Developing a Community Model to Reduce Emergency Visits for Mental Health Care: Quality Improvement Project

Tracy Gemmell, Sarah Locken, and Kelsey Trepczyk

The College of St. Scholastica

In Partial Fulfillment of the Requirements for the Doctor of Nursing Practice

Dr. Sherry Johnson

May 12, 2022

Abstract

Nature and Scope of the Project: According to the National Alliance of Mental Illness (2020), one in five Americans experience a mental illness each year with only 43.8% of them receiving treatment. To address this, St. Louis County Behavioral Health created the initiative: "Clarity Center of Well-Being," as a behavioral health crisis center (2019). This quality improvement project included creating an outreach tool and education for local law enforcement (LE), emergency medical services (EMS), schools, crisis response teams (CRT), and emergency departments (EDs).

Synthesis and Analysis of Supporting Literature: Due to ED challenges of overcrowding and lack of mental health protocols, facilities designated for compassionate mental health response can positively impact the well-being of patients. This happens by employing staff educated in psychiatric services, promoting preventative care, and scheduling follow-ups (White, 2020). Patients find these centers less intimidating than EDs, containing individualized care, and utilizing appropriate resources and referrals (Heyland & Johnson, 2017).

Project Implementation: Implementation involved meeting with Clarity Center supervisors and community leaders to discuss tools for guiding individuals to the center. Further information was processed on what was to be included in educational materials. After approval, education was dispersed. Challenges included busy schedules of stakeholders and large sample sizes of stakeholders within each department.

Evaluation Criteria: After completion of the education, a survey and attestation of completion were submitted to the project leaders. As the surveys were qualitative, no quantitative data needed analysis. Completion was measured through review of survey answers.

Outcomes: The community outreach tools were included in the outreach education and plan and a total of 94 participants completed the education out of 485. A total of 54.5% found this education helpful, 45.5% felt they learned everything they needed to know about the Clarity Center. Qualitative data was taken to identify what questions still needed answers. In future research, successful outcomes can be appraised via the usage of the center, referrals made, and a decrease in ED visits and length of stays for mental health crises.

Recommendations: Evaluation following the opening of the Clarity Center and its impact on ED use and use of resources in mental health crises will be needed in the future. Additional projects could be conducted to further educate the community based on resource utilization after the center opens.

Developing a Community Model to Reduce Emergency Visits for Mental Health Care: Quality Improvement Project

According to the National Alliance of Mental Illness (2020), one in five Americans experience a mental illness each year, and of that, only 43.8% of those received treatment. In both youth and adults, depression and suicidal ideation are worsening. Depression rates are climbing up to 10% in children and adolescents, and suicidal ideation has increased by over 460,000 adults in the United States (US) over the last year (Mental Health America, 2021). Crisis care within the US is fragmented and often inadequate, leading many individuals suffering from an acute mental health event to go to the emergency department (ED) for their care (Substance Abuse and Mental Health Service Administration, 2020).

One out of every eight ED visits are attributed to mental illnesses or substance abuse disorders, totaling 12 million visits per year. As EDs often do not have adequate protocols to care for these patients, the results are decreased patient satisfaction, poor outcomes, and increased morbidity (Laderman et al., 2018). Studies regarding patient experiences in the ED for mental health crisis visits have shown they frequently spend hours to days awaiting an inpatient bed and may feel improperly cared for as the processes are geared more towards medical patients (Digel Vandyk et al., 2017). The potential community impact due to lack of crisis care includes homelessness, unnecessary incarceration, overuse of police and emergency medical services (EMS), and overuse of EDs (National Alliance of Mental Illness, 2020). Like a physical crisis, a mental health crisis can be distressing and unpredictable. Finding a way to plan for these unexpected events can deliver structure in how services or resources are best utilized to meet this patient population's needs.

Problem Identification

Individuals experiencing psychiatric emergencies often lack access to care because of improper management of mental health resources. If this trend continues, the health status of these individuals is likely to continue to decline, medical costs will rise, and resources will continue to be depleted. Inadequate crisis care services negatively impact individuals, families, and communities; therefore, this phenomenon should be evaluated and addressed.

Background

Inadequate care for individuals experiencing a mental health crisis can be detrimental to their health. The Center for Disease Control (CDC) found that since 1999, suicide rates have increased 30% and are now the 10th leading cause of death in the US (Hedegaard et al., 2017). Even more staggering, suicidal ideation visits in the emergency department are progressively climbing by 415% between 2006 and 2014 (Kalter, 2019, September 3). With poor funding and resources for those struggling with mental illness, receiving care during a crisis may seem insufficient to meet their needs, and at times, impossible or unobtainable. This issue is not foreign to Minnesota: In 2019, there were 830 deaths by suicide reported in the state (National Center for Health Statistics, 2021). In St. Louis County, Minnesota, services for mental health needs and crisis intervention are severely lacking, leading to high depression and suicide rates.

Problem Scope

In an alliance between numerous local organizations including healthcare facilities in the area, a coalition known as Bridging Health Duluth was formed to develop a community-centered needs assessment and plan for implementation (Kjos et al., 2016). Every three years, Bridging Health Duluth conducts a needs assessment to identify and prioritize community health needs within the area. The top three priorities of the 2020-2022 needs assessment included (1) mental

health, (2) substance abuse, and (3) food insecurity (Kjos et al., 2016). Key findings of the survey provoked interest when they found that 24.6% of adults within Duluth reported having depression compared to the Minnesota state value of 18.9%. The Minnesota Department of Health Vital Statistics found that within Duluth, suicide rates have increased by 5.4% from 2011 to 2016, and among females, there was a 24% increase (Kjos et al., 2016). Additionally, the Minnesota Student Survey (2016) found that within the Duluth School District, 13.9% of ninth graders communicated seriously considering suicide compared to the Minnesota state value of 11.8%.

Problem Consequences

Crisis care that is lacking can be detrimental to individuals, families, and communities resulting in increased cost and poor health outcomes (Substance Abuse and Mental Health Service Administration, 2020). Too often, people experiencing a mental health crisis receive insufficient care in EDs, with extended wait times for treatment (Balfour et al., 2020). These visits, in turn, become very expensive for both the patient and healthcare organization, depending on the patient's ability to pay, as well as overcrowding the ED.

According to Balfour et al. (2020), individuals experiencing a behavioral health crisis account for "a quarter of police shootings and over 2 million jail bookings per year" (p. 3). Healthcare and the Criminal Justice System are faced with increased challenges due to the growing number of mental health disorders and the minimal options for a person experiencing a mental health crisis. The current procedures for this type of care are disorganized, offering minimal treatment for some. In contrast, others fall through the cracks leading to frequent hospital readmissions, detainment in the Criminal Justice System, homelessness, early death, and suicide (Substance Abuse and Mental Health Service Administration, 2020).

