Emergency Room Enhancement

Participant Focus Group Findings

June 2018 - Results from ERE Year 5

EMERGENCY ROOM ENHANCEMENT

Improving Access to Behavioral Health Care

UMSL | MIMH
Missouri Institute of Mental Health

MISSOURI DEPARTMENT OF MENTAL HEALTH

DBH
Division of Behavioral Health

MISSOURI COALITION FOR COMMUNITY BEHAVIORAL HEALTHCARE

Emergency Room Enhancement
Program Participant Focus Group Findings

Consistent with past years' evaluations of the Emergency Room Enhancement (ERE) program, the Missouri Institute of Health (MIMH) conducted focus groups with program participants from the various sites to learn first-hand from clients' experiences with the program, perceptions of program quality, personal outcomes, and suggestions for possible improvements. A total of 8 focus groups were held in March and April, 2018 across seven ERE implementation sites, yielding a total of 71 focus group participants.

Key focus group (FG) findings:

- When attempting to access help for behavioral health issues prior to enrollment in the ERE program, participants report dissatisfaction with treatment by emergency department (ED) staff – **feeling judged, unimportant, and tolerated rather than cared for.** They recommend education and training on mental illness and substance use disorders for providers and staff alike to help **mitigate the stigma** they feel and subsequently improve care for themselves and others.
- The majority of responses indicate **hospitals/EDs as the primary referral source to ERE**. Additional key sources are other agencies/shelters and providers, law enforcement, and the corrections system.
- Client **suggestions for improving the ERE referral process** are to **educate ED staff** and the community about the program and the program's importance in addressing behavioral health issues, and to **strengthen a "warm hand-off"** model to ensure that referred patients make it to their first appointment with the community mental health centers (CMHC).
- **The services indicated as most valuable** to participants are coordination of services and resources, social support & motivation, and transportation - provided via **Case Management**; and **Behavioral Health Resources** including psychiatric medications, psychiatrists, and counseling/therapy – both individual and in group format, including meetings.
- Most respondents reported feeling **comfortable asking questions and taking part in their own treatment planning and goal-setting.**
- Primary **Gaps in Service** are unmet **psychiatric and medication needs**, and **housing.**
- Positive experiences with the ERE program center on appreciation for ERE program personnel being **understanding, non-judgmental, and genuinely caring**; numerous types of **wrap-around support from case managers** and other staff, and enthusiasm about seeing progress toward reaching their own treatment goals and "getting our lives back together."
- Negative stories regarding ERE experiences were relatively few but involved **poor treatment from staff** – disrespect, non-caring attitudes, etc. – as well as limited staffing/resources and **lack of behavioral health support outside normal business hours**.
- The **#1 reported plan of action** when faced with future behavioral health concerns or crises **is to contact their caseworker or call the agency crisis line.**
- **Participants (93.3%) affirmed positive outcomes** including reductions in ED visits for behavioral health issues, decreased involvement with the criminal system and incarcerations, lessening of symptoms, and better relationships with family and others.
- The majority (69.2%) of participant **comments to the Governor** and state legislators comprised **praise for the ERE program** with calls for **increased funding and promotion of it.** Another 23% highlighted the need for **enhanced mental health resources** in Missouri.

Introduction

The 2018 ERE Focus Group template consisted of open-ended questions pertaining to participant experiences prior to and during their affiliation with the ERE partnering agency, including recollections of emergency department visits prompted by substance use issues and/or mental/behavioral disorders. Additional questions pertained to clients' experience of treatment and assistance once engaged with the ERE program/agency and appropriate behavioral health services including those provided through ERE affiliated agencies and providers. Clients shared views on services most valuable in terms of their current stage of recovery and functioning, suggestions for ways to improve client services and assistance, specific skills they have attained due to their participation in the program, and opinions and suggestions for the governor and state legislature regarding the ERE program overall. This qualitative focus group dataset, together with qualitative data from our ERE collaborator survey, expands upon quantitative participant outcomes reported throughout the year (i.e., decreases in ER visits, hospitalizations, homelessness, unemployment and law enforcement contacts). Focus group findings augment and strengthen the overall assessment of the program's impact by providing rich and detailed accounts of client experiences and perceptions. This mixed-method utilization of key quantitative and qualitative analyses enables a more comprehensive approach toward strategic program adaptations and further development.

Methods

FG Script and Questions

Based on facilitation and findings from last year's FGs, the MIMH evaluation team made strategic revisions to the template/questions used previously, and obtained approval from the Missouri Department of Mental Health, Division of Behavioral Health. Subsequently, the full focus group protocol and questions were approved by the Institutional Review Board (IRB) at the University of Missouri – St. Louis.

Sampling and Recruitment

Participant eligibility was initially defined as clients at all sites who were initially engaged in the ERE program during the fiscal year of 2018 (FY18) and had a 3-month follow-up form completed. Lists of participants meeting these criteria were sent from MIMH to ERE program coordinators at each site. Coordinators used this list to enlist 8-12 focus group participants per site. Given the nature of this population – i.e., struggling with serious mental health and substance use disorders, as well as unstable housing, work, etc. - if a site coordinator was unsuccessful in recruiting at least 8 FG participants, MIMH generated a broader list including all consumers at that location engaged in ERE since the beginning of FY18, whether or not they had completed a 3-month follow-up form. This occurred with 4 of the 7 sites, and all but one (who had several drop-outs on the day of the FG) was able to provide the targeted 8-12 participants.

Data Collection/Focus Group Facilitation

Verbal consent to be included in the audio recorded focus group was required for each participant and verified by the facilitators before beginning each focus group. As compensation for their time and sharing, each participant received lunch and a $50 gift card of their choice for Walmart or Walgreens. Each focus group was facilitated by two MIMH ERE project coordinators including at least one with clinical training to address any behavioral health concerns that could arise during the discussion. As one facilitator led the discussion, the other took notes, asked additional questions for clarification, and aided in providing a supportive environment to elicit input from participants. **During March and April, 2018, eight focus groups were held, yielding a total of 71 participants, a 22% increase from last year's sample (Table 1).** Because Mark Twain Behavioral Health serves a large geographic, rural area, two focus groups were conducted in this region to allow participants from both Kirksville and Hannibal to be represented in the data.

Table 1. Focus Group Participation by Site

Site	Date Conducted	# Participants
STL/Eastern Region | Behavioral Health Network	March 21, 2018	13
Poplar Bluff | Family Counseling Center	March 28, 2018	11
Springfield | Burrell Behavioral Health	April 10, 2018	9
Rolla | Pathways Behavioral Health	April 11, 2018	13
Hannibal | Mark Twain Behavioral Health	April 17, 2018	7
Kirksville | Mark Twain Behavioral Health	April 18, 2018	6
Kansas City | ReDiscover	April 26, 2018	8
Columbia | Burrell Behavioral Health	April 27, 2018	4
		Total = 71

Data Preparation and Analysis

Audio recordings from each focus group were transcribed and relevant notes from facilitators taken at the time of the focus groups were incorporated into final transcripts then uploaded into the online qualitative data management and analysis application, Dedoose (Version 8.0.42). Dedoose facilitates collaborative coding and a dynamic interpretive process of consensus formation and inter-rater reliability via a memo system for documenting decisions and analytic reminders to assure transparency in data interpretation and coding. Two MIMH qualitative researchers coded responses from 8 focus group transcripts separately but systematically (codes=211; excerpts=979), assigning a priori (pre-set) root codes as well as sub-codes and additional root codes for emergent themes that naturally presented during FG conversations. Coders reviewed and edited each other's work, met regularly for consultation, and engaged in ongoing dialogue to ensure accuracy/validity and consistency/reliability in data preparation for analyses. Excerpting, coding, cleaning and analyses were completed using Dedoose and MS Excel per protocols outlined by Saldaña, 2009 and informed by Zhao et al, 2016.

Results

Following are results presented in the general order of the **ERE Script and Questions for Focus Group with Participants 2018** document (see Appendix A) which guided these discussions.

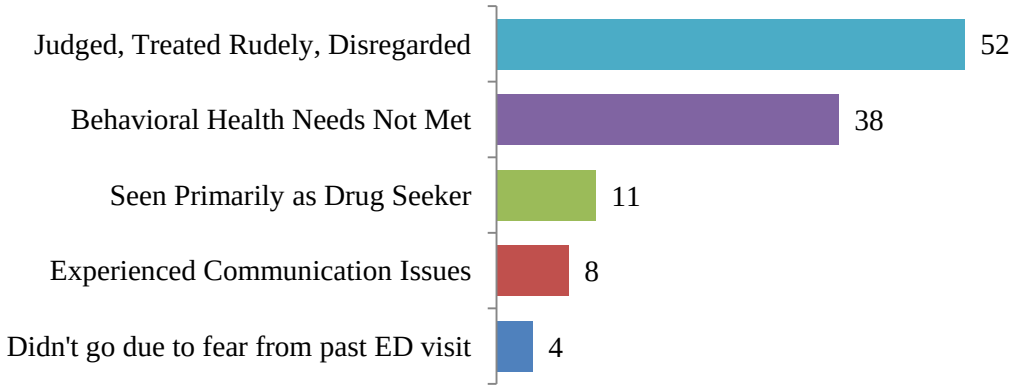
1) **Experiences in the Emergency Department prior to ERE engagement;**
2) **ERE referral process and experiences with program engagement;**
3) **Tenure in the ERE program;**
4) **Services provided through the ERE program**
5) **Most valuable services in regard to treatment goals;**
6) **Autonomy and partnership in treatment plan and goals;**
7) **Gaps in services/unmet needs;**
8) **Positive experiences with the ERE program;**
9) **Negative experiences with the ERE program;**
10) **Plan for addressing future behavioral health concerns or crises;**
11) **Coping skills learned in the ERE program;**
12) **ERE impact on client outcomes;**
13) **Recommendations for the governor/state legislators**

