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BARRIERS TO MENTAL HEALTH CARE ACCESS FOR THE INDIVIDUAL IN CRISIS

A Dissertation Presented

by

ANNE L. BATEMAN

Submitted to the Graduate School of the
University of Massachusetts in partial fulfillment
of the requirements for the degree of

DOCTOR OF EDUCATION

May 1993

School of Education

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ABSTRACT

BARRIERS TO MENTAL HEALTH CARE ACCESS FOR THE INDIVIDUAL IN CRISIS

MAY 1993

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The delivery system of health care to Americans is in crisis. As costs continue to escalate, and as access to services deteriorates, an increasing number of individuals in need of physical and mental health care are experiencing difficulty accessing the necessary services.

Changes in economic resources have resulted in quantitative shifts in mental health service delivery. A greater number of individuals seek mental health services as a result of the stress and anxiety created from a threatened or actual loss of financial stability. This increase in demand for service comes at a time when mental health programs are experiencing a decrease in resources which has resulted in reduced access to services.

The emergency mental health service utilization patterns and client characteristics have changed during the same period of time that the overall mental health care delivery system has undergone transformation. However, the changes in mental health care have not necessarily evolved out of careful rational planning, but rather as a response to chaotic shifts in the mental health system at large. The purpose of this study was to gather data about access to these mental health outpatient services as they related to client diagnostic characteristics, system ability to provide the service needed, and ability of the service to meet the client's perceived need.

The implications of the findings are clear. Access to services during a crisis was dependent upon system response, degree of psychopathology and a supportive environment. Any reform effort must include adequate crisis intervention and social services to meet the need of the changing population. Education for the general population and the professional would

enhance understanding of the needs of the mentally ill and service availability.

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CHAPTER 1

PROBLEM STATEMENT

The crisis in American health care has been well documented in the literature. As costs continue to escalate, and system provider retrenchment necessitates a reduction in available resources, access to services has deteriorated. The result has been that an increasing number of individuals in need of physical and mental health care have experienced difficulty with accessing the necessary health care services (Bachrach et al., 1990). An estimated 38 million people do not have health insurance and another 15 million are considered to be underinsured. Only one million of the 30 million senior citizens have coverage for long-term health care. Sixty percent of the poor are not covered by Medicaid. About one-quarter of this country's pregnant women received no prenatal care last year, a figure that has risen by 50 percent since 1980 (Mizrahi, 1991). The impact of these problems is significant to the future health care delivery system.

In the provision of mental health services, the organizational strains, service pressures and budgetary problems generated in the past decades have resulted in quantitative changes in service delivery. These changes have included a shift from inpatient psychiatric treatment to a greater focus on managing clients in an outpatient setting. Outpatient providers have been forced to serve a client population with high acuity levels that require greater amounts of collateral time that has been traditionally not reimbursed by third part payors. At the same time, a greater number of individuals have been seeking mental health services for a variety of complex reasons. The stress of changing family life, loss of employment, and reduced social supports all contribute to the deterioration in an individual’s overall ability to cope. The result has been an increase in service demand in an environment of diminishing resources (Astrachan and Schenl, 1991: Norquist and Wells, 1991).

As the system of previously available outpatient services becomes less accessible, the utilization of emergency mental health services has dramatically increased. The lack of adequate follow-up resources has resulted in significant qualitative changes in service delivery. Shifts have been reported in the social and demographic characteristics of persons utilizing emergency mental health services, in their mental health (and other) needs, and in the ways in which these services are utilized. The trend has been an increase in visits by younger, poorer, unmarried, and socially isolated persons, i.e. towards a greater volume of visits by individuals who lack social supports and/or material resources. In addition, many clients require not only psychological care, but also may be in need of jobs, food, shelter, education, and social support. All of these services are well beyond the original scope of the emergency mental health service focus of psychiatric evaluation, crisis intervention, and referral (Gerson and Bassuk, 1980; Ellison, et al., 1989; Bassuk and Schoonover, 1981; Bachrach, et al., 1990; Durenberger, 1989; Sureles and Mcgurrin, 1987; Mizrahi, 1991).

The emergency mental health service often functions as the point of entry into the larger system of mental health care delivery. In addition, due to the difficulty experienced with gaining access to the limited on-going outpatient mental health services, clients frequently utilize emergency services as primary care provider sites (Durenberger, 1989; Ellison, et al. 1989). With this critical role in the provision of care, the emergency mental health service can provide important data about access to the larger system. Therefore, the additional information about client need and resource availability gained through research into this area could be aimed at assisting the mental health planner in gaining enhanced understanding about both user and service need.

Purpose

This study was conducted to investigate the current barriers to access mental health care for the individual presenting in crisis to the emergency mental health service. The primary question of this investigation was "Do barriers to mental health care access exist for the individual in crisis?"

Although it has been recognized that numerous theories are germane to the nature of physical and mental health care delivery systems, this researcher has considered four significant theoretical perspectives associated with health care delivery systems, nursing, organizational development and the applied behavioral sciences as salient to this discussion. A conceptual framework was developed from the constructs contained within General Systems Theory, Crisis Theory, and those derived from Critical Social Theory and Social Support. A problem statement was derived from each theoretical perspective.

Delimitations / Limitations

The delimitations of this study were considered with the results obtained during the structured interviews in the Pre- and Post-interview. The data gathered during these interviews analyzed to determine client need and system service availability. The post-interview was intended to determine actual service accessibility as it relates to the client and evaluator description. The data gathered was intended to be inherently generalizable to other populations in similar settings.

The limitations of this study were consistent with the conditions and difficulties that exist in the process of collecting data within any emergency mental health delivery system. Included were: 1) an inability to access adequate numbers of clients who met the inclusion criteria; 2) discrepancies in staff interpretation of questions about service descriptions (inter-rater reliability); 3) inability of client to provide required information and/or to answer every question during the interview, either due to the client's unwillingness or degree of pathology; 4) inability to reach every identified client by mail or phone for six week follow-up interview; 5) lack of adequate time in the course of the interview process to gain the necessary information; 6) inconsistent interpretation and coding of the qualitative information obtained in the interview process.

A further limitation of this study was its inability to identify additional methods of intervention for the individual in crisis or to measure the effectiveness of the existing services. Research of this nature is recommended for further investigation.

Significance and Implications of the Study

Research into the area of access is important to the system of health care delivery since it can provide data about potential problems in the overall service system. This study was intended to expand upon previous research about the subject of barriers to physical and mental health care access (Astrachan and Schenl, 1991; Bachrach, et al., 1990; Ball and Havassy, 1984; Bassuk, et al., 1981; Burns, et al., 1981; Durenberger, 1989; Holder and Blose, 1987; Meyerson, 1987; Norquist and Wells, 1991).

In these works, a variety of methods were used to identify what, if any, barriers impede access to mental health care and for whom. Primarily through record review, staff reports and client function assessments based upon diagnosis, barriers related to broad categories were identified. Access concerns have been associated with service delivery structures, special population needs and societal trends. In addition, systems factors that affect accessibility have been identified as financial, geographic and attitudinal barriers, medicolegal controversies, and client readiness (Mitchel, et al., 1991). All of these factors are important considerations for the system of care if client need and service expectation are to be met.

There are several reasons further corroborating the importance of research of this nature. First, the emergency service component of the mental health system has been identified as one of the essential components of comprehensive community based care (Geller, 1991), and it is often the initial access point for all other aspects of mental health care. Second, it has been suggested that clients presenting to the emergency service often have a need for social support as well as ongoing psychiatric treatment. Both functions, however, are in contrast with the original conceptualization of the psychiatric emergency services as primary an evaluation and referral resource (Bassuk, 1988). Third, in practice, there appears to be longer waiting lists for outpatient mental health services for clients without insurance, who by the nature of their circumstances are a group identified as having high acuity and greater stressors.

This study was intended to gather information specifically about the outpatient mental health care access concerns for the individual experiencing a crisis. This research is significant to the system of mental health care for its information about the effects of more rapid intervention follow-up on the individual in crisis which has been identified as crucial for reducing the long term negative effects of the crisis.

General Systems Theory

General Systems Theory, when applied to living people systems provides a conceptual framework within which the content of the biologic and social sciences may be logically integrated with that of the physical sciences (Hersey and Blanchard, 1988). As early as 1963, Menniger reported that General Systems Theory when applied to psychiatry, offered a new resolution to the mind-matter dichotomy. This theory offered a new integration of biologic and social conceptualization to the nature of human beings, and a new approach to the delivery of mental health services.

Some nursing theories paralleled systems theory in their development. Martha Rogers (1970) considered man within an open system while Calista Roy (1981) focused on holistic person as an adaptive system. Each of these theorists based their assumptions on the basic notion of a systems approach to patient care which views the whole rather than the parts. The premise being that seeing the parts does not lend itself to understanding the functioning of the whole (Torres, 1986).

Any discussion of systems theory must consider that systems respond to change in the internal and external environment. Chin (1980) believed that practitioners must have a clear understanding of the individuals within the total system in order to make observations and diagnoses that lead to assumptions about client system. He reported that the system is never static and responds to the stress and strain that occurs within as well as outside itself. The system is constantly changing and attempting to achieve a balanced relationship between the parts.

The external influences on the larger system of health care delivery include overpopulation, pollution, homelessness, poverty, escalating costs, and a deterioration of the quality and availability of services. All of these contribute to an imbalance in the system (Mizrahi, 1991) and influence the human/individual relationship to the environment. Assuring access to mental health care for the client in crisis requires a clear understanding of the internal and external stressors affecting the individual within the context of his or her environment and of the health care system identified to provide the care.

The query for this investigation derived from General Systems Theory was "Are there system imposed barriers to outpatient mental health care access for the individual in crisis?"

Socialization Theory and Social Support

Human beings in western society are socialized to seek social contact and to rely on one another as they strive to meet their individual needs. Chin (1980) viewed socialization in the context of social matrices that affect the individuals "ways of looking at the world" and "ways of doing things." The extent of the social matrix determines the extent of the paradigm that is comprised of common ideas and practices developed from member interactions with one another. The content and process of these interactions influence the individual's perception of health and mental health. Social and cultural beliefs will influence the individuals ability access care in traditional settings, particularly in a crisis (Hoff, 1989).

A review of some of the social support literature provided a better scope of understanding of the external societal influences upon the individual. The effects of rapid social change, social and family disorganization, reduced family cohesiveness, cross-cultural migration, and psychosocial dysfunction on health outcomes are well documented. The literature identified "deprivation of meaningful social contact" as a common theme contributing to diminished health or well-being of the individual and therefore the system (Cassel, 1970; Cobb, 1976; Norbeck, 1982; Cohen, et al., 1984; Hoff, 1989). The quality of emotional and task-oriented support available from ones social network will greatly influence the outcome of a crisis. The perception of support assists the individual in mobilizing psychological resources (Caplan, 1974).

In consideration of Socialization Theory and Social Supports this investigation queried:

- "Are there social barriers to mental health care access for the individual in crisis?"
- "Do preceived social supports influence access to mental health care for the individual in crisis?

Crisis Theory

A crisis is described as an internal disturbance that results from a stressful event or a perceived threat to self integrity. A crisis occurs when a conflict, problem, or situation of basic importance to the individual is perceived as threatening and not readily resolvable by means of previously successful problem-solving methods. Crisis Theory provides health care professionals and the individual with a framework for assessing and alleviating those stressful situations for which the individual's customary problem-solving or decision making methods are not adequate. Crisis intervention is a form of brief, community-based therapy that utilizes a problem-solving approach to resolve the immediate stress-provoking problem in a growth promoting way (Aguilera and Messick, 1990).

Immediate, short-term intervention with individuals, families, and groups has been shown to be effective in reaching and helping larger numbers of people in distress and cutting down on the harmful residual effects (Caplan, 1974; Aguilera and Messick, 1990). However in the present mode of mental health care delivery, rapid intervention is often not readily available. Emergency mental health services are experiencing greater numbers of clients presenting in crisis who are faced with limited access to follow-up and ongoing intervention. This emergency access problem appears to be directly linked to the issues associated with the crisis in the organization of health care delivery. Budgetary limitations and service cutback, shifts in third party reimbursement, and changes in the characteristics of the client population all play a major role in limiting access (Brecht, 1990).

Queries generated from Crisis Theory for this investigation included:

- "Does waiting time for rapid follow-up care access influence the individual experiencing a mental health crisis?"
- "How does the individual in crisis describe the effectiveness of the follow-up services?

Critical Social Theory

When considering the factors that influence access to any type of health care critical social theory can be instrumental to accurate assessment. Critical social reconceptualization of the environment involves uncovering and critiquing the oppressive social structures that constrain an individuals health, limit life possibilities, and restrict their equal and fully conscious participation in society (Stevens, 1989).

The more accurately and extensively that individuals are able to perceive and reflect upon their social, political, and economic environment, the more effective they become in their interaction with the environment, a condition that is the essence of health. Through a critique of the persons lived experience one can determine how within the accepted social structures the experience of privilege, exploitation and powerlessness are distributed among persons and groups in the society. Racism, sexism, classism, ageism, and heterosexism are some of the fundamental dogmatic ideologies that are internalized in social structures and thus operate in unexamined ways. These kinds of ideologies both limit the concrete alternatives open to individuals and maximize the life opportunities of some groups by minimizing those of others (Allen, et al., 1986).

Research and analysis within the realm of critical social theory promote conscientization among persons who are impeded by oppressive constraints. They bring about conditions in which oppressive elements are illuminated and a dialogue about action for change can occur. But they do not prejudge or mandate the future actions of persons involved (Habermas, 1973). Offering challenges and identifying possible strategies for action in critical social research and theory can serve to interpret hypothetically the constellations of struggle for liberation and political change and can open up a liberating perspective. Critical social theory can only aid in the anticipation of strategic action; it does not compel action, because that would elevate those who do the research and theorizing above those who are experiencing the phenomena addressed by the theory, in itself a situation of domination (Stevens, 1989).

