



National Association of State Mental Health Program Directors
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Assessment #3

Crisis Services' Role in Reducing Avoidable Hospitalization

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Alexandria, Virginia

*Fourth in a Series of Ten Briefs Addressing: **What Is the Inpatient Bed
Need if You Have a Best Practice Continuum of Care?***

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Crisis Services' Role in Reducing Avoidable Hospitalization

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Human Trafficking Around the World: Hidden in Plain Sight
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Executive Summary

Crisis health care in the United States is built on the premise that a person needs either outpatient or inpatient treatment. The system is not nuanced, even though the needs of individuals with behavioral health issues may be incredibly so. David Covington, LPC, MBA, Chief Executive Officer and President at RI International, likens it to giving everyone the same sized shoe—if all that is available is Level 6 acute care, then that is what people will receive.

The result is that people often end up in an Emergency Department's (ED's) stream of care, which is problematic as patients can be stuck in the ED for long periods of time without receiving appropriate psychiatric care. In fact, researchers at Wake Forest University found that people with psychiatric emergencies spend more than three times longer in the ED than those with physical illness and injuries. It is not in the patient's best interest and is costly, resulting in a cost of \$2,264 per psychiatric patient.¹

The Agency for Healthcare Research and Quality (AHRQ) Healthcare Cost and Utilization Project (HCUP) stated in a May 2015 Statistical Brief that hospital readmission within 30 days of discharge typically represents a negative clinical outcome for patients with mental disorders. The brief goes on to point out that this may be due to a variety of factors, including a person's lack of access to adequate community-based aftercare, challenges to medication adherence, and self-care.² The same brief stated that between 2003 and 2011, mental health hospitalization increased at a faster rate than any other type of hospitalization.³

In response, behavioral health programs across the nation are fervently working to improve mental health crisis services as part of the care continuum they provide consumers. A retrospective quasi-experimental design in Australia found that consumers who used mobile community-based services were three times less likely to be admitted to a psychiatric inpatient unit than those who used hospital-based emergency services, *regardless of their clinical characteristics*.⁴ The Substance Abuse and Mental Health Services Administration (SAMHSA) states in its report *Crisis Services: Effectiveness, Cost-Effectiveness, and Funding Strategies* that crisis services can indeed decrease avoidable hospitalizations.⁵

¹ Nicks B.A. & Manthey D.M., The Impact of Psychiatric Patient Boarding in Emergency Departments, *Emergency Medicine International Volume 2012, Article ID 360308* (June 2012) <https://www.hindawi.com/journals/emi/2012/360308/>.

² Heslin K.C. Ph.D. & Weiss A.J. Ph.D., *AHRQ/HCUP Statistical Brief #189: Hospital Readmissions Involving Psychiatric Disorders, 2012* (May 2015) <https://www.hcup-us.ahrq.gov/reports/statbriefs/sb189-Hospital-Readmissions-Psychiatric-Disorders-2012.pdf>.

³ *Ibid.*

⁴ Hugo M., Smout M., & Bannister J., A comparison in hospitalization rates between a community-based mobile emergency service and a hospital-based emergency service. *Australian and New Zealand Journal of Psychiatry* 36, 504–508 (2002).

⁵ *Crisis Services: Effectiveness, Cost-Effectiveness, and Funding Strategies*, HHS Publication No. SMA-14-4848. Substance Abuse and Mental Health Services Administration, Rockville, MD (2014).

The research base on the effectiveness of crisis services is growing. There is evidence that crisis stabilization, community-based residential crisis care, and mobile crisis services can divert individuals from unnecessary hospitalizations and ensure the least restrictive treatment option is available to people experiencing behavioral health crises. Additionally, a continuum of crisis services can assist in reducing costs for psychiatric hospitalization, without negatively impacting clinical outcomes.⁶

The objective should be to create what John Draper, Chief Clinical Officer of the New York City Chapter of Mental Health America and Project Director of the National Suicide Prevention Lifeline, calls “ground and air supports.” Crisis services need to go far beyond the health care system and into the community, including virtual, mobile access to support, hope, help, and self-care. To adequately reduce avoidable hospitalizations crisis services need to collaborate with other agencies and service providers—including social services. They must also address consumer vulnerabilities such as homelessness, severe mental disability, and substance abuse.

In this paper, we look at how Magellan Health Services matched people to available and accessible crisis services, law enforcement as partners in mobile crisis services, follow-up after crisis, and the role of public health campaigns in the care continuum. We also examine the roles of technology and people with Lived Experience in crisis services, and how hospital collaboratives can reduce hospital readmissions. Research for this paper included interviews with David Covington, John Draper, Charryse Wright, a social worker and military veteran with Lived Experience, and numerous members of the New York State Office of Mental Health Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES) team. We also interviewed Mary U. Vicario, LPCC-S Certified Trauma Specialist and founder of Finding Hope Consulting, and Janice Johnston, Program Administrator at the Kentucky Department for Behavioral Health, Developmental and Intellectual Disabilities.⁷

Introduction

Most states acknowledge the importance of and provide some semblance of a crisis services continuum that may include hotlines, mobile crisis units, and short-term residential services. In fact, SAMHSA has identified numerous other core crisis services, such as 24/7 crisis hotlines, 23-hour crisis stabilization/observation beds, warm lines, peer crisis services, and psychiatric advance directive statements.⁸ Nevertheless, most communities fail to provide a sufficient array of available and accessible crisis services. As a result, providers often don’t match people to appropriate services.

⁶ *Ibid.*

⁷ Interview with David Covington on May 9, 2017; Interview with John Draper on May 8, 2017 and again on May 25, 2017; Interview with Charryse Wright on June 2, 2017; Interview with Chris Smith, Erica Van De Wal, Molly Finnerty, and Denise Balzer on March 2, 2017, Interview with Denise Balzer and Erica Van De Wal again on May 10, 2017; Interview with Mary U. Vicario via email on April 24, 2017; and interview with Janice Johnston on March 2, 2017.

