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# Crisis Intervention Services in Mental Health: A Review of the Literature

Roger A. Lohmann

Ellen Neidermeyer

Mental health crises come in many different forms and contexts. The wife beaten by her husband, the acting-out adolescent threatening suicide, the delirious alcoholic or substance abuser, the mentally impaired older person wandering along a busy highway, the developmentally disabled adult lost or abandoned in a public setting, and many other similar crises big and small, must be seen as part of the spectrum of extraordinary situations to which the contemporary mental health system must respond.

Crises may occur in the home, in the neighborhood, in the office or store, or on the street. They may occur at any time of the day or night. One particularly difficult set of problems arises out of the fact that mental health crises are notoriously indifferent to professional office hours -- occurring as frequently late at night or on weekends as during the regular business day. The challenge for the mental health system, therefore, is to be ready to respond adequately to crises wherever and whenever they occur.

## The North Central West Virginia Study

This paper is a review of the literature on mobile crisis services and other forms of modern crisis intervention services. It is the first part of a study of the need for additional crisis intervention services in the four-county area of North Central West Virginia served by Valley Community Mental Health Center. The second phase will involve construction of a detailed profile of the existing Community Support Systems (CSS's) in the four counties, with particular attention to responsiveness to mental health crises of various types. The third phase of the study will survey a broad range of consumers of mental health services in the four counties to determine the range of crisis experiences encountered and their evaluations of the existing system.

The purpose of this literature review is to identify recent published literature on crisis services, with particular attention to crisis response services. No attempt has been made to survey the voluminous literature on crisis intervention practice skills and techniques. Certain key concepts of critical importance to the case for crisis response services throughout this review are highlighted to call special attention to them. Complete bibliographic citations of all of the literature discussed are included at the end of the paper. Appendix A is a list of specific crisis response services cited or discussed in the contemporary mental health literature.

For purposes of this review, a mental health crisis is defined as any situation in which an individual or group experiences a sense of being overwhelmed by events or circumstances and is unable to respond in an appropriate manner or to call upon established or pre-existing problem-solving skills and abilities.

## Historical Background

Modern crisis intervention has its origin in the work of Erich Lindemann following a fire which raged through the Boston's Coconut Grove Melody Lounge in 1942 resulting in the death of nearly 500 people. This disaster, which at the time was the largest single building fire in this country's history, led Lindemann and his colleagues from the Massachusetts General Hospital to actively help the survivors cope with losing loved ones.

The clinical report of their efforts which focused on **bereavement reactions** (Lindemann, 1944) became the cornerstone for subsequent grief process theories and an important foundation of contemporary crisis theory. Lindemann's study described both brief and abnormally prolonged reactions by individuals in route to accepting or adjusting to their losses. He concluded that community caregivers, such as the clergy, played important roles in assisting and providing the **social approval** necessary to help bereaved persons work through the **grief process**. He believed an individual must go through this process of grieving, and that successful completion of the process could help the individual avoid psychological difficulties later in life. The importance of approval and affirmation to crisis victims is one of the underlying factors in the tremendous recent growth of the self-help/support group phenomenon in the United States (Newsweek, 1990).

Although the term crisis intervention was not in existence at the time, Lindemann's work in fact resulted in the development of the first crisis intervention techniques. These techniques were utilized by Lindemann and Gerald Caplan in 1948 when they established a community-wide project in Boston known as the Wellesley Project.

Further work by Caplan (1961) underlined the importance of the concept of **crisis periods** in individual and group development. These crisis periods occurred when a situation was faced in which customary problem-solving techniques could not be used to return to a state of desired emotional equilibrium or homeostasis. The incurring reaction varied from inner tension to other signs of anxiety and led to a prolonged period of emotional upset. The outcome to this crisis was determined by the kind of intervention that took place.

Caplan's ideas of preventive psychiatry influenced the development and role of all mental health professionals. His crisis theory was instrumental in the development of the **suicide prevention** movement (McGee, 1974), which

had a rapid growth in the sixties. In detailing the work carried out at the Los Angeles Suicide Prevention Center McGee noted that the center was staffed with nonprofessional and paraprofessional volunteers who offered 24-hour, telephone hotline counseling services 365 days each year. Although the original goal of this and most other such centers was aimed at suicide prevention many soon moved into a broader range of crisis intervention activities.

The spreading influence of crisis intervention theory and practice also had an important impact upon the creation of the Community Mental Health system in the U.S. The Kennedy Administration's increased concern with broad social issues including mental health, and the recommendations of the Congressional Joint Commission of Mental Illness and Health in 1961 were responsible for the emergence of the **community mental health** movement in this country. The book, *Action for Mental Health*, published in 1961, documented that people were not getting adequate help with mental health problems where or when they needed it which the report considered was nearest their **natural social setting**. With the passage of the Mental Health Centers Act of 1963 (P.L.88-164), crisis intervention and 24-hour emergency services in the community setting were incorporated as essential components of a community mental health system.

The central concepts of crisis theory gained increasing legitimacy in the expanding world of community mental health practice. A major milestone in the acceptance of crisis intervention occurred in 1970 when the term was included in the fourth edition of Hinsie and Campbell's *Psychiatric Dictionary* as one of several modes of community psychiatry (Aguilera and Messick, 1974). The Hinsie-Campbell article contrasts the crisis intervention model of community mental health with a medical model of mental disease.

As crisis intervention programs developed in the seventies several journals such as *Crisis Intervention*, *Psychosocial Rehabilitation Journal*, and the *Community Mental Health Journal*, began to deal more frequently with crises situations and intervention techniques. These journal articles dealt with evaluation of programs in the crisis centers as well as pointing toward the cost effectiveness of short term psychotherapy (Cummings 1977; Auerback and Kilmann, 1977).

