The Role of Psychiatric Emergency Services in Aiding Community Alternatives to Hospitalization in an Inner-City Population

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In the proper political/economic environment, Crisis Intervention Programs can reduce the recidivism rate of patients who suffer from recurrent intermittent acute psychotic episodes. The author seeks to outline such a program and demonstrate its effectiveness in providing an alternative to brief hospitalization. It is believed that this form of management of the psychiatric emergency aids the practice of community psychiatry and supports the use of day treatment facilities, outpatient clinics, emergency housing, family therapy, and other community support systems.

In recent years there has been an ever-growing trend to shorten hospitalization for mentally ill patients. This has been fostered by the advent of psychotrophic medication, the community mental health movement, and the rising cost of hospitalization. It is for these reasons that there has been an attempt to go a step further and circumvent impatient hospitalization altogether by offering alternatives to hospitalization. These include day treatment facilities, temporary housing, halfway houses, boarding homes, family therapy, crisis intervention, and various workshops and rehabilitation programs/services which were historically provided via inpatient hospitalization.[1] It is clear that alternatives to hospitalization will not have significant impact if the management of the psychiatric emergency is not handled in a manner drastically different from admission to the inpatient ward.[2] This paper seeks to give guidelines and clinical support of the type of psychiatric emergency management which aids alternatives to hospitalization and which is ethically, morally, and therapeutically sound.

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Chicago's Mental Health Services

In order to understand the setting in which the clinical work was done, it is necessary to briefly sketch the delivery system of mental health services of south side Chicago.[3] Illinois was one of the first states to regionalize, ie, set up specific target areas to be serviced by specific state institutions. Region 2 is one such region composed of Chicago and several surrounding counties. Region 2 is divided into 53 planning areas with one or more making up one of the nine subregions. This paper concentrates on subregion 12 which comprises a target population of 700,000 and is located on the south side of Chicago.

Subregion 12 is composed of six planning areas consisting of South Shore, Chatham-Avalon, Roseland, Southwest, Southeast, and Beverly-Morgan.[4] The first four areas are primarily inhabited by black residents with 25 percent of the population on welfare in each area. The latter two planning areas are predominately white and their rate of welfare recipients (10.6 and 3.7 percent, respectively) is low enough to produce a welfare recipient rate of 17 percent for all of subregion 12. Subregion 12 patients are served by Tinley Park Hospital which has a total of 290 adult beds. Tinley Park also serves two other subregions and, as a result, 290 psychiatric beds serve a target population of three million. Fortunately, the other two subregions have available several private and university-affiliated psychiatric inpatient services. As a result, beds utilized by subregion 12 patients ranged between 110 to 140 of the 290 "first come-first served" state hospital beds. Eighty-six percent of patients at Tinley Park are black and come from four predominately black planning areas. Residents of the other two areas have lower rates of utilization due not to less mental illness, but rather to the use of private white hospitals. Blacks are not as welcome by "other than subregion 12 facilities" due to the Department of Public Aid's lack of timely and adequate payment of bills for services rendered. The result is that white-owned hospitals limit their welfare patients to about 20 percent. Black-run hospitals usually do not refuse welfare patients and, thus, have financial difficulty (eg, Provident, Meharry, and Homer G. Phillips, etc).

In terms of other than state resources, subregion 12 has six outpatient psychiatric clinics whose target population is the six planning areas comprising subregion 12. Five are operated by Chicago's Department of Mental Health and one by Jackson Park, a white private general medical hospital. There is not a Community Mental Health Center in the area and, as a result, federal funds are not available. The state funds some aspects of outpatient services. In addition, the state aids Jackson Park Hospital in maintaining a "14-21-day stay" unit with 14 beds and provides for patient overflow with backup hospitalization at Tinley Park. Thus, there are two entrance points to the State Mental Hospital, one being the intake system of Tinley Park which is not located in the city (public transportation to the hospital is poor). The other is Jackson Park which is in the subregion and easily accessible. Thus, 30 percent of subregion

12 patients hospitalized at Tinley Park were first seen at Jackson Park Hospital.