The queries generated from critical social theory for this investigation included:

- "What individuals in crisis have ready access to follow-up mental health services?"
- "How do the individual and evaluator describe mental health care needs during a crisis?"
- "What are the oppressive barriers to mental health care access as described by the individual in crisis and the evaluator?"

In sum, several of the problems associated with obtaining access to mental health services for the client in crisis have been discussed. The purpose of this investigation was to identify and describe the specific barriers to mental health service access for the individual presenting in crisis to the emergency mental health service.

CHAPTER 2

REVIEW OF THE LITERATURE

Emergency Mental Health Service as the Access Point: Utilization

In 1963, the Community Mental Health Centers Act in the United States mandated that the care and treatment of the mentally ill shift from the institution to the community. The result was the establishment of community based outpatient and residential programs specifically designated for the chronically mentally ill. In the development of this system of care, emergency services were identified as one of the essential components of a comprehensive community care system (Geller, 1991).

The intended purpose of this approach to treatment was to improve the quality of care through a supportive and therapeutic network of comprehensive care in an environment within the general society. The general assumption was that the well being of the mentally ill was to some extent influenced by the social context within which they lived. More specifically, derivations of the socialization theory state that the success of the reintegration of the mentally ill into society is affected by the attitudes of the primary caregiver, family members and the general public (Meyerson, 1987). The goal of the emergency component was to provide early intervention for chronically ill and disadvantaged psychiatric patients who were presenting to general hospital emergency rooms (Wesbrod, et al., 1980).

The progression of deinstitutionalization has further accentuated this trend and has led to a growing number of chronically mentally ill clients seeking emergency care. Bassuk and Schoonover (1981), in a review of psychiatric emergency services reported that the volume of psychiatric emergency client visits to Beth Israel Hospital in Boston increased from approximately 800 visits in 1970 to 1500 in 1980. These figures were consistent with the national pattern of increased utilization estimated at around 300 percent for that time period. In a later study conducted in Philadelphia, Sureles and McGurrin (1987) reported an increase in emergency psychiatric client visits of approximately 15 percent each fiscal year between 1980 and 1987. This study also revealed an increase in length of stay per visit and in repeater visits to the service.

Swigar, et al., (1988) reported on the characteristics of clients (n=202) utilizing the Connecticut mental health crisis system units. The survey indicated that at least one third of the clients who were hospitalized could be treated in a timely manner with energetic acute alternatives. The target population best served in alternative settings consisted of clients who were poor or near poor, chronically and/or severely ill, lacking in social supports, and needing crisis oriented inpatient or community based stabilization with rapid connection to aftercare. Key to this service delivery model is access to alternative interventions for both the acute first time or chronic client.

Arriving at a clear definition of what constitutes an emergency has contributed to the client, provider and system dilemma of access and availability of care through the mental health emergency services. Often it is the lack of an available social support system and treatment alternatives, not necessarily the severity of the psychopathology, that constitutes an emergency.

The emergency clinician knows more about the immediate management of the severely suicidal or acutely psychotic individual than of the individual experiencing a first time, less severe crisis (Bassuk, 1980). In addition, Gerson and Bassuk (1980) reported that those clients perceived by the system as most "difficult" were chronically maladjusted individuals who had scanty social supports and were difficult to engage in continuing treatment. They found that "chronic crisis" clients have increasingly become the responsibility of the emergency provider not because of the services provided by most emergency units but because of the status of the emergency psychiatric service as the easy access or "last resort" facility.

In a study (n=130) of who presents and who frequently repeats to the emergency psychiatric service, Ellison, et al., (1989) found that first time users were often those with acute anxiety or major psychosocial difficulties, including recent unemployment, and minimal or no insurance. Frequent repeaters were those individuals with chronic mental illness and a prominence of anxiety or impulsive disorders. The repeater also had previous or concurrent outpatient treatment that was not able to meet the client’s acute needs.

What seems evident is that the rapid progression of deinstitutionalization and the shift towards a community-based system of care for the mentally ill have had a marked effect on the delivery of services in community centers and in general hospitals. The development of a comprehensive range of community alternatives has not kept pace with the closing of large numbers of state hospital beds and the increasing number of clients seeking first time services (Ellison, et al., 1989).

The decades since the development of community based services have evidenced significant quantitative and qualitative changes in utilization patterns of psychiatric mental health services. Not only has there been a 15 percent increase in the overall utilization of emergency services (Bassuk and Rosenburg, 1988), but the manner in which the psychiatric emergency facility is perceived and utilized is also changing. More specifically, such facilities now often serve as key entry points to the larger network of mental health services. The emergency component frequently functions as primary caregiver and, at times, as sole source of treatment (Gerson and Bassuk, 1980). The emergency facility has thus come to function as a source of social support as well as a source of ongoing psychiatric treatment. This provider role is in sharp contrast to the original conceptualization of the psychiatric emergency facility as primarily an evaluation and referral resource for psychiatric crisis care (Bassuk and Schoonover, 1981).

Several factors have contributed to this trend. As previously mentioned, the deinstitutionalization movement of the sixties served to shift the responsibility of mental health care from centralized institutions to community based alternatives yet the development and/or expansion of these alternative treatment resources were seldom adequate (Bassuk, 1980). The resulting elevated proportion of severely or chronically mentally ill individuals in communities with insufficient mental health resources has pressed hospital based emergency facilities to assume a central role in the management and crisis intervention needs of this population. The emergency facility often functions as the "revolving door" between the client and the established mental health service network (Bassuk and Schoonover, 1981).

Utilization patterns are also reflecting changes in the social and demographic characteristics of individuals using emergency psychiatric services (Gerson and Bassuk, 1980). Greater numbers of young clients with a variety of problems are being seen as are greater numbers of drug and alcohol related problems (Szusler, et al., 1990). An increasing representation of people in lower socioeconomic groups has been noted due to inadequate insurance as well as a growing trend in the general population towards using emergency facilities in both medical and psychiatric situations other than true emergencies (Swigar, et al., 1988).

In a study (n=2358) of the characteristics of users of psychiatric emergency services and the disposition resulting from the encounter, Slaby and Perry (1981), found that factors associated with social isolation and poverty appeared to be linked to both initial presentation, multiple episodes and disposition to a public inpatient facility. Black males who were in the age range of 50 to 94, divorced, separated or widowed and with less than a high school education and/or with a diagnosis of alcoholism were significantly above the mean percentage for disposition to a public inpatient facility. White females who were in the age range of 16 to 39, married or single, with at least a high school education and diagnosed as having a personality disorder, neurosis or transient situational disturbance were above the mean percent for referral to either an inpatient or outpatient facility in the community. Those who had greater psychopathology and with fewer social supports, appear more likely in this study to have been sent to a distant (more than 45 miles from the community studied) public inpatient facility for either psychiatric treatment or detoxification. Only a very few during the year studied were eligible and sent to a local Veterans Administration Hospital.

One hypothesis intended to explain the findings developed from this study was that individuals were referred to the public inpatient facility because of an inability to pay or lack of insurance coverage. This group tended to be of lower socioeconomic status with less than a high school level of education, more socially isolated, and generally more disadvantaged.

Psychiatric emergency services have been thrust into the forefront of mental health care under circumstances of increasing client demand, rising costs, changes in reimbursement rates, and reallocation of resources in both the public and private sector. The significance of this development is further weighted by the potentially dramatic impact of the emergency psychiatric intervention on the course of the client's problems and the subsequent treatment (Gerson and Bassuk, 1980). The critical role of the emergency psychiatric service in relation to the client's urgent and longer-term needs and the high costs of providing such services underscores the need to more accurately assess the situation and to anticipate the client's mental health needs. Greater specification of current client profiles should serve to aid mental health planners in designing appropriate and efficient services (Nurius, 1984).

There is a critical role of the emergency psychiatric service provider in the total spectrum of mental health care delivery. The high cost of provision of these services makes it imperative that mental health planners understand what drives an individual to seek help on an emergency basis and what causes them to return, rather than continue in treatment elsewhere in the system (Slaby and Perry, 1981).

Crisis Population with Special Needs

The concerns affecting the delivery of emergency mental health services include issues related to special needs populations. In the past few decades, clinicians have identified client groups who have special needs affecting traditional assessment and treatment. The care of adolescent and geriatric clients has required emergency service providers to consider developmental and psychosocial issues that differentiate these groups from young and middle-aged adults. Victims of rape and domestic violence, young adult chronic patients, the psychiatrically impaired homeless, and emergency service repeat visitors are additional groups whose care issues demand attention to a broad range of intrapsychic, medicolegal, and socioeconomic considerations (Ellison, et al., 1989).

These groups are reviewed below with respect to their special needs in the psychiatric emergency service.

Adolescents

By virtue of their dramatically increasing suicide rate alone, adolescents have forced their way into psychiatric and public awareness during recent years (Hillard, et al., 1987; Rome, 1985). Suicide attempts, gestures, ideation and self-destructive behaviors are more than twice as common among adolescent clients presenting to the psychiatric emergency service as among adult clients (Hillard, et al., 1987).

In contrasts to adults, who more often describe multiproblem precipitants of crisis, adolescents tend to present with a single identifiable problem. A family crisis is the single most common precipitant of an adolescent emergency visit and is three times more likely to be a precipitant than for adults (Hillard, 1987).

The prominent role of the family in an adolescent's life is also reflected in data on referral and residential patterns. While the majority of adults are self-referred, adolescents are more often referred by family members or friends. Most adults seen in the psychiatric emergency service live alone or with a spouse, while the majority of adolescents live with one or both parents (Hillard, 1987).

As with adults, alcohol or substance abuse often initiates or compounds an adolescent's crisis. Recent studies indicate that approximately 20 percent of adolescent and adult psychiatric emergency cases involve substance abuse (Rechler, et al., 1983). In contrast to adults, however, adolescents more often have patterns of mixed or non-alcoholic substance abuse (Hillard, 1987).

Adolescents presenting to the psychiatric emergency service are less likely than adults to have had previous outpatient treatment (Hillard, 1987). The emergency service interventions can have even more powerful and lasting consequences as a result. Because of the special needs of adolescents in crisis, psychiatric emergency service staff should understand developmental, family, and systems issues, and families should be involved when appropriate. Referral for follow-up treatment involving other agencies is often necessary, so emergency service staff must be aware of available adolescent services. Special staff training or access to experienced consultative staff facilitates diagnosis and treatment planning with this group (Ellison, et al., 1986).

Geriatric Clients

Clients age 65 or older account for 12 percent of the population of the United States but only 2 to 5 percent of the clients seen in the psychiatric emergency service (Bassuk (1), et al., 1983). Among the explanations proposed for this under-representation are the geriatric client's bias against psychiatric care and the availability of other services, such as those available through social service agencies with staff trained to respond to crisis among the elderly (Herst, 1983). However, geriatric clients have increased their use of psychiatric emergency services in recent years, particularly for severe behavioral problems associated with organic disorders such as Alzheimer's Disease and dementia (Abrams and Alexopoulos, 1987).

As with adolescents and younger adults, substance abuse is an important diagnostic consideration with the geriatric client. In a recent survey of psychiatric emergency services, Abrams and Alexopoulos (1987) found that alcoholism was diagnosed in 4 to 19 percent of patients over sixty. Misuse or abuse of prescribed medications may also complicate the picture, as may concurrent medical disorders or depression, both of which are common among the elderly (Bassuk (1), et al., 1983); Winogrond and Mirassou, 1983).

Evaluation and treatment of geriatric clients in crisis require modification of procedures designed for use with younger clients. Of particular importance in the hectic and confusing environment of the emergency setting is acceptance of the need for a lengthier evaluation, due to the quantity of information that must be gathered. If cognitive dysfunction, psychosis, or psychomotor retardation impair the client's cooperation, there is a need to draw on adjunctive sources of information such as social agencies, family members, and physicians. The medical history and cognitive mental status examination are particularly important with geriatric clients because of the physical complications associated with the aging process (Herst, 1983).

Any medications prescribed for elderly clients must take into account their increased sensitivity to side effects and their decreased drug clearance. The risk of suicide, which is increased by the presence of substance abuse, medical illness, or depression, requires careful assessment. Treatment of geriatric crises usually requires both acute intervention in a complex biopsychosocial system and careful attention to follow-up services (Ellison et al., 1986).

Victims of Rape and Domestic Violence

A growing literature provides guidelines about the special difficulties and emergency needs of these two groups. Rape, the fastest-growing violent crime in this country, affects both sexes and all ages. Though most rapes are never reported, victims who do seek help often turn to a medical rather than a psychiatric emergency service. Thus collaboration between medical and psychiatric staff is crucial if psychological help is to be offered. Prompt initiation of rape counseling is increasingly recognized as important, based on evidence from follow-up studies that many victims suffer prolonged post traumatic disturbances when this service was not available (Hicks, 1978; Smith, 1991).

In response to the profusion of medical, forensic, and behavioral problems that follow rape, some hospitals have developed a multi-disciplinary team approach that combines the services of specially trained mental health and medical staff (Lenehen, et al., 1983). This approach permits coordination of medical and counseling services from the beginning of treatment, limits the number of additional people to whom clients must recount their experiences, and facilitates constant availability of support. Current emergency treatment also emphasizes the value of an interview style that combines personal concern with professional objectivity. The psychiatric emergency service should facilitate the victim’s use of outside supports and should refer the victim to a specialized rape follow-up program when one is available (Lenehen, et al., 1983; Davis, et al., 1991).

In recent years, victims of domestic violence were more readily recognized by clinicians in medical emergency settings, primarily due to increased awareness through training and education (Davis, et al., 1991). One study estimated that domestic violence victims account for 22 percent of all clients seen in general emergency rooms. Evidence suggests that such individuals often accept counseling or resource information when it is offered, yet fewer than 50 percent are referred for psychiatric evaluation and follow-up (Goldberg and Tomanovich, 1984).