Cost effectiveness arguments were to become increasingly important in the constricted fiscal climate of the late 1970's and 1980's. Those arguments generally appeared to agree with a series of court rulings endorsing the provision of care in the least restrictive alternative. As well as being legally and ethically preferable, community based care was (and still is) thought to be more cost effective than institutionalization. Thus at a time when federal funding for many social services were being cut, reports indicated techniques used in many crisis center were not only effective as treatments, but also

more cost-effective in reducing the need for future long term inpatient treatment.

## Converging Models of Crisis Intervention

Practice theories dealing with crisis situations are still evolving. Slaikeu (1984) states "we are not at a point where we can summarize tried and true principles or strategies of crisis interventions" (p.77). He points out that one difficulty has been the lack of studies to examine both the process of what therapist actually say and do, and the outcome or what happened to the client after treatment. For the purpose of this literature review a comprehensive model (utilizing both first and second order interventions) as outlined in Slaikeu will be considered along with a convergent model (based on the work of Caplan) as presented in Burgess and Baldwin (1981).

In Slaikeu's comprehensive model as shown in Table 1 first-order crisis intervention, or **psychological first-aid**, involves immediate assistance and usually takes only one session. The immediate goal is coping and front-line care-givers usually attempt to achieve this goal by providing support, reducing lethality (suicide), or injury to others (child abuse), and providing linkages to helping resources. Such psychological first aid can be offered almost anywhere -- over the telephone, at school, or in the home.

The second order intervention what he terms **crisis therapy** refers to short-term therapeutic processes that aim at crisis resolution rather than immediate coping. These services ordinarily are provided by professionals with formal training in short-term therapy and in settings with the space necessary for counseling (private areas for the client and crisis therapist).

This model is based upon the work of Lazarus (1976) which takes a multidimensional approach to psychotherapy. Very briefly this crisis therapy describes the behavioral, affective, somatic, interpersonal, and cognitive aspects of a client's crisis. This would include patterns of work, use of drugs (behavioral), health (somatic), and relationship with family and friends (interpersonal). The initial task of the therapist is to assess the client's functioning into one of these five modalities and then to work through the situation using appropriate therapeutic strategies.

According to Burgess and Baldwin (1981) the previous training of practitioners and particular philosophies of change are reflected in the various styles of crisis intervention. They examined two divergent crisis models to provide a perspective on trends of recent years and to encourage a convergent model. As detailed in Table 2 the **screening/assessment model** and the **problem-solving model** reflect contrasting approaches at every level. The screening/assessment model is essentially a medical model. It has an emphasis on underlying disease processes manifested in the client. The

primary responsibility of the therapist is to evaluate the client's past and present ability to function and make referrals to necessary treatment.

The problem-solving model is grounded in the pragmatism of John Dewey. Its impact upon crisis theory and mental health can be traced to the 1960's. Many innovative mental health services have been developed in the past three decades to deal with problems related to changes in values and life styles. **Peer counseling** is one such services which enabled young people to help others their age by the use of active listening, establishing rapport, and dispersing information.

In what they term the **convergent model**, Burgess and Baldwin combine elements of screening, assessment and problem-solving approaches to crisis intervention. This model offers a useful base for considering the full range of crisis response services. It has a past-present-future time orientation. The therapist's goal is seen as rehabilitative -- restoring the client to the precrisis functioning level as quickly as possible. The authors believe that combining assessment and problem-solving is the basis for most actual crisis therapy in practice by professionals in the community mental health field today.

## Typology of Crises

Since the early research work by Lindemann and Caplan on grief and the effect of crisis periods on individuals, many of the clinicians and researchers who followed agreed that **crisis experiences** were often precipitated or touched off by some specific event. However, investigations to the present have not produced a comprehensive typology or categorization of the broad range of possible **precipitating events, crisis periods** or **crisis experiences**.

In 1978, Baldwin (Burgess and Baldwin, 1981) classified crises into six major categories which frequently come to the attention of the clinician. A brief definition of each class, as well as an example or examples of individual or groups involved, and a typical response by the clinician will follow.

The first class is a **dispositional crisis** defined as distress which resulted from a current problem faced by the client. The client is confronted with a sense of immediacy and the clinician's response varies from providing educational information to a referral to a specific agency. An example of this type of crisis would arise from the stress an alcoholic person might place upon other family members. Referral to a support group such as Al-Anon would be one type of intervention in a dispositional crisis. In general terms, information and referral type services are an important component of the service response to dispositional crises. Because many of the precipitating events are family-oriented, many of the precipitating events and crisis periods for dispositional crises are likely to occur in the home. (This is consistent with the large proportion of police calls for "domestic incidents").

**Transitional life crises** described in the second class can be upsetting, but are usually normative life situations over which the client may have little control. Assistance may be sought at any time during this transitional period. Included in this class would be crises resulting from life cycle transitions or signaling shifts in social status. Life cycle transitions are well documented in the literature. They range from the birth of a child (Erikson, 1959; Newberger, et. al., 1986) through old age (Erikson, 1959; Butler and Lewis, 1982). Mid-life career changes and women reentering the work force are examples of shifts in social status. Segre (Burgess and Baldwin, 1981) states "despite the fact that returning to work has been embraced by society as a panacea to the mid-life crisis, this drastic role change, in and of itself, can precipitate a crisis for the long-time homemaker" (p 171). The role of crisis response services in dealing with transitional life crises could vary from support to helping with coping mechanisms. Transitional life crises involving children and youth are likely to occur at home or at school or at leisure "hangouts". Similarly, transitional life crises involving adults may be anticipated at home, at work and at adult leisure locales (from bars to sport and exercise clubs, country clubs, etc).