1. <u>Experience in the Emergency Department prior to ERE Engagement</u>

When asked to share experiences in the ED when they sought help with behavioral health issues *prior* to their involvement with the behavioral health agency and ERE services, participants shared 113 comments with **15 describing positive experiences, 8 of which were specifically attributed to their ERE engagement while in the ED** (example: "I had a really good experience in concern with what you're talking about. I went to [the hospital] and…I was suicidal when I walked in but I also had substance abuse issues and when I was there, somebody from [CMHC], a guy, [Case Mgr.]

came and visited me. I think they do that now. He offered to send me to treatment and he got me a bed and everything else."). Notably, 85 (75%) of excerpts portrayed ***negative ED experiences*** and included feelings of "being judged" (*n*=31) and/or "treated rudely as if I don't matter" (n=21), "being seen primarily as a drug seeker" (n=11), ED staff lacking knowledge of mental illness and/or substance use disorders (n=4), having communication issues in the ED resulting in poor service or bad referrals, resistance to going to the ED based on fear from past experiences (n=4), and overall, behavioral health needs not being met by the ED (n=38). Figure 1 represents these coded excerpts.

Figure 1. Themes Related to Negative Experiences in ED prior to ERE Engagement (*n* = 113 coded excerpts)



The following are exemplary quotes within each of the top four themes that emerged regarding participants' negative experiences in the ED when the presented with behavioral health issues prior to ERE engagement.

Felt Judged, Treated Rudely, Marginalized (n = 52)

- *"Pretty much just like you're nothing to them. They're above you.* ***You're wasting their time…but they're not going to do anything to fix it.*** *They could be seeing somebody else instead of seeing you."*
- ***"They treat you like you're a drug addict,*** *like you're less than human, like you're trash pretty much, like they don't want you there, exactly. They treat you like you're crazy."*
- *"You go in there with an anxiety attack* ***their idea of helping is just basically sitting you in a room and say wait.*** *If you don't like it, oh well too bad. Suck it up."*
- ***"Most ERs don't help.*** *They treat you like kaka when you go, like you're a drug addict. When I went I was like, well I've got a problem—substance abuse, I'm depressed, I'm this and I'm that—they let me sit there for three hours."*

Released from ED with Behavioral Health Needs Not Met (n = 38)

- *"I went and they didn't help me at all.* ***I went in for attempted suicide****…shot myself with a shotgun and blew a hole through the front, out the back. They didn't so much as do anything. Nothing…nobody come up, said anything. I was there; I got fixed and out the door I went. I went through that for … probably three years… in and out, but* ***nobody ever talked to me about what happened, why, or nothing, absolutely nothing."***
- *"I was told something totally different when I was being discharged before I was actually even admitted, which I wasn't admitted. I just didn't understand that whole situation… it was the nurse that was working back there doing intake. She went and was saying stuff towards the counselor and going back to the psychiatrist before he had already had a preconceived ideas brought to him about their own personal opinion before he could actually assess me. I didn't have my psych meds with me. I wasn't medicated. I didn't have any of my medicine. I thought I better bring it up…****I'd hate to see somebody else get treated in that manner because that made me a lot worse off… I was worse than even before I'd got there after that."***

Treated primarily as a Drug Seeker (n = 11)

- *"I think the ER doctors do not examine to the full extent…**they just label you pill or drug seeker** or whatever."*
- ***"They put me as pill seeking even though I'd been off pills for three years now**…but now I take them prescribed and it's still right there in my records—pill seeking. So I just don't bother."*

Stigma of ED Staff - Inadequate Understanding of Behavioral Health Issues and Needs (n = 7)

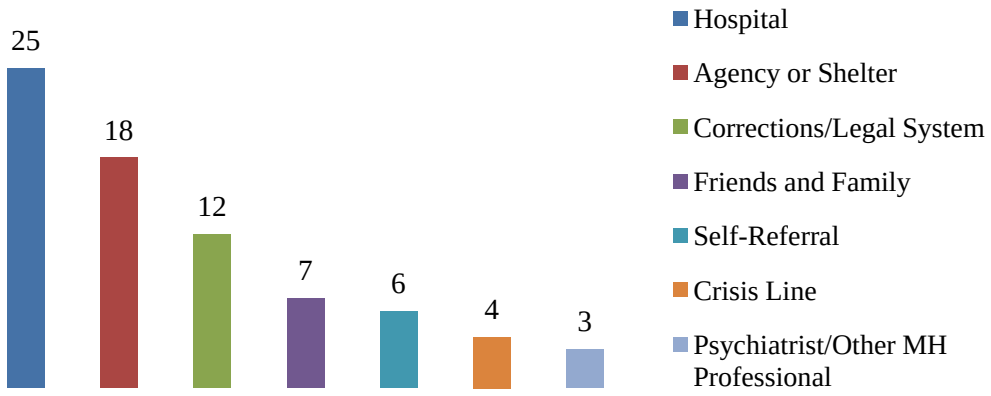
- *"I hate going to the ER… I really try not to go…**I think a lot of the people who work with us in the ER are not trained on how to work with us.** There've been times when I didn't go to the hospital when I needed medical attention, because of the judgements I get."*
- ***"The hospitals around here are extremely triggering if you have PTSD** because there's so many security precautions and I understand that and I respect that. But it's very difficult to be there because… **it's almost like they treat you like a criminal** because if you're not on your meds or you're struggling you do present in that kind of way—out of control or whatever—they just kind of generalize and treat you kind of like you're paranoid. It's really rough… and the [lack of] privacy and stuff. It's almost…more stressful than it is helpful."*
- ***"**When I was 19 or 20, I'd started my drinking and I went to a doctor here... He had lost [someone close] from over-drinking and substance abuse. **I told him I have a drinking problem and I foresee this being a problem** because I like to drink. **He told me there was nothing to worry about, that I was pretty much being a whiner** and it was nothing. I have a problem and I continued to drink pretty much until I got pregnant. They don't care."*
- *"My concern is **they don't treat addiction as a disease."***

2. ERE Referral Process and Experiences with Program Engagement

We asked respondents to talk about how they came into the ERE program, including where and how they learned about the program and who facilitated their engagement. Following are a) reported referral sources and key quotes regarding the process, b) reasons for seeking behavioral health treatment in the ER in the past, and c) client suggestions for improving the referral process.

A. Referral Source. Respondents shared 75 comments specifying referral sources for their engagement in the program. As shown in Figure 2, twenty-five (25) reported that their referral came from a hospital, 18 from another agency or shelter, 12 from the corrections/legal system, 7 from family or friends including at church (1), 6 were self-referrals, 4 were referred from a crisis line, and 3 indicated a referral to ERE from a psychiatrist or other external mental health professional.

Figure 2. Referral Source for ERE Engagement (*n* = 75)



Key Participant Quotes on the Engagement Process with Referrals from:

Hospitals

- *"What I was really impressed with was, when I was at [the hospital], [someone from the CMHC] came in. I don't know how that worked.* ***They just called me and I thought, oh my God I'm in trouble; here's the social worker. It had an official looking seal on the car and I'm like crap I'm arrested for trying to kill myself. They ended up being the most wonderful people."***

- ***"It's mainly my own choice but I got connected through the hospital when I was there having a bounce back between anxiety attack and panic attack and I couldn't get it to stop.*** *So they set me up to meet people here [at the CMHC]."*

- ***"I got in through the psychiatric ward at [the hospital].The lady got me with a social worker who in turn got me with [the CMHC]."***

- ***"I had overdosed and they rushed me to the hospital and put me on the psych ward up there. The [CMHC] case worker came into the ER and talked to me and the doctor entered me into the program."*** *At [another agency] I went and did the 21-day treatment and followed up with [them]…and then had [this CMHC] even at times, giving me a ride back and forth to [the other agency]!*

Agency or Shelter

- *"I was at the [local rescue mission] and* ***my counselor referred me. I guess the person who does the intake or interview for [the ERE program] came to the mission and did the intake."***

- *"I was* ***working at the mission; they started coming up there to check on people****—a lot of people coming out of the behavioral health units—and I just decided since I had just gotten out myself to sit down and talk to them.* ***They had me enrolled in probably three days. Basically they had somebody to talk to."***

Corrections/Legal System

- ***"In jail – [my CMHC Caseworker] was actually there seeing one of her other clients and they gave me the opportunity to talk to her.*** *That's how we got hooked up."*

- ***"My family called 911 on me… I was going through an unspecified psychosis.*** *I thought the world was ending and it was partially drug-related but a lot of it was like a mental,* ***I had a mental break from all the crap going on and the officer that picked me up is the one that referred me."***

- ***"My probation officer sent me here.*** *That's when I met [my CMHC caseworker] over here and it's been great."*

Friends and Family

- *"I was* ***referred by a friend****…I had lost my brother…he'd been gone maybe two days and I started to realize that the problem was much bigger than I could handle by myself.* ***My friend actually called up here for me because she had used the services and I was in within an hour. So it was very quick."***

