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**CLIENTS SERVED AND OUTCOMES ACHIEVED BY THE ADULT MOBILE CRISIS TEAM**

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# I. Program Description

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## PROGRAM CREATION

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The Adult Mobile Crisis Team (MCT) was authorized by a Resolution of the Governors of the Cuyahoga County Community Mental Health Board (CCCMHB) in November, 1994.

CCCMHB led the design and development of an effective crisis response system by working with MCT and other contract agencies to establish service protocols and coordinated service agreements.

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## GOALS OF THE ADULT MOBILE CRISIS TEAM

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To provide prompt, sensitive, professional, and effective responses to persons experiencing a psychiatric crisis or emergency. MCT services are designed to offer a flexible, rational, and graduated system of responses to persons currently served in, or unknown to, the community mental health system.

To serve the community by being a creative and effective participant in its emergency services network.

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## TELEPHONE REFERRAL & CONSULTATION

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In referrals, information is obtained to assist the person to secure services most appropriate to his or her needs. The conversation is sensitive and responsive to the person's ethnic and cultural background, and to factors of the social environment that may affect the person's ability to process and communicate important information. Consultations are conducted in the spirit of helping the person to understand the presenting problem, and to explore appropriate responses.

MCT phone consultation complements the phone support services offered by the Suicide Hotline and the Phoenix Society's Warm Line.

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## CRISIS INTERVENTION SERVICES

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MCT staff go to the person in crisis, in locations throughout Cuyahoga County. Initial interventions are always directed to assure the client's safety and health. After assessment, interventions may include crisis counseling, referral, and transportation to a crisis shelter, emergency service provider, detoxification facility, temporary housing site, or other facility offering an appropriate level of structured, supportive services.

Individualized service planning focuses on assisting clients to reduce and manage subjective distress, and to use the coping skills available to them.

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## CRISIS INTERVENTION SERVICES

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Specific interventions in the service plan may include:

- ♦ brief cognitive and cognitive-behavioral techniques, relaxation and imagery techniques, and other psychosocial interventions,
- ♦ an evaluation by a MCT psychiatrist to discuss treatment options, and decide on psychiatric and other health interventions, and
- ♦ assistance in obtaining prescribed antipsychotic or antidepressant medicine.

Upon resolution of the crisis, clients are linked to appropriate outpatient providers for ongoing services.

## PARTNERS

MCT is only one component of the CCCMHB's crisis response system. Critically-important partners in this system include:

- ♦ East Side Crisis Stabilization Unit of Community Guidance, Inc.,
- ♦ West Side Crisis Shelter of West Side Community Mental Health Center,
- ♦ Respite of Murtis H. Taylor Community Mental Health Center, and
- ♦ Harbor Light Dual Diagnosis Crisis Stabilization Detox Center of the Salvation Army.

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## II.

### Characteristics of Referrals

There were 1,463 referrals to MCT in 1995. Figure 1 presents the number of monthly referrals.

From April, the first full month of 24-hour operations, referrals increased an average of 14% each month.

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## BENEFITS

A mobile team brings critical services to the person in crisis, and can assist the person to access the structured, supportive services that may be needed for crisis resolution.

Mobile crisis intervention services preserve a person's opportunity to maintain major supports within the community, and may serve as an effective alternative to hospitalization.

Mobile services support and promote the realization of effectively-coordinated public services, through cooperation with police, public health, and social service systems.

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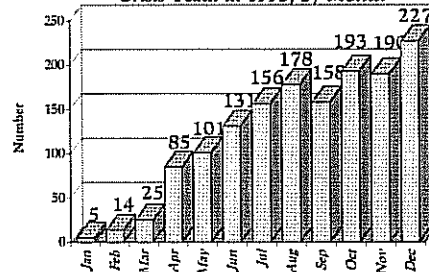
## REFERRAL SOURCES AND TIMES

Table 1 shows that referral sources were remarkably varied. Most referrals were made on behalf of, rather than by, the person in crisis. Providers of health, social, and justice services made 28% of referrals, and hospitals made another 10%.

Figure 2 presents the times during the day that referrals (N=1,415) were received. Nearly 40% of referrals were made during weekends, holidays, and from 5 p.m. to 9 a.m. -- times when community mental health centers and other service providers are not available.

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Figure 1.  
Number of Referrals to the Adult Mobile  
Crisis Team in 1995, by Month

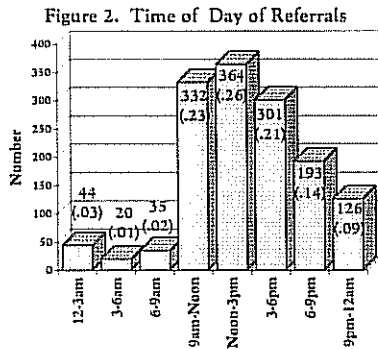


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TABLE 1. SOURCES OF REFERRALS

Source	Number	Percent
Family, Friends, Relatives	331	23
Person in Crisis	270	18
Community Mental Health Centers	176	12
Private Hospital Emergency Rooms	89	6
Police Departments, Courts	78	5
Health & Social Service Agencies	70	5
St. Vincent Psychiatric Emergency Room	46	3
Employers, Clergy, Attorneys, Private Doctors	33	2
Alcohol / Drug Treatment Agencies	32	2
Crisis Shelters	27	2
Northcoast Behavioral Health System	26	2
Other, or Unknown	285	19

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#### PRESENTING PROBLEMS

Calls made to MCT are answered directly by professional staff, who code up to three of the problems that best characterize the nature of the crisis. Tables 2 and 3 present the most frequently-reported primary and secondary presenting problems.