The intake system for Jackson Park's inpatient unit was simply a 24-hour service which determined whether the patient needed hospitalization or referral to an outpatient clinic. The state was constantly at odds with Jackson Park because of the overflow of patients from Jackson Park into its system. The overflow was lightened to a degree by an agreement with a West Side hospital (Garfield Park) to hospitalize patients referred from Jackson Park. However, in spite of this agreement, Jackson Park's referrals to the state hospital were, in the state's estimation, too high (30 percent of the subregion 12 admission rate). This resulted in overcrowding (patients sleeping on couches), and the state, therefore, provided Jackson Park Hospital with additional funds for a Crisis Intervention Program (CIP) to be added to the standard emergency intake services.

Crisis Intervention Program

Illinois statistics for subregion 12 showed a clear drop in admissions to Tinley Park between the six months before and after the start of CIP (Table 1). During the first two weeks of the program, utilization of Jackson Park's 14-bed brief-stay unit dropped from full to two to three patients. Only two patients were sent to Tinley Park for committal as opposed to the usual 15-20 patients. This brought quite a reaction from the economic/administrative faction of the private hospital's Department of Psychiatry and questions were raised about the quality of such a program as it was obviously not keeping the beds full. Therefore, the aggressiveness of the Crisis Intervention Program was to be hampered. It is the author's contention that the program was valid and important in this setting.[5] A description of CIP, with follow-up data given for a random sample of treated patients to substantiate that the program is clinically and ethically sound, follows.

Aside from the function of admission to either Jackson Park or Tinley Park Hospitals, the program practiced aggressive crisis intervention in order to deal with certain psychiatric emergencies. The aggressiveness of the intervention techniques depended on the training of the staff involved. At night, the staff consisted of a medical resident and a psychiatric nurse who were responsible for two areas (the inpatient unit and, when emergencies presented, the Emergency Room). During evenings, a trained psychiatric nurse (assigned only to the emergency program) and a medical resident were available. During both the evening and night shifts, a psychiatrist (one of three) was available for consultation by phone. If possible, the night and evening team medicated the patients (if necessary) and referred them to the day shift next morning. In more serious cases voluntary hospitalization was attempted, but if the patient refused and was felt to be of harm to self or others (based on prior behavior or verbalized intent), he was admitted to Tinley Park via certificate. During days, a board-certified psychiatrist, a psychiatric nurse, a social worker, and a patient aide were available, as well as a driver to transport patients to Tinley Park. There was support from other day staff involved in the outpatient clinic. Linkage to the Chicago Mental Health Clinics or Jackson Park's outpatient clinic was accomplished during days while the patient was available.

Table 1. Comparison of Admission Rates Before and After CIP

	Six Months Prior to CIP	Six Months After CIP
Average total admissions	126.1	106.1
Average readmissions	78.0	63.3
Average first admissions	47.0	40.3

Families and patients were seen in diagnostic interviews done by either the psychiatric nurse or social worker; however, during the day, all patients seen had contact with the psychiatrist and supervision was thereby provided to other members of the primary care team.[6] Every patient was used as a teaching case. It was felt that evening and night personnel could rotate through days and enhance their skills. As this was an emergency service, the first questions cleared were legal ones. The patient was first asked to sign a voluntary emergency service treatment form. If he agreed, as soon as he was medically cleared by a physician, the emergency was evaluated and handled by the use of physical restraints (if needed), intramuscular medication (if needed), and counseling as ordered by the physician in charge. Once patient combativeness, agitation, excitement, panic, and overwhelming anxiety or fear had been "cooled out," a more extensive interview was performed, focusing on precipitating events leading to the crisis. A past history of previous psychiatric treatment was elicited. From this evaluation, a determination of need for referral, hospitalization, or crisis intervention was made. If crisis intervention were appropriate, the patient was adequately medicated and given an appointment to return to the crisis program.

If hospitalization were needed, the patient was asked to sign voluntary admission forms. If the patient refused hospitalization, he was evaluated for the probability that he would harm himself or others. If that probability could not be documented on the basis of verbal declaration, recent history of such behavior, or goal-directed behavior towards that end, the patient was released with an explanation that he needed treatment but was not "crazy" enough to be legally forced to accept treatment. All patients in this category were offered services of the Crisis Intervention Program provided they would agree to a treatment contract of cooperation which included taking medication if needed.[7] If the patient refused voluntary hospitalization and was of harm to self or others, he was certified and sent to Tinley Park.