Proposed Solution

To better address and serve this area of need, St. Louis County's Public Health and Human Services Department has restructured its branch into two divisions: Home and Community Based Services and Behavioral Health (St. Louis County Minnesota, 2019). The Behavioral Health Division will focus on various issues, including substance abuse, adult mental health, individuals involved in the criminal justice system, and efforts to work with the Regional Crisis Center in St. Louis County. This project is called the "Clarity Center for Well Being" and is in the early planning and structuring phase of how the county and community will work together to offer a wide variety of services to address accessibility, destigmatize mental health, and implement this new behavioral health crisis center (St. Louis County Minnesota, 2019). The objective of this quality improvement project was to develop a community outreach tool that can be used as a resource and to educate members of local LE, EMS, Department of Child and Family Services for local schools, emergency departments, and crisis response teams (CRT) within the area for triage to the Clarity Center as well as provide education to each department regarding this new facility and its services.

Knowledge Gaps

A significant knowledge gap within this project was that the Clarity Center is still in the planning stage, and to many of the key stakeholders, has not yet been recognized for future resources within their respective departments. A critical purpose of this quality improvement project was to provide the necessary education to the key stakeholders to address this knowledge gap. Through community outreach education and feedback from stakeholders within St. Louis County on the outreach tool, the current lack of knowledge of the key stakeholders was addressed. This project not only provided education on the outreach/assessment tool but also

required the project leaders to inform the stakeholders about the future of the Clarity Center, what it is, and how it will become a key resource for their departments and the larger community.

PICO Question

A generalized PICO question used for this problem gap included: In patients experiencing a mental health crisis, how does care from a mental health urgent care compared to standard emergency room care, improve patient and healthcare facility outcomes? More specifically to this project, another PICO question was developed: For St. Louis County LE, EMS, and Schools, does having an outreach tool positively impact appropriate patient placement to avoid overcrowding of the ER?

Literature Process and Matrix

A literature review was conducted using four databases: CINAHL, MEDLINE, ScienceDirect, and The College of St. Scholastica's SOLAR. Of these four databases, CINAHL yielded the results that were most applicable to the problem. Key terms used during the search process consisted of: Mental health crisis, mental health, emergency department, substance use disorders, Minnesota, integrative care models, psychology, mental health facility, crisis implementation, consequences, outcome measures, and crisis care. From these key terms, "mental health crisis" became the primary search term used.

CINAHL produced a total of 399 articles, Medline had 420 articles, and SOLAR yielded 635,161 articles. From these results, additional keywords mentioned previously were added to the search to narrow down the results. From these results, titles and abstracts were reviewed to determine the appropriateness of the articles and their relevance to the clinical problem. Sources were chosen if they were published between 2016-2021 (unless otherwise noted in the review),

available in English, and full text available through the database or the College of St. Scholastica Library. The information found within this literature search was compiled into a literature matrix table located in Appendix A. The purpose/question, design, sample, intervention, results, and additional notes can be found in this table for each original reference (Appendix A).

Literature Synthesis

After completing the literature review, correlations were found within the following topics. Recent studies have found that one in five Americans suffer from chronic mental health and substance use disorders (Lee et al., 2017). Mental health-related ED visits have been steadily increasing from 4-6% percent in 1992 to an estimated 12% in 2007. Those with mental health disorders have been found to visit the ED five times more often than those without a psychiatric diagnosis leading to increased financial burden, negative healthcare experiences, and unintended consequences related to mental health stigma and criminalization (Digel Vandyk et al., 2018).

Due to the limited community mental health service centers, access for an individual experiencing a mental health crisis can be challenging and often leads to police involvement with transportation to the ED (White, 2021). White (2021) discussed his lived experience when he suffered a mental health crisis and found that such police intervention had escalated these situations and exaggerated the levels of psychotic distress. The ED is a challenging environment for these individuals to improve psychiatric symptoms, leading to feelings of isolation, anxiety, and agitation. Opportunities to develop a more compassionate response to those undergoing a mental health crisis are needed and can significantly impact the health and well-being of these patients.

Project Setting, Sponsors, Stakeholders, and Participants

Project Setting

The Clarity Center for Wellbeing will be located in Duluth, MN serving all in the St. Louis County area, including those in the Arrowhead Region. It will be an outpatient, urgent care-like center with no overnight admissions. Patients accepted will be those undergoing a crisis that can be treated on an outpatient basis, not requiring 24-7 care. This center will also offer outpatient follow-up appointments with mental health providers in addition to their primary care appointments.

Interprofessional Team and Stakeholders

The interprofessional team and stakeholders directly working with the Clarity Center include LE, EMS, Department of Child and Family Services for local schools, emergency departments, and CRTs as well as patients going through a crisis and their families. Indirect stakeholders include law and policymakers, insurance companies, mental health pharmaceutical representatives, and the public of the St. Louis County area. It involves many different departments to achieve one common goal, improving the wellbeing and care of patients suffering from a mental health crisis.

Inclusion and Exclusion Criteria

Certain factors include or exclude individuals from obtaining care at the Clarity Center. Inclusionary criteria are those experiencing a mental health crisis that does not require immediate emergency room care and is medically stable. The age of patients is not limited, serving all people from children to the elderly. Those considered unstable or who may require an overnight

stay are excluded from care at the Clarity Center. Inclusion criteria regarding the education, the outreach tool, and surveys are those that are in the key stakeholder roles. These stakeholders must have their departments located within St. Louis County to be included in the project.

Organizational Needs Assessment

A portion of the Bridging Health Duluth Survey was retrieved from community input, where community focus groups identified common themes. From this survey, members reported a lack of access to behavioral health centers, substance abuse providers, and services. A correlation was found between substance abuse and poverty to mental health. Additionally, community members expressed concern regarding the efficacy of the depression screening tool and the lack of adequate follow-up care afterward. These individuals also noted a need to minimize mental health stigma and identified elevated stress levels in people with daily hardship, including work environments, minority stress, chronic pain, lack of sleep, and trauma.

Theoretical Framework

Through the literature review, two nursing theories were found that are relevant to this project. First, Ball's Middle Range Theory on crisis care applies both to providing background on the Clarity Center for Wellbeing as a whole, as well as outlines how crisis care for those with severe mental illness can be addressed at the center. The second theory of focus is the Theory of Nursing for the Whole Person (TNWP).

Brennaman’s Middle Range Theory

Developed by Jeffrey S. Ball, the middle range theory of crisis care for individuals with severe, persistent mental illness (SPMI) centers around a situation-specific theory for nurses, especially within EDs, using an integrative approach for mental health interventions (Brennaman, 2012). Ball’s original study was based on qualitative interviews with individuals

with SPMI. Brennaman (2012) used Ball's theory to validate and provide ways to implement the idea in emergency nursing care through an extension theory. Brennaman's (2012) article speaks on frequent hospitalizations worsening mental health illnesses, and increasing crisis care to emergent levels rather than preemptively intervening at a low-risk time. A literature review was conducted, to which the extension was formulated to appropriately apply Ball's crisis theory to use by healthcare providers and nurses specifically within an emergency setting.

