depression. Stewart and Cole (1968) present a different view, stating that the degree of emotional distress is not a deterring factor in the selection of clients in the research on short term therapy which they reviewed.

It is possible that the relevant dimension around which this conflict could be resolved is crisis theory. It seems that a rather limited number of people could be helped by short term therapy when they are not in crisis. However, if the short term therapy is applied at the time of crisis, rather large gains could be made no matter what the diagnosis. Saucier (1968) has made some specific recommendations concerning the aim and content of each of the six sessions. He suggests: 1) finding the common thread from one crisis to the next; 2) helping the patient recognize the warning symptoms of crises; 3) reviewing the factors responsible for a patient's crises and "rehearsing" alternative new behaviors; 4) reviewing the current distressing situations. It seems that an approach similar to this, using a combination of the twenty four hour crisis service and the approximately six week short term therapy for those who need follow up would serve a client's needs far better than a simple referral to another agency or program.

Crisis Intervention: Suicide Prevention

Suicidal behavior is commonly regarded as one of the

major crises requiring immediate professional help. Yet, in assessing the attitudes of different cultures at different times toward suicide, there are many instances where suicide was viewed as a societal norm under given circumstances (variously, loss of family pride, drain on community, etc.). In Western culture itself, customs and attitudes have varied over time. Diggory (1968) feels that 1823 was a dividing point with a stern moralistic view of the sin of killing oneself being prevalent before that date and a more lenient approach being taken after that time. Diggory himself feels that not all suicidal behaviors are the same and recommends that the mental health worker not get stuck in a blind rut of suicide prevention at all costs. On the other hand, while it may be unfair or unnecessary to interfere with a person who truly wants to kill himself, the bulk of the literature indicates that it is the rare suicide who experiences his wish to die in an unambivalent way. It seems logical to assume that it is almost always the ambivalent who contact the suicide prevention centers and the worker can deal with the suicidal person on the basis that he at least partially wishes to live.

Despite the current growth of suicide prevention centers, indicating a possible increase in the suicide rate, Pokorny (1968) maintains that the suicide rate now is approximately the same as it was in 1900 though it has fluctuated from a low of 9.6/100,000 during World War II to a high of

13.6/100,000 in 1932. The current rate in the United States is 10.5/100,000 or one every twenty four minutes (Yolles, 1968). The World Health Organization estimates that 1000 persons per day commit suicide and eight times that number attempt it (Bergin and Garfield, 1971).

There are many traditional attitudes toward suicide and suicidal behavior which have been called into question by the intense scrutiny which this behavior has attracted in the last fifteen years. Some of these centers are conducting a great deal of research which provides a much clearer picture of suicidal behavior than had previously been available. Before this time, according to Krauss and Tesser (1971) there have been two major approaches to the study of suicide: 1) the "Freudian" approach which sought the key in the intrapsychic development, structure, and economy of the individual; and 2) the "Durkheimian" or sociological approach relating suicide to the operation of such societal variables as the degree to which the individual is integrated within his society. In their study Krauss and Tessor have attempted to unite the two approaches with their theory of "thwarting disorientation." This refers to a situation in which one person feels disoriented with respect to his society by the action of another (i.e. an unwilling divorcee). They analyzed written reports of a large group of societies with respect to seven types of thwarting disorientation behavior and found that two--men's freedom to divorce and defiant homicide--were associated with higher suicide rates than the others. They

are not attempting to say that the victim of the thwarting disorientation himself is necessarily the one who will commit the suicide: it could be a child or another relative who will show the symptoms.

Many other theorists agree that much suicide and suicidal behavior is basically interpersonal. The phrase "cry for help" is repeated so often in the literature that it is a cliche, but it well expresses the interpersonal dynamic accompanying suicidal behavior. Neuringer (1964) found that suicidal and psychosomatic individuals both reflect more instability in dyadic interpersonal relationships under stress than normal hospital populations. The suicidal and psychosomatic individuals tended to make "snap" decisions and to cut off important dyadic relationships with little information. Thus, suicidal behavior was seen by the authors as one of a number of possible outcomes when a close dyadic relationship is threatened by stress. This research could bear further investigation in light of the many researchers who find that interpersonal loss is a very common antecedent to suicidal behavior. It appears that certain types of individuals tend to cut off their interpersonal relationships more precipitously than others, then some will react to this loss with suicidal behavior while others become psychosomatic, etc.

Using another interpersonal loss approach, Moss and Hamilton (1956) report that in 95% of the cases of persons

making serious suicide attempts in their study, there was a history of death or loss of a parent, sibling or mate. In 75% of the cases, death had taken place before the patient had completed adolescence. Pokorny (1968) states that attempted suicide usually signals that social circumstances and interpersonal relationships are badly disturbed, while in successful suicides, social isolation is more typical. De Vos (1968) adds that studies have well established the fact that there is some relationship between the rate of suicide and the degree of social cohesion to be found within a particular society. Thus, suicide rates are higher for new immigrants and are associated with residential instability in a study done by Murphy (1954). People with no primary group membership were more prone to suicide than were members of simple or complex family groups. Murphy also notes that, since World War II, the relatively high rate of suicide among young women in Singapore has been declining coincidental with increased personal freedom. This point seems to apply to suicidal behavior in general--suicidal persons either have or perceive themselves to have fewer options. "Suicide is the only way out," is a common theme.

Physical illness or injury presents an intolerable reduction of options for many people, as noted by Dorpat, Anderson and Ripley (1968). They found that 90% of the eighty cases of completed suicide they studied had an active illness at the time. Of the attempted suicides, 34.5% had a current

illness. They also noted that physical illness is more often a precipitating factor in suicide in men than in women. The underlying cause for this seems to be lack of flexibility and individuation. In addition, many researchers mention fear of death as a precipitant for suicide--apparently action is preferable for these people than a passive waiting for death to arrive.

More and more detailed outlines of the internal and external lives of suicidal people are emerging from the experiences of the suicide prevention centers. Litman and Tabachnik (1968) describe the more common fantasy systems to be found in persons with suicidal behavior. These include: 1) tired wish for surcease; 2) guilty wish for punishment, atonement; 3) hostile wish for revenge; 4) erotic wish for surrender, union with dead loved ones; 5) hopeful wish for rescue and rebirth (the basis of "call for help" suicide prevention services). They also emphasize that the state of development of the suicide plan is important. At first the suicidal plan seems alien and anxiety provoking, but gradually it is incorporated into the ego structure and then becomes an internal action-plan which tends to go to its logical completion.

Farberow and Shneidman in 1961 described the modal suicide attempter in the following way: 1) female; 2) caucasian; 3) in twenties or thirties; 4) housewife; 5) native born; 6) attempted suicide with barbiturates; 7) living

in apartment in apartment house area; and 8) gives as "reason" marital difficulties or depression. In contrast, the modal suicide committer is likely to be: 1) male; 2) caucasian; 3) forties or older; 4) married; 5) a skilled or unskilled worker; 6) native born; 7) commit suicide by gunshot, hanging or carbon monoxide poisoning; 8) give as "reason" ill health, depression or marital difficulties; and 9) live in an apartment in an apartment house area.

Suicidal ideas are almost universally communicated either covertly or overtly before a suicide occurs. This again emphasizes the interpersonal content of suicidal behavior. The recipients of these communications of intent were listed by Murphy and Robins (1968) in their survey of 371 completed suicides as: spouse (60%); relatives and in-laws (51%); friends (35%); and physicians (18%). These and other contributors to the book Suicidal Behaviors emphasize that a person should be asked directly about suicidal ideas, particularly by doctors. Some researchers have noted that suicidal persons have often been in touch with their doctors recently before their suicide attempt, very possible as another aspect of their "cry for help." Because many people feel that asking a person about his suicidal intent may "put ideas in his head" if they weren't there already, the L.A. Suicide Prevention Center studied 10,000 suicidal patients and 3,000 suicidal deaths and found no evidence that such questions harmed patients. As a further guide for family and

physicians, they found that the most dangerous period with relation to suicide is within three months after a suicidal crisis. Yolles (1968) states that the two groups most at risk from suicide are those who have attempted suicide and the survivor-victims of committed suicide, especially young children of a parent who commits suicide. These groups may suffer long-range deleterious effects if they remain untreated.

