

AIN

Advocacy Initiative Network of Maine, Inc.

## Consumer Response to Crisis Services

Five consumer forums held across the state to discuss what works & doesn't work in Maine's Crisis Service System and share their ideas for solutions.

MAINE'S STATEWIDE CONSUMER NETWORK & RECOVERY EDUCATION CENTER

JUNE 2005

## Consumer Response to Crisis Services in Maine

As part of its ongoing effort to improve adult mental health services in the State of Maine and in keeping with the philosophy and values of a consumer driven system, the Department of Health and Human Services (DHHS) requested consumer input to one crucial component of this system: Crisis Services.

The Advocacy Initiative Network of Maine (AIN) the statewide consumer association developed by, for and with customers of mental health services throughout Maine. Our mission is to support the creation and sustainability of programs & initiatives that provide a better quality of life for Maine consumers. It is a core belief of our membership that "We can best say what we need in order for our lives to be better & direct the planning for our recovery."

We used several methods to solicit consumer participation. (1) Direct mail to our membership; (2) We asked the mental health agencies in the targeted areas to hand out flyers to their clients and to put up a poster in their agency waiting rooms. We mailed flyers and posters to social clubs and peer centers; (4) We posted the flyer on our web site; and (5) We used direct consumer to consumer recruitment.

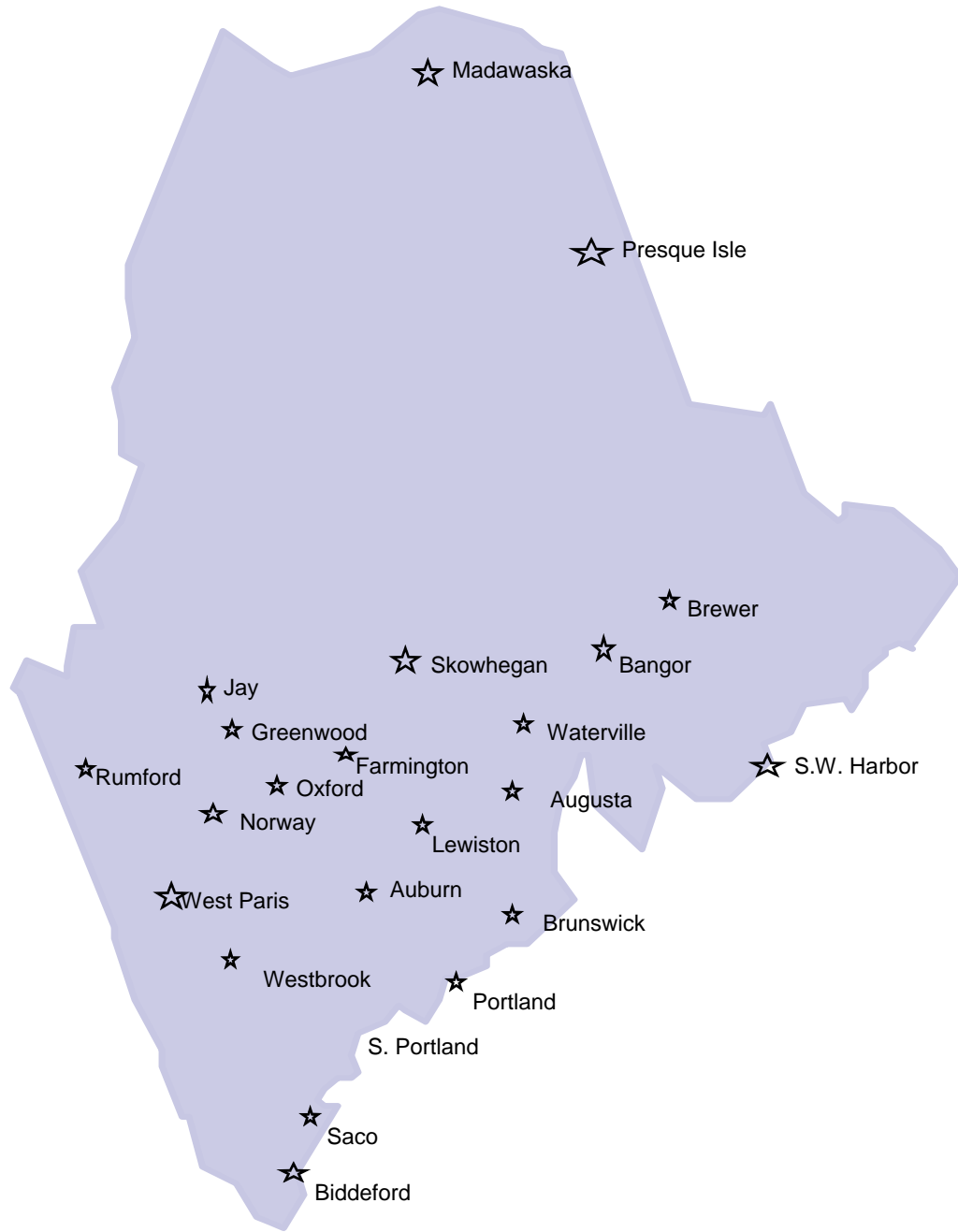
We asked consumers to register by phone or post card. It was our expectation to have 10 to 25 consumers participate in each forum. 61 consumers registered and 44 actually participated. We have addressed the barriers to participation in our narrative following the overall summary. We stressed the importance of each participant to commit to the full process and all of the 44 consumers participated from beginning to end. We used trained facilitators/recorder(s) and assured that facilitators asked the same questions in the same way at each forum. We used a participant sign-off as to the accuracy and validity of recorded contributions.

The forums will be conducted using the following format:

1. All participants signed a confidentiality agreement in which it is stated that the signature sheet will be kept confidential in a locked file at AIN's corporate office. The written report will have no personal identification.
2. Addressing the group as a whole a uniform definition of crisis services (Appendix1) was presented verbally and in writing up-front to all participants.
3. We asked at the outset (and counted the responses) for a show of hands of how many participants or people they know have, within the last two years experienced a crisis. Of that number ask how many have used DHHS crisis services and to identify which crisis service/agency they used.

4. If the group was large we divided into two smaller groups which allowed for a better level of comfort and safety during personal discussions of an extremely stressful subject. When folks gave an opinion or made judgments we asked by way of illustration for specific examples and to identify the crisis service agency involved.
5. We guided the discussion by asking "What Helps?"- "What Doesn't Help?" – What Are Some Possible Solutions?" (Questions B, C, & D)
6. All responses were recorded on newsprint and posted in order of completion around the room for everyone to read.
  - A. If you were to experience a crisis in you life at this time and wanted assistance, what would you do?
  - B. "Name the most important thing that has been helpful (and not helpful) about crisis services in your region."
  - C. "If you were in charge, what is the most important action you would take to improve crisis services?"
  - D. "Again, if you were in charge, what would you not do that is being done now?"
  - E. "On a scale of 1-7 (with 1=awful, worse than nothing, and 7=great, wouldn't change a thing) how do you feel about the quality and availability of crisis services in your region?" (Count the numbers against the total).
  - F. "What advice would you give to a friend (who might experience a crisis) who had just moved into this region and knew nothing about what help might be available?"
  - G. If you or someone you know had a crisis within the past two year overall, did you or did you not get the help you needed?' (Count the show of hands).
7. Each group as a whole reviewed their responses edited, added/deleted any information they wished. Each group signed off on the collective responses
8. The lead facilitator then combined the summaries into a single document.
9. Each participant will receive a copy of this document as will the Department of Health and Human Services.

