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Community Mental Health Journal, Vol. 32, No. 1, February 1996

Service Delivery Using Consumer Staff in a Mobile Crisis Assessment Program

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ABSTRACT: Interest has developed in the use of mental health consumers as staff members in community programs for persons with serious mental illness. The present study investigates consumer service delivery in a mobile assessment program designed to assist homeless people with severe psychiatric disorders. Consumer and non-consumer staff were generally comparable. Results suggest that consumer staff engaged in more street outreach and were less often dispatched for emergencies. There was a trend for consumer staff to be more likely to certify their clients for psychiatric hospitalization. In sum, consumer staff appear to provide a valuable contribution to this form of service delivery.

INTRODUCTION

In an effort to empower persons with mental illness to increase their activity in and control over community services, initiatives designed to enhance consumer input have been advanced (Chamberlin, 1984;

The contents of this paper were developed under a grant from the National Institute of Disability and Rehabilitation Research, Department of Education cooperative agreement number H133B00011, and the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration. The content does not necessarily reflect the views of the Institutes and does not imply endorsement by the U.S. government. The authors would like to thank Jon Gershon, Travis Seymour, Randy Osuna, and Amy Nelson for their contributions to this research.
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Chamberlin, Rogers, & Sneed, 1989). One aspect of this movement has been the advocacy of hiring people with personal experience as recipients of mental health services to provide mental health services (Levine & Kennedy, 1985; Stroul, 1988).

While the movement towards the use of consumer staff has grown in the past few years, little empirical data have been reported regarding the impact of consumer status on service delivery (Sherman & Porter, 1991). Galanter has reported that consumer participation in the form of self-help groups can be a valuable adjunct to psychiatric treatment (Galanter, 1988). Sherman and Porter (1991) have reported on the training and development of consumers as case management aides. Solomon & Drain (1995a, 1995b) report on one and two-year follow-ups of consumer case managers. For the most part, these authors reported no service delivery or efficacy differences indicating that consumer staff can be as equally effective as non-consumer case managers.

Mobile crisis assessment is a recently devised form of mental health service delivery intended to help persons with serious mental illness and problems of homelessness find linkage to needed services (Bond, Witheredge, & Wasmer, 1989; Putnam, Cohen, & Sullivan, 1986; Slagg, Lyons, Cook, Wasmer, Witheredge, Dincin, Ruth, 1994). This form of service delivery, in which staff members work directly with clients in non-traditional locations (e.g. the street, shelters, etc.), may be a form of service provision for which consumer staff are especially well-qualified given their relevant life experiences (Atkisson, et al; Nikkel, Smith, & Edwards, 1992). People with mental illness living on the streets can be particularly hard to engage in conversation regarding service options. They may be suspicious of anyone approaching them or they may be quite cognitively disorganized (Segal, Baumohl, & Johnson, 1977). Interaction with service deliverers may be facilitated when the providers' own experiences and empathy can be utilized to establish trust and overcome interpersonal barriers (Nikkel, Smith & Edwards, 1992).

In order to better understand the role of consumer staff members in providing mobile crisis assessment services, a naturalistic study was undertaken. The purpose of the study was to identify similarities and differences in the nature and amount of services delivered by consumer versus non-consumer staff. To address this question, staff of a mobile assessment service were interviewed and followed for a two year period using empirical service data.

METHODS

Setting

In 1989, a mobile crisis assessment unit was funded to serve a large midwestern city. This program was designed to serve people city-wide, who were both mentally ill and homeless, on a 16-hour basis (8am to midnight). The program was initially planned as a 24-hour service, however, the high costs of full day coverage and low utilization during the night time resulted in a change to the 16-hour program.

In hiring staff, consideration was given to prior consumer experience. Of the nine initial staff persons, two reported prior psychiatric hospitalizations at the time of hire. All staff rotated across the ten weekly shifts (Monday through Friday, day and evening). Staff always worked in dyads.

The Mobile Assessment Unit (MAU) has three basic forms of service delivery. First, routine calls on shelters and other social service agencies are made in order to serve any of these agencies; clients who are in need of linkage to mental health services. For example, one team of staff would always visit a large, westside shelter on scheduled days. Shelter staff would alert residents of the visit before hand. Second, emergency dispatches occur when someone (often a social service agency or a housing agent) calls requesting on-site crisis services. For example, an SRO landlord called because a tenant had become floridly psychotic and was threatening other tenants. Finally, street outreach occurs when MAU staff travel around the city in a van and identify individuals on the street who appear to need mental health or social services. These individuals are approached and provided with linkage to services when appropriate. One example of street outreach was the hospitalization of a man found partially naked, living in a box under a viaduct. Finding him incoherent and in danger of freezing (it was winter), a certification for hospitalization was initiated.