When victims of domestic violence request emergency assistance, they present special medical and forensic needs. Social services, including emergency housing, money, and food, are often required. The medical or psychiatric emergency service should maintain a list of resources, including battered women's shelters, and staff should be aware of legal avenues of protection, including police interventions or court restraining orders if the victim chooses to return to the setting in which the violence occurred (Ellison et al., 1989).

In addition, early in 1991 changes in the state and federal statutes have provided police with greater powers to intervene in domestic disputes. With this new legislation, police have the power and the obligation to remove the abuser from the scene and/or provide protection for the abused individual. The Department of Social Service is also reviewing the laws surrounding rights of children in chronically abusive situations.

Young Adult Chronic Clients and the Psychiatrically Impaired Homeless

These two groups form overlapping groups whose needs are poorly met by conventional treatment agencies and who often turn to the psychiatric emergency service in times of crisis. Young adult chronics form a generation of uninstitutionalized clients and present complex psychosocial problems complicated by major mental illness and substance abuse. Their repeated demands have often exhausted available social supports. Though they are difficult to engage in traditional treatment relationships, the emergency service can sometimes function as their portal of entry to a range of needed services (Schwartz and Tomanovich, 1984; Sureles and McGurrin, 1987).

The psychiatrically impaired homeless often avoid contact with the health system, though they suffer from a multitude of medical and behavioral disorders. For many of the homeless, basic survival needs are of greater importance and urgency than treatment for their mental illnesses. In some cities mobile outreach services have helped these individuals obtain shelter, food, clothing, and medical and psychiatric care (Ball and Havassy, 1984; Weinreb, L. and Bassuk, E., 1990).

In a study of family homelessness, Bassuk and Rosenburg (1988) compared 81 housed female-headed families with 49 homeless female-headed families in Boston. This study found the frequency of serious psychiatric problems was greater among the homeless mothers and the children of these mothers had serious developmental and emotional problems. This group was found to have a history of family violence and their support networks were fragmented; the housed mothers had female relatives and extended family living nearby whom they saw often. The data suggested the need for increased assistance from social welfare agencies focused on rebuilding supportive relationships and stability for these homeless families.

Repeat Visitors

Recividists constitute 7 to 18 percent of total psychiatric emergency clients. However, they account for a disproportionate number of visits and for the majority of negative staff countertransference. A study of utilization (n=3835) conducted by Ellison, et al., (1986) differentiated between early repeaters, those who returned to the psychiatric emergency service within a month's time, and later repeaters, those who returned after more than a month. Early repeaters, or those who make a cluster of visits, may be individuals with unresolved crises who temporarily need increased support, while later repeaters often suffer from chronic and severe mental illnesses, most often substance abuse, severe personality disorders, or psychosis. Like deinstitutionalized and young adult chronic clients, the latter group used the emergency room as part of the network of mental health services that helped maintain them in the community.

Current treatment approaches in the psychiatric emergency service stress the importance of maintaining a respectful, formal manner with repeaters to avoid encouraging a primary treatment relationship. With repeaters who habitually respond to stress with self mutilation or suicidal behavior, emergency staff must take special care to provide appropriate assessment and treatment without reinforcing the self-destructive behavior. Any other caregivers involved in the client's treatment should be contacted so that a collaborative treatment plan can be formulated.

Periodically, brief hospitalization may be necessary (Ellison, et al., 1989).

Aids and Its Impact on Delivery of Emergency Mental Health Services

A series of studies attest to the alarming frequency with which medical illness may cause or exacerbate psychiatric symptoms. The prevalence of such disorders among psychiatric clients is estimated at between 24 and 80 percent (Labruzza, 1981). In many cases, the medical illnesses have been previously undiagnosed (Hall, et al., 1978).

In recent years the degree of medical attentiveness required of psychiatric emergency service clinicians has increased because of the spread of acquired immune deficiency syndrome (AIDS) and related disorders. In June, 1981, the Morbidity and Mortality Weekly Report bore the first report of what was to be defined as acquired immune deficiency syndrome (MMWR, 1981). It was taken seriously by only a handful of professionals. Since then, more than 179,000 Americans have been reported as developing AIDS; it has been estimated that worldwide HIV has infected eight to ten million adults and a million children (MMWR, 1991).

As with any crisis, people have responded with denial, fear or hatred. In a report on nursing and AIDS, Moyer (1991) conducted interviews of nurses in California involved in the caring for the early victims of the epidemic in 1981. He reported how one nurse experienced one of the earliest incidents of AIDS hysteria. An emergency room physician at another hospital, where one of her patients had shown up with a fever, phoned for information. When she told him that the patient had epidemic Karposi's Sarcoma, as it was called at that time, the physician replied, "I've heard of that" and then she heard him scream to his staff, "Get away from him - he has that disease!" Since that time, Moyer reports that nurses have had a significant role in educating other health professionals.

Though most of new cases nationwide still occur in gay or bisexual men, the epidemic has undergone a metamorphosis over the decade. In many parts of this country those infected through IV drug abuse predominate and their sex partners and children have followed in the wake. Care for these patients has proved profoundly different from the care of the cooperative, middle-class gay men with social support networks. New York's Bellevue Hospital reports entire families who are infected. Many are still using drugs and don't know how to go about getting help. When they get services, they don't know how to keep them. They often receive a notice about benefits in the mail from Medicaid and don't follow-up on it (Moyer, 1991).

The clinical problems have been formidable. Even before prominent physical evidence of the disease appears, HIV positive and AIDS clients may seek emergency psychiatric help because of behavioral symptoms. Symptoms of AIDS encephalopathy appear in 30 to 40 percent of AIDS clients and may manifest as dementia, delirium, or depression. Dementia may be the first sign of the illness. Delirium more often occurs later, in up to 50 percent of AIDS clients who are medically hospitalized, and typically results from a secondary infection or electrolyte disturbance. Presentation of AIDS in the guise of acute psychosis has also been reported (Fraulstich, 1987; Perry and Markowitz, 1986; Beckett, et al., 1987).

The emergency service may also become involved because of psychodynamic factors related to HIV infection or to the establishment of a diagnosis. AIDS clients face emotional problems brought on by the illness itself, the reactions of others, and the prospect of death. Many of those at risk for AIDS already have suffered poverty and prejudice, and the addition of an AIDS diagnosis often precipitates crises related to job loss, eviction, social ostracism, and difficulties obtaining medical or legal services. In the early stages of AIDS, when adaptation to a profoundly serious illness is taking place, the large majority of clients show symptoms of an adjustment disorder or depression (Perry and Markowitz, 1986).

In addition, fear of AIDS among the uninfected or "worried well" is taking its psychological toll. Increasing numbers of uninfected individuals seek help for symptoms arising from a fear of AIDS. Contributing to these fears is the fact that early symptoms of AIDS may resemble anxiety or depression, each of which may include weight loss, lethargy, or increased sweating. Thus clinicians in the psychiatric emergency room must now consider HIV infections or fear of AIDS when evaluating clients with a broad range of syndromes including adjustment disorders, depression, anxiety, psychosis, delirium, and dementia (Fraulstich, 1987).

AIDS' growing presence makes sexual and drug abuse histories essential components of medical or psychiatric evaluation. Appropriate information to request includes the clients relationship status, drug abuse practices, HIV status if known, and precautions for avoiding the spread of AIDS. Doubts about the comprehensiveness of current approaches were intensified by the report of a survey of 1,000 internists in California, the state with the second-highest in number of AIDS cases. Sixty-five percent reported that they did not ask new or continuing clients about their sexual orientation or practices (Psychiatric News, July, 1987).

At the time of the California study, these questions were not being asked frequently enough in the psychiatric emergency service either. Health care providers' discomfort with this type of questioning can interfere with information gathering, delay the recognition of sexually transmitted illnesses, and impede counseling about high-risk behaviors. Just as important, the clinician's discomfort is apparent to the client, who is then less likely to admit worries or seek information about sexual practices (Psychiatric

News, July, 1987). Since that time, organizations like the California Nurses Association have developed educational programs aimed to address not so much the lack of knowledge as the fears and prejudges that would stand in the way of learning. In the past five years, California's program has educated some 85,000 health care providers in that state (Moyer, 1991).

Substance Abuse Trends

By conservative estimates, the lifetime prevalence of substance abuse in the United States is near 15 percent. Among the chronic mentally ill, the rate of alcohol abuse is at least several times higher. The complications of alcohol and opiate abuse and dependence, as well as the increased use of cocaine and inhalants impact the psychiatric emergency service (Ellison, et al., 1989).

Psychiatric emergency service clinicians must watch for the dangerous complications of acute intoxication. Cocaine induced psychosis and withdrawal can lead to severe depression, irritability, fatigue, hyper-insomnia and increased risk of suicide. Emergency services should encourage abusers to enter detoxification and drug counseling programs (Ellison, et al., 1989).

The substance abuser who also takes prescribed psychotropic medications presents special considerations in the emergency evaluation because of the many interactions between abused and prescribed substances. In many combinations, anticholinergic effects produce toxic symptoms ranging from discomfort to delirium. Alcohol can increase the sedative effects of antipsychotics or antidepressants. Combined acute ingestion of alcohol and tricyclic antidepressants can triple plasma levels, enhancing toxicity. Alcohol’s fluid load and diuretic effect can destabilize lithium levels (Weller and Preskorn, 1984). Stimulant abuse can interfere with antipsychotic medication’s effect on psychosis and can precipitate hypertensive reaction in clients taking prescribed antidepressants. Opiate abuse can augment sedation, respiratory depression, or postural hypotension in clients taking antipsychotics (Glassman and Salzman, 1987).

The scope and complexity of the emergency psychiatric service has greatly increased in the past decades. The emerging of special client populations, new substance abuse patterns, and AIDS have complicated the service activity. Since the emergency service has evolved into the frequent entry point into the mental health system, planners of mental health services need to consider the impact of these special populations on the overall delivery of mental health services (Ellison, et al., 1989).

Systemic Barriers Affecting Access To Mental Health Care Services

In the previous review of the literature on the utilization of emergency mental health services and their role as the access point to mental health services, recent trends in utilization and special clinical considerations for client crisis have been discussed. The circumstances affecting individuals at the time of a mental health crisis contribute to the complexities of emergency care and follow-up treatment. In addition to the access concerns associated with service delivery, special population needs and societal trends, a variety of general systems factors may affect accessibility such as financial, geographic and attitudinal barriers, medicolegal controversies, and client readiness (Mitchel, et al., 1991). In this section, these barriers to mental health care access are discussed.

Financial Barriers

Financial barriers to health care access exist when people do not have a source of funds to pay for personal acute and chronic care. The proportion of people covered by private health insurance is shrinking because the number of part-time and service industry jobs, which provide limited or no insurance coverage, is growing while the number of manufacturing and transportation jobs that traditionally provided coverage is shrinking (Hudson Institute, 1989).

Private insurance is not the sole source of financial access to health care. An additional 9.3 percent of the population is covered by Medicaid. While Medicaid was instituted to improve access for the poor, federal budget cuts during the Reagan years have drastically reduced to proportion of indigent persons actually served by this program. While the number of persons with incomes below the federal definition of poverty has grown by nearly one third since 1978, the number of Medicaid recipients has remained stable.

This is largely due to the fact that eligibility requirements were tightened, so that an individual or family must be much "poorer" to receive Medicaid benefits (Norquist and Wells, 1991).

Having no health insurance at all is the most obvious financial barrier to access. The percentage of uninsured has been steadily rising since 1970, with as many as 12 million children among the uninsured. Only 18 percent of the uninsured are unemployed workers or their dependents, with the remainder being part-time or full-time workers and their dependents whose employers do not offer health insurance. Estimates of the "underinsured" (those with some insurance but who would face severe financial hardship or even ruin with a major illness) have ranged from eight to 26 percent of the insured. The uninsured and underinsured are less likely than the adequately insured to seek preventive care or early attention to existing health problems. The uninsured and underinsured together have been estimated to be as many as 27 percent of the population, or nearly 56 million people (Mitchel, et al., 1991).

Assuring access to health care for all Americans has become one of the major health policy issues facing the nation as we enter the 1990s. This past decade began with significant funding cuts in key federal health programs such as Medicaid, Community Health Centers, and Community Mental Health Centers. The impact of these cuts was amplified by the recession of the early 1980s, leaving hundreds of thousands of low-income citizens with severely restricted access to health care as they either could not afford care, or the sources of care were limited. The financial difficulties associated with health care continue to affect how care is provided in the 1990s (Brecht, 1990).

Access for the poor to mental health services is varied and in many sections of the nation reflects Medicaid payment policies and the availability of state and/or county-supported programs. Norquist and Wells (1991) demonstrated that in Los Angeles, a relatively resource-rich community with fairly extensive state-supported services, those without health insurance may well have less adequate access to mental health care than do poor residents who are eligible for Medicaid, yet the Medicaid-eligible residents and uninsured residents had similar prevalences of serious psychiatric disorders.

The experience with chronic mental illnesses over the last two decades provides at least one clear lesson as we contemplate the needs of those who lack access to care for mental illnesses because they are uninsured or poor: while there is much that we do not know and must study at length and in detail, there is much that is known, and that we do not use. More might be done had our society the desire and the will (Astrachan and Schenl, 1991).

We often act as though poverty, dishonesty and dishonor were synonymous. We want to be sure that the poor merit the care that we provide them and that public support of their care is absolutely necessary. While the advent of Medicaid and Medicare profoundly altered the relationship of the medical profession to the disadvantaged, societal attitudes toward the poor were not dramatically changed. These entitlement programs made it possible for physicians to be paid for services that had formerly been rendered free. The inability of individuals to pay for care, something physicians believed they had to deal with individually, instead became a matter removed from individuals and assigned to "society," its accountants, and its regulators. Concurrently, medicaid, in many states and for many services, reimbursed physicians so poorly that the client's perception of an entitlement and the physician's sense of being forced to do what one would rather not do conflicted, building further distrust. In the process, the individual relationship of the practitioner to the client, and the duty each has to the other, has been changed in ways that are difficult to comprehend (Astrachan and Schenl, 1991).

