UNDERSTANDING THE 5150 PROCESS: A NEEDS ASSESSMENT FOR THE
INTERAGENCY COLLABORATION AND TRAINING IN A RURAL
ENVIRONMENT

A Project

Presented to the faculty of the Division of Social Work
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by

Megan Emily Harris

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by

Megan Emily Harris

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Division of Social Work
Abstract

of

UNDERSTANDING THE 5150 PROCESS: A NEEDS ASSESSMENT FOR THE
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This exploratory study examined the perceptions and knowledge of human service agency professionals who are involved in the 5150 process in a rural community agency offering crisis intervention services. The eighty-two participants in this non-probability sample represent six human service agencies in a rural California community. Research data was collected through an eighteen question survey made up of both true and false questions as well as open response questions meant to elicit input on interagency difficulties, potential solutions and programming to improve collaboration. Study findings reflect that there are many misconceptions and varying perceptions about the 5150 process among the service providers within this community. There is also a great deal of interest in interdepartmental training and ongoing opportunities for line staff to meet and process issues that arise around the process as it exists now.
Recommendations for fostering interagency collaboration and increasing the understanding of 5150 process requirements are listed for future action and research.

__________________________, Committee Chair
Jude M. Antonyappan, Ph.D.

__________________________
Date
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Chapter 1
THE PROBLEM

Introduction

Crisis intervention is one of the many approaches to meet the multifaceted needs of people with mental illness. Whether crisis intervention is used to keep people safe from themselves, safe toward others or to assist them with providing for food, clothing and shelter, there are times when outside agencies must intervene. The State of California has provided guidelines for these interventions in the Welfare & Institutions Code 5150 and California counties have taken these guidelines and done their best to implement policy and procedure to further guide the process.

In some counties there are acute psychiatric care facilities, specialized crisis response teams, and certified crisis workers. In some counties, such as in many rural counties such as the county of Calaveras, the focus of this project, the level of coordination and outreach that is required in crisis intervention can be lacking. Thus, the process by which a person is psychiatrically hospitalized from Calaveras County involves several other agencies and many more steps than in larger, urban counties. A typical hospitalization involves: the mental health crisis worker, law enforcement, hospital staff and the ambulance company. A hospitalization can also involve social services and family members. The process itself can take anywhere from three to five hours and often takes between eight and twelve, not including the time it takes the ambulance to transport the person which can be as many as six hours round trip.
The lack of comprehensive and consistent training on the 5150 process leads to strain between mental health and other human service agencies. This strain perpetuates the stigma against people with mental illness and makes an already difficult process that much harder. While multiple agencies must work together as a team during psychiatric emergencies, without a shared understanding of the process, there is a lack of collaboration which impacts professional relationships and affects morale. This study proposes to investigate the perceptions and understanding of members of the human service agencies in rural counties in regards to crisis intervention and the 5150 process, in order to make recommendations for training to increase knowledge and improve collaboration.

**Background of the Problem**

In rural communities throughout the state of California, the effects of the deinstitutionalization of people with mental illness that began in the 1960’s and their return to the community have impacted not only community behavioral health centers, but has taxed the resources of law enforcement agencies, hospitals and other social service departments (Segal, 1979; Grob, 1995; Thesen, 2001; Early, 2006; Dumont & Dumont, 2009).

While these changes have been impacting rural community agencies for several decades, at a county level the training on mental illness and mental health law and policy has been limited primarily to county behavioral health agencies.

Though it is not reasonable to expect members of other human service agencies to have the breadth of knowledge that a mental health worker has regarding mental illness,
or the 5150 process, in a rural setting in particular there is the need for some basic level of collaborative training and a paradigm shift toward partnership.

Calaveras County Behavioral Health Services (CCBHS) has occasionally made training available to the Calaveras County Sheriff Department and has had some incident-related communication with managers of other departments that are involved in crisis situations. However, there remains a discrepancy in the regularity of training and the fact that it is not offered to line staff from all of the agencies that can be involved in the 5150 process. In part because of this training gap, the working relationships between line-staff of the various human service agencies involved in crisis work are often strained. While there is CCBHS policy in place to guide the 5150 process, it was not created with the input of line staff from either CCBHS or the other human service agencies affected by the process. Furthermore, while members of these agencies are called upon to work together, they are not trained together, nor do they have the opportunity to come together to discuss issues or ideas for a better process.

The hospitalization process is made up of several contingencies that often lead to inter-agency strain. If a person is brought in by law enforcement on a 5150 hold, the law enforcement agent has to wait until a mental health crisis worker arrives to dismiss the hold and if it is after hours this can take over an hour. Additionally, the issue of medical clearance affects the 5150 process.

Acute psychiatric care facilities are not equipped to handle most medical issues. In theory the mental health crisis worker is not supposed to evaluate the person until they have been medically cleared. However, if the hospital emergency room is busy, or the
person is under the influence of alcohol or other substances, medical clearance can take hours. Furthermore, hospitals in most rural counties, including Calaveras do not have security so if the person is agitated or leaves while on a 5150 hold, law enforcement has to come back to the hospital to “baby-sit” or track the person down. Other factors that affect the length of time to acquire a psychiatric hospital bed include: (1) acute care psychiatric facilities do not have to accept anyone they do not feel is appropriate for their facility and (2) insurance companies require hospitalization only in certain hospitals. Thus, a person may remain in the emergency room for hours waiting for a bed. Finally, once a bed is found the client has to be transported by ambulance to an out of county facility. Sometimes these transports are to facilities as far as three hours away. This description is not unlike typical hospitalization.

Some examples of the involvement of other human service agencies include the following: (1) if a person is found to have an organic condition, i.e., dementia or traumatic brain injury, they cannot be psychiatrically hospitalized which means Adult Protective Services has to become involved, (2) if the person being evaluated has children and they are deemed unsafe or unable to care for themselves, Child Protective Services has to become involved, (3) people with no insurance must immediately be assisted with applying for the county medical services plan, which then involves Eligibility Workers, (4) family members are often involved.

While ensuring the care for a person experiencing a psychiatric emergency is done by a team of professionals from various agencies, there is little to no feeling of working together as a team. There are inter-agency agreements on policy for psychiatric
emergency, but no inter-agency training or education on the policy, or the 5150 statute. There appears to be no shared perceptions, nor shared understanding of the process of psychiatric evaluation. Consequently there are often misunderstandings and frustration between members of the various agencies. While there may never be consensus or complete unity amongst the differing agencies, there appears to be room for creating training and building a sense of collaboration. Broadly stated, this is the goal of this project.

**Statement of the Research Problem**

The lack of training and collaboration between rural county agencies involved in crisis intervention is associated with the ongoing discord and misunderstandings between the line staff of the agencies involved in psychiatric emergencies. The lack of comprehensive training on the 5150 process has led to staff of different agencies having differing perceptions and levels of knowledge about the 5150 process that are neither informed nor shared in common with each other.

**Purpose of the Study**

The purpose of this study is to examine the areas of training needed for a more collaborative process between human service agencies in a rural county that work with people experiencing a psychiatric emergency.

The process of evaluation to place a person on a legal hold for the purposes of an involuntary psychiatric hospitalization, commonly referred to as a “5150 hold” always involves multiple members of several rural county agencies. While limited policy and
procedure exists to guide this process, there is often frustration and strain between the line staff of these various agencies.

Theoretical Framework

This study is guided by two primary theories, systems theory, social constructivist theory and two supporting theories, the theories of social capital and coordination theory. Systems theory is a theory that originated in the field of biological science (Kast & Rosenzweig, 1972; Ambrosino, Ambrosino, Heffernan & Shuttlesworth, 2007). Its application to social science has maintained many of the key concepts. These concepts include that a system or organization is composed of interrelated parts that are separate but always interconnected in some way (Kast & Rosenzweig, 1972). Another key concept is that social systems are typically considered “open systems”, meaning there is an exchange of energy or information between them (Kast & Rosenzweig, 1972). However, even in open systems there is the concept of boundaries. In organizations boundaries that are meant to distinguish one system from another, and can become barriers to equilibrium, threatening the openness of the system itself (Kast & Rosenzweig, 1972; Ambrosino, et al. 2007). Systems theory as it relates to this project posits that each of the agencies involved in this study are part of a larger system in the context of crisis intervention.

While each agency is a separate part of the whole system, during a psychiatric emergency they all become interactive and interdependent (Ambrosino, et al., 2007). Systems theory emphasizes that feedback and open communication are necessary for a healthy system (Ambrosino, et al., 2007). Based on this theory the researcher has
postulated that the lack of collaboration between agencies in relationship to crisis intervention has led to a system that is unhealthy, disordered and disorganized (Kast & Rosenzweig, 1972). By encouraging collaboration, this project hopes to assist in remedying the disordered system of crisis intervention in a rural county, by encouraging feedback, multiple goal-seeking and more permeable boundaries (Kast & Rosenzweig, 1972).

Social Construction Theory posits that all reality is subjective and defined by perception (Johnson & Rhodes, 2010). It provides the concept of standpoints which are defined as the knowledge of reality gained by people based on what their social location is (Johnson & Rhodes, 2010). The culture of an organization is made up of standpoints that are an agreed upon reality, a construct that defines how members of the organization perceive the world around them (Johnson & Rhodes, 2010; Muijs, West, & Ainscow, 2010).

Social constructivist theory in relation to this project, builds on system theory by contributing the idea that each of the smaller parts of the larger system of crisis intervention, each individual agency, has its own organizational culture, values, assumptions and expectations (Johnson & Rhodes, 2010; Muijs, West, & Ainscow, 2010).

Within each agency there is a shared meaning and understanding of the 5150 process. This construct is in part created by the fact that most of the agencies involved in the 5150 process have never been formally trained on the nuances of the 5150 statute. Therefore each agency has developed its own reality around the 5150 process based on
shared perceptions of how it affects their agency, with little no understanding of why the process happens the way it does, or input into how it might be done better. By offering an inter-agency collaborative process, this project aims to redefine the construct of crisis intervention to one that is agreed upon by all of the agencies that are involved in the 5150 process.

Finally this study is supported by the theories of social capital and coordination theory. Social capital is defined as creating norms and networks that enable people to act collectively (Wolcock & Narayan, 2000). Creating social capital between agencies involved in the 5150 process would allow for the improved sharing of resources and increase the flow of information (Muijs, et al., 2010). Coordination theory is simply the idea of work that is done in a way that aims to create positive outcomes within interdependent activities (Malone & Crowston, 1990). It posits that interdisciplinary cooperation is key to work that is successful and enjoyable (Malone & Crowston, 1990).

For this project, the application of social capital and coordination theory is important in emphasizing what the lasting effects of collaborative training could mean for the rural county agencies involved in psychiatric emergencies.

By creating agreed upon norms that are grounded in the value of coordination and cooperation, rural county agencies can begin to build a structure of crisis intervention that is valued and perpetuated by all of the participants.

**Definition of Terms**

Key terms that are used often in this study are defined in this section.
5150 Hold - The language commonly used by crisis workers and other professionals to describe the use of an Involuntary Psychiatric Hold in order to detain a person believed to be a danger to themselves, a danger to others and/or gravely disabled due to a mental illness for up to 72-hours.

Calaveras County Behavioral Health Services (CCBHS) - The agency responsible for 5150 policy and procedure in Calaveras County.