Combining data from both lists shows that depressed mood was an important component of the crisis in 35% of persons referred; suicidal ideas, in 25%; and housing needs, in 14%. Medication maintenance and alcohol use were among the most common of the secondary problems.

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TABLE 2  
MOST FREQUENT PRIMARY PRESENTING PROBLEMS  
OF PERSONS REFERRED TO MCT (N = 1,419)

Problem	Number	Percent
Depressed mood	341	24
Suicidal ideas	153	11
Housing needs	123	9
Agitation, hyperactivity	99	7
Hallucinations	89	6

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TABLE 3  
MOST FREQUENT SECONDARY PRESENTING PROBLEMS  
OF PERSONS REFERRED TO MCT (N = 1,082)

Problem	Number	Percent
Suicidal ideas	153	14
Depressed mood	120	11
Medication maintenance	65	6
Alcohol use	60	6
Housing needs	53	5

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### III. Characteristics of Persons Provided In-Person Services

In 1995, MCT conducted 767 initial crisis outreach visits to 745 clients (22 clients were served more than once). Follow-up visits to most of these clients were made until they had been linked with an outpatient provider for ongoing services. Mean duration of open cases was approximately 17 days.

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TABLE 4. CLIENT DEMOGRAPHIC CHARACTERISTICS

Ethnicity	Sex		Total	%
	Female	Male		
African-American	223	158	381	50
Asian	4	1	5	1
Hispanic	11	28	39	5
Other	1	2	3	~
White	178	161	339	44
Total	417	350		

For females, the mean age was 41 (s.d. = 16), and ages ranged from 18-90.

For males, the mean age was 36 (s.d. = 13), and ages ranged from 18-82.

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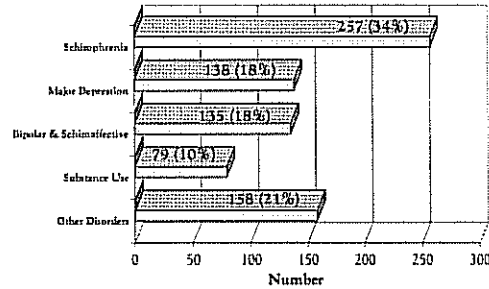
**INCOME SOURCES, LIVING ARRANGEMENTS, AND EDUCATIONAL STATUS OF CLIENTS.**

SSI was the major income source for 35% of clients; 20% had no income; 11% were employed; and 13% received SSD or AFDC income.

Less than half of clients had their own home or apartment; 22% were homeless; 10% lived with relatives; 4%, with friends; and 3%, in group homes.

One-fourth of clients had a high school diploma; 31% had less than 12 years of education; 15% had some college education with no degree; and 7% had earned a college degree.

**Figure 3. Principal DSM-IV Diagnoses of MCT Clients**



**DISTINCT SUBGROUPS (CLUSTERS) OF CLIENTS**

To more precisely study outcomes of services, the Ohio Department of Mental Health commissioned research studies to identify distinct subgroups of clients sharing common strengths, problems, and life situations. Cluster analytic procedures identified eight distinct subgroups, or clusters.

Upon closing a case, MCT staff assign each client to the cluster that best identifies that client's features. Table 5 presents cluster assignments for those MCT clients for whom data were available.

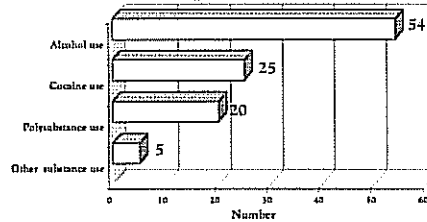
The majority were described as having severe mental health problems; one-third had drug and alcohol problems.

**DIAGNOSES OF MCT CLIENTS**

Figure 3 presents the principal diagnoses of MCT clients, using DSM-IV criteria. Diagnoses were determined for most by assessments conducted by MCT professional staff. For others, diagnoses were provided by referring agencies or hospitals. Among the "other disorders," 70 were personality disorders. Adding this number to the data for schizophrenia and major mood disorders, 600 clients (78%) had a qualifying diagnosis for a State-defined severe mental disability.

Figure 4 presents data on secondary substance use disorders among MCT clients.

**Figure 4. Secondary Substance Use Disorders Among MCT Clients**



In addition to the 79 clients having a primary diagnosis of a substance use disorder, 104 (14%) had such a disorder as a secondary diagnosis. Thus, one-fourth of all MCT clients in 1995 had a clinically significant substance use disorder.