This country had few resources to meet the need for a response to the suicide's cry for help until approximately 1958. Before that time, the country appears to have had only two formal suicide prevention agencies--the Salvation Army's anti-suicide department and the National Save a Life League, both founded in 1906. In 1958 the Los Angeles Suicide Prevention Center was formed influencing the formation of most of the suicide prevention centers which now exist. Most of these centers assess the lethality and attempt to alleviate the suicidal danger in interpersonal as well as individual terms. Thus, the LASPC uses these five factors to determine lethality: 1) the stress the individual is currently suffering; 2) his character structure, including both weaknesses and strengths; 3) his suicidal plan (how specific it is with respect to details and timing); 4) his present physical and psychological symptoms; 5) his resources, including especially his friends, relatives, finances, etc. In another book, Litman and Farberow (1961) state that it is important to note who brings the suicide in and what kind of relationship

exists between the two. The situation becomes much more serious when communication is cut off. In the same vein, Speck (1968) recommends that the suicidal patient be treated in a family context in the home because this prevents the family from investing all its pathology in one family member. As Farberow and Shneidman note, "...a number of cases involving marital and parental relationships could be seen as family neuroses." (1961, p. 10).

As a summary to the above, Bergin and Garfield (1971, p. 796) quote the World Health Organization which reported that: "1) a suicidal act is committed frequently as a "cry for help" rather than a clear desire to die; 2) a person who has made a previous attempt is more likely to die through suicide than one who has no history of suicide attempts, and if there have been two previous attempts, the subsequent risk is considerably increased; 3) the danger of a repititive attempt depends on whether the act has brought about a change in the life situation and mental state; 4) a high percentage of persons committing or attempting to commit suicide have given previous warning of their intent; and 5) a disruption of close personal relations is one of the main precipitating factors in suicidal behavior."

There is now much discussion concerning how the many suicide prevention centers function and how effective they are. The Los Angeles Suicide Prevention Center was started in 1958 as a 5 year research grant to provide extensive

psychological evaluation of those who had attempted suicide. As their work progressed, Farberow and Shneidman (1961) found themselves being used to counsel those who had threatened suicide -- thus the service unit of an essentially research oriented unit, "began itself." Some of their results give additional handles on suicidal persons. As is commonly noted, they found the following ratios for attempted and committed suicide:

Committed		Attempted	
Male	70	Male	31
	--		--
Female	30	Female	69

They also found that more young people attempt suicide while more older people commit it. Divorced and separated groups contribute more than their share to suicidal populations, and women listed as "housewives" both commit and attempt suicide more often than would be expected.

From this pioneering work, Houghton noted in 1968 that the number of suicide prevention centers had grown within the last year from 47 to 74. Of the 74 operating at that time, he contacted 60 and described some of their characteristics. He found that most of the 60 act as referral services and noted that their twenty-four hour availability seems to be an important asset. He found that clergy run many of the programs and that volunteers are heavily relied upon by almost

all the programs. The range of funding is quite wide -- from $500 to $50,000/yr. Most programs seem to cluster at $8-15,000/yr. by using professionals who are also working at other jobs, and by utilizing sub-professionals. Seven have volunteers who will "go out" into the community and this seems to be a priority item for those who don't yet have this service. Use of the services also varies widely from eleven calls in a 9 month period to 7,000 calls in 1966 for the Los Angeles Suicide Prevention Center. Because many who call suicide prevention centers don't seem truly suicidal, many such centers have broadened their scope and are now referring to themselves as emergency or crisis centers. In fact, in 1970, Hitchcock and Wolford stated that they feel that "suicide prevention" centers are forcing people to define their crises as suicidal, when in fact, they may not be. They believe that the broad-range "emergency service" is much more useful. Houghton also finds that many emergency services utilize imaginative and fresh approaches to resources in the attempt to avoid hospitalization. One of the more valuable services they can perform is an inventory of resources in towns which have few.

Because of the widespread use of suicide prevention centers, many people are concerned about judging the effectiveness of these centers. Suicide statistics in communities having suicide prevention centers don't seem to show a significant change. Several explanations are plausible:

one might be the small size of the centers in relation to the size of the community, another could be the possibility that even those centers called "suicide prevention" may be tapping into a general crisis population rather than a suicidal one. The authors represented in this review all seem to feel that the suicide prevention centers are performing some necessary service, even though they may or may not prevent suicide. As Pokorny notes, "Suicide hints or threats are viewed as feelers or pleas to the persons in the environment to help restore hope." (1968, p. 65)

David Lester (1971) has described a method of evaluating the effectiveness of suicide prevention centers by comparing the geographical location of those calling the center with the geographical location of successful suicides. He feels that an agency can adjust its community outreach activities according to the results of this comparison and thus provide a more useful service. Another interesting study by Greer and Bagley (1971) followed up after 1-2 years 204 persons who had attempted suicide and found that significantly more subsequent suicide attempts occurred in a group who had received no psychiatric help than in the group who had received either brief (1-2 interviews) or prolonged psychiatric and social help. In addition, they found that prolonged treatment was associated with the best prognosis.

Another issue which is frequently discussed in the suicide literature is that of treatment approach. Since many

centers use non-professionals and since many professionals are not particularly familiar with suicide prevention, careful selection and training is widely recommended. (Shneidman, Farberow, Hankoff and Waltzer, 1968). However, once selected and trained, most authors feel that non-professionals and natural community caregivers can provide excellent service to the suicidal individual. Beahan (1970) has described his own efforts to improve the handling of suicidal patients which include courses for ambulance drivers and close liaison with the police with emphasis on the availability of psychiatric help. In addition, he has paid close attention to the training of his professional staff including legal aspects of suicide, community resources and hospital resources. Every suicidal patient receives psychiatric attention throughout his hospital stay and may be referred to a crisis (5 sessions or less) or outpatient clinic on discharge. When patients fail to keep their clinic appointments, a staff member or a public health nurse is sent to the home. Beahan has also made some recommendations for other such programs which seem excellent: 1) public health nurses be included on the staff; 2) organized training for all staff; 3) attention to the morale of all staff; 4) the psychiatric staff should be close to the emergency room but autonomous; 5) short term holding beds should be available in or near the emergency room; 6) a follow-up crisis clinic should exist; 7) development of a procedures manual to ensure consistent handling.

To summarize the general feeling, Farberow (1961) has stated that despite widely varying theoretical backgrounds and use of different procedures, the most important ingredients for successful suicide prevention seem to be warmth, sensitivity, interest, concern and consistency within one's own theoretical framework.

Family Crisis Intervention

Though theorists have noted the characteristics of families in crisis for some time, emphasis was placed on the family as the source of the trouble but treatment was still centered on the individual, leaving him to change his family if he could. As family theory progressed, the mental health of the individual family member was assessed, perhaps by criteria similar to Parad and Caplan's (1965). An individual's mental health was judged by his ability to: 1) initiate and maintain satisfactory emotional relationships with others; 2) work productively and fulfill inner resources; 3) perceive reality undistorted by fantasies; 4) adapt to his environemnt if this is conducive to his welfare; 5) change the environment, when not conducive to his welfare, in a way that impinges minimally upon the rights of others. However, with the development of family systems theory it has become obvious that it is not sufficient to treat individuals, as change at one point in the system must be accompanied by change in the rest of the system. A very apt case in point is

an article by Langsley, Fairbairn and DeYoung (1968) which points out that in their experience with the Family Treatment Unit at Colorado Psychiatric Hospital many family crises center around an adolescent's changing role in the family. The authors have noted, however, that the adolescent is not always the identified patient, which reinforces the notion that the stress on the system may show up at any point.