**Traumatic stress crises** are described as emotional crises precipitated by externally imposed stressors or situations that are unexpected and uncontrolled. Psychological assistance may be sought immediately following the event or at a later time. Examples of this class include sudden death of a family member or spouse (Lindemann, 1944; Sabatini 1985), sudden loss of job or status, stresses caused by natural disasters such as floods (Gleser et. al., 1981), acts of human aggression such as war, combat stress or crimes of rape (Gilmartin-Zena, 1985). The usual professional response is to utilize generalized acute crisis intervention techniques. A specialized literature dealing with techniques especially suited to individual types of disasters has also grown up.

By their very nature, traumatic stress crises are highly unpredictable, depending upon somewhat random precipitating or "triggering" events. A former student reported being overwhelmed by grief in the ticket line at Orly Airport in Paris, while traveling home for the funeral of his wife who had been killed in a traffic accident while he was abroad. Simply because of the sheer unpredictability of such events, virtually the entire adult population, and significant portions of the youth population as well, must be seen as potential providers of psychological first aid in such circumstances.

Class four includes **developmental or maturational crises** which are the result of attempts to deal with interpersonal situations which reflect struggle with a deeper and usually circumscribed issue. These crises are typically encountered in adolescent and young adults, although an unresolved childhood trauma could extend beyond young adulthood. Blazyk (1983) argues, for example, that while severe head injuries may occur at any

age, they are particularly devastating for adolescents because they halt developmental progress and foster prolonged dependence. The intervention necessary by the clinician is to identify the key developmental issues involved and the impact of current stressor. Although there are a wide range of examples of this type of crisis one which appears frequently in present literature is child abuse. The discussion of child abuse in terms of crisis intervention is expanding rapidly, and we have not attempted to review it here. Many of the precipitating events of developmental and maturational crises in the modern world are likely to occur in or near educational settings, such as classrooms, lunchrooms, high school hallways and college dormitories.

Burgess and Baldwin describe crises reflecting **preexisting psychopathology** in which the psychopathology is instrumental in precipitating the crisis. The crisis therapist must have the correct diagnosis of the preexisting condition in order to adapt the therapy response. Examples of this class of crisis would include severe neuroses and schizophrenia. Like traumatic stress crises, preexisting psychopathologies may be triggered almost at random. Further, it may be unclear to others in the situation exactly what is occurring or why. This is often one of the most vexing areas for the provision of psychological first aid in crisis situations, because non-therapeutic professionals, support group members and others may be uncertain in their responses. Psychological first aid training which deals with reducing the fears and uncertainties of potential helpers may be a particularly useful strategy in this case.

The last class of crises identified by Baldwin are **psychiatric emergencies** which involve crisis situations in which general functioning has been impaired. As such, the location of such crises is largely irrelevant except with respect to elements of discomfort (extremes of heat or cold), danger (traffic, potential violence, etc.) and the like. Examples of these emergencies include acutely suicidal clients, drug overdoses, and alcohol intoxication. It is this type of crisis which is most commonly associated with crisis intervention in public perceptions. The general strategy used in psychiatric emergencies emphasizes rapid assessment of the individuals' medical and psychiatric condition, understanding the situation leading up to the emergency, and utilizing all available medical or psychiatric resources necessary to treat the client.

## Service Delivery Systems

Many individuals in the course of their daily activities in the community are in a position to offer assistance to individuals who are in crisis situations. These may include members of the clergy, police officers, attorneys, teachers and other school personnel and hospital emergency room staff and others. Although they may have short term contact with the individual in crisis, they

are able to provide psychological first aid and linkage to the resources which are available within the community. Thus, their role in adequate community crisis response services must be noted.

## Clergy

Lindemann (1944) noted that members of the clergy are often sought out first to help in crisis situations. This continues to be true in many West Virginia communities. Stone (1976) suggests ministers are in a unique position to offer counseling because they often make visits to a parishioner's home following news of marital problems, loss of a loved one, or other crisis situations. Their role in psychological first aid would seem an especially critical component of an overall crisis response system.

Many of these situations result in feelings of depression or lack of control, and the minister is in a position to offer hope and follow-up support in an effort to work through these feelings. Furthermore in several of the transitional life crises and/or traumatic stress crises described earlier in this review the minister will be present to perform the religious ritual (Clinebell, 1966).

It should be noted that although members of the clergy are in this unique position to offer counseling and have made advances in this area the curriculum in many seminaries still offer counseling courses as elective (McCauley, 1990). While trained and certified pastoral counselors have become an established component of the mental health system in many areas of the country, there appear to be relatively few trained and certified pastoral counselors available for crisis intervention services in North Central West Virginia.

In addition to the counseling which is offered within the church setting the church has been shown (Steinitz, 1981) to frequently serve as a surrogate family for older people. This relationship was noted in the use of family like terminology and the wide range of services offered. The same may also be true of other populations at risk of crisis, and point toward more formal roles for organized religion in community crisis response systems. Along this line, recent media attention in news magazines such as Newsweek and television news and feature reports have called attention to the use of churches as a frequent meeting place for support groups, for example.

## Law Enforcement Officials

While the mention of police work typically brings to mind criminal intervention and law enforcement Goldstein (1979) claims that only 10-20 percent of a typical officer's day is spent performing these duties. The large part of the remainder is spent in order-maintenance activities, a great many

of which involve crisis situations, such as domestic violence, intoxication, and suicide attempts.

In light of this, it is disturbing that law enforcement officials typically are not well prepared in techniques of psychological first aid and other aspects of crisis intervention. Jacobs (1976) indicates only approximately 10% of an officer's training is involved with human relations. In addition to the order maintenance calls, the police are often summoned to handle crises with mentally ill persons. Such calls occur frequently on weekends or after hours when the mental health centers are closed.

