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Mental Health Crises As A Regional Problem

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Introduction

My purpose in this presentation is to treat the problem of mental health crisis as a regional issue or question. Although I have been a Faculty Associate of the Regional Research Institute for some time, since Andy Isserman approached me about applying to join the faculty associates. I have no special claim to expertise in regional science. I also am not – and never have been – a psychiatric social worker or specialist in any of the vast range of mental health therapies. However, my doctoral degree is in social policy planning and I have long been interested in the spatial and regional distribution of human services in rural areas. About ten years ago, I did a study of regional concentrations of aging services in West Virginia (Lohmann, 198x). My first research project with the Institute was also in this general area.

In the past few months, I have once again found my way back to these questions in the context of a study on crisis services that I am currently doing for the regional Valley Community Mental Health Center, funded by the State Division of Mental Health, Community Services Division. This project is a first-ever process evaluation of a state-model Mobile Crisis Unit at Valley. It was first piloted in Monongalia County and has since been expanded to Marion, Preston and Taylor Counties. It is attracting a good deal of attention among mental health centers across the state.

Mental Health Crisis As A Regional Issue

Mental health crises are often treated as individual psychic events occurring in the "mind" of an "individual. The category of mental health crisis might include so called "nervous breakdowns", psychotic episodes, suicide attempts, alcoholic binging or drug overdosing, depression, the wild mood swings of bi-polar disorders, violent outbursts, or any number of additional conditions and disorders. Regardless of how you approach things, these and other mental health crises are seldom restricted to individuals. Family members, neighbors, friends, and even casual passers-by are nearly always also involved in such crises.

In a rural state like West Virginia as well as in large urban centers, there is also an inherently regional aspect to mental health crises. A part of this is historical. There was a definite regional basis for "community" mental health from the very start in the 1960s, since community mental health center (CMHC) "catchment areas" – or service districts – were frequently defined on a regional basis. Part of the reason for this is economic; shortages of clinical experts together with

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unpredictable frequencies of particular disorders and the high costs of training often mean that particular specialists must be conserved and dispatched across wide territories or regions.

Background

In addition, at least since the Elizabethan Poor Law of 1601, and probably for some time before that, dealing with mental health crises has been at least as much a facet of real, day-to-day local government as garbage collection or road maintenance and often an integral part of fire and police services. Suicide-threatening "jumpers" on tall buildings or bridges, for example, often draw responses not only from local police, including those trained in negotiations, but also fire department ladder trucks and EMS or other ambulances. Police are routinely called for "domestic violence" and "domestic abuse" cases.

Unfortunately, local government units established for other purposes have seldom been completely comfortable with the mental health aspects of their missions, and local policy often has an ad hoc, and highly variable aspect.

One of the anomalies of all of this is the role of county officials in the mental health system. Mental health competency hearings and requests for involuntary commitments, for example, have for centuries been the province of county commissioners in many states including West Virginia. When a patient must be transported to a state hospital like Weston or a successor regional in-patient care facility like Sharpe Hospital, that task has historically fallen to county Sheriff's deputies. And municipal and county "911" services bear the burden of routing initial responses and inquiries for emergency services.

Definitions

What I am calling a "mental health crisis" goes by a number of different names. Some of these are popular terms; "going crazy", "flipping out", "losing it", "having a nervous breakdown." Some are very controversial. The issue of whether or not an individual has a right to end their own life, for example. Most have technical definitions, descriptions and "etiologies" discussed in the current editions of the widely respected *Diagnostic and Statistical Manual (DSM)* published by the American Psychiatric Association. Mental health crises can also include a broad range of episodes including terrorist attacks, hostage situations, drive-by shootings, sniper attacks; not only the episodes themselves but also the after-effects for those involved, spectators and others. Some crises of this nature, such as public nudity of dementia patients or suicides in public places, may be very public events; others, like domestic violence cases, profound depression, cases of mental confusion, may be highly private affairs.

Distinct Approaches to Regions

There are at least three distinct approaches to region as it relates to mental health crises. First, there is the unmistakable regional concept in the original 1963

Community Mental Health Centers act already mentioned. In the implementation of that act in West Viginia, general principles of regions elsewhere in West Virginia government as well are evident as regions are defined as multi-county entities. In the case of Valley CMHC, for example, that region extends to four counties as noted previously. Secondly, the notion of "comprehensive and coordinated service delivery systems" in mental health and other service domain – like aging services – seeks to implement a kind of "building block" approach to regional mental health services. This is an issue which I have long been familiar with and have studied in the past (Lohmann, 1980; Lohmann, 1990; Lohmann, 1991; Lohmann, 1992). The concept is a simple one: Some types of services (e.g., banks, lawyers and accountants) are pre-requisite to others (e.g., retail stores). In health care, there must be physicians and nurses available in a community before it is possible to organize and operate a hospital).

Although not strictly hierarchical in nature, there are similar building blocks involved in mental health crisis services, varying all the way from police officers trained to respond to suicide attempts, or hostage negotiators, to various arrays of teams of specialists. In West Virginia's multi-county approach this results in definite geographical arrays and deployments of mental health crisis specialists. In the Valley region, for example, several types of specialists are available only in the "mother ship" here in Morgantown. Others are found here and in Fairmont and Clarksburg, and a few are found in all of these locations and also in Kingwood, Grafton, and West Union.