Overall Summary of The Five Forums Held in Farmington, Portland, Presque Isle, Brunswick, & Bangor



DEMOGRAPHICS			
Participants			Total #
# of females			
# of males			
Total # of Participants			44
# who have experienced a crisis within past two years			40
# who experienced a crisis longer than two years			4
# who have used DHHS Crisis Services			44
Geographic Area Represented			Crisis Service Agencies Represented
Norway	Augusta	Bath	Oxford County Mental Health Tri-County Mental Health Evergreen
W. Paris	Portland	Brunswick	Ingraham
Greenwood	S. Portland	Bath	Broadway Crossing Crisis In-home Support
Oxford	Westbrook	Topsham	St. Mary's Psych Unit
Lewiston	Saco	Bangor	Catholic Charities
Rumford	Biddeford	Brewer	Shalom House
Farmington	Madawaska	S.W.Harbor	Aroostook Mental Health Center Community Health & Counseling Services
Waterville	Presque Isle	Skowhegan	DHHS Regional Office Sweetser (& SweetserPeer Center) Veterans Administration Ken-som Crisis Program/Crisis & Counseling Community Health & Counseling Services Washington County Psychotherapy Associates

<p>QUESTION E: On a scale of 1-7 (with 1 = awful, worse than nothing), and 7 great, (wouldn't change a thing) how do you feel about the quality and availability of crisis services in your region?</p> <p>N/R Did not wish to respond</p>	<p>QUESTION G: If you or someone you know had a crisis within the past 2 years overall, did you or did you not get the help you needed.</p> <p>N/R Did not wish to respond</p>
<p>Total Polled: 44 – N/R: 4</p> <p>Overall Quality: 4.7 32-46-50-33-27 = 188÷40 = 4.7</p>	<p>Total Polled: 44 – N/R: 4</p> <p>Overall Availability: 4.425 28-44-44-27-34 = 177÷40 = 4.425</p> <p>Total Polled: 44 – N/R: 6</p> <p>Overall: 25 out of 38 got the help needed 66% got the help needed</p>

The following responses are derived from questions B, C, & D

WHAT HELPS	WHAT DOESN'T HELP	SOLUTIONS
<p style="text-align: center;">Respect</p> <ul style="list-style-type: none"> <li>Listen &amp; take time to treat you as an individual. [5]</li> <li>Being treated with respect &amp; dignity by all sources involved in my crisis care. Not being labeled. Being taken seriously. [4 ]</li> <li>On the telephone or in person being treated with respect. [3]</li> <li>Being treated with respect and kindness whether on the phone or in person. [3]</li> <li>Being listened to respectfully. Treated like a human being. [3]</li> <li>They work with you not against you [2]</li> </ul> <p>Being asked what would you like to have happen. [2 ]</p> <p style="text-align: center;">Kindness</p> <ul style="list-style-type: none"> <li>Knowing person will stay with me until the end. Promises never to leave! [2]</li> <li>During one crisis the most caring treatment I received was from a Security Guard in the ER, even so, that one person made a difference for the better. [1]</li> </ul> <p>Having a peer with you who can help with your situation even if it is just conversation or games. [1]</p>	<p style="text-align: center;">Disrespect</p> <ul style="list-style-type: none"> <li>Crisis worker being disrespectful to you on the phone. [4 ]</li> <li>They make assumptions about what the problems are. [ 4]</li> <li>Not listening [5]</li> <li>Condescending attitude by ER staff. [3]</li> <li>Not seeing me as a whole person not just someone with a mental illness. [3]</li> <li>Being examined and treated poorly out in the open in the ER. [2]</li> <li>Having to tell your story over and over. [2]</li> <li>Cardiologist ignored medical issue because I have mental health issues. [2 ]</li> <li>Being asked if they were drinking [2]</li> <li>Going to ER-stigma/labeled by ER staff and had other medical problems ignored. [2]</li> <li>Maine Med I had a real physical problem and they sent me to Psych Unit instead of Med Unit. [2]</li> </ul> <p>Assumption from peers/warm line volunteers that they understand where you're at [2]</p>	<p>Prevention &amp; Evaluation- Inactive status protocol needed to facilitate re-entry to activate services. Providers work harder to develop relationship with person-maybe intervene before crisis. Follow-up after discharge to assure services are in place. Have better communication during transition. Clear communication from provider to provider. Like a resume of what works best for you and what doesn't.</p> <p>Supervision of counselors/case managers needs to be better. A simple flow chart needs to be created showing the different services. So we can see the services and how they are connected.</p> <p>Increase consumer input in the design and delivery of services. An evaluation of crisis services provided by each state contracted agency needs to be done at least once a year by a panel of consumers.</p> <p>Standards for Peer Centers and Social Clubs need to include opportunities for self-directed recovery. Increase the number of support groups available. More jobs.</p> <p>Drop-in inspections by consumers of state-funded clubs- (is organization meeting standards).</p>

WHAT HELPS	WHAT DOESN'T HELP	SOLUTIONS
<p style="text-align: center;">Kindness</p> <ul style="list-style-type: none"> <li>• My parents-they nurture me [1]Staff at group home &amp; peers [1]</li> <li>• They don't act like care takers, they act like friends [1]</li> <li>• Responsive to needs [1]</li> </ul> <p>They're not pushy. [1]</p> <p style="text-align: center;">Someone to Listen</p> <ul style="list-style-type: none"> <li>• Being able to just talk and be listened to. [4]</li> <li>• Peers to talk to [3]</li> <li>• Talking with psychiatrist-feels relaxed &amp; can say anything. [2]</li> <li>• Having a face to face interview where the crisis worker comes and sits with you and takes the time to show concern and really listens. [1]</li> <li>• Only having to tell your story once. [1]</li> <li>• Talking with family [1]</li> <li>• Talking with peer they understand mental illness (unlike family) [1]</li> <li>• Talk with staff &amp; peers at group home [1]</li> <li>• Someone (friend) I can call 24 hours [1]</li> </ul> <p>My counselor helped-having someone to talk to confidentially [1]</p> <p style="text-align: center;">Services</p> <ul style="list-style-type: none"> <li>• Prompt connection to needed services. [3 ]</li> <li>• Having a trained Peer Support person available as quickly as possible. [2 ]</li> <li>• Receiving medication on time while you are waiting for services. [1]</li> </ul> <p>Being provided with transportation home. [1]</p>	<p style="text-align: center;">Disrespect Cont'd.</p> <ul style="list-style-type: none"> <li>• volunteers presume that their story is your story &amp; for me personally that doesn't work [2]</li> <li>• When they call your full name out loud in front of everybody. [1]</li> <li>• Having to ask to go to the bathroom and being escorted there. [1]</li> <li>• "People who do not view me as an adult and don't respect my decisions, values, wishes. They want to take care of me" [1]</li> <li>• ER-loss of dignity making you undress when you have trauma history. [1]</li> <li>• Person on crisis line making less or trivializing your situation-'Good Luck' Saying "Take a bubble bath" [1]</li> <li>• "I was threatened to control my behavior by RCU and hospital unit staff. You try anything and I'll flatten you". [1]</li> <li>• When they assume they know what's going on by reading my chart before coming to see me. [1]</li> <li>• Using my history against me when creating a crisis solution. [1]</li> </ul> <p>Clock watchers-psychiatrist, case management [1]</p> <p style="text-align: center;">Services</p> <ul style="list-style-type: none"> <li>• Waiting so long for help. [5]</li> <li>• Service so difficult to obtain. [3 ]</li> <li>• Extensive intake process. From first contact to RCU bed was 12 hours. [3]</li> <li>• You have a crisis plan and it is ignored. [3]</li> </ul> <p>Confusion about crisis plans [3]</p>	<p>Warm Lines – Should provide early intervention. They should be staffed by trained peers with history of good recovery available 24/7 365 days. Call needs to be long enough to make a connection with caller. Training and ongoing training would include methods of conducting a verbal interview to assess a patient's emotional status, as well as how to offer recommendations for treatment and referral. Continuous updating of available community services i.e. help with family responsibility issues, learning self-advocacy, self-directed recovery, peer support groups &amp; programs.</p> <p>Find private funding for warm lines/peer supports. Expanding ER peer supports &amp; warm line. Use other charitable foundations to support crisis.</p> <p>Education &amp; Training - All providers of crisis services (ER Doctors &amp; Nurses and Crisis Workers and Peers) well trained in mental health including recovery. Trained in how to respond to &amp; treat people with mental health issues who are in crisis as well as how to respond to &amp; treat trauma victims. They need to be trained in how to look beyond the psych label to prevent ignoring physical problems. A training should be developed by consumers on crisis services &amp; treatment that will educate providers on how to apply the reality of the person's life that they are treating to a treatment plan. i.e. Individual's situation regarding poverty, socio-economic status, education, and culture. Emphasizing women's issues, men's issues, family issues, parenting, aggression concerning men &amp; women individually. More consumer &amp; community interaction and training, education.</p>