Reports of worsening or stagnating physical and emotional health among the poor, and a rise in number of uninsured citizens, led Congress to consider steps in eliminating one of the most serious barriers to care: the inability to pay. In the mid-1980s, Congress passed legislation expanding eligibility for Medicaid to include more and more pregnant women and young children. As important as this was, however, Medicaid eligibility alone is no guarantee that necessary services will be obtained. Evidence abounds of inadequacies in our health care system which especially affect the poor (Brecht, 1990).

Some alternative is needed for the unemployed who are poor and without community-provided care. It is recognized that sickness destabilizes an already marginal life. Chronic illness strains the capacity of even caring friends and relatives. The poor who are ill have difficulty negotiating multiple service systems. While access to care may be available, it may be difficult to maintain treatment. Disabling mental illness and chronic physical illness are equally devastating to the client and any supportive individuals (Astrachan and Schenl, 1991).

Geographic Barriers

Location of the site of health care delivery can negatively impact the access to care. Geographic barriers exist when a population is distant from a source of health care, as is the case in many rural areas. As the competitive mode of containing costs of hospital care gains momentum, small hospitals, that provide health care to rural areas become less and less financially viable. The lack of viability is reflected in the increasing rate of hospital closures in small often rural facilities (Mitchel, et al., 1991).

The urban communities are experiencing equally devastating consequences, as recently experienced with the closure of Worcester City Hospital in Worcester, Massachusetts. This 400 bed facility that generated 60,000 outpatient visits per year was the primary provider of all facets of health care for the city. The largest segment of the population served by this facility was the local neighborhoods in which reside the highest percentage of poor, disadvantaged, and chronically ill individuals and families. The area surrounding the hospital campus is site of the largest concentration of residential and subsidized housing for children and adolescents, elderly, mentally ill, homeless, and substance abusers.

As facilities similar to Worcester City Hospital consolidate and either eliminate some or discontinue all services, a cycle of difficulties is initiated for the general population served by that facility. In the best of circumstances, the poor, very young, elderly, and physically or psychologically challenged often have difficulty negotiating or paying for public transportation. Greater distances and a different location of often larger more complex facilities further complicate the process of getting to an appointment or to the emergency room. In addition, when faced with changes in service delivery sites, this population is often suspicious and reluctant to go elsewhere.

The combination of these factors frequently results in an interruption in or cessation of on-going treatment for acute or chronic disorders which further contribute to overall health problems. Predictably, when the physical or psychological state deteriorates and an acute emergency develops, the greater geographic distance necessary to travel for access to care, further exacerbates the difficulties experienced by this undeserved group (Mitchel, et al., 1991).

Of equal concern is the effect of geographic barriers on the client’s support system. Physical and psychological treatment today is largely dependent upon family involvement to assist with care. Greater distances limit the ability of families to participate in the care of ill members. The lack of integration of social support further isolates the client from effective health care (Briones, 1990).

The geographical configuration of community based mental health care often poses problems for client and family alike. Catchment areas designated with the responsibility for the provision of outpatient and emergency mental health services require travel over great distances to access the "designated site" for service (Bassuk, 1980). On-going assessment of family stability and ability to reintegrate the member are greatly dependent on participation in regular family meetings. In addition, the inability to participate in planning often leaves family support systems unprepared to assist the client with compliance in complex ongoing treatment regimes.

Attitudinal Barriers

Although we speak of health care insurance, the majority of public and private plans to compensate individuals for the costs of care do so for episodes of disease, sickness, or those health care visits that can be forced into a category of disease. A true health care system would encompass those activities that promote health as well as prevent, treat, and rehabilitate from disease. As Mitchel, et al., (1991) pointed out, a true health care system would use a "health-promoting, public policy strategy" and would integrate those social factors such as adequate housing and nutrition that influence the development of disease with the long term support and personal services necessitated by chronic illness. The common tendency to define health promotion in terms of prevention or early detection of specific diseases perpetuates the medicalization of health care, makes health promoting activities commodities in the market place, and leaves the promotion of community and societal health outside the health care system.

Medicolegal Barriers

In recent years increasing attention has been paid to the medicolegal aspects of psychiatric emergency care. Because the emergency service, particularly the psychiatric emergency service, so often treats involuntary, incompetent, or dangerous clients, concerns have been raised about the protection of the individuals' rights and the safety of those potentially in danger from violent individuals. Among the most clearly delineated areas of current controversy are the regulation of involuntary hospitalization, clients' rights to refuse involuntary treatment, and clinicians' "duty to warn" individuals in potential danger of harm (Ellison, et al., 1989).

The legal controversies influencing psychiatric emergency care have a great affect upon access to mental health services. Commitment laws vary from state to state, providing a wide range of standards and procedures for hospitalization. Increasingly restrictive guidelines that focus primarily on the criterion of dangerousness have limited the power of emergency services to impose treatment on non-dangerous but severely impaired individuals such as those incapable of looking after their own needs for safety and shelter. An important trend is the effort to obtain legislation that recognizes the need to commit clients who are not likely to cause physical harm but nonetheless demonstrate severe mental disordered and incapacity to make an informed decision about treatment (Appelbaum, 1985). Changes in legislation would enable access to care before the individual decompensates to the level of dangerousness.

The client's right to refuse treatment presents another access issue, and emergency services must take into account the decision in Rogers v. Commissioner (Nov. 1983) and other recent cases. The Rogers decision specifies that involuntary use of medication is permissible in cases of threatened violence in an emergency, but judgement of what qualifies as an emergency has been controversial. The issue focuses on the concern that clinicians will avoid using seclusion or medication even when clinically indicated for fear of violating the Roger's decision's recommendations (Gutheil, 1985). Access to care is hindered when legal concerns interfere with clinical judgement.

Also important to psychiatric emergency service clinicians are the medicolegal concerns raised by the "duty to warn". It has been more than 14 years since the California Supreme Court's original Tarasoff decision in 1974. In 1985, a further clarification of the law that requires psychotherapists to warn and protect third parties of the risk of serious treat of physical violence was made (Tarasoff 1976 and 1985). However, again it is questionable if the results and effects of this law are the best way to help a client or even to help a third party.

Client Readiness Issues

The association of values, belief and ethics encourages examination of societal attitudes toward individuals with severe physical disability and mental illness. The disabled are often shunned due to the social stigma associated with the disease (Goffman, 1963). Seeking help for a mental disorder often has risks associated with it. The emergency service must be sensitive to the cultural influences affecting the client in crises and the impact of these influences upon effective referral and follow-up.

Ethnicity and socioeconomic status of the individual and the support system should be considered by the emergency clinician. These issues of diversity are a crucial part of a multiplicity of factors leading to a decision to seek help during periods of emotional crisis. Specifically, ethnicity and socioeconomic status indirectly affect this decision by influencing such factors as having a support network and the tendency to become depressed. All of these factors are powerful predictors of utilization readiness of the client (Briones, et al., 1990).

The ability to focus on the cultural diversity and the special considerations it brings especially to the emergency mental health setting has not been a priority in education and staff development. Only in the past several years has UMass Medical Center in Worcester, Massachusetts actively developed a program that provides both skilled interpreter services 24 hours a day and training in cultural diversity for staff and students. This highly effective program is directed by a nurse and represents the facilities long overdue recognition of the diversity of the population it serves. Through a variety of educational and awareness programs for staff and students, major teaching facilities like U-Mass Medical Center could enhance access to the health care services provided by the facility.

In sum, the barriers to all facets of health care access are numerous and complex. In this discussion of the barriers to mental health care access, concerns affecting the ability of the system to provide emergency mental health services have been considered.

The literature indicates that in recent decades various techniques have been explored to determine interrelated health and mental health care needs and the related access issues. Most commonly used has been community surveys, social indicators, selected community opinions, and service statistics.

The studies of outpatient mental health service needs and psychiatric admission rates have found relationships associated with financial, geographic and attitudinal barriers, medicolegal controversies, client readiness, and the accessibility of mental health services (Goplerud and Guillemette, 1985). However, none of these approaches has been fully satisfactory in providing complete identification of solutions to the mental health service delivery access concerns. Further investigation into the mental health needs of the client in crisis and an assessment of the effectiveness of existing services in meeting those needs is necessary.

Mental Health Care Systems

Organizational and Interorganizational Considerations

In the last two decades professionals in health care have recognized the benefits to be gained from coordinating health and mental health services. Nurses and other health care providers have a professional responsibility to act on behalf of the public they serve by influencing health policy (Gorenberg, et al., 1991). Although professional health care organizations have worked within their own discipline to develop initiatives dealing with service delivery, a coordinated interorganizational effort would be more effective.

The rationale for coordinated effects could be developed from information acquired through the physical and mental health care experience over time. First, within the health care delivery system generally, the interrelationship between medical and psychological problems has been more widely acknowledged in recent years. This relationship has been discussed from several perspectives: physical and psychological problems can coexist in the same client; physical problems can produce secondary emotional reactions; psychological and behavioral problems can lead directly to poor physical health; and both physical and psychiatric conditions serve as hidden causes or complications of each other (Shepard, 1980; Mizrahi, 1991).

The acknowledgement of the interrelationship of physical and psychological problems by components of the health care delivery system is an important first step to the facilitation of an interorganizational effort aimed at improving care delivery. Only a shared effort between medicine, psychiatry, nursing, psychology, and social work can assure that the limited resources available for research and development will be allocated effectively.

Second, from the perspective of client utilization of general health services, the need for a closer relationship between physical and mental health care has been further highlighted. In the United States, it has been estimated that 60 percent of all clients in the United States with emotional problems are seen only in the general health primary/care sector. Of this group of clients only 10 percent are referred for additional services in the mental health specialty sector (Regier, D., et al., 1980).

In a more recent study, Mizrahi (1991) reported that the referral rate by primary care physicians to mental health services has increased to 18 percent. These results indicate that in 1990 an estimated 82 percent of the clients with emotional problems, such as anxiety or depression, were provided treatment (usually medication) by other than the mental health specialist. The difficulty experienced from this lack of integrated care is often manifested as a misdiagnosis and over- or under-treatment of a psychiatric disorder, particularly with the geriatric client or one with substance abuse issues.

Third, from the perspective of research studies aimed at assessing the effectiveness of coordinated health mental health care delivery, several areas of investigation suggest the need for such coordination. In one investigation of the effectiveness of coordinated care, Burns and colleagues (1981) reported that integrated general health-mental health services lead to more effective client care. This study of neighborhood health centers (n=19) in Boston where integrated general and mental health care was provided, identified higher rates of mental health case findings, specialty referrals, and follow-up of clients when compared to other non-integrated settings.

In a study aimed at the health care needs of psychiatric population, Black, et al., (1985a) investigated the patterns of mortality among former inpatients (n=4,859) of the University of Iowa Psychiatric Hospital during a ten-year period. Comparing mortality rates of this group with a relevant Iowa control population, the researchers found significant excessive mortality from "natural" causes, particularly cancer, heart disease, influenza and pneumonia. The primary site of out-patient care for the former inpatients was the area community mental health center that was not structured to respond to the client's physical complaints and referred them elsewhere.

Although the findings reported may be limited, the implications are clear. Health care sites structured to meet whether the physical or psychological needs of the client may not adequately provide for the overall health concerns, and integrated services are more effective in delivery of service.

While the legislation for both general health and mental health services suggests the need for coordination of services and comprehensive care, funding specifically targeted towards facilitation of this goal is not readily available. Several factors make coordination difficult. Besides being sponsored by different federal agencies and receiving different kinds of funding, these two types of services provide care in different ways. Primary physical health care projects are frequently federally funded to serve populations defined according to target population characteristics, such as the rural poor or the urban school age child. Concurrently, community mental health services are funded through state governments and are targeted to serve a much larger population base, which includes individuals of all ages living within a usually large geographic catchment area (75,000 - 200,000 people). More recently, individual programs have begun to receive grant funding from both the Bureau of Community Health Services and the National Institute of Mental Health to establish interagency relationships and integrated physical and mental health linkages (Durenberger, 1989).

Health care delivery within the public and private sector is being greatly affected by the trend towards managed care. Planning, coordination, and integration of services by the specialized providers of these services are crucial. The seeds for this movement were sown in the early 1980s, when health insurance policies started offering generous psychiatric benefits, and various states stopped regulating the development of new private psychiatric facilities. The number of private, for profit psychiatric hospitals rose from 220 in 1984 to 444 in 1988, an increase of 100 percent (Gentile, 1991).

The health care insurance benefit market has also dramatically changed as employers felt the sting of rising health-care costs. By the late 1980s, insurance plans were limiting psychiatric inpatient and outpatient care. As third-party coverage options were restricted and as length of treatment became shorter, the need for interagency coordination of services has increased (Gentile, 1991).

Health maintenance organizations have been in the forefront of managed care, with the primary focus on preventive maintenance. Olfson (1991) reported that more than 20 million people are now enrolled in close to 600 HMOs across the United States. The cost of care provided to these enrollees is 10 to 40 percent lower than that provided by conventional indemnity health insurance plans. The savings are thought to be achieved primarily through decreased use of inpatient services.

Within the HMO model, intensive outpatient services are often used in place of inpatient care. Outpatient, family, crisis intervention, case management that includes training in community living skills, and day hospital with comprehensive back-up support are examples of effective alternatives to hospitalization. However, the replacement of hospitalization with intensive outpatient treatment puts greater responsibility for continuing care on the individual and his or her family. As deinstitutionalization has created the potential for family burden in the public sector, HMO policies that promote aggressive outpatient care create this potential in the private sector (Olfson, 1989).