Self-Referral to CMHC including Crisis Line Referral

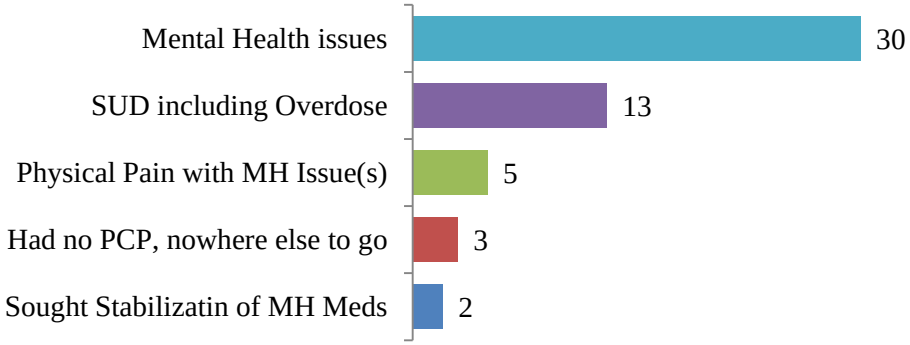
- ***"****I didn't go to the ER.* ***I called [the CMHC]****…because* ***my mom goes there and so I had heard of it through her.*** *I was kind of losing it and didn't know if I needed to go to the hospital or check myself in somewhere because I was…thought I was losing it, going crazy."*

- ***"[The CMHC crisis line] gave me a crisis appointment*** *and I think that was a couple of years ago."*

B. Reasons for Seeking ED Treatment. Of 53 coded comments elicited by "Why did you go to the ER in the past for help with behavioral health needs like mental health or substance use issues?" 30 responses specified mental health (MH)

issues, 13 reported substance use disorders (SUD), 5 reported MH issues in conjunction with physical health issues, 3 said they had no physician and did not know where else to go, and 2 sought stabilization of their psychiatric medications (See Figure 3 below). Overall, 94.3% specifically indicated that participants sought assistance and/or treatment for mental/emotional and/or substance use issues. To note, suicide attempts or other serious suicidality as assessed by the client or someone who took them to the hospital accounted for 56.7% of reported "mental health issues" cited as the reason for going to the ED.

Figure 3. Reasons for Seeking ED Treatment in the Past (*n* = 53 coded excerpts)



Key: SUD = Substance Use Disorder MH = Mental Health PCP = Primary Care Physician

Participant Comments regarding Reasons for Going to the ER in the Past

- *"I went to the ER because several times **I didn't have insurance and it was an emergency situation. It was either I go there or I do something real, real stupid.** I wasn't willing to wait on how to get a psychiatrist or something like that… It's not that I wasn't willing…I wasn't able. So I had to go. I had to go."*

- ***"I'd been suicidal in the past and had attempted suicide.** The thing was when I was attempting suicide I wasn't going to the ER because I was attempting suicide. It was other times when I was starting to move in that direction when I was still able to think about what I was doing. Then I would decide to go to the ER but also… [when] I was a regular substance abuser…I would have falls…broken bones and seizures and various other medical physiological things. **The underlying thing for me was always the mental health issues,** depression and that sort of thing, but that was the main reason either true emergencies or psychiatric emergencies."*

- ***"The last time I ended up in the hospital I was drinking rubbing alcohol.** That's how bad it was. They had me in the poison control section and they helped me get into [ERE-linked alcohol treatment services] and I've been there ever since. I got a little over eight months of sobriety."*

C. Suggestions for Improving the ERE Referral Process. When we asked for suggestions for improving the referral process, 17 responses were generated. Main themes centered on ***educating ED staff about the importance of addressing behavioral health needs along with physical health issues*** *and* ***providing more education about the nature of substance use disorders and mental health issues*** to mitigate stigma, both in the ED and in the community at large (*n*=8), ***increased marketing about the ERE program*** in the community for patients/families and in hospitals (*n*=6), and ***providing a warm hand-off with solid assistance*** in the period between referral and the first ERE appointment (*n*=5). Illustrative comments are presented below.

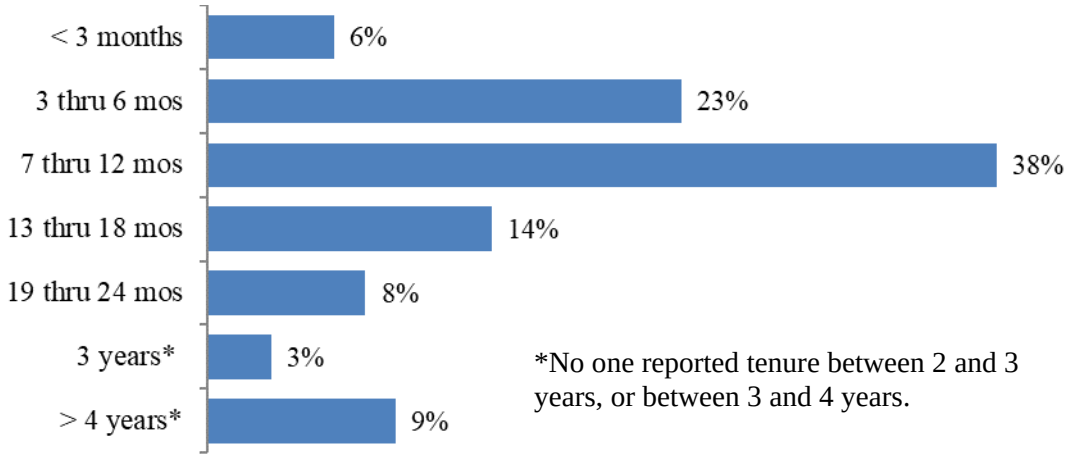
- *"I think they could actually **take mental health issues more seriously for sure.** [Yeah. Uh huh (*agreement from others)] *I don't think they do and it's becoming an epidemic honestly, a very big problem. Suicide rates are through the roof."*

- *"I think the hospitals … our hospital could sure use **some training like with their staff on how to deal with people that do go into ER and make the signs [of mental/behavioral issues] and know to call as soon as possible** like [CMHC] or somewhere."*
- *"I was reading even in the community that they was trying to teach the police to identify mental health issues because a lot of people get mishandled there as well. **It starts with the community."***
- *"I don't want to make people do more jobs but I know in the past, if you give me numbers and you send me home, I may slip again and may not even follow through. So if there's **some sort of follow up or some sort of accountability for say did you make that appointment? Can I help you make the appointment?** … It's very hard to accept that when you physically literally can't do something a person without a mental illness can, when you're really struggling, a lot of times because of the stigma and misunderstanding about mental illness a lot of people with mental illness are alone because nobody knows how to stick around and really help because it's really stressful. So there's no one to help you when you can't do it yourself until you can."*

3. Tenure in the ERE Program

Reported lengths of engagement in the ERE program are shown in Figure 4 below. With responses from 93% (n=66) of FG participants, the majority (40, 61%) reported being in for 3 through 12 months, , another 14 (22%) reported program tenure of 13 months through two years, 2 (3%) stated " 3 years",6 (9%) reported "4 years" or more, while 6% had less than 3 months of program engagement,. Facilitators noted that for some reporting 4 years or more, there was confusion about whether or not their time with the agency had been exclusively with the ERE program; many suspected that they' been served under more than one agency program/grant over the years. A few participants indicated no understanding of placement or participation in the ERE program per se, but shared their estimated time receiving services from the BH agency. (In these instances, facilitators reiterated the program's main objectives and answered related questions.)

Figure 4. Participant Tenure in the ERE Program (*n* = 66, 93% participants reporting)



4. Services provided through the ERE Program

Participants described services they had received as part of their ERE engagement, for a total of 90 responses. Table 2 illustrates the range and variety of services received, including behavioral health services and social services support.

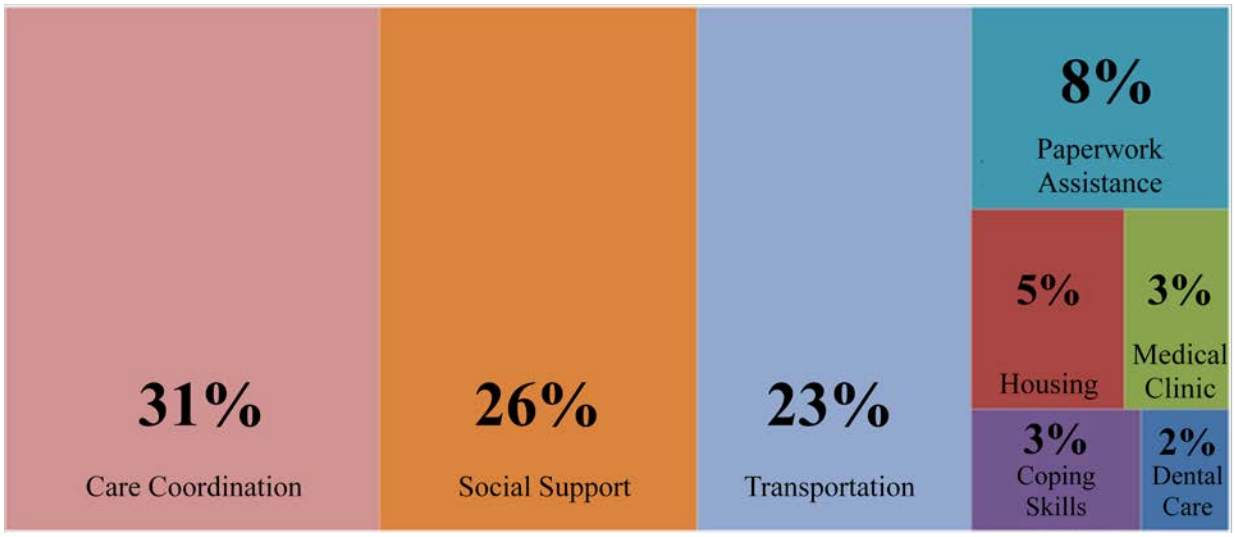
Table 2. Services Provided by ERE (*n* =172)