WHAT HELPS	WHAT DOESN'T HELP	SOLUTIONS
<p style="text-align: center;">Services Cont'd</p> <ul style="list-style-type: none"> <li>• Having follow-up phone calls and appointments. [1]</li> <li>• Someone who has the right (helpful) information about services. [1]</li> <li>• Process of finding right meds; working with open-minded doctor; need good rapport &amp; determination [1]</li> <li>• DHHS-Social Services SSA [1]</li> <li>• service animals [1]</li> </ul> <p style="text-align: center;">Community</p> <ul style="list-style-type: none"> <li>• Having access to Peer Centers and Social Clubs. [5]</li> <li>• Peer support groups [3]</li> <li>• Having a life in our community. [3]</li> <li>• chance to be with people, make friends [2 ]</li> <li>• While using respite being able to continue community involvement. [1]</li> <li>• opportunity to volunteer [1]</li> <li>• Creating a natural support system. [1]</li> </ul> <p>having forums [1]</p>	<p style="text-align: center;">Services Cont'd.</p> <ul style="list-style-type: none"> <li>• "Crisis and counseling lost my crisis plan and couldn't find it when I needed it." [2 ]</li> <li>• Having to talk to about 5 people [1]</li> <li>• Late at night, operator answers &amp; says someone will call you back but no one does [1]</li> <li>• Phone tag &amp; waiting list for ongoing services [1]</li> <li>• The fact that you have to be in Crisis to get any services. If you have not used services for quite a while you can not re-enter the system unless you are in crisis. This causes a very unnecessary traumatic situation especially if you have children. [1]</li> <li>• Warehouse you in a waiting room and leave an armed guard watching you. [1]</li> <li>• Homeless people cannot get services from Broadway Crossing [1]</li> <li>• Providers not able to deal with people who have disassociation issues [1]</li> <li>• Intake process by crisis worker duplicates hospital unit questions. [1]</li> <li>• Going from crisis call to the ER without any intervention or planned procedure. [1]</li> <li>• "Crisis programs and community agencies I used were unable to provide a safe alternative environment. They said I had to develop internal supports instead of using external supports. Then they said they weren't going to do anything until I broke the law. They said we don't do long term trauma". [1]</li> <li>• Crisis workers who do not know what questions to ask or how to talk with someone in extreme emotional distress. [1]</li> </ul> <p>Ingraham tells you to go to the ER. [1]</p>	<p>Crisis Service - One phone one crisis worker to stay with person all the way through the process.</p> <p>Crisis worker needs to be well trained in the interview process for crisis. They need to understand mental illness and know how to listen. They need to establish a connection with the person before assessing suicidal or homicidal. Ask caller what they need. Ask "open-ended" questions. Don't tell me how to fix my problems, maybe I just need to talk it out. Don't talk down to people. Need People who understand me and create plan with caller for safety &amp; help</p> <p>The crisis worker on the phone should, at any phase of the crisis, tell the person calling what action they are planning to take, i.e. sending police, an ambulance, a mobile unit to do a face to face. More people need to be hired and the pay needs to be better. Hiring more mature workers with wider life experience. Provide support and incentives to increase retention. Address burnout.</p> <p>Need more outreach offices.</p> <p>Do not use the police unless there is evidence of violence. If police must be used let us know that a police officer will be coming to pick us up.</p> <p>Intake – Single intake process to follow patient wherever they will be receiving crisis services. Shorter process using more conversation then pre-determined questions. Empathic listening. If the Individual has a Crisis Plan or a WRAP Plan it should be followed.</p> <p>Individual Crisis Plan – ICP's should be placed with the consumer, the consumer's ISP at the case management agency and local crisis programs. ICP's put the person in charge of their life.</p>

WHAT HELPS	WHAT DOESN'T HELP	SOLUTIONS
	<p style="text-align: center;">Services Cont'd.</p> <ul style="list-style-type: none"> <li>• Crisis worker trying to write an ICP for you during a crisis call and writes it without your input. [1]</li> <li>• Short-staffed--means there's no one to talk with me</li> <li>• when workers have gone to do assessments [1]</li> <li>• Lack of transportation to get home afterwards [1]</li> </ul> <p>The ER never did a plan to send me back home [1]</p> <p style="text-align: center;">Uncaring/ Added Stress</p> <ul style="list-style-type: none"> <li>• Not allowed to go smoke. [4]</li> <li>• Noisy, high stimulus environment [2]</li> <li>• You must take ambulance-private insurance doesn't fully cover bill. [2]</li> <li>• Too much stimuli-moved 5 times [2]</li> <li>• At hospital not being able to get out and around people [2]</li> <li>• When I call crisis they won't come to me-they make me go to them. [2]</li> <li>• Not offered food or drink. [1]</li> <li>• Not made comfortable. [1]</li> </ul> <p>Security screening/metal detectors. [1]</p> <p style="text-align: center;">Police (Trauma)</p> <ul style="list-style-type: none"> <li>• When you call crisis and they send police. [4 ]</li> <li>• Being transported via police vehicle. [4]</li> <li>• Calling police unnecessarily [4]</li> <li>• Calling/threatening to bring police [4]</li> <li>• Being transported to ER via Police when you are not violent. [3]</li> <li>• Restraining with handcuffs &amp; leg restraints [2]</li> <li>• Police escort-in cuffs [2]</li> </ul> <p>Not talking long enough to make a traumatic plan; just immediately call the police. [2]</p>	<p>ICP's let providers know what works best for them. It saves time and money. There should be policies for state contracted agencies to respect and implement Individual Crisis Plans. If everything is in place and approved and it is not followed there should be some kind of recourse.</p> <p>Walk-in service (not ER): Crisis assessment/intake Should not be like hospital (not medical model) . There should be trained staff and on-call doctors available. Relaxed atmosphere, less formal, less focus on filling out forms. Take time to talk through problems, admit to hospital if needed. Recognize that walk-ins may not be ready to plunge into process immediately.</p> <p>Mobile Crisis Units: Have more mobile crisis units that will go to the patient's home. In rural communities have small outreach offices with a trained mobile crisis response team from the community such as local nurses, paramedics, trained peers and/or trained concerned persons from that community.</p> <p>In the ER's – (See education) First preference is NOT to use ER's. Information should be given to the patient-let them know what's going on. Take you into private room to treat you. Do not leave patient alone in room at ER. They need to pay attention to real physical medical issues. If you are in the ER for a long period of time they should administer the medication you are on. They need to see that you receive your prescribed medication on time while in the ER. Offer food &amp; water or at least make the possibility available. Free access to restrooms. If discharging Inform folks of available transportation</p>

WHAT HELPS	WHAT DOESN'T HELP	SOLUTIONS
	<p style="text-align: center;">Police (Trauma) Cont'd</p> <ul style="list-style-type: none"> <li>• Police used to transport you it's labeled protective custody. This can lead to loss of housing-HUD's one strike your out. Or your landlord's policy. [1]</li> <li>• Handcuffed when you are not violent. Is this a law or just police protocol? It is extremely damaging. [1]</li> <li>• Ingraham tells you to call police yourself (because of Ingraham calling police so many times).</li> <li>• there and they cuffed me to the bed in ER." [1]</li> <li>• "Ambulance took me to the hospital. Police met me</li> <li>• Over reaction by crisis line. Sent police, handcuffs, drawn guns. [1]</li> <li>• Mistreated by police-trying to leave hospital. Threatened me-I was afraid cop would hurt me because he did before. He cuffed me &amp; was verbally assaultive. [1]</li> </ul> <p>Tried to leave ER; 4 staff &amp; cops kept me from leaving; then they blue papered [1]</p> <p style="text-align: center;">Medication Issues</p> <ul style="list-style-type: none"> <li>• Lack of protocol regarding psychotropic medications in ER specifically use of anxiety meds/bias by ER doctors. [1]</li> <li>• "I went to the hospital psych unit, I had all my medications and they wouldn't give me my physical</li> <li>• medications for physical problems, and I ended up at the Inland hospital for 2 weeks and it was the most</li> <li>• painful thing I ever went through." [1]</li> <li>• "I went into the psychiatric hospital and they took both medical &amp; psychiatric medication away." [1]</li> <li>• Having meds forced on you then being released. [1]</li> </ul> <p>Getting your medication in ER over long periods of time. [1]</p>	<p>Transportation – Crisis services should have the ability to transport you without using the police or an ambulance.</p> <p>Crisis services should have cars to transport you or offer a taxi or call case manager to transport you.</p> <p>RCU's - - More RCU's spread out across the State especially in rural areas. Expand respite services to be used instead of hospitals, include peer services. It is helpful to have both interaction with people and to allow people to spend time in their room or have alone time.</p> <p>In-home support: Trained crisis worker could be sent to my home to stay with me up to 72 hours before using a Residential Crisis Unit (RCU) bed. Especially during life events such as a death in the family, discharge for major medical reasons, change of medication or if there are no RCU beds available.</p> <p>Public Education - More consumer and community interaction, training and education on mental health &amp; recovery concerning people of all ages. Publicize what is available for crisis services in each community.</p> <p>Discharge from hospital - Make crisis planning part of Discharge Planning. Shift perspective to self-directed planning vs. agency providers telling consumer what to do on discharge. Consumer must be actively involved in goal-setting &amp; planning</p> <p>Jail Services They need to care for the person and make sure they watch for suicidal behavior and they get their medication. That they can get peer support in some anonymous way to avoid further stigmatization within the jail population.</p>

## NARATIVE

Many of the participants expressed that having the opportunity to freely air some of the issues they have had with the crisis services they have used felt the experience was cathartic and validating. All 44 participants in these five forums met the task of providing solutions with incredible thoughtfulness. They demonstrated a genuine attitude of positive personal investment to effect positive change in the crisis service system.