Empirical data are essential to provide evidence to effect change in public and private mental health policies. Research findings and policy recommendations must be presented to decision makers clearly and at key times in the policy process. Access to mental health services must be considered in combination with physical health services expansion in order to better serve the public interest (Durenberger, 1989).

In sum, numerous organizational and interorganizational considerations surround the overall health care delivery systems. While the information provided in the literature and data gained from experience of service delivery support the rationale for the provision of integrated care, changes in the system of health care are not rapidly forthcoming. Since integrated care has been identified as more effective, and the system continues to have difficulty with integration, the client in need of physical and/or mental health care is being denied access to a more effective service.

This discussion has identified some of the benefits of collaboration between the various organizations providing health care, and it is apparent that formal networking is necessary to assure effective delivery of services. Some recommendations for organizational integration include: (1) health care interdisciplinary and interorganizational planning aimed at improving service delivery integration and political advocacy; (2) more equitable funding allocation and distribution aimed at service delivery and research; and (3) public and private sector health care collaboration around policy development and decision making, particularly in these times of shrinking resources.

Theoretical Perspective From Applied Behavioral Sciences

The previous discussion has included an overview of emergency mental health services and client utilization, a review of some of the crisis populations with special needs, a summary of key systemic barriers affecting access to mental health care, and some of the organizational and interorganizational considerations linked to the provision of integrated physical and mental health care. For the purpose of the review, this researcher has considered three theoretical perspectives that are associated with mental health care delivery systems, nursing, organizational development and the applied behavior sciences, namely, General Systems Theory, Socialization and Social Support, and Crisis Theory. It has been recognized that numerous theories affect the nature of physical and mental health care delivery and the overall system of care, however, the theories selected have been identified as highly salient to the scope of this research.

General Systems Theory

In the discussion of any organization, the influence of general systems theory must be considered. It is particularly relevant in a discussion of health care delivery systems. General systems theory, when applied to living people systems, provides a conceptual framework within which the content of the biologic and social sciences may be logically integrated with that of the physical sciences (Hersey and Blanchard, 1988). As early as 1963, Menniger reported that general systems theory, when applied to psychiatry, offered a new resolution of the mind-matter dichotomy, a new integration of biologic and social approaches to the nature of human beings, and a new approach to the delivery of mental health services.

The systems-oriented nursing theories emerged during the late sixties, about the same time as Robert Chin, Talcott Parsons, and Ludwig von Bertalanffy's writings emerged. Chin (1961) wrote about systems and developmental theory in relation to change. Parsons (1968) wrote from a social-psychological point of view and von Bertalanffy (1968) from a biological one.

The development of certain nursing theories was parallel to that of system's theory. Martha Rogers (1970) focused on unitary man within an open system. Imogene King's theory (1971) built on von Bertalanffy's, focusing on human beings interacting with the environment. Betty Neuman described her theory as the health care systems model, a total-person approach to patient problems. Calista Roy focused on a holistic person as an adaptive system. These theorists based their assumptions on the basic notion of a systems approach which views the whole rather than the parts of a given situation: seeing the parts does not lend itself to understanding the whole (Torres, 1986).

Chin (1980), who wrote about change, believed that practitioners must have concepts in order to make observations and diagnoses that lead to assumptions about the client-systems. His systems approach is thought to be universally applicable to human relationships and the physical sciences. Chin visualized a system by drawing a large circle. Within the circle are elements, variables, and parts which show relationships among them. Boundary lines assist in separating the inner circle from the environment. The system is never static and responds to stress and strain that occurs within as well as outside itself. The system is never static nor can it attempt to be: it is constantly changing and attempting to achieve a balanced relationship between the parts, which is called a steady state.

Katz and Kahn (1978) developed an open-systems framework to analyze the social psychology of organizations. They conceptualized a "cycle of events" occurring in systems whereby a system imports inputs from the environment, transforms them, and exports outputs back to the environment, and the cycle repeats itself. Receipt and processing of information are crucial to system survival.

At the larger system level of health care delivery, overpopulation, pollution, homelessness, poverty, the escalating cost, and deterioration of quality and access to services are instances contributing to imbalance affecting the system (Mizrahi, 1991). In systems theory, all of these factors represent abnormalities or stresses on matter-energy processes affecting the individual-environment interaction of client and provider alike.

Systems theories have gained increasing attention across disciplines during the last twenty years. Nursing theorists and researchers in greater numbers are moving toward a systems approach and away from an individual need based orientation.

According to Torres (1986), there are basic similarities among the systems theories discussed, from Chin's to Roy's including:

1. Human beings are an open system; thus, the individual constantly interacts with the

environment, and there are many variables that must be accounted for at any given time.

2. The feedback system incorporates the dynamic nature of the system.
3. Systems have organizations, patterns and integration, and are reflective of wholeness.
4. The direction in the utilization of systems theory involves adjustments/adaptation or nonspecific goal achievement.

General systems theory is crucial to the discussion of access to mental health care for the individual in crisis. The major concepts reflected within all systems theories are human/individual and his/her relationship with the environment. Assuring access to health care for all clients requires a clear understanding of the internal and external stressors upon the individual within the context of his or her environment, as well as the internal and external stressors upon the system of health care delivery.

Socialization and Social Support

The importance of socialization and social support to the interdisciplinary focus for research and clinical practice have been discussed previously in this review. It has been accepted that human beings in our society, are socialized to seek social contact and to rely on one another as we strive to meet out needs. Researchers and clinicians from the fields of anthropology, epidemiology, medicine, nursing, psychiatry, psychology, social work, and sociology have contributed to the literature in this field.

Two early writers introduced the concept of social support in the 1970s. The epidemiologist John Cassel (1974) reviewed studies of the effects of rapid social change, social and family disorganization, family competence and cohesiveness, cross-cultural migration, and psychosocial assets on health outcomes. Cassel reported a common theme in these and other studies as a deprivation of meaningful social contact. Such lack of social support was shown in the studies he reviewed as contributing to diminished health or well-being (Cassel, 1974).

The community psychiatrist Gerald Caplan (1974) expanded on the work of Cassel to discuss how social support facilitates dealing with crisis. In Caplan’s view, the outcome of the crisis is influenced not only by the characteristics of the stress and the ego strength of the individual but also the quality of emotional and task-oriented support available from the person’s social network. Caplan speculated that social support consists of three elements: "They (support persons) help the individual mobilize his psychological resources and master his emotional burdens; they share his tasks; and they provide him with extra supplies of money, material, tools, skills, and cognitive guidance to improve his handling of his situation" (p 6,). Caplan described two additional functions of support systems: first, as a source of collecting and storing information about the outside world which can be used to offer guidance and direction, and secondly, as a refuge or sanctuary for the individual to rest and recuperate (Caplan, 1974).

The current practice of community based care and treatment of individuals experiencing a mental illness greatly affects the individual’s social network. Deinstitutionalization of the chronic mentally ill has proven to be an equal burden to the client, family, and system of care delivery. The trend in the private sector towards cost containment, managed care, and a more community based focus to mental health care delivery, like deinstitutionalization, will necessitate a strong social network (Mizrahi, 1991; Olfson, 1989).

King's theory of nursing identified the major component within a social system as being the environmental forces that have an impact on the individual's personal and interpersonal systems. These forces in the external environment include the structure of the health care organizations, such as the site of service delivery and the perceived accessibility within the individual's personal or interpersonal environment (King, 1981).

Chin (1980) described socialization in the context of social matrices. He describes "ways of looking at the world" and ways of "doing things" as assuming human agents. The initial component necessary to create a paradigm, is the social network, community, or group that adopts ideas and practices. The extent of this social matrix determines the extent of the paradigm. But more than simply having ideas and practices in common, the members of the paradigm's social matrix interact with one another. Both the content and the process of these interactions serve to solidify and perpetuate the social paradigm.

Effective delivery of physical and mental health care requires a clear understanding of the socialization and social support network of the client. The perception of support assists the individual in mobilizing psychological resources. At the same time rapid social change, family disorganization, and depletion of psychosocial assets interfere with the client's ability to utilize available resources. Therefore, access to physical or mental health care would be hindered by the provider's lack of consideration of these issues.

Critical Social Theory

Critical ways of knowing are manifested in the tradition of the German scholars, Third World liberation scholarships, and feminist theory. Critical social theory refers to a series of ideas that emerged in Frankfurt, Germany in the 1920s and 1930s. These ideas were based on critical Marxist self-understanding and Hegelian dialectics that stressed the principles of contradiction, change, and movement (Thompson and Held, 1982).

Habermas (1979) rejuvenated critical social theory in the Frankfurt School tradition in the late 1960s.

He emphasized communication and the collective coordination of social action. The task of Habermas's critical social theory was to understand how people communicate and develop meanings, and by means of this process to uncover the distortions and constraints that impede free, equal, and uncoerced participation in society. The ultimate goal of critical social theory is to facilitate liberation from constraining social, political, and economic circumstances. He suggests that inquiry into the individual's lived experience be done with a critical eye.

For a social critique to be useful in liberating persons and aggregates from domination it must be aimed at the fundamental structures and ideologies of the social systems. According to Habermas (1979) the fundamental structures of society include:

- the kinds of work and wages that are available and to whom;
- the meaning of privatized, unpaid work and who does it;
- assumptions about what constitutes family;
- access to education;

- images of women, Blacks, Latinos, and gay people in the media;

Neuman (1986) asserts that the focus of nursing is the health of persons in interaction with the environment. She defines health as expanding consciousness in which the patterns of openness, diversity, and quality of individual's interactions with the environment are increased. Conditions of freedom and unrestricted choice are essential for health as they allow for expansion of the individuals' potential and increase their consciousness about their situation in the world. This definition of and conditions for health echo the basic assumption of critical social theory, which maintains that liberation from oppressive structures is an indispensable condition of the quest for human potential (Stevens, 1989).

Using the framework of critical social theory necessitates that the understanding of environment be expanded to incorporate critical analysis of the social, economic, and political worlds or nursing clients, families, and communities (Hedin, 1986). The critical way of thinking may be a powerful lens, a frame of reference or interpretive scheme to accurately assess the individual's experience of access to health care.

Crisis Theory

The crisis concept and early formulation of crisis theory originated in the field of preventive psychiatry in the early 1940s. Preventive psychiatry is concerned with the maintenance of mental health and the prevention of mental illness. Specialists in this field used psychoanalytic theory as the basis for a theoretical framework which explored brief intervention for individuals having stressful like experiences. People experiencing particularly stressful life events were noted to exhibit a characteristic sequence of reactions and outcomes. Intervention strategies for particularly stressful life experiences were developed to minimize negative outcomes and maximize resolution of the problem (Caplan, 1974).

A crisis is an internal disturbance that results from a stressful event or a perceived threat to self integrity. A crisis occurs when a conflict, problem, or situation of basic importance to the individual is perceived as threatening and not readily solvable by means of previous successful problem-solving methods. Crisis theory provides health professionals and the individual with a framework for assessing and alleviating those stressful life situations for which the individual’s customary problem-solving or decision making methods are not adequate. Crisis intervention is a form of brief, community-based therapy that utilizes a problem-solving approach to resolve the immediate stress-provoking problem in a growth promoting way (Aguilera and Messick, 1990).

Immediate, short-term intervention with individuals, families, and groups has been shown to be effective in reaching and helping larger numbers of people in distress and cutting down on the harmful residual effects (Caplan, 1974; Aguilera and Messick, 1990). However, in the present mode of mental health care delivery, rapid intervention is often not rapidly available. Emergency mental health services are experiencing greater numbers of clients in crisis who are faced with limited access to follow-up and ongoing intervention. This emergency access problem appears to be directly linked to the issues associated with the crisis within the health care delivery system. Service cutbacks, poverty, changes in insurance coverage, and stresses on social systems play a major role in limited assess (Brecht, 1990).

Crisis intervention is best considered in a continuum perspective. Primary, secondary and tertiary prevention are important to prevent crisis and enhance growth. Anticipatory and participatory techniques can be viewed as possible services for people with different kinds of psychosocial problems. The continuum suggests that people with problems vary in their dependency on other people and agencies for help (Hoff, 1989). Therefore, incorporating a comprehensive crisis intervention service would assist client and health care providers alike in assuring access to timely and cost-effective services.

In sum, this discussion has attempted to overview some of the key concepts salient to the process of providing physical and mental health services. What this review has demonstrated is that the assurance of access to care requires the consideration of the concepts within general systems theory, socialization and social support, and crisis theory.

CHAPTER 3

DESIGN METHOD AND PROCEDURES OF THE STUDY

Design

For this study this investigator conducted a descriptive study utilizing a survey tool. This type of research was selected due to the suitability of the design in describing the characteristics, opinions, or behaviors as they exist in the population to be researched (Borg and Gall, 1989; Wilson, 1985). Since this study was expected to describe the needs of the client in a mental health crisis and the resources available at the time of presentation to the emergency mental health service, a series of questions was developed to measure these variables (Appendix B, C).

The design of this study was to survey clients (n=171) who presented in crisis to the emergency mental health service at UMass Medical Center who were then referred to outpatient follow-up. Clients who agreed to participate were administered the initial interview questionnaire and asked to sign the Consent Form (Appendix A). At a four-eight week point following the initial crisis presentation, a second structured interview was conducted to determine the client’s current status and the outcome of the referral (Appendix C). The survey tool was administered by the trained emergency mental health clinical staff evaluating the client at the time of the crisis. Staff were trained in the specifics of the interview tool by this researcher to minimize the variation in question interpretation.

Data Collection Method

As delineated in the problem and purpose statement this investigation was structured according to the salient issues as addressed in the conceptual framework developed from the constructs contained within General Systems Theory, Socialization Theory and Social Support, Crisis Theory, and Critical Social Theory. Data collection has been discussed within the specific theoretical framework of the research questions as presented.