Theory of Nursing for the Whole Person

The Theory of Nursing for the Whole Person (TNWP) is a framework that conceptualizes nursing for the whole person, through five triads: 1) body, mind, and spirit; individual, family, and community; internal and external environments and interactions; health, illness, and wholesomeness; and health promotion, maintenance, and restoration (Swanson et al., 2019). By combining all five triads, the TNWP can be used by nurses to holistically care for patients and can be applied to mental health care. TNWP is based on the thought that individuals cannot be treated in a one-size-fits-all manner. A significant tenet to this theory is that the context and culture in which a person lives are significant, and it encourages an integrative approach to healthcare. Within this framework, a crisis center for mental health care would integrate the patient's physical, as well as the mental state of being, and address all concerns.

Project Goal: Overall Goal/Mission

There is one broad goal to be accomplished through the implementation of this quality improvement project: The creation of an outreach/assessment tool for LE, EMS, Department of Child and Family Services for local schools, EDs, and CRTs along with associated education surrounding the Clarity Center. These tools will serve as a guide for assessing individuals in a

mental health crisis and determining when to bring patients to EDs or if they would be appropriate for admission to the Clarity Center. Due to the broad aim of this project, the goal was split into three sections to better focus on the objectives, measurable outcomes, and implementation of the overall goal.

SMART Objective One

The first objective for this project was to create a tool that can be used for LE, EMS, CRT, and EDs during emergency mental health calls to assist in determining when individuals would benefit from services at the Clarity Center versus bringing the individual to the emergency department for care. This objective was measured through the finalized creation of a tool, including a written guide and graphic aid (flow chart), designed through collaboration with local EMS and LE, as well as the Clarity Center (Appendix B).

Data Analysis Approach

The first step in implementing this objective was achieved by reaching out to the local leaders of these groups within the community and understanding what type of guide is needed and how it will best be used or presented to them. It was also vital to collaborate with Diane Holliday-Welsh, the lead of the care delivery model at the Clarity Center, to keep the project focused in a way that would benefit future use. During these contacts with local departments, a survey to best assess their needs concerning the outreach tool would was sent out. The survey included a due date to send responses back for review by the project writers within the appropriate timeframe of the project. Due to the time constraints of the project, this step needed to be completed in an urgent matter upon the start of the project.

Following the submission and review of the survey, setting up stakeholder meetings followed, including the project writers, the Clarity Center staff, and the local departments that

are interested in participating. The purpose of the meetings was to determine from the survey results how the outreach tool can best be created, presented, and utilized. Due to the large area of the state that is to be covered by the Clarity Center, it was most appropriate to host the meeting via web-based video conference. Due to difficult schedules, this step required multiple virtual meetings as well as continuous email and phone correspondence. A slide presentation was created before the meeting to present the findings from the survey and suggestions for the outreach tool. Once the preliminary tool was approved by the local department heads, a formal version of the outreach tool was written, and a visual was designed in the form of a flow chart. This visual aid guides the reader via a step-by-step path to assist in determining the appropriate placement for an individual requiring EMS, CRT, or LE during a mental health crisis. If individuals are brought to the ED, care coordinators can use this tool to help providers determine if they would be better suited for care at the Clarity Center or in need of a hospital admission.

Outcomes, Measures, and Evaluation

Completion of this objective was measured through collection and review of the surveys before the deadline of the stakeholder meeting via zoom. As the surveys are qualitative in measure, no quantitative data needed to be analyzed, but rather the project writers evaluated via a comprehensive review of survey answers. Secondly, completion of the outreach tool by the project team and approval of the final version by the Clarity Center staff was required before the completion of the third objective below.

SMART Objective Two

The second objective for this project was to create a tool for mandated reporters within local schools to use during their assessment of an individual they feel may benefit from the Clarity Center. Because this center is created to be a facility for adolescents to older adults, it

was crucial to include school-aged individuals that will benefit from this type of care during a crisis event. This objective was measured in similar terms as the first objective above with a few variations; creation of a tool, including a written guide and graphic aide (chart), created through collaboration with Child and Family Services for local schools (mandated reporters) and the Clarity Center.

Data Analysis Approach

The first step in completing this objective was to reach out to local schools and mandated reporters to understand their current practices, gaps, and procedures when there is a need for legal reporting of an individual or situation. The research was then conducted to compare these current practices and what is legally required to determine what type of tool is most valuable and easy to use when needed. The project writers also continuously collaborated with Clarity Center staff to keep this project aligned with what is most beneficial to the facility. Following these meetings, a survey was provided to assess the needs of this department and the Clarity Center's needs for the best use of this tool moving forward. Along with the timeline of the first objective, this survey had a deadline to be completed and was one of the first steps within implementation of this project.

After research and the submission of the surveys were completed, multiple meetings with key stakeholders related to this objective were both conducted via Zoom and via phone and email correspondence to best accommodate each member's time and geographical location. A slide presentation was created with the results of the surveys and a proposal of the tool before the meeting to facilitate discussion of what is approved and what needed further changes moving forward. These meetings included the project writers, key members of the Clarity Center, and at multiple different leaders, including local school social workers and St. Louis County

supervisors within the county's Department of Child and Family Services. These meeting provided crucial information regarding the development of the outreach tool and what was needed for the tool's future success. Once all the key stakeholders approved a preliminary tool within the project, a final tool was created in the form of a flowchart that is easy to understand and use when needed to provide a step-by-step guide to determine the appropriate placement for the adolescent in need.

Outcomes, Measures, and Evaluation

Like objective one, outcomes were measured through qualitative data received through surveys and meetings with stakeholders. A comprehensive review of the survey answers and important topics discussed during the virtual conference was analyzed by the project writers and was considered while developing the outreach tool to accommodate all parties involved best. The second outcome that was measured is the development of the outreach tool itself and approval of the final version by the Clarity Center staff.

SMART Objective Three

The third objective in achieving the overarching goal of this project was to create and implement an educational outreach plan for the St. Louis County LE, EMS, CRT, and school district mandated reporters involved. As the project developed, local EDs were also found to benefit from education surrounding the Clarity Center and were included in the outreach education plan. The first two objectives needed to be completed before this section, as the tools created for each branch were included in the education. During the implementation of the initial two steps, outreach for each local group was included.

For objective three, all individuals who work with potential patients were informed on many aspects of the Clarity Center. These included its purpose, when it is appropriate to make a

referral to the center, and the tools used to determine which individuals may need their services. As St. Louis County currently does not have a mental health center, it is vital for those in the community working with individuals experiencing a mental health crisis to be aware and fully educated on the benefits of this facility. In this way, more people in need can be reached and receive adequate services.