It was our expectation to have collectively 65 –75 participants in the five forum. 61 registered to attend but only 44 actually came. We were able to ask a few of the 17 who did not show what kept them from attending. We also ask a random # of consumer who did not register to attend why, if they use crisis services, they did not want to participate. The various answerers from both groups were: Transportation; forums were not held in their area of local experience; poor experience with agency or state conducted focus groups or forums; lack of faith in their voice making a difference; uncertainty or unfamiliarity with focus groups or forums; I forgot; I didn't feel well that day.

### Facilitator's observations, interpretations and recommendations:

The recurring theme of education and training for all providers of crisis services reveals itself to be the single most impacting action that could be taken to improve crisis services in our state. All providers (ER Doctors & Nurses, Crisis Workers and Peers) well trained in mental health including recovery. Trained in how to respond to and treat people with mental health issues who are in crisis as well as how to respond to and treat trauma victims. Including training in how to look beyond the psych label to prevent ignoring physical problems would have a dramatic effect on the reduction of nearly every statement under "What Doesn't Help."

It is important to note that the use of police as a form of transportation when violence is not an issue creates additional unnecessary deep trauma to an already traumatized individual. The unnecessary use of restraints i.e. handcuffs, legcuffs deepens the trauma. The stigma created by the unnecessary use of police criminalizes mental illness and cause reverberating consequences to the individual. These consequences such as deep shame, loss of dignity, loss of respect real or perceived in one's community, loss of housing can all spiral into continuing crisis for the individual. The inclusion of non-traumatizing transportation methods in crisis programs needs to be a high priority.

Crisis occurring within the jail system was talked about in one of the forums noting that incarcerated consumers need to be watched for suicidal behavior and see that medications are administered as prescribed. There is a great need for peer support within the jail systems however strategies need to be developed to allow this to happen in some anonymous way to avoid further stigmatization within the jail population.

Consumers feel crisis can be prevented by having the appropriate services and supports that promote and sustain recovery in order to have a life in the community i.e. socialization, work and/or volunteering. They need to be informed about services and resources. They need a good rapport with an open-minded doctor who is as determined as they to find the right medication. They need to know that there is a safety net in the crisis service system that will do no harm.

When people are in crisis they want to be treated with kindness and respect, be heard, have appropriate services to meet their needs in a reasonable amount of time, and a ride home.

## Additional Information

Being familiar with New Zealand's crisis service system we could not help but notice the resemblance of their crisis service system to this group of consumer's responses to "Solutions:.. With very little tweaking, the following would make an excellent framework for our crisis service system here in Maine.

The Framework: key principles for the provision of service to people experiencing a crisis.

Services should:

- Provide 24/7 access to assessment
- Promote and sustain recovery
- Be part of a whole system approach and forge good relationships with other services and sectors
- Be culturally capable of meeting the needs of consumers
- Ensure service design is determined by local populations and needs, and includes regional and sub regional agreements
- Ensure interventions are evidence based and designed to resolve the presenting crisis.

Expectations for service delivery

Access must be available

Services need to be easy to access. Contact details need to be easy to find in telephone directories and known by service users and their families, including those who do not speak English or are hearing impaired.

Triage always follows assessment

Triage is about determining the direction to take, and the allocation of resources to meet needs. Assessment identifies needs so that good decisions can be made. Assessment need not only be made by doctors and could be undertaken by other disciplines such as nurses, social workers, and psychologists.

Good working relationships with other services, agencies and sectors.

Key relationships must be identified and actively supported. Good relationships and understanding of each other's areas of interest, expertise, responsibility, and constraints, will contribute to more appropriate referrals and more informed decision making at point of triage.

Consistent application of criteria for accepting people for ongoing service delivery

Crisis teams decide entry to the "Whole system of care."

Supervision mechanisms for clinical practice

Services need to develop ways for everyone working in a clinical capacity to have ongoing access to clinical supervision including cultural supervision.

Creative and innovative solutions for ensuring available supervision need to be encouraged.

Clear processes for transitions including the transfer of information between service areas, organizations and agencies

A "whole system of care" approach includes all agencies and organizations, families and friends. Smooth transitions eliminate the gaps that service users can fall through.

Services are orientated to supporting recovery

An understanding of the concepts of recovery, and practitioners who demonstrate recovery competencies are required.

Policies and procedures for the identification and management of risk

This includes the clinical risk of the presenting person, risk for the families and/or other significant persons and risks for staff. The services needs a comprehensive approach to risk management,

Formalized relationships with community mental health teams

This is essential for "stand alone" or "dedicated" crisis services to ensure consistency and continuity of care.

Where best practice is usual practice

Best practice must permeate all aspects and activities of services. "staff may have been in many crisis situations but for the person concerned it is often new and frightening".

1

Access is about Provision

- Services need to be proactive to ensure access
- Services need to be identify barriers to access
- Services need to take action to address barriers

3

Assessment is about Information

- Assessment is about gathering of information
- Assessment is the process for identifying needs
- Information is needed to make good decisions at the point of triage

2

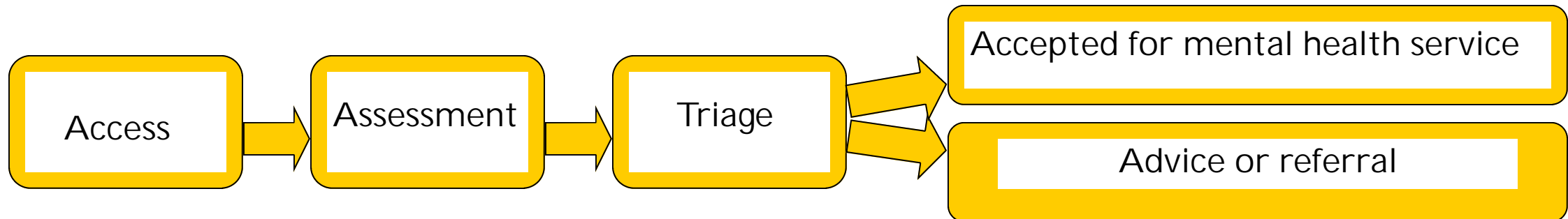
Triage is about Allocation

- Triage is about making the right decision
- Triage follows assessment
- Triage is the allocation of resource to meet needs identified from the assessment

4

Intervention is about Resolution

- It may or may not be provided by the crisis
- Whatever action is taken contributes to resolving the presenting crises
- It may be the provision of advice or the active referral to another organization or agency
- Intervention is about action







Farmington: Consumer Response to Crisis Services– April 20, 2005

<p>DEMOGRAPHICS</p>	<p>Responses are in regard to the individual's experience with agency providing crisis services.  QUESTION: If you were to experience a crisis in your life at this time and wanted assistance, what would you do?"</p>	<p>QUESTION: On a scale of 1-7 (with 1 = awful, worse than nothing), and 7 great, (wouldn't change a thing) how do you feel about the quality and availability of crisis services in your region?</p>	<p>QUESTION: What advice would you give to a friend (who might experience a crisis) who had just moved into this region and knew nothing about what help might be available?</p>	<p>QUESTION: If you or someone you know had a crisis within the past 2 years overall, did you or did you not get the help you needed.</p>
<p>Participants: The Farmington Forum had 10 participants. The group consisted of 7 females - 3 males.  Geographic area represented: Norway W. Paris Greenwood Oxford Lewiston Rumford Farmington Waterville Augusta Skowhegan Franklin County  Agencies represented : Oxford County Mental Health (OCMH) Tri-County Mental Health (TCMH) Crisis &amp; Counseling (C&amp;C) Evergreen (E)</p>	<p>Response:  OCMH: Call caseworker; Call parents or pastor; Call my wife or friend;  TCMH: Call therapist; Call caseworker; Call my doctor; Call Crisis Services; Walk into police station and ask for help; Call police; Call family doctor; Call for an ambulance.  C&amp;C: Call my psychiatrist; call warm line peer center in Brunswick; Call my best friend who is also a consumer; call to family who I named in my advance directives; Call my ACT team; Call consumer family member; Call friend who is consumer; take myself to the ER; Call therapist; I have a WRAP and I would go back to my WRAP and try to stabilize myself</p>	<p>Response:  Quality: 1-1-1-3-4-5-6-5-6-N/A  Availability: 1-1-1-5-3-2-4-5-6-N/A</p>	<p>Response:  OCMH: Try to make contact with someone (consumer or crisis service) before <u>crisis</u> develops  TCMH: Come to social club for peer support; Come and stay with me and keep safe; Go to the shelter for help. Tell them to use crisis service or go directly to the hospital.  C&amp;C: Call Pastor, family member, then call crisis; Call me and I'll walk you through it; Try to make a contact with someone (consumer or crisis service) before <u>crisis</u> develops  E: N/A</p>	<p>Response: 10 polled  OMCH: Didn't get the help needed (1)  TCMH: Not from crisis. (2) Got the help they needed (2)  C&amp;C: Didn't get the help they needed (3)  E Yes <u>eventually</u> (1)  N/A (1)</p>