	# of Responses
Behavioral Health & Medical Support **Total**	**115**
Case Mgt. Assistance with Medicaid & Disability Claims & Applications	30
Psychiatry/Counseling/Therapy	25
Medication Assistance	22
Case Management Social/Emotional Support	21
SUD Treatment (1=smoking cessation)	11
Access to Medical Care	3
Access to Dental and/or Vision Care	3
Social Services **Total**	**57**
Transportation	20
Housing Assistance	12
Financial Support	11
Various Paperwork Assistance	4
Employment/Volunteer Assistance	4
Basic Needs Assistance	6

5. Most Valuable Services in regard to Treatment Goals

Clients were asked which of the services received had been most important to them in regard to their own treatment and recovery goals. This elicited 74 responses, with 62 specifying ***Case Management*** and various types of support it provides. Another 42 responses expressed great appreciation for ***Behavioral Health Treatment*** received. Figure 5 illustrates aspects of Case Management most appreciated by participants, and is followed by representative participant quotes. Themes for Behavioral Health Treatment follow.

Figure 5. Areas of Case Management Assistance Most Valued by Respondents (*n* = 62 coded excerpts)

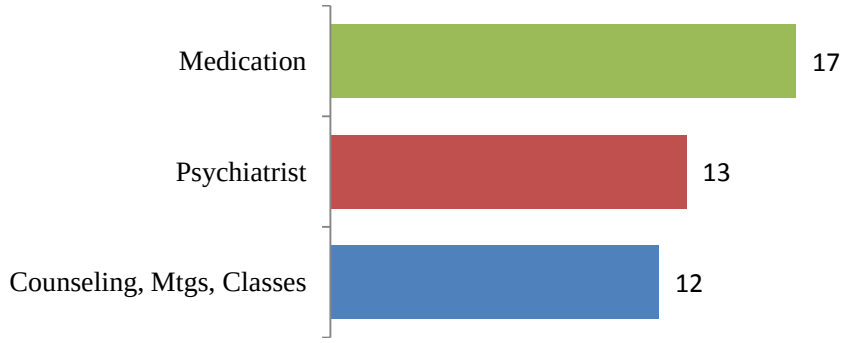


Case Management/Comprehensive Support & Assistance Quotes (n = 62)

- *"They helped me like pretty much change everything. Honestly they like saved me for sure. They got me in as soon as possible. I got my case worker as soon as possible. She was amazing**. She was genuine and actually cared**."*
- *"Talking to my case worker because she's taught me… I didn't know how to cope and everything with everything that's wrong with me and stuff. Now I feel good enough that when somebody has problems I can sit there and basically counsel them because I've learned so much from my case worker. One of my friends is having some suicidal thoughts and everything and they were cutting themselves. I helped them out and I was telling them how to not think like that and stuff like that. Then I helped them find a way to get help. **I know how to help people out just because my case worker helped me out. Now everybody appreciates that about me."***
- *"I've got a lot of support. I don't have a lot of motivation and **they kind of give me a lot of motivation to get out of the house."***
- *"I stay inside a lot and I've got anxiety issues. I don't even like being here. It's nothing to do with anybody but I just get nervous around people. That's what helped me. **I didn't have to deal with a lot of people. They dealt with them for me—my lawyers and everything.** And they got [stuff] done. They got it done for me."*
- *"…**to get connected to all the other services**. I wouldn't have found a good psychiatrist without her or housing so **she kind of does everything that I can't."***
- ***"Just that checking in,** and I know she's only obligated to stop by once a week to check on me once a week, but she calls me periodically; she stop by because I don't, we don't make appointments. **She just comes by!"***
- *"I just think **the accessibility to the people** like you were saying you can call if you need to. These guys stop in at the mission just to say hi, how you doing? You need something? No appointment, no nothing, they just want to talk to you for a minute."*
- *"They **give you a ride to and from the places where I needed to go to do what I needed to do in order to help me get up on my feet and get my life straightened around** a little bit better. That's what they've done for me."*
- *"My case worker showed up for court for me and talked to the judge. "Look, he has a home plan…we have a plan to get him the help he needs" and stuff like that, which is very helpful…**somebody standing up, helping, speaking on your behalf… it's a lot better!"***
- ***"My case worker convinced me to come home when I was running away from the law…** convinced me to come home and turn myself over. I kind of listened and came home and have been clean, away from doing the things I'm supposed to be cleaning up."*
- *"My case worker… she'll show up and sit down and talk to you in your house. You can sit down and have coffee with them or whatever, and **they say if you need anything "call me" and by golly they mean it.** If you need anything they're willing to help you and go out, **they go out of their way. They really do."***
- *"She's not scared to tell me how good I'm doing, my progress, and the fact that she can see progress in me. She really upholds that and it makes me just want to keep going**. Somebody sees a change in you - so it's working! - and it makes you just want to keep on going."***

Figure 6 below depicts specific behavioral health services also reported as very important to their treatment goals: 17 said Medications, 13 Psychiatrist, and 12 said Counseling and/or Meetings & Classes.

Figure 6. Aspects of Behavioral Health Treatment Most Important to Clients *(n = 42 coded responses)*



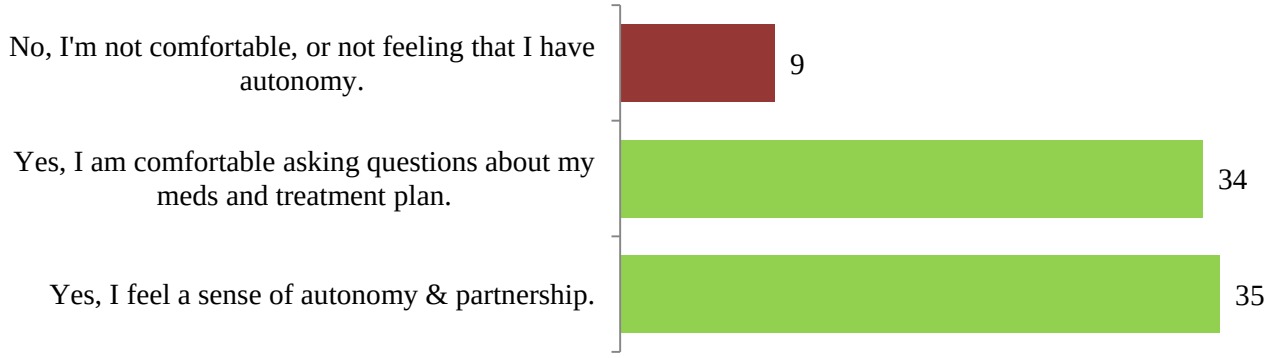
Participant Comments on Behavioral Health Treatment and its Impact

- ***"I talked to an alcohol counselor here. That helped a lot*** *and plus, when they (Case Mgrs.) take me to and from meetings."*
- *"Counselor.* ***For me it's the interaction between me and my counselor*** *who I basically wound up losing when I lost the Medicaid."*
- *"Mine's been* ***the individual therapy with the counselor. She's good. She'll come by and help me if I need it****… psychiatrists these days, they don't do any psychoanalysis or anything like that. All they want to do is prescribe medicine. They don't spend any time with you whatsoever."*
- *"To me there was no light at the end of the tunnel. It was all drinking because I knew, homeless and everything… like you say, that was all there was to it.* ***There was no light at the end of the tunnel until I got with [ERE and SUD treatment]. They put a light at the end of my tunnel.****..You stumble once in a while. You pick yourself up and go on with it and [Case Mgr.] has put a light at the end of my tunnel to where I have an outlook now, and places to go and live now…but I'm not going to blow that drinking alcohol. I will stumble again. I'm not going to say I'm not, but* ***I got options now… going to [ERE affiliate] and getting with [the SUD program]."***

6. Autonomy and Partnership in Treatment Plan and Goals

To get a sense of participants' involvement in treatment planning and decision-making, we asked two questions: "How comfortable are you asking questions about your treatment plan and medications?" and "Do you feel like you have a say in your treatment plan and medications; like you are a partner in your own healthcare?" Seventy-eight (n=78) responses were elicited, with 34 indicating ***comfort with asking providers*** questions about medications, assignments related to treatment goals, etc., and 35 reporting a ***sense of autonomy*** in terms of establishing and inquiring about treatment plans/goals. Nine (9) responses indicated ***feelings of discomfort or lack of control*** over their treatment plan and meds. See Figure 7 below, followed by exemplary quotes in each category.