⁸ *Crisis Services.*

Most communities in the United States build their behavioral health services under the binary assumption that a person needs outpatient or inpatient treatment. David Covington says the problem is that people’s treatment needs are much more nuanced than that. People whose needs require Level 3 or 4 services often get sent to Level 6 acute care when their family members get overwhelmed or when the person is afraid and anxious. Covington says that there are numerous entry points into the Emergency Department (ED)—law enforcement, 9-1-1 services, or a community mental health center, but that once a person is in the ED, it automatically triggers a higher intensive call of services. “The ED is a current all its own,” Covington says. “It doesn’t matter which way the person is swimming.”

In communities where there is not a sufficient array of crisis services, providers match people with the next available higher service level. Meaning, if the person needs level 3 or level 4 services but what’s available is Level 6 acute care, then Level 6 is what he or she will receive. Covington says, when management staff reviews the case two days later, they may determine that the patient did not meet clinical criteria for that level of service, but they are not going to be able to provide a lower level of service if it is not available. “Providers don’t go down the continuum to something less than the person requires. They must go up.”

The Emergency Room as Default Crisis Service Provider

People who need access to crisis programs are generally first directed to get medical clearance from a hospital. The rationale is that providers want to ensure the person in crisis is medically safe for the crisis program to treat. Covington says this sounds good, but the result is—depending on the ED system they enter—those referred can be trapped in the ED for days, shackled to gurneys before they are sent to crisis facilities. Psychiatric boarding, also known as “warehousing,” is a controversial practice that gained nationwide attention in 2013 when psychiatric patients in Washington State were involuntarily detained in a hospital ED setting while awaiting certified evaluation and admittance to treatment facilities. According to reports published in the [Seattle Times](#), people were involuntarily detained for an average of three days or, in some cases, months, bound to beds or parked in hallways without receiving any psychiatric care aside from medication. In some cases, even medication was delayed.

Ten Washington State psychiatric patients filed suit. Each had been treated in acute care facilities or EDs not certified as evaluation and treatment centers. Each had been placed in facilities/hospitals under single bed certifications, a certification that Mental Health Commissioner Craig Adams found unlawful at an evidentiary hearing on February 27, 2013. He determined that a patient involuntarily detained in a single bed certification “gets no psychiatric care or other therapeutic care for their mental illness” and that it’s unlawful to use the certification to avoid overcrowding certified facilities for evaluation and treatment. In 2014, the Washington State Supreme Court sided with the patients and banned psychiatric boarding, ruling that Washington State’s Involuntary Treatment Act

(ITA) “does not authorize psychiatric boarding as a method to avoid overcrowding certified evaluation and treatment facilities.”⁹

Not only is psychiatric boarding not in the patient’s best interest and can result in trauma and safety issues for both the patient and staff, but it is also [millions of dollars](#) spent that does not lead to the care the patient needs. In fact, researchers at Wake Forest University found that it costs \$2,264 per psychiatric patient.¹⁰

Psychiatric hospitalization and rehospitalization are not always avoidable, but establishing why they occur is critical to determining which ones could have been avoided. According to a 2009 study, nearly 20 percent of Medicare beneficiaries were rehospitalized within 30 days of discharge in 2004, resulting in a cost of [\\$17.4 billion](#).¹¹ The top reasons for hospital readmission among Medicare admissions in 2011 were schizophrenia and other psychotic disorders, and mood disorders. In that year, mood disorder [readmissions among Medicaid enrollees](#) (41,600) cost \$286 million, schizophrenia and other psychotic disorders readmissions (35,800) cost \$302 million.¹²

Crisis community-based intervention reduces hospitalization, even among particularly vulnerable patients, such as those with mood and psychotic disorders. A retrospective quasi-experimental design found that consumers who used mobile community-based services were three times less likely to be admitted to a psychiatric inpatient unit than those who used hospital-based emergency services, *regardless of their clinical characteristics*, thereby reducing the influence of health disparities.¹³ Another quasi-experimental study found that community-based crisis intervention successfully reduced hospitalization by 8 percent.¹⁴ In fact, within 30 days after a crisis incident, a consumer in a hospital-based intervention was 51 percent more likely to be rehospitalized than one using community-based mobile crisis services.

Covington says the answer is not increasing inpatient psychiatric beds but instead keeping people out of the ED when it’s avoidable and pairing them with appropriate services. He makes an argument similar to that of SAMHSA, which states that a continuum of crisis services not only reduces psychiatric hospitalization, it can do so without adversely affecting clinical outcomes.¹⁵ Covington says that it is in the best

⁹ *IN RE: THE DETENTION OF D.W. et al., Respondents, Franciscan Health Care Systems and Multicare, Health System, Respondents/Intervenors, v. The DEPARTMENT OF SOCIAL AND HEALTH SERVICES and Pierce County, Appellants*, Supreme Court of Washington, No. 90110-4, (August 7, 2014).

¹⁰ Impact of Psychiatric Boarding in Emergency Departments.

¹¹ Jencks S.F., Williams M.V., and Coleman E.A., Rehospitalizations Among Patients in the Medicare Fee-for-Service Program, *N Engl J Med* 2009;360:1418–1428 (April 2, 2009).

¹² Pincus H.A., *Care Transition Interventions to Reduce Psychiatric Re-Hospitalizations*, https://www.nasmhpd.org/sites/default/files/Assessment%20%233_Care%20Transitions%20Interventions%20toReduce%20Psychiatric%20Rehospitalization.pdf (September 15, 2015).

¹³ Hugo, Smout & Bannister.

¹⁴ Guo S., Biegel D., Johnsen J. & Dyches H., Assessing the impact of community-based mobile crisis services on preventing hospitalization, *Psychiatric Services*, 52, 223–228 (2001).