The concept of the Family Treatment Unit (Langsley and Kaplan, 1968) is one of the most interesting of the approaches to crisis intervention which are now in operation. The Family Treatment Unit functions as a three-member team (psychiatrist, psychiatric social worker and psychiatric nurse) operating a twenty-four hour service at the Colorado Psychiatric Hospital in Denver, Colorado. One of the best aspects of this service is the rigorous research component which provides different types of data on the results of the service. The Unit operates in the following way. Whenever a patient has been examined and recommended for immediate admission to the psychiatric hospital and if he meets the FTU requirements (he must live in a family and live within 1 hour's drive of the center -- about 53% meet these requirements), a sealed envelope is opened which says "yes" or "no." If the envelope says no, the person is admitted to the hospital and becomes part of the control group. If the envelope says yes, the FTU team is called immediately and they begin treatment of the family. Their approach is based on the

"family doctor" concept and proceeds in two stages: 1) examination of the family system; 2) diagnosis and prescription -- the crisis is identified as an acute disorder brought on by identifiable recent stress. Everyone in the family is assigned tasks which may include reducing pressure on the identified patient or at other times increasing demand on the identified patient to function.

In contrast to Gerald Caplan (1964), the FTU feels that crisis is a type of reaction by a family, not a set of hazardous external events or circumstances. Nor is it a mere upset in family equilibrium. Some families can handle external and internal upsets within their own confines and with competence. The families seen by the FTU are very seldom, if ever, overwhelmed by events in outer reality without significant contributions of intrafamilial pathology. In addition, they believe that the "...object of crisis therapy is not to explain and understand symptoms. It is to improve the current situation so as to diminish the need for regressive and pathologic behavior, affects and thinking." (Langsley and Kaplan, 1968, p. 158).

Another common stress found by the FTU in addition to that brought on by adolescense is the "caretaker crisis." This occurs in approximately 20% of the families seen where the caretaker either allows regressive dependency, then dismisses the client or where the caretaker becomes unduly concerned about a client. In these cases the FTU treats both

the family and the caretaker until the caretaker can take over again.

In evaluating the results of their procedures based on 65 experimental families and 75 control families, the FTU has used the following criteria: 1) subsequent mental hospital admissions; 2) Social Adjustment Inventory scores (Berger et al.); 3) Personal functioning scale; 4) clinical evaluation of family functioning (the interviewer is a social worker unconnected with the family treatment); 5) post-treatment crises and their management. Though these initial results are preliminary, they are encouraging.

Of the 75 experimental families, none were hospitalized during the crisis for which they were referred. The families were treated with an average of 4.2 office sessions; 1.6 home visits; 4.5 telephone calls; and 1.3 contacts with other social agencies. The treatment took place over an average 22.7 days. Of the 75 controls, all were hospitalized for an average stay of 26.1 days per case. The FTU feels that the following results are obtained by family treatment: 1) all the first 75 experimentals could be treated by family therapy; 2) rapid recompensation of acute psychosis is possible with these techniques; 3) the treatment avoids hospitalization and when subsequent hospitalization takes place, it is briefer; 4) there is no evidence that patients treated outside the hospital are more homicidal or suicidal or chronically disabled; 5) the family may have certain

burdens added but advantages also accrue -- cohesiveness, a new awareness and handling of crises; 6) the stigmata and social disability of mental hospitalization is avoided; 7) the symptomatic member returns more rapidly to role functioning within the family; 8) the cost of family crisis therapy is less than 1/6 the cost of mental hospital treatment; 9) the patient treated by family therapy without hospitalization is likely to have gained 2 weeks of role functioning in a 6 month period.

Other researchers and authors are now beginning to look more carefully at the family crisis intervention model. Argles and MacKenzie (1970) note that some families in their experience can sometimes accept help during a crisis period better than at other times and they recommend close contact between the mental health team and community caretakers who can call on the team when family crises occur. Leona Shields (1969) describes some of the advantages of and contraindications for family crisis intervention from the nurse's point of view. She describes the goals as: 1) achievement of a clear definition of the real conflict; 2) relief of the distressed and disabled functioning; 3) strengthening of a family's shared resources for problem solving; 4) reduction of conflict and improvement in level of coping; 5) encouragement of the substitution of appropriate controls and defenses for inappropriate ones; 6) bolstering of a family's immunity against disintegrative effects of emotional upset.

Shields feels that family crisis therapy is inappropriate when the following conditions exist: 1) absence of a common family goal or concern; 2) use of the family therapy sessions to support destructive defenses so firmly there is no point of entry; 3) when one member's anxiety, hostility or dependency seem to overwhelm another member; 4) when one member completely withdraws; 5) when one member has such pressing needs that common goals are impossible; or 6) when one member is too afraid of disclosure or too much closeness with his family.

As can be seen from the previous discussion, the emphasis in the family treatment approach is in outreach to the community, relying very little on an ivory tower, "you come to me" approach. This is also the theoretical approach used by the community mental health concept to be discussed in the next section. In a profession where most personnel have been trained in an individual approach, however, the theoretical committment is somewhat difficult to put into practice.

Crisis Intevention: Community Mental Health Setting

The concept of community mental health is based on the growing realization experienced over the twentieth century that it is a devastating experience for a family to live with a member labelled "crazy." Langsley and Kaplan (1968) point out that this label derives not from symptoms but from the fact of admission to a psychiatric hospital. They describe a survey in which the respondents were unperturbed by the

description of the most severe psychoses, but wouldn't want to live next door to a mental hospital dischargee with or without symptoms. As crisis theory developed and theorists accepted the fact that stress is necessary for growth and change, it became apparent that it is important not to stigmatize a person for what is held to be normal "growing pains." In addition, putting a person in a mental hospital obscures the interpersonal factors which led to decompensation. As a substitute for hospitalization several crisis units have a small number of "holding" beds where a person can get brief rest and shelter but which do not give his family the opportunity to readjust without him.

In addition to these rather altruistic reasons for greater emphasis on community mental health care are the quite practical ones of lower cost and lack of state hospital facilities for all those who are judged to need them. In fact, one of the classic experiments designed to increase outpatient treatment and decrease hospital admissions was prompted by a lack of sufficient hospital beds. The study, reported by Carse in 1958, succeeded in reducing admissions the first year by 56 percent. The patients not admitted were seen as outpatients, were visited in their homes, were given day care or referred to private nursing homes.

In a more recent study, Pasamanick, Scarpitti and Dinitz (1967) attempted to find if schizophrenics were better cared for in the hospital or in the home during a three year

study in Franklin County, Ohio. From their data, the authors conclude that the project demonstrated conclusively that home care under medication with systematic public health nursing care is quite feasible for newly hospitalized and ambulatory schizophrenic patients. Munoz, Tuason and Dick (1970) feel that the important factors involved in keeping patients out of the hospital are precision in diagnostic formulations, an early intervention in situations of stress and utilization of community resources. They also feel that the use of social workers and visiting nurses is essential in promoting and maintaining the changes necessary for a patient's reintegration into the community. In a recent (1971) study reported by Armsby, he also found that many of a group of adolescents referred for inpatient treatment could be treated successfully in the community. In his study, the adolescents were treated in their homes for 2-8 sessions with their families and other significant persons present by a crisis team composed of trained non-professionals and natural community helpers. The team used only existing community resources. After 6 months of operation, 22% of the adolescents were hospitalized, 40% were referred for outpatient follow-up and 38% needed no further treatment. At a cost 1/15th that of hospitalization, Armsby feels that these teams have been an effective alternative to hospitalization.

Waltzer and Hankoff (1963) have also had good results by offering immediate psychological treatment in the hospital admitting office as an alternative to hospitalization.

A thorough history is taken with the help of family and friends and most patients are offered regular outpatient appointments one or two times a week with daily or emergency appointments also available. During a 6 month period, 392 patients were seen, 60% diagnosed psychotic, 13% were admitted. One third of the patients broke their outpatient appointments but of those seen, 38% were judged improved and 19% were the same.

Even when the patient is admitted to a general hospital, Wright and Dale (1970) have found that it is to the advantage of all patients to have the separation of psychiatric patients from regular patients eliminated. A psychiatric nurse on each floor is recommended by the authors in order to give training and moral support to her colleagues. They also recommend that the activity room and other facilities for the psychiatric patients be available for all patients physically able to use them. Using these and other steps, the authors feel that the psychiatric care of all the patients is improved.