Farmington: Consumer Response to Crisis Services– April 20, 2005

WHAT HELPS	WHAT DOESN'T HELP	SOLUTIONS
<p>On the telephone or in person being treated with respect. Being able to just talk and be listened to. Using conversation to assess rather than a form. Having a trained Peer Support person available as quickly as possible. Prompt connection to needed services. Crisis workers that really advocate for what you need. Respite Care Units available. While using respite being able to continue community involvement. Having crisis workers come to where you are. Receiving medication on time while you are waiting for services. In-home crisis peer support. Being provided with transportation home. Having follow-up phone calls and appointments. Having Peer Centers available.</p> <p>During one crisis the most caring treatment I received was from a Security Guard in the ER, even so, that one person made a difference for the better.</p>	<p>Being treated disrespectfully.            When you call crisis and they send police.            Going from crisis call to the ER without any intervention or planned procedure.            Intake process too long.            Extensive intake process. From first contact to RCU bed was 12 hours.            Intake process by crisis worker duplicates hospital unit questions.            Extremely long wait for services.            Security screening/metal detectors.            Condescending attitude by ER staff. Lack of protocol regarding psychotropic medications in ER specifically use of anxiety meds/ bias by ER doctors.            Warehouse you in a waiting room and leave an armed guard watching you.            Strip you of your dignity(hospital)            They don't keep you informed as to what is going on.            Not offered food or drink.            Not made comfortable.            Not allowed to go smoke.            Noisy, high stimulus environment            Being examined and treated poorly out in the open in the ER.            When they call your full name out loud in front of everybody.            When they assume they know what's going on by reading my chart before coming to see me.            Having to ask to go to the bathroom and being escorted there.            Poorly informed crisis workers around community resources and common sense solutions to a crisis plan.            Being constantly told crisis program policy (what we can't do) rather than working toward a positive crisis solution.            Using my history against me when creating a crisis solution.            Hospitalization            Crisis workers who share their personal issues, experiences - crossing boundaries.</p>	<p>Warm Lines – Staffed by trained peers with history of good recovery available 24/7 365 days. Training and ongoing training would include continually updating available community services i.e. help with family responsibility issues, learning self-advocacy, peer support groups &amp; programs.</p> <p>Education &amp; Training - All providers of crisis services (ER Doctors &amp; Nurses and Crisis Workers well trained in mental health including recovery. Trained in how to respond to &amp; treat people with mental health issues who are in crisis as well as how to respond to &amp; treat trauma victims. A training should be developed by consumers on crisis services &amp; treatment that will educate providers on how to apply the reality of the person's life that they are treating to a treatment plan. i.e. Individual's situation regarding poverty, socio-economic status, education, and culture. Emphasizing women's issues, men's issues, family issues, parenting, aggression concerning men &amp; women individually.</p> <p>Crisis Service - I wish I could make a phone call, have the person who answers be the crisis person who would follow me all the way through to the conclusion.</p> <p>The crisis worker on the phone should, at any phase of the crisis, tell the person calling what action they are planning to take, i.e. sending police, an ambulance, a mobile unit to do a face to face.</p> <p>Do not use the police unless there is evidence of violence. If police must be used let us know that a police officer will be coming to pick us up.</p> <p>Intake – Single intake process to follow patient wherever they will be receiving crisis services. Shorter process using more conversation then pre-determined questions. Empathic listening. If the Individual has a Crisis Plan or a WRAP Crisis Plan it should be followed.</p>

Farmington: Consumer Response to Crisis Services– April 20, 2005

WHAT HELPS	WHAT DOESN'T HELP	SOLUTIONS
	<p>"I went to the hospital psych unit, I had all my medications and they wouldn't give me my physical medications for physical problems, and I ended up at the Inland hospital for 2 weeks and it was the most painful thing I ever went through."</p> <p>"I went into the psychiatric hospital and they took a medical medication away and a psychiatric medication away. I signed myself in, so I signed myself out and I was worse than when I went in. My psychiatrist lied to me two times. I was upset with my kids because of the lie."</p> <p>"I was threatened to control my behavior by RCU and hospital unit staff. You try anything and I'll flatten you".</p> <p>"The staff did not want me to stay at their RCU twice and I've seen this happen to other patients."</p> <p>"Crisis programs and community agencies I used were unable to provide a safe environment by alternatives. They said I had to develop internal supports instead of using external supports. Then they said they weren't going to do anything until I broke the law. They said we don't do long term trauma".</p> <p>"Psychiatrist at hospital unit was from a different country and his attitude was like I'm the Doctor and you are the patient, don't talk back to me, you have no rights, do as I say. I was told to put my hand on the table, then he hit my hand with a belt as part of the treatment. I attempted suicide 3 times while I was on the Unit."</p> <p>"Crisis and counseling lost my crisis plan and couldn't find it when I needed it."</p> <p>"People who do not view me as an adult and don't respect my decisions, values, wishes. They want to take care of me"</p>	<p>Mobile Crisis Units: Have mobile crisis units that will go to the patient's home. In rural communities have small outreach offices with a trained mobile crisis response team from the community such as local nurses, paramedics, trained peers and/or trained concerned persons from that community.</p> <p>In the ER's: First preference is NOT to use ER's. Information to the patient-let them know what's going on. Take you into private room to treat you. Do not leave patient alone in room at ER.</p> <p>They need to see that you receive your prescribed medication on time while in the ER. Offer food &amp; water or at least make the possibility available. Free access to restrooms. If discharging Inform folks of available transportation.</p> <p>RCU's - More RCU's spread out across the State especially in rural areas.</p> <p>Allow people using RCU's to spend time in their room or have alone time.</p> <p>In-home support: Trained crisis worker could be sent to my home to stay with me up to 72 hours before I using a Residential Crisis Unit (RCU) bed. Especially during life events such as a death in the family, discharge for major medical reasons, change of medication or if there are not RCU beds available.</p> <p>Public Education - Community education on mental health &amp; recovery concerning people of all ages. Publicize what is available for crisis services in each community.</p> <p>Discharge from hospital - Make crisis planning part of Discharge Planning.</p>

Portland: Consumer Response to Crisis Services—May 9, 2005

DEMOGRAPHICS	Responses are in regard to the individual's experience with agency providing crisis services.  QUESTION: If you were to experience a crisis in your life at this time and wanted assistance, what would you do?"	QUESTION: On a scale of 1-7 (with 1 = awful, worse than nothing), and 7 great, (wouldn't change a thing) how do you feel about the quality and availability of crisis services in your region?	QUESTION: What advice would you give to a friend (who might experience a crisis) who had just moved into this region and knew nothing about what help might be available?	QUESTION: If you or someone you know had a crisis within the past 2 years overall, did you or did you not get the help you needed.
<p>Participants: The Portland Forum had 10 participants. The group consisted of 8 females - 2 males.</p> <p>Geographic area represented: Portland S. Portland Westbrook Saco Biddeford</p> <p>Agencies represented: Maine Med (P6; McGeachy Hall &amp; Access Team; ER) Ingraham Broadway Crossing Maine Med Counseling Crisis In-home Support Spring Harbor St. Mary's Psych Unit Catholic Charities Shalom House AMHI</p>	<p>Response: Maine Med Access Team: Call Act Team Ingraham: They will contact doctor &amp; will talk to you for a little while before they call the cops. Will send someone for face to face Reach out to others before Ingraham</p> <p><b>Broadway Crossing:</b> will come, sit, take time with you; show concern; consumer friendly; warmer They are fine if you are "just not okay" but they don't know what to do if you show high emotional stress (crying) They see it as "problematic"</p> <p>Shalom House: Call personal contact</p> <p>AMHI My medical doctor has referred me to psych unit</p> <p>In General: Talk with counselor or case manager Call the warm line Call 1-800 crisis # Call Minister I do everything possible short of calling the crisis line. Tends to want to admit you rather than help or talking.. I could call the hospital directly.</p>	<p>Response: Quality: 5-7-5- 4-3-5-5-2-5-5  Availability: 4-5-2-5-3-7-3-3-5-7</p>	<p>Response: ING: Because I have hesitation around Ingraham I would tell them to call their psychiatrist I had a good experience with Ingraham so I would send them there.</p> <p>In General: Call warm line Call 1-800-Crisis #</p>	<p>Response: 10 polled</p> <p>ING: Did not get the help needed (4) Did get the help needed (2)</p> <p>All Other Agencies: Did get the help needed (6) Eventually got the help needed (4)</p>

