NACBHDD National Association of County Behavioral Health & Developmental Disability Directors
The voice of local authorities in the nation's capital

UNDER THE MICROSCOPE

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THE GROWING ROLE OF PEERS IN DELIVERY OF CRISIS SERVICES

ISSUE:

To a 911 operator or to first responders such as law enforcement officers, the request to respond to a "mental health crisis" likely triggers a range of emotions and uncertainties, a burst of adrenaline, and instant recall of carefully-rehearsed procedures designed to address a "worst case scenario" that could involve unpredictable or dangerous behavior by a person in the throes of an acute crisis.

In counties and communities that haven't yet developed alternative methods, the standard crisis response is made by law enforcement personnel, who are to detain the individual and then, according to procedure, deliver him/her to the local hospital emergency room (ER) for assessment and treatment. While this practice is "standard" in many localities, it is far from perfect.

The problems begin with law enforcement training. Although efforts to expand Crisis Intervention Training (CIT) are growing nationwide, the majority of law enforcement personnel lack training. Therefore, they turn to their primary police training, which emphasizes the need to establish control and preserve safety, starting with their own. But for persons in crisis — many of whom are already in an state of fear or anxiety about their lives or their safety — typical policing practices such a using a loud "command" voice, ordering immediate compliance with instructions, or using physical methods to establish control or restraint can be terrifying and traumatic. Instead of containing the situation, these practices can cause the person in crisis to further decompensate and experience even worse symptoms, leading in some cases to the application of additional force, occasionally with tragic consequences.

The problems extend to hospital ERs, whose mental health crisis response capabilities are as limited as those of local law enforcement, but in different ways. Few ERs can afford the specialized staffing needed to assess, treat, and stabilize individuals in crisis. And, because they were designed to respond to physical, not mental health trauma, they're ill equipped to provide the kind of calm and quiet needed to help a person in crisis to regain control, make better choices, and cooperate when possible in treatment. Thus, crisis cases referred to local ERs are not only expensive and often ineffectively treated, but also lead to further system costs – referrals (many involuntary) to specialized psychiatric treatment, discharge to local resources, or discharge to the street. For many in crisis, a cycle of repeated crises and expensive, ineffective treatment begins.

ANALYSIS:

Crisis response: A matter of perspective

In a recent webinar offered by NASMHPD, "Peers as Crisis Service Providers," Heather Rae, Vice President of Programs and Services with Common Ground (Bloomfield Hills, MI) asserted that costly

problems with local "crisis response" systems are rooted in poor definition and poor understanding of what "crisis" is and what it can mean for the persons involved.

Pointing to a SAMHSA analysis, Rae asserted that "public systems often respond as though a mental health crisis equals a danger to self or others." But, she continued, a narrow focus on dangerousness – what SAMHSA calls "a blunt measure of extreme emergency" used to justify involuntary hospitalization – isn't a valid way to address a mental health crisis. "You've got to have the perspective to look beyond whether a person is dangerous and whether they need hospitalization."

Common Ground, which provides crisis-focused services in Michigan's Oakland and Genesee Counties, used that perspective to develop services that recognize a broad range of personal crises, including behavioral health, basic needs, legal issues, and victimization. Their approach assumes that people reach out for help in many ways: by calling, texting, computer chatting, or walking into its crisis center.

The organization's mental health crisis resources emphasize alternatives to hospitalization and include a prominent role for trained peer specialists, who help to ensure a reassuring, person-centered, and recovery-focused environment. Teamed with master's level clinicians on a mobile crisis team, peers assist in face-to-face visits with crisis intervention, assessment, de-escalation, and relapse prevention planning. Trained peers also work at the regional walk-in assessment and crisis intervention center and in its 10-bed short-term crisis residential program, where they provide a range of support and recovery coaching services.

Thanks in part to the hope and recovery skills modeled by its peer staff, the crisis response services offered by Common Ground have delivered impressive results for Oakland and Genesee counties, including reduced rates of psychiatric hospitalization, reduced emergency department usage for behavioral health crises, and (relative to hospital treatment) lower recidivism rates for those treated in the region's short-term crisis residential program.

Recent annual data (April 2013 – March 2014) demonstrate the impact:

Total number presenting for crisis services	6,005
Walk ins:	4,856
Ambulance:	764
Police:	385

Rae noted that of the 6,005 presenting for behavioral health crisis services, 4,477 would have gone to a hospital emergency department if the crisis center had not been available. She added that of all those who arrived at the crisis center on a petition and/or a clinical certification – the first step toward an involuntary psychiatric hospitalization – just 38 percent went on to involuntary hospitalization. Most – 62 percent – were "decerted" and diverted to effective, alternative treatment resources.