As a refinement of these procedures which attempt to keep <u>everyone</u> out of the hospital are those who are attempting to develop measures to determine who will ultimately require hospitalization anyway. Freedman, Rosen, Engelhardt and Margolis (1967) have done preliminary work on a "Hospitalization Proneness Scale" using psychological, social and demographic data. Further efforts in this area would be extremely valuable in fitting the treatment to the

person.

As an indicator that a tendency to avoid hospitalization is becoming ingrained in mental health professionals is Satloff and Worby's (1970) study of the ten years of operation, from 1958-1968, of the psychiatric emergency service at the Rochester Medical Center. In 1958, 65% of those using the service were judged to need hospitalization, while in 1968 only 48% were judged to need hospitalization. Some of the other changes noted were: 1) an increased service load of 49.2% (689-1,026); 2) an increase in the percentage of women from 59.5% to 62.6%; 3) an increase in the percentage who had previous contact with mental health professional from 52% to 64%; 4) an increase in the percentage of attempted suicides from 9% to 12.4%. The diagnoses remained quite constant with all categories remaining with 2% of one another. There was a distinct downward trend for age representation.

	Under 18	18-45	46-65	66 & Over
1958	4.1%	59.5	26.0	10.4
1968	9.3	66.6	18.8	5.2
Change	127%	11.9%	27.7%	100%

The authors hypothesized that younger people in the population are more psychologically sophisticated and are also responsible for the higher suicide attempt rate. They also felt that young people are alienated from their parents

and are relying almost entirely on peer group support. When this fails, they seem to see the emergency service as a more impartial and trusted source of help, one not viewed as an agent of their parents or society. An additional interesting note from this study is the fact that the poor seem to be using the emergency service in preference to the regular outpatient care.

Several authors have discussed their view of the shape which community mental health should take in the literature. As McGee and McGee (1968) see it, community mental health should include the following principles: 1) the shortage of professionals demands utilization of trained non-professionals with access to professional consultation; 2) the professionals should become consultants to natural community caregivers rather than give direct services; 3) mental health programs must forsake exclusive attachment to the medical model and add primary prevention focus of public health model; 4) deviant behavior should be defined less as sickness and more as problems of living; 5) mental health services shouldn't be autonomous, but should provide a network or umbrella of care.

To add to these principles, many authors (Bartoletti, 1969; Lewis, 1970; Garell, 1969) emphasize again and again the importance of outreach for the community mental health model. Weisz, Houts and Straight (1970) have done an interesting experiment in techniques for increasing therapist commitment in an emergency service setting which is important

in preventing an emergency counselor from thinking of himself as a revolving door or referral agent with little therapeutic responsibility.

On the other hand, Jacobson (1967) has emphasized the importance of keeping in mind the very short term nature of crisis therapy. He recommends that only those interventions be made which can be assimilated in the available time. He also recommends that the therapist stay in the current crisis without going to the roots of the problem. Long-term dependency is to be avoided with emphasis on the time limit.

With this outline of the "state of the art" of community mental health, the Ingham Medical Community Mental Health Center will be discussed in the next chapter, with special focus on the emergency service of that center.

CHAPTER III

METHOD

Emergency Service: Description

The setting for the study described in this paper is the Ingham medical Community Mental Health Center. This Center is now providing mental health services for Catchment Area II of the Tri-County (Ingham, Eaton and Clinton) Act 54 Mental Health Board. The population of this Catchment area is approximately 200,000 including Eaton County and the greater part of Ingham County. This area includes rural, small town and urban populations. The main mental health center offers inpatient, outpatient, partial hospitalization, pre-care-after-care, consultation and education, and emergency services for the entire area while three satellite centers in Mason, Charlotte and Lansing's Inner City offer more convenient outpatient facilities in their respective areas. The inpatient service is offered through the use of regular medical beds at Ingham Medical Hospital. The outpatient service is essentially a brief therapy model with the new client receiving five or less individual sessions before referral into a group if further help is necessary. The client's status is then re-evaluated every three months. The partial hospitalization program is an activity

program which is run on the week days and evenings. The pre-care-after-care segment of the program offers a long term relationship with a therapist for those clients released from Kalamazoo State Hospital or some other psychiatric hospital. All clients with a primary therapist have access to the center's doctors for medication review. The function of the consultation and education unit is to provide help and training to natural caretakers, whether agency or individual, in the community. The reason for this is the fact that these caretakers are aware of problems earlier, have already established relationships in the community and can often take the "stitch in time" with much less effort and loss of client morale than a "mental health" worker can. The emergency service exists to ensure that persons in crisis will get immediate attention. Again, this crisis counseling often takes place on the consultation and education model, where the person in crisis may not be counseled directly but, rather, natural caretakers (teachers, ministers, parents, friends, etc.) are assisted in coping with the crisis.

The emergency service began functioning October 15, 1971 and has maintained twenty-four hour availability by the mental health center telephone number since then. During working hours (8AM-9PM Monday through Thursday; 8AM-6PM Friday and Saturday) walk-ins may be seen at the mental health center. At other times walk-ins may be seen at Ingham Medical Hospital's emergency room. The emergency room staff

may also call in the mental health emergency staff if they feel a medical emergency has psychological overtones. The main hospital also relies on the emergency service staff for immediate counseling with psychiatric and regular medical patients. Each psychiatric admission has a doctor and/or primary therapist but when these personnel are not available, emergency services is often called. In general, if the person requesting service has a primary therapist, emergency services will attempt to contact him. If the primary therapist is unavailable, the emergency services staff person will handle the situation until the therapist is reached. Every effort is expended to provide continuity of care for a person and to avoid passing him from therapist to therapist.

In hiring the staff of emergency services, a deliberate attempt was made to include personnel with varied backgrounds. The staff includes the coordinator, five full time staff members, one three-fifths time psychiatric nurse and two center workers. In terms of background this represents two persons with vocational rehabilitation counseling training, one with an M.A. in the psychology of school children, one second year graduate student in an M.S.W. program, one M.A. level graduate student in family intervention and a first year graduate student in an M.S.W. program. This diversity of background has been a potential source of much staff strength, but it has not yet been exploited as well as it might have been.

Of the full time staff, only one person was not also a full-time student. The emergency staff tended to be younger than the rest of the center staff, and preferred the night and weekend shifts to accommodate school and family schedules. (As a member of another crisis service observed about their young emergency personnel, "They are at a time of their life when they find it exciting to be awakened in the middle of the night!") The Emergency Service continued to function normally over all weekends and holidays with only formal vacation time offering a break from the constant routine. The effects on the staff of the continuous strain of being "prepared for anything" at all times has shown that most cannot function as full-time emergency personnel for extended periods of time. Nine months to one year seems to be the point at which a majority of the personnel find themselves suffering from cumulative fatigue. In light of these and other considerations, Ingham Medical Community Mental Health Center is experimenting with a different staffing model.

Description of Study Subjects

The subjects of the questionnaire administered in this survey were all persons who had made contact with the emergency service in March, 1972. This number included one hundred and twenty one (121) different clients who made a total of two hundred and twenty (220) contacts. March was chosen as a month which had neither the highest nor the lowest number of contacts, which was neither winter nor spring,

and which has not been discussed in the literature as a particularly unusual month with regard to psychological crises. Also the service had been in operation for 6 months and was working smoothly. Of the one hundred and twenty one individuals recorded as contacting the service in March, there was insufficient data available to make any attempt to contact fifty one. From the remaining seventy, thirty four useable responses were obtained.

Some of the subjects used the twenty-four hour service, others walked in either to the emergency room or to the center, while others were referrals from other individuals (primarily physicians) or agencies. The contact sheet used in recording pertinent information is included in Appendix A. This sheet was designed to record basic demographic data (client's name, age, phone number, time of contact, marital status, etc.) together with the pertinent details of the presenting problem as an orientation to the case for the next worker. The questionnaire used in this study was designed by the author with the assistance of the coordinator of emergency services and her academic advisor. A copy with the totalled responses is included in Appendix B. The two major types of information desired were: 1) an indication of how clients perceive the emergency service and 2) a demographic description of the types of people who are using the service. Several attempts were made to reach by telephone each of the seventy persons for whom there was sufficient information to

do so. Five persons collected the data, all of whom had worked with emergency services either as staff or volunteer. As is indicated on the questionnaire, the respondent was able to choose a time convenient for him to respond though most preferred to answer immediately. All information for this study was derived either from the questionnaire or from the contact records from the month of March.