¹⁵ Substance Abuse and Mental Health Services Administration. Crisis Services: Effectiveness, Cost-Effectiveness, and Funding Strategies. HHS Publication No. (SMA)-14-4848. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.

interest of the patient not to be hospitalized when it is avoidable, and that crisis services are the best place to start.

Matching People to Available and Accessible Crisis Services: Magellan Health Services Case Study

David Covington says it's not just mental health providers that want to increase crisis services, but also health plan providers. As Vice President of Magellan Health Services' Clinical & Program Outcomes division, Covington was responsible for \$750 million in continuum-of-care services, ranging from Level 6 acute care to Level 1 peer support. When he joined Magellan, it had just experienced a loss of 30 million dollars. "That's not the trajectory a for-profit company wants."

Simultaneously, the 2008-09 recession hit and members faced unemployment and underemployment, forcing Magellan to reduce rates. The crisis triggered the company to think "outside the box" and find opportunities to meet people's needs in an effective and less costly way, which Covington says was challenging. Crisis services, where members can be diverted from hospitalization, became the focal point. The strategy resulted in reduced costs, and members could be matched with the appropriate level of services.

A health plan is designed to create effective, safe, and cost-effective care that is optimal in that specific scenario. Covington and his team examined the needs of Magellan's members, roughly a million individuals covered by Medicaid. Roughly 25,000 members were adults with serious mental illness such as schizophrenia, bipolar disorder, or major depression, or were schizoaffective. Nearly the same number were children with severe emotional disturbances, and 55,000 were adults with general mental health and substance abuse issues that did not meet state diagnostic and functional criteria for serious mental illness.

According to Covington, all levels must be available *and* accessible; otherwise, they are not really available and providers are likely going to ramp up to a higher level of care. At Magellan, he specifically targeted areas in Phoenix where the population had grown dramatically, after which his team developed core services and a call center hub that served as a real-time valve for orchestrating service access and ensuring capacity and accessibility.

Covington and his team saw the ED as the Alamo; the battle was lost once the consumer ended up there. The team developed mobile crisis services outreach in the community, to meet people as they needed services, so they would not fall into the ED stream. The Magellan outreach team would meet people in crisis wherever they were—a street corner, the person's home, a social service agency, or jail. Instead of the person having to go to clinical staff, the staff would come to him or her. "It's simply the virtue of protocols, procedures, and risk management," Covington says. Similar to the inter-relationship between engagement with law enforcement and incarceration, there is a higher likelihood of inpatient admission once a person enters the ED in the absence of community-based engagement.

Magellan also helped higher-risk consumers avoid the ED stream by appropriately matching them with small, acute Level 5 Living Room stabilization facilities with 16

beds, which are much less intrusive and costly than hospitalization. His team also focused on ensuring that programs were fulfilling their contracted duties. For example, one program had 31 subacute beds that had been co-opted as a discharge step-down program for longer-term acute care. The length of stay was supposed to be 3 to 5 days but had turned into 70 to 90 days on average. “It was as though they looked at the HOV lane and decided it was not as full as the other lanes, so they stopped using it,” Covington says. “It could have been catastrophic for Magellan because a diversion program—which is what it was designed as—is much more powerful and less costly than longer-term beds when the ED is looking to discharge people appropriately.”

Over a five-year period, Covington and his team drilled down into their data and realized there was a Level 3 cohort entering the ED because services were not available at the time of day they needed them. For example, people who faced a medication need—e.g., they ran out or lost their medication—at 2 a.m. did not have appropriate options. They could only access available services and those were at the ED, putting individuals not in acute need in the ED stream. “These were people who were receiving outpatient care but ran out of their anxiety, depression, or antipsychotic medication and needed the problem solved,” Covington says. To address the issue, the team opened 24-hour urgent care outpatient centers that were physically co-located with short term residential facilities. This allowed Magellan to meet this population’s specific needs.

Covington says that nationwide, communities are not matching people with their need level, which is much like giving everyone the same shoe size. “It just doesn’t make sense. We are trying to squeeze everyone into a size 4 when they may be a 7, 8, 9, or 10. We decided that maybe people should get matched with their actual size and began looking at half sizes.”

Law Enforcement as Partners in Mobile Crisis Services

Law enforcement and first responders are critical partners in mental health crisis services. The hurdle, says Covington, is that law enforcement will do what is easiest and fastest—whether that’s charging people with a nuisance crime, dropping them in jail, or redirecting them. “Cops are going to do their job, but we cannot expect them to be the mental health team.”

To reduce avoidable hospitalization and reduce costs, it is essential that mental health service providers allow law enforcement to drop off people who are experiencing psychiatric issues at crisis programs. Covington says the key to fostering a partnership with law enforcement and first responders is twofold: Law enforcement needs to be back on the street in 5 to 7 minutes, and crisis programs must take every person law enforcement brings. It’s so simple, says Covington, but it has a huge impact on accessibility, safety, and cost-effectiveness.

RI International has 14 crisis programs in 5 states. Twenty-three percent of admissions come directly from law enforcement drop-offs. RI International personnel manage a quick turnaround of no more than three minutes from the time law enforcement personnel

drive up to their facility to the moment they drive away. “Every time you make it efficient for law enforcement, you strengthen the relationship,” Covington says.

He says that, before he joined RI International, many programs were turning away drop-offs. “They were receiving nearly 100 police drop-offs a month that they were telling law enforcement they could not accept” because the person was intoxicated or the program was overextended. The denial of care ended up hurting the programs and chipped away at their relationships with first responders. Now RI International programs make it as easy on law enforcement as possible. There is no referral process; officers simply walk in with the person, give the facility information they have, and return to their jobs. The programs now get hundreds of drop-offs each month who can avoid the ED stream and find programs that adequately match their needs.