General Systems Theory

Hypothesis #1

There are system imposed barriers to mental health care access for the individual in crisis.

Method #1

The system presence imposed barriers to outpatient mental health care access was measured by Pre-interview items gender, age, education, employment, marital status, ethnicity, and questions #1, 2, 4, 5, 7, 12, 14 and 15 and Post-interview item #2, 6, 7.

Analysis #1

A Chi square method of regression for paired variables with matched-groups design provided a score that tested the hypothesis by estimating the differences for each pair of responses as compared to the computed value of variables. Pre-interview items #12 and Post-interview items #7, 9, 10 required a content analysis and coding for analysis of frequency distributions.

Socialization Theory and Social Support

Hypothesis # 2 a., 2 b.

a. There are societal barriers to mental health services for the individual in crisis.

b. Lack of social supports affects the individual's access follow-up services during a crisis.

Method #2

The barriers to mental health service for the individual in a crisis associated with Socialization theory and social supports were measured by Pre-interview items AGE, YRS ED, EMPLOYMENT, MARITAL STATUS, ETHNICITY, GENDER #1, 2, 4, 5, 6, 7, 9, 10 and Post-interview items #3, 5, 6, 7, 8, 9.

Analysis #2

As with hypothesis #1 chi square was used to analyze the questions correlated with this issue. Post-interview items #6, 8 required content analysis and coding for analysis of frequency distribution.

Crisis Theory

Hypothesis #3 a., 3 b.

a. There are limited rapid follow-up options available for the individual experiencing a mental health crisis.

b. The individual in crisis describes the follow-up options as ineffective in attaining crisis resolution.

Method #3

The influence of waiting time for and access to mental health care on the individuals reported improvement were analyzed with Post-interview items #2, 3, 4, 5, 6, 7, 8, 9.

Analysis #3

A chi square was used to analyze the items associated with Hypothesis #3. Post-interview items #2, 3, 4, 5, 6, 7 required a content analysis and coding for frequency distribution.

Critical Social Theory

Hypothesis #4 a., 4 b.

a. Individuals in crisis have limited access to follow-up mental health services due to oppressive societal barriers.

b. Individuals in crisis cannot accurately describe their own mental health needs or the barriers to service access to meet those needs.

Method #4

The issues associated with critical social theory were identified with Pre-interview items AGE, YRS ED, EMPLOYMENT, REPEATER, MARITAL STATUS, ETHNICITY, GENDER, #1, 2, 4, 5, 6, 7, 8, 10, 11, 12, 13, 14, 15 and Post-interview #2, 3, 4, 5, 6, 7, 8, 9.

Analysis #4

A chi square was used to analyze Pre-interview items #1, 2, 5, 6, 7, 8, 10, and Post-interview items #2, 4. All other items associated with Hypothesis #4 required a content analysis and coding for frequency distribution.

Study Setting

The study was conducted at the University of Massachusetts Medical Center Department of Psychiatry Emergency Mental Health Service. This facility is a 350-bed teaching hospital located in Central Massachusetts area. The Emergency Mental Health Service (EMHS) is a multi-funded, 24 hour emergency evaluation, intervention and referral program located in the Emergency Department. It is the only designated State Department of Mental Health screening unit in the central Massachusetts area.

EMHS is staffed by bachelor and master prepared psychiatric nurses and crisis counselors. The program averages 350 evaluations per month of all age individuals who present in varying degrees of emotional, psychological and/or psychosocial crisis. Referrals come to the program from community and private agencies, police departments, area hospitals, individuals and families. Upon completion of the evaluation and stabilization, clients are referred out to the most appropriate, least restrictive setting for further treatment.

During the study, this researcher was the clinical director of EMHS and was familiar with the population served and the available resources. Permission for the investigation was granted by the Chairman of the Department, and followed UMMC Research Guidelines.

Sampling Description

A survey through structured one-to-one interviews was conducted of clients (n=171) presenting consecutively to the Emergency Mental Health Service at UMass Medical Center. The sampling represented the approximate number of adults presenting to the emergency service during a sixty day period of time who were referred to an outpatient setting following the initial evaluation and assessment of the crisis. The sample was analyzed by descriptive statistics according to individual characteristics, symptom descriptions, demographics, and clinical history. The individual and evaluator description of need at the time of the crisis, the follow-up referral plan, and effectiveness of the plan were content coded to determine categorical definition and relevance to the research question.

The inclusion / exclusion criteria was identified due the complexities involved with service delivery for certain segments of the population.

Inclusion Criteria

- clients 18 years of age or older (adults)
- clients who were referred to outpatient services
- clients who agreed to participate in this research project

Exclusion Criteria

- clients under 18 years of age (children)
- clients who were referred to an inpatient setting
- clients who were mentally retarded or are primarily substance abusers
- clients who were incarcerated in a prison setting
- clients over 60 years of age residing in a rest home setting.

The confidentiality of the data sources were preserved by limiting the people other than the principal investigator and interviewers from access to the raw data. Full disclosure of purpose, procedures, and risks of this investigation were provided at the time the subject agreed to participate. The survey tool was coded with the subject's individual medical record number only and was kept in a locked file of a separate area. All raw data was destroyed following the completion of this investigation.

This research proposal was approved by the University of Massachusetts Medical Center Human Subjects Committee.

Data Collection Tools

Appendices B and C represent the instruments used for data collection in this investigation. The questions contained in these tools were selected because of their relevance to the salient issues in the literature and this researcher's experience and observations in clinical practice. Specific items were included for their ability to measure the operational definition of the study variables, including circumstantial vicissitudes and information about the experience for the client. For example, Crisis Theory stresses that effective rapid intervention at the onset of the crisis is necessary to reduce the long term negative effects of the crisis. Therefore, long waiting lists for access to crisis follow-up services will directly impact the outcome of the crisis experience. Pre-interview items #11, 12, 14 and Post-interview items #3, 4, 5 measured the plan, length of wait to access the service, outcome of the follow-up and the client's perception of effectiveness of the plan.

The Post-interview tool was intended to determine what actually happened as a result of the crisis intervention and referral. The objective outcomes as they related to the extrinsic issues and the subjective responses of both client and evaluator were analyzed. For example, the client's subjective assessment of what is needed at the time of the crisis and what is better or worse since the client initially presented to EMHS were compared with that of the evaluator's to determine the correlation between the perceived need as described by both. Critical Social Theory states that access to health care services if often impeded by a discrepancy between the individual client’s actual need and the need as perceived by the health care provider. Pre-interview items #11, 12 and post-interview items #5, 6, 7, 8, 9, 10 measured the client and evaluator perception of need at the time of the crisis and at the six week follow-up. Crisis Theory further stresses that without adequate or timely intervention at the time of the crisis less than 50% of the individuals will achieve a desirable outcome to the crisis situation.

A pilot study (n=10) was conducted as the methodological approach to determine the effectiveness of the questions and the content codes. Internal consistency, reliability, and content-criterion-construct validity estimates were determined by a systematic review of responses by several senior clinicians in the department of psychiatry.

Analytic Procedure

The goals of this analysis was to summarize the data in ways that would answer the research questions. The procedure included a descriptive analysis using frequencies to compare the individuals demographics, clinical characteristics, and past and present experience with the system providing services. The chi square analysis of the selective variables was done to address each hypothesis and to determine significance. For example, comparisons were made between the client with or without private insurance and if they gained access in order to address the question "Do people with private insurance identify easier access to mental health services than those without private insurance?"

In sum, the primary question for this investigation was "What barriers to mental health care service access exist for the individual in crisis?" This research design method and procedure of analysis have described how to answer this question.

CHAPTER 4

RESEARCH FINDINGS

The results of this study have been organized here by the theoretical perspectives and presented in relation to each hypothesis generated from the research questions as stated in Chapter 1 of this paper. A Chi-square test method of analysis was used to determine the significance of factors under consideration for this study. This method was selected for its ability to determine the significance of the difference in the frequency distribution between two or more of the selected variables. This researcher was interested in what affected the access to outpatient mental health service for the individual in crisis. The sample included adult individuals who presented in crisis to the Emergency Mental Health Service at the University of Massachusetts Medical Center and who were referred to outpatient follow-up services.

Description of Results

The Initial Interviews were completed on individuals (n=171) who presented in crisis to the

Emergency Mental Health Service at University of Massachusetts Medical Center. Individuals who were being referred for outpatient follow-up care were invited to participate in the study.

The Six Week Post-interviews were laborious and became very complicated. Although at the time of the initial interview individuals who agreed to participate were very forthcoming with time and method for the Post-interview, circumstances were such that some were unable to be contacted for the second meeting. As it turned out, addresses and phone numbers had changed with no forwarding information. Successful Post-Interviews were completed on 64.9% (n=111) of the subjects (n=171) who agreed to participate during the initial phase.

Demographics of the Pre-Interview Population Sample

The sample of individuals included in the initial phase this study consisted of 83 males (48.5%) and 88 females (51.5%) which represented a slightly higher percentage of males (40%) than in the overall average population presenting to the Emergency Mental Health Service. The sample group was age 26-39 years (48%) followed by 18-25 years (31%), caucasian (74.9%), single (47.4%) or divorced (35.1%), living with at least one other person (75.5%), educated high school level (33%) or less (48%). They were unemployed (71.9%), uninsured (26.1%) or receiving public entitlement (57.9%) with previous mental health care experience (45%) or no previous experience (55%).

The subjects reported mental health problems of major mental illness (50.3%), including psychosis and depression, and psychosocial disorders (49.7%), including anxiety and adjustment disorders and substance abuse (64.3%). They presented requesting help with accessing treatment (60.2%), including inpatient or outpatient mental health and substance abuse treatment, or assistance with a psychosocial problem (24.6%), including relationship, housing, or financial difficulties. Others (20.5%) were unable to identify what they thought would help at the time.

The plan at discharge included a referral to public sector (48.5%) or private sector (51.5%) outpatient services. The subject predicted rate of compliance was reported as high or probable (79.6%) by the evaluator.

Post-Interview Descriptive Statistics

Post-interviews were conducted during the four (4) to eight (8) weeks following the initial interview. This time interval was intentionally selected for its relevance to crisis resolution as reported in the Crisis Theory literature (Caplan, 1974; Hoff, 1989; Aguilera and Messick, 1990).

Post-interview information was gathered in telephone or one to one interviews. Of those interviewed (n=111) a group of subjects (68%) indicated they were able to follow-up with the recommended plan at discharge in two (2) weeks or less and that either their psychopathology or psychosocial problems had improved. This finding suggests that rapid intervention at the time of the crisis assists the individual with restabilization and is consistent with the literature.

The group (32.4%) interviewed who indicated they were unable to access the recommended plan reported that since the initial interview nothing had changed or that their situation had worsened. These subjects also reported continued difficulty with psychopathology, social supports, and relationships. Of those reporting difficulty with psychopathology (61%) were more likely to report difficulties with their psychosocial situation. This finding may suggest that lack of a social support contributes to the individuals difficulty resolving the issues related to a crisis. This finding would be consistent with the socialization and social support literature (Cassel, 1974; Caplan, 1974; King, 1981; Chin, 1980; Olfson, 1989; Mizrahi, 1991).

This study attempted to identify some of the barriers that affect access to outpatient services for the individual in crisis. Barriers were coded as either system imposed or client imposed. System imposed barriers were described as those that resulted from the structure of the existing health care delivery available to the individual at the time of the crisis referral. Client imposed barriers were those that resulted from the individuals behaviors and psychopathology.

Barriers to access were reported by subjects (56%) in both the group who was able to get follow-up care and the group who was not. For this study barriers reported as system imposed were coded as non-existent or inadequate insurance (30.1%), long waiting lists or unavailability of needed service (58%), lack of available transportation (11%), and lack of child care (6%). The reported client imposed barriers as identified by these subjects included dissatisfaction with previous mental health experience (44%) and psychopathology (29%).

However, additional clarification of what constitutes a system or client imposed barrier is necessary. The overlap of a variety of influences on service access was apparent in the results. For example, the inability to access needed service may more accurately be a reflection of the individual's psychopathology or non-compliance which would indicate a client imposed barrier. Likewise, lack of available transportation or child care could in fact be a result of social stigma and oppression.

Although the data generated from this study suggested the presence of barriers to mental health care access for the individual in crisis, there was no conclusive evidence about the impetus of the barriers. Therefore, caution was necessary in how the results were interpreted.

The amount of data generated in this study was monumental, although much of it was difficult to apply within limitations of the design of this study. Organization of the pertinent information proved to be an arduous task. To reach this goal, the results have been presented here according to the demographics, the individuals previous experience with the mental health system, identified barriers to access, described support system, and reported improvement.

Demographics of Post-Interview Population Sample

There was no significant influence of demographic variables as barriers to outpatient mental health care access for the individual in crisis. Sample diversity did not demonstrate the significance of ethnicity, although the raw score indicated that twice as many hispanics were referred to the public sector (n=26) than to private sector (n=11) for follow-up. Although gender demonstrated no significant influence as a barrier to access further discussion is merited. In the initial interview more females than males reported that nothing would help their current situation which could suggest a higher prevalence of helplessness or good reality testing. Females were rated as more compliant by the evaluator twice as often as males, and when they did access service, females were more likely to rate the service as good, suggesting an eagerness to please. These gender related issues were consistent with the literature on oppressive power and learned helplessness (Habermas, 1979; Stevens, 1989).

Employment status and insurance were significant to plan at discharge. Employment status (x2=0.000; df=2) and insurance status (x2=0.000; df=4) resulted in statistical significance to the plan at discharge. Employed and insured individuals were referred to the private sector for follow-up at a rate of 3:1.

The type of insurance, public entitlements (Medicaid/Medicare) or private insurance, was not significant to plan at discharge. This result suggests that type of insurance did not influence whether individuals were referred to the public or private sector.