Client - A person who engages the professional advice or services of another; a person under treatment for a psychiatric illness or disorder (Merriam-Webster, 2003). For the purposes of this project, a client is anyone experiencing a psychiatric emergency who requires an evaluation for a 5150 hold.

Collaboration - To cooperate with an agency or instrumentality with which one is not immediately connected (Merriam-Webster, 2011)

Crisis Intervention - Any intervention that involves the use of a CCBHS crisis worker to evaluate for and determine whether or not someone needs to be hospitalized in a psychiatric facility and/or is safe to return to the community.

Crisis Worker - Any member of CCBHS line staff who is designated to respond to a psychiatric emergency in order to complete a crisis intervention.

Deinstitutionalization - The name given to the policy of moving severely mentally ill people out of large state institutions and then closing part or all of those institutions (Torrey, 1997).
Human Service Agency (HSA) - Umbrella term used to describe any agency that provides a human service that are also involved in some way during the 5150 process. For the purposes of this study the researcher has included:

Ambulance: The staff of the company that is charged with transporting clients to the local emergency room and to the psychiatric hospital.

Behavioral Health: Substance Abuse and Mental Health staff.

Community Group: Members of two non-profit groups dedicated to promoting awareness of mental illness and suicide prevention.

Law Enforcement: Staff of the three local law enforcement agencies and probation.

Medical: Staff of the emergency room and intensive care departments at the local hospital

Social Services: Staff of Calaveras Works and Human Services

Knowledge - The range of one's information or understanding (Merriam-Webster, 2011).

Mental Illness - Mental illnesses are medical conditions that disrupt a person's thinking, feeling, mood, ability to relate to others and daily functioning (NAMI, 2011)

Perception - To regard as being such (Merriam-Webster, 2011)

Psychiatric Emergency - An emergency in which the person presenting has been brought into the emergency room due to behavior that indicates they are suffering from a psychiatric issue. Some examples of psychiatric emergencies are: a person who has made a suicide attempt and/or expressed the desire to end their life, a person exhibiting bizarre
behaviors or are unable to care for themselves due to a known or suspected mental illness, and/or a person who is engaging in behaviors that are putting themselves or others in danger due to their mental illness.

*Rural Community* - Defined by the U.S. Census Bureau in comparison to its definition for an urbanized area, which is identified as a densely settled area with a census population of at least 50,000. Calaveras County is designated as a rural community (United States Census Bureau, 2011).

*Welfare and Institutions Code (W & I C) 5150* - California statute that allows for a designated person to detain someone for up to 72 hours because that person has been determined to be a danger to themselves, a danger to others or gravely disabled due to a mental illness.

**Assumptions**

There are three basic assumptions in the research study. The *first* assumption is that there is a lack of collaboration between members of rural county agencies that are involved in the 5150 process.

*Second*, it is assumed that the reason for this lack of collaboration is the lack of formal training on the 5150 process which has led to misunderstandings and skewed perceptions of members of human service agencies toward the 5150 process, mental health crisis workers and people experiencing psychiatric emergencies.

*Finally*, this researcher assumes that human service agencies prefer to increase their understanding of the 5150 process and would participate in training that would foster collaboration.


**Justification**

The justification for this project is that it is motivated by the researchers identified research question based on clients experiencing a psychiatric emergency, whose quality of treatment depends on inter-agency collaboration. By gauging the knowledge and perceptions of the 5150 process of members of other agencies, this study will elicit areas of need for training development. By offering inter-agency training and an invitation to make the process more collaborative, this project can be used to create a more informed process and the foundation for building a cohesive team of professionals who all understand the 5150 process in the same way.

The success of crisis intervention within a rural setting depends on the relationships between the agencies that work together during crisis situations. The community members that often experience psychiatric emergencies are often clients of multiple agencies. There are also always several agencies involved in the 5150 process, other than mental health. Without collaboration, Calaveras County Behavioral Health Services (CCBHS) cannot be as effective when dealing with a crisis situation.

In order to better serve our community members with mental illness, as well as those community members seen in crisis that are not chronically mentally ill but still require emergency intervention, we must work toward a framework that supports training, teamwork and collaboration.

According to the National Association of Social Workers one of the seven core values is the importance of human relationships (2008). Thus this study is inspired by the ethical principal based on this core value that states: Social workers understand that
relationships between and among people are important vehicles for change. Social workers engage people as partners in the helping process. Social workers seek to strengthen relationships among people in a purposeful effort to promote, restore, maintain, and enhance the wellbeing of individuals, families, social groups, organizations, and communities (NASW, 2008). By surveying the various agencies in a rural area that deal with people who are experiencing a psychiatric emergency and analyzing what their perceptions and knowledge of the 5150 process are, this study has the potential to provide insight and suggestions for improving training and increasing collaboration within this context.

Furthermore, it has the potential to improve the treatment of the individuals experiencing the impact of being evaluated for a psychiatric emergency by decreasing the bias, stigma and frustration that is often conveyed toward them due to the lack of collaboration between members of partner agencies.

Limitations

This study is limited in its scope. This study is limited to the experience of rural counties and is not necessarily adaptable to larger counties with more resources and differing interpretations of the 5150 law. The sample of this study is purposive and non-random, thus limiting the generalization of the findings even to other rural counties.
Chapter 2

REVIEW OF THE LITERATURE

Introduction

This chapter is a review of literature related to understanding the impact of psychiatric emergencies on human service agencies. It examines the literature in the field to delineate the perspectives of authors on the training and collaboration amongst these agencies as they struggle to work together toward the common goals of community safety and appropriate interventions for people in crisis within a rural community. It is organized into four themes that were chosen in order to highlight and give credibility to the problem identified in Chapter 1.

In order to give the reader an understanding of how the current system of psychiatric emergencies and involuntary holds came into existence, the first theme will be a history of the deinstitutionalization of people with mental illness in the United States and the subsequent effects this policy had on California communities. This theme will be followed by the second theme, an exploration of the idea that mental illness and therefore emergencies related to it are interdisciplinary by nature and thus cannot be left just to the field of mental health, and/or the practitioners that deal with mental illness on a daily basis to understand. The third theme will build on the second theme, with authoritative examples of the effectiveness of collaboration between mental health and other human service disciplines.
Finally, the last theme will highlight Calaveras County, the location of this project, and will attempt to illustrate for the reader the intricacies of a rural community and why, if anywhere, the need for collaboration and interdisciplinary training is that much more important for a county of its nature.

**History of Deinstitutionalization in the United States**

The deinstitutionalization of people with mental illness is a movement that began in the late 1940’s, took hold as major policy in the United States in the 1960’s and began having community impact in California and other states in the early 1970’s (Segal, 1979; Grob, 1995; Thesen, 2001; Early, 2006; Dumont & Dumont, 2009).

As with many social movements in the United States the movement to deinstitutionalize people with mental illness began as a backlash against current policy due to a media sensation (Early, 2006). Thus, although the institutionalization of people with mental illness had been widely accepted as compassionate and enlightened treatment since the early nineteenth century (Grob, 1995; Earley, 2006), one *Life* magazine article published in 1946 set of a reactionary firestorm that led to the dismantling of this system in less than three decades (Early, 2006). It was this article that showed in graphic detail torturous conditions within institutions across the country that included: overcrowding, filth, starvation and slave-labor (Early, 2006). The outrage over this article led to a string of court decisions and political stances that began with the creation of the National Institute of Mental Health (NIMH) through the National Mental Health Act signed into law by then President Harry Truman in 1946, the same year as the *Life* expose (Grob, 1995; McGrew, Wright & Pescosolido, 1999; Thesen, 2001; Early, 2006).
This, coupled with increasing medical advancements, in particular the discovery of the drug Thorazine, in the 1950’s, gave credence to the idea that people with mental illness could live independently (Grob, 1995; McGrew, et al., 1999; Krieg, 2003; Early, 2006).

By the time President Kennedy took office in 1961, changing the mental health system was not only a national priority; it had also become part of the ground swell of the civil liberties movement that would come to define this decade (Earley, 2006; Dumont & Dumont, 2009).

Two fundamental shifts helped to instigate what is known as the Community Mental Health Act which was signed into law by the then President Kennedy in 1963 (Grob, 1995). The first shift was the availability of federal funding in the form of Medicaid and Medicare for individuals with a mental illness (McGrew, et al., 1999; Krieg, 2001; Krieg, 2003; Earley, 2006). The second and perhaps more important shift was the ideological shift in American society toward the idea of civil liberties and the concept of “the least restrictive environment” (Grob, 1995; Krieg, 2001; Dumont & Dumont, 2009). Based on the court decision, Shelton v. Tucker in 1960, and widely litigated by the American Civil Liberties Union (ACLU), the idea that people with psychiatric issues should be held involuntarily only if all other resources have been exhausted and even then, only when they are deemed to be dangerous, became the basis for almost a decade of national policy (Grob, 1995; Krieg, 2001; Solomon, 2001; Earley, 2006).
Part of the Community Mental Health Act included funding for Community Mental Health Centers (CMHCs), with the idea being that persons with mental illness could be better cared for and have the right to live independently within their communities (Grob, 1995; McGrew, et al., 1999; Earley, 2006; Dumont & Dumont, 2009). Unfortunately, several events happened that undermined what seemed like the new ideal for the treatment of people with mental illness that ultimately led to the failure of the entire program. The first and most important proponent to failure came as the result of underfunding. This was due in part to the costs of the Vietnam War and more extensively to the change in leadership under President Richard Nixon, who was elected in 1968 (Grob, 1995; Dumont & Dumont 2009). By the time Nixon had been in office only a half a term, what was to be a $3-7$ billion dollar project, had been cut to approximately $140 million annually and what was to be 2,000 CMHCs ended up being less than 200 (Earley, 2006; Dumont & Dumont, 2009). This led to the second failure which was that the funding cuts and the policy shift had not caught up to the state hospitals. They were still releasing patients back to their communities with little if any supports, training or at times notice to the communities meant to care for the individuals released from their care (Segal, 1979; Grob, 1995; McGrew, et al, 1999; Krieg, 2001; Earley, 2006; Dumont & Dumont, 2009). Finally, what would lead to the third and most long-lasting failure was that the general public was not prepared to face the realities of living and working with the seriously mentally ill in their communities, setting up an unwelcoming system steeped in stigma that still exists to this day (Grob, 1995; Krieg, 2001; Thesen, 2001).
In addition to the impacts on the states caused by the aforementioned failure in policies related to deinstitutionalization, communities were also left to figure out what to do with people who did need a higher level of treatment than a CMHC or out-patient clinic could address. While many people with mental illness do live successfully in their communities, there remains the need at times for emergency intervention and detention of people experiencing a psychiatric emergency for their safety and the safety of the community. In California, this need was recognized in the early 1960’s and was written into law in 1967 in the form of the Lanterman, Petris, Short (LPS) Act which is found in the California Welfare and Institutions Code (W & I Code 5000 et seq. (recoverymodel.com). Specifically, the section of the act numbered 5150-5157 allows for the director of county mental health agencies to designate certain county mental health professionals to detain a person on a legal hold whom they feel is either a danger to self (DTS), danger to others (DTO) or gravely disabled due to a mental illness on what is commonly referred to as a “5150 hold” (Welfare and Institutions Code 5150). It then allows for that designee to place the person in a locked psychiatric hospital for up to 72 hours for acute psychiatric treatment and further evaluation (W & I C 5150-5157).