Suicide Prevention and Follow-Up After Crisis

When darkness closes around a person and he or she begins to contemplate suicide, it is difficult for that person to find reasons to live, reasons to *want* to live. John Draper says this is because it is the limbic system that responds to acute stress. It is designed to deal with threat and is programmed to have one of three responses: Fight, Flight, or Freeze. He says that when the brain determines a threat, the prefrontal cortex—the rational and newer part of the brain—goes offline and allows the limbic system to take over to address the threat. Rational thinking, says Draper, goes out the window.

People assisting a person in crisis have to start by helping that person feel safe so that they no longer believe they are threatened in some way. Drapers says this allows the prefrontal cortex to come back online. Crisis support does this by developing rapport with the person, connecting with him or her, and developing a sense of safety. “It’s important that people in crisis have a place where they can go and feel safe, where they aren’t judged, where there is anonymity, and immediate access to crisis services,” Draper says. This is why hotlines are critical—they do just that for free.

One hiccup in crisis response is that the rapport and sense of safety by one provider is not always passed along to the next step in the continuum. This is where Draper says many people get lost. They may be engaged in one environment where they feel safe and then are discharged or sent to another place where they no longer feel that way. A particularly high-risk time is when people are discharged from an inpatient unit or the ED. “We know that there is a greater number of suicides post-discharge from inpatient rooms or the ED.”

There are numerous reasons why the risk increases. It could be that whatever led the person to be a danger to him- or herself or others is still present at discharge. While the individual may have felt safe and comforted on the inpatient unit or in the ED, the environmental stressors leading them to feel badly in the first place do not necessarily exist there. When the individual is sent back to his or her home without any support is when he or she may be most at risk.

Another possibility, says Draper, is that the individual had a negative experience at the hospital or that being hospitalized adversely affected his or her business or personal

relationships. The individual may face stigma, shame, and fear. “It’s essential, in the chain of care, that there is someone on the other side of discharge that can receive and support people, helping them feel safe, connected, and provide needed services. To do just this, many National Suicide Prevention Lifeline crisis centers not only accept calls but often make two critical follow-up calls:

1. If people who call in are deemed in some way to be suicidal, but not suicidal where they need to be in a protected environment like a hospital, call responders seek consent from callers to follow up with them to provide continuing support until the risk is significantly reduced and/or they are linked to treatment.
2. Thirty percent of Lifeline centers collaborate with hospitals to follow up with individuals discharged from the hospital or ED. Centers make contact with people on discharge, typically within 24 to 48 hours.

Draper says follow-up is crucial because it fosters a critical human connection. A recent analysis of Lifeline’s follow-up calls, funded by SAMHSA, was conducted by Madelyn S. Gould, Ph.D., M.P.H., Professor of Epidemiology in Psychiatry at Columbia University, College of Physicians and Surgeons, and a Research Scientist at the New York State Psychiatric Institute (NYSPI). Her study revealed that only 20 percent of people who consented to follow-up said they did not need it because they were feeling much better. The vast majority (80 percent) said it made some difference in keeping them alive; half of this group said it was the *reason* they were alive.¹⁶

When asking why the latter was the case, people pointed to the human connection—simply another person valuing them enough to call and see how they were doing was powerful enough to keep them alive. “It’s a simple but remarkable finding,” Draper says. “Just having another person care and reach out can change a person’s trajectory.”

Suicide Prevention Public Health Campaign as Part of the Care Continuum

Discovering that follow-up calls can alter a person’s trajectory is, in part, why Draper believes suicide prevention should be part of a holistic public health campaign. He believes empowering people to become crisis responders is akin to teaching them cardiopulmonary resuscitation (CPR). When people know CPR, they will call 9-1-1 in an emergency, but they also have an additional tool to use until emergency services arrive. “Why should suicide prevention be any different?” Draper asks.

Over the past 60 years, the number of people dying of heart disease and certain cancers has drastically decreased. This is not simply because of advancements in medicine, but also because people are empowered with preventative changes they can make in their everyday lives—such as not smoking or chewing tobacco, improving their nutrition, and

¹⁶ Gould M.S. Ph.D., MPH *et al.*, Follow-up with Callers to the National Suicide Prevention Lifeline: Evaluation of Callers’ Perceptions of Care, *Suicide and Life-Threatening Behavior*, American Association of Suicidology (March 2017), <http://onlinelibrary.wiley.com/doi/10.1111/sltb.12339/abstract>.

exercise. Yet, says Draper, when it comes to suicide prevention messaging, no one is sharing the message that simple acts of caring can make a significant difference:

For every person that dies by suicide, annually, we know that there are 278 other people who think seriously about it but don't do it. They aren't necessarily calling hotlines or going to mental health professionals; many are speaking with friends, family, clergy, teachers, and coaches. They are speaking to people in their lives who are accidentally saying and doing the right things.

When people are asked what stopped them from committing suicide, Draper says the first three reasons they list are: Spirituality, talking to friends and family, and positive thinking. The fourth reason is mental health treatment and reaching out to a hotline. This is why, says Draper, mental health experts need to pull the camera back a bit, become less myopic, and look at the entire picture. They should not just focus on the health care system they are engaged in, but also on the public health messaging surrounding suicide prevention. It's akin to war, he says—doctors, therapists, and peer support are on the ground, but it's family members, public service messaging, and the community that is in the air. “We need a cloud of support that can surround individuals in need. We need more people in the air.”

Technology and Crisis Services

Mental health providers are increasingly aware of the benefits mobility offers consumers and providers. Technologies that integrate crisis services and suicide intervention are rapidly growing—on one end mental health providers are quickly able to access critical patient information and on the other, people in distress can reach out to peer support communities that are learning basic cognitive behavioral therapies. On the mental health provider side is PSYCKES, a technological platform used throughout New York that can be accessed by mental health providers on their desktop, iPhone, or iPad. Among new consumer technologies are #BeThe1To and Koko, an app designed to empower at-risk populations and arm community members with intervention tools.

