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OMHSAS Workgroup Seeks to Improve Pennsylvania's Crisis Intervention Services

By Elisa Ludwig

During his most difficult times, Fred McLaren recalls, the crisis intervention services provided by Pennsylvania's behavioral health system helped him get the care he needed while avoiding involuntary commitment. McLaren, a Montgomery County resident who has been diagnosed with bipolar disorder and obsessive-compulsive disorder, said that Montgomery County Emergency Service (MCES) has made all the difference. "I was able to either go into the hospital voluntarily or they gave me the help I needed to stay out of the hospital," McLaren said.

Required Services

States have been required to provide crisis intervention services since 1966, when the Mental Health and Mental Retardation Act was signed into law. In 2008, based upon data reported to the Office of Mental Health and Substance Abuse Services (OMHSAS) by the counties, approximately 78,000 Pennsylvanians received at least one type of crisis intervention service from the public behavioral health system.

A statewide survey, regional focus group discussions, and a time-limited stakeholder workgroup were part of a larger effort by the Commonwealth to assess current practices in all areas of crisis intervention. "We asked which services the counties provided directly and which they contracted out, and we asked them to identify any gaps and barriers they faced," said OMHSAS acting deputy secretary Sherry Snyder.

The workgroup, comprising a wide range of stakeholders – including representatives from the Crisis Intervention Association of Pennsylvania, county behavioral health staff, managed care companies, peer specialists and other individuals in recovery from psychiatric disorders – met in June 2010 to analyze the data and seek meaningful recommendations for improving the system. Regional focus groups had previously looked at key challenges for services in their respective geographical areas.

The focus of the workgroup was to identify best-practice recommendations for refining crisis intervention services that would reduce the potential for future crises and produce better outcomes supporting recovery. In November 2010, before the change in Commonwealth administration, Snyder was hopeful about addressing the recommendations. "It's no secret we face major budget challenges in the state, but not all of the recommendations will require additional funding," she said. "It may be more a matter of shifting funds around in order to reprioritize and strengthen services."

Different Models

Initially, the most common crisis intervention service was the 24-hour emergency hotline, with emergency room backup. As counties recognized the need for additional services, mobile crisis services were developed. To support other services, OMHSAS defined walk-in, mobile, medical-mobile and residential services, and published draft regulations. Services in all five models are licensed by the state. Since its adoption statewide in 2007, HealthChoices – Pennsylvania's behavioral health insurance program for Medical Assistance (Medicaid) recipients – has funded state-mandated telephone and mobile crisis services across the Commonwealth.

Stakeholders in various venues have identified challenges to providing crisis services, and the statewide

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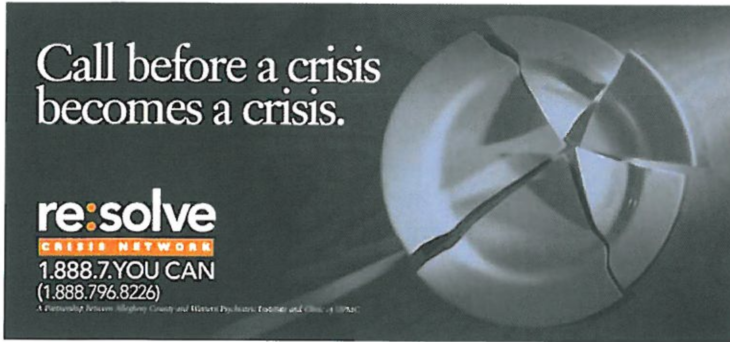

crisis workgroup developed recommendations for meeting these challenges.

Key Recommendations

The workgroup's paper, *Crisis Intervention Services Transformation Recommendations* (available at http://parecovery.org/advisory_materials/april_2011_handouts/Crisis_Intervention_Recommendations.pdf), summarizes these and other findings.

Key recommendations for enhancing crisis services include diversion resources, timely access to community supports before and after a crisis, peer support services, psychiatric advance directives, standard training curriculums, consistent interpretation of crisis intervention regulations across the state, and cost-effective strategies to support effective crisis intervention services.

One challenge the paper notes is that the line between emergency services and crisis services is often blurred, and the services available in some counties are closer to the former than the latter, resulting in more hospitalizations. "What we see in these cases is that the person tends to be committed," Snyder said, "whereas crisis services are intended to be a set of opportunities to both assess whether a person needs to be admitted to higher levels of care or needs supports to avoid unnecessary hospitalization." The workgroup recommends the availability of diversion resources throughout the crisis intervention process.

Other areas of concern include increased numbers of crises across the board, with too few staff and funds to support the flow. "It's fair to say that just about every county is struggling with increased volume," Snyder said. "Whether it's calls on a hotline or walk-ins, there are a lot of people who are uninsured and don't have access to other supports. With the stress of the economy and people losing jobs and homes, there is a lot more strain on individuals and families. We're also seeing increased numbers of people involved with drugs and alcohol, and suicide in teens and older adults."

A lack of coordination and follow-up care was a problem in many counties. "No matter how well developed and well functioning the crisis intervention service is, its success is dependent upon having available resources and supports it can refer and connect people to, such as housing, or clinical intervention, or follow-up," Snyder said.

