

A Crisis Services Compendium



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The Continuum of Crisis Services in Ohio

With the passage of the Community Mental Health Act of 1963, behavioral health treatment shifted from a hospital- and institution-based treatment model to being provided in less restrictive environments in the community. While this shift in the location of treatment was a vast improvement for persons living with behavioral health disorders, there was a lack of services in the community to meet people's needs. As a result, persons who experienced crises due to mental health or substance use symptoms have often been treated in emergency departments or admitted to hospitals, with the hope that once discharged they would receive outpatient services in their community. Reliance on emergency departments often as the first line of treatment for persons experiencing acute life crises has resulted in insufficient treatment, psychiatric boarding, and poor follow-up rates in community treatment settings. Emergency departments have become the health care provider of first resort for many, leading to overcrowding and an inability for these locations to meet the complex needs of their patients, particularly those with psychiatric and substance use issues.

Because of the shift to community treatment and the over-reliance on emergency departments, crisis services were developed as a component of the continuum of services to be offered in the community. The goal of crisis services is to work in the community to alleviate immediate psychological distress and engage individuals in treatment and ancillary services. There is an array of services in the crisis continuum that are designed to reach individuals in their communities, including, but not limited to:

- Hotlines
- Warm lines
- Mobile crisis outreach
- 23-48 