Figure 7. Participant Involvement in Treatment Planning and Decisions *(n = 78 coded responses)*



Satisfactory Comfort and Autonomy (n = 69)

- ***"One of the reasons I stick to my treatment plan is because it's so easy to do. I don't have to feel like I don't have a say in what's going on with me*** *because I know my body. I know my mind and so when you don't have a say in your own treatment then you stop getting treated."*
- *"I've had problems sleeping and stuff like that. There had been one time that* ***[the doctor] put me on a medicine that was too strong. I asked for it to be lowered…he was more than happy to do it. He seems to listen pretty good."***
- ***"I have no problem talking with them.*** *I want to be proactive because I always check the side effects on every kind of medication that they give me. Because like I say I've been through the psychiatrist before just pushing pills through any kind of symptom they think I'm to exhibit. I'm more like a holistic approach trying a little bit of everything. (Interviewer: You feel like you have a good partnership with your treatment team?) Yeah.* ***No problem whatsoever."***

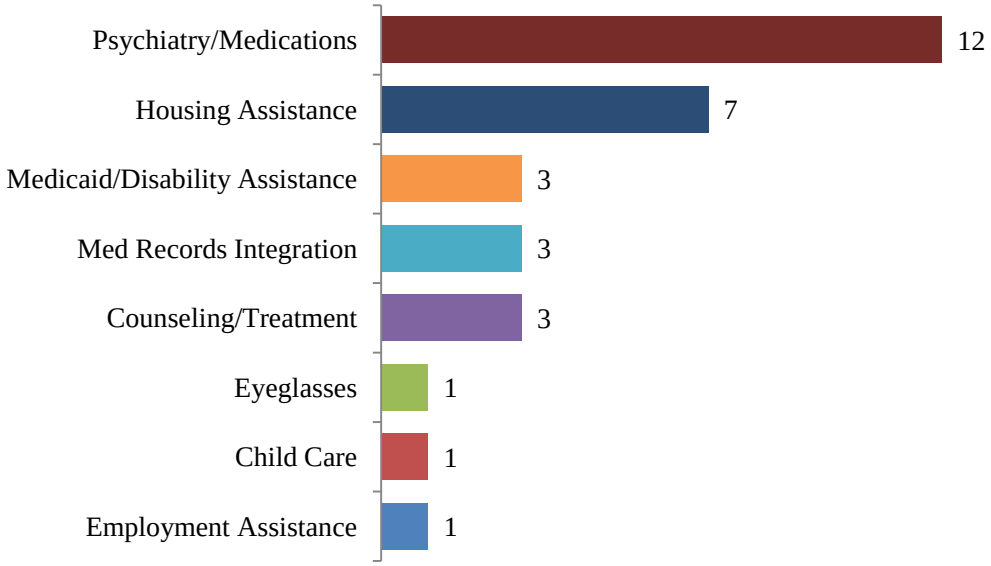
Negative Assessment of Comfort/Autonomy (n = 9)

- ***"They make their own treatment plan and they suggest a lot*** *and I myself ain't ready or comfortable with a lot of it."*
- ***"Not at all comfortable*** *but I still force myself to ask questions anyway."*
- ***"I've never been given a treatment plan.*** *I haven't really met with [CMHC] except for [Case Mgr.] over at [the hospital]… I think she's more of a social worker than anything else…if I have anything to say about my medications, it's that [****the doctor] throws these medications at me and I don't feel like they're doing what they should do. So a treatment plan would be nice and working on medications that I actually need."***

7. Gaps in Services/Unmet Needs

We had 36 responses to "Please talk about any needs you have that [the CMHC] has not been able to help you with." Five (5) of those were essentially, ***"All my needs have been met!"*** Figure 8 shows themes for the remaining 31 comments, ***the primary area of concern being Psychiatry/Psychiatric Medications (n* = 12).**

Figure 8. Gaps in Services (*n* = 31)



Representative Quotes Regarding Unmet Needs and Gaps in Services

- ***"Need a doctor who can work with addictions - prescribe and diagnosis****. I feel comfortable talking with [Case Mgr.] about certain things and there are other things I'd feel more comfortable talking to a doctor about…* ***If they were all in the same office they could get together and compare notes. One's got a treatment plan and the other's got a treatment plan.*** *I honestly think that I could be further along had there been a doctor in this office. Just my opinion."*

- ***"It's just frustrating because [a certain physician] asked me how are you doing; have you found a psychiatrist or psychologist yet. I can't afford it.*** *So he just keeps saying well you really need to try to get some of it… but I can't pay it if I don't have the money."*

- ***"I still haven't been able to get psych evaluation and get some help****… I know my case worker is trying to do whatever she can… It's more about the insurance but somebody's got to pay for all of this. They only have so much funding themselves here. If they can get the insurance…I need to talk to somebody… need to get to where I can regularly see somebody…a counselor.*

- *"They should have more psychiatrists in this area honestly. I don't know if they're just short staffed but* ***I've been needing a psychiatrist appointment… having really bad issues in January and I'm discussing now in April."***

- *"Well they're supposed to be working on helping me with housing…****community living is not doing very well with me. We've been doing this for months and I still haven't found a place.*** *It's either because of my past, my credit, or I just can't find me a place yet.* ***That's the only thing that they haven't helped me with but they're supposed to be, they're trying…I have to be on Medicaid in order to get in. So I'm not on Medicaid so I'm still screwed****… I need a place really, really fast so that's the only negative thing that they really haven't helped me with yet."*

- *"I think…as a whole around here,* ***housing is an issue.*** *I don't know if that even be addressed here but housing is hard to find. I think you guys or try to build some* ***apartments that are made for schizophrenics.*** *That would help a lot with housing and we'd have a place to stay. We wouldn't have to go to a group home."*

- *"The* ***case worker is supposed to help with disability*** *but been saying that for months and ain't done nothing."*

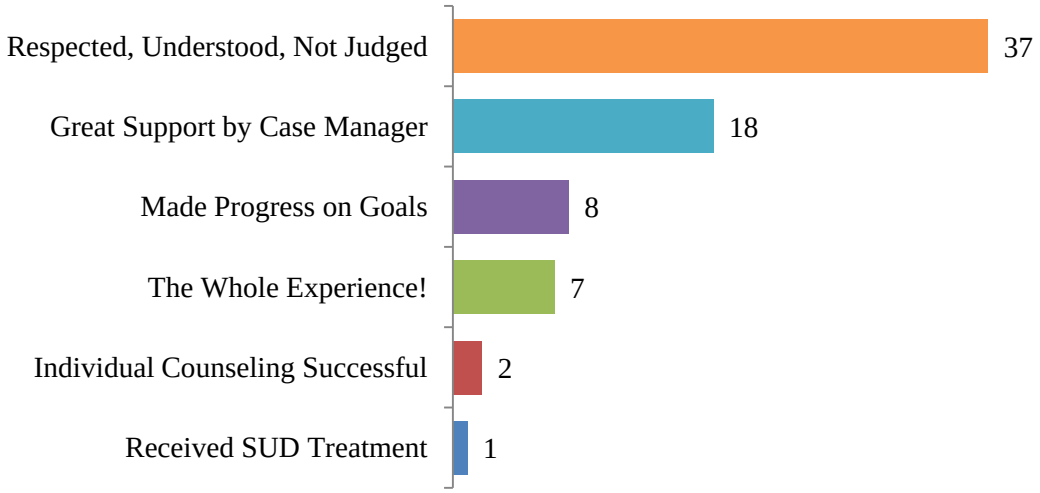
- ***"They stopped my counseling**...my program needs were met through the probation and parole office and I missed a couple of appointments. I was going through, **I was struggling but that's when I needed somebody to help pick me up** instead of them giving me a foot in the ass. I missed some meetings and my counseling ended."*

- *"They have all that counseling at [CMHC] but I had to find me a place at [another agency] to go for $5. Why can't [this CMHC] do something like that? Keep it all in… me myself, **I'd like having everything, all my records at one place."***

8. Positive Experiences with the ERE Program.

When asked to share positive experiences they had while in the ERE program, respondents provided 58 comments. Figure 9 shows the breakdown of coded themes in this category.

Figure 9. Positive ERE Experiences *(n = 58)*



Following are representative quotes from the top four themes coded under Positive ERE Experiences.

Treated Well by ERE Team – Felt Respected, Understood, Genuinely Cared For, Not Judged (n = 37)

- *"I love **the individual attention you get… just that nonjudgmental, "let you talk" [attitude]** is a huge deal to me. And then [my Case Mgr.] comes up with these ideas and I'm like, "Okay, well let's try that!"*

- *"I'm treated like an individual case**. They look at my case. They look at everything and they don't force me and they respect me and if they don't understand they try to and they advocate for me.** This may sound really silly, but one of the coolest things is like when I ride with my case worker, she lets me jam out on the radio. It's awesome…I think it's that they empower me, so I'm not stuck in the ER."*

- *"Sometimes I just have to be calmed down and my case manager is really great about doing that. I can call her cell phone at any time. If she can't get to it right then, she definitely calls me back in that same day. She always concerned about how I'm doing and it's just that **sometimes you just need that one person that really cares about how you're doing and you can just be open and honest and let them know what you're feeling and there's no judgment on her face. So that's what I like about the program."***

- *"One time…I was not feeling well and hadn't gotten on my medication just yet and I was kind of flipping out. I was irritated. I remember something wasn't going right. **It was just a bad day. Everything was just tearing me down. I was just ready to kill everyone around me. I was in the ER and I heard [my ERE Case Mgr]. He came up there to see me… I will never forget.** He didn't have to do that…on his own time…he came up there to see*

how I was doing and check on me and stuff, and sat there and talked to me for like 10 minutes. I didn't even ask him to do that. He just knew."