Unfortunately, the police crisis-response repertory is extremely limited: If the hospital emergency room or mental health center response team can not refer the crisis victim to a suitable facility they may have to be incarcerated, simply because the police may be aware of no other available alternatives. Pogrebin (1985) found that when this occurs problems with self-destructive behavior often arise. He reports a need for mental health screening in jails and more front-line involvement of mental health professionals to find appropriate solutions in such cases. Such needs are likely to be particularly great in small towns and rural communities where lack of specialized training or backup support may be particularly acute. Where backup supports have been attempted, they appear to produce satisfactory results. Mallory (1979), for example, claims that the use of police and social workers to cool down family crises is an effective intervention strategy.

## Legal Services

Although the clergy may be the first professional who many individuals seek out during a crisis, and the police may be forced by circumstances into crisis situations whether or not they are sought, a broad range of other possibilities also exist. In some circumstances an attorney may be the initial contact. This could involve not only the involuntary incarceration of a person accused of a crime, but a mentally ill person, a delirious alcoholic or substance abuser, or wife trying to protect herself against harm from an abusive husband. Attorneys and legal services are in fact contacted by individuals with emotional problems. Frequently, attorneys must first deal with the emotional state of the individual and/or family members before any legal questions can be addressed.

In fact, the necessity of dealing first with their clients' crisis responses is so customary that it has made its way into legal counseling technique: Binder and Price (1977) suggest a three-step approach to legal counseling which follows: First, encourage client to express concerns and emotional reactions; Then, help client acknowledge emotions; and finally, obtain a chronological overview of the problem and develop the theory of response. It is estimated that 30 to 80% (Shaffer, 1976) of an attorney's time is spent in counseling their clients, yet, as in the seminaries, many courses in legal

counseling at law schools are offered only as elective seminars. Thus, many lawyers like the clergy and police, may find themselves unprepared for the realities of crisis intervention in practice.

## Hospital Emergency Rooms

Frequently the first professionals to see individuals in crisis are the personnel in the hospital emergency room. Their use has increased greatly in the last decade because of 24-hour availability and the growth of insurance reimbursement for emergency treatment. The use of emergency rooms as a first line of treatment extends to mental as well as to physical conditions. Mentally ill individuals often go or are taken to a hospital emergency room for initial treatment.

Unfortunately, emergency room procedures often provide only psychological first aid or treatment not second order crisis theory. Corten and Pelc (1984) found that emergency room staff view their role in psychiatric emergencies as shunting these patients off to someone else rather than as beginning the therapeutic process.

The situation is not entirely bleak, however. Several hospitals have expanded their emergency rooms to be more comprehensive by having a multidisciplinary team available to deal with mental health crises. Winter (et. al., 1987) conducted a survey of psychiatrists, psychiatric social workers, clinical psychologists, occupational therapists, psychiatric nurses and general practitioners to consider crisis intervention attitudes and therapeutic strategies. They found attitudes and treatment styles of crisis team members and nonmembers differed largely by professions. They reported initial crisis intervention interviews exhibited more confrontation and less exploration by therapists than did initial psychiatric outpatient interviews.

## Other Health Professionals

Many other health professionals have a direct impact in crisis resolution including physicians, nurses, physical therapists, social workers occupational therapist, and others who have contact with individuals during acute and chronic illness and life crises. Aside from the fact that these professional are in a unique position to offer advice on an ongoing basis to clients with physical and emotional problems no further discussion of the roles played by these professionals will be attempted in this literature review.

## Crisis Intervention in Schools

An abundance of literature has emerged dealing with crises in the school. Crisis intervention responses in school including bereavement programs (Schonfeld, 1989; Trachta, 1988), suicide prevention (Shaffer et. al., 1988;

Joan, 1986) divorce and remarriage (Jarmulowski, 1985; Stanton, 1986) and other subjects. The public school setting provides an excellent location to be involved in crisis intervention because of the amount of time teachers and other school personnel spend daily with the students. Teachers are in a position to note changes in student's behavior, emotional state, and/or academic performance. Although an argument can be made that teachers are already overworked, it can also be argued that if they were familiar with crisis skills a number of the problems that arise with students could be dealt with more easily.

Woldrich (1986) describes a series of events including a dramatic increase in suicide threats and attempts in a small community in central Indiana following the successful suicide of a high school student there. The role of in-service training for school personnel and classroom based programs to build students' social skills and self esteem are discussed.

## Crisis Intervention in Hospitals

Sands (1983) argues that crisis intervention theory, with its emphasis on focused treatment in a limited time frame, is adaptable to social work practice in hospital settings. Three kinds of medically oriented crises are identified and discussed: those caused by the illness or injuries, those associated with the events of hospitalization, and those associated with specific treatment procedures (such as surgery or chemotherapy).

A primary orientation of crisis intervention in hospital settings involves assisting patients and their families in coping with new or unfamiliar circumstances. Berger (1984) describes a professionally staffed drop-in support group for cancer patients and their families as a means of promoting adaptive responses and encouraging movement away from maladaptive responses to the stresses of cancer. The protocol of a SID Crisis Intervention in Australia, for example, like (many similar services not documented in the literature) assigns social workers to notify police of the death and arrange for an autopsy -- tasks likely to increase the stress of parents of an infant who had just died. (Bradey, 1985)

## Community Support System

The past two decades has seen a dramatic reduction in the number of individuals who reside in public mental institutions as a result of court orders mandating an individual's right to treatment in the **least restrictive environment**, the fiscal incentives, and use of new drugs and other treatments. This has resulted in large numbers of individuals who once lived in institutions now requiring care in **community based services**. It has also shifted the locus of mental health crises in this population out of the institution and into the community.

Shortly after the deinstitutionalization movement began the National Institute of Mental Health (NIMH, 1974) began promoting a concept to assist persons with long term mental illness live in the community which became known as the **Community Support System**. Stroul (1989) describes the Community Support System concept as a broad range of basic community services and supports which include a wide array of treatment, life support and rehabilitation services required by individuals with chronic mental illness living in the community. Since the U.S. Department of Health and Human Services (1980) reported two million individuals in the United States are considered to have chronic long-term mental illness, it is essential that any community support system have adequate crisis services.