CHAPTER IV

RESULTS

The findings of this study are derived from analysis of the demographic and other data obtained on the 121 individuals who contacted Emergency Services in March and from the questionnaire survey data collected from 34 of the 121 March clients. I had intended to try to find whether different age groups, sexes or other groups responded positively or negatively to Emergency Services. There are also many other questions which could be asked, in addition to these basic ones. However, the range of response to the questionnaire was so limited and so positive that a differential analysis would be useless. Only three responses of the thirty-four can be characterized as negative and for this reason I will simply report the percentage results of the questionnaire without further statistical analysis of this type. There are some additional observations which can be made about the questionnaire data, however, and these will be discussed in the third part of this chapter.

The statistical techniques used in analyzing the contact record data include simple percentage reporting, binomial comparisons, and chi square (Armore, 1967). In some parts of the analysis, chi square was used even though the number of males made it difficult to know whether the results were

due to real factors or to small sample size. In general, the analysis for all the subgroups of March is tinged with the small male sample size and the results should be considered indicative rather than conclusive. In general, the female sample size was large enough to produce more reliable results.

In assessing the validity of the questionnaire one runs up against the problem of trying to ascertain whether a client is saying what he <u>really</u> feels. The surprisingly positive results of the survey (only 3 overall negative responses of 34) brings up the old question--if one asks a person his opinion on a subject is his opinion of the subject being measured or his mood of the day? The questionnaire seems to have face validity as measured by the opinion of two professionals in the field and an academic advisor. Another possibility, rather than invalidity, which might explain the results is a systematic, but accidental, sampling error. It is possible that mental health workers, like doctors, may figuratively "bury our mistakes" and they become unavailable for follow-up. Thus, those who have drifted on, gone to Kalamazoo or changed their phone number to an unlisted one might have a different opinion of the service than the respondents.

Because of the lack of differentiated response on the opinion parts of the questionnaire, the raw and percentage responses for the questionnaire will be supplied and the analysis will concentrate on the demographic parts of the

data. In order to give some idea of what the total March sample is like, the characteristics of all March clients will be discussed in the next section as well as a description of some of the ways in which the questionnaire sample is different from the total sample.

The statistical hypotheses which were analyzed and which will be discussed are:

(1) There were no differences in distribution for age and sex for all March contacts.

(2) There was no difference in type of contact preferred by sex.

(3) There was no difference between men and women with regard to preference for single or repeated contacts.

(4) There was no difference between men and women in diagnostic categories assigned.

(5) There was no difference between men and women with respect to marital status or age.

(6) There was no difference between male and female counselors with respect to tendency of same-sexed clients to call them back.

(7) There was no difference between counselors with respect to tendency of clients to call back.

Description of Total March Sample

As Table 1 shows, 59 per cent of all contacts in March fell between 16 and 35 years of age. As is also noted in the table, there are significantly more females aged 26-35 than males this age represented in the March contacts. This age group is the largest among March contacts, and is the only one where male under-representation is significant, though in no age category do males outnumber females.

These data were analyzed to find if there was any significant malrepresentation of age groups in my questionnaire sample. Statistically there was no significant difference between the March age distribution and the questionnaire sample age distribution for males. This result could be due to the small sample size for males. For females, however, the age group 36-50 was significantly over-represented ($p = .92$). Though the sample distribution for males was well distributed for age, the entire contacted sample was significantly under-represented for males ($p = .01$). There was no such bias present in the group which I attempted to contact so some unknown factor is at work which selects out males. It seems possible that men may be more mobile than women and thus would tend to have more wrong addresses, changed phone numbers, etc. Because unemployed women might tend to be home more often than men, it is more probable that such a woman could be reached in three or four attempts than an employed man even though attempts were made at different

Table 1: Distribution of Age and Sex for All March 1972 Contacts

Age Range	Reached		Not Reached		Not Attempted		Total For March		% For March	
	M	F	M	F	M	F	M	F	M	F
10-16	-	-	-	1	2	5	2	6	08	05
16-25	2	3	7	6	3	9	12	18	23	28
26-35	3	14	6	8	3	7	12	29	28	37
36-50	1	7	1	2	3	-	5	9	11	12
Over 50	2	2	2	2	-	2	4	6	08	09
Unknown	-	-	-	1	8	9	8	10	13	18
TOTAL	8	26	16	20	19	32	43	78	100	100

times of day.

Table 2: Type of Contact Preferred by Sex

Type of Individual Contact	Raw Data M	F	Total
Phone	13	44	57
Walk-in	30	34	64
TOTAL	43	78	121

Table 2 shows the strong preference which men appear to have for face to face contact ($p = .01$). In March, 70% of the male contacts were walk-ins, while for females the ratio is approximately 50/50. If both males and females are considered together, however, the greater number of females washes out the male preference and the total sample shows no significant preference. Oddly, these figures may simply show greater male mobility again, rather than a feminine preference for the telephone. Though the questionnaire sample bias was definitely female, only 20% said they preferred phone contact while 64% definitely preferred face to face contact. This result emphasizes the need for better transportation facilities provided by the mental health center or by such volunteer organizations as FISH.

Table 3: Comparison of Repeated Versus Single Contacts by Sex

No. of Contacts	Raw Data M	Raw Data F	% M	% F
1	31	58	72	74
More than 1	12	20	28	26
TOTAL	43	78	100	100

Using the data in Table 3, there is no significant difference between men and women with regard to multiple contacts with the Mental Health Center in a given month. The data also show that a great majority (74% : p = .05) had a single contact with the center during that month.

When subjected to a chi square test, the data in Table 4 revealed no significant difference in diagnostic categories for males in March. That is, each subgroup possessed roughly the same distribution as the entire group, indicating that the sample I reached was representative of the month with respect to diagnosis. This was not the case for females. There was a significant (p = .10) difference between the diagnostic categories represented by the three subgroups of March and the entire month of March. However, no one diagnostic category in any of the subgroups seems badly over or underrepresented so the error must be cumulative and evenly distributed through each subgroup. For example, the largest deviation from the expected value in the questionnaire

Table 4: Diagnostic Categories for the Month of March and for Three Subgroups

Diagnostic Categories Assigned to Contacts	Total Individual Contacts For March		Subjects Not Attempted For Evaluation		Subjects Attempted But Not Reached		Subjects Reached For Evaluation		Total % For March	
	M	F	M	F	M	F	M	F	M	F
Depression	13	30	2	8	5	8	6	14	21	27
Unknown	11	9	4	-	3	3	4	6	18	8
Drug Related	8	6	3	5	4	-	1	1	13	5
Suicidal	8	15	-	4	3	3	5	8	13	13
Marital	7	11	3	3	3	-	1	8	11	10
Anxiety	7	26	3	11	2	3	2	12	11	23
Homicidal	3	-	-	-	-	-	3	-	5	-
Hysterical	-	8	-	4	-	3	-	1	-	7
Angry	-	3	-	-	-	-	-	3	-	3
Other	4	4	-	2	4	2	-	-	8	4
Total	61	112	15	37	24	22	22	53		

Table 4 (cont'd.)

Diagnostic Categories Assigned to Contacts	Total Individual Contacts For March		Subjects Not Attempted For Evaluation		Subjects Attempted But Not Reached		Subjects Reached For Evaluation		Total % For March	
	M	F	M	F	M	F	M	F	M	F
Av. # of Diag. Per Individual	1.42	1.44	0.79	1.16	1.50	1.10	2.75	2.04		
Total Individ.	43	78	19	32	16	20	8	26		

respondent group was three too many "marital" and three too few "hysterical." Three diagnostic categories had deviations of two from the expected value, two categories had deviations of one each and three categories were right on the expected value. None of these deviations seems large individually but together they add a significant component of error.