Finally, if the patient refused to sign the initial voluntary emergency treatment form, he was evaluated from the standpoint of being dangerous to himself or others and if he was not harmful, he was told either to sign or remove himself (or be escorted) from the premises. If certification was appropriate, he was taken into custody against his will, certified, and sent to Tinley Park. Patients who presented violently were not asked questions. They were simply and quickly put into restraints as a self-defense measure to protect staff and medical equipment. If the patient could not be reasoned with when calm, then he would be certified and sent to Tinley Park on the basis of presenting behav-

ior. The importance of organic factors causing such behavior was clearly shown and several clinical examples (delirium tremens, phencyclidine overdose, and hyperthyroidism) were available to make the differences in management of organic agitation, as opposed to mood or cognitive agitation, clear.

The following intramuscular medications were given: haloperidol 5-10 mg every one-half hour with a second dose being rarely necessary; diazepam 5-10 mg every one-half hour up to two doses, or benztropine mesylate, 1-2 mg. Use of haloperidol or diazepam depended on whether or not the anxiety was, respectively, primarily psychotic or stress-related.[8,9] Benzotropine mesylate was administered to patients with acute dystonic reactions secondary to neuroleptic medication. In addition to these short-term intramuscular medications, fluphenazine decanoate, 25 mg, was given intramuscularly to patients who presented with (1) symptoms of an acute psychotic episode (confusion, auditory hallucinations, no history of drug abuse, sleep loss, incoherence, bizarre behavior, flat, or agitated affect, disheveled appearance, etc); (2) a clear history of previous psychiatric hospitalizations due to acute psychotic episodes which benefited from neuroleptic medication; and (3) histories that they had discontinued outpatient clinic visits or psychotrophic medication.[10] These patients were referred to the CIP five days after they received the fluphenazine injection and were given a three-day supply of chlorpromazine, 200 mg, twice a day until the medicine could take effect. They were also given a two week supply of 2 mg tablets of benztropine mesylate to take at bedtime. Although fewer than one third would have neuroleptic side effects, it was best to "overprevent" any reactions which might give patients further negative feelings towards medication. Families were invited to bring the patient back in three days if they did not see improvement. Patients rarely returned before their "five days after initial contact" appointment and those few that did were usually hospitalized because the family could not tolerate the patient's psychotic behavior even with CIP support.

Patients were able to receive three crisis sessions in addition to the initial contact, however, two crisis sessions per patient were rare. This was primarily due to the fact that a number of patients referred to the CIP had acute psychotic episodes. They responded to medication and to the aggressive linkage with local outpatient clinics. It was primarily the social worker's function to see patients after their initial visit and attempt to perform linkage. In addition, she often called or wrote patients who did not return for their first crisis visit. During the initial interview and subsequent crisis sessions (if indicated) patients were confronted with their behavior, intrapsychic dynamics, familial pathology, and strengths, point-blank. It was felt that the defenses had broken down (thus, producing a crisis) and the underlying dynamics, thus exposed, were to be handled directly. Before this direct rapid-interpretation technique was used, the staff person had established a firm empathetic rapport with the patient.[11] Problems were clearly identified "out loud" for all persons concerned and it was made clear that the staff would, without hesitation, take total control to ensure a calm "working through" of the crisis.[12,13] There was a clear distinction made between understanding the "whys" of behavior and the acceptance of that behavior. Patients and family were essentially told that they were in "our house" and that we respected them. We also expected them to respect us. Everything done to the patient was explained simply and an attempt was made to answer all questions (except personal ones). In short, the milieu was down-to-earth and directive with the staff maintaining a warm but no-nonsense attitude.

A total of 70 patients was studied retrospectively during the first two weeks of August 1976. Most patients were placed into one of four categories, depending on the clinical pictures during the intake interview. These were acute psychotic episode, character disorder in crisis (usually due to pressure from social forces), substance abuse with intoxication, and acute transient situational stress with or without previous psychiatric illness (Table 2). Six percent were certified and sent to Tinley Park. Of 94 percent who were not dangerous, only four percent refused treatment. Of 70 patients, 24 (34 percent) were referred to the Crisis Intervention Program with two thirds of that number returning to the program for their first crisis appointment. On return, they were substantially improved and follow-up revealed that half of them were successfully linked to their local mental clinics.