Unfortunately this history has left us with a set-up for conflict. Although the Welfare and Institutions Code (W & I Code) gives guidelines for involuntary detention, it has done nothing to mediate between the conflicting ideologies regarding the treatment of the mentally ill which plague this nation. Nor did the W & I Code do anything about the stigma related to mental illness or the reality that once stable, those people held on a 5150, are ultimately returned to communities with limited resources or adequate funding.
From policy-makers to line-staff, people have struggled with determining where the line between individual rights and best interest of the community should be drawn. The law has been written to emphasize civil liberties and freedom to remain in the community above the previous concept of forced-care and institutionalization. Yet, the reality remains that the effects of a person with an unstable mental illness, and the determination of treatment for such persons, happens every day, reverberates across every human service discipline and strikes to the core of every individual’s sense of right from wrong.

In conclusion, this is a historical review of the literature related to how mental health policy changes across a century have led to the implementation of the 5150 process in California counties. It is an important foundation for understanding the complex issues that arise for human service agencies which must work together to understand this Welfare and Institutions Code and enforce it within a rural community.

**The Interdisciplinary Nature of Mental Health Service Delivery**

There is perhaps no other area of health and human services that impacts society like mental illness. People with mental illness are found in the child welfare system, criminal justice system, education system and health care system. Mental illness can affect a person’s ability to maintain housing, gain employment, succeed in school, care for their children and ultimately can lead to the losses of liberty and freedom.
Furthermore, the increased responsibilities of family members who often times are ultimately responsible for the long term care of a person with a mental illness additionally impacts human service systems by adding to the need for supports (Segal, 1978). The following are several examples meant to illustrate this statement.

**Human Impacts**

*Suicide*: Perhaps one of the most noticeable impacts of mental illness and the failed policies of deinstitutionalization of the mentally ill across the disciplines is the human cost. From a humanistic standpoint, untreated mental illness is devastating. In 2007, suicide was the eleventh leading cause of death in the United States for 10-24 year olds and 90 percent of those who died by suicide had a diagnosable mental illness (Krieg, 2001; NAMI, 2007).

*Homelessness*: Another devastating impact that is the direct result of deinstitutionalization is the rate of the homeless mentally ill population in the United States. Studies estimate that anywhere from twenty to fifty percent of homeless people in this country have mental illnesses (Rosenfeld, 1989; Krieg, 2001, NAMI, 2007; Center for Families, Children and the Courts, 2010). Furthermore, studies show that of the homeless mentally ill on the streets; thirty percent eat from garbage cans. Of homeless mentally ill women, another thirty percent have been raped and almost all homeless mentally ill people report being victims of some type of violence at one time or another (Early, 2006).
While social safety nets such as Social Security and Supplemental Security Income do exist for persons with serious mental illness, the income they provide is estimated to be less than half of a poverty-level income and housing for persons with mental illness is typically substandard, if it exists at all (Rosenfeld, 1989).

**Unemployment:** From a financial standpoint, one could argue that mental illness and the unemployment and/or under-employment that often results from it, is one of the most financially costly human impacts, particularly when it is coupled with addiction, which it is estimated in 45-65 percent of patients (Solomon, 2001; Inaba & Cohen, 2007). In 2007 the estimated indirect cost of mental illness in the United States was $79 billion dollars, with $63 billion of this amount reflecting the loss of productivity (NAMI, 2007). This number is almost twice what was reported by the Journal of the American Medical Association in 2001 (Solomon, 2001). While many people who are mentally ill do want to work, the system is set up in a way so that if they have become so disabled as to need assistance in the form of Social Security benefits and Medicare, they must be disabled for at least one year. If they return to work after that time, even part-time, they run the risk of earning too much money and losing their benefits (Solomon, 2001).

**Families:** There are also human impacts to the family of a person with a chronic mental illness. It is important to remember that when state hospitals began to close and people were returned to their communities, the existence of CMHCs to help shoulder the burden was unrealistic, especially in light of the cut funding.
This resulted in families being made to be responsible for caring for family members, some of whom needed 24-hour care. The effects of caring for a person with a chronic mental illness have been shown to have a direct relationship to rates of divorce and family violence (Krieg, 2001).

Stigma: Finally, there is the human impact of stigma toward people with mental illness. The image that is conjured, when a lay-person, or even those who work for other human service agencies, hear the words “mentally ill” is one that provokes fear, disgust, anger and misunderstanding (Grob, 1995; Thesen, 2001; Solomon, 2001; Pinfold, Thornicroft, Huxley, & Farmer, 2005; Early, 2006). Due in part to Hollywood’s exploitation, dating back to movies such as One Flew Over the Cuckoo’s Nest and the images on the news of the homeless mentally ill, or the substance abusing mentally ill, negative perceptions of persons with mental illness have not changed much since they were returned to their communities (Pinfold, et. al, 2005). According to a survey conducted by Porter Noveli in 2006, only about one quarter of adults aged 18-25 believe people with a mental illness can recover, and only half of Americans believe a person with a mental illness can be a successful employee (SAMHSA, 2006). Thus almost sixty-five years after Life magazine’s expose and fifty years since the passage of the Community Mental Health Act Americans in general still have more ignorance than knowledge of the mentally ill.
System Impacts

Healthcare: The impacts of mental illness are felt in a variety of human service systems that were and still are ill-prepared to serve people with such high needs. The first example of this is the impact on the health care system.

Almost as soon as people began to be released from state hospitals, regular hospitals within local communities began to experience the impact of mental illness (Grob, 1995). The first place a person with a mental illness who is experiencing a psychiatric emergency usually seeks help is his or her local emergency room. Yet emergency room doctors and nurses typically do not receive specialized training in psychiatric emergencies, nor are emergency rooms equipped in many places to handle persons with such emergencies (Kunen, Niederhauser, Smith, Morris, & Marx, 2005). The health care system is further impacted by the rate at which many people with mental illness also have at least one other co-occurring chronic health condition (NAMI, 2007). In fact, adults with serious mental illness die an estimated twenty-five years younger than their peers due largely to medical conditions (Reynolds, Chesney, & Capobianco, 2006; NAMI, 2007).

Social Services and Schools: The social service and school systems are also impacted systemically by the effects of mental illness. Approximately one in ten children have a serious mental health issue, and of those who are over age fourteen, approximately fifty percent drop out of school (NAMI, 2007).
Within school systems, the advent of policies based on “zero tolerance” towards violence and substance use has eliminated the ability to triage students for mental health treatment, impacting both emergency rooms and crisis services (Shah & Donise, 2010).

Social service systems, which are charged with protecting the most vulnerable members of the population, elders and children, bear the brunt of the impact of mental illness on both ends of the spectrum. Children in the foster care system are seen in mental health systems ten to twenty times more than children in their own homes and they are three times more likely to be on some type of psychotropic medication (Raghavan, 2010). Twenty percent of adults aged fifty-five and older struggle with mental disorders considered abnormal to typical aging: Alzheimer’s disease, increased suicidality, increased depression, substance abuse and late-onset Schizophrenia (United States Surgeon General, 2006).

Criminal Justice: Finally, the system that has been the most impacted by people with mental illness is the criminal justice system. From the beginning, law enforcement agencies have been the only institutions that consistently dealt with the impacts of the deinstitutionalized mentally ill, twenty four hours a day, 365 days a year (Woolf & Rudman, 1977). Police departments spend thousands of hours annually responding to people with mental illness (Thompson, Reuland, & Souweine, 2003); however they have never been adequately trained on how to deal with people with mental illness, particularly those who are symptomatic or experiencing a psychiatric emergency (Center for Families, Children and the Courts, 2010).
The residents of any jail or prison in this country are likely to be populated with a preponderantly large number of mentally ill clients. The most egregious affect of deinstitutionalization is that for many people with serious mental illness it was not “de-institutionalization” at all, and rather a form of “trans-institutionalization”, the transfer, from state hospitals to cell blocks (Earley, 2006; Steverman & Lubin, 2007). In 2006, the Bureau of justice reported that fifty-six percent of state prisoners and sixty-four percent of jail inmates had a mental illness (Center for Families, Children and the Courts, 2010). The Los Angeles County Jail in Southern California is infamously and consistently referred to as the largest mental institution in the country (Thompson, et al., 2003; Center for Families, Children and the Courts, 2010). Youth offenders with at least one diagnosable mental illness make-up approximately seventy percent of the juvenile offender population (NAMI, 2007). Studies that have been conducted in court rooms indicate that nearly one third of all defendants met the criteria for a mental illness; furthermore, probationers and parolees with mental illness have twice the recidivism rates of those who do not.

In summary, it is clear that the impacts of the needs of the seriously mentally ill can be seen in every area of human service: increased rates of homelessness (Rosenfeld, 1988), increased frequency of emergency room care and psychiatric evaluations (Kunan, S. et al, 2005), impacts on social service and school systems (Surgeon General, 2006; Shah & Donise, 2010; Raghavan, 2010), and the significant impact upon the criminal justice system (Thompson et al., 2003, Judicial Council of California, 2007).
In addition, the human and fiscal impacts leave no system or person in society untouched by mental illness. It is the authors premise that even with its interdisciplinary effects, it is an illness that historically has not been treated collaboratively. Yet, as the next section identifies, collaborative treatment may in fact be the only way to increase successful recovery.

**Collaboration Works**

Across the human service disciplines collaboration between agencies proves itself time and again to be the most effective way to address interdisciplinary issues while also cutting costs. Although we tend as professionals to have tunnel vision about our respective disciplines, when we come together in collaborative, or teams, or committees, we improve and expand our abilities to help others exponentially. In the area of crisis intervention during a psychiatric emergency there are never less than three agencies involved, and usually at least five. As the following examples will highlight, collaborative training and partnerships are vitally important to effective and positive outcomes with a variety of disciplines impacted by mental illness and serve as examples for the potential of bettering any system or process with multiple agency partners.

**Criminal Justice Examples**

The literature supporting collaborative training, particularly between the fields of law enforcement and mental health is vast. Literature reflects that social workers have realized the need to work collaboratively with law enforcement in several areas of human service, including mental health for the past century (Wolf & Rudman, 1974; Henderson, 1976; Dean, 2000).
This, coupled with a shift in the United States in the 1980’s toward what is known as: community policing, which emphasizes partnerships as one of its core principles (Dean, 2000) has led to affective interventions in many areas including that of psychiatric emergency or crisis intervention.

*Crisis Intervention Team (CIT) Training:* Perhaps the most well known of these collaborative efforts is the Crisis Intervention Team (CIT) model. Crisis Intervention Team training (CIT) is a program developed by law enforcement for law enforcement personnel to provide education and training on dealing with people experiencing psychiatric emergencies in the field that has been successful nationally and internationally (Dean, 2000; Thesen, 2001, Gentz & Goree, 2003; Pinfold, et. al, 2005, Watson, Angell, Morabito, & Robinson, 2008). Begun in Memphis, Tennessee in 1988, the CIT model has several key elements that outline effective interdisciplinary training and collaboration (Earley, 2006). The first is that CIT training is peer to peer and includes line staff from law enforcement agencies intermingled with line staff from mental health agencies in order to give the opportunity for relationship-building (Gentz & Goree, 2003). The second is that it addresses stigma against people with mental illness and allows for law enforcement officers to perceive people with mental illness as being sick and in need of help, rather than dangerous and in need of arrest (Earley, 2006). Finally, CIT training provides mental health workers with a unique view into the training and culture of law enforcement, giving them better competence in communicating their needs and the needs of their clients (Early, 2006).
Research on the results of CIT training shows evidence that trained officers have a more scientific-based understanding of the causes of mental illness, less stigma toward people with mental illness and a more general understanding for people suffering with mental illness (Levin, 2009).