PSYCKES

In New York State, the Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES) is a web-based platform supported by the Office of Mental Health (OMH) that is used by over 400 provider agencies, counties, and managed care organizations (MCOs). The system can be accessed on a mental health provider's desktop, iPhone, or iPad. MyCHOIS is the consumer-facing PSYCKES component, where people can access their health records and other recovery tools.

The platform is used for assessment, treatment, planning, and quality management. It's also implemented in the majority of hospitals, community mental health clinics, local government authorities, and MCOs statewide. The system pulls from Medicaid billing and other state administrative databases and displays an integrated view of a patient's

treatment history. This includes medications dispensed at the pharmacy, outpatient services, hospitalizations, and health home care management. It features built-in quality measures and alerts that monitor medication adherence and whether a person has been prescribed multiple medications in the same class, such as antipsychotics.

PSYCKES is designed to give clinicians and quality managers the critical information they need for data-driven decision-making and to be as user-friendly as possible. That said, OMH and partners wanted to do more by adding new functions within PSYCKES to support crisis management in the state. Using a NASMHPD Transformation Transfer Initiative (TTI) grant, OMH developed a crisis suite with essential clinical information, suicide screens, suicide alerts from the state incident management system, safety plans, and psychiatric advanced directives that are accessible with the click of a button for crisis response units. The crisis suite is designed to improve crisis assessment and service planning and to reduce unnecessary ED visits and inpatient hospitalization.

New crisis enhancements were added to the My Collaborative Health Outcomes Information System (MyCHOIS). MyCHOIS has three primary components: (1) treatment data, which allows Medicaid consumers to access their treatment history; (2) a learning center with recovery tools and educational materials; and (3) screenings and assessments. It supports shared-decision making, active participation in treatment decisions, and patient-centered care. The new crisis features added to MyCHOIS include the ability for clients and clinicians to complete a suicide screening using the Columbia Suicide Severity Rating Scale (CSSRS), load new safety plans and psychiatric advanced directives, or create a new safety plan using a Stanley-Brown template. Users can also screen for and monitor depression symptoms using the Patient Health Questionnaire (PHQ-9).

Also, the TTI grant supported development of a secure PSYCKES mobile application for iOS devices (iPhone and iPad), which launched in late April 2017. The “app” allows providers to securely log in, look up a client whom they are serving, and view the Clinical Summary for that client. The information at a glance includes demographics, care coordination, medication, suicide attempts and suicidal ideation alerts, as well as inpatient and outpatient medical and behavioral health services. “It will make it even easier for crisis units in the field to access PSYCKES and quickly review critical clinical information,” says Chris Smith, OMH Director of Adult Services at the NYC Field Office.

To train PSYCKES users on the new crisis suite, OMH has conducted several live demonstrations for Assertive Community Treatment (ACT) teams, the Comprehensive Psychiatric Emergency Department (CPEP), mobile crisis teams, Performing Provider Systems, Greater New York Hospital Association members, and hospitals participating in OMH’s Hospital Readmission Quality Collaborative. Also, mental health clinics participating in OMH’s Suicide Prevention quality collaborative will receive training on how to use the new PSYCKES crisis suite to support suicide prevention. Finally, a Crisis Learning Collaborative is planned where participating providers will be trained to use the crisis suite features to support delivery of their crisis services, including mobile crisis, respite, and crisis stabilization.

The crisis suite is already being used in some initiatives, including a pilot project that seeks to reduce mobile crisis response time and connect people to care more rapidly in the Upper Manhattan area of New York City. This pilot project is a collaboration between OMH, the New York Office of Alcoholism and Substance Abuse Services (OASAS), the Mt. Sinai Performing Provider System, NYC Well, the NYC Department of Health and Mental Hygiene, and other community partners. NYC Well provides a centralized phone emergency response and triage hotline. Clinicians answering the hotline link callers to mobile crisis providers who have quick access to the critical data and can rapidly respond to crisis situations and ensure that follow-up care is implemented. The pilot group in Manhattan can access PSYCKES on the go from their laptops and mobile phones, which helps them provide better quality of care. The goal of the pilot is to reduce mobile crisis team response time, which previously was as long as 48 hours, down to two hours. The team has thus far succeeded, responding to callers within the two-hour objective.

Molly Finnerty, M.D., Director, Bureau of Evidence-Based Services and Implementation Science and PSYCKES Initiatives at OMH, says the crisis suite is essential to helping reduce readmission.

“Knowing a client is critical,” Dr. Finnerty says. “The less a clinician knows about a client, the less comfortable he or she feels managing the client’s crisis. Clinicians don’t want to be responsible for making the wrong decision—they will admit someone if they have a bed, can see that he or she is sick, and they don’t have a way to find out more information about the person. The mobile suite gives clinicians essential information on the client, including his/her outpatient contacts and prescribed medications. The clinician can identify whether the client has gone off his/her medication, for how long, and whether that’s a contributing factor in the current crisis. Rapid access to the PSYCKES suite helps clinicians engage in dialogue with the client’s existing provider, helping to divert him or her from hospitalization.”

Suicide Intervention

The more people are educated and trained in suicide intervention, the more they are open to talking about suicide. At present, most public health messaging focuses on warning signs in individuals at risk. Draper says this approach is not reducing the suicide rate because people generally know when someone they care about is in trouble; what they do not know is what to do about it. He says it’s essential to give people options beyond suffering alone or trying to get a hard-to-schedule outpatient clinic appointment. “It’s about putting the power in people’s hands, giving those close to the person the resources to help.”

To do just that, the National Action Alliance for Suicide Prevention and the National Suicide Prevention Lifeline launched Bethelto.com, a campaign that aims to shift the conversation from suicide to suicide prevention and create a space where people can learn how to help themselves and others, and consult with trained providers. The website also includes a [toolkit](#) with five action steps—supported by evidence—that individuals can take when communicating with someone who may have suicidal thoughts. Those action steps are:

1. **Ask:** “Are you thinking about killing yourself?”
2. **Keep them safe:** Separate them from anything they are thinking of using to hurt themselves.
3. **Be there:** Listen without judgment and with compassion and empathy.
4. **Help them connect:** Whether it’s 800-273-Talk (8255), family, friends, clergy, coaches, co-workers, or therapists.
5. **Follow up:** Check in with the person you care about on a regular basis.