Finally, I want to mention another micro-level, social psychological (or, in mental health jargon, psycho-social) approach to region that is important from an everyday life world perspective on mental health crises. The phenomenologist Alfred Schutz suggests that our worlds of everyday life can be divided into four regions, or "zones." He described these as:

1. The *world within my reach*. I can reach the podium, for example, where my notes are lying. I can also reach my wallet in my pocket and this glass of water on the podium.
2. The next zone is the *world within attainable reach*. I can step out from behind the podium, for example, and approach any of you here in the audience. I can even walk out of the room completely and still be within my zone of attainable reach. One of the genuinely maddening aspects of intervening in suicide attempts, for example, is that the victim is often just out of reach of the interveners, but moving into the zone of attainable reach may be enough to provoke the very suicide act they are seeking to prevent.
3. Schutz' third zone is the *world within restorable reach*. In this case, for example, it is not attainable for me to go to the library while I am making this presentation, but it is clearly within my power to give up on this presentation right now, walk out and go to the library instead. The whole

point of numerous interventions in mental health crises is introducing the world within restorable research as an alternative: Don't jump off this roof

4. Schutz final zone is *the world beyond reach*. As a practical matter, for example, regardless of whether or not I walk out right now, being in Japan this afternoon is in the zone beyond reach. In mental health crises, civil commitment of dangerous mental health patients, and imprisonment of violent abusers are both efforts to place in the zone beyond reach of ordinary community members those who pose a threat to the community.

Likewise, telephone hotlines including 911, and specialized suicide, substance abuse, and domestic violence phone lines are efforts to bring possible victims within zones of attainable reach. Recent court rulings on the rights of mental health patients have held that indefinite commitment combined with lack of suitable treatment cannot be used to keep people beyond restorable reach. In order to get a better idea of the overall structure of the handling of mental health crises in the North Central West Virginia region we designed procedures for mental health workers in the region to track the occurrence and disposition of all mental health crises over the better part of the past year. Table 1 below summarizes the results of that investigation.

For eight months, we have been tracking calls to the 4-county mental health hotline to determine the proportion of crisis calls, and information about the disposition of those calls in the North Central West Virginia region. In that eight month period, we tracked almost 1,000 calls to the hotline. The first thing that is evident is how variable the frequency of calls can be; a finding that conforms to the experiences reported to us by those who staff the hotline. Even so the fluctuations are not orders of magnitude apart, as the second line of Table 1 shows. They vary between an average low of less than 3 calls per day to a high of less than eight calls per day. (These are averaged by month; No data on actual daily fluctuations were collected.) The actual proportion of calls involving possible crises varies much more widely from a low in July of less than 28 percent to a high in March of almost 78 percent. Thus, unpredictability of mental health crisis is very clearly evident here.

We also looked more closely at several aspects of the disposition of these crises cases. Somewhat consistently, somewhere between one third (35.8%) and half (50%) of all crises were referred by the hotline workers to various service provides in the CMHC itself. The proportion of crises each month referred to the Mobile Crisis Team that had been created as part of this effort, however, varied much more widely from a low of just over two percent in July to a high of over 20% in February. It is worth noting that February was not only the first month of the study but also the first month of operation for the Mobile Crisis team. Given how much higher that initial parentage is, it is highly likely that hotline workers were over-referring initially. This – and in particular, the strong likelihood that some of these referrals did not require the special services of the Mobile Crisis Team – is consistent with the data in the next line: the proportion of crises resolved by the team. A significant number of referrals were also made by the hotline operators to hospital emergency

rooms. Again, we see that somewhere between one third and half of all crisis calls involved an emergency room referral.

It is also evident that a small number of actual crisis calls resulted in a legal hearing over the decision of whether or not to commit someone to a period of involuntary commitment. The current legal standard for such a commitment decision is that the person constitutes a danger to themselves or others. Our data suggest that over this eight month period fairly low proportion of crisis calls – between 10% and 25% each month – resulted in convening a commitment hearing, but that fairly high proportions of those hearings – from 66.7% to almost 92% resulted in actual commitment decisions.

Table 1
Summary of Eight Months of Calls to M.H. Hotline

	Feb.	March	April	May	June	July	August	Sept.
Total Calls	77	77	120	120	84	169	175	131
Avg. Calls/Day	2.75	2.48	4	7.8	2.8	5.45	5.64	4.36
Crises	39	60	53	44	60	47	52	48
Pct. Crisis Calls	50.6%	77.9%	44.1%	36.6%	71.4%	27.8%	29.7%	36.6%
Referrals Made	17	22	19	22	28	23	19	18
Crises Referred (%)	43.6%	36.6%	35.8%	50%	46.7%	48.9%	36.5%	37.5%
Mobile Crisis Team	8	7	8	4	7	1	5	2
Crises Refer to MCT (%)	20.5%	11.7%	15.1%	9.1%	11.7%	2.1%	9.6%	4.2%
Crisis Resolved by MCT	7	4	2	1	4	0	1	0
MCT Resolved	87.5%	57.1%	25.0%	25.0%	57.1%	0%	20.0%	0%
Emer. Rm. Evaluation	15	34	32	16	24	28	28	21
Pct. Of Crisis to ER Eval	38.5%	56.7%	60.4%	36.4%	40.0%	59.6%	53.8%	43.7%
Commitment Hearing	6	6	9	6	8	12	10	11
Pct. Of Crisis to Hearing	15.3%	10%	16.9%	13.6%	13.4%	25.5%	19.2%	22.9%
Commitment?	4	5	7	5	7	11	9	9
Pct. Hearing/Committed	66.7%	83.3%	77.7%	83.3%	87.5%	91.6%	.90%	81.8%