Portland: Consumer Response to Crisis Services—May 9, 2005

WHAT HELPS	WHAT DOESN'T HELP	SOLUTIONS
<p>Being treated with respect and kindness whether on the phone or in person. Having a face to face interview where the crisis worker comes and sits with you and takes the time to show concern and really listens. Only having to tell your story once. Being asked what would you like to have happen. They really hear what it is you need and don't make assumption about what the problems are. If you have trauma issues they need to respect that and ask how they can accomplish what the need to without making things worse. Someone who has the right (helpful) information about services. Voluntary short-term hospitalization available, someplace to go vs. home alone                      Process of finding right meds; working with open-minded doctor; need good rapport &amp; determination                      Crisis Plan-being able to say who can be involved and who can't and having your Crisis Plan respected and implemented. Having a peer with you who can help with your situation even if it is just conversation or games.                      Having access to Peer Centers and Social Clubs.                      Creating a natural support system.                      Meditation                      Warm blankets helpful</p>	<p>The fact that you have to be in Crisis to get any services. If you have not used services for quite a while you can not re-enter the system unless you are in crisis. This causes a very unnecessary traumatic situation especially if you have children.                      Crisis workers who do not know what questions to ask or how to talk with someone in extreme emotional distress. They make assumptions about what the problems are. Immediately go into "Problem solving". This is not helpful in moment of distress-I need to be able to share what is going on before-so I can diffuse problems.                      Not talking long enough to make a less intrusive or less restrictive plan just immediately call the police.                      Providers not able to deal with people who have dissociation issues                      Having to tell your story over and over.                      You have a crisis plan and it is ignored.                      Crisis worker trying to write a ICP for you during a crisis call and writes it without your input.                      Being transported to ER via Police when you are not violent.                      You must take ambulance-private insurance doesn't fully cover bill.                      Phone tag &amp; waiting list for ongoing services                      Going to ER-stigma/labeled by ER staff and had other medical problems ignored.                      At intake psych clearance happens before Medical Clearance.                      Cardiologist ignored medical issue because I have mental health issues.                      ER-loss of dignity making you undress when you have trauma history.</p>	<p>Prevention - Inactive status" to facilitate re-entry to activate services. Providers work harder to develop relationship with person-maybe intervene before crisis. Follow-up after discharge to assure services are in place Have better communication during transition (like a resume). Clear communication from provider to provider.                      Supervision of counselors/case managers needs to be better. A simple flow chart needs to be created showing the different services. So we can see the services and how they are connected.                      Increase consumer input in the design and delivery of services. Consumer panels to review services and policies for state funded agencies.                      Standards for Peer Centers and Social Clubs need to include opportunities for self-directed recovery.                      Drop-in inspections by consumers of state-funded clubs-is organization meeting standards?                      Warm Lines – Should provide early intervention. They should be staffed by trained peers with history of good recovery available 24/7 365 days. Call needs to be long enough to make a connection with caller. Training and ongoing training would include methods of conducting a verbal interview to assess a patient's emotional status, as well as how to offer recommendations for treatment and referral. Continuing training updating available community services i.e. help with family responsibility issues, learning self-advocacy, self-directed recovery, peer support groups &amp; programs.                      Find private funding for warm lines/peer supports. Expanding ER peer supports &amp; warm line. Use other charitable foundations to support crisis.</p>

Portland: Consumer Response to Crisis Services—May 9, 2005

WHAT HELPS	WHAT DOESN'T HELP	SOLUTIONS
	<p>Waiting so long for help.            Having meds forced on you then being released.            Too much stimuli-moved 5 times            Taking away cigarettes!            Bare walls Case Manager role is so narrow-they can't step out and help with "Community Supports"            Case Manager doesn't always understand my way of stating my needs.            Being transported via police vehicle. Sometimes police vehicle is only transport available, so it's labeled protective custody. This can lead to loss of housing-HUD's one strike. Or your landlord's policy.            Being handcuffed when you are not violent. Is this a law or just police protocol? It is extremely damaging.            Homeless people cannot get services from Broadway Crossing            Ingraham tells you to call police rather yourself (because of Ingraham calling police so many times). They tell you to go to the ER.            Blacklisting callers (Ingraham claims people are tying up phone lines). Consumers complain it is because they are unwilling to do what Ingraham says they have to do.            Ingraham came to me to do a face to face. They tried to get me into a stabilization bed. Never asked if I was willing to go to hospital. Gave me limited options. They didn't assess my needs appropriately. They left and I felt the same as before they came.            Maine Med I had a real physical problem and they sent me to Psych Unit instead of Med Unit.</p>	<p>Education &amp; Training - All providers of crisis services (ER Doctors &amp; Nurses and Crisis Workers well trained in mental health including recovery. Trained in how to respond to &amp; treat people with mental health issues who are in crisis as well as how to respond to &amp; treat trauma victims. They need to be trained in how to look beyond the psych label to prevent ignoring physical problems.            Crisis Service - Crisis worker needs to be well trained in the interview process for crisis. They need to establish a connection with the person before assessing suicidal or homicidal. Ask caller what they need. Ask "open-ended" questions. Don't tell me how to fix my problems, maybe I just need to talk it out. Don't talk down to people. Need People who understand me and create plan with caller for safety &amp; help            The crisis worker on the phone should, at any phase of the crisis, tell the person calling what action they are planning to take, i.e. sending police, an ambulance, a mobile unit to do a face to face.            Do not use the police unless there is evidence of violence. If police must be used let us know that a police officer will be coming to pick us up.            Intake – Single intake process to follow patient wherever they will be receiving crisis services. Shorter process using more conversation then pre-determined questions. Empathic listening.            Individual Crisis Plan – ICP's put the person in charge of their life. It lets providers know what works best for them. It saves time and money. Policies for state contracted agencies to respect and implement Individual Crisis Plans.</p>

Portland: Consumer Response to Crisis Services—May 9, 2005

WHAT HELPS	WHAT DOESN'T HELP	SOLUTIONS
	<p>“The psychiatrist was going to discharge me to home even though he voiced the worry I was not safe enough to be in Residential Crisis Unit.”</p> <p>“I was in the crisis stabilization unit for 3 days and no one talked to me until 2 hours before my discharge.”</p> <p>“I had been in the hospital being treated for cancer and had Crisis In-home support and they could not help with things like carrying in groceries. She said they could only help with mental issues not physical.”</p>	<p>Walk-in service (not ER): Crisis assessment/intake Should not be like hospital (not medical model) . There should be trained staff and on-call doctors available. Relaxed atmosphere, less formal, less focus on filling out forms. Take time to talk through problems, admit to hospital if needed. Recognize that walk-ins may not be ready to plunge into process immediately.</p> <p>Mobile Crisis Units: Have mobile crisis units that will go to the patient's home.</p> <p>In the ER's – See education</p> <p>Transportation – Crisis services should have cars to transport you or offer a taxi or call case manager to transport you.</p> <p>RCU's - <b>Expand</b> respite services to be used instead of hospitals, include peer services. Allow people using RCU's to spend time in their room or have alone time.</p> <p>In-home support: Trained crisis worker could be sent to my home to stay with me up to 72 hours before using a Residential Crisis Unit (RCU) bed. Especially during life events such as a death in the family, discharge for major medical reasons, change of medication or if there are not RCU beds available.</p> <p>Public Education - Community education on mental health &amp; recovery concerning people of all ages. Publicize what is available for crisis services in each community.</p> <p>Discharge from hospital - Make crisis planning part of Discharge Planning.. Shift perspective to self-directed planning vs. agency providers telling consumer what to do on discharge. Consumer must be actively involved in goal-setting &amp; planning</p>

Presque Isle: Consumer Response to Crisis Services—May 17, 2005

DEMOGRAPHICS	Responses are in regard to the individual's experience with agency providing crisis services.  QUESTION: If you were to experience a crisis in your life at this time and wanted assistance, what would you do?"	QUESTION: On a scale of 1-7 (with 1 = awful, worse than nothing), and 7 great, (wouldn't change a thing) how do you feel about the quality and availability of crisis services in your region?	QUESTION: What advice would you give to a friend (who might experience a crisis) who had just moved into this region and knew nothing about what help might be available?	QUESTION: If you or someone you know had a crisis within the past 2 years overall, did you or did you not get the help you needed.
<p>Participants: The Presque Isle Forum had 9 participants. The group consisted of 8 females - 1 male.</p> <p>Geographic Area Represented: Madawaska</p> <p>Agencies Represented: Aroostook Mental Health Center Community Health &amp; Counseling Services DHHS Regional Office</p>	<p>Response:</p> <p><b>AMHC:</b> Call AMHC Madawaska /Presque Isle &amp; they contact crisis line (only in daytime) Direct call crisis line after hours Call Peer line in Presque Isle (from 4pm-12 midnight)</p> <p><b>CHCS:</b> Talking with counselor, psychiatrist, peer line to prevent crisis</p> <p>Call Parents (natural supports) Call 911 Call my medical doctor</p> <p>DHHS: Nothing at all</p>	<p>Response:</p> <p><b>Quality;</b> 7-7-7-7-7-7-1 <b>Availability:</b> 6-7-6-7-6-4-7-1</p>	<p>Response:</p> <p><b>AMHC:</b> :Call AMHC-secretary refers on down Call Helpline-Peer line Talk to Priest/Minister</p> <p><b>CHCS:</b> Gives you a pamphlet on services Call Hotline!-Madawaska/Presque Isle</p> <p><b>DHHS:</b> Nothing at all</p>	<p>Response: 9 polled</p> <p>All Agencies have been used: Got the help they needed (5) Didn't get the help needed (1)</p> <p>N/A: 3</p>