Studies have also shown that CIT trained officers are less likely to use physical force when involved in training vignettes that dealt with an escalating situation with a person suspected of having a mental illness and were more likely to direct persons with mental illness to mental health services (Levin. 2009; Watson, Ottati, Morabito, Draine, Kerr, & Angell, 2010).

It is the CIT model of collaboration that inspired this project. It is the researcher’s observation that CIT training is an excellent start to a more collaborative 5150 process. While Calaveras County has recently begun implementing CIT training, it was not inclusive of all of the different agencies that are involved in psychiatric emergencies. Nor is CIT training able to address issues that are particular to how Calaveras County has interpreted the 5150 code or the policies in place based on this interpretation that affect other agencies. Thus it is the researcher’s goal to use this project as a way to expand on the concepts of CIT training in order to make recommendations for future trainings that are even more inclusive and specific to rural counties.

*Mental Health Courts:* Another example of collaboration that comes from the criminal justice system is the creation of Mental Health Courts. Mental Health Courts are a type of specialty court that seeks to reduce the recidivism of a specific population, in this case criminal defendants with a diagnosed mental illness.
Some of the features of mental health courts include: a separate docket from regular court proceedings and a designated team of a judge, district attorney, public defender, probation officer and mental health worker who meet regularly to coordinate on cases (McNiel & Binder, 2007). The emphasis of these courts on recovery, collaborative treatment and community involvement rather than punishment and incarceration, has led to an overall reduction of recidivism and an increase in treatment participation and sustained recovery (Harvard Mental Health Letter, 2006; Judicial Council of California, 2007; McNiel & Binder, 2007).

Social Service and School Examples

While social service agencies provide a multitude of different services to different populations, the two most critical are those services provided to children and those provided to the elderly. Within these two populations, mental illness is often the norm rather than the exception. While workers are often confronted with the prevalence of domestic violence, substance abuse, and mental health problems they historically have not been trained on either the language or the prevailing theories of the aforementioned disciplines. Additionally schools are often confronted with children who have serious mental illness and school staff has also lacked the capacity and/or training to feel confident in working with these children (Packard, Jones, & Nahrstedt, 2006). The following are examples of both local and national collaborative efforts to address these issues.
**Image Exchange:** San Diego State University has identified the use of interdisciplinary training that involves “image exchange”, a process whereby members of differing professions identify and discuss perceptions they have of each other’s areas of expertise as a way of redefining attitudes that have previously led to role conflicts and bias ((Packard, et al, 2006).

**Landscape of Aging:** Within the systems that serve the elderly, the Surgeon General of the United States has suggested the incorporation of a perspective called “the landscape of aging” in order to address this population’s interdisciplinary needs (United States Surgeon General, 2006). This framework for working with the elderly is based on a health and humanities focus for dealing with mental health problems as part of overall health promotion. It is dependent on the idea that community agencies must work together in order for the elderly to be given the services they need to maintain their quality of life (United States Surgeon General, 2006).

**Expanded School Mental Health (ESMH):** Schools across the country are also engaging in more collaborative relationships with their community mental health partners. Perhaps the largest collaborative effort has been seen with the establishment of Expanded School Mental Health (ESMH) programs as part of a response to the President’s New Freedom Commission on Mental Health (PNFC) that in part identified the limitations of schools as one barrier to mental health access for children (Weist, Ambrose, & Lewis, 2006). Within the ESMH framework, there is an emphasis not only on bringing together members of the different disciplines to address student issues, there is also a focus on parent education on mental illness, coordination on prevention
programs, and the provision for mutual supportive supervision amongst members of the interdisciplinary team (Weist et al, 2006).

**Healthcare Examples**

With the advent of national health care policy and the passage of mental health parity laws, it has become clear that mental illness is an illness that no longer exists in a world separate from that of general health care concerns. In a literature review spanning two decades from 1985 to 2005 it was found that interdisciplinary care led to better clinical outcomes and improved satisfaction of both patients and providers (Rossen, Bartlett, & Herrick, 2008). While there are a multitude of differing programs and models that attempt to integrate primary and mental health care across the country and in other western countries, there are a few standouts.

*Washtenaw Community Health Organization (WCHO)*: The first of these is the Washtenaw Community Health Organization (WCHO) which was created in 2000 by the University of Michigan Health System and the local Community Mental Health (CMH) program to provide services to clients who were either on Medicaid or who had no insurance (Reynolds, Chesney, & Capobianco, 2006). Some of the highlights of their programs include: the staffing of psychiatrists and mental health workers at local primary health clinics, the staffing of nurse practitioners at community mental health clinics, and the use of a health risk appraisal (Reynolds, et al., 2006). The results of the implementation of this model have been successful overall in increasing access, decreasing no-shows to appointments, and improving early identification of chronic health conditions (Reynolds, et al., 2006).
University of Carolina School of Nursing: In another collaborative model at the University Of Carolina School Of Nursing, the recognition that interdisciplinary team skills needed to be taught as a professional standard of nursing practice led to the inclusion of rotations at both an inpatient psychiatric facility and a homeless shelter as part of the educational requirements (Rossen, et al., 2008). Among the areas of expertise the nursing students were expected to develop were: understanding and appropriate use of the Mini Mental Status Exam and the Beck Depression Inventory, weekly care plans, and the ability to communicate effectively with members of the social work, family studies and substance abuse fields in clinical decision making (Rossen, et al., 2008). The response of the students involved in these rotations was overwhelmingly positive. When interviewed they reported that sharing the assignments made their job easier and that they felt it was a good way to gain knowledge about other disciplines in order to learn to work together toward a common goal (Rossen, et al., 2008).

In summary, it can be seen by the above review of the literature on the collaboration of other human service disciplines around the issues of mental illness, that whether it is in community programs, educational training, national policy or theoretical frameworks, collaboration is effective and necessary in a country with ever growing need and disappearing resources.

Collaboration amongst the disciplines has been proven time and again to not only improve services to clients, but also to better educate and prepare workers in all of the human service disciplines.
Based on all of the examples mentioned, it is not a giant leap to hypothesize that collaboration between county agencies that are involved in psychiatric emergencies and involuntary detentions is an idea whose time has come.

**Calaveras County: A Rural Community Example**

Calaveras County is a small, rural, county in the Sierra Nevada Foothills of California located about an hour east of Sacramento and Stockton. Located in the Gold Country region, Calaveras County has managed to remain rural despite the over-all population growth in the state of California. It has an overall population of just over 46,000 people (California Department of Mental Health, 2007), several townships and one incorporated city. There is one hospital, Mark Twain St. Joseph’s, with an emergency room with eight beds that is equipped for trauma stabilization only. There are no psychiatric facilities and thus no psychiatric beds in Calaveras County or either of its neighboring counties. Thus, Calaveras County Behavioral Health Services must contract with psychiatric facilities in other counties that are located at least one hour drive time and sometimes as many as three hours away. There are also no detoxification facilities in Calaveras except for the “sober cell” at the county jail. In general, as in many rural communities, Calaveras County has fewer services than its urban counterparts, yet a similar proportion of people with complex psychiatric needs per capita and the same mandates for mental health treatment and emergency intervention as in any other county (Amundson, 2001).
As is outlined in the Welfare and Institutions Code 5150-5157 in California, the director of each county mental health department designates which professionals can evaluate and detain people experiencing a psychiatric emergency (W & I Code of California). In the county of Calaveras, these designees include law enforcement, for purposes of transportation only and all of the clinical staff members of the Calaveras County Behavioral Health Services (CCBHS), mental health department. Yet, while the CCBHS designees are the only ones with the authority to “hold” someone and place them in a psychiatric facility, there are often multiple stakeholders involved in the process of an involuntary psychiatric hospitalization (5150). Additionally, it is often the case that the person experiencing the psychiatric emergency is a client of multiple Human Service Agencies (HSAs) in the community.

As has been described in chapter one, the problem is that there is an inherent need for collaboration during a psychiatric emergency in Calaveras County and nothing in place to support such an effort. From the CCBHS 5150 policy and procedure, to training on psychiatric emergencies, to the almost complete absence of communication between line staff of various agencies regarding high-needs mental health clients, nothing resembling collaboration exists. The following are three specific examples to outline this.

First of all, although it affects several other county HSAs, the CCBHS Policy and Procedure regarding 5150 crisis services was created unilaterally by the mental health department without input from the other agencies it affects.
Created in 2004 and updated periodically, the policy specifically identifies situations that involve everyone from emergency room doctors, law enforcement, jail staff and the ambulance company staff (CCBHS, 2011), but at no time were those entities given the opportunity to give input as to whether or not the policy worked for them. In essence, they were told by mental health what their roles and responsibilities would be without regard to the impacts on their staff or resources. In some situations the policy even goes so far as to tell one agency how they will respond to another agency. For example, in the case of a situation at the emergency room, when a patient being evaluated or placed due to a psychiatric emergency becomes violent or is a flight risk, the policy states for the mental health worker to call the sheriff to come to the emergency room to act as a standby (CCBHS, 2011). Unfortunately, this fiscal year alone saw a ten percent cut to the Sheriff’s department, resulting in layoffs that shrunk the number of deputies on patrol by seven, the equivalent of almost one third of the department (Janssen, 2011). Additionally, according to the same policy, while the patient is in the emergency room they are the responsibility of the emergency room staff, and not the mental health worker (CCBHS, 2011). The deputies do not want to sit at the emergency room with an out of control mental health patient. Nor do they have the resources to provide such a presence. Furthermore, mental health workers and nurses are often in conflict over what the best intervention for a violent mentally ill person should be.

Yet the policy that neither the sheriff, the nurses, or the CCBHS line staff had any input indicates the response, regardless, which is an inherent set-up for animosity amongst the line staff of all of the agencies involved.
Second, and perhaps the most important area that is missing any type of collaboration is the almost complete lack of training on psychiatric emergencies both within CCBHS and of its partners. While there is a power point presentation about 5150’s, created by the Quality Assurance manager, it is only presented annually if that often and to date has only been presented to the sheriff’s deputies. There has never been training for the dispatchers, the hospital staff, the ambulance company staff, or either of the other law enforcement agencies within the county. There has also never been training offered to probation, the jail staff, or Calaveras Works and Human Services (CalWorks) staff, despite the fact that they are often times involved or affected by a decision regarding a person experiencing a psychiatric emergency. Furthermore, there is no formal training for CCBHS staff designated to intervene on behalf of the agency during a psychiatric emergency. Thus, there is no continuity regarding when a hold is placed, which leads to further frustration on the part of the other agencies involved.

Additionally, there is really no continuity between counties on how to interpret the W & I code 5150. For example, according to San Francisco County’s training materials, a person can only be held as a danger to self as the result of a mental disorder, and that the threat to self must be imminent (San Francisco Department of Public Health, 2010). Yet Lassen County’s training documentation states that in their county a person can be held as a danger to self as the result of a mental disorder if they are refusing medical treatment for a life threatening medical problem (Lassen County, 2011).
Calaveras County’s policy and procedure does not speak to this dilemma or many other grey areas of the law, leaving CCBHS staff to interpret the code for themselves, again often leading to conflict with staff from other agencies, who if they do know something about the W & I Code 5150, have interpreted it differently.