Also significant to plan at discharge was level of education (x2=0.004; df=0) suggesting that the more educated an individual the more likely the referral to the private sector. Level of education was significant to rate of compliance (x2=0.0827; df=0), suggesting that individuals with more education are more likely to follow-up with the recommended plan. Assuming that referral to the private sector is a more desirable plan and that higher education is more available to the privileged, these results could suggest a barrier to access and oppression of the less educated.

General Systems Theory Generated Hypothesis

Hypothesis #1. There are system imposed barriers to outpatient mental health care access for the individual in crisis.

Outcome. System imposed barriers were considered by comparing initial interview responses with client reported access to the recommended plan at disposition and barriers to access as identified by client and evaluator.

Access to mental health outpatient care for the individual in crisis as measured at follow-up did not significantly differ according to demographic variables. The results were not significant to support evidence of the influence of gender (x2=0.2878, df=0), age (x2=0.7975, df=2), education level (x2=0.6963, df=0), employment status (x2=1.00, df=0), marital status (x2=0.9785, df=5), ethnicity (x2=0.9652, df=0), major presenting problem, (x2=0.4486, df=2) evaluator's description of what would help (x2=0.4774, df=3), diagnostic group (x2=0.8717, df=2) plan at disposition (x2=0.2452, df=2) on the measured outcome of the individual's reported access to the recommended plan.

Hypothesis #1 was supported in various ways. Analysis supported evidence that access to follow-up was significantly related to current mental health services (x2=0.0034, df=2; see table 1), insurance status (x2=0.0493, df=3; see table 2), previous mental health care (x2=0.0721, df=2; see table 3) evaluator's rate of compliance (x2=0.0063, df=2; see table 4), client perceived barriers (x2=0.000, df=2; see table 5), and evaluators perceived barriers (x2=0.0000, df=2; see table 12).

Client and Evaluator Identified Barriers

Perceived barriers influenced the plan and the individual's access to the plan in a variety of ways. Evaluator perceived barriers were significant to the individual's description of what would help at the time of initial evaluation (x2=0.0491; df=3) and to the plan at disposition (x2=0.0728; df=3). The evaluator's perception of barriers to meet the client identified

TABLE 1
Access To Follow-Up Plan By Current Psychiatric Outpatient

	Current Psychiatric Outpatient			
Access To Follow-Up Plan	Private	Public	None	Row Total
	7	5	24	36
	19.4	13.9	66.7	32.4
No	23.3	15.6	49.0	
	23	27	25	75
Yes	30.7	36.0	33.3	67.6
	76.7	84.4	51.0	
Column	30	32	49	111
Total	27.0	28.8	44.1	100.0

Chi-Square	Degree of Freedom	Significance
11.38100	2	0.0034

TABLE 2
Access To Follow-Up Plan By Insurance Type

	Insurance Type				
Access To Follow-Up Plan	None	Medicaid	Medicare	Private	Row Total
	14	9	3	9	35
	40.0	25.7	8.6	25.7	31.8
No	51.9	20.5	37.5	29.0	
	13	35	5	22	75
Yes	17.3	46.7	6.7	29.3	68.2
	48.1	79.5	62.5	71.0	
Column	27	44	8	31	110
Total	24.5	40.0	7.3	28.2	100.0

Chi-Square	Degree of Freedom	Significance
7.84406	3	0.0493

TABLE 3
Access To Follow–Up Plan By Previous Psychiatric Outpatient

Access To Follow–Up Plan	Previous Psychiatric Outpatient			Row Total
	Private	Public	None	
	9	7	20	36
	25.0	19.4	55.6	32.4
No	27.3	21.2	44.4	
	24	26	25	75
Yes	32.0	34.7	33.3	67.6
	72.7	78.8	55.6	
Column Total	33	33	45	111
	29.7	29.7	40.5	100.0

Chi–Square	Degree of Freedom	Significance
5.25973	2	0.0721

TABLE 4
Access To Follow–Up Plan By Rated Compliance

Access To Follow–Up Plan	Rated Compliance			Row Total
	High	Probable	Low	
	11	17	8	36
	30.6	47.2	22.2	32.4
No	20.8	37.0	66.7	
	42	29	4	75
Yes	56.0	38.7	5.3	67.6
	79.2	63.0	33.3	
Column Total	53	46	12	111
	47.7	41.4	10.8	100.0

Chi–Square	Degree of Freedom	Significance
10.14559	2	0.0063

TABLE 5
Access To Follow–Up Plan By Client Identified Barriers

Client Identified Barriers	Access To Follow–Up		Row
	No	Yes	Total
	12	15	27
System	44.4	55.6	24.3
	33.3	20.0	
Client Psycho–Pathology	21	14	35
	60.0	40.0	31.5
	58.3	18.7	
	3	46	49
None	6.1	93.9	44.1
	8.3	61.3	
Column Total	36	75	111
	32.4	67.6	100.0

Chi–Square	Degree of Freedom	Significance
29.39394	2	0.0000

TABLE 6
How Long Did Client Wait For Follow–Up By Access To Follow–Up

	Access To Follow–Up		Row
Time	No	Yes	Total
	2	28	30
<1 Wk	6.7	93.3	27.0
	5.6	37.3	
	6	42	48
>1Wk<2	12.5	87.5	43.2
	16.7	56.0	
	28	5	33
>2 Wk2	84.8	15.2	29.7
	77.8	6.7	
Column Total	36	75	111
	32.4	67.6	100.0

Chi–Square	Degree of Freedom	Significance
59.16469	2	0.0000

need was an influence on the plan according to these results.

Of equal importance was the significance of the individual's description of what would help to the evaluator's rate of the individual's compliance (x2=0.0864; df=0) and the evaluator perceived barriers to whether the individual accessed the recommended plan (x2=0.000; df=0). The subjects in this study were more likely to improve if they were rated more compliant by the evaluator (x2=0.0361; df=1).

Individual and evaluator perceived barriers were significant to the individual's reported improvement (x2=0.000; df=0) and individual improvement was significant to the plan at discharge (x2=0.0158; df=2). These results suggest that evaluator and client perceived barriers influence not only the plan of discharge, but also client reported improvements. As reported in the literature, helplessness and hopelessness on the part of the client and caregiver have a direct influence on the outcome of a crisis (Aguilera and Messick, 1990; Hoff, 1989; Geller, 1991; Bachrach, et al., 1990).

Previous Mental Health Care Experience as a Barrier

Current follow-up was significant to plan at discharge (x2=0.000; df=3) indicating that individuals were referred back to the same system at the time of crisis. These results could suggest the limitations of the system of mental health care delivery to provide an alternative method of intervention when circumstances had changed for the individual. Since a crisis often results from the inability of current resources to meet the needs of an individual (Aguilera and Messick, 1990; Hoff, 1989), lack of alternatives at the time of the crisis could be an access barrier to the needed services.

If the individual was a repeater to the Emergency Mental Health service they were rated by the evaluator as more likely to follow-up (x2=0.0681; df=0), as was the individual currently followed in the private sector (x2=0.0043; df=0). At the same time, the individual's report of a positive previous mental health care experience was significant to gaining access to the recommended plan at discharge (x2=0.0341; df=2) and improvement (x2=0.0137; df=2). These results suggest that the quality of the individual's experience with mental health care and treatment, as well as the evaluator's experience with the individual, influence access to follow-up possibly by the specific plan formulation. As reported in the literature, both client and health care provider imposed barriers to care access result from previous experience and do influence the current plan (Bateman, 1988; Ellison, et al. 1989; Gerson and Bassuk, (1980).

Significant to disposition plan access was the waiting time experienced by the individual (x2=0.000; df=0). Individuals who waited longer periods of time were less likely to access the recommended plan. Delays in access, as suggested by this finding, could function as barriers to mental health care.

Socialization and Social Support Generated Hypotheses

Hypothesis #2 a. There are societal barriers to mental health services for the individual in crisis.

Hypothesis #2 b. Lack of social supports affects the individual's access to follow-up services in a crisis.

Outcome. Societal and social support barriers to mental health follow-up access were considered by comparing initial interview responses that described living arrangement, marital status, and identified support system with reported access to the recommended plan. The social system variables influencing access to care as measured in the initial interview did not differ significantly. The results did not support evidence of the influence of marital status (x2=0.9785, df=4), living arrangements (x2=8769, df=3), and identified support (x2=0.8722, df=0) on reported access to the recommended plan.

Perceived Supports and Access

Individuals with identified supports were more likely to access the plan at disposition and to report improvement. Subjects in living situations with at least one other person reported significantly more supports (x2=0.0382; df=2). Those with greater supports were rated as more likely to follow-up with the recommended plan (x2=0.0232; df=0). Those with greater supports reported significantly greater improvement (x2=0.000; df=0). These results would suggest that a supportive environment is more conducive to the individuals return to a more stable state following a crisis, as is reported in the literature (Caplan, 1974; Cobb, 1976; Hoff, 1989; Davis, et al., 1991; Norbeck, 1982).

In sum, the results of the statistical analysis of the variables important to this study have been provided. A discussion of the implications of this information follows in Chapter 5.

The analysis of the support variables in this sample were not significant enough to support evidence of the influence on the individual's reported access to the recommended follow-up plan. Hypothesis #2a and 2b were rejected.

Crisis Theory Generated Hypotheses

Hypothesis #3 a. Waiting time for rapid follow-up care access influences the individual experiencing a mental health crisis.

Hypothesis #3 b. The individual in crisis describes general improvement with access to follow-up mental health care.

Outcome. Hypothesis #3a and 3b were supported in a variety of ways. Access to rapid intervention for the individual in crisis was significant to support evidence of influence of waiting time on access to follow-up services ($x2=0.000$, $df=2$; see table 6). Of further significance was the influence of waiting time on reported improvement ($x2=0.000$, $df=2$; see table 7).

Critical Social Theory Generated Hypotheses

Hypothesis #4 a. Individuals in crisis have limited access to follow-up mental health services due to oppressive societal barriers.

Hypothesis #4 b. Individuals in crisis cannot accurately describe their own mental health needs or the barriers to service access to meet those needs.

Outcome. Analysis of the variables associated with possible oppressive societal barriers were significant to support evidence of the influence of years educated on plan at disposition (x2=0.0004, df=2; see table 8), repeater status on plan at disposition (x2=0.0469, df=2; see table 9), evaluator perceived barriers on plan at disposition (x2=0.0728, df=4; see table 10), client description of what would help on evaluator perceived barriers (x2=0.0491, df=4; see table 11), and evaluator perceived barriers on access to plan (x2=0.000, df=2; see table 12). Therefore, Hypothesis 4a and 4b were supported.

TABLE 7
Has Client Improved By How Long Client Wait For Follow-Up

	How Long Wait For Follow-Up			
Has Client Improved	< 1 Wk	>1 Wk <2	>2 Wks	Row Total
	3	9	24	36
	8.3	25.0	66.7	32.4
No	10.0	18.8	72.7	
	27	39	9	75
Yes	36.0	52.0	12.0	67.6
	90.0	81.3	27.3	
Column Total	30	48	33	111
	27.0	43.2	29.7	100.0

Chi-Square	Degree of Freedom	Significance
35.44053	2	0.0000

TABLE 8
Years Educated By Plan At Disposition

	Plan At Disposition			
Years Educated	Private	Public	None	Row Total
	29	53		82
Less Than 12 Years	35.4	64.6		48.0
	33.7	63.1		
	57	31	1	89
H.S. Grad.	64.0	34.8	1.1	52.0
	66.3	36.9	100.0	
Column Total	86	84	1	171
	50.3	49.1	.6	100.0

Chi-Square	Degree of Freedom	Significance
15.61781	2	0.0004

TABLE 9
Repeater Status By Plan At Discharge

Repeater Status	Plan At Disposition			
	Private	Public	None	Row Total
No	54	38	1	93
	58.1	40.9	1.1	54.4
	62.8	45.2	100.0	
YES	32	46		78
	41.0	59.0		45.6
	37.2	54.8		
Column Total	86	84	1	171
	50.3	49.1	.6	100.0

Chi-Square	Degree of Freedom	Significance
6.12112	2	0.0469

TABLE 10
Evaluator Perceived Barriers By Access To Follow-Up

Evaluator Described Barriers	Access To Follow-Up			
	Private	Public	None	Row Total
System	10	9		19
	52.6	47.4		17.1
	15.9	19.1		
Client Psycho-Pathology	24	28	1	53
	45.3	52.8	1.9	47.7
	38.1	59.6	100.0	
None	29	10		39
	74.4	25.6		35.1
	46.0	21.3		
Column Total	63	47	1	111
	56.8	42.3	.9	100.0

Chi-Square	Degree of Freedom	Significance
8.56899	4	0.0728

TABLE 11
Client Description of What Would Help By Evaluator Perceived Barriers

	Evaluator Perceived Barriers			
Client Help	System	Client Psychopath.	None	Row Total
Treatment	11 14.9 61.1	32 43.2 61.5	31 41.9 79.5	74 67.9
Support	2 9.1 11.1	15 68.2 28.8	5 22.7 12.8	22 20.2
Nothing	5 38.5 27.8	5 38.5 9.6	3 23.1 7.7	13 11.9
Column Total	18 16.5	52 47.7	39 35.8	109 100.0

Chi-Square	Degree of Freedom	Significance
9.52967	4	0.0491

TABLE 12
Evaluator Perceived Barriers By Access To Follow-Up

	Access To Follow-Up		
Evaluator Barriers	No	Yes	Row Total
System	7 36.8 19.4	12 63.2 16.0	19 17.1
Client Psycho-Pathology	29 54.7 80.6	24 45.3 32.0	53 47.7
None		39 100.0 52.0	39 35.1
Column Total	36 32.4	75 67.6	111 100.0

Chi-Square	Degree of Freedom	Significance
30.89922	2	0.0000

CHAPTER 5

DISCUSSION

This research was conducted to gather further information about the access barriers to mental health services for the individual in crisis. The hypotheses were supported in various ways. The information gathered was excessive and the task of sorting it out was often difficult, however, the key themes to service access barriers are clear.