Data Analysis Approach

An outreach plan for the public service professionals of St. Louis County included creating and disseminating an educational presentation to the sectors involved with potential Clarity Center patients. As the research and development of tools for assessing individuals experiencing a mental health crisis has been completed in objectives one and two, objective three consisted of educating those using these tools on how and when they are applicable. Much of each department were either unaware of this center or had little knowledge surrounding its future and it being an alternative to delivering these patients to emergency departments. Research has shown that LE, EMS, and other public service workers, are often not receiving education regarding appropriate mental health crisis treatment (Hector & Khey, 2018). Due to this, a comprehensive presentation to engage community professionals in the work of the Clarity Center was essential to its success.

A narrated slide presentation was chosen as a delivery method as each department could decide when the education would be delivered based upon their workflow. A timeline to complete the education was given to the department heads based upon the opening of the Clarity Center at the end of 2022. A brief history of the project and its purpose was included in the educational presentation to ensure an understanding of the facility itself. More detailed slides included the services the Clarity Center provides, the individuals who can be referred there, how

to use the assessment tools, and the importance of receiving proper mental health evaluation and treatment. The education was created in a way in such that it would be applicable at the time as well as for future community members that would benefit from the education moving forward.

Outcomes, Measures, and Evaluation

Objective three was based upon LE, EMS, Department of Child and Family Services for local schools, ED's, and CRTs receiving education on the Clarity Center, and the assessment tools, measures, and evaluations would be conducted in future research. Successful outcomes of this objective may be appraised via the usage of the Clarity Center (visits per day), referrals made to the center, and a decrease in ED mental health visits in the area. Due to the center not yet being open upon completion of this project, these outcomes would require additional projects post-opening of the center. A brief survey and attestation upon completion of the slide presentation was used as an immediate measure of the number of employees within the stakeholder groups that finished the education. The goal was be to have 80% of those involved in the care of this population complete the education. To keep the goal realistic, having a percentage of completion less than 100% was necessary, as the timeline was very succinct in order to be completed before the Clarity Center opens. For those unable to provide an attestation of completion, it was requested that they provide a plan for completion to project leaders.

Methodology and Analysis

Data analysis was completed as a means of inspecting and transforming data to understand the success of the project and identify useful information. The methodology used for this project included pre-implementation, implementation, and post-implementation.

Pre-Implementation

The pre-implementation phase consisted of several steps within the planning process. A review of literature and needs assessment was initially conducted to identify if this project was worth completing as well as to identify the usefulness within St. Louis County. After the review, the creation of a preliminary guide for EMS, LE, CRTs was designed to assist in determining who and when to bring individuals to the Clarity Center. ED coordinators could also use this tool after a patient has arrived to the ED for possible Clarity Center usage. A second preliminary guide was created as well for mandated reporters. A survey was produced to be given to all the key stakeholders on the preliminary guide for feedback and recommendation changes.

A mental health triage tool was also be created for easy identification of whether the individual is a high risk, moderate risk, or low risk and should be brought to the Clarity center versus the emergency department. A final attestation of the education was developed and given out after distributing the education to all departments involved in the St. Louis County area. Before meeting with stakeholders within this project, approval was granted through the College of Saint Scholastica's Institutional Review Board (IRB). After approval, steps were completed to set up meetings with lead stakeholders within each department. Upon these meetings, further contacts were added, such as local ED leaders and the Department of Child and Family Services.

Implementation

The implementation stage of the clinical project revolved around applying the actions planned during pre-implementation. Once IRB approval was given (Appendix C), this phase began. During implementation, the preliminary tools created specifically for the key stakeholders was sent to the Clarity Center staff, as well as the project chair, to make recommendations for improvements. Once this had been completed, they were then sent to the teams that would be

utilizing them in real-time to review and complete surveys based on feedback for the outreach tools. Once all surveys were retrieved, the clinical project team reviewed the feedback and made changes to the tools based on their responses. After the outreach tools were altered and ready for use, the clinical team created educational PowerPoints with voiceover presentations for each group to distribute to their staff. After the education, there were attestation surveys to ensure at least 80% of the staff were able to get the information about the Clarity Center.

Post-Implementation

During the post-implementation phase of the Clarity Center outreach project, there was little data collection aside from the percentage of attestation through the educational surveys. However, future work with the Clarity Center will require data analysis to determine how the facility has decreased ED use for mental health patients that could be seen in outpatient settings. Other future research on the Clarity Center's benefit to the community would include this data methodology in determining when patients are brought there, who is utilizing the services, and if ED use is declining overall.

Ethical Considerations

Despite this project not using human subjects for research purposes, to gain approval from the IRB a consent form was required. Ethical considerations of the Clarity Center itself revolve around the populations it is intended to serve, all residing in the large Arrowhead Region of Minnesota. This is a substantial area with many diverse communities, both urban and rural. Rural populations tend to have lower socioeconomic statuses, higher numbers of comorbid medical conditions, and are more likely to experience mental illnesses than their urban counterparts (Erwin et al., 2020). Due to these disparities, rural patients must have access to appropriate medical and mental health services. The Clarity Center will be physically located in

Duluth, which is a more urban area of the county. As distance may be a barrier to the outlying populations, the Clarity Center will include telemedicine to serve people virtually. Telemedicine may not be appropriate for everyone in rural areas, however, especially for those who do not have stable Wi-Fi access or proper technology/computers to allow for virtual medical visits (Erwin et al., 2020).

Work Plan

The goal for the timeline of this project was to be completed over a maximum of 12 weeks so the Clarity Center can move forward in its next steps to open the center. With a tight timeline of 12 weeks, staying aligned with each of the steps on time was significant.

Project Timeline

Starting with week one of the project implementation, two surveys were sent out to key stakeholders of the project: One to leaders of local EMS/LE chiefs, and one to leaders at local schools and the Department of Child and Family Services in St. Louis County. Before the implementation stage, these surveys were completed and a final outreach tool was approved by Clarity Center staff. Along with these surveys, a brief introduction of the Clarity Center was included, to provide the reasoning behind the surveys as well as some background information about the project to the key stakeholders.

During week four, survey results were due from the stakeholders and were analyzed during week six by project writers and Clarity Center lead. At week six, multiple meetings with the Clarity Center staff, local chiefs of LE/EMS, and local school leaders were held via Zoom to discuss the results of surveys as well as review the preliminary tool created by project leaders. Any recommendations or changes that needed to be made to the tool were completed by week eight.

At the end of week eight, final approval of the outreach tool was made by Clarity Center staff. At this time, an educational tutorial of the tool was completed via a narrated slide presentation and submitted to local leaders to share with their staff. Alongside the educational presentation, a post-survey was attached. A deadline of four weeks later (week 12) was requested for the return of post-education surveys with the attestation of completion to project writers. By the end of week 12, a list was compiled and submitted to the Clarity Center staff showing that the education had been completed, or planned for completion, by the LE, EMS, CRT, ED coordinators, and school staff. This was the final measurement of success following the completion of the outreach tool, as the Clarity Center will still not be operational at this time.