- *"There's something to be said about my counselor here being my age, been there done that. It's easy for me to open up to him and [he] is younger than I am but is sincere.* ***He cares; he'll text you. How you doing or text you good morning. I don't see him for a week and he'll text good morning, how you doing. He thinks about you. A lot of these other places you're just a number."***

Great Support by Case Manager (n = 18)

- *"I was stuck in depression…faced with a mountain of things I had to do to take care of with [my mother's] estate…* ***my case worker came every Tuesday and while I was in the hospital she called and we talked, just talked with me. She helped me get through the grief, offered services at each step.*** *She literally… just by talking…led me through depression out of isolation where I was headed."*

- ***"[My Case Mgr.] knew everything about me*** *and she would take me to the DFS office to help me get all my insurance. We were on [them, at FFS] 24/7 trying to get it done. I even had a tumor on my back that I needed to get, that I had and was bothering me and she helped me get in to just a primary doctor to get that taken care of and they paid for that. Helped me see a psychiatrist and a therapist and got all my medication. Even when I was on insurance they were paying for my medication to be sent to me.* ***Constantly calling me just to see how I was doing, to check up to see if I needed help with anything."***

- ***"Once [the Case Mgr.] called me she got everything transferred for me and got me into [CMHC].*** *[They] took care of mental health, or primary care, dental, hearing, vision—one-stop shopping for everything.* ***But without Medicaid it's impossible to afford because for the months that I didn't have my Medicaid my prescriptions were $2000 a month. So if I didn't have that transfer there's no way you can afford that."***

- *"If I've ever called my case worker or I had an appointment or* ***if an emergency came up****…like if I had a doctor's appointment or something…or couldn't get to pick up my medication,* ***he would arrange it to where another case worker would come get me and make sure that I went and got my meds…got me to the doctor, whatever."***

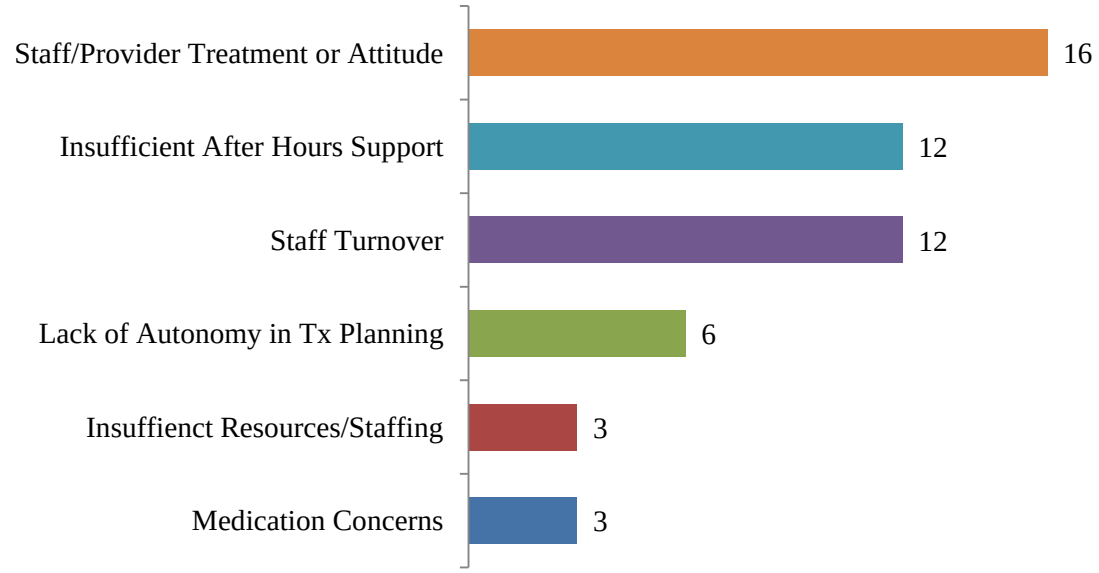
Client Sees Progress on Treatment/Life Goals (n = 8)

- *"I don't know if it's just [the particular CMHC] but I'm not from Missouri but I've had a positive experience at Kansas City and I've been in psych wards since I was 11 and I almost gave up on the psych field and getting help. Now… I see hope in it. I see the difference whether it's [this CMHC] or Missouri or what you [FG facilitators] are doing…* ***I see a difference and I think that's a positive experience because it gives me hope and I can share with other people not to give up!"***
- ***"I've had them do things or at least set up things that they thought I may agree with.*** *Of course they didn't put it in stone but then they'd say, 'What do you think about doing this?' Like this housing thing I've got coming up, I wasn't looking at that. I'm in a pretty good position at [my current group housing]. They're like, 'Don't you think you might want to be employed and kind of maybe have a pet?' 'Yeah!' so boom within two weeks they had everything set up…* ***but they asked me how I felt about it first."***

9. Negative Experiences with the ERE Program

We also asked about negative experiences with the ERE program, to which we received 52 responses, coded as shown in Figure 10 below.

Figure 10. Negative Experiences with the ERE Program (*n* = 52)



Poor Treatment from ERE Staff or Service Provider (n = 16)

- *"My residential services when I first initially called to see if I could get to see a psychiatrist or psychologist. The girl just kind of acted like I was putting her out. I didn't get her name or anything but they answered the phone.* ***She wasn't really sympathetic whenever I said I can't afford the $30 to pay. Well I'm sorry that's just how it is."***
- *"I don't know if the person I started with quit or was fired but I never knew and I kept calling and so* ***when you are interacting with someone I think it would be productive to let the person know that who you've been dealing with isn't there anymore."***
- *"My only complaint is that* ***I stopped counseling for some reason and they didn't tell me why."***
- ***I don't like that you've got to switch. I was comfortable with the case worker****, the first two that I had. I had [caseworker name]; she was very good and then I don't understand why you're in a program and then got to switch case workers. I don't like that at all period. The moment you go from not having insurance to having insurance you have to get a new case worker and I don't agree.*

Staff Turnover (n = 12)

- ***"Yeah I've had six case workers****... five since October."*
- *"I understand the turnover rate and some people can't handle the job. I get that.* ***When you've got people like us that are trying to… that aren't comfortable with strangers anyways or we have anxiety, it's really hard for us to open up to someone*** *and tell them because they get to learn a lot about you, your case worker does because they're there all the time. Sometimes it's good for them to know about you so they can understand why you are the way you are.* ***It's really hard to do that when you're going through five and six and seven case workers in five months.*** *With me is that they're there and they won't even tell me hey this is your new case worker, and she'll be right in front of me. I feel like I'm put on the spot."*
- ***"Workers go into different areas and a new worker pops up and then a new worker and then a new worker.*** *To me it throws a wrench in my spokes. When I get used to somebody and I'm working with them and they been with me for a while it's like now I've got to get used to somebody else."*

Insufficient Support Outside of Regular Business Hours (n =12)

- "The last time I had to call the crisis line I didn't even call them. My mom had to call them but she called them and ***the lady was like I don't know what to tell you. Just call 911 and hung up the phone.*** I think it was a new lady or something because she was like I don't know what to do so just call the police and hung up the phone."

- *"One thing I'd like to see is an option besides the hospital to go to especially in the evening times when… If your problem comes some time besides 9-5, you don't have an option as far as where to go. It's just the ER…* ***There is a crisis line but they don't offer much help except to go out to the ER*** *and have a conversation on the phone."*

- ***"One of the things I'm seeing just being new too is they're stretched really thin.*** *I know from talking to my case worker. We've got to remember that they're people too and they have a life as well outside of what they're doing for us."*

Lack of Autonomy in Treatment Planning (n = 6)

- *"When I first got admitted in this program I had substance abuse problem but what don't make sense I went from ERE to another new program and it's still substance abuse but I have been clean for a year I think. It was a lot of hard work. I'm still in the same program.* ***They're still treating me like I'm a drug addict and that includes cigarettes.*** *I do great. I do one a week or maybe three. It depends but it's frustrating that they're still making me go to classes about it and I understand they want me to stay on the same road but I've got it."*

Insufficient Staffing/Resources (n = 3)

- ***"If there was a way for them to be able to hire more people on to relieve some of the case workers caseloads,*** *it would benefit more people but it's just so much and funding can only go so far."*

- *"I had some of the same issues about calling my case worker.* ***There have been times where she can't even, she don't call me back for a couple of days or whenever.*** *It's times when I need her but I'm sure for me to try to put myself above anybody else is kind of, I'm not the only one out there."*

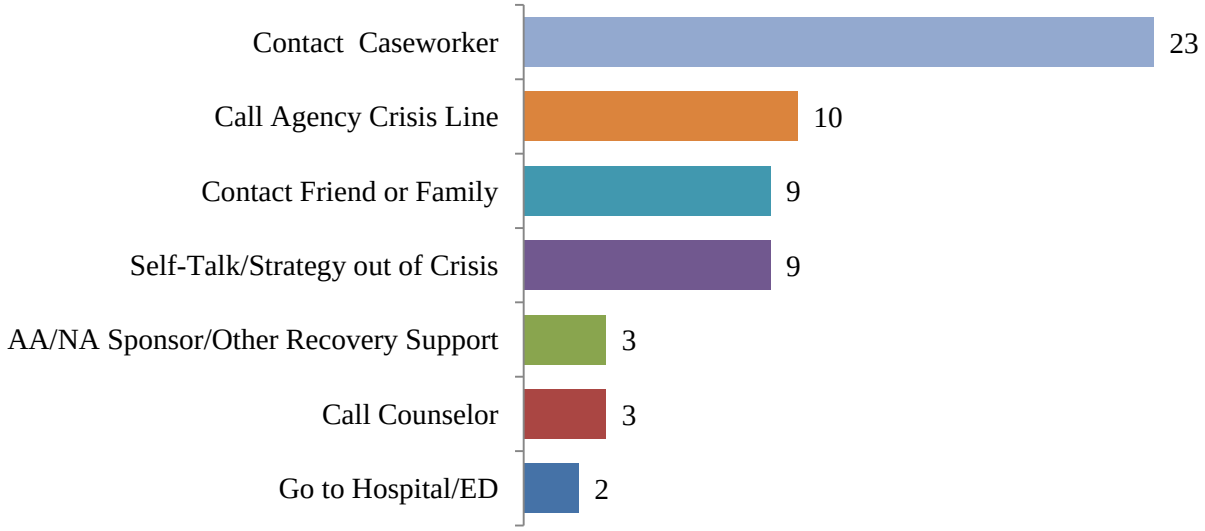
Medication Concerns (n = 3)