Presque Isle: Consumer Response to Crisis Services—May 17, 2005

WHAT HELPS	WHAT DOESN'T HELP	SOLUTIONS
<p>Being listened to respectfully. Treated like a human being.                      Being referred to a psychiatrist.                      Talking with psychiatrist-feels relaxed &amp; can say anything.                      My counselor helped-having someone to talk to confidentially                      Call AMHC because they get back to you &amp; they help                      My parents-they nurture me                      Talking with family                      Talk with staff &amp; peers at group home                      Peer support groups                      Staff at group home &amp; peers                      DHHS-Social Services SSA                      Money for meds &amp; rent                      Having a job</p>	<p>Being discriminated against because you have a mental illness.                      Crisis worker being disrespectful to you on the phone.                      Not listening                      Not seeing me as a whole person not just someone with a mental illness.                      Crisis worker on phone should be like me (peer).                      Having to talk to about 5 people                      At hospital not being able to get out and around people                      Being told by staff that it isn't there job to get you out.                      Would not use crisis line/wait until morning                      Calling police unnecessarily                      Restraining with handcuffs &amp; leg restraints                      Family doesn't com to see her.                      Family not helpful/push away                      Friend was not helpful</p> <p>“Ambulance took me to the hospital. Police met me there and they cuffed me to the bed in ER.”</p> <p>(</p>	<p><b>Prevention:</b> Increase number of support groups                      More jobs</p> <p><b>Warm Lines:</b> Very helpful in preventing crisis-just to talk</p> <p><b>Education &amp; Training:</b> Better training of crisis line workers</p> <p><b>Telephone Assessment:</b> Thoughtful listener. Tell your story one time.</p> <p><b>Individual Crisis Plans:</b> Teach how to do an ICP.</p> <p><b>Mobile Crisis Visits:</b> Would like to have this service</p> <p><b>RCU's:</b> Would like to have this service.</p> <p><b>Transportation:</b> Needs to be by crisis car not police.</p> <p><b>Protective Custody:</b> No restraining if you are not violent.</p> <p><b>Emergency Room:</b> Not having to wait so long.</p> <p><b>Evaluation:</b> Services need to be evaluated to make sure people are doing what they are supposed to.</p>

Brunswick: Consumer Response to Crisis Services—May 23, 2005

DEMOGRAPHICS	Responses are in regard to the individual's experience with agency providing crisis services.  QUESTION: If you were to experience a crisis in your life at this time and wanted assistance, what would you do?"	QUESTION: On a scale of 1-7 (with 1 = awful, worse than nothing), and 7 great, (wouldn't change a thing) how do you feel about the quality and availability of crisis services in your region?	QUESTION: What advice would you give to a friend (who might experience a crisis) who had just moved into this region and knew nothing about what help might be available?	QUESTION: If you or someone you know had a crisis within the past 2 years overall, did you or did you not get the help you needed.
<p>Participants: The Brunswick Forum had 6 participants. The group consisted of 6 females - 0 males.</p> <p>Geographic Area Represente: Brunswick Bath Topsham</p> <p>Agencies Represented: Sweetser Peer Center Crisis Stabilization</p>	<p>Response:</p> <p>Call Peer Center Call friend Call Sweetser crisis program Call crisis hotline- 1-800</p>	<p>Response:</p> <p><b>Quality:</b> 7-7-7-7-5-N/A <b>Availability:</b> 5-5-7-6-4-N/A</p>	<p>Response:</p> <p>Call Sweetser Crisis program Call Sweetser and talk to my friend—act as go-between especially if crisis was having a bad day or if she just got answering service Tell friend about Peer Center</p>	<p>Response: 6 polled</p> <p>Sweetser CSU: Did get the help needed (4) N/A: (2)</p>

Brunswick: Consumer Response to Crisis Services—May 23, 2005

WHAT HELPS	WHAT DOESN'T HELP	SOLUTIONS
<p><b>Sweetser Crisis Stabilization:</b>  Short staffed-get answering service when staff are out assessing someone else  homelike atmosphere  They don't act like care takers, they act like friends  They're not pushy  Responsive to needs  They understand mental illness (unlike family)  Contact Crisis Services before going to ER  They distract me (from strong thoughts) by having me focus on another thing like reading poetry to them  They work with you not against you  They don't minimize my problems  They reassure me I haven't called too many times</p> <p><b>Sweetser Peer Center:</b>  nurturing female atmosphere  you can let your hair down &amp; be yourself  having forums  service animals  resources  opportunity to volunteer  field trips like HOPE conference  chance to be with people, make friends  peer support  writing group  sense of security  feeling of safety</p>	<p><b>Sweetser Crisis Stabilization:</b>  Don't always get thru  Assumption from peers/warm line volunteers that they understand where you're at  Late at night, operator answers &amp; says someone will call you back but no one does  you agree to call (in plan) &amp; you do but crisis worker denies that you did &amp; sends police  It depends who's on duty  Crisis services not helpful in general.  They're frightening-ok on phone but if they come they often take me to hospital  Short-staffed--means there's no one to talk with me when workers have gone to do assessments  Crisis worker leaving person alone in ER, without finding out where person will be staying  Ambulance-got stuck with big bill after I was involuntarily committed to a hospital in another town  Lack of transportation to get home afterwards  Lack of available help like CSU beds  Confusion about crisis plans</p> <p><b>Sweetser Peer Center:</b>  no men  volunteers presume that their story is your story &amp; for me personally that doesn't work  no follow-thru after case workers stopped coming—camaraderie between peers &amp; CM's died  Once or twice as a volunteer I've been left here alone  occasionally I get someone who doesn't understand what's on my mind</p>	<p><b>Sweetser Crisis Stabilization:</b>  hire more people  pay more to workers  increase # of beds at CSU &amp; at hospitals  provide support/incentives to help improve worker retention (esp. older)  burnout prevention  assign one crisis worker to stay with person through whole process  seek out corporate support  Crisis program needs outreach offices.  Diversion drivers  All Maine hospitals should provide psychiatric beds.  Individual Crisis Plan (ICP) should be placed with the consumer, the consumer's ISP at the case management agency and local crisis programs.</p>

Bangor: Consumer Response to Crisis Services—May 25, 2005

DEMOGRAPHICS	Responses are in regard to the individual's experience with agency providing crisis services.  QUESTION: If you were to experience a crisis in your life at this time and wanted assistance, what would you do?"	QUESTION: On a scale of 1-7 (with 1 = awful, worse than nothing), and 7 great, (wouldn't change a thing) how do you feel about the quality and availability of crisis services in your region?	QUESTION: What advice would you give to a friend (who might experience a crisis) who had just moved into this region and knew nothing about what help might be available?	QUESTION: If you or someone you know had a crisis within the past 2 years overall, did you or did you not get the help you needed.
<p>Participants: The Bangor Forum had 9 participants. The group consisted of 7 females - 2 males.</p> <p>Geographic Area Represente: Bangor Brewer Augusta S.W. Harbor</p> <p>Agencies Represented: VA-Togus Healthreach-(HR) Community Health &amp; Counseling Services (CHCS) Washington County Psychotherapy Associates (WCPA) Penobscot Community Health Center (PCHC) Spruce Run (SR) Protea (P) Mount Desert Island Hospital ER (MDI) MaineGeneral (MG) Eastern Maine Medical Center (EMMC) St. Joseph's Hospital (SJ)</p>	<p>Response:</p> <p>VA: Call psychiatrist emergency walk in Pamphlets have been helpful Sleep</p> <p>HR" Crisis line</p> <p>CHCS: Go to family or friends Call clergy Talk to my Boyfriend therapist Call psychiatrist Phone Help Call case manager Music Relaxation techniques Take to the ER</p> <p>P: Go to family or friends Call clergy Talk to my therapist</p> <p>PCHC: Call casemanager</p> <p>WPCA: Knowing person will stay with me until the end. Promises never to leave! Phone Help Crisis line Self-help group</p> <p>MDI: Take to the ER</p>	<p>Response:</p> <p><b>Quality:</b> 1-1-6-4-2-5-4-4-N/A</p> <p><b>Availability:</b> 2-3-6-4-3-6-5-5-N/A</p>	<p>Response:</p> <p>Tell them about phone help Use police as last resort Give address crisis center Use skills to analyze their situation-intervention, phone, crisis, etc. Give name of therapist; take care of me first; phone number; peer help offered me later. Call clergy Be available &amp; give my experiences with phone help; take them to my pastor</p> <p>CHCS: Listen to them-have them talk</p> <p>P: will take you to EMMC ER Listen to them-have them talk</p> <p>HR: Don't go; will offer face to face Someone (friend) I can call 24 hours</p> <p>MG: Don't go</p> <p>EMMC: Don't go to</p> <p>Don't use police except as last resort</p>	<p>Response: 9 polled</p> <p>All Agencies have been used by participants:</p> <p>Did get the help needed (5) Did not get the help needed (4)</p>