Of the 46 patients (66 percent) who were not referred to the CIP, one fourth were hospitalized (half were certified

Table 2. Diagnostic Categories of Patients Seen the First Two Weeks in August

	Treated by Standard Emergency Psychiatric Procedures	Treated by CIP	Total
Acute psychotic episode			
N	13	20	33**
%	28	83	46
Acute transient stress			
N	10	3	13
%	22	12	19
Substance abuse†			
N	13	—	13
%	28	—	19
Character disorder			
N	4	—	4
%	9	—	5
Total			
N	46*	24*	70*
%	100*	100*	100*

N=Number of patients.
* Totals do not add up evenly because of seven miscellaneous diagnoses.
**Only three were without previous histories of such episodes.
† 2/3 were alcohol abuse.

and half were voluntary), one fourth were successfully linked to their local mental health clinics, one eighth were not referred or refused referral, one eighth were lost to follow-up because they did not belong to subregion 12, and one fourth were given appointments to their local mental health clinics, but did not show for their initial appointment.

Case Reports

Examples of management of typical emergency psychiatric treatment cases are presented. Patient A, a 32-year-old black male patient was brought to the emergency psychiatric service by his family with a complaint that he was "acting peculiar again." The patient presented in an agitated, bizarre, and combative fashion. It was necessary to place the patient in four-way leather restraints and give him an injection of haloperidol, 10 mg, intramuscularly. As the patient calmed, a history was obtained from the family. He had been in the hospital five times previously for the same reasons. He had felt that he was better, had stopped going to his local mental health clinic, and had stopped taking his medication. Although the family was familiar with this pattern, they again allowed him to discontinue his clinic visits and were well aware of his regressive behavior five weeks before they brought him to be rehospitalized. The patient was now calm enough to be removed from restraints (the cart to which he was restrained was in the same room in which the interview was held) and allowed to join the family discussion. The family and patient were advised that they had acted unwisely by allowing the patient to discontinue treatment and for their lack of early intervention. It was explained that if the family could wait five weeks being tolerant of regressive behavior they could wait three days with the support of the CIP program. It was further explained that the patient would be given a "two-week" injection (fluphenazine decanoate, 25 mg). Chlorpromazine, 200 mg, was prescribed, one in the morning and one at bedtime, for three days until the injection had its full effect. The family members were visibly angry, but said they were willing to try.[14]

They did have concerns about what should be done if the patient became violent again. It was suggested that they call the police and have the patient brought back to the emergency service. He would be re-evaluated for possible hospitalization and probably be admitted. Since he was on welfare, it was likely that during hospitalization he would be dropped and it would take at least two months for him to be restored. They agreed to try to keep the patient out of the hospital. It was requested that the patient return in five days to check for improvement and to reconnect him to his clinic. Five days later, the patient returned unescorted. He expressed gratitude that hospitalization had been avoided since he had recently obtained a job. During this first crisis visit, he was given a clear understanding of the importance of taking his medication and that, even if he felt he was better, he should remain in contact with his clinic "just in case." Finally, the patient was linked to his former outpatient clinic, however, they were unable to see him before his medication would be due. Therefore, he was seen one more time. He kept his appointment.

Patient B, a 17-year-old black female, was brought by the police because she had attempted suicide by drug overdose. Although, it was reported that the patient had regurgitated most of the capsules, undigested, her stomach was pumped. The examiner found her to be an upset, angry, arrogant adolescent who gave a history of breaking up with her boyfriend and deciding she would overdose. It was revealed that she had called police but no longer cared to discuss the matter because she had to keep a date to go shopping with her girlfriend. From her mental status examination, it was determined that the patient was not psychotic. She had poor impulse control. She was not devoid of hope nor the capacity for humor and had good judgment when not upset. However, the examiner felt that she needed to be appraised of the consequences for her behavior. He informed her that on the basis of her recent suicidal behavior he would have to certify her to a state hospital for the mentally ill. She balked, became extremely angry, and stated that such a thing was out of the examiner's jurisdiction. The seriousness of her act and the examiner's concern for her life were impressed upon her. She was reassured that it probably would not be as bad as she thought and that, if she cooperated with the inpatient evaluation, she might be discharged in two to three weeks. It was at this point that she stopped her arrogance and began to say she had "really gone too far this time." She went on to talk about how "silly and immature" she felt when she let her emotions carry her thinking away. In talking, she gave assurances that she would seek treatment regardless of whether or not she was hospitalized. She said she had not dealt with the fact that she had a problem and she could not deny it any longer because of "the way it was brought to me." She was linked to her local mental health center instead of being certified and on follow-up she had made the connection.[15]