Established models of community support systems offer an appropriate framework with which to consider reports of particular crisis intervention services, because of the emphasis on comprehensiveness. NIMH (1980) defined a community support system as "an organized network of caring and responsible people committed to assisting persons with long-term mental illness to meet their needs and develop their potentials without being unnecessarily isolated or excluded from the community". Stroul (1989) indicates that although the actual organizational structure may vary from community to community and state to state, several values should be found in all community support systems. Foremost among these values is the idea that these individuals with mental illness have the same rights and privileges as other citizens. Secondly the community is the best setting in which to receive long-term mental health care. A few of the other values included in the general concept of these services include having the services be: consumer-centered, racially and culturally appropriate, flexible, and coordinated.

For a comprehensive model of a community support system developed by Stroul see Table 3. Although all components in this model are important in the management of individuals with severe and long-term mental illness we will concentrate on four of these service components (crisis response services, client identification and outreach, mental health treatment, and family and community support ) in this literature review. This is primarily because the bulk of the literature on crises services fall within these topics.

### **Crisis response service**

Individuals with serious long-term mental illness frequently have recurrent crises even when they are being treated in community support services. Crisis services are necessary to handle these situations on a 24-hour seven day- a-week basis. The primary goal of these services is to assist the individual in the crises and to maintain him/her in the community, if possible. Stroul (1989) identified five crisis response services: telephone

crisis service, walk-in crisis service, mobile crisis outreach service, crisis residential service, and inpatient service.

One major option for dealing with emerging crises is what Surratt (1980) terms “crisis intervention by phone.” Although the use of the **telephone crisis service** has been noted to be the subject of abuse (Tarran 1982) the value of such services can also be found in recent literature. Telephone crisis services has been utilized solely or as an integral part of other services offered in connection to teenage suicide prevention. In a critical review of available literature, Shaffer (et al., 1988) included hotlines as a essential ingredient in teenage suicide prevention and presented evidence of their efficiency. Stein (1984) believed the availability of telephone crisis services may be related to reduced suicide rates among young white females.

It is not difficult to locate recent literature detailing **walk-in crisis intervention services** in mental health agencies. These articles range from the description of a fully indigenous mental health program serviced and controlled by a Papago Indian tribe (Kayn et. al., 1988), service delivery of this type in a rural setting (Shybut, (1982), to serving the chronically mental ill client in an urban setting (Bennett, 1988; Surles and McGurrin, 1987; Soloman and Gordon, 1988). These studies show need to alter the services to the setting being provided. Similarities in the studies by Kahn and Shybut noted rural settings are known to seek to solve their problems by relying on informal paraprofessionals. While a traditional centralized mental health system is often available there is frequently no coordination between it and the informal nonprofessional network. Although several factors are involved Shybut cited as reasons the traditional professional system was geographic maldistributed and the lack of accessibility and acceptability by individuals within the rural setting. On the other hand, the informal nonprofessional group were strained by lack of expertise.

Services provided in urban setting have noted the increased use of **psychiatric emergency services**. They resulted from the community health legislation of the 1960's and appear to be very adaptable due to their flexible personnel requirements and lack of need for elaborate technology. Bennett (1988) identified their role as functioning as gatekeeper, the management of clinical information, principles for organizing clinical space, and trends in clinical program management. Their rise in use can be observed by the fact that there were fewer than 160 facilities in 1963 and their number exceeded 2,000 in the early 1980's (Wellen et. al., 1987). Golden (1990) cited the increased use of psychiatric emergency room in New York City could be traced to two factors. First the recent drastic reduction of funds to community mental health problems, and the increased use of crack among the emotionally disturbed homeless---noting in 1987 11% of all

psychiatric emergency room visits were tied to crack compared to 45% in 1989. Findings of study by Solomon and Gordon (1988) who tracked 114 adults after evaluation at a psychiatric emergency room and referral to community mental health services and substance abuse agencies showed two-thirds subsequently made contact with these agencies, but fewer made contact with the agency to which they were specifically referred.

The effectiveness of **mobile outreach services** is shown in an article by Benglesdorf and Alden (1987) which stated that 70% of all patients seen in crisis could be maintained in the community with a mobile outreach team, with two-thirds of the rest being admitted to community hospitals rather than state or county institutions. Moreover, Bond (et al., 1988) reported that clients randomly assigned to an assertive outreach team had significantly fewer hospital episodes and total days of hospitalization than during the previous year and significantly fewer than clients randomly assigned to a low-expectation drop-in center. Also reported was only one client dropped out of the assertive outreach program compared to 74% of the drop-in center clients who never returned after an initial visit. Putnam (et. al., 1986) described a mobile psychiatric outreach team in New York City which was used to transport mentally ill homeless persons at risk to self or others to an emergency room for evaluation. They reported about 1% of the contacts are determined to be at imminent risk and are taken to an emergency room, while the largest group considered high risk but adaptive were monitored regularly. Reynolds and Hoult (1984) noted that there was more satisfaction with the outreach services by both family and clients, but no significant differences on job maintained, money earned, medications, or symptoms.

One of the most useful sources to consult in the development of a mobile crisis intervention program would be a recently published book by Joel Foxman, **A Practical Guide to Emergency and Protective Crisis Intervention: Dealing with the Violent and Self-Destructive Person**. The book is based on Foxman's 10 years of experience in developing and administering the Mobile Psychiatric Emergency Team in San Pedro California. Most of the book is devoted to detailed discussion of the clinical methods and intervention techniques most appropriate for working in emergency and protective crisis settings. As such, it is likely to be highly useful for professionals working in emergency and protective crisis intervention. It is also useful for our purposes, however, since it is possible to extract some fairly clearcut principles of programming in this area from the discussions as well.