Finally, there is no structure in place for collaboration between agencies regarding mutual clients or non-mutual clients who may be of concern. Therefore there is no ability to discuss preventative interventions or aftercare plans for people at risk of or coming home from a psychiatric placement. While mental health is bound by the Health Insurance Portability and Accountability Act (HIPAA), to not disclose health information unless given permission to do so by the client (CCBHS, 2011), they are allowed to receive information and offer general information regarding services, possible interventions and guidance to other agency staff and/or concerned family and friends. Unfortunately, without a forum to do this, other agencies are often frustrated with clients they suspect as having mental health issues that are not known to the mental health worker until a crisis happens. Then, unless the mental health worker is made aware of the other agencies involvement, they do not know to include them in the aftercare plans, leading to further missed opportunities for collaborative supports.

In Calaveras County as in other rural counties, the need for collaborative efforts in any area of human service is a necessity. In the realm of psychiatric emergencies it is paramount in order to offer community members continuity of care, reasonable and appropriate interventions that are based on an agreed upon interpretation of the law, as well as to foster the relationships and teamwork necessary among all HSA staff involved
in the process. By involving other agencies in policy creation; by offering training and clear standards of evaluation; by implementing forums to increase communication, CCBHS has the opportunity to take a process steeped in misunderstanding and turn it into an example of collaborative leadership.

Summary

To summarize, the history of deinstitutionalization has been presented in order to give insight into the macro-level policy decisions that continue to shape mental health law and standards of care. It was followed by a discussion of the multitude of mezzo-level systems that mental illness affects, as well as a discussion of the ideology of collaboration among these systems. Several best-practice examples when dealing with mental illness across the disciplines were given in support of the idea of collaboration. Finally, an overview of Calaveras County and the current process of psychiatric emergency were discussed in order to highlight the specific focus of this project, the need to improve collaboration in this area.

It is the intent of the researcher to use the insight gained from history and the promising research of collaborative efforts in other areas of human service dealing with mental illness to investigate and determine how the specific process of psychiatric emergency in a rural county can be made to be a collaborative process that meets the needs of all of the stakeholders. The measurement tool used in this study will evaluate the perceptions and knowledge of members of different HSAs regarding the 5150 code and policies in order to make recommendations for trainings that better educate and further include these agencies in the 5150 process.
It is intended to serve as an analysis of a rural county’s experience regarding inter-agency collaboration specific to psychiatric emergencies. By highlighting Calaveras County the researcher hopes to highlight the issues that exist within a rural county regarding psychiatric emergencies.
Chapter 3

METHODOLOGY

Introduction

This chapter discusses the methods used to conduct this study on the perceptions and knowledge of line staff in human service agencies involved in crisis intervention services, with regard to psychiatric emergencies.

Study Design

This project is based on a mixed quantitative and qualitative exploratory study design. An exploratory study is similar to an investigatory project in that it is a study that is done when little is known about a subject. It seeks to gather primary research and portray the data for use in interpretation. The use of an exploratory study was employed in order for the researcher to investigate what the issues related to psychiatric emergencies are, to what degree they are recognized as a problem and what variables might affect the perceptions and knowledge of various agencies toward these issues (Yegidis & Weinbach, 2009).

This researcher also employed methods of association analysis when analyzing this data. Research studies to what extent one variable is related to the differences in other variables (Leedy & Ormond, 2010). In relation to this research the researcher explored whether or not the profession of the respondent was related to their perceptions and knowledge of the 5150 process in a rural county, as well as to what extent their profession contributed to their responses to the qualitative questions.
The quantitative data was gathered through the use of survey research in order to gather information about how different groups of people perceive and understand a certain topic (Leedy & Ormond, 2010). This particular survey was based on fifteen true or false questions relating to the 5150 process intended to measure answers to identify the perceptions and level of knowledge about psychiatric emergency procedures. The qualitative portion was based on the content analysis (Leedy & Ormond, 201), of the responses of line staff to three open-ended questions intended to measure how participants think the process can be improved, what difficulties they have encountered with the process as it exists now and what services they would like to see introduced in order to improve collaboration.

There may have been some reactivity as there are times that psychiatric emergency situations have angered people in other agencies who did not agree with the CCBHS crisis worker’s decision. In order to strengthen the internal validity of this study the researcher shaped the questions in order to identify relevant issues in a non-threatening way. The researcher used general examples so that participants did not read the questions and think that the questions had something to do with them personally or a specific situation they may have been a part of. The open-ended questions were designed to provoke interest and participation in inter-agency collaboration by allowing for participants to have a confidential way to express frustrations and suggest improvements.
Study Sample

The sample for this study was made up of line staff from several different human service agencies in Calaveras County, a rural county in the Sierra Nevada foothills in California. There were a total of 150 surveys issued, divided amongst and administered to six main rural human service agency entities: law enforcement staff, medical staff, ambulance staff, social services staff, community groups and behavioral health staff. This type of sampling is referred to as non-probability sampling. In non-probability sampling the researcher has no way of guaranteeing that each element of the population is represented either equally or at all (Leedy & Ormond, 2010). The type of non-probability sampling that was used is considered convenience sampling. The survey participants of each agency were included in the sample if they happened to be available and/or interested (Leedy & Ormond, 2010). Of the available study population eighty-two responded (N=82). No inducements were offered to participate in this project.

Protection of Human Subjects

This study was approved by the California State University, Sacramento, Division of Social Work Committee for the Protection of Human Subjects (Appendix A). The study will utilize an exploratory research design based on the analysis of quantitative and qualitative data from the approved survey (Appendix B). The researcher obtained informed consent from all survey participants (Appendix C). Protocol for the Protection of Human Subjects was submitted and approved by the Division of Social work as a minimal-risk research project.
The number that has been assigned to this project is 10-11-003. This study poses “minimal risk” to its participants because it deals directly with line staff who are familiar with psychiatric emergencies.

Before completing the surveys, participants were briefed about the voluntary nature of this study through the informed consent procedure, as explained in the informed consent document (see Appendix C). In order to provide comfort and security, surveying took place at an appropriate location. The participant’s identity and information remained confidential. The surveys were assigned a random number in order to remove identifying information.

All participants were treated in accordance with the National Association of Social Work Code of Ethics. Participants were encouraged to discontinue participation in the survey process and were told they could skip questions they did not feel comfortable answering. No other equipment or instruments, nor any drugs or pharmaceuticals were used in this study. All surveys and signed copies of the informed consent have been separated and stored in a secure area. All data will be destroyed upon approval of this research project.

**Data Collection**

Upon approval from the agency supervisors from Calaveras Woks and Human Services (CalWorks), American Legion Ambulance Company, Mark Twain Saint Joseph’s Hospital, Calaveras County Sherriff, Angels Camp Police Department, California Highway Patrol, Calaveras County Probation, Calaveras County Behavioral Health Services and the National Alliance on Mental Illness (NAMI)—Gold Country,
this researcher distributed the informed consent (Appendix C) and the approved survey (Appendix B), during the months of September, October and November of 2011.

The researcher presented the project at each location and then left the informed consent and surveys with each department to alleviate bias. The survey consisted of fifteen true or false questions and three open-ended questions. Upon receipt of the surveys the researcher verified that each informed consent was signed before being separated from the accompanying survey. All data collected was kept locked and confidential. In order to generalize by professional area, the researcher ensured that there was no way to identify which survey belonged to which respondent or department.

**Data Analysis**

The goal of this analysis was to assess what members of rural human service agencies involved in psychiatric emergencies perceived and understood about the 5150 process. This data was gathered and analyzed in an attempt to discover what if any areas demonstrated the need for further training in order to make this process more collaborative. All questionnaires have been reviewed by the researcher. Themes were identified from the qualitative portion and these themes were analyzed using a nominal value in order to analyze professional correlation, as well as for quotes that reflected common themes. Upon collection of all data, cross tabulations utilizing Pearson’s Chi-Square test of association and Phi and Crammers V were run to determine significance.
Chapter 4

FINDINGS

Introduction

The information for this study was gathered from human service agency line staff in a rural county involved in psychiatric emergencies, specifically the 5150 process. There were both closed-ended questions and open-response questions which were formulated with the intent of provoking thoughtful response to how members of various agencies think the process can be improved, what difficulties they have experienced with the process as it currently exists, and what services they would like to see introduced in order to improve inter-agency collaboration. The design utilized quantitative data, as well as qualitative analysis of the various themes found within the open-response questions.

The analysis is presented in this chapter presents: 1) a representation of respondents by professional area based on the number of surveys returned from the six agencies surveyed, 2) data reflecting issues regarding level of understanding and perceptions of the 5150 process based on the responses as a whole, 3) data reflecting areas of statistical interest when cross-tabulations of responses based on professional area and 4) data reflecting the common themes found in an analysis of the three open response questions.
Demographic Information

For the purposes of this study the only demographic information collected was the professional area of the respondent. The researcher’s intent was to show level of understanding and perceptions based on professional area only. Thus, the demographics relate to the six professional areas in a rural county that are involved in psychiatric emergencies: law enforcement, social services, behavioral health, medical, ambulance, or non-profit community group.

Table 1
Professional Area

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valid Law Enforcement</td>
<td>40</td>
<td>48.8</td>
<td>48.8</td>
<td>48.8</td>
</tr>
<tr>
<td>Social Services</td>
<td>10</td>
<td>12.2</td>
<td>12.2</td>
<td>61.0</td>
</tr>
<tr>
<td>Community Group</td>
<td>2</td>
<td>2.4</td>
<td>2.4</td>
<td>63.4</td>
</tr>
<tr>
<td>Ambulance</td>
<td>7</td>
<td>8.5</td>
<td>8.5</td>
<td>72.0</td>
</tr>
<tr>
<td>Medical</td>
<td>6</td>
<td>7.3</td>
<td>7.3</td>
<td>79.3</td>
</tr>
<tr>
<td>Behavioral Health</td>
<td>17</td>
<td>20.7</td>
<td>20.7</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>82</td>
<td>100.0</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

Of the eighty-two respondents (N=82), forty represent law enforcement agencies, ten represent social services, two represent non-profit community groups, seven are ambulance staff, six constitute medical staff and seventeen represent behavioral health.
While the percentages of respondents reflected in this data is not representative of the number of surveys distributed to each of the agencies that make up the particular area, the numbers can be interpreted to represent the level of participation each professional area has in the 5150 process. For example, the professional area of law enforcement consisted of four different agencies and their responses make up forty-eight percent of the total responses.

While this is not indicative of the number of responses in proportion to the number of staff, it is representative of the level of involvement law enforcement has in the 5150 process. Law enforcement professionals are the first responders to most psychiatric emergencies. They are also called upon to subdue psychiatric patients who become agitated and/or who leave the medical facility they are being evaluated in. Similarly, while the number of surveys distributed to social services was equal to the number of surveys distributed to law enforcement, the fact that social service respondents only make up twelve percent of the total respondents indicates their level of involvement in the process, which is typically indirect involvement or involvement after the fact.