Patient C was a 29-year-old black male, brought by the police because he was involved in a robbery. Because of a previous psychiatric history, he was brought for hospitalization instead of being taken to jail. On examination the patient was not psychotic, neurotic, homicidal, or suicidal. His prior hospitalizations were secondary to drug abuse and episodes of anger secondary to conflict with persons in authority. He was able to tell right from wrong, to adhere to the right, and to cooperate with a lawyer in his defense. He had not been engaged in treatment for two years but wondered if he could be hospitalized for several days at Tinley Park and given diazepam, 10 mg, while there. He was returned to the custody of the police.

Patient D was a 78-year-old black male who was brought to the emergency service by his wife because of growing confusion. The wife wanted him "committed to an old folks home because of his senility." The patient denied all of his wife's complaints but did show signs of disturbance in recent memory and orientation. He was given haloperidol, 1 mg, three times a day and told to return to the clinic in five days. His wife returned with the patient in three days. This time she brought papers requesting she be made executor of his estate and a request from their lawyer that the psychiatrist document his mental incompetence. The patient seemed improved at this visit. On calling the lawyer, it was learned that while he did not feel the patient was incompetent, he, due to the wife's insistence, had given her the papers. The papers were not filled out, however, and the patient's medication was increased to haloperidol, 2 mg,

three times a day. On the patient's last visit before linkage to his local outpatient clinic, he appeared to be much improved although still dependent on his wife for care. On follow-up, he had not returned to the clinic.

Discussion

The difference between the total number of patients admitted six months prior to the start of the CIP and the total number of patients admitted six months after the program began had a Student t-test probability value of between 0.1 and 0.2 The average total number of admissions per month dropped by 20 patients after initiation of the program. The percentage of total admissions to Tinley Park from Jackson Park dropped from an average of 30 percent per month to an average of 20 percent per month. In addition, the total number of patients readmitted dropped by 15 patients per month when comparing rates of readmission six months before and six months after beginning the program. The drop in first admissions per month between the two samples was only seven patient per month. This was probably due to the focus of the program which was to maintain previously admitted patients with clear histories in the community and to circumvent rehospitalization. Patients referred to the CIP had hospitalization rates of 12.5 percent, although the majority ordinarily would have been hospitalized owing to their diagnosis of acute psychotic episode.[16] Patients with first episodes of psychiatric difficulties were likely to have been managed in the standard fashion due to a lack of a thorough inpatient diagnostic evaluation. As a result, the rate of hospitalization for patients not referred to the CIP was 21.7 percent during the two-week sample. These results concur with the observation of a greater impact readmission rates in subregion 12 with the start of the program, and although there was a drop in first admissions, it was not so large. In addition to the fact that patients referred to the crisis program were clearly less likely to be hospitalized, they were also more likely to be successfully linked to their local mental health clinics than were patients managed by standard emergency psychiatric techniques.

Finally, in terms of patients' reasons for seeking hospitalization, it is probable that patients with high readmission rates were able to learn that they could get relief from the chaos of an acute psychotic episode on an outpatient basis rather than through hospitalization. In addition, the technique used increased the families' awareness of their role and responsibility in keeping the patient out of the hospital. One parent told me, "I've been lackadaisical in seeing that my son got to the clinic but after all this trouble—he'll go from now on." By enlisting the aid of the family in the treatment, the family members and not the treating agency put pressure on the patient to confirm to standard codes of behavior. The patient and family became responsible for issues of "how to act" which allows for a more cooperative type of treatment contract to be formed between the patient and therapist. One woman (whose son was not in the author's opinion dangerous, but who insisted on opening the bathroom door while she was using the toilet) was advised to get a lock on the door, or to put him out, or see to it that he got proper treatment for his "nerves." As she was afraid of what he would do in a locked bathroom and could not put her 26-year-old "baby" out, she agreed to see that he got to the clinic regularly for his "three-week shot" (fluphenazine decanoate). Although her new attitude was in the best interest both for her and her son, she left the service angry because he had not been hospitalized as on six previous times.