The presence of peers in local crisis programs sends a signal that the region's behavioral health consumers really appreciate, said Common Ground peer Paul Lyons. Recalling his own experience, he said that consumers are seeking alternatives to the trauma typically associated with a mental health crisis: forcible removal from their homes, followed by involuntary detention, commitment, and hospitalization. The presence and experience of peers at the regional center offers immediate and calming assurance to those in crisis that their voice and choices will be respected.

Peers help "get out in front" of crisis situations

Peer support programs, large and small, are growing around the country. A promising pilot program, funded by the Montana Health Trust and administered through the state's Health and Human Services Department, offers at-risk individuals an alternative to more intensive and costly services.

"We respond as needed to those in crisis," said Jim Hajny, Executive Director of the Montana Peer Network. "But this is really a prevention program." And, as service costs continue to rise overall, and continue to strain budgets, Hajny noted that "it is more and more important to find ways to 'get out in front' of crises.

The program itself is "activated" by law enforcement personnel, and built around a shared framework of crisis intervention training that involves both officers and peers. The program emphasizes communication, coordination, and linkage with other community resources that provide treatment or offer referrals of consumers who may need extra support, such as those discharged from state hospital care or those receiving more intensive services from local professionals.

Hajny noted that all referrals are served. "Our goal with the CIT process was to have virtually all of our local officers trained sufficiently in mental health to understand this demographic and appreciate the problems that people are having. We sat down with every officer, every deputy at their daily briefings to explain the program in detail and answer questions," said Hajny. He added that "law enforcement are the usually the first to know when someone is headed toward a crisis, because they're getting multiple calls into 911 from family, friends, or neighbors."

The program's focus on "getting out in front" of crisis has implications for how law enforcement responds and when peers get involved. "If police respond and someone is already in full-blown crisis, it's too late for us. At that point, the standard protocol – taking the individual into custody and going to the hospital ER – applies." Hajny says that peer support services are most effective earlier in the process, when trouble may be brewing but hasn't boiled over yet. "If law enforcement have 'seen a lot of someone' lately, if they're getting calls, or if they have visited someone's house and are called out again, that's the time to call us."

"We always go with the officers to make sure things are safe," he said. At that point, the consumer's history isn't important. "We just want to make that initial connection." At the same time, peers provide an information packet, full of local resources and suggestions for additional supports. The goal of each introduction is create one-on-one relationships that set the stage for a weekly supports that range from a chat over coffee, to a home visit, or a friendly phone call. Because of the program's community focus, few visits take place in an office. Conversation usually focuses on recovery, what the peers can do to assist individuals in that process, and how consumers can link with local health resources. "We want them to take responsibility for their own health."

To date, the two peer supporters have made 828 community contacts and received 100 consumer referrals in their two-county service area. In its first 15 months, the program provided an estimated cost avoidance of $174,000 against a startup budget of $118,000. "And that's just year one," said Hajny. "I bet we can do better in the future, even with a similar operating budget. So, we've provided a good return to the state."

Critical to the program's success has been solid peer support training and supervision. The training includes peer support certification, trauma-informed care, Wellness Recovery Action Planning (WRAP), Crisis Intervention (CIT, with law enforcement), ASIST suicide-prevention, and compassion fatigue

prevention. The peers also receive 3-5 hours per month of clinical supervision, including individual, group, and coaching sessions.

Peer services break the cycle: home-crisis-hospitalization

While Montana is piloting a smaller scale program, New York State is home to larger and more sophisticated offering of peer-run and peer-delivered services. PEOPLe Inc. (Poughkeepsie, NY) is one of those organizations, serving "people with psychiatric labels" in seven counties through primary funding from the NY Office for Mental Health. PEOPLe offers a continuum of diversion services, including a hospital diversion service that have, over 15 years, grown to include four "Rose House" locations that serve six counties.