Results from Data Collection

After dissemination of the educational material and community outreach tools, each party had four weeks to complete the education and submit an attestation of completion survey. There was a total of five questions on the survey, including qualitative data on how helpful this education was in learning about the Clarity Center, if participants felt they benefited from the education, additional information they wished would have been included, an attestation of completion, and any additional comments they wished to include.

After the four-week deadline of completing this education, a total of 94 participants out of 485 sent out completed the education. A total of 54.5% of the participants felt that this education was helpful regarding learning about the Clarity Center. As well as 45.5% felt that they learned all they needed to know about the Clarity Center. Questions regarding additional information the participants wished were answered in the education consisted of general particulars including access to mental health support, chemical dependency programs, age groups that will be cared for, and what type of providers will there be. There were a few

questions about what transportation will look like to and from emergency departments or from individuals' homes. A few questioned how referrals would be made as well as what wait times would look like for patients suffering during a crisis. Additionally, questions about how this center would be funded with concerns about taxpayers putting up the cost for this type of facility. Lastly, some asked what type of professional disciplines will staff the Clarity Center and what will staff training entail.

The last question of the survey completed by each participant was not required but was left for individuals to leave any additional comments they had. Out of eight responses, three responses felt that this material was a good starting point for educating about the Clarity Center but felt moving forward they would need to get more information regarding the specifics. Three responses were very pleased with the material and the usage of the up-and-coming Clarity Center as a much-needed resource within St. Louis County. Two responses discussed how the Clarity Center is a very helpful resource for mental health assistance in the area, but as LE or EMS, they are required by law to bring individuals to the emergency department due to liability.

Discussion and Data Interpretation

In total, 19.4% of participants completed the post-survey and attestation of completion that was provided along with the presentation. The goal for the project was to have 80% attestation of completion within the short timeframe of data collection. Unfortunately, as many of the participants that received the education had received it in a group setting, many members did not complete the post-survey or attestation form. Additionally, there were limitations due to the survey form not being accessible by many participants due to lack of access to Google Forms, where the survey was created. This led to the skewed attestation of completion numbers in comparison to the estimated amount that completed the education. The nature of the project

results was qualitative. The actual number of participants that completed the attestation is not accurate in comparison to the number of participants that received the education to date, or in the future as it continues to be disseminated to the community. In retrospect, it would have been beneficial to have collected a specific number of participants at each meeting in which the presentations were presented, that way a more accurate final number could be provided. If time and scheduling had permitted, it would have been advantageous to have a project team member available to answer questions at each presentation rather than providing a narrated presentation.

As the survey results showed, most participants found the education to be helpful. Additionally, a verbal report from Diane, the project partner within the Clarity Center, reported a positive response to the presentation provided to staff and community stakeholders at their virtual meeting in which the presentation was presented to the group. The survey results did provide for additional learning regarding continued education needs by members of the community as the center comes closer to its opening date. Due to this, it may be beneficial to continue future projects concerning detailed questions provided by the post-survey results, such as providers and programs that will be available to patients upon opening.

Limitations

There were a series of limitations to discuss regarding this project. Limitations included a short window of time for this large group of participants to complete the educational material. For example, it was found that any new material that needed to be sent out to the schools had to go through various people, and with their busy schedules, finding a time to complete the education was found to be difficult. In addition, at the time of the release of education and tools, LE was dealing with a large sentinel event within St. Louis County, as well as new leadership that was unaware of this project. Both events made the distribution of material difficult.

A second large limitation was the use of Google Forms for the survey platform. To use this survey, participants were required to use their personal Gmail accounts to access, and many did not feel comfortable doing so, so a second survey was created. Having the second survey link not directly attached to the education itself created a reason to believe that some who may have completed the education did not also complete the survey, skewing the results.

A third limitation that was only found in a handful of individuals was an inability to open and play the education. Whether the problem was in computer glitches or lack of computer competency, there may have been more participants completing the education if it was played for them rather than getting them to open the education themselves.

Dissemination

The project presentation was completed and provided to The Clarity Center and was presented in a large group meeting. Additionally, information from the surveys collected was also provided to Diane, the key stakeholder with The Clarity Center. The project poster, a 3-Minute Thesis Presentation (3MT), and manuscript paper were completed and submitted to the College of St. Scholastica for review. Overall dissemination of the results of the survey will be provided to the Clarity Center for future projects that may benefit the center as it continues development and opens for service to the community.

Conclusion

Mental illness crises within communities throughout America are rising, yet local crisis care is lacking (Hogan & Goldman, 2021). In the US, the current practice for dealing with a patient in a mental health crisis is fragmented, leading to overutilization of emergency room visits, escalated costs, and poor patient outcomes. This literature review, and results from the Bridging Health Duluth Survey (Kjos et al., 2016), show a significant need for additional crisis

care centers and identification of ways to manage this area of need properly. The Clarity Center is a joint initiative created to serve the growing numbers of behavioral and mental health patients in the Arrowhead Region of Minnesota. This facility's vision is to provide whole-person care by professionals, in a non-intimidating environment, to those who can benefit from mental health crisis care.

As this is a large undertaking requiring significant collaboration, this current project focused on creating and disseminating education on the Clarity Center for each stakeholder group. The education's purpose was to inform those in the community who interact with mental health patients, including LE, EMS, and social workers, what the center is, who could benefit from its services, and when it would be appropriate to refer individuals. With millions of Americans affected by mental health crises each year, finding ways to increase access to care is crucial. Outpatient mental health crisis centers like the Clarity Center are one piece to the puzzle for providing efficient and adequate mental health care to the community.

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Appendix A

Literature Review Evidence Table

Reference	**Purpose/ Question**	**Design**	**Sample**	**Intervention**	**Results**	**Notes**
Aby, M. (2019). A case study of implementing grant-funded integrated care in a community mental health center. *The Journal of Behavioral Health Services & Research*, *47*(2), 293–308.https://doi.org/10.1007/s11414-019-09671-7	To determine the effects of adding primary care to a community mental health clinic utilizing federal grants.	Case studies were utilized as the study was determining a phenomenon during real-life situations in the clinic. Semi-structured interviews, staff observations, and agency documents were used.	Ten individual interviews were used that were obtained from individuals intimately involved in the implementation, designing, and sustaining of integrated care at the clinic. One outpatient team was also selected for in-depth	Primary care collocated with mental health care in a mental health community center.	Via interviews and observations, staff determined patients were more likely to adhere to their medications and had positive health outcomes.	This is a small sampling from one clinic, however, it describes one of the main visions of the Clarity Project: to integrate mental health care with primary care.

			observations on their care delivery.			

