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An Innovative Approach to Mental Health Crisis Services: A Case Study

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Abstract

The increase in mental health crises and the need for a comprehensive, cost-effective response have posed challenges to the public health system. The emphasis on providing services in a "safe environment" has enforced the notion that hospitals are most secure for the individual in crisis. This paper describes an alternative to hospital-based mental health crisis services based on the principles of trauma-informed care. The outcomes of this alternative model are also outlined.

Background

In the United States, there has been a significant increase in emergency room use for both adults and youth experiencing mental health crises. For adults, between 2010 and 2015, approximately 4-5% of ER visits were related to mental health disorders. This percentage rose to 12% between 2018 to 2020. ER use for adults was related to depression, anxiety, substance use, and suicidal ideation. For youth, ER visits related to mental health doubled between 2011 and 2020. It is important to point out that for youths during this period, there has been a five-fold increase in suicide-related ER visits.[i, ii]

Although most mental health crises are handled in a hospital-based emergency setting, in the last 10 years, we have witnessed major modifications and innovations in how we manage mental health crises. The structure of programs and the approach associated with our understanding of best practices coincide with a service delivery system that has embraced trauma-informed care. Historically, crisis services depended upon emergency rooms and inpatient care, which conflicted with the principle of providing care in the least restrictive environment. Too often, the overutilization of law enforcement and emergency departments leads to an exacerbation of a mental health crisis rather than a community-based intervention that maintains the individual in the community and returns to stability quickly. A common practice of hospital-based ER crisis centers is that people are often given a referral with little or no follow-up to determine if the person was linked with care. In addition, the cost and pressures placed on individuals and family members create an unnecessary burden on the individual and crisis system, leading us to develop strategies for community-based interventions.

The medicalization of a mental health crisis traditionally leads to extended emergency room waits in an environment that may be trauma-inducing. The cost of the emergency room visit is prohibitive and serves as a deterrent to accessing care. Recognition of the emotional, financial,

and systemic pressures inherent in the medicalized system has led advocates and SAMSHA to develop National Guidelines and Toolkits for Behavioral Health Crisis Care. Included in the guidelines is a definition of "crisis" and the no-wrong-door approach that stipulates that crisis services are for anyone, anywhere, and anytime. (SAMSHA Toolkit, TIP 57).

SAMSHA identifies three core services and best practices in the delineation of national guidelines.

1. A regional crisis call center operating 24/ 7 staffed with clinically trained individuals is established.
2. A mobile crisis team response is able to reach any person in the community in a timely manner
3. Crisis receiving and stabilization facilities provide a homelike, non-hospital environment.

In addition to the three core services, the critical ingredients of an optimal care crisis system are 1) Addressing Recovery Needs. 2) Role of Peers; 3) Trauma Informed Care 4) Zero Suicide 5) Safety/Security for Staff and People in Crisis; 6) Crisis response partnership with law enforcement, Dispatch and EMS. The recovery-based approach promotes a no-force-first policy that emphasizes engagement, choice, and collaboration. Natural support is integral to the crisis resolution and post-crisis process. Peer support and the involvement of people with lived experience are critical to engagement and helping to guide the individual in crisis in a non-judgmental fashion.

Bridgeway's Model

In 2017, Bridgeway acquired the Psychiatric Emergency Screening Service (PESS) contract in Somerset County in central New Jersey. In New Jersey, the majority of PESS programs operate within a hospital structure where most individuals are transported to a hospital emergency room for evaluation. Each county in New Jersey has at least one Designated Screening Center funded by the Division of Mental Health and Addiction Services. Most Screening Centers are embedded in Hospital Emergency Departments. Clarke, Dusome, and Hughes (2007) state that hospital environments can be perceived as "traumatizing, overstimulating, dehumanizing and expensive." Prior to Bridgeway's award of the Somerset County Screening Center, PESS was located in a hospital where the emergency room diversion rate (back into the community) was 3.5%, the lowest in the state. Having witnessed this system and the traumatization of the individual in crisis, Bridgeway proposed an alternative, trauma-informed approach. The agency designed a mobile outreach system that goes directly to individuals in crisis wherever they are. Bridgeway established the first walk-in Living Room Screening Center in New Jersey in 2017. The setting is warm and inviting with soft lighting, comfortable furniture, and paintings on the walls, and is staffed with counselors, peer support, and a prescriber.

Mobile outreaches increased from a rate of 10.4% from adults under the hospital base PESS service to 66% in FY 2024 when Bridgeway took over the program. Law enforcement is accessed to accompany a Certified Screener only when dangerousness or lethality is positively assessed. The establishment of a community-based, trauma-informed setting has enabled

individuals to utilize respite in a setting that serves as an alternative to a hospital emergency department. Within this setting, two "Living Rooms," one for adults and one for children, serve to provide individuals with a calming, soothing environment, a change in the setting that may have contributed to the crisis. The Living Room Model, founded in Arizona in 1997, has been replicated in a number of places. One of the early Living Room models was developed in Illinois as a community crisis respite program and Hospital ED Diversion option (Heyland, Emery, & Shattell (2013) for individuals 18 and above. The program yielded impressive outcomes where 95% of the encounters helped avoid an emergency department admission. The Illinois model was framed as respite and demonstrated excellent short-term results. Bridgeway's full continuum of services has fully embraced a trauma-informed care system. The majority of the individuals who interact with Bridgeway's mental health and substance use programs have experienced significant trauma, as evidenced by the ACES (Adverse Childhood Experiences). SAMSHA reports that 61% of men and 51% of women had experienced at least one traumatic event in their lifetime. These individuals are susceptible to a triggering event or stimuli causing a re-experiencing of these events. Traumatic experiences may have led to self-harm and suicidal behaviors. As challenging as it appears to be cognizant of an individual's experience with trauma on the first encounter, there are principles that guide our interactions. In Bridgeway's Mobile Outreach and Living Room approach, safety is forged by allowing individuals to maintain choice throughout the crisis. Care is taken to explain what will occur to both the individual and natural supports to eliminate surprises and to gain trust.