Again drawing from Table 4 data, a chi square test was performed to find if any group was contributing more than its share of multiple diagnoses. The results indicate that those individuals who were contacted had a significantly larger number of diagnoses ($p = .01$) than any other group. Thus, 19% of the males in the March contacts account for 36% of the male diagnoses while 33% of the females account for 47% of the female diagnoses. One speculation on this result might be that a person with more diagnoses is less able to change his environment and to become as mobile as other members of the March population. Such a seriously disturbed individual might also tend to be chronically unemployed, to have fewer friends and to stay home more frequently, thus making him easier to reach than a less disturbed individual.

I also tested for significant differences in the assignment of diagnostic categories to men and to women. The conclusions to be drawn from this test indicate that the diagnostic categories for men are not any different than if they had been assigned at random but there is a significant difference for women, with depression being assigned significantly more

often (p = .01) than other diagnostic categories. I attempted to find out if different counselors had their own idiosyncratic patterns of diagnosis but some categories had too few representatives to use the chi test effectively. One item did seem apparent, however, and that was that counselor #4 (see Table 7) saw 10% of the females in March but accounted for 30% of the diagnoses of "depression" among the females. At least in this case there seems to be a clear counselor tendency to see women as depressed.

As an interesting sidelight to the data on diagnosis, there are three instances of "homicidal" diagnosis for men but none for women while there are three diagnoses of "angry" for women but none for men. However, in reading the logged report of these "angry" women, at least two mentioned the desire to kill husband or children. For some reason, women are apparently not seen as homicidal by their counselors. Though there is no conclusive evidence to support this contention, some of the female diagnoses may represent cultural myths about women rather than real diagnoses.

From Table 5 several pieces of information can be drawn. Significantly more males than females (p = .01) were placed in the "unknown" category with respect to marital status, probably reflecting the fact that culturally it is considered more important to know whether a woman is married than a man. This value is reflected in our terms of address and possibly also in a therapist's tendency to ask a female client her

Table 5: Breakdown of March Contacts by Marital Status, Age and Sex

Marital Status	10-16 # of Ind.	10-16 # of Cont.	16-25 # of Ind.	16-25 # of Cont.	26-35 # of Ind.	26-35 # of Cont.	36-50 # of Ind.	36-50 # of Cont.	Over 50 # of Ind.	Over 50 # of Cont.	Unknown # of Ind.	Unknown # of Cont.	Total # of Ind.	Total # of Cont.
						MALE								
Single	2	2	6	11	2	6	1	1	-	-	-	-	24	28
Married	-	-	1	4	7	16	3	3	4	4	-	-	35	37
Separated	-	-	3	6	2	2	-	-	-	-	1	3	15	16
Divorced	-	-	1	3	1	2	-	-	-	-	1	1	7	8
Unknown	-	-	1	1	-	-	1	1	-	-	6	6	19	11
Total	2	2	12	25	12	26	5	5	4	4	8	10		
Av. # Cont. Per Ind.		1.0		2.1		2.2		1.0		1.0		1.25		
						FEMALE								
Single	6	6	10	20	1	1	-	-	-	-	-	-	22	18
Married	-	-	6	7	18	29	5	6	3	4	3	3	45	33

Table 5 (cont'd.)

Marital Status	10-16 # of Ind.	10-16 # of Cont.	16-25 # of Ind.	16-25 # of Cont.	26-35 # of Ind.	26-35 # of Cont.	36-50 # of Ind.	36-50 # of Cont.	Over 50 # of Ind.	Over 50 # of Cont.	Unknown # of Ind.	Unknown # of Cont.	Total # of Ind.	Total # of Cont.
						FEMALE								
Separated	-	-	-	-	2	5	3	22	-	-	-	-	6	18
Divorced	-	-	2	3	7	20	1	10	1	1	-	-	14	23
Unknown	-	-	-	-	1	1	-	-	2	2	7	8	13	8
Total	6	6	18	30	29	56	9	38	6	7	10	11		
Av. # Cont. Per Ind.		1.0		1.7		1.9		4.2		1.2		1.1		

marital status.

There are significantly more married females than married males ($p = .05$) among those who contacted the center in March as well as more divorced females than males ($p = .02$). On the other hand there are significantly more separated males than females ($p = .01$) in the total March sample. One is tempted to suggest that women find marriage less satisfying and divorce more onerous than men, while men seem to find separation harder to handle than women. Perhaps men tolerate the status quo of a bad marriage better than women, become quite upset when the status quo is disturbed by separation, but readjust rather well to divorce by forming new relationships. In contrast, women may become quite disturbed over a bad marriage (particularly if they have few emotional options), are somewhat relieved by the separation, but find the multiple problems of divorce (rearing children alone, financial worries, lack of options and mobility) to be quite severe.

Further analysis of characteristics of the total March contacts indicate that, while for males there is no significant tendency for a man with a given marital status to contact the center more than once in a month, for females there is ($p = .01$). This tendency is strongest in the separated female group, but if divorced and separated females are considered together, 20% of the total female individuals account for 41% of the female contacts. It seems that these

women are substituting an ongoing relationship with emergency services for the more usual marital and community relationships.

When the contacts for March are considered by age groups, it becomes apparent that, although women are over-represented in all categories, the heaviest over-representation falls in the 26-35 age group. Combining information from the last paragraph with this fact, one might hypothesize that divorced or separated women of this age would frequently have small children and could easily become overwhelmed by the stress of coping with everything alone. Another interesting fact about females in this sample is that while there are more individuals in the 26-35 age range, there are significantly more ($p = .01$) repeaters in the 36-50 age group. Thus, while more younger women become overwhelmed, they are not using the emergency service as an ongoing relationship in the way that the older women are.

Table 6: Comparison of Percentage of Contacts and Callbacks by Sex of Counselor and of Client

Sex of Counselor	% of Contacts		% of Callbacks	
	M	F	M	F
M	66	58	78	42
F	34	42	22	58

Table 6 shows the significant ($p = .02$) tendency of

Table 7: Comparison of Number of Contacts and Callbacks by Counselor

Therapist #	Sex	Amt. Time Worked	# of Contacts M	# of Contacts F	# of Callbacks M	# of Callbacks F	% of Contacts M	% of Contacts F	% of Callbacks M	% of Callbacks F	% of Total Contacts	% of Total Callbacks
1	M	5/5	1	5	1	5	2	5	3	6	7	9
2	M	5/5	19	14	13	17	36	13	35	20	49	55
3	M	5/5	7	17	10	6	13	15	28	7	28	35
4	M	5/5	3	11	2	6	6	10	6	7	16	13
5	M	1/2	3	9	2	6	6	8	6	7	14	13
6	M	1/2	2	8	0	5	4	7	-	6	7	6
7	F	5/5	5	17	3	26	9	15	8	31	24	39
8	F	5/5	8	22	1	18	15	20	3	22	35	25
9	F	3/5	3	7	3	4	6	6	8	5	12	13
10	F	1/2	2	1	1	0	3	1	3	-	4	3

clients to call back a counselor of the same sex. This finding could have some application to staffing patterns with a possibility that the staffing should follow as nearly as possible the approximate sex ratio of the clients. This theory could also be extended to therapist background and training with an attempt to match training in proportion to the types of problems being seen.

From the information in Table 7 I attempted to find whether there is a significant difference between the percentage of initial contacts and percentage of callbacks for each counselor on the emergency services staff. The results indicate that there is such a difference ($p = .01$), for females but not for males, with three counselors (2, 3, and 7) responsible for most of the difference. Therapist 2 is an exception to the general tendency for same sex preference by clients in their callback behavior. Counselor 2 also accounts for 49% of the total contacts, indicating that his shifts (Monday 9PM to 9AM; Friday 9AM to 6PM; and Saturday 8:30AM to 6PM) must, on the average, have been considerably busier than others. His callback percentage of 55% is probably due partially to the same effect since some of the callbacks are random with no attempt to reach a particular therapist.

With this picture of the total March sample and an idea of some of the skewed distributions present in my 34 respondents, I will discuss the questionnaire results in the next part of this chapter.