- *We (my psychiatrist and I) had finally just found what worked for me and then bam, I was pregnant. So our goal was to just get me back on those medicines just a lower dosage after I had [the baby]. I literally went to the hospital I think it was two days after she was born. The day you leave the hospital kind of thing, I was going to the doctor. He was just really cocky and kind of an asshole to be honest. My daughter was there with me and he was acting like he didn't know why I was there, which that irritated me in itself (given our previous trouble when I told him I wouldn't take meds while I was pregnant). Then* ***I had to bring up 'What are we going to do my medications?'*** *That's why we had this appointment, what it was for. He said' I'm just going to put you on this one.' (I asked), 'What about the other three medications that I take?' Then he's like 'Well. I don't like this one. I'm going to take you off this one.'…'I don't like this one. I don't think you need a mood stabilizer'…so that was really frustrating for me and he was just really rude about it and just made me…****he treated me like I was a drug addict and I was there for drugs or something. It was really bad. I felt very judged.***

10. Plan for Addressing Future Behavioral Health Concerns or Crises.

When asked what actions they would take in the future if/when they experience a mental health or substance use concern or crisis for which they've previously gone to the ER, participants responded as shown in Figure 11 (*n*=59 responses).

Figure 11. Future Action Plan re: Behavioral Health Concerns/Crises *(n = 59)*



11. Coping Skills Learned in the ERE Program

In 20 responses, participants shared a number of skills they have learned through work and interactions with their ERE caseworkers and counselors. These were comprised of: Focus and Calming Techniques (*n*=7), Skills for Self-Reflection and Comfort (*n*=6), and Interaction with/Asking Others for Assistance (*n*=9).

Exemplary Quotes on Coping Skills Acquired

- ***"They teach you breathing, counting back from 10. Coloring is one they talked to me about.*** *They sometimes suggest or ask things that you like to do. Do you listen to music? Do you ever go for walks?"*
- *"Yeah.* ***Focus points like when I see that my anger's going to get really bad then I have to focus on something.*** *Maybe it's the sprinkler…it's free. Just focus on something else to get my mind off of the crap that ticked me off because I couldn't move."*
- *"I've just learned [to identify my feelings]. I used to just go. I didn't even think about the consequences and that's why I spent 20 years out of the last 27 in prison.* ***Now I think about the consequences so I identify it now and I catch myself. So far so good."***
- *"I would get into these, this frame of mind where I would, it seemed impossible and hopeless. So I just wouldn't even ask. I talked myself out of it before I'd even discuss it with somebody and now* ***I just feel a lot more comfortable just bouncing things off of my case manager or some of the other people that I've come into contact with here."***
- ***"I have learned to actually ask for help and say what I need and speak up for myself*** *because they're not always going to be there…kind of* ***redirecting my thoughts****, that kind of self-efficacy, that I can, I'm not helpless."*
- *"Mine is (to)* ***get out more and interact with people*** *because at first I was scared to go outside because I was always getting into something...just lately with the PTSD and the bipolar and all of that stuff that's going on, my mind has just been doing its own thing and so* ***I've learned how to open up my box, put it in there if I can't deal with it the proper way, and then take it a little bit at a time… I have definitely come up with a better way to deal with myself."***

12. ERE Impact on Client Outcomes

Facilitators shared previous findings on client outcomes including an overall decrease in ER visits, hospitalizations, arrests, homelessness and unemployment after being engaged in the program for just 3 to 6 months. When asked if this matches up with their own experience in the program, 84 (93.3%) of the 90 responses were "*Yes.*" Specific positive outcomes were shared in 15 comments including responses of Reduced Symptoms (n=6), reduced involvement in the Criminal Justice System (*n*=3), Improved Family Relationships (*n*=2), Improved Attitudes *(n*=2), Sobriety in Recovery (*n*=1), and Improved Work Stability (*n*=1).

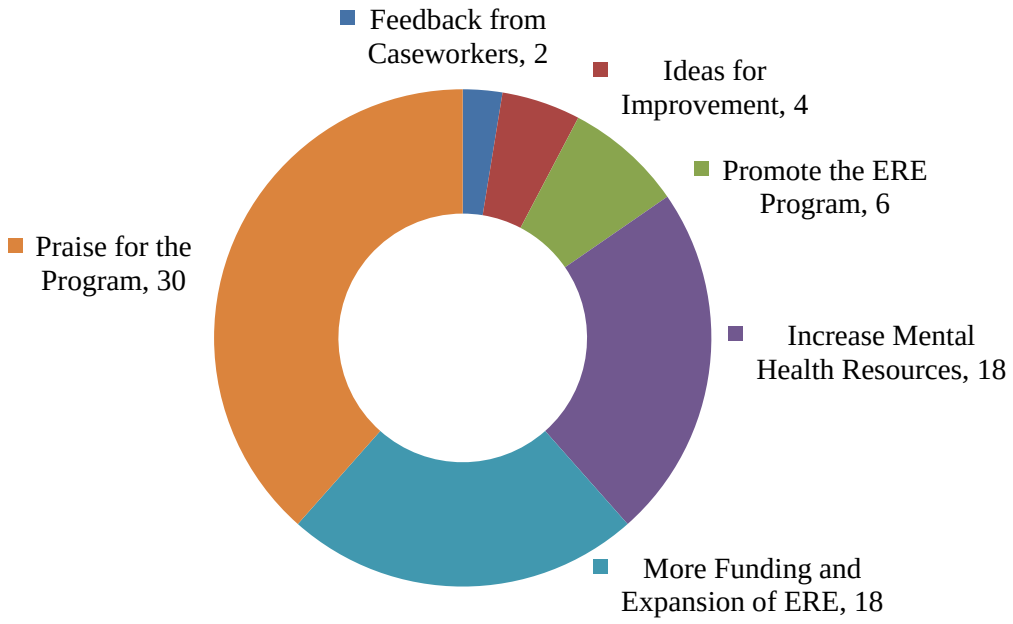
Quotes

- ***"I'm actually pursuing a long hidden passion of mine*** *which is content creation via videos and things of that nature. I'm doing it… using video games, giving reviews, live streams…combining the passion for video creation with the tool of game-playing in my own space.* ***Getting stable has given me the courage to pursue it."***
- ***"Pretty much every aspect of my life.*** *I'm not depressed all the time. My anxiety is doing better. I'm having less night terrors."*
- ***I haven't gone back to prison since I've been here.***
- ***I'm alive and I'm clean and sober*** *and I got my head screwed back on my shoulders right.*

13. Recommendations for the Governor/State Legislators

Asked what they would like to share with the Governor or state legislators, participants gave 78 responses, coded as shown below in Figure 12. Praise and appreciation for the program (*n*=30), requests for increased funding and expansion of the program (*n*=18), and suggestions to promote the program more (*n*=6) combined accounted for 69.2% of participant comments, with another 18 (23%) calling for an increase in mental health resources in Missouri. Remaining were miscellaneous ideas for improvement (*n*=4) such as adding transportation services, the suggestion to solicit feedback directly from caseworkers given their valuable front-line experience and understanding of client needs (*n*=2).