In the next few years, Draper plans to add more examples (e.g., videos) to the toolkit demonstrating the five steps. “We want people to understand and get a feel for how to do it,” Draper says. “They need to see it and practice it.”

Hope Contagion and Self-Help

The opposite of resilience is what mental health experts call “suicide contagion.” Marilyn Monroe committed suicide in 1962, which resulted in extensive nationwide media coverage and a 12 percent increase in suicides the very next month.¹⁷ Draper hopes to create similar momentum behind an entirely different contagion, hope. Hope is such an essential component to mental health and substance recovery that SAMHSA calls it the [recovery process catalyst](#).

On the National Suicide Prevention [Lifeline for Attempt Survivors](#) website are videos of people sharing their hope and recovery stories. “Many people use social media to connect with others and use the internet to obtain information, including those who are suicidal,” Draper says. “Historically, this has resulted negatively because of how the media reports on suicide. Our goal is to make hope and recovery stories more prominent and accessible so that people can easily find help and hope.”

There are two, often overlapping, audiences—those who need help and those who can learn lifesaving tools to give help. Draper says one audience could quickly become the other, where the person in recovery can become a peer for someone in need. Draper says that a few years ago, he met a man who survived several suicide attempts and began working as a peer. The work as a peer aided his recovery. “Beforehand, he wasn’t sure about peer support and was skeptical about its impact. Afterward, he told me, ‘When I saw that I can have a positive impact on somebody’s life, I never wanted to live more in all of my life.’” Draper says this emphasizes the incredible and beneficial power of mutual self-help. It fosters hope for both those helping and recipients. This is a space where technology and social networking can be immensely powerful.

Social media can also be a space where crisis, abuse, and bullying transpires, which is why MIT Media Lab coder Robert Morris co-founded [Koko](#) as a safety net for social networks. Koko is available via its website, [Facebook Messenger](#), [Twitter](#), [kik](#), and [Telegram](#). The anonymous self-help community provides positive responses for those

¹⁷ Stack S., Media Coverage as a Risk Factor in Suicide, *Journal of Epidemiology and Community Health* 57 (4) (2003), <http://jech.bmj.com/content/57/4/238>.

seeking them, while the Koko bot teaches users basic tips on cognitive reformulation and reframing.

When the chat begins, Koko prompts the user to share what he or she is struggling with from a list of categories: Dating, work, friendships, school, family, or other. Then Koko suggests the user write three to four sentences about the issue and asks “What’s the darkest thought you have about your situation?” Next, Koko prompts the user to reframe the situation with something positive. The scenario is then sent out into the Koko-universe where people can reply with positive reframing and suggestions. The entire process is anonymous.

While users await a reply, Koko prompts them to try helping others, rewarding them with “Karma,” a score that illustrates how much they have helped. The site states that 90 percent of its users say helping others helps them feel better. The Koko bot gives helpers tips on how best to formulate scenario responses to help a person with suicidal ideation think more positively. Draper says this approach means users enter the community as a person who both wants and can give help. He says this reduces the stress the person feels, as aiding others boosts the helping individual’s resilience, fostering hope.

Safety Plan

When people are in distress, it can be helpful to turn to an individually tailored safety or crisis response plan. Included is a list of what the person finds soothing, such as a warm bath, taking a walk, petting his or her dog, or dimming lights and listening to music. Another component is a contacts list—those people in the person’s life who are excellent at distracting him or her and those who are great to reach out to when the person needs to work through problems. “They are not necessarily the same people,” Draper says. A third list includes formal supports and professionals who the person can turn to when informal supports are not available or appropriate for what he or she wants to discuss.

Also, people can add their reasons for living to the safety plan/crisis response plan. “This includes what’s meaningful to them and what they need to be reminded of when in distress,” Draper says. People can also create a hope kit that includes mementos, photos, documents, trinkets, and anything that reminds them of what and who is meaningful to them. “These plans and kits help provide people with a lifeline out of the darkness. It’s a map to a better place.” There are numerous ways people can personalize and store their safety plans, including taking photos of a handwritten plan with a smart phone or using a mobile app to create a plan.

The benefit of making the safety plan mobile is that it allows the individual to immediately access his or her plan, no matter where he or she may be. That is why the National Suicide Prevention Lifeline created [MY3](#), a safety plan mobile app that is available on Apple and Android. MY3 is owned and maintained by Link2HealthSolutions, Inc., a Mental Health Association of New York City subsidiary. It was created in partnership with the California Mental Health Services Authority and funded by the California Mental Health Services Act (Prop. 63). It is aptly named to

mirror the three people an individual would want to talk to when having suicidal thoughts.

MY3 allows people to customize a safety plan from a [template](#) adapted from content developed by child psychologist Barbara Stanley Ph.D. & clinical psychologist Gregory K. Brown Ph.D. and the Department of Veterans Affairs. The template includes: (1) the person's warning signs that a crisis may be developing; (2) internal coping strategies; (3) people and social settings that provide distraction; (4) people whom the person can ask for help; (5) professionals and/or agencies to contact during a crisis; and (6) ways to make the environment safe. It also contains critical resources, including those for especially at-risk populations such as veterans and LGBTQ youth.

Including People with Lived Experience in Providing Crisis Services

Mary U. Vicario, LPCC-S, Certified Trauma Specialist and founder of Finding Hope Consulting, LLC, says including people with Lived Experience in crisis services is critical. She says peer support, in particular, helps foster the second strongest resilience factor, affiliation. "This deters people from returning to unhealthy affiliation sources, like gangs," says Vicario. Peer support also provides recipients external support and a sense of self-worth, two other critical resilience factors. Clients have told her that connecting with someone like them helps them feel more understood and less alone. "They often say, 'It's so nice to know that I am not the only one,'" says Vicario.