Foxman subsumes all categories of emergency and protective crisis intervention under the rubric of "out-of-control behavior". In this category, he includes suicidal and homicidal actions, psychotic behavior, child abuse, family conflict and other domestic violence, and acting-out behavior related to substance abuse. (1990, v) The bulk of such out-of-control persons are not in

touch with the formal mental health system or defined as mentally ill, hospitalized or seen in emergency rooms or psychiatric hospitals. In fact, they are much more typically contacted initially by local police for what police refer to as "the family beef". As noted elsewhere in this paper, such episodes are a major preoccupation and danger for police. Such family beefs may account for half of all police calls, 40 percent of injuries to policemen and 20 percent of all police fatalities. (Foxman, 1990, 11)

In all settings, such out-of-control behavior often engenders two responses which are inappropriate-- violence and what Foxman terms "diversion". Diversion from institutions to nowhere in particular continues to be a major trend in crisis intervention, with local police playing a major role in diverting clients due to the lack of community programs and the inability of the courts and law enforcement to handle inappropriate referrals. (Foxman, 1990, 11) The underlying direction of this book is to suggest emergency and protective crisis intervention as a preferable alternative to either violence or diversion.

Foxman (1990, 3) defines emergency and protective crisis intervention as "the steps taken to gain control of the client's out-of-control feelings and behavior in order to protect the client from himself, or to protect the community from the client where the risk of life is involved; and the related steps to engage the client in a working relationship with the therapist/worker/interventionist which will lead to a resolution of his particular dilemma."

Foxman identifies two components to emergency psychiatric crisis intervention: First, is reducing any potential for violence, engaging the individual in a working relationship, developing rapport and mutual trust. Foxman places great emphasis on controlling the potential for violence through controlling the person's feelings, in a process he refers to as "verbal self-defense". The second is solving the particular dilemma which brought the client to a crisis. (Foxman, 1990, 26)

"In emergency protective crisis intervention, it is crucial that the worker be in control of the interaction...being in control does not mean necessarily to be overtly directive or authoritative. It means leading the client from a state of high stress to low stress, belligerence to cooperation, hostility to friendliness, confusion to understanding, and indecisiveness to a state of being able to make decisions." (49)

Foxman identifies 10 major components to intervention with violence-prone persons. Together, they virtually define the program for an emergency crisis intervention service:

The **Triggering Event**, a specific situation, precipitating event or hazard which caused the client to enter a crisis state. (33-34) First, he says, the **Plan of Action**, or what the violence-prone person intends to do, must be identified and understood before any successful intervention can proceed. (35-

37) One will often find, he says, evidence of a series of **Practice** sessions, or rehearsals leading up to the current crisis. (37-39) In addition, a triggering event will often have been immediately preceded by **The Crescendo**, or drastic and obvious changes in mood and behavior. (39-40) Agitation, depression, self-recrimination, self-preoccupation, and reclusiveness are often observable manifestations. Sometimes prior to a crescendo or specific triggering event, clients will engage in **Seeking Help** often from clergy, hot lines, teachers, and others. (40)

**A Violent History and Prior Institutionalization** are, according to Foxman, often associated with out-of-control behavior. In particular, an **Early History of** brutality, rejection and/or confusing seductive or sexual relationships are often found in such cases. (41-43)

Certain **personal characteristics** are commonly associated with cases of out-of-control behavior as well: Important among such characteristics are tendencies to low tolerance for anxiety and tension; an "action orientation" -- the need to act out rather than being able to verbalize or talk about stresses; tendencies toward limited, superficial and ambivalent relationships with others, often accompanied by tendencies toward suspicion, distrust and paranoia about others; self-centeredness; morbid fantasies; and swings between being over-controlled and impulsive. (43-47)

When making an intervention with "out-of-control" clients, Foxman says, the greatest safeguard is to have important significant others present. Selection of such **Key Collaterals and Resources** is complicated, however, by the fact that some significant others may act instead as provocateurs and instigators of out of control behavior in the client. (46)

Finally, he says, it is important to remember that in emergency work the intervention is not finished when the parties separate. It is necessary to obtain an agreement with the client, or **Contract** that certain behavior will not be continued or resumed. If a client refuses to make such an agreement, the crisis is not over, he says. (47)

There are several types of **crisis residential centers** ranging from feminist shelter (Rodriguez, 1988) to a crisis home shelter (temporary foster home care for clients with chronic emotional problems) Leaman (1987); Britton & Matteson-Melcher (1985). Bond (et. al., 1989) compared outcomes for 85 demographically matched clients four months after their hospital admission to two short-term crisis programs which included crisis housing and case management services. In both programs, two-thirds of the clients avoided hospitalization during four month follow-up and both programs were effective in stabilizing clients' housing and financial situations. Similarly Weisman (1985) reported the success of the La Posada program in California over a six year period, and the development of 13 similar programs in that state which indicated that the model was cost-effective and readily

reproducible and was effective in reducing hospital utilization by diverting patients directly or allowing early discharge to La Posada.

The final crisis response service mentioned by Stroul is **inpatient hospitalization**. This type was formerly the common and most widely utilized of all services mentioned but presently should be reserved for the most severe cases in which clients need intensive support and/or supervision during a period of stabilization. These inpatient beds may be in the psychiatric unit of a general or community hospital or state hospital. An article by Stroul (1987) follows as a representative offering of the costs of various residential crisis programs and factors influencing cost. Per Diems of programs surveyed vary from \$35 to \$285 with the average stay between 10 and 14 days for most programs. Inpatient programs would be the most expensive of the services.

## Client identification and outreach

Individuals with mental illness frequently have difficulty seeking out available services. Therefore, these persons may need assistance from various front-line workers to provide access to the services. It has been noted that 30 to 40% of the homeless are mentally ill (Morrissey and Levine, 1987) and that this group is among the least able to locate appropriate agencies.