Furthermore, if one can extrapolate the number of responses as being in relation to the level of involvement each professional area has in relation to the 5150 process, the percentages of respondents from both the medical and ambulance staff also makes sense.
While they make up only a small number of the respondents, it could be interpreted that this is based on both numbers of staff affected by the 5150 process, as well as the level of involvement and impact the process has on their staff. While psychiatric emergencies impact both medical and ambulance staff, it is not nearly as much of an impact as it is on law enforcement. Psychiatric emergencies require no more investment from emergency room staff and/or transport ambulances than any other emergency or transport. Once the crisis worker arrives at the emergency room to evaluate for a 5150 hold, the only responsibility medical staff have is to medically clear the patient.

Similarly, once the patient has been held and accepted to a psychiatric facility all the ambulance staff is responsible for is the transport. Thus, there is no difference in impact whether the patient is having a psychiatric emergency or a cardiac emergency, and in fact, in a psychiatric emergency the bulk of the work lies on the crisis worker to evaluate, determine if a hold is appropriate, find a bed, etc.

Finally, that behavioral health is the second most represented professional area also speaks to level of involvement in the 5150 process. While the survey was distributed to the entire agency, the responses that made up the twenty percent seen in the above table are representative of those members of the agency who are involved in the 5150 process. Unlike law enforcement, crisis intervention in the context of a psychiatric emergency is expected as part of the job for behavioral health staff.
While a similar number of surveys were distributed to behavioral health as were law enforcement and social services, the number of respondents is concurrent with the level of involvement and interpretation of impact on the job.

Similarly, the limited response of non-profit community groups also represents the level of involvement they have in the process. While many group members have family members that have been affected by the 5150 process, the responses can be interpreted to reflect the level of impact they feel they have on the process.

**Understanding of the 5150 Process**

The data reflected that across the professional areas there is a general level of understanding of the 5150 process. The majority of the questions were answered correctly by more than sixty-five percent of the respondents. There were however some questions that were only answered correctly approximately fifty percent of the time which indicates that there are areas for improvement regarding training and education to increase the level of understanding.

Table 2

Knowledge of the Professionals With Regard to Whether Or Not Only a Designee of a County Mental Health Agency Can Place Someone on an Involuntary Hold (5150)

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valid</td>
<td>True</td>
<td>40</td>
<td>48.8</td>
<td>48.8</td>
</tr>
<tr>
<td></td>
<td>False</td>
<td>42</td>
<td>51.2</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>82</td>
<td>100.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>
One example of an area the data reflects a lack of understanding is in regards to who is designated to place a 5150 hold. The correct answer to the above questions is that it is true; within each county in California the director of the mental health department designates which professionals in their county may be responsible for placing a 5150 hold during a psychiatric emergency. As can be seen in Table 2, more than fifty percent of respondents were unclear about who is designated within a county system to evaluate and place an involuntary hold. This can be interpreted to reflect a general lack of understanding about roles within the 5150 process.

Table 3
Knowledge of Professionals With Regard to Health Care Decisions and Involuntary (5150) Holds as a Danger To Self

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valid True</td>
<td>38</td>
<td>46.3</td>
<td>46.3</td>
<td>46.3</td>
</tr>
<tr>
<td>False</td>
<td>41</td>
<td>50.0</td>
<td>50.0</td>
<td>96.3</td>
</tr>
<tr>
<td>No Response</td>
<td>3</td>
<td>3.7</td>
<td>3.7</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td>82</td>
<td>100.0</td>
<td>100.0</td>
<td></td>
</tr>
</tbody>
</table>

In regards to whether or not a 5150 hold can be used to address a person who is making a medical decision that puts their life in danger is also an area the data reflects lacks clear understanding. The correct answer to this question is false. That almost half of the respondents believe it to be true indicates that there is misconceptions regarding what the 5150 hold can be used for. The key phrase in this question is “not due to mental illness.” The use of an Involuntary Hold is only appropriate when someone is doing something to endanger their life due to a diagnosable mental illness.
Thus a mental health worker cannot hold someone who is choosing to not get recommended medical care unless they are clearly doing so because the symptoms of their mental illness are affecting their judgment.

Table 4

Responses of the Respondents to the Statement that Inpatient Psychiatric Facilities Must Take People On Involuntary Holds on a First Come First Serve Basis

<table>
<thead>
<tr>
<th></th>
<th>Frequency</th>
<th>Percent</th>
<th>Valid Percent</th>
<th>Cumulative Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valid</td>
<td>True</td>
<td>39</td>
<td>47.6</td>
<td>47.6</td>
</tr>
<tr>
<td></td>
<td>False</td>
<td>39</td>
<td>47.6</td>
<td>95.1</td>
</tr>
<tr>
<td></td>
<td>No Response</td>
<td>4</td>
<td>4.9</td>
<td>100.0</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td>82</td>
<td>100.0</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Finally, the data in Table 4 reflects another significant area of misunderstanding. The correct answer to the question is false. Inpatient facilities are under no obligation to accept any patient at any time. They base their decisions to accept people on bed availability as well as the acuity of the patient, their presenting issues, past history and medical stability. This often means that transferring a patient from the emergency room to a psychiatric facility can be a lengthy process. Psychiatric facilities will not accept patients who are not calm or who have any unaddressed medical issues. That half of the respondents do not know this indicates an area of need for training on the 5150 process.
Cross Tabulation of Professional Area

When cross tabulation was conducted with the computation of Chi Square to determine the statistical significance of the association between professional area and understanding the procedures, in relation to the responses to the true or false questions there were three questions that showed statistical significance.

Table 5

Responses of Respondents to the Statement that Once Someone Has been Involuntarily Hospitalized and Released, They Can Immediately Be Made to Adhere to Medications

<table>
<thead>
<tr>
<th>Professional Area</th>
<th>Law Enforcement</th>
<th>Social Services</th>
<th>Community Group</th>
<th>Ambulance</th>
<th>Medical</th>
<th>Behavioral Health</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mandatory Medication Adherence Post 5150</td>
<td>True Count</td>
<td>4</td>
<td>1</td>
<td>0</td>
<td>4</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>% within Professional Area</td>
<td>10.0%</td>
<td>10.0%</td>
<td>.0%</td>
<td>57.1%</td>
<td>50.0%</td>
<td>.0%</td>
</tr>
<tr>
<td></td>
<td>False Count</td>
<td>35</td>
<td>9</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>17</td>
</tr>
<tr>
<td></td>
<td>% within Professional Area</td>
<td>87.5%</td>
<td>90.0%</td>
<td>100.0%</td>
<td>42.9%</td>
<td>50.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td></td>
<td>No Response Count</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>% within Professional Area</td>
<td>2.5%</td>
<td>.0%</td>
<td>.0%</td>
<td>.0%</td>
<td>.0%</td>
<td>.0%</td>
</tr>
<tr>
<td>Total</td>
<td>Count</td>
<td>40</td>
<td>10</td>
<td>2</td>
<td>7</td>
<td>6</td>
<td>17</td>
</tr>
<tr>
<td></td>
<td>% within Professional Area</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
<tr>
<td>Symmetric Measures</td>
<td>Value</td>
<td>Approx. Sig.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>------------------------------------</td>
<td>-------</td>
<td>--------------</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nominal by Nominal Cramer’s V</td>
<td>.360</td>
<td>.019</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N of Valid Cases</td>
<td>82</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

While overall respondents to this question answered correctly (false), the above data reflects an interesting variance in the number of correct responses by professional area. While almost all of law enforcement, and social services and all of behavioral health and the non-profit community groups answered correctly, medical and ambulance staff answered incorrectly fifty and fifty-seven percent of the time respectively.

The Chi Square test for statistical significance to determine the significance of the association between professional area and the question on whether once someone has been hospitalized they can immediately be forced to take medications was conducted. However, sixty-six percent of the cells had an expected value of less than five. The assumption for the Chi Square test is an expected value of five or more in eighty percent of the cells and thus statistical significance was not met based on Chi Square due to the violation of this assumption.
Table 6
Responses of Respondents to the Statement that People Can Be Placed on an Involuntary Hold (5150) For Any Condition Affecting Their Mental Health

<table>
<thead>
<tr>
<th>Use Of 5150 For Any Condition Affecting Mental Health</th>
<th>Professional Area</th>
<th>Count</th>
<th>% within Professional Area</th>
</tr>
</thead>
<tbody>
<tr>
<td>True</td>
<td>Law Enforcement</td>
<td>9</td>
<td>22.5%</td>
</tr>
<tr>
<td></td>
<td>Social Services</td>
<td>1</td>
<td>10.0%</td>
</tr>
<tr>
<td></td>
<td>Community Group</td>
<td>0</td>
<td>.0%</td>
</tr>
<tr>
<td></td>
<td>Ambulance</td>
<td>5</td>
<td>71.4%</td>
</tr>
<tr>
<td></td>
<td>Medical</td>
<td>2</td>
<td>33.3%</td>
</tr>
<tr>
<td></td>
<td>Behavioral Health</td>
<td>2</td>
<td>11.8%</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>19</td>
<td>23.2%</td>
</tr>
<tr>
<td>False</td>
<td>Law Enforcement</td>
<td>31</td>
<td>77.5%</td>
</tr>
<tr>
<td></td>
<td>Social Services</td>
<td>9</td>
<td>90.0%</td>
</tr>
<tr>
<td></td>
<td>Community Group</td>
<td>2</td>
<td>100.0%</td>
</tr>
<tr>
<td></td>
<td>Ambulance</td>
<td>2</td>
<td>28.6%</td>
</tr>
<tr>
<td></td>
<td>Medical</td>
<td>4</td>
<td>66.7%</td>
</tr>
<tr>
<td></td>
<td>Behavioral Health</td>
<td>15</td>
<td>88.2%</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>63</td>
<td>76.8%</td>
</tr>
<tr>
<td>Total</td>
<td>Law Enforcement</td>
<td>40</td>
<td>100.0%</td>
</tr>
<tr>
<td></td>
<td>Social Services</td>
<td>10</td>
<td>100.0%</td>
</tr>
<tr>
<td></td>
<td>Community Group</td>
<td>2</td>
<td>100.0%</td>
</tr>
<tr>
<td></td>
<td>Ambulance</td>
<td>7</td>
<td>100.0%</td>
</tr>
<tr>
<td></td>
<td>Medical</td>
<td>6</td>
<td>100.0%</td>
</tr>
<tr>
<td></td>
<td>Behavioral Health</td>
<td>17</td>
<td>100.0%</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td>82</td>
<td>100.0%</td>
</tr>
</tbody>
</table>
Another area of statistical importance found through cross tabulation based on professional area can be seen in Table 6. As in the previous table, while the responses to this question were correct overall (false), over seventy percent of ambulance staff answered incorrectly and interestingly, some respondents from behavioral health also answered incorrectly. This reflects an area where there is a lack of understanding about mental health issues can be addressed with a 5150 hold.

Organic conditions, such as dementia and/or a traumatic brain injury do not qualify as mental illness based on the definition used in the language of the 5150 statute. It is interesting that ambulance staff are not aware of this as they are often charged with transporting people with organic brain conditions, as well as those with mental illness. The data reflects the need for education regarding the difference in treatment and procedure.