In consideration of the hypothesis associated with systems theory, previous experience with the mental health care system was an important influence on current access to services. Both client and evaluator perceived barriers to care access reflected a described previous experience, as when the individual was receiving services at the time of the crisis or if he or she was known to the emergency mental health service. The plan at disposition and how compliant the evaluator rated the individual was influenced by what had occurred in the past. If the individual was currently in treatment and/or had a positive outcome in the past, the outcome at this presentation was more likely to be positive. The individuals with previous experience tended to rate the services received at follow-up and if they had improved or not in correlation with what they had experienced in the past. If things reportedly had gone well in the past, they were more likely to go well this time.

These results were concerning since they suggested an oppressive influence upon how one gains access to services at the time of a crisis. Not only was the system guided by what services the individual received in the past, but the individual also viewed the system in light of how it worked previously. The literature suggests that a mental health crisis for the individual is often the result of a breakdown in the existing system (Caplan, 1974). Therefore, limited alternative services, whether client or system influenced, interfere with access to different more appropriate care.

The information generated in this study provided limited support to the hypothesis that social situation has a positive or negative influence on access to follow-up services. While the data were not conclusive to support existence of societal barriers to access, nor the influence of a supportive system upon access, some important findings were apparent.

The design of this study limited an accurate measurement of the role of social situation on the specific variable of gaining access to follow-up services. The questions in the interviews were not structured in a way that clearly determined significance of social factors. However, the presence of social support was a factor in the individual's report if the situation had improved overall. A higher level of improvement was more likely if the individual identified some type of support. In addition, identified support had a direct influence upon the individual's reported experience with the system. The implication is that a supportive environment may assist the individual in maneuvering the mental health care system in a way that results in a more positive outcome.

While identified social supports enhance the possibility of improvement, individuals with more acute psychopathology were more likely to report fewer or non-existent supports. In a system that has been developed around community based care, the implications poses a problem. These results suggest that the sicker you are the more you need a supportive environment and the less likely you are to have it.

The current literature supports these findings. The cycle of stress, social supports, and emotional stability are crucial components of individual adaptation and coping. Social support is a moderator of life stressors that are a greater burden for an individual already compromised by a mental illness (Cobb, 1976). The system of health care delivery has been slow to recognize the need for supportive intervention to assist the support system of the mentally ill, and the result has been a further deterioration for the individual and family alike (Durenburger, 1989).

Oppressive societal forces influence client and family alike. Living with the guilt and shame associated with a mental illness is further complicated when the client is a parent or child (Goffman, 1963). The last few decades of change in the treatment focus for the mentally ill that brought the problem out of the institution and into the streets, has only perpetuated fear and stigma towards those living with a psychiatric disorder. Improved consumer education result in the potential benefit for all.

Critical Social Theory states that the more accurately and extensively individuals are able to perceive and reflect upon their social, political, and economic environment, the more effective they become in their interaction with the environment, a condition that is the essence of health (Stevens, 1989). An effective mental health care delivery system has an important role in helping the individual and family more clearly identify the barriers to service access. Understanding the nature of barriers has the potential to empower one to overcome them.

Waiting time for follow-up was an important influence on the individual's improvement. The literature on Crisis Theory supports this finding. Rapid intervention at the onset of the crisis will contribute to a more rapid re-stabilization and return to the pre-crisis state (Caplan, 1974; Aguilera and Messick, 1990). However, as the system of health care is restructured and access is limited to a specifically defined group, individuals will be forced to wait longer for service, if they can gain access at all. In this scenario, the cycle of the crisis will continue and predictably acuity levels will increase.

The crisis in American health care has become a major focus of our daily lives in these the first 100 days of the Clinton administration. The popular and professional literature is replete with today's latest update on the status of health care reform and its potential effects upon every aspect of health care delivery.

The mounting tension resulting from escalating costs, discriminatory access, and mediocre outcomes has led to a flurry of public debates on proposals to reform the financing and delivery of health care. The "Holy Trinity" of access, cost, and quality has been reconfigured according to several plans that purport to resolve the health care dilemma faced by the U.S. Universal access and cost controls are included in all serious proposals. How quality is to survive is a matter of debate (Santiago, 1992). Limited understanding of who will be seeking the services defined in a current system of health care reform contribute to the difficulty.

Our population is experiencing dramatic shifts. The number of elderly persons in the U.S. will continue to increase in the upcoming decades and with this the labor force will decrease in overall numbers. The continued influx of immigrants from non-European countries will increase diversity. The consequences will be higher utilization, fierce competition for fewer resources, difficult adjustments created by cultural and linguistic factors, and a more costly adaptation in the delivery of services (Billings, 1993).

The organizational strains, service pressures and budgetary problems generated in the past decades have resulted in quantitative shifts in the delivery of mental health care services. The focus has been away from institutional based care to the management of clients in a variety of outpatient settings. Outpatient providers have been forced to service a population with higher acuity levels which require greater amounts of collateral time that is not reimbursed by third part payers. While the population has become more difficult to manage on an outpatient basis, societal shifts have forced more individuals to seek mental health services. The stress of changing family values, loss of employment, and the increased lack of social supports have all contributed to the individual's difficulty with coping. The result has been an increase in service demand in an environment of diminishing resources (Astrachan and Schenl, 1991; Norquist and Wells, 1991; Billings, 1993). As mental health care delivery has shifted to community based care, greater demands have been placed upon an increasingly over-stressed family and social system.

The trend in individual's seeking mental health service access has been an increase in the very young or the elderly, poorer, unmarried, and socially isolated persons, or those who lack social supports and/or material resources. More and more individuals require not only psychological care, but also may be in need of jobs, food, shelter, education, and social support (Brown and McCool, 1990).

Since the Community Mental Health Center Acts was passed in 1963, little has been done to test the belief that the improved health of the nation hinges on access to mental health services that revolve around primary health care delivery to families and communities.

Instead, the community health agencies have replicated a private sector, allopathic reductionistic model of care delivery that for the most part, amounts to individual outpatient prolixin treatment at the Mental Health Clinic during office hours. The dream of readily accessible primary care and social reform was viewed as unrealistic and died from lack of sufficient support and funding (Billings, 1993). Learning from the shortcomings of this previous attempt is crucial to the current health care reform effort.

Summary and Implications

This investigation has attempted to identify some of the barriers to mental health care access for the individual in crisis. The results were consistent with previous studies of the factors that influence access to services for both individuals and families affected by emotional turmoil. The process of regaining a stable state of health following a crisis is difficult and is influenced by the individual's degree of psychopathology and a system of available care. In this era of health care reform, a concise plan for mental health services must be included. Further investigation into the client and provider identified barriers to needed services is important to the process of more accurate service development.

The implications of this study are threefold. First, the system of mental health care delivery should be more responsive to the social service needs of the individual experiencing a mental health crisis. The current system of mental health care delivery is often unable to respond to the individual’s basic need for clothing or shelter.

Second, the data support the crucial elements of crisis theory in that more immediate access to services at the time of the crisis will facilitate a more rapid return to the pre-crisis state and reduce the long-term negative effects of the crisis. Development of a system that is more able to meet the needs of the individual in crisis is necessary for effective crisis resolution.

Third, the data support the key elements of critical social theory in that a better understanding of the individual’s lived experience is important to reducing the potential for oppression and stigmatization. Critical social thinking is developed through improved education about mental illness and the services needed for it to be adequately managed. This educational process would best be aimed at the general population of both the consumer and the health care professional to foster a better understanding about what factors contribute to maintaining a healthy emotional state.

In sum, future health care system development should be informed by research into the areas of client need, service delivery and the effects of focused consumer education.

APPENDIX A

SUBJECT CONSENT FORM

CONSENT TO PARTICIPATE IN THE RESEARCH PROJECT,
HSC DKT#________________

BARRIERS TO MENTAL HEALTH SERVICE ACCESS FOR THE INDIVIDUAL IN CRISIS

SUBJECTS NAME__________________________
P.I.'S NAME: ANNE L. BATEMAN

YOUR PARTICIPATION IN THE PROJECT IS ENTIRELY VOLUNTARY.
YOU MAY WITHDRAW FROM THE STUDY AT ANY TIME.
THE QUALITY OF CARE YOU RECEIVE AT THIS HOSPITAL WILL NOT BE AFFECTED IN ANY WAY IF YOU DECIDE NOT TO PARTICIPATE OR IF YOU WITHDRAW FROM THE STUDY

A study is being done by A. Bateman, R.N., C.S. to learn more about the experience of the services available for people in crisis. She has asked me to be in the study. If I agree to be in the study, I will be asked some additional questions at this visit and will be interviewed again in four to six weeks. This will be no benefit or consequence for me, though the study may produce information of use to the system of health care delivery in the future.

As a result of answering these questions, there is a possible loss of my privacy. The investigator will separate names from responses and will keep the names coded and locked so my confidentiality will be protected as much as possible.

I have had the opportunity to talk with Ms. Bateman about the study. I may reach her at 508-856-3573 if I have questions later.

I have received a copy of this form and I know I have the right to refuse to participate or to withdraw at any time without any jeopardy to my care at this hospital.

Date ______________________ Subject’s Signature ______________________

Date ______________________ Investigator’s Signature ______________________

INVESTIGATOR’S DECLARATION

I have explained to the above-named subject the nature and purpose of the procedures described above, and the foreseeable risks, discomforts, and benefits that may result. I have considered and rejected alterative procedures form obtaining this information. I have asked the subject if any questions have arisen regarding the procedures and have answered these questions to the best of my ability.

DATE ______________ PRINCIPAL INVESTIGATOR ______________________

APPENDIX B

PRE-INTERVIEW FORM

MED REC#____________GENDER____DATE____________DAY________

DOB___________________AGE____YRS ED_____________
EMPLOYMENT_________ TIME IN___________TIME OUT__________
TOTAL TIME________________________
REPEATER Y N - METHOD OF F/U - TELEPHONE #____________
RETURN________

1. CURRENT PSYCH FOLLOW-UP: 1.UMASS OPD 2. CMHC
3.PVT 4.OTHER PUBLIC
5.OTHER 6.NONE

2. INSURANCE: 1. UNKNOWN 2. NONE 3. MEDICAID
4. MEDICARE 5. PRIV
WAS IT VERIFIED? 1. YES 2. NO

3. EXTENDED HOLD 1. YES 2. NO REASON_________________

4. PREV PSYCH ADMITS: 1. ALL OR MOST PUBLIC
2. ALL OR MOST PVT 3. MIXED
4. UNKNOWN 5. NOT APPLICABLE

5. PREV PSYCH OUTPATIENT: 1. UMASS 4.OTHER PUBLIC
2. CMHC 5. OTHER
3. PVT 6. NONE

6. PSYCH SOCIAL SUPPORT SX. (CIRCLE ALL THAT APPLY):
1. SIGNIF OTH 2. FAMILY 3. FRIENDS
4. RES. PROGRAM STAFF 5. NONE 6. UNKNOWN

7. MAJOR PRESENTING PROBLEM: 1. PSYCHOTIC
2. NEEDING TO TALK 3. STRESS/ANXIETY 4. SI/HI
5. REQ MEDS 6. DEPRESS 7. SIT.CRISIS
8. FAMILY CRISIS 9. ETOH CRISIS

8. DSMIII: AXIS I:______AXIS II:______AXIS III:_______
AXIS IV:_____AXIS V: ______

9. REF BY: 1. SELF 2. FAM/FRI 3. MED ED 4. PD
5. THERAPIST 6. SOCIAL SERVICE AGENCY
7. OTHER DEPT 8. OTHER HOSP 9. OTHER

10. LIVES WITH: 1. SIG OTHR 2. FAM 3. FRIENDS
4. ALONE 5. HOMELESS 6. GRP HOME
7. UNKNOWN 8. OTHER

11. CLIENTS DESCRIP OF WHAT WOULD HELP_________________
____

12. EVALUATORS DESCRIP OF WHAT WOULD HELP______________
____

13. CLIENTS DESCRIP OF PREV. OPD PSYCH EXPERIENCE AND TYPE: ____
____

14. PLAN AT DISPO:____________________________________
____

15. EVALUATORS RATE OF CLIENT COMPLIANCE:
1. HIGH 2. PROBABLE 3. LOW
EVALUATORS INITIALS______________________

APPENDIX C

POST-INTERVIEW FORM

MED REC #______________DATE__________EVALUATOR_________

1. TYPE OF F/U: TELEPHONE ONE/ONE

2. WERE YOU ABLE TO FOLLOW RECOMMENDED PLAN: Y N

3. HOW WOULD YOU RATE THE SERVICE RECEIVED IN THE PLAN:
   1. GOOD 2. FAIR 3. POOR
   EXPLAIN____

4. HOW LONG DID YOU WAIT FOR FOLLOW-UP:
   1. 1-3 DAYS 2. 4-6 DAYS 3. 1 WEEK
   4. MORE THAN 1 WEEK BUT LESS THAN TWO WEEKS
   5. TWO WEEKS OR MORE

5. SINCE YOU CAME TO EMHS HAVE THINGS IMPROVED: Y N
   1. WHAT'S BETTER__________________________________
   2. WHAT'S WORSE __________________________________
   3. WHAT HAS CHANGED_______________________________

6. WHAT WOULD YOU DESCRIBE AS THE BARRIERS OR DIFFICULTIES GAINING ACCESS TO FOLLOW-UP SERVICES

7. HOW DOES THE EVALUATOR DEFINE BARRIERS TO ACCESS____

8. WHAT WOULD HELP IMPROVE THE SITUATION NOW__________

9. EVALUATORS DESCRIPTIONS OF WHAT WOULD HELP NOW______

10. OTHER INFORMATION SIGNIFICANT TO THE SITUATION AT THIS TIME

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