Summary and Conclusions

In summary, the things to be learned from this experience are as follows:

1. Clinicians must take into account political, administrative, and economic factors when introducing a program which will cause a shift in patient flow. This is an especially important factor to consider when there is a conflict of interest in the facility which is delivering the service. These factors are probably the main reasons that day treatment centers, crisis intervention programs, emergency housing, etc. are not gaining more popularity in treating psychiatric patients.

2. Crisis intervention techniques described, herein, will reduce the total admission rate to state hospitals with a greater impact being seen on readmissions than first admission. First admission rates will also decrease.

3. Crisis intervention techniques used for patients, falling into the category of acute psychotic episode, who have had previous hospitalizations, will probably be more successful than those who are having an acute psychotic episode for the first time.

4. Psychiatric emergency intervention is best done with an attitude of interest in the patients' well-being and an attempt to "hookup" with the patient while at the same time being clear that no foolishness will be tolerated.

Follow-up data support the contention that the program described is just as effective as most brief hospitalization units. CIPs, put into effect statewide, would change the manner of managing psychiatric emergencies and would greatly benefit the practice of community psychiatry. The decrease in hospitalization, resulting from the use of this program would allow for better utilization of day treatment programs, emergency housing, outpatient clinic involvement in early intervention, and sheltered living facilities.

Literature Cited

1. Borus JF: Community mental health and the deinstitutionalized patient. Weekly Psychiatry Update Series, Parts 1 and 2, 1977
2. Levison DJ, Astrashan BM: Organizational boundaries: Entry into the mental health center. Administration in Mental Health, NIMH, Summer 1974
3. Borus JF: The coordination of mental health services at the neighborhood level. Am J Psychiatry 132(11): 1171-1181, 1975
4. Region 2 Street and Coding Guide. Illinois Department of Mental Health, 1972
5. Ghetto psychiatry: Harlem version, parts 1 and 2. Psychiatric Annals 4(4&5): 1974
6. Lazare A, Cohen F, Jacobson AM, et al: The walk-in patient as a customer: A key dimension in evaluation and treatment. Am J Orthopsychiatr 42(5):872-883, 1972
7. Whittington HG, Zaburck R, Grey L: Pharmacotherapy and community psychiatric practice. Am J Psychiatry 126(4):133-136, 1969
8. Anderson WH, Kuehnle JC, Catanzano DM: Rapid treatment of acute psychosis. Am J Psychiatry 133(9)1076-1078, 1976
9. Mann PL, Chen CH: Rapid tranquilization of acutely psychotic patients with intramuscular haloperidol and chlorpromazine. Psychosomatics 14:59-63, 1973
10. Ayd F: The depot fluphenazines: A reappraisal after 10-years clinical experience. Am J Psychiatry 132(5):491-500, 1975
11. Orlinsky DE, Howard KI: Communication rapport and patient progress. Psychotherapy: Theory, Research and Practice 5(3):131-136, 1968
12. Navaco RW: The functions and regulations of the arousal of anger. Am J Psychiatry 133(10):1124-1128, 1976
13. Morcornity E: Aggression in human adaptation. Psychoanal Q 42:226-232, 1973
14. Herz MI, Endicott J, Spitzer RL: Brief versus standard hospitalization: The families. Am J Psychiatry 133(7):795-801, 1976
15. Weissmann M: Prognostic factors in attempted suicide. Am J Psychiatr 131(9):987-990, 1974
16. Tucker GJ: Psychiatric emergencies: Evaluation and management. In Freedman DX, Dryud JE (eds): American Handbook of Psychiatry, ed 2. New York, Basic Books, 1975, vol 5, pp 567-592