The Chi Square test for statistical significance to determine the significance of the association between professional area and the question on whether a person can be placed on an involuntary hold for any condition affecting their mental health was conducted.
However, fifty-eight percent of the cells had an expected value of less than five. The assumption for the Chi Square test is an expected value of five or more in eighty percent of the cells and thus statistical significance was not met based on Chi Square due to the violation of this assumption.
Table 7

People Who Have Made Health Care Decisions, Not Due To a Mental Illness But That Could Endanger Their Life Can Be Put on an Involuntary Hold (5150) As A Danger To Self

<table>
<thead>
<tr>
<th>Use Of 5150 To Address Medical Decisions</th>
<th>Professional Area</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Law Enforcement</td>
</tr>
<tr>
<td>True Count</td>
<td>21</td>
</tr>
<tr>
<td>% within Professional Area</td>
<td>52.5%</td>
</tr>
<tr>
<td>False Count</td>
<td>18</td>
</tr>
<tr>
<td>% within Professional Area</td>
<td>45.0%</td>
</tr>
<tr>
<td>No Response Count</td>
<td>1</td>
</tr>
<tr>
<td>% within Professional Area</td>
<td>2.5%</td>
</tr>
<tr>
<td>Total Count</td>
<td>40</td>
</tr>
<tr>
<td>% within Professional Area</td>
<td>100.0%</td>
</tr>
</tbody>
</table>
As was seen in the data reflecting the responses to this question by the surveyed group as a whole, this particular question is one in where there is a lot of misunderstanding. While the answer is false, more than fifty percent of law enforcement, sixty percent of social service staff, and eighty-five percent of ambulance staff answered incorrectly. Again this reflects a lack of understanding about the appropriate use of a 5150 hold that half of the professional areas surveyed are not clear on.

The Chi Square test for statistical significance to determine the significance of the association between professional area and whether or not people who have made medical decisions that could endanger their life can be placed on an involuntary hold was conducted. However, seventy-two percent of the cells had an expected value of less than five. The assumption for the Chi Square test is an expected value of five or more in eighty percent of the cells and thus statistical significance was not met based on Chi Square due to the violation of this assumption.
Open-Ended Questions

The following graphs reflect data gathered on the open-ended questions on the questionnaire (See Appendix B).
### Table 8

What Are Some Of the Difficulties You Currently Experience in Working With Other Departments Related to Crisis Intervention

<table>
<thead>
<tr>
<th>Interdepartmental Difficulties Related To Crisis Intervention</th>
<th>Law Enforcement</th>
<th>Social Services</th>
<th>Community Group</th>
<th>Ambulance</th>
<th>Medical</th>
<th>Behavioral Health</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack Of Knowledge</td>
<td>Count % within Professional Area</td>
<td>4</td>
<td>4</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Lack Of Consistency And Timely Response</td>
<td>Count % within Professional Area</td>
<td>9</td>
<td>3</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>No Feedback</td>
<td>Count % within Professional Area</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Conflicting Policies Or Interpretations</td>
<td>Count % within Professional Area</td>
<td>5</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>Lack Of Other Resources</td>
<td>Count % within Professional Area</td>
<td>5</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Impacts Emergency Services</td>
<td>Count % within Professional Area</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>No Response</td>
<td>Count % within Professional Area</td>
<td>15</td>
<td>2</td>
<td>0</td>
<td>3</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>Count % within Professional Area</td>
<td>40</td>
<td>10</td>
<td>2</td>
<td>7</td>
<td>6</td>
<td>17</td>
</tr>
</tbody>
</table>
Table 8 (Continued)

<table>
<thead>
<tr>
<th>Symmetric Measures</th>
<th>Value</th>
<th>Approx. Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nominal by Nominal</td>
<td>Cramer’s V</td>
<td>.354</td>
</tr>
<tr>
<td>N of Valid Cases</td>
<td></td>
<td>82</td>
</tr>
</tbody>
</table>

The Chi Square test for statistical significance to determine the significance of the association between professional area and difficulties encountered within the 5150 process was conducted. However, ninety-two percent of the cells had an expected value of less than five. The assumption for the Chi Square test is an expected value of five or more in eighty percent of the cells and thus statistical significance was not met based on Chi Square due to the violation of this assumption.

While perhaps not statistically significant, the responses to this question reflect the most relevant feedback obtained from the three open-response questions. It also provides interesting data based on the lack of response, which can be interpreted as either people being unsure or unwilling to respond. For those that did respond, the answers reflect impact based on professional area. For example, for law enforcement, “lack of timely response was the most common response. Law enforcement consistently reported that: “the time it takes at the hospital for mental health to arrive to handle the patient”, and/or, “there is always an argument when it comes down to who responds and why they should.”
These issues for law enforcement are further exacerbated when the patient is under the influence: “the biggest problem is when a deputy takes the patient to the ER for an evaluation and if the subject is intoxicated, mental health will not respond until they are sober and the ER won’t let the deputy leave. If a deputy is stuck at the hospital, he/she might be one of two or three deputies for the whole county.” This reflects a lack of policy and procedure on what to do with people who are under the influence. Mental health cannot legally evaluate someone under the influence of drugs or alcohol, so when a deputy brings someone in, it becomes a volley as to whose responsibility it is to sit with the patient. Other issues related to response time also came up, particularly for law enforcement. In the case of people with dementia or some other organic condition law enforcement reported: “Elderly people with dementia or Alzheimer’s are not always taken by mental health. APS will not take an individual either and want mental health to respond. Then I am in a battle between mental health and APS and the problem of who is going to help an elderly person remains.” This response is interesting in that it reflects the data on whether or not a 5150 hold can be used for any condition affecting mental health. It was the only question that was missed the most and showed statistical significance based on profession, leaving one to interpret that this area is one where training is important. Furthermore, impact on ones professional area can be seen in the response of medical and ambulance who both report: “impact on emergency services” as being their primary concern.
For medical staff, monitoring psychiatric problems seems to be where most of the impact is felt: “psychiatric patients need interventions during the hospitalization process, before medical clearance”; “we need security personnel in the hospital; it is difficult to provide monitoring for patients on a 5150”. Similarly, for ambulance staff, taking ambulances out of service to transport psychiatric patients to facilities that are least one hour, if not three hours away is problematic: “the large amount of 5150 transfers that go out of hospitals that are taking ALS ambulances out of service for a large amount of time. This creates a deficit in the number of ambulances that can serve the county in case of a true emergency.”

Finally, the data reflects an interesting congruence in the responses of behavioral health, social services, and community groups who all agree that “lack of knowledge is the most pressing difficulty related to psychiatric emergencies. However, based on the responses it is interesting to see whether the perceived lack of knowledge is occurring. For example, for behavioral health workers: “ER staff not understanding the limitations of a 5150 hold”, was the most common theme. For social services it is “lack of training on how to deal with the mentally ill”. For members of non-profit community groups, it is the perception that all of the other agencies involved “lack the knowledge of what it is like for a family member. These responses clearly represent a disconnect between agencies that should be working together as team. Psychiatric emergencies impact all of the professional areas surveyed and yet based on the data it is apparent each discipline is responding as a separate unit, rather than a collaborative partner.
Table 9

How Do You Think the 5150 Process in Calaveras County Can Be Improved to Become a More Collaborative Process For the Agencies Involved?

<table>
<thead>
<tr>
<th>How The 5150 Process Can Be Improved</th>
<th>Professional Area</th>
<th>Law Enforcement</th>
<th>Social Services</th>
<th>Community Group</th>
<th>Ambulance</th>
<th>Medical</th>
<th>Behavioral Health</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interagency Training: Count</td>
<td>% within Professional Area</td>
<td>11</td>
<td>4</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>9</td>
<td>26</td>
</tr>
<tr>
<td></td>
<td></td>
<td>27.5%</td>
<td>40.0%</td>
<td>50.0%</td>
<td>14.3%</td>
<td>.0%</td>
<td>52.9%</td>
<td>31.7%</td>
</tr>
<tr>
<td>Line Staff or Panel: Count</td>
<td>% within Professional Area</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2.5%</td>
<td>10.0%</td>
<td>.0%</td>
<td>.0%</td>
<td>16.7%</td>
<td>11.8%</td>
<td>6.1%</td>
</tr>
<tr>
<td>Mandatory Family Or Agency Input: Count</td>
<td>% within Professional Area</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td></td>
<td>5.0%</td>
<td>20.0%</td>
<td>50.0%</td>
<td>.0%</td>
<td>.0%</td>
<td>5.9%</td>
<td>7.3%</td>
</tr>
<tr>
<td>Provide Other Options: Count</td>
<td>% within Professional Area</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td></td>
<td>5.0%</td>
<td>.0%</td>
<td>.0%</td>
<td>28.6%</td>
<td>.0%</td>
<td>.0%</td>
<td>4.9%</td>
</tr>
<tr>
<td>Security At ER or Facility: Count</td>
<td>% within Professional Area</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>.0%</td>
<td>.0%</td>
<td>.0%</td>
<td>.0%</td>
<td>16.7%</td>
<td>5.9%</td>
<td>2.4%</td>
</tr>
<tr>
<td>Improved Response Times: Count</td>
<td>% within Professional Area</td>
<td>8</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td></td>
<td>20.0%</td>
<td>.0%</td>
<td>.0%</td>
<td>14.3%</td>
<td>16.7%</td>
<td>.0%</td>
<td>12.2%</td>
</tr>
<tr>
<td>No Response: Count</td>
<td>% within Professional Area</td>
<td>16</td>
<td>3</td>
<td>0</td>
<td>3</td>
<td>3</td>
<td>4</td>
<td>29</td>
</tr>
<tr>
<td></td>
<td></td>
<td>40.0%</td>
<td>30.0%</td>
<td>.0%</td>
<td>42.9%</td>
<td>50.0%</td>
<td>23.5%</td>
<td>35.4%</td>
</tr>
<tr>
<td>Total: Count</td>
<td>% within Professional Area</td>
<td>40</td>
<td>10</td>
<td>2</td>
<td>7</td>
<td>6</td>
<td>17</td>
<td>82</td>
</tr>
<tr>
<td></td>
<td></td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
</tbody>
</table>
While not statistically significant in that there is not a high enough discrepancy among the various professional areas, this table is still interesting in reflecting what different agencies believe can be done to increase collaboration. Specifically in that, other than “no response” the data reflects that inter-agency training would be the most effective improvement.
Chapter 5

CONCLUSIONS, RECOMMENDATIONS AND IMPLICATIONS

This chapter presents the conclusions that emerged from the study findings and lists the recommendations and implications in regard to social work theory, practice, research, policy and behavior on the micro, mezzo and macro levels.

Conclusions

The study findings lead the author to conclude that there is a certain degree of disarray of line-staff from various human service agencies in this rural county who are involved in dealing with psychiatric emergencies. Much of this disarray is caused by the lack of training on the 5150 statute and how it has been interpreted and made into policy at the county level. More importantly, the disarray is due to the fact that the statute itself is outdated. At the time it was created, the authors could not have foreseen the massive impact the deinstitutionalization of people with mental illness would have on counties. The statute does not take into account lack of resources, counties with no inpatient psychiatric hospitals, or rural issues such as, distance to facilities, limited after-hour services or the impact psychiatric emergencies have on other agencies. It assumed collaboration where collaboration does not exist.
This study and the literature that supports it reflect a call to professionals involved in psychiatric emergencies to a higher standard of collaboration. Particularly in a rural county, and specifically during difficult economic times, where we have seen an increase in crisis services and yet no further resources to assist us, collaboration is paramount in order to provide the best standard of care for our clients, with the least amount of strain on our partners in crisis intervention.