Discussion of Questionnaire Items

It appears from noting the response to question one that a large part of the emergency service function is non-specific. Eleven stated that they wanted a specific type of response from the counselor while 26 seemed most interested in venting their feelings. This finding could explain the success which has been found with the use of sub- or non-professional volunteers for emergency counseling. The emphasis here is certainly on listening rather than counseling for the majority of the respondents. On the other hand, it is well to note that one third had rather specific expectations for the type of service they wanted.

The responses to questions two, three, five, six, seven and ten were so overwhelmingly positive that I suspect that either the responses came from a non-representative sample or that the effectiveness of emergency service is almost entirely non-specific. It seems hard to believe that even a highly-skilled group of professionals could avoid personality clashes, bad nights and accidental circumstances well enough to support this type of response.

Question four and its results show the need to continue to offer both telephone and walk-in service for those in crisis. Approximately 50% of the contacts in March occurred on the telephone despite the fact that only about 20% of the questionnaire respondents prefer using the phone. This result could be caused by the greater convenience of the

telephone for those with transportation difficulties (this comment was made by several of the respondents) or by the fact that those not reached are more likely to prefer the anonymity of the telephone. This possibility is further supported by the fact that the reason for failing to reach about half of these people seemed to be of a paranoid nature. These included: denial that they had used emergency services (5), unlisted phone number (5, 2 of which had had two unlisted phone numbers in the three month period from March to June) and giving the wrong telephone number (5). (See Table 8 for a listing of the reasons for failure to reach March contacts.)

Table 8: Reasons for Inability to Reach a Client

Denied use of service	5
Unlisted phone number	5
No phone	5
Wrong number	5
No answer	3
Phone disconnected	3
Couldn't find phone number	3
In State Hospital	2
Other	3
	34

As the response to question seven shows, more than half

of the March contacts didn't need referral. Most of this number already had a therapist who was unavailable at the time and the patient was using emergency services until the therapist became available. Of the remainder, 15 were referred for some sort of continuing therapeutic involvement, most as outpatients at Ingham. Thus, a rather small number of the respondents needed only crisis counseling. This is consistent with the contention of the Family Treatment Unit (Langsley, 1968) that crises don't overwhelm people without a significant component of pre-existing pathology.

The most important aspect of emergency services seems to be its twenty-four hour availability, as the responses to question 8 indicate. The next most important asset is the concern shown by the counselors. Both of these categories again emphasize the non-specific nature of the emergency service -- no one mentioned skill or competence as a significant factor in their use of the service. On the other hand, it would seem that certain personality traits like warmth and apparent concern for others are important for these short-term contacts.

Apparently, the most serious problem with an emergency service is one that seems hardest to overcome: the fact that the client is likely to talk with a different person every time he calls. Five respondents to question 9 felt this was what they liked least about the service. Seventeen, however, stated that there was nothing they "liked least" about the

service while four more said they disliked either that they had to come or that they had to leave! Eight mentioned assorted problems they had had with the service, some avoidable and some not.

Questions 11 through 14 were designed to find out the level of use of prescribed medication. Slightly under half the sample was taking some type of prescribed medication and of the nine who specified what this was, eight were "nerve" pills. Four respondents stated that they are currently taking non-prescription medication, but the responses were not specific enough to discover what they are taking or what their source of supply is. The question also doesn't discover what proportion of the respondents are taking such street drugs as marijuana, heroin, etc. It was felt that enough people would be offended by such a question that it was not feasible to include it in the questionnaire.

Questions 17 and 18 and 20 through 23 were intended to find whether a change in marital status or financial instability were factors in the use of Emergency Services. Either these questions did not tap the phenomenon (the change may have occurred before the emergency services contact) or it doesn't exist. Both marital and employment characteristics were quite stable over the four month period from March to June.

The questionnaire respondents seem to have a relatively large number of children with an average of 2.5 children per respondent. In addition, 85% of these children are below the

age of 15. This does not contradict the possibility that many of Emergency Service's March contacts represented divorced women having a hard time rearing these children by themselves. A further possible source of stress is the fact that 55% of the 34 had annual incomes less than $10,000 and 20% had incomes below $5,000 per year. Given the number of children in these families, financial worries seem certain to be a problem for a majority of the respondents.

Questions 25 and 26 indicate that about 50% of the respondents had had their first contact with the center in March, while 65% had had fewer than three contacts with the center. This again emphasizes the fact that most clients use the service for a very limited time while a smaller number (23%) use the service very intensively.

CHAPTER V

SUMMARY AND CONCLUSIONS

The study described in this report was designed to investigate two main areas of interest: 1) characteristics of the clients who are using the emergency service at Ingham Medical Community Mental Health Center, and 2) client perceptions of how well they were served by this unit of the mental health center. In order to achieve these two goals, all demographic data available from the 121 individuals who contacted the emergency service in March, 1972 was analyzed and a telephone questionnaire was administered to a sample of 34. To obtain this sample an attempt was made to reach all but 30 of the March clients (there wasn't enough information logged to reach these 30) by telephone.

Summary of Findings

The total number of March clients contains 65% females with the greatest difference between males and females falling in the age group 26-35. Considering both males and females together, approximately 60% of the entire March sample fell between the ages of 16 and 35. Males in March showed significantly greater tendency to come to the center rather than call (70%) while females used the telephone about half of the time. There was no significant difference between

males and females with respect to tendency to contact the emergency service more than once in a month and 74% of the total sample had only one contact with emergency service in March. There was no significant difference in assignment to diagnostic categories for males but there were significantly more females assigned a diagnosis of "depression" than other diagnoses.

Among those who contacted the center in March significantly more males than females had an unknown marital status or a separated status while significantly more females than males were either married or divorced. Divorced and separated women had a significant tendency to contact the center more than once in a month which was not the case in any other male or female marital group.

The clients in March had a significant tendency to call back a therapist of the same sex as themselves and three counselors were pinpointed as the major recipients of client callbacks.

The sample of 34 clients who responded to the questionnaire is different in several ways from the total March sample. For females, the age group 36-50 is significantly over-represented, as is the total number of female respondents. The sample of 34 was 76% female while the total March sample was 65% female. The 34 respondents to the questionnaire also had a significant tendency to have more multiple diagnoses than the total March sample or any other subgroup.

On the opinion questions in the questionnaire, 31 respondents gave consistent positive responses while 3 gave negative responses. Marital status and employment status remained quite stable from march to June and the majority had annual incomes below $10,000. The majority of clients appear to have quite non-specific expectations of the service and more than half didn't need referral. The most important aspect of the emergency service seems to be its twenty four hour availability and what clients appear to like least is talking with someone different each time they call. Twenty seven questionnaire respondents had a total of 67 children, an average of 2.5 each. Of these children, 85% are below the age of 15.

Sixty-five percent of my questionnaire sample had used the service three or fewer times, while 23% had used the service 6 or more times, some more than 20 times.

Implications

It appears that those clients who responded to the telephone questionnaire were more stable in the community, had more multiple diagnoses and repeated contacts with emergency services. It may be that the high positive response together with these other factors could all be associated with the "well-trained client" phenomenon. These people seem to find mental health intervention helpful, thus use it more often, play by the "rules" (therefore could readily say, "I'm depressed, anxious and suicidal because of marital

troubles," providing the counselor with multiple diagnoses) and would, obviously, have a positive attitude toward emergency services.

Some of the directions in which these data point seem to be:

(1) The need for an objective rather than subjective measure of emergency service effectiveness.

(2) Further investigation of the many male-female client differences recorded in this study.

(3) Further investigation of the characteristics of different counselors. The results indicate that certain counselor characteristics may be associated with certain client characteristics.

(4) Further investigation of counselor bias in client perception, particularly with respect to women.

(5) Further investigation of weekly and daily differences in client calling patterns with an attempt to assign counselors appropriately if significant patterns emerge.

(6) An attempt to match personnel sex ratio to client sex ratio in light of the preference clients indicate for counselors of the same sex.

Obviously there are many more questions which have been raised by this study than have been answered. It would be very valuable to replicate the study for October 1972 when the service will be one year old, since both client and counselor characteristics may have changed significantly by

that time as the service becomes more accustomed to the community and the community becomes more accustomed to the service.