Another similar group which may need outreach services are individuals who do not remain in services even after they have been informed. Minoletti and colleagues (1984) reported that results of a 20 year computerized literature review of compliance with referrals showed rates ranged from 28 to 64%. In other words, as many as half to three quarters of all mental health clients referred to services since the passage of the community mental health centers act may have fallen out of the system before reaching the referral destination. This points to a role for some type of early involvement of a **case-management** role.

Solomon (et. al., 1986) affirmed these findings noting that one-fourth to two-third of the people referred for treatment do not follow up and 30 to 40% of the people who do follow still dropped out of treatment (Sue et. al., 1976) or missed scheduled appointments (Miyake et. al., 1985).

One implication, among many of such drop-out patterns is the service costs. It is difficult to determine the cost effectiveness of non-engagement. Miyake (et. al., 1985) note that while the failure to keep appointment wastes professional time, the engagement in services by individuals not previously utilized will obviously increase the cost of the use for these services. Another issue here is the cost of services provided to clients versus the cost to society if the client were not receiving services.

## Mental health treatment

An integral part of a community support system is the ongoing management of individuals with severe disabling mental illness. There are many aspects to this management including medication regulation, (chemotherapy as well as drug abuse problems), activities of daily living, and recognizing signs of relapse. The two components which should be included in all mental health care are: diagnostic evaluation and ongoing assessment and monitoring of psychiatric conditions and supportive counseling and therapy (Stroul, 1989).

The areas of treatment which most frequently are associated with mental illness are psychotherapy and the use of medication. Studies show 90-100% of the long-term mentally ill have had chemotherapy at some time during their course of treatment (Dior, et. al., 1982; Matthews et. al., 1979). The use of intensive psychotherapy as a treatment for the people with severe mental illness is not utilized as frequently as it once was, mainly because of the expense involved in providing it. Some research has suggested that long-term supportive psychotherapy, which Neligh and Kinzie (1983) describe as designed to help the person learn basic problem solving skills and work on day-to-day practical issues in the context of a caring, accepting relationship, combined with the minimum amount of medication (Conte and Plutchik, 1986) needed is the preferred choice of treatment at this time. No studies were located to determine the cost effectiveness of this type of therapy.

## **Family and community support**

Over one-third of long-term mentally ill adults live with their families (Lefley, 1987) and 50-90% remain in contact with their families (Fadden et. al., 1987). Therefore it is important for families to be involved in the treatment planning and in service delivery whenever possible. When family support and advocacy organizations are available families should be appraised of their existence. The National Alliance for the Mentally Ill (NAMI) is one such group which has many local chapters.

The availability of community programs is also a benefit to the family. Frequently the providers will need to have community members accept persons with psychiatric disabilities. Studies have indicated of all individuals with disabilities ones with mental illness are the most stigmatized (Anthony, 1972; Scheider and Anderson, 1980). It is obvious that changing public attitudes toward individuals with psychiatric disabilities is essential. If given the chance many of these individuals can help with this change in attitude by functioning favorably in an employment situation (Brand and Claiborn, 1976).

Families may also be important as part of the over all treatment plan for recovering from crises. Brook, Tollard and Martinez (1979), for example, describe a program in which recovering crisis victims temporarily "live in" with a family.

## **Rural Mental Health Issues**

Mental health policy-makers in states which contain relatively large concentrations of rural populations (including West Virginia) are generally aware of the need to adapt models of community mental health programs which were originally designed for urban-based populations and to consider the special needs of rural areas. They are not, however, always willing or able to do much about adapting to the special requirements of rural mental health systems.

Sundet and Marmelstein (1984) suggest that adaptation of classic crisis intervention techniques to the rural environment requires an appreciation of specific contextual factors. Rural values and helping networks impact both how and when crisis reactions come to the attention of the rural practitioner. Other studies have shown that small rural communities require a different kind of attention because of their unique characteristics such as: pride in independence, rejection of the unfamiliar (Bachrach, 1977), tendencies to take problems to family rather than professionals (Shybut, 1982), generally larger proportions of the population living well below the poverty line, and less acceptance of mental illness (Morrison, 1979).

Soloman (1986) suggests three factors as relevant to the entry of a community mental health center or service in a rural system: a) location of the center, 2) rural attitudes toward mental health services, and c) service models. In discussing these factors he notes the eventual success or failure of some rural community mental health center is partially determined by its' location.

Frequently each and every small town and rural community would like to have easily accessible tax-supported public services within its own borders, but is unable to support such a luxury on its own. Although having a regional facility located centrally within a multi-community or even multi-county catchment area offers a cost-effective solution in rural areas, it is often necessary to locate smaller direct service satellite center throughout the area.

In considering the second factor of rural attitudes toward mental health services Soloman notes the necessity of overcoming resistance from not only the general community, but also from the established practitioners. He suggests rural citizens may not have had past experience with mental health workers and thus have a fear of the unknown which can best be overcome by use of community awareness and education strategies. This could be attempted by use of informative radio programs, newspaper coverage of available service, and the distribution of brochures.

Perhaps the best approach is to have staff members of the mental health facility available for speeches at local churches, civic and social groups, and service organizations. One suggestion offered to overcome some of the resistance from established community professionals is individualized, face-to-face contact. This individualized introductory meeting with local professionals may help in the distribution of information and to decrease any fears that may exist concerning the role of the community mental health facility. The need to alter service models to fit rural areas has been mentioned previously in this literature review when it was noted professional must be aware of the informal support system which is used frequently and successfully which includes paraprofessionals and family members.

## **A Wealth of Possibilities**

Review of the current literature on crisis intervention reveals a wealth of possible community responses to the ever-present possibilities of mental health crises. While it would appear that many far-sighted and innovative new services have been reported, very few communities have actually developed comprehensive, coordinated delivery systems for crisis services. In Appendix A, we have pulled together brief, descriptive summaries of some of the crisis response services discussed in current literature.