The concept of Rose House is to help people break the cycle from home to crisis to hospital," said PEOPLe CEO Steve Miccio. Through the process of opening and operating the first two hospital diversion houses, the PEOPLe team recognized the value of crisis prevention, the importance of integrating with community, and the need for a broader continuum of crisis-diversion services. Today, that continuum has grown beyond the houses to include:

- 24/7 "warm" support lines
- In-home peer companionship, for those uncomfortable in leaving their own homes
- Social inclusion "nights out" to build personal relationships among consumers and peers
- Health care peer advocates based in ERs, hospitals, health clinics, and partial hospitalization programs who greet and assist consumers in obtaining care, avoiding trauma, linking to educational and employment services, considering non-hospital crisis alternatives, and joining local health homes.
- Open access peer navigators, to help at-risk individuals connect to community resources
- Mobile crisis support teams

Critical to the effectiveness of these services is a culture that continually seeks to engage consumers, educating them about choices and alternatives while building mutually trusting and empowering relationships. Because people often aren't familiar with what to expect from a hospital diversion program, Miccio explains that "transparency about what our programs can do is important. We want people to understand the choices that are available, that there are other ways to deal with crises." And when consumers arrive, the team focuses on providing a safe, trauma-informed, clean, and supportive environment. A typical Rose House location has only three beds.

Miccio said that although the Rose House concept was originally developed not to save money, but to provide a crisis-care alternative to ERs and inpatient psychiatric care, the concept is providing substantial cost-avoidance benefits. He cited conservative cost-avoidance estimates for one of the six Rose House locations in 2014:

Guests served:	128 (unduplicated)
Days in residence:	506
Estimated cost avoidance:	$ 809,600 (506 days x average hospital cost of $1,600/day) - 249,000 (Rose House operating cost) $ 560,600

He added that additional analysis suggested that each location could generate annual cost-avoidance of $2 to $4 million annually. "People come to Rose House for all of the same things that they would bring to an emergency room – coping issues, depression, abuse, suicidal thoughts, anxiety, stress – but they come back because they've learned that there's another way to deal with crises, without the fear of having to go to the ER and the risk of a hospitalization that they often don't need."

Working with managed care to expand peer programs

Offering a payer/managed care perspective on the value of peer support programs was Sue Bergeson, VP of Consumer Affairs for Optum Health. She explained that Optum Health reimburses for peer coaching when "people are having a hard time with recovery." Citing six-month results (pre/post) for consumers enrolled in peer coaching programs in New York and Wisconsin, Bergeson noted that enrollees:

- Were about 40% less likely to use inpatient services
- Spent significantly fewer days in inpatient treatment
- Increased their use of outpatient visits about 25%
- Cost 24 to 47% less to serve (total behavioral health treatment costs)

Bergeson explained that consumers who experience frequent crises "often don't have a community of support." In such cases, peer coaches can offer that support, teaching consumers a range of coping techniques and wellness practices that help them to adapt past, unhelpful behaviors and adopt more constructive approaches. At the same time, peers can introduce the consumer to mutual support and social opportunities, helping the consumer to build a community of his/her own that can make them feel more stable and secure.

Should a crisis come, "It's so important to create a space for the consumer – whether on a warm line, in an ER, a hospital, or on a call with first responders," Bergeson asserted, explaining that a little space often affords the chance for the person to reconsider their situation and decide, 'maybe I don't really need hospitalization' or 'can I cope with this situation in another way?'

"Many times in crisis situations, people just need to be 'safe,' so short-term services are often enough," said Bergeson. The respite offers a safe space where people can go, have a rest or something to eat, recall their strengths, and reactivate their recovery skills. After this pause, people are often ready to talk about and begin to address the issue that triggered the crisis.

ACTIONS:

When it comes to approaching a managed care organization to offer a service, Bergeson suggested that counties:

- Clearly identify who's involved—companies, partners, doctors, and other providers.

- Briefly present the programs you intend to offer and show their outcomes, specifically in the areas of improved health and decreased costs.
- Be patient – and forthcoming – when a payer requests detailed cost data. "Keep in mind that for many programs like these, an MCO is contractually accountable to a state or another customer for all of the moneys that are used. They must be able to justify the expenditures based on program outcomes."
- In circumstances when a program is new and no data is yet available, seek out and use data from a comparable program to illustrate your proposal.

Resources

Webinar: "Peers as Crisis Service Providers" available at http://www.nasmhpd.org/content/peers-crisis-service-providers

ACHMA Peer Services Toolkit: A Guide to Advancing and Implementing Peer-run Behavioral Health Services 2015 https://www.acmha.org/images/uploads/files/Peer-Services_Toolkit_2014.pdf

Hospital Diversion Services: A Manual on Assisting in the Development of a Respite/Diversion Service in Your Area http://www.power2u.org/downloads/OH-Hospital-Diversion-Manual.pdf

Paving New Ground: A Guide for Peers Working in Hospitals
http://www.nasmhpd.org/docs/publications/docs/2008/Bluebird%20Guidebook%20FINAL%202-08.pdf

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