Mutual self-help or peer support helps increase treatment participation among consumers. This is true even for people traditionally difficult to engage in mental health, such as veterans with substance use disorders¹⁸ and people with co-morbid mental health and substance use conditions.¹⁹ Charryse Wright, a social worker with Lived Experience, says it shows recipients that they can get through the recovery process because the peer working with them has. She says she does not try to make the experience look pretty or easy, but sometimes people compare themselves to others in the recovery process and get frustrated. Wright reminds the people she works with that everyone's journey is different; what works for one person does not necessarily work for another. "When triggered, people often default to what's comfortable and familiar, whether that's having sex with random people, drinking, or using drugs. We work on finding a place where the person feels safe enough to, when triggered, write in a journal or call a friend. It takes time and constantly reminding people not to beat themselves up if they slide backward."

Janice Johnston, Program Administrator at the Kentucky Department for Behavioral Health, Developmental and Intellectual Disabilities, has jump-started coordinated trauma-informed peer support services as a bridge from the hospital to the community for young

¹⁸ Tracy K., Burton M., Nich C., Rounsaville B., Utilizing peer mentorship to engage high recidivism substance-abusing patients in treatment, *The American Journal of Drug and Alcohol Abuse* 2011;37:525–531 (2011).

¹⁹ Singh N.N., Barber J.W., Van Sant S, *Handbook of Recovery in Inpatient Psychiatry. Series: Evidence-Based Practices in Behavioral Health*, Springer International Publishing (2016).

adults in Kentucky. The program, funded by a NASMHPD Transformation Transfer Initiative (TTI) grant, is geared to people 30 years old and younger who are discharged from their first hospitalization from any of Kentucky's four state-operated psychiatric hospitals. She says the number one ingredient for developing a peer support program is involving the consumer voice. "Words are not adequate to express its necessity," Johnston says. "The incredibly rich discussions held at each meeting could not have happened without the voices of young adults with Lived Experience and peer specialists who were willing to share their thoughts throughout the process. They have been integral to our success."

Peer support has been associated with improved recovery, improved quality of life, and job skills, as well as fewer major life problems and greater social support. This is true even for participants with co-occurring mental health and substance abuse issues; they experienced fewer crisis events and hospitalizations, greater reduction in substance abuse, and improved quality of life and social functioning.²⁰

Also, peer support is mutually beneficial, aiding recipients and peers. A Pennsylvania study examined benefits experienced by the State's Certified Peer Specialists (CPS), finding that participating CPSs had significant reductions in inpatient hospitalization and crisis services. The experience helped both psychologically and financially; peers—most of whom were not working before CPS employment—became employed. This reduced or eliminated their dependence on Social Security Benefits.²¹ The vast majority of CPS participants agreed or strongly agreed that training helped them develop critical skills that aided their life and recovery, making them more hopeful and confident. They also agreed/strongly agreed that the experience gave them an ability to give back to others, which was useful in their recovery and resilience.

Another way to integrate Lived Experience into a program is through an advisory committee. In March 2010, the New York State OMH combined the Recipient Advisory Committee and the Committee for Families into one group called the [Regional Advisory Committee](#) (RAC). The RAC's public meetings are designed for recipients and families to provide actionable advice to OMH. They take place quarterly through video-conferencing and in-person meetings. During one of these meetings, the OMH TTI grant workgroup collected feedback from consumers on crisis intervention services. "It was really exciting to see all the consumers throughout the state who actively gave feedback to NYS OMH. They were really interested in sharing what it's like to be in a crisis and hurdles they face," reports Erica Van De Wal, OMH Research Scientist on the PSYCKES team.

During the RAC meeting, the workgroup asked consumers, "If you were given a magic wand, what would you want in a crisis management system?" Consumers advocated for the ability to have their relapse prevention plans available to clinicians serving them in a

²⁰ Salzer M.S., & Mental Health Association of Southeastern Pennsylvania, *Consumer-Delivered Services as a Best Practice in Mental Health Care and the Development of Practice Guidelines: Psychiatric Rehabilitation Skills*, 6, 355–382 (2002), <http://www.cdirectory.org/SalzeretalBPPS2002.pdf>.

²¹ Salzer M.S., Darr N., Calhoun G., Boyer W., Loss R.E., Goessel J., Schwenk J., & Brusilovskiy E. (2013). Benefits of Working as a Certified Peer Specialist: Results from a Statewide Survey, *Psychiatric Rehabilitation Journal* 36 (3), 219-221 (2013), <http://psycnet.apa.org/record/2013-32236-005>.

crisis. They highlighted the importance of also providing non-mental health providers with access to critical data in the PSYCKES suite, such as their primary care physicians. To expedite response time, consumers also suggested sending an emergency text notice to providers when a patient is in crisis. When asked about post-crisis follow-up, consumers suggested that OMH incorporate positive affirmations. This would include not only “How are you doing?” but also “Everything is going to be okay”.

Other consumers underscored the importance of offering individual choice in the modality of follow-up contacts, post-crisis. For example, some consumers were more comfortable with phone calls, while others preferred emails or texts for post-crisis follow up. Finally, consumers showed interest in getting access to PSYCKES to view their data and safety plans. Presently, consumers can use MyCHOIS to access their treatment history and recovery tools, but it does not yet have the functionality for consumers to view or upload their care plan or advanced directives.

What stood out to Van De Wal in her conversations with consumers is that people in crisis may not necessarily want a clinical intervention. Meaning, she says, they do not always want to talk about their medication. Instead, they want someone to check in with them about what is happening in their lives. “Our job is to also incorporate that, not just say, ‘Hey, we are going to link you up with a mental health worker.’ That’s not necessarily what they need.”