In terms of the overall picture, this crisis service seems to be getting fewer seriously suicidal persons than other services of this type. This experience raises the question of what sort of "fit" there is between the crisis and suicide theory discussed in Chapter II, and the functioning of an emergency service. Crisis theory indicates that the prime users of this type of service should be persons who are temporarily overwhelmed by an insoluble problem who can be influenced by skillful intervention to reintegrate at a higher level as a result of the crisis. A classic example of this type was found in the March sample. A Mrs. A called in and talked with a female counselor for 30 minutes concerning marital difficulties. When this woman was contacted in June, she reported that this conversation had been a turning point in her married life, that she and her husband had never had such good communication, all thoughts of divorce were gone, and that the counselor had spent at least an hour and a half with her!

However, considering the month of March as a whole, this type of situation seems the exception rather than the rule. The general population seems to fall into two categories: 1) the very stable chronics who call frequently; and 2) the phantoms who call once or a few times and vanish.

Thus, out of crisis theory has grown the crisis intervention model but the model seems to be performing a very different function than that predicted by the theory.

The reality is that approximately one-fourth of the users of the service are not in crisis at all but seem to be using the service as a ritualized friendship. For the others, if the intervention had helped them reintegrate it seems odd that they would disappear at such a rate. It seems that there are a substantial number of people in this area who are so alienated from society that the only person they have to talk with is a telephone social worker. We need to seriously consider whether we are helping or hindering these people by allowing them to use the service in this way. I am not aware of any rigorous studies which have been conducted in this area but opinion seems to fall into two categories. One feels that chronic callers should not be permitted to use the service repeatedly in order to force them to form outside relationships. Others say that not permitting chronics to use the service only forces them to have crises in order to qualify for service! The mental health workers in this category feel that the emergency service is a relatively inexpensive service if it can keep seriously and chronically disturbed individuals functioning in the community by allowing them to touch bases with the service frequently.

This discussion also has some bearing on the level of training required to perform this service. I feel that well-

trained sub- and para-professionals and volunteers could do a good job with many of the chronic callers. However, there do occur true crisis situations where quick intervention by well-trained and experienced professionals is necessary. Perhaps the next step is to look at ways of separating these two populations from one another in order to provide the best service for each.

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APPENDICES

APPENDIX A

CONTACT SHEET

NO# _____ CONTACT SHEET

EMERGENCY SERVICE

NAME _____ ADDRESS _____

PHONE _____ DATE _____ TIME OF CONTACT ___o'clock/ a.m. p.m.

ON DUTY _____ THERAPIST _____

Phone In	Male	Under 10	Single	Anxiety
Walk In	Female	10 - 16	Married	Depressed
E.R. Visit		16 - 25	Separated	Hysterical
Hospital Visit		26 - 35	Divorced	Suicidal
Consult with Doctor		36 - 50	Unknown	Marital
Consult with Therapist		Over 50		Drug Related
Consult with Agency				Business
Training & Education				Personal
Out Patient				Other
Time Spent				(explain)

DESCRIPTION/DETAILS

SIGNATURE _____

APPENDIX B

QUESTIONNAIRE AND RESPONSES

We are attempting to assess the Emergency Service Program at Ingham Medical and I would like to set up a time either now or later when it would be convenient for you to spend about 30 minutes talking with me about this. When would you like me to call you back?

Questions:

1. What did you need when you contacted Emergency Services?
   a. Someone to talk to 26
   b. Advice 4
   c. Marital Counseling 4
   d. Problem solving 3

2. Did you feel that the person you talked with was really concerned about you? Why/why not?
   a. Yes 32
   b. No 0
   c. Undecided 1

3. Were you able to see or talk with someone without a long wait?
   a. Yes 31
   b. No 2

4. When you have a problem, do you prefer talking over the phone or seeing someone face to face?
   a. Phone 7
   b. Face to face 22
   c. Indifferent 4

5. Do you feel that you were given enough time to talk about your concerns?
   a. Yes 29
   b. No 3
   c. Undecided 1

6. After talking with the counselor, did you feel you could trust him or her?

a.	Yes	31
b.	No.	1
c.	Undecided	1

7. How was followup of your concern handled? (Were you referred to another agency? Another program within this agency, etc.?)

a.	Well	20
b.	Badly	3
c.	Neutral or not applicable	11

Referral:

a.	Not necessary	16
b.	IMCMH outpatient	11
c.	St. Lawrence	2
d.	Doctor	1
e.	Activity	1

8. What did you like best about your contact with Emergency Services?

a.	24 hour availability	14
b.	Concern	13
c.	Warmth	3
d.	Someone to talk to	3
e.	Not left hanging	1
f.	Loosened up	1
g.	Treated as person	1
h.	Don't know	1
i.	Nothing	17

9. What did you like least about your contact with Emergency Services?

a.	Not same person every time	5
b.	Fact that I had to come	2
c.	Fact that I had to leave	2
d.	Was not helpful	2
e.	Counselor disagreed with me	1
f.	Language problem	1
g.	Another crisis intervened	1
h.	Lack of confidentiality	1
i.	Lack of privacy	1
j.	Lack of availability	1

10. Would you use Emergency Services again? Why/why not?
    a. Yes 31
    b. No 2

11. Are you now taking any medication prescribed by your doctor?
    a. Yes 15
    b. No 18

12. Were you taking any medication prescribed by your doctor when you contacted Emergency Services?
    a. Yes 14
    b. No 19

13. Are you now taking any medication not prescribed by your doctor?
    a. Yes 4
    b. No 29

14. Were you taking any medication not prescribed by your doctor when you contacted Emergency Services?
    a. Yes 3
    b. No 30

Now I'd like to ask some general questions about you.

15. How old are you?
    a. Less than 10 0
    b. 10-15 0
    c. 16-25 5
    d. 26-35 17
    e. 36-50 8
    f. Over 50 4

16. What is your address?

17. What is your marital status now?
    a. Single 3
    b. Married 19
    c. Separated 4
    d. Divorced 6
    e. Widowed 1

18. What was your marital status when you contacted Emergency Services?

a. Single	4
b. Married	19
c. Separated	5
d. Divorced	4
e. Widowed	1

19. Do you have children?

a. Yes	27
b. No	6
c. Pregnant	1

Ages:

a. 0-4	13
b. 5-10	28
c. 10-15	10
d. 16-20	5
e. 21-30	8
f. Over 31	2

Total, 67; Avg., 2.5/person; 85% below 15.

20. Are you now employed?

a. Yes-Full	13
b. Yes-Part	4
c. No	15

21. Were you employed when you contacted Emergency Services?

a. Yes-Full	13
b. Yes-Part	3
c. No	14

22. Is your spouse employed now?

a. Yes-Full	17
b. Yes-Part	2
c. No	4
d. No answer	11

23. Was your spouse employed when you contacted Emergency Services?

a. Yes-Full	18
b. Yes-Part	2
c. No	5
d. No answer	9

24. What is your yearly income? Your spouse's?

a.	0-$4999	7
b.	$5000-$9999	12
c.	$10,000-$14,999	5
d.	$15,000-$19,999	4
e.	$20,000-$30,000	2
f.	Unknown	4

$10,000/yr. - 19; $10,000/yr. - 11

Average income - $10,000/yr.

25. When did you first call Emergency Services?

a.	Sept.	1
b.	Oct.	1
c.	Nov.	3
d.	Dec.	2
e.	Jan.	5
f.	Feb.	3
g.	Mar.	18

26. How many times have you used the Service?

a.	1 time	12
b.	2 times	6
c.	3 times	4
d.	4-5 times	2
e.	6-10 times	1
f.	11-20 times	3
g.	21 or more times	5

Record data from E.S. record here:

Name: _____ Phone Number: _____

Time spent_____ Anxiety _____ Sex_____

Phone in _____ Depressed ____ Age Group

Walk in _____ Hysterical ____ _____

E.R. visit _____ Suicidal _____

Hospital visit _____ Marital _____

Outpatient _____ Drug Related _____