Amirsadri, A., Pizzuti, A., Smith, D., Duckett, D., & Arfken, C. L. (2017). Training for direct support staff at group homes for people with chronic mental illness. *Community Mental Health Journal*, *54*(1), 54–57.https://doi.org/10.1007/s10597-017-0152-5	This study sought to examine how a training program for staff at six different group homes containing patients with mental health disorders affected patient complaints, hospital admissions, psychiatric stays, and emergency calls	Pre- and post-design was utilized. The data gathered included the number of 911 calls, hospitalizations, safety and health emergencies, resident complaints, and legal incidences three months before the course and three months after the resolution	Six group homes were included with 13 staff undergoing training.	The six-week training program revolved around compassionate care, adult learning principles, role-playing, and contained low literacy requirements. Each week of the curriculum built upon the previous week with a goal of training the staff in de-escalation techniques, communication skills and body language, as well as building rapport with the residents	An independent contractor reviewed these reports and found that most of these adverse events decreased by 41.7% to 64% over the three months post-training program	This study can be helpful for the Clarity Project as the staff there may need specialized training for de-escalating patients in a mental health crisis

Brennaman, L. (2012). Crisis emergencies for individuals with severe, persistent mental illnesses: A situation- specific theory. *Archives of Psychiatric Nursing, 26*(4), 251-260. https://doi.org/10.1016/j.apnu.2011.11.001	Explores Ball's middle range theory on crisis care for patients with severe, persistent mental illnesses (SPMI) and situation-specific theory on crisis emergencies.	n/a - this is an article that explains the theory	n/a	Implementation of Ball's crisis theory in nursing	This theory is appropriate to apply to nursing within crisis care, practice, policy, and research.	Older article, though it explains crisis theory well as well as provides great background information that is relevant to the Clarity Center Project.

Comartin, E. B., Swanson, L., & Kubiak, S. (2019). Mental health crisis location and police transportation decisions: The impact of crisis intervention team training on crisis center utilization. *Journal of Contemporary Criminal Justice, 35*(2), 241–260.https://doi.org/10.1177/1043986219836595	To evaluate educating law enforcement officers in transporting individuals having a mental health crisis to mental health crisis centers as opposed to the ED. Also to evaluate the effect this had on ED usage for this population after education has been given.	The researchers analyzed crisis call reports in a Midwestern county, as well as the amount of ED usage for these patients before and after law enforcement received education.	Law enforcement officers in a Midwestern county (61 of the 312 received education on crisis intervention).	Crisis intervention training for law enforcement.	Crisis intervention trained officers were more likely to transport patients to a crisis center when appropriate.	1,617 calls during the time period were involved with mental health crises, these were all included in the study.

Cummngs, J. R., Smith, J. L., Cullen, S. W., Marcus, S. C. (2021). The changing landscape of Community mental health care: Availability of treatment services in national data, 2010-2017. *Psychiatric Services, 72*(2), 204-208. https://doi.org/10.1176/appi.ps.201900546	To describe changes in crisis services availability between 2010 and 2017.	Descriptive study	6505 outpatient and 2038 inpatient facilities in 2010 and 8805 outpatient and 2698 inpatient facilities in 2017.	n/a - descriptive study	Number of outpatient facilities for crisis care actually decreased (numbers only increased for substance abuse treatment facilities, not for crisis care). The findings from the study conclude that services have not adequately adjusted to care for the growing need of crisis care.	This study would aid throughout the paper to explain why crisis care is needed and that it is currently lacking.

Digel Vandyk, A., Young, L., MacPhee, C., & Gillis, K. (2017). Exploring the experiences of persons who frequently visit the emergency department for mental health-related reasons. *Qualitative Health Research*, *28*(4), 587–599.https://doi.org/10.1177/1049732317746382	To explore the experiences of a person who frequently visits the emergency department for mental health related reasons	Qualitative study	10 participants with 12 or more visits to the emergency department within one year.	n/a, qualitative study through interviews	Participants felt disrespected, rushed, and treated poorly by the health care providers within the emergency department. They all felt that their visit to the ED was necessary and unavoidable.	The researchers recommend a more tailored approach to treating mental health rather than a one-size-fits-all strategy.

Ee, C., Lake, J., Firth, J., Hargraves, F., de Manincor, M., Meade, T., Marx, W., & Sarris, J. (2020). An integrative collaborative care model for people with mental illness and physical comorbidities. *International Journal of Mental Health Systems, 14*(1), 1–16.https://doi.org/10.1186/s13033-020-00410-6	This article describes the collaborative care model.	N/A- describes a care model.	N/A	This theory proposes that by incorporating evidence-based integrative medicine interventions, providers may be more able to address mental health conditions that coincide with medical conditions.	An integrative clinical practice would be the intended outcome for the Collaborative Care Model.	This care model is significant for the Clarity Project as an emphasis will be on both physical and mental health needs.

Heyland, M., & Johnson, M. (2017). Evaluating an alternative to the emergency department for adults in mental health crisis. *Issues in Mental Health Nursing*, *38*(7), 557–561.https://doi.org/10.1080/01612840.2017.1300841	The purpose for this project was to evaluate a model of crisis care as a community - based alternative to the ED for individuals going through a mental health crisis	N/A this is a model for crisis center care	Patients, 18 years and older, who presented to the crisis respite program May 1 to June 26, 2015	A crisis respite program was created for patients who may be experiencing suicidal thoughts, panic attacks, severe depressive symptoms, and psychotic symptoms and were offered a series of interventions and talking with a peer counselor.	Within the 30-day trial period, 94% did not require ED use. The average cost per visit at the respite center was $269 versus the average cost at the ED was $2500. 258 out of 262 were able to sufficiently relive their crisis state and able to return to the community without additional care in the ED.	These programs offer individuals a safe space during a crisis. This model was found to be a cost-saving and clinically indicated alternative to the ED.

Kubiak, S., Comartin, E., Milanovic, E., Bybee, D., Tillander, E., Rabaut, C., Bisson, H., Dunn, L. M., Bouchard, M. J., Hill, T., & Schneider, S. (2017). Countywide implementation of crisis intervention teams: Multiple models, measures and sustained outcomes. *Behavioral Sciences & The Law, 25*(5), 456-569. https://doi.org/10.1002/bsl.2305	To assess needs and evaluate the efforts required to enhance mental health crisis care delivery at a countywide level rather than at a small city level. The focus is on CIT training for police officers.	Case study design	79 officers in training, 67 completing both pre- and post-tests. 919 police encounters.	Pre- and post- tests after CIT training.	CIT Training outcomes were measured and it was found that changes in officer perception of those struggling with a mental health crisis, decreases in drop offs at mental health crisis centers (specifically emergency departments) and increasing community treatment services.	

Larsen, C. A., McKay, A. K., & Van Steinburg, P. J. (2020). Creating a flexible outpatient mental health transitions program. *Issues with Mental Health Nursing*, *41*(6), 500–505.https://doi.org/10.1080/01612840.2019.1681566	The purpose of this article was to design a program to address the gaps in treatment for an individual going through a mental health crisis.	N/a this is a model for crisis center care	N/a this is a model rather than an implementation	The Transitions Program is a multidisciplinary approach that allows for assessment and reassessment to meet the patient's needs within the hospital. It not only involves active participation with the team but as well as the patient. It allows for frequent review of patients' status, progress, and concerns.	This program resulted in lower inpatient stay, reduced readmissions, improvements in assessment scores, and able to meet patient goals for improvement.	Development of a flexible program to meet the needs of this vulnerable population is within the brainstorming session of implementation of this project in order to deliver a whole person approach and meet the needs of these patients.