**Recommendations and Implications**

*Micro Level*  With regard to theory on the micro-level, the implications of this study highlight the need for social workers engaged in crisis intervention to offer a humanistic approach toward members of other agencies, as well as, the clients they are evaluating during such emergencies. Particularly in a crisis situation, on an interpersonal level, professional to professional, or professional to client, positive outcomes are found when social workers base their practice and model for others the Rogerian perspective that is based on congruence, unconditional positive regard and accurate empathetic understanding (Corey, 2009). This theoretical perspective also influences social work practice at the micro level in that it provides the foundation for crisis training and the creation of leadership within crisis intervention. Whatever the inter-departmental difficulties, humane and fair treatment should be the expectation and social workers, who are trained in these concepts, should be called upon to be the models and leaders in order to promote this ideal as a standard for interaction between line staff and clients.
With regard to research in and policy creation around, the difficulties in collaboration and the differences that were found in the responses to the survey questions, the researcher recommends the use of focus groups made up of community members, family members and staff members involved in crisis intervention. For example, according to the findings of this project only half of all respondents are aware of the policy that designates which professionals may place an involuntary hold. Similarly, approximately half of the respondents believe that psychiatric hospitals must take people on a first come, first serve basis. These types of misunderstandings of policy reflect a lack of training that often provokes reactionary issues for line-staff during the 5150 process. Based on this study, the researcher recommends offering stakeholders the opportunity to contribute to policies that affect them on a personal level. The implication of this study is that the respondents are invested in the outcomes of such policies and having a voice would lead to behavior in the field that was based on cooperation and mutual respect.

Mezzo Level The data from this project supports the theories of Social Capital and Coordination Theory (Wolcock & Narayan, 2000; Muijs, et al., 2010; Malone & Crowston, 1990). By creating social capital and basing policies on coordination and interdisciplinary cooperation, the flow of information between rural agencies involved in crisis intervention would improve, as would positive outcomes. The conclusion from this project is that social work practice, with regard to crisis intervention, needs to be based on social capital and coordination theory through collaborative training.
The research from this project supports the literature which shows that models of interagency collaboration such as, Crisis Intervention Team (CIT) training and Mental Health Courts are evidenced-based and effective. Further research into the difficulties in collaboration between inter-agency staff, such as a training effectiveness study should be considered, and should include research into factors other than and combined with professional area that may affect perceptions. Such areas could include: length of time on the job, gender, age, level of education, etc. Presently, however, the research that exists, including what was found through this project, supports the formulation of a continuing consortium around crisis intervention issues within Calaveras County.

With regard to social work policy, by creating agreed upon norms that are grounded in the values of coordination and cooperation, rural county agencies can begin to build a structure of crisis intervention that is agreed upon and perpetuated by all of the participants. In addition to the above recommendations, at the mezzo level, the use of an anti-stigma campaign that involves all of the agencies that work within the realm of crisis intervention with people with mental illness, would serve to improve behavior toward people with mental illness and mental health workers, as well as improve ingrained agency stereotypes toward their role in crisis-intervention.

Macro level With regard to social work theory on a macro-level, this project is based on and the data supports both Systems Theory and the theory of Social Construction. Each of the agencies involved in this study are part of a larger system in the context of crisis intervention.
While each agency is a separate part of the whole system, during a psychiatric emergency they all become interactive and interdependent (Ambrosino, et al., 2007). The lack of collaboration between agencies in relationship to crisis intervention has led to a system that is unhealthy, disordered and disorganized (Kast & Rosenzweig, 1972). The disordered state of the system as it relates to crisis intervention reflects the social constructionist theory which posits that all reality is subjective and defined by perception (Johnson & Rhodes, 2010). Social Constructionist Theory postulates that the culture of an organization is made up of standpoints that are an agreed upon reality, a construct that defines how members of the organization perceive the world around them (Johnson & Rhodes, 2010; Muijs, West, & Ainscow, 2010). The data from this study reflects discord between the agencies based upon the differences in responses to the survey the respondents had in conjunction with their professional area. The implications of this are that, within each agency there is a shared meaning and understanding of the 5150 process. This construct is in part created by the fact that most of the agencies involved in the 5150 process have never been formally trained on the nuances of the 5150 statute. Therefore each agency has developed its own reality around the 5150 process based on shared perceptions of how it affects their agency, with little no understanding of why the process happens the way it does, or input into how it might be done better. By offering an inter-agency collaborative process, this project aims to redefine the construct of crisis intervention to one that is agreed upon by all of the agencies that are involved in the 5150 process.
With regard to social work practice, this study reflects the need for advocacy on the part of the National Association of Social Workers (NASW), for interdisciplinary trainings and collaboration and curriculum modification to include evidence-based practices that reflect the need for interdisciplinary efforts with regard to crisis intervention. This study also supports the implication that the NASW should be involved in political action on a national level on issues regarding community-based-resources for people with mental illness and the line-staff, regardless of their profession, who encounter people with mental illness in a crisis. With regard to research, it is important to note that this study took place in a rural, California community and is limited in its scope. It is the researcher’s recommendation that further research and investigation on a macro-level, into how psychiatric emergencies are handled in other states and other countries is imperative in informing best practices for social workers.

Finally, the implications of this study for social work policy and behavior reflect a need to revisit the California Welfare and Institutions Code 5150. This code was put into place in the late 1960’s. The researcher feels it is imperative to point out that most of the people this policy affects, as well as the line-staff surveyed for this paper, were not born at that time. Nor did ideas such as the “recovery movement” exist. In order to address even the most basic issue amongst professionals involved in the 5150 process, the statute should be revisited and modified, with additional attention paid to the differences in resources and access that particularly affect rural counties.
APPENDIX A

APPROVAL BY THE COMMITTEE FOR THE PROTECTION OF HUMAN SUBJECTS BY THE DIVISION OF SOCIAL WORK

CALIFORNIA STATE UNIVERSITY, SACRAMENTO
DIVISION OF SOCIAL WORK

TO: Megan Harris
Date: September 22, 2011

FROM: Committee for the Protection of Human Subjects

RE: YOUR RECENT HUMAN SUBJECTS APPLICATION

We are writing on behalf of the Committee for the Protection of Human Subjects from the Division of Social Work. Your proposed study, “Understanding the 5150 Process: A Needs Assessment for the Interagency collaboration and training in a Rural Environment.”

___X_ approved as ____ EXEMPT  ____ NO RISK  ___ MINIMAL RISK.

Your human subjects approval number is: 10-11-003. Please use this number in all official correspondence and written materials relative to your study. Your approval expires one year from this date. Approval carries with it that you will inform the Committee promptly should an adverse reaction occur, and that you will make no modification in the protocol without prior approval of the Committee.

The committee wishes you the best in your research.

Professors: Jude Antonyappan, Maria Dinis, Serge Lee, Kisun Nam, Francis Yuen

Cc: Dr. Jude Antonyappan
APPENDIX B
APPROVED SURVEY

Please circle the agency and department (if applicable) that you represent:

- Law Enforcement
- Ambulance
- Social Services
- Medical
- Community Group
- Behavioral Health

Please answer the following questions by circling T for True or F for False:

1. People have the legal right to be “psychotic” as long as it is not endangering themselves or others.
   - True
   - False

2. People who are involuntarily hospitalized under a 5150 may never own a firearm.
   - True
   - False
3. Involuntary psychiatric hospitalizations are always 72 hours.
   True    False

4. People on an involuntary hold (5150) can immediately be forced to take medications.
   True    False

5. Only a designee of a county mental health agency can place someone on an involuntary hold (5150) and these designees can differ in title from county to county.
   True    False

6. Once someone has been involuntarily hospitalized and released, they can be made to adhere to the medications they were prescribed.
   True    False

7. Restraints may be used in order to keep someone from leaving the hospital once they are placed on an involuntary (5150) hold.
   True    False

8. A person must be “medically cleared” (including not being intoxicated) in order to be evaluated for an involuntary (5150) hold and may not be accepted to a psychiatric hospital if medical issues exist.
   True    False
9. People who have made health care decisions, not due to mental illness but that could endanger their life can be put on an involuntary (5150) hold as a “danger to self”.
   True    False

10. People can be placed on an involuntary hold (5150) for any condition affecting their mental health.
    True    False

11. Parents/guardians can override the decision to place an involuntary hold (5150) on a minor.
    True    False

12. Inpatient psychiatric facilities must take people on involuntary holds on a first come first serve basis.
    True    False

13. Involuntary holds (5150’s) are a form of legal detention that temporarily restricts some of a person’s civil rights.
    True    False
14. A person’s insurance determines where they will be placed when they are on an involuntary hold (5150), regardless of distance to the facility.

True    False

15. During a crisis situation, HIPPA laws regarding confidentiality do not apply when a crisis worker is attempting to gather information from other agencies and/or family members.

True    False

Please answer the following three open-ended questions: (You may use the back of this form if necessary.)

1. How do you think the 5150 process in Calaveras County can be improved to become a more collaborative process for the agencies involved?

2. What are some of the difficulties you are currently experiencing in working with other departments related to crisis intervention?

3. What services would you like to introduce to increase the quality of the collaborative process?
APPENDIX C

INFORMED CONSENT FORM


Informed Consent to Participate in a Needs Assessment for Interagency Collaboration and Training in a Rural Environment
I hereby agree to participate in a study entitled, “Understanding the 5150 Process: A Needs Assessment for Interagency Collaboration and Training in a Rural Environment.”, conducted by a graduate student from California State University, Sacramento.

I understand that the participation in the study involves the following:

Why is this study being conducted?
This study is being conducted by a social work graduate student of California State University, Sacramento to find out what can be done to improve collaboration and training for people involved in the 5150 process in Calaveras County. I have been requested to take part in this study because I can provide information on my perceptions and knowledge on the 5150 process.

What am I being asked to do?
I will be one of about 30-50 respondents in the area who will be asked to complete a survey because I am a professional who can provide information on the topic being investigated.
I will be asked questions about the 5150 process for people experiencing a psychiatric emergency in Calaveras County. The questionnaire is expected to take approximately 20 minutes. The types of questions are similar to those I encounter in my practice and daily work with clients and fellow professionals.

Is this voluntary?
Yes. I am under no obligation to participate. When I agree to participate, I can skip any questions that I'd rather not answer and I am also free to stop participating at any time.

What are the advantages of participating?
Participating in this study will be instrumental in improving training and collaboration between county agencies that work with people during the 5150 process.

Will participating in this study affect my employment?
No. Whether or not I agree to participate in the study will not affect anything related to my employment or any other aspect of my work.

Is this confidential?
Yes. Nothing learned about me by the researcher will be told to anyone else. The study will remove identifying information from my questionnaire. All records will be identified only by a number, and the link to that number will only be available to the principal researcher. At the completion of the study all identifying information will be destroyed and only the compiled content of the questionnaire will be kept. Everything I say will be strictly confidential and any reports or other published data based on this study will appear only in the form of summary statistics or condensed account without the names of or other identifying information about the participants.
What risks do I face if I participate?
There are minimal risks expected as the researcher is trained to create the survey in a way that ensures my dignity and privacy and I have the right not to answer any question that I do not want to answer.

Who do I contact if I have questions about this research?
If I have any questions about the study, I can ask the researcher’s thesis:

Advisor by emailing: Judea@saclink.csus.edu
Or the researcher at: meganem74@comcast.net

My signature below indicates that I consent to be interviewed, that I have been given a copy of this consent form, and that I read and understood it.

Signature: ___________________________ Date: ___________________________
REFERENCES


Arlington, VA.