Consumer Status

In order to adequately assess staff members' level of prior experience with the mental health service system, each staff member was interviewed by one of the authors (JSL, JC). Part of this interview included a discussion of psychiatric history. Four (hereafter referred to as consumers) of the nine staff reported prior psychiatric hospitalizations and psychotropic medication use. One of these staff members also reported periods of homelessness characterized by living in shelters. Of the other five staff, four had outpatient mental health service consumer experience. Two of the four consumer staff were qualified examiners which means that they had the ability to certify clients for hospitalization. Two of the five non-consumer staff were qualified examiners.

Procedures

For the first two years of the study, service data were collected on each open case. These data included basic demographic and clinical characteristics of the clients served and categorizations of the assessed needs and service linkages made. Characteristics of the service contacts (e.g., emergency, location, referral source) were also documented. Finally, the members of the service dyad were recorded. A consumer dyad was defined as any pair which included at least one consumer staff member. Thus, a consumer dyad could have either one consumer and one non-consumer staff or two consumer staff members. A non-consumer dyad always had two non-consumer staff.

The assignment of cases was not systematic. Dyads formed naturally and partners were not generally assigned. Case assignments were given at the beginning of shifts. Requests for services that came in during shifts were assigned to the next available dyad. These assignments were handled by the program coordinator using radio dispatch.

RESULTS

Due to the multiple statistical comparisons, a Bonferroni correction (within variable domains, e.g., service delivery variables) of the p-value to $p<.01$ was made to the alpha necessary to detect a significant difference. Therefore, for the present study, only statistics with $p<.01$ were considered 'statistically significant'. A $p<.05$ was considered a statistical 'trend'.

Client Variables

Table 1 presents comparisons of consumer and non-consumer staff on client variables. Consumer dyads served clients who differed significantly on funding sources ($X^2=19.0$, df=3, $p<.001$). Consumer dyads were less likely to serve clients on General Assistance. Hooever, consumer dyads were no more likely to serve combined publicly funded-clients (SSI/SSDI or General Assistance) nor were they different on their likelihood of serving clients with no funding source. On other client variables, there were few significant differences as the clients served by consumer and non-consumer dyads appear generally comparable.

Service Delivery Variables

There were some significant differences in service variables (Table 2). First, consumer staff engaged in more mobile outreach than did non-consumer staff ($X^2=11.9$, $p<.001$). Second, consumer staff dyads were less likely to be dispatched to an emergency ($X^2=7.46$, df=1, $p<.01$). Third, while consumer and non-consumer staff were equally likely to hospitalize clients, there was a trend for consumer staff dyads to be more likely to involuntarily hospitalize by certificate than were non-consumer staff dyads ($X^2=3.88$, $p<.05$).

In order to determine whether the trend for a difference in certification rates was related to the difference in street outreach or dispatch disposition, hospitalization rates (voluntary and certified) were studied individually across four categories of referral: street outreach or dis-

TABLE 1

Characteristics of Clients Served by Consumer and Non-Consumer Staff Dyads

Client Characteristic	*Consumer Dyad*		*Non-Consumer Dyad*	
Gender:				
Male	433	(59.1%)	413	(59.3%)
Female	279	(38.1%)	256	(36.7%)
Race/Ethnicity:				
African American	419	(57.2%)	439	(63.0%)
White	261	(35.6%)	213	(30.6%)
Hispanic	26	(3.5%)	25	(3.6%)
Asian	11	(1.5%)	2	(0.3%)
Income Source:				
No source	97	(13.2%)	59	(8.5%)
General Assistance	123	(16.8%)	178	(25.5%)
SSI/SSDI	156	(21.3%)	178	(25.5%)
Unknown	166	(22.6%)	174	(25.0%)
Primary Presenting Problem:				
Mental Illness	514	(70.1%)	482	(69.2%)
Substance Abuse	67	(9.1%)	69	(12.6%)
Other	85	(11.6%)	88	(9.9%)
History of Hospitalization in State Facility:				
Yes	250	(34.1%)	280	(40.2%)
No	210	(28.6%)	226	(32.4%)

patch, emergency or routine. There was a trend for consumer dyads to be significantly more likely to certify a client for hospitalization during a routine dispatch than were non-consumer dyads ($X^2 = 5.70$, df=1, $p<.02$). This difference was not significant for emergency dispatches. Emergency dispatches were much more likely to result in certifications compared to routine dispatches ($X^2 = 136.23$, df=1, $p<.0001$).