Lee, S., Herrin, J., Bobo, W. V., Johnson, R., Sangaralingham, L. R., & Campbell, R. L. (2017). Predictors of return visits among insured emergency department mental health and substance abuse patients, 2005-2013. *Western Journal of Emergency Medicine*, *18*(5), 884–893.https://doi.org/10.5811/westjem.2017.6.33850	The purpose is to identify patterns and risk factors of early-return ED visits and inpatient admissions in mental health and substance abuse related ED visits.	Retrospective cohort study	A total of 350,406 individuals qualified for an index ED visit	The researchers identified the frequencies of each risk factor and compared between groups based on the study outcomes.	A total of 49,672 (14.2%) had a return visit to the ED or had a hospitalization within 30 days following discharge. Average time to the next ED visit or inpatient admission was nine days. Increased age, chronic medical comorbidities, and prior ED utilization were all associated with early return visits within 30 days.	This study identifies risk factors associated with return visits for acute care. There is a need to explore additional solutions to improve care for patients with mental health or substance abuse conditions after ED evaluation.

Lewis, A. K., Harding, K. E., Snowdon, D. A., & Taylor, N. F. (2018). Reducing wait time from referral to first visit for community outpatient services may contribute to better health outcomes: A systematic review. *BMC Health Services Research, 18*(1), 1-14. https://doi.org/10.1186/s12913-01803669-6 -	Investigate patient outcomes related to reducing wait times for outpatient care	Systematic review	14 studies including 69,606 adult patients	n/a	Reducing wait times improves overall patient outcomes, though more research is needed on psych conditions, quality of life improvements, and patient experience outcomes.	Focuses on medical needs, but is applicable to overall patient outcome improvement with less wait time. Would be applicable to the implementation or outcomes section.

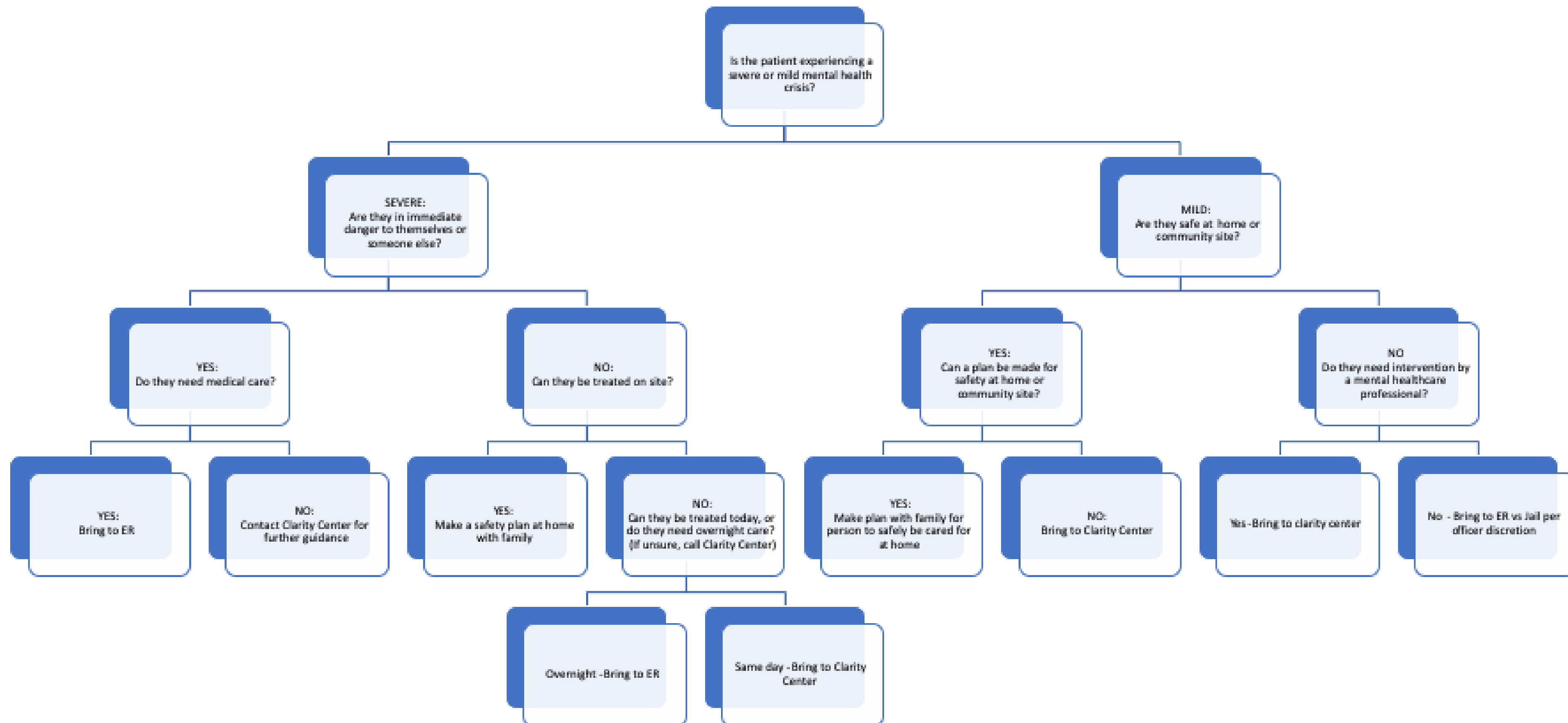
Rossi, L. M., & Cid, M. F. (2019). Adolescents, mental health and crisis: The story told by relatives. *Brazilian Journal of Occupational Therapy*, *27*(4), 734–742.https://doi.org/10.4322/2526-8910.ctoAO1811	To gain the understanding of family members of adolescence about crisis situations and the route taken in the search for care.	Thematic analysis	Five family members of adolescents linked to the Center for Psychosocial and Adolescence Care	n/a qualitative research to identify themes after a crisis event	Family members found difficulties during encounters with professionals and services which potentially could have facilitated understanding of that situation.	This study offers data about the understanding and perceptions the family members have when their adolescent may be going through a mental health crisis.