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WHAT HELPS	WHAT DOESN'T HELP	SOLUTIONS
<p>Being treated with respect &amp; dignity by all sources involved in my crisis care. Not being labeled. Being taken seriously.</p> <p>Having peer support from the beginning! Affirm that life &amp; people are precious &amp; what they are saying is important Being believed. Listen &amp; take time to treat you as an individual.</p> <p>Look at us, we have plenty to offer, we are not our disability.</p> <p>Having a life in our community.</p> <p>Finding psychiatrist to listen. Provider show that they know me-familiarity Ask you about kids &amp; other positive things</p> <p>Talked me out of suicide</p> <p>Learning skills in groups &amp; utilizing them</p> <p>Knowing person will stay with me until the end. Promises never to leave!</p> <p>Peers to talk to</p> <p>Someone (friend) I can call 24 hours</p> <p>Pre-work set up support system before crisis occurs, have a crisis plan.</p> <p>Using the Warm-Line for anxiety.</p> <p>If phone help could become familiar with people who call it would make it a more comfortable relationship.</p>	<p>Being asked if they were drinking</p> <p>Calling/threatening to bring police</p> <p>Over reaction by crisis line. Sent police, handcuffs, draw guns.</p> <p>Sent police to family's work</p> <p>Person on crisis line making less or trivializing your situation- 'Good Luck' Saying "Take a bubble bath"</p> <p>Ask if you're suicidal/not waiting/reacting not listening</p> <p>Agency not willing to give support just takes action not wanted by the person; will not listen to what the person wants; no follow through</p> <p>Clock watchers-psychiatrist, case management</p> <p>Son in system afraid to talk because of getting shipped to large prison. No help in groups, can't count on confidentiality. How can he get help to move on?</p> <p>Don't check in prison on suicide watch</p> <p>Force people to do things they don't want to</p> <p>Service so difficult to obtain</p> <p>Getting your medication in ER over long periods of time.</p> <p>I have had one experience with mobile crisis and the person made me more agitated, when I said I was okay the crisis worker threatened to take me to hospital anyway.</p> <p>When I call crisis they won't come to me-they make me go to them. I don't even bother talking to them anymore.</p> <p>Police escort-in cuffs</p> <p>Tried to leave ER; 4 staff &amp; cops kept me from leaving; then they blue papered me</p> <p>Mistreated by police-trying to leave hospital. Threatened me-I was afraid cop would hurt me because he did before. He cuffed me &amp; was verbally assaultive.</p> <p>They keep you at the ER even though you are no longer in crisis then sent me to hospital.</p>	<p>Warm Lines - They should be staffed by trained peers with history of good recovery available 24/7 365 days. On-going training updating available community services</p> <p>Education &amp; Training - More consumer &amp; community interaction and training, education. Training for police, phone, therapist, emergency departments, EMS, all providers of crisis services (ER Doctors &amp; Nurses well trained in mental health including recovery.</p> <p>Crisis Services - Crisis workers need to be well trained. They need to understand mental illness and know who to listen.</p> <p>They should not use the police unless there is evidence of violence. If police must be used let us know that a police officer will be coming to pick us up.</p> <p>Intake - Single intake process to follow patient wherever they will be receiving crisis services.</p> <p>Individual crisis plan – Crisis services and the agency where I receive my services should have a copy of my ICP. I would have one and at least one other person in my natural support system should have one. They should be respected and followed . If everything is in place and approved and it is not followed there should be some kind of recourse.</p> <p>Walk-in service It would be helpful</p> <p>Mobile Crisis Units: Have mobile crisis units that will go to the patient's home.</p>

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	<p>I have been to RCU's in this region and sometimes rather go to hospital. I had problems with the staff. Boring place and I have felt rushed to get out of there</p> <p>The ER never did a plan to send me back home Made trips from hospital (EMMC) to Acadia because of medical issues. Could have looked at what needs were instead of moving back and forth from medical hospital to psychiatric hospital. Nursing home would not allow psychiatric treatment even though they recognized my need for it. The need to treat you as "whole person" In summary, sometimes crisis services make crisis worse Terrible in Bangor-asked if person was drinking Person called phone help &amp; wound up being more suicidal</p>	<p>In the ER's – See education. They need to pay attention to real physical medical issues. If you are being released to go home there should be a plan in place. If you are in the ER for a long period of time they should administer the medication you are on.</p> <p>Transportation – Crisis services should have the ability to transport you without using the police or an ambulance.</p> <p>RCU's - <b>Expand</b> respite services to be used instead of hospitals. It is helpful when there is more interaction with people. Helps to keep people out of hospital.</p> <p>In-home support - Having someone come to my home for a day or two would be very helpful.</p> <p>Public Education – More consumer and community interaction, training and education. Have a program where administration goes through there own crisis services so they can see how it is.</p> <p>Jail Services They need to care for the person. Make sure they watch for suicidal behavior Give medications Jails need peer support</p> <p><b>Peer Support</b> - Peer support training-what to do/what not to do</p>

## Current Crisis Services Should Offer:

1. Warm Lines
2. Crisis Service
  - Walk-in service (other than emergency room)
  - Telephone Assessment - to determine level of distress and competence i.e. safety, suicidal ideation, homicidal ideation.
- a. During first five minutes necessary personal information is gathered:  
Where are you calling from and #, name, address, home phone #.
  - ▶ During this first 5 minutes a determination of the need is made. If the initial assessment determines the situation NOT to be an emergency and safety can be achieved with a plan then the Crisis Worker should ask the caller if they have a written INDIVIDUAL CRISIS PLAN (ICP)? Is it on file with the agency they receive their mental health services? And... do they have a copy with them? - If a vial plan exists and can be carried out (solutions within the individual's crisis plan apply to the situation) it must be followed. If no written ICP exists than a plan is made to assist the person who is under emotional distress i.e. call Doctor, Case Manager, meet with one of your natural support people etc. (A plan must be made that fits the level of crisis acuity that is assessed). Include calling back if needed.
  - ▶ If during this first 5 minutes it is determined that an emergency may exist a plan is made to further assess the level of stress. This could include mobile crisis visit (face to face),
  - ▶ A further assessment of safety and competence is done where the mobile work may offer:
    - I. Solutions in ICP that apply to the situation
    - II. The possibility of using an RCU bed at which point the Crisis Worker looks for one. If no bed is available....
    - III. And it is determined that hospitalization (as last option) is the necessary step to take than arrangements must be made to transport consumer to the nearest ER for medical clearance. (See At the ER).
  - ▶ If assessment shows a volatile situation (imminent danger to self or others).
    - ⇒ Police need to be called to the site of where the consumer is to assess the need for protective custody....
    - ⇒ If the police assessment determines a need for protective custody using the least restrictive process they will take the consumer into custody and take them to the nearest ER at which time the Crisis Worker will re-connect with the consumer to determine if a mobile unit is requested or necessary.

### 3. At The ER:

Once the Crisis Worker obtains medical clearance at the ER for the consumer they will call the nearest hospital psychiatric units to look for an open bed then present the consumers situation. At this time the hospital will either except or deny the admission.

If no hospital bed is immediately available and the person continues to be assessed as in need they will remain in the ER until the Crisis Worker is able to obtain an admission.

If it is determined that the person is no longer in need of an admission a plan must be made to address the level of existing acuity that allows the consumer to return safely to the community.

This protocol can be done with the consumer who voluntarily wants intervention, however, a consumer may be determined to have an involuntary need at any point during the crisis intervention. Should involuntary intervention be needed the full protocol of the Involuntary Status must be applied.