Inherent in mental health crisis services is the adoption of the practices and principles of Zero Suicide. Since 2022, Bridgeway has trained the full organization in these practices, including clinicians and support staff who adopt a no-wrong-door approach to suicide prevention. Those at high risk for suicide are placed in the suicide risk pathway to ensure that all team members are cognizant of the individual's risk level.

Safety and security for the individual are fundamental to a trauma-informed system. The physical environment, counseling, and support within a home-like environment help to mitigate the crisis experience. The Living Room fosters care, and "no force first" practices are implemented. Physical restraint and seclusion are avoided, although a relationship with law enforcement is necessary in highly threatening situations.

Successful engagement requires a staff and approach fully steeped in the principles of multiculturalism, reflecting an understanding of the culture of each individual encountered. Building trust in a crisis setting is a challenge requiring special skills. Human resources seek crisis workers to match the demographic of cultures represented in the service area.

Understanding and embracing the family and support structure of the individual in crisis will lead to a positive outcome, and the ability to communicate with a person's support system is critical to building trust and respect.

Case Study: The case study below exemplifies the principles that are employed in the crisis program.

Ashley has a diagnosis of PTSD and Agoraphobia. She was discharged from an inpatient hospital stay with 30 days of medication 24 days ago. Today was her scheduled intake for her psychiatric prescriber, and she had a panic attack when trying to get into the car.

PESS scheduled an outreach with Barbara and Ashley in their home with a screener and PESS psychiatrist. PESS psychiatrist refilled her medication for 4 weeks and adjusted her anxiety medication in hopes that this would help her manage leaving her home. PESS referred Ashley to outpatient services and scheduled two follow-up visits to ensure that the medication was effective, and no side effects were seen.

On the day of intake for outpatient services, Ashley had another panic attack when trying to leave her home. Barbara called PESS, and mobile outreach in the home was provided by both the screener and the Psychiatrist. The recommended disposition for linkage to outpatient services changed to in-home services with a Psychiatric provider. A doctor-to-doctor communication occurred, with the assistance of the county mental health administrator with a local non-profit mental health clinic, who agreed to work with Ashley in the home with intensive CBT and Medication Management to work up to outpatient services. Another two weeks of medication was prescribed by the PESS psychiatrist, and a follow-up phone call confirmed a successful linkage.

Pre and Post Bridgeway Comparative Data

The PESS Living Room Model has maintained competitive emergency department diversion rates over the last 7 years. When statewide PESS comparative data was released in the first 3 years of operation, this model had the highest diversion rate in the state.

The table below reflects comparative data between a hospital-based Emergency Department crisis service and a trauma-informed community-based Living Room model. The diversion rate is defined as the percentage of people who do not require ER services.

Metric	Before New Model	New Model
Adult Diversion Rate	4%	63%
Community Outreach	10%	66%
Rapid Deployment < 1 hour	4%	90%
30 Day Readmission Rate	15-20%*[iii, iv]	7%

This is based on national data (Fleury, MJ., Fortin, M., Rochette, L. et al. Assessing quality indicators related to mental health emergency room utilization. BMC Emerg Med **19, 8 (2019). https://doi.org/10.1186/s12873-019-0223-8*

- ALL Bridgeway PESS data has been extracted from County System Review Committee data reports

Implications

This paper aims to describe an innovative approach to mental health crisis care, incorporating best practices endorsed by SAMHSA. Post-pandemic models must be comprehensive in their approach to serve greater numbers of youth and adults experiencing mental health and substance use challenges. Inherent in the approach is creating an environment that avoids re-traumatization and triggering of mental health symptoms. The data is compelling and supports a system that is empathic, supports choice, and is cost-effective. Diversion from Emergency Departments and involuntary commitment are goals that affect communities across all cultures. Emergency Department visits are more likely to lead to hospitalizations and poor linkage to ongoing care. Based on our experience and data, we believe that community-based interventions can be highly effective in maintaining individuals in the community, which is a goal for a healthy society.

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[i]Bommersbach, Tanner J, Alastair J McKean, Mark Olfson, and Taeho Greg Rhee. "National Trends in Mental Health-Related Emergency Department Visits among Youth, 2011-2020." JAMA, May 2, 2023. https://ncbi.nlm.nih.gov/pmc/articles/PMC10155071/.

[ii]Emergency department visits related to mental health disorders among adults by race and Hispanic ethnicity: United States 2018-2020, National Health Statistics Report, Number, 181. Centers for Disease Control and Prevention. March 1, 2023

[iii]Cushing AM, Liberman DB, Pham PK, et al. Mental Health Revisits at US Pediatric Emergency Departments. JAMA Pediatr. 2023;177(2):168–176. doi:10.1001/jamapediatrics.2022.4885

[iv]Fleury, Marilyn Fortin, Louis Rochette, Guy Grenier, Christophe Huỳ nh, & Eacute;ric Pelletier, and Helen-Maria Vasiliadis. "Assessing Quality Indicators Related to Mental Health Emergency Room Utilization - BMC Emergency Medicine." BioMed Central, January 15, 2019. https://bmcemergmed.biomedcentral.com/articles/10.1186/s12873-019-0223-8.