Figure 12 Participant Comments to the Governor/State Legislators *(n =78)*



Key Comments to the Governor/State Legislators

- ***"I cannot tell you the difference this program has made in my life.*** *I literally just came from getting my move-in date to my apartment and I've been homeless for two years".*
- ***"To all of you who actually are the ones providing the services*** *working on the program, the best thing I can say is thank you.* ***Without this program and the help that we've received, my wife and I wouldn't be anywhere near close to where we are right now.****"*
- *"****I think listening more to us would be helpful. I appreciate the opportunity to share my experiences and I think they're doing a good job*** *and it's really helpful"*
- ***"Housing is an issue. Mental health education for people who work with [us] is an issue…awareness and education for people going through it and the people helping them*** *or walking with them."*
- *"This program has worked for me.* ***There are doors that have been opened up that I've never had before... keep this program going!"***
- ***"It not only helps the individual in the recovery program but it helps individuals outside, immediate family members, support group family members or support groups...****I think [the Governor] would be cutting his own throat if he did away with any funding."*
- *"I would say to the governor that* ***we need more funds for places like this also because people need their medicine. You want less crime rates and all of that. You've got all these people with mental health and even other programs with substance abuse…People need help...*** *I was out there in the streets…* ***I almost killed myself because I did not have my medicine. I was on my own."***
- ***"I think the mental health needs to be a number one issue in funding.*** *I think there needs to be* ***more help from the state and federal level*** *for mental health issues.****"***
- *"I think that there should be more types of programs like this…****The people that do all these massive shootings and stuff, maybe they don't have a case worker that's helping them solve the problems that would make them so upset*** *that they would go to a school and shoot everybody up.… I think that's the big problem…its people that need help…****you go to a doctor for your physical body so why don't we have the same thing available for our brains?"***
- *"Getting [the program]* ***more resources… more psychologists and actual mental hospital where people can stay longer term versus just getting a couple of days help."***
- *"Yeah and then it's* ***just not enough [MH professionals]…****not enough to go around."*
- *"I think* ***it's going to be such a hassle for people with mental health issues to get insurance to be able to get the help they need****, for sure."*
- *"You need to* ***get this thing up and running inside your hospitals and have you guys out in the community training these officers."***
- *"There are* ***more people out there than what we even realize that are going through problems that don't know where the resources are or too embarrassed to even talk about that they have a problem."***

Summary of ERE 2018 Focus Group Findings

Results from this year's focus groups bolster quantitative findings confirming substantial value of the ERE program. Participants expressed heartfelt appreciation for the impact the program has had on their lives. From the time they were engaged in the ERE program – most coming in through outreach by CMHC caseworkers or other staff while in hospital ERs or psychiatric wards – **they report experiencing mental and emotional support from program staff and partners quite unlike they previously received in hospital ERs.** An abundance of participant stories indicated the client-centered, humanistic aspect of ERE services. Participants feel empowered to become more stable mentally and emotionally, take steps toward goals they previously believed were unattainable, and discover that they can have a say in decisions about their own lives and healthcare. **As one respondent put it quite succinctly when asked about impacts of this program, it *"Saved my life!*"**

Overall, participants are highly satisfied with ERE services they have received, noting **case management as the most important service, specifically in that it provides excellent coordination of the full range of services they need**. **Likewise, they express appreciation for the variety of behavioral health** services and the dedication of caseworkers was reported as a significantly important to their individual recovery progress. The **great majority reported that most, if not all, of their needs were being met by the ERE program at present.** However, **c**urrent **gaps in service for some included psychiatric treatment and medications, housing, and attainment or reinstatement of Medicaid insurance.**

Positive ERE experiences centered on appreciation for **ERE program personnel being understanding, non-judgmental, and genuinely caring; numerous types of wrap-around support from case managers and other staff, and enthusiasm about seeing progress toward reaching their own treatment goals** and "getting our lives back together." **Negative ERE experiences reported are consistent with reports of negative past experiences while seeking help with behavioral health needs in the ED.** A strong majority **(93.3%) affirmed positive personal outcomes similar to previous years of the program.** These included **reductions in ED visits for behavioral health issues, decreased involvement with the criminal justice system and incarcerations, lessening of symptoms, better relationships with family and others, and overall, a sense of hope for their future since becoming engaged with this program.**

Clearly **heartened by being asked for their input** for the Governor and state legislators regarding the ERE program, participants enthusiastically **shared deep appreciation for the opportunities this program has provided, along with urgent calls for more funding and support for it and others like it. They passionately expressed the need to expand these resources and life-changing opportunities to others who "fall through the cracks" due to personal hardships and systemic issues** within our healthcare systems, due to social and economic inequity. **Numerous comments highlighted continued stigma regarding behavioral health issues both in their community as well as from medical professionals across our healthcare systems.** A key recommendation from participants is **enhanced education and training on behavioral health issues for both providers and communities to help mitigate the stigma** they feel around behavioral health issues, subsequently improving quality of care and health outcomes for themselves and others.

MIMH will continue to augment quantitative findings via qualitative methods that enhance our understanding of ERE client experiences to provide greater insight into consumer perspectives so valuable for designing effective systems of care and support for those in need. Soliciting this voice from program participants empowers them in ways that can positively affect their commitment to the program and progress toward treatment goals. For sound program design and development, we acknowledge the value of these personal stories, insights, and recommendations. As the program continues to expand, ensuring that client voices are heard will remain a vital component of the MIMH evaluation, essential to policy decisions, client outcomes and program success.

References

Saldaña, J. (2009). *The coding manual for qualitative researchers.* Los Angeles: SAGE Publications.

Zhao, P., Li, P., Ross, K., & Dennis, B. (2016). Methodological Tool or Methodology? Beyond Instrumentality and Efficiency with Qualitative Data Analysis Software. *Forum Qualitative Sozialforschung / Forum: Qualitative Social Research, 17*(2). doi:http://dx.doi.org/10.17169/fqs-17.2.2597

Appendix A: ERE Script and Questions for Focus Group with Program Participants 2018

ERE Focus Group with Participants

Introductions:
Hi, I am _____. I will be moderating this discussion and this is _____ (motion to the note-taker) who will be recording the discussion and taking notes.

Directions for Participants:
Thank you for agreeing to participate in this focus group. We appreciate your willingness to share your time and experiences. We are with the Missouri Institute of Mental Health and are working with _____ (site) to see how the program called Emergency Room Enhancement (ERE) is working. The purpose of this program is to help people who are experiencing mental health or substance use issues by connecting them with a Community Mental Health Center that can better address their needs. We would like to know how this program is working for you to better understand where the program is succeeding and where it might need to improve. As the client, YOU are the experts here and your feedback is key in helping us develop and improve programs to help others!

We are interested in hearing your experiences and encourage you to be open and honest. Please know that what you say here is **confidential**. Your name will not be included in any reports. If you have any questions about this interview or the project after we leave, you can call us at the number we have provided on the information sheet we handed out, or you can talk to _____ here, who can get in touch with us. Also, your participation in this group is **voluntary**. That means you can change your mind at any time, and it will not have any impact on the services you receive, now or in the future.

During the discussion, please talk to and with each other rather than to me. I will start the conversation with a question, and then listen as all of you take it from there. I will only jump in to get us back on track if we have gotten off topic or I have information that's helpful to the discussion. It's important that we hear from everyone in this group, so please be mindful of giving each person the opportunity to speak about each question as it's presented.

It's important that everyone feels comfortable sharing their thoughts and opinions without being interrupted, criticized or disrespected. Feel free to respectfully disagree with what others have said or give another opinion; the more different ideas we hear, the more information we will have to work with. Please feel free to ask if any of my questions do not make sense, and keep in mind there are no right or wrong answers or questions. Again, we are interested in hearing experiences from each of you, how you remember them.

With your permission, we will be recording the audio from this focus group; the recording will not be shared with anyone but the evaluators. We will be recording so that we can refer back to make sure we are accurately reporting your thoughts and feelings. Your name and any personal names you mention during the focus group will not be used in any reports. With that being said; is it okay with everyone that we record this discussion?

I will let you know when we are near the end of our time. If you have to go to the bathroom, just slip out quietly and come back as quickly as you can as to not disturb the recording or individuals in the room. Are there any questions before we begin?

(If there are questions, answer them. If not, start with the focus group questions).

START RECORDING and *Introduce Opening Question*

1. About how long ago did you start receiving services here at _____(site/here)?

2. Think back to the time before you received services from _____ (site/here)… Can you describe what your experiences in the emergency department were like, when going in for a mental health or substance use concern, before you got connected with _____ (site)? *(Probes)*
    a. How were you treated by the hospital staff?
    b. In what ways did you feel they met your needs?
    c. In what ways did you feel they did not meet your needs?

3. What were the main reasons you used the ER as a place to get the help you needed?

4. We are interested in knowing how you got connected to services at _____(site). Can you describe the steps that got you into services here? *(Probes)*
    a. Who helped set up an appointment?
    b. In what setting/where did these steps begin?
    c. What changes could be made to make this connection process easier or more helpful?

5. Can you please describe what services you have been offered here at _____(site)? *(Probes)*
    a. Housing, transportation, Rx assistance, other?
    b. Have you been offered any services related to substance use disorder (drugs or alcohol)?

6. Thinking about all the services you receive from _____ (site), which services are most helpful in meeting your treatment goals?
    a. How comfortable are you asking questions about your treatment plan and medications?
    b. Do you feel like you have a say in your treatment plan and medications; do you feel like a partner in your own healthcare?

7. Can you share some examples of positive experiences you have had with your services here at _____(site)?

8. What has _____(site) not been able to help you with? *(Probe if needed)*
    a. Is this need still unmet?
    b. Do you have ideas or suggestions for how they might have helped or some other solution?

9. Can you share some examples of negative experiences you have had with your services here at _____(site)?

10. The data that we have collected on participants in this program has shown an overall decrease in ER visits, hospitalizations, arrests, homelessness and unemployment after being engaged in the program for just 3 to 6 months. Does this match up with your experience in the program?
    a. What other outcomes, or changes in your life, have you experienced as a result of receiving services at _____(site)?

11. What will you do in the future when you experience a mental health or substance use concern or crisis for which you've previously gone to the ER? *(Probes)*
    a. What resources or skills have you learned through your services here that may help in these situations?

<u>OPTIONAL IF RUNNING SHORT ON TIME</u>

12. To wrap up, suppose you had one minute to talk to the governor about your experiences with the ERE program - what would you say?

Conclusion and Thank You

That concludes the questions I have for you at this time. Does anyone have any final thoughts to add? (If so, stop to hear them. If not, proceed with thank you.)

We want to thank you again for your help. We recognize you have a busy schedule. Your input is important to help us ensure that the new services provided by _____ (site) will help to meet the needs of people in this community.