There was no relationship between street outreach and certification. Consumer dyads were no more likely to certify clients for hospitalization on either routine or emergency street outreach cases. There was also no relationship between shift and certification.

TABLE 2

Comparison of Service Delivery Characteristics of Consumer Dyads and Non-Consumer Dyads

Service Variables	*Consumer Dyads*		*Non-Consumer Dyads*	
Street Outreach	133	(15.4%)	81	(11.6%)
Dispatch				
Routine	581	(79.3%)	498	(71.4%)
Emergency	114	(15.6%)	147	(21.1%)
Hospitalizations				
Voluntary	63	(8.6%)	72	(10.3%)
Certification	93	(12.7%)	65	(9.3%)

It should be noted that certification for hospitalization allowed for transport of persons to a nearby hospital for evaluation. It was possible, although rare, for persons certified by the MAU staff to not be admitted to a psychiatric hospital. Unfortunately, such follow-up data was unavailable for the present study.

DISCUSSION

The results of the present study suggest that consumer staff can be a valuable addition to a mobile assessment program. There were few differences in the descriptions of clients served by consumer and non-consumer staff. There were several differences between the two groups in the fashion in which services were delivered.

Mobile assessment staff with personal consumer experience were more likely to do street outreach than were non-consumer staff. This is consistent with the hypothesis that consumer staff are more willing and better able to engage mentally ill people on the street (Nikkel, et al, 1992). Several of the consumer staff chose to communicate their own experiences to the clients they were serving on the street. This perspective could translate into a greater willingness to engage in this form of service delivery by dyads with consumer staff members.

Consumer staff, however, were less likely to engage in emergency dispatch calls. Given the greater level of street outreach, consumer staff were possibly less available in the office for emergency dispatches.

However, there is an alternative explanation based on how the MAU's handled organizational procedures. When emergency calls came in, there was often a number of staff available. Who actually took the call was often a complex negotiation. If more than two staff were in the office at the time of the dispatch, the assignment was partially voluntary and partially up to the program director's discretion.

Factors influencing either the likelihood of volunteering or of receiving an assignment may have resulted in the disparity of emergency responses between consumer and non-consumer staff dyads. Emergency dispatches were more likely to result in involuntary certifications for consumer dyads which might have reduced their motivation to volunteer for these calls. Finally, it is possible that if the director decided the dispatch disposition, he may have felt less willing to burden consumer staff with an emergency.

The third service delivery difference was that despite a comparable probability of hospitalization between the two staff groups, consumer staff tended to be more likely to certify clients for involuntary hospitalization. This difference did not achieve significance after Bonferroni correction, so caution is needed as it may be a difference occurring only by chance. However, since this difference was observed for routine dispatches, it is probably not the case that the observed rates reflects the consumer staffs' apparent greater willingness to do street outreach. There are a number of alternative explanations for this possible finding. It may be that non-consumer staff were generally better able to convince clients to seek voluntary hospitalization. No differences were observed between consumer and non-consumer staff in terms of their client case-mix. However, the measures used presently did not include sensitive measures of psychiatric illness severity. Thus, it may be that consumer staff provided services to more psychiatrically disturbed clients and this difference was not measured sufficiently in the present study. It is also possible that consumer staff readily engaged more difficult cases that required a certification.

In understanding the implications of these findings it is important to emphasize that mobile assessment is a somewhat unique form of service delivery and thus findings regarding consumer staff in this service do not necessarily generalize to other service venues. Most other consumer service delivery research has focused on case management services which tend to involve a more predictable schedule and case load and longer term relationships with clients than the MAU.

For the present study, it appears that consumer experience can be an advantage for mobile crisis assessment with persons with problems of

mental illness and housing instability. Further understanding of the efficacy of consumer service providers should facilitate a productive and positive integration of people with consumer experience into the community mental health service sector.

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