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## A Sampling of Existing Crisis Response Services

### **Benjamin Rush Center for Problems of Living**

Established 1962

Location: Los Angeles, California

A no waiting, unrestricted intake, walk-in crisis intervention center organized under aegis of the Didi Hirsch Community Mental Health Center.

### **Bronx Mental Health Center**

Established early 1970's

Location: Bronx, New York City, New York

A crisis intervention center created for low socioeconomic Spanish speaking people staffed with Spanish-speaking psychiatrists.

### **City College of San Francisco Mental Health Program**

Established 1970

Location: San Francisco, California

A program to offer short term crisis-oriented psychological services to college students.

### **Crisis Center of Corbeil**

Location: Corbeil, France

A service offering an alternative to psychiatric hospitalization.

### **Crises Intervention Support Unit**

Location: Hartford, Connecticut

A unit to train police officers and social workers to work together in providing assistance to victims of

violent crimes.

### **Dorothea Dix Hospital Child Psychiatry Training Program**

Location: Raleigh, North Carolina

A voluntary intervention team aided at providing mental health services to children in tornado disaster area.

### **Erie County Suicide Prevention and Crisis Service**

Established early 1960's

Location: Buffalo, New York

One of the first 24 hour 365 day hotline services aimed at preventing suicide.

### **Family Crisis Shelter in Hawaii**

Location: Hilo, Hawaii

A shelter for women who had been abused which was staffed by nonprofessional former shelter residents.

### **Family Walk-In Centre - Eaton Socon**

Location: Cambridge, England

A program for parents who abused or were afraid they might abuse or neglect their difficult or disabled children.

### **First Step Program**

Location: Nassau County, New York

A program to treat widowed people through crisis intervention approach in group setting.

### **Gay Men's Health Crisis**

Location: New York City

A multiservice intervention program that attempts to respond

to the immediate needs of patients by providing 'hands on' assistance, material support, and case advocacy.

**Gouverneur Diagnostic and Treatment Center: Homeless  
Emergency Liaison Project**

Location: New York City

A mobile psychiatric outreach team providing crisis services to mentally impaired homeless people in New York City.

**Hennepin County Medical Center Crisis Intervention Center:  
Crisis Home Program**

Location: Minneapolis, Minnesota

A crisis home program to provide alternative to psychiatric hospitalization.

**Inst Universitarie de Psychiatrie Crt de Therapies Brenes**

Established 1970's

Location: Geneva, Switzerland

Crisis intervention model used during the deinstitutionalization period.

**La Posada Program**

Location: San Francisco, California

A program started as a short-term alternative to hospitalization for acutely disturbed, chronic patients which combined crisis intervention with techniques developed in halfway houses.

**Los Angeles Suicide Prevention and Crisis Service**

Established early 1960's

Location: Los Angeles

A 24 hour 365 day hotline aimed at preventing suicide formed as a result of work of two psychologists Norman Farberow and Edwin Shneidman

### **Mobile Psychiatric Emergency Team**

Established in 1970

Location: San Pedro CA

Operated by Dept. of Mental Health of Los Angeles County

A unique program developed in response to the Lanterman-Petris-Short Act

(July, 1969), which spelled out the civil rights of the mentally ill in California.

### **Northern Nebraska Comprehensive Mental Health Center**

Established 1979

Location: Northern Nebraska

A center developed to educate paraprofessional in crisis intervention and management of behavioral emergencies. Included an emergency mental health hotline and had special emphasis on the rural mental health issue.

### **Paradocs Adolescent Crisis Center**

Location: Grenoble, France

A program offered as an alternative to psychiatric hospitalization.

### **Pine Rest Christian Hospital Crisis Service for Adolescents**

Location: Grand Rapids, Michigan

A crisis assessment unit for adolescents in acute psychiatric crises.

### **Rape Crisis Program**

Location: Yale-New Haven Hospital, Connecticut

The program was developed as response to identify deficiency in delivery of comprehensive care to victims of sexual assault.

### **Sign Out Rounds**

Location: Newton, Maine

A communication/support group at day hospital to assess suicide potential and confront issues of safety.

### **Southlake Center for Mental Health Family Violence Program: Caring Center**

Location: Merriville, Indiana

A shelter program which applies family systems theory to victims of violent family situations.

### **Southwood Psychiatric Hospital Bereavement Program for High School Students**

Location: Pittsburgh, Pennsylvania

A program to help students deal with precipitous death of classmate by working through the grief process and to identify students at high risk of suicide.

### **Special Initiative Team of the Indian Health Service**

Location: Albuquerque, New Mexico

A service to provide crisis and prevention consultation to American Indian and Alaska native communities in response to violent behavior.

### **Sudden Infant Death Crisis Team**

Location: New South Wales, Australia

St. George Hospital Casualty Department operates an on-call crisis intervention unit for families experiencing Sudden Infant Death Syndrome.

### **Tohono O'odham Reservation Mental Health Program**

Established 1971

Location: Tucson, Arizona

A crisis intervention center for suicidal in acutely disturbed cases, child abuse, and substance abuse. Used traditional medicine man or woman, as well as professionals.

### **University of South Dakota Sexual Abuse Program**

Location: Vermillion, South Dakota

A program which involves use of theater and social work interventions.

### **Utica-March Psychiatric Center**

Location: Utica, New York

A 24 hour emergency psychiatric service system (EPSS) which included a community evaluation team, crisis residence, and 5 bed facility for short term psychiatric emergencies.

### **Wellesley Human Relation Service**

Established 1948

Location: Boston, Massachusetts

One of the first mental health community-wide programs organized by Erich Lindeman and Gerald Caplan.

### **Youthdale Psychiatric Crisis Service**

Location: Toronto, Canada

A program for handling "hard to serve" behaviorally disturbed youth by increasing the effectiveness of interagency treatment service delivery.