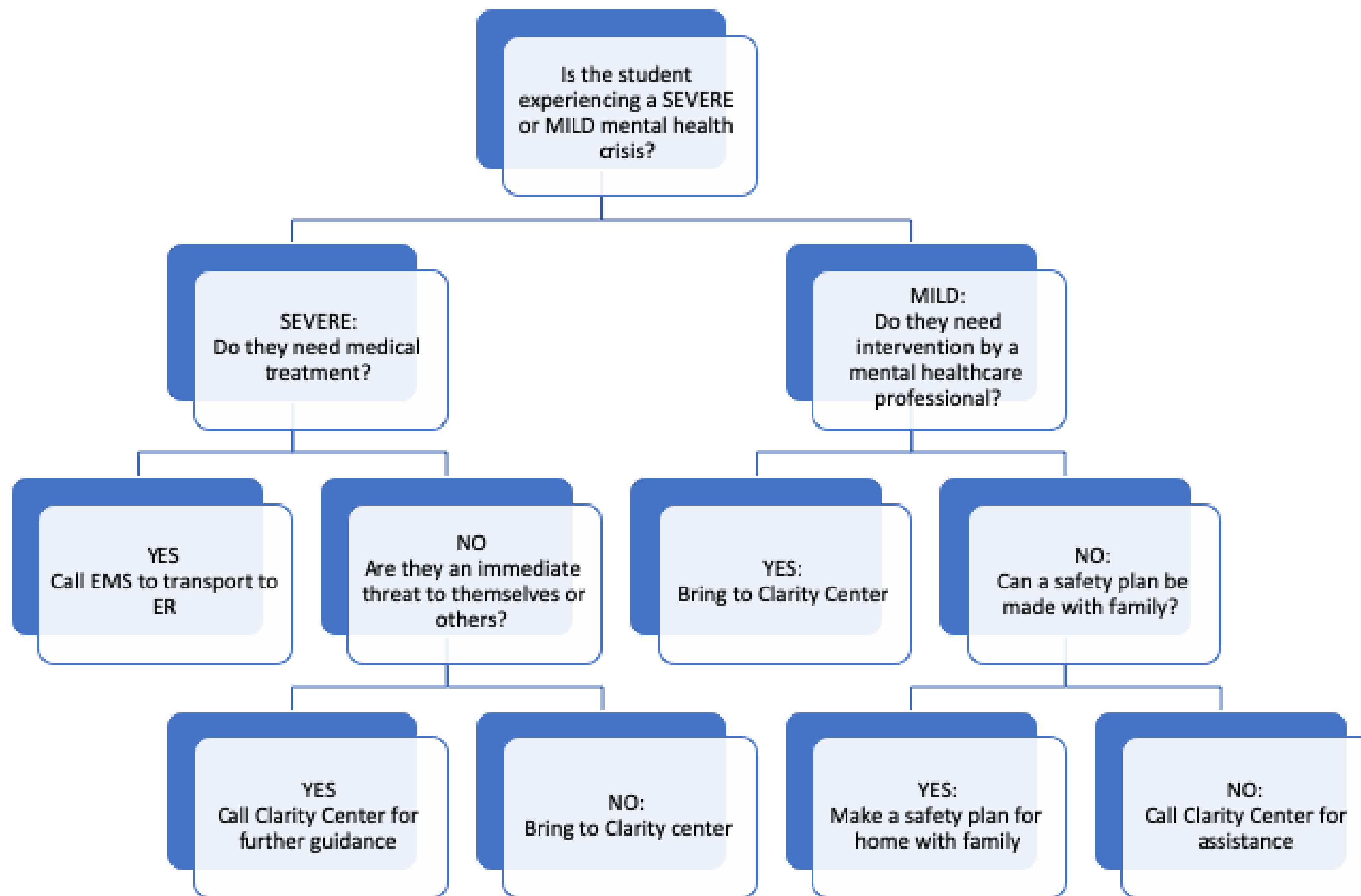
Swanson, C., Thompson, A., Valentz, R., Doerner, L., & Jezek, K. (2019). Theory of nursing for the whole person. *Journal of Christian Nursing, 36*(4), 222–227. https://doi.org/10.1097/cnj.0000000000000656	Describes the Theory of Nursing for the Whole Person (TNWP). Five conceptual triads for the framework are explained: 1) body, mind, and spirit; 2) individual, family, and community; 3) internal and external environments and their interactions; 4) health, illness, and wholeness; and 5)	N/A, this article is describing a nursing theory.	N/A	N/A, no specific intervention, however the article goes into detail how this theory can be applied to nursing practice.	This article describes the benefits of utilizing this nursing theory to care for individuals, families, and communities cross-culturally.	Essential nursing theory for the Clarity Project as it emphasizes treating patients as unique beings, taking into consideration the culture and context in which they are living. The Clarity Project will involve not only mental health providers, but medical as well.

	promotion, maintenance, and restoration of health.					

Appendix B

Flowcharts for Law Enforcement/EMS and Schools




Is the student experiencing a SEVERE or MILD mental health crisis?
SEVERE: Do they need medical treatment?
MILD: Do they need intervention by a mental healthcare professional?
YES Call EMS to transport to ER
NO Are they an immediate threat to themselves or others?
YES: Bring to Clarity Center
NO: Can a safety plan be made with family?
YES Call Clarity Center for further guidance
NO: Bring to Clarity center
YES: Make a safety plan for home with family
NO: Call Clarity Center for assistance

MENTAL HEALTH TRIAGE TOOL

FOR LAW ENFORCEMENT & EMS

High Risk: Bring to Emergency Department

Moderate to Mild Risk: Bring to Clarity Center for Wellbeing

Low Risk: In home plan, give resources for Clarity Center

HIGH RISK PATIENTS	MODERATE TO MILD	LOW RISK PATIENTS
Current actions endangering self/others	Suicidal ideation with/without plan	Stable, requesting resources
Possession of weapon	Ongoing history of self-harm, risk behaviors	Requiring mental health services without immediate intervention needed at this time
Severe psychosis, delirium	Thought disturbances, early psychosis/delirium	
Current overdose	Mood disorders/increasing symptoms of mental condition	

Appendix C

IRB Approval Letter

Institutional Review Board

DATE:	January 13, 2022
TO:	Kelsey Trepczyk and [*Dr. Sherry Johnson*]
FROM:	The College of St. Scholastica, Institutional Review Board
RE:	Developing a Community Model to Reduce Emergency Visits for Mental Health Care: Quality Improvement Project
SUBMISSION TYPE:	New Project
ACTION:	NOT RESEARCH
REVIEW TYPE:	Expedited Review

Thank you for your submission of materials for your project. The College of St. Scholastica Institutional Review Board has reviewed your application and determined that the proposed activity does not meet the definition of research under the Code of Federal Regulations 45 Part 46.102 provided by the Department of Health and Human Services. As such, your project does not require ongoing review or approval from The College of St. Scholastica Institutional Review Board. We will retain a copy of this correspondence within our records.

Any modification to your project procedures that could change the determination of "not research" must be submitted to the IRB before implementation.

When your project is complete, submit a protocol closure form by following these steps: (1) log in to your project in IRBNet, then create a new package (not project), (2) download the protocol closure form from the Forms and Templates menu, (3) complete, sign and submit the protocol closure form.

If you have any questions, please contact Nicole Nowak through the project email function in IRBNet or nnowaksaenz@css.edu. Please include your study title and reference number in all correspondence with the IRB office.

Best regards,

Nicole T. Nowak

Nicole T. Nowak, Ph.D.
Chair, Institutional Review Board

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