"Peer Services Will Be Crucial"

The workgroup also concluded that peer services are a fundamental component of the crisis response process, yet the survey found that only one county used peer supports as part of crisis intervention.

"Peer services will be crucial going forward," Snyder said. "Peers can provide an important adjunct to intervention, offering hope, support and someone to talk to who understands the situation; and they can also offer options for aftercare, such as helping the individual develop a WRAP plan." (WRAP – Wellness Recovery Action Plan – teaches recovery and self-management skills and strategies.)

While the paper focuses on the many gaps in county services, particularly in rural areas, some model programs in the state are redefining the way crisis interventions are handled.

Allegheny County

In 2006, the Western Psychiatric Institute and Clinic of UPMC in Pittsburgh won a bid to become the countywide provider of crisis services. Though telephone, mobile and walk-in services had long been available in the county through multiple providers, the system needed integration.

"Before that time, there were a number of moonlighting staff for mobile and afterhours care. Sometimes calls would be dispatched to other contractors and it wasn't a timely process," said Mary Jo Dickson, administrator of the Allegheny County Bureau of Adult Mental Health Services.

Now, in Allegheny County, re:solve™ Crisis Network provides telephone, mobile, walk-in and residential services, plus a non-licensed 24-hour drug and alcohol crisis engagement center, and fosters all of the necessary connections between these units. For instance, someone calling a peer warmline might be transferred to the crisis telephone service for linkage to mobile services in their community or the Pittsburgh-based walk-in crisis program. "The fact that we have all these services housed under one roof helps us to coordinate care and provide continuity," said Jewel Denne, re:solve™'s clinical administrator.

A new facility for walk-ins, featuring bright colors, peer-created artwork and open floor plans, was designed with peer input. "People told us they wanted the building to feel warm and welcoming so we based our design on these suggestions," Denne said.

Guiding Principle

re:solve™ is staffed by dedicated (non-moonlighting) personnel, including six paid peer specialists, with around-the-clock services. The guiding principle is that an individual should define his or her own crisis, and the

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program maintains a "no eject/no reject" policy.

The program is also working hard to move away from emergency-centric responses, trying to intercede in crises at the earliest possible point. To that end, a recent public awareness campaign featured common images, such as a full laundry basket with the slogan "Call before a load becomes too heavy to carry."

The center continues to serve an array of individuals with a variety of concerns, and reports nearly 12,000 individual interactions a month. Mobile services go wherever needed: they have attended to people in their homes, but also to people calling from grocery stores and parking lots.

Janice,* who has been diagnosed with depression and schizoaffective disorder, has made use of re:solve™'s mobile, telephone, walk-in and residential services. "With their education and skill, they can really calm the situation down and nip it in the bud," she said. "They've helped me not only through the crisis but also to get my finances in order, and [to] get back on my feet again. It's a blessing – it really is."

"Our goal, no matter what, is to divert people from being hospitalized where possible and to provide an individual approach to care," Denne said. "We are here to walk alongside our consumers as opposed to pushing them into services."

Successes Realized

About 85 percent of people that re:solve™ sees remain in the community after a mobile visit, and the walk-in and residential center has a 97 percent success rate in hospital diversion, Denne said. While she suspects that the exact structure of the program might not work in other areas of the state, she believes that certain basic principles could be replicated, such as the emphasis on recovery, and the flexibility to respond to the individual needs of people in crisis.

In some senses, the program has become a victim of its own success, Dickson said. "It can be difficult for us to determine what a crisis is or isn't, and we have some individuals coming here when it is not entirely appropriate. We are continuing to redefine the program but I think we have made great strides in moving towards more recovery-oriented crisis services," she said.

Montgomery County

Also cited as a model is Montgomery County Emergency Service (MCES), which was founded in 1974 after a collaboration between the local mental health/mental retardation emergency service and Eagleville Hospital began successfully diverting individuals with mental illnesses and drug and alcohol addictions from jail. "Over the years we have grown incrementally, adding services along the way," said MCES director of development Tony Salvatore.

Like re:solve™, MCES houses multiple services under one roof, including a hotline and mobile, residential and walk-in services. MCES also maintains a dedicated ambulance for people who need to be transported in a time of crisis. "That's an important part of our service because it keeps the police available for other emergencies," Salvatore said.

MCES also hires peer specialists, who work in the residential unit as well as in WRAP training. Salvatore would like to eventually add peer-led warmlines. "Often people don't call hotlines because they are fearful of hospitalization, but warmlines can help people get the services they need without the worry," he said.

Today, after having benefited firsthand from MCES crisis intervention services, Fred McLaren works as a peer specialist in the MCES outreach and criminal justice department. He also served on the crisis intervention workgroup, testifying about his own experience. He is hopeful about the workgroup's recommendations and the future of crisis intervention in Pennsylvania. "The challenges for crisis services are out there," he said. "But the workgroup hopefully addressed some of them and will help people come up with solutions in a variety of settings, budgets and situations."

Snyder asserts that crisis intervention improvement should remain a priority moving forward. "I do believe that crisis intervention is a cornerstone of the mental health system; oftentimes it's the first contact a person or their family members will have with the mental health system," she said. "As such, it's critical that it be an available, identifiable and easily accessible service."

* *Janice's last name has been omitted at her request to protect her privacy.*