**TABLE 5. CLUSTER IDENTIFICATION OF MCT CLIENTS (N = 330)**

No.	Cluster Description *	N
1	Severe drug/alcohol addiction, and psychosis	44
2	Severe problems with drugs, alcohol, mental health, and daily living	67
3	Older and more severely-disabled	42
4	More severely-disabled, helped by family	41
5	Younger, severely-disabled, who reject help	45
6	Community successes	21
7	Older, in poor health, with psychiatric symptoms	20
8	Young adults with work potential	50

\* Taylor, J., & Rubin, W.V. (1994). Cluster analytic planning and evaluation implementation manual. (Research report prepared by Synthesis, Inc., for ODMHL)

## IV. SERVICE OUTCOMES

Prompt response to a crisis is a crucial service outcome. Table 6 presents the intervals between a referral call and the arrival of MCT at the client's location. Nearly 60% of initial MCT visits were made within two hours of referral. Many of those seen more than four hours after referral had left their original location, or had initially declined services.

Table 7 shows that, of those clients who received psychiatric services from MCT, 75% saw our psychiatrist within two days of referral. Many initially declined or did not need psychiatric services.

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TABLE 6.  
TIME BETWEEN REFERRAL & INITIAL MCT VISIT (N=516)

Response Time	N	%
< 1 hour	218	42
1 - 2 hours	90	17
2 - 3 hours	79	15
3 - 4 hours	37	7
4 - 5 hours	31	6
> 5 hours	60	12

TABLE 7.  
DAYS BETWEEN REFERRAL & INITIAL DOCTOR VISIT (N=232)

Interval	N	%	Interval	N	%
Same day	95	41	3 days	16	7
Next day	59	25	4 days	9	4
2 days	20	9	> 4 days	33	14

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## UTILIZATION OF COMMUNITY RESOURCES

The most highly-valued outcome of MCT services is to assist clients to safely resolve crises. This is best accomplished through efficient use of community resources. Table 8 presents use of these resources by MCT clients, during the entire span of time each was a client.

These data show that 75% of MCT clients were able to remain at home or were effectively served by crisis shelters, detox services, or E.R.'s. Of those hospitalized, MCT helped 64% gain admission to a private hospital; others were admitted to Northcoast Behavioral Healthcare System (NBHS). Of those taken to St. Vincent Psychiatric emergency room, 72% were hospitalized, mostly at NBHS.

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TABLE 8. NUMBER OF MCT CLIENTS HOSPITALIZED,  
USING EMERGENCY ROOM SERVICES, AND  
USING CRISIS SHELTERS OR DETOXIFICATION FACILITIES.

USE OF HOSPITALS: (of a sample N of 505 clients)	Number	%
Northcoast Behavioral Healthcare System	45	9
Private Hospitals	79	16
Not Hospitalized	379	75
USE OF EMERGENCY ROOMS: (N=518)		
St. Vincent Psychiatric E.R.	69	13
Private Hospital E.R.	71	14
Did Not Use an E.R.	378	73
USE OF CRISIS SHELTERS/DETOX: (N=474)		
East Side Crisis Stabilization Unit	37	8
West Side Crisis Shelter	45	9
Harbor Light Dual Diagnosis Detox	19	4
Other Detox	7	1

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## POSSIBLE CLINICAL DISTINCTIONS BETWEEN THOSE ADMITTED TO STATE VS. PRIVATE HOSPITALS

Examination of cluster identifications of MCT clients who were hospitalized suggests that those admitted to the State hospital (NBHS) were disproportionately those with severe psychiatric, substance use, and daily living problems. Although insufficient data are now available for statistical analyses, those admitted to private hospitals appear to have had more evenly-distributed cluster identities.

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TABLE 9.  
CLUSTER IDENTITIES OF CLIENTS ADMITTED TO STATE  
VS. PRIVATE HOSPITALS, AND OF THOSE NOT  
HOSPITALIZED.

Cluster #	State Hosp.		Private		Not hosp.	
	#	%	#	%	#	%
1	1	4	9	17	33	14
2	10	42	9	17	46	19
3	1	4	11	20	28	11
4	2	8	10	19	29	12
5	7	29	5	9	33	14
6	0		4	7	17	7
7	3	13	3	6	13	5
8	0		3	6	45	18

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## ADVERSE EVENTS

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Incidence of adverse events is the most salient and tragic measure of failed outcomes. During 1995, 14 adverse events occurred among the 302 clients for whom data are currently available.

Five clients were arrested for property crimes and drug law violations; four engaged in assaults (for which they were not arrested), and two in self-injurious conduct. One client had an adverse medication reaction from which he quickly recovered; one died from a physical illness; and one client killed herself.

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## LINKAGE WITH OUTPATIENT PROVIDERS

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Following crisis resolution, secure linkage with outpatient health-care providers is a critical outcome. Only 38% of MCT clients in 1995 were receiving services from any provider at the time of referral, though most had chronic mental disorders. The table below shows the number of MCT clients, of 346 for whom data are available, who were linked with new service providers, and/or re-linked with current outpatient providers.

Provider	New	Current
Community Mental Health Center	106	141
Hospital-based Outpatient Services	20	20
Private-practice Professional or Clinic	43	35
Chemical Dependency Services	16	16
Total	185	212

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