Denise Balzer, LCSW, Program Advisor at the Division of Managed Care in OMH, says what people may need in those moments are connections to the community and to interests that they have, whether that is a new interest or growing an existing one. “It can be as simple as going to the movies and having a social life. These are the kinds of things they may be separated from and need a way to reconnect. Not everything is a therapy or clinical issue.”

New York State’s OMH Hospital Readmissions Quality Collaborative

Since January 2015, the OMH Bureau of Evidenced-Based Services and Implementation Science has put together a voluntary learning [collaborative](#) made up of more than 50 hospitals and health homes throughout the state. The collaborative focuses on reducing all cause (not just psychiatric) 30-day readmissions following a behavioral health inpatient hospitalization. Each participant implements evidence-based practices based on the hospital setting. For example, participating EDs identify patients who may be potential readmissions and ED staff consult with the treatment team before deciding to admit with the goal of diverting patients to appropriate community services. The participating hospitals have the opportunity to use PSYCKES and its quality indicator reports as a tool to identify and track, over time, clients who meet criteria for the readmission flag and the hospital’s readmission rate. As part of the collaborative’s activities, participating hospitals conduct chart reviews (41 hospitals, 421 patients) and patient interviews (39 hospitals, 324 patient/caregivers) to identify actionable readmission root causes.

Findings related to the collaborative's impact and the root cause chart reviews and patient interviews are part of several working manuscripts. Preliminary analysis of Medicaid billing data on the ratio of psychiatric discharge to psychiatric rehospitalization suggests that participating hospitals have experienced a significant reduction in 30-day behavioral health readmission compared to non-participating hospitals.

There are numerous reasons why readmissions are lower among participating hospitals, not least of which is that participants are learning and sharing among themselves what works. No one operates in a silo. They come together, form interdisciplinary teams, and test and measure evidence-based innovations. They share with one another their experiences and best practices, which result in faster adoption.

Additionally, participating hospitals choose from OMH recommended interventions, including ways to increase medication adherence to reduce rehospitalization. For example, a clinician may recommend to a non-adherent client that he or she goes on a long-acting injectable medication. Another popular technique among participating hospitals is dispensing a month's supply of prescriptions medications at discharge. Van De Wal suggests "This may improve medication adherence, with the goal of reducing hospitalization readmission after discharge."

Conclusion

Every person interviewed for this paper highlighted how important it is that people are matched with appropriate services. They warned that not doing so increases patient and staff trauma and safety risks.

In the ED, warehousing and psychiatric boarding is a controversial practice that can result in psychiatric patients waiting for long time periods, bound to beds or parked in hallways. In fact, researchers at [Wake Forest University](#) examined length-of-stay at an academic medical center ED and discovered that psychiatric patients ended up waiting three times longer than non-psychiatric patients. In Washington State, in 2013, ten patients filed a lawsuit against the Department of Social and Health Services and Pierce County, bringing nationwide attention to psychiatric boarding. Patients were involuntarily detained for days, sometimes even months, without psychiatric care. In some cases, even medication was delayed. The Washington State Supreme Court sided with the patients, banning psychiatric boarding and ruling that the state's Involuntary Treatment Act (ITA) did not authorize it as a method to avoid overcrowding certified evaluation and treatment facilities. Yet, psychiatric boarding continues around the nation, resulting in prolonged suffering for patients and families, and mounting costs at \$2,264²² per psychiatric patient. Annually, this adds up to millions of dollars,²³ all without patients receiving the care they need.

²² The Impact of Psychiatric Patient Boarding in Emergency Departments.

²³ Boarding Mentally Ill Becoming Epidemic in State, *Seattle Times*, originally published October 5, 2013; updated April 2, 2015, <http://www.seattletimes.com/seattle-news/times-watchdog/squoboardingsquo-mentally-ill-becoming-epidemic-in-state/>.

Nationwide, the issue is that many communities do not have a sufficient array of options, which David Covington says is analogous to giving everyone the same shoe size. In essence, the lack of options forces everyone to ramp up to the next highest available service level since providers cannot drop down in the care continuum. The puzzle for Covington and his team at Magellan was to find effective and less costly ways to meet people's needs, and it quickly became evident that making crisis services available was the answer; it reduced costs and paired members with appropriate services. The novel approach also allowed Covington and his team to discover a Level 3 cohort entering the ED stream because they needed medication and had no other option. The Magellan team responded by opening 24-hour urgent care outpatient centers that were physically co-located with short term residential facilities.

Other programs have also found unique ways to approach crisis services and the readmission challenge, such as the New York State OMH Hospital Readmissions Quality Collaborative. Participants share experiences and best practices, resulting in the quicker adoption of innovative and effective interventions. Unsurprisingly, medication is a consistent challenge, where a person can end up in the ED if non-adherence had been avoidable. An intervention as simple as dispensing prescriptions at discharge may make a difference.

Follow up calls also play a powerful role. Researcher Madelyn Gould found that the vast majority (80 percent) of the National Suicide Prevention Lifeline follow-up call recipients said the calls made some difference in keeping them alive, with half of respondents stating it was the reason they were alive. National Suicide Prevention Lifeline Project Director John Draper says that simply having another person value the at-risk person enough to reach out can change his or her trajectory.

Changing people's trajectory means putting power in their hands—power to help others and themselves. Mutual self-help is a process that allows people to come together, whether through peer support or via social network safety nets, mobile app, or websites. It fosters hope and teaches positive reframing and allows people to enter the support community as a person who needs help and can also give help. This fosters resilience and hope, as Certified Peer Specialist training has been shown to help peers develop critical skills applicable to their life and recovery, making them more hopeful, confident, and resilient.

As John Draper says, what people in crisis need are “both ground and air supports” with family members, public service messaging, and the community in the air, and doctors, therapists, and peer support on the ground. *Together*, all these people and pieces create a crisis services safety net that helps those in crisis avoid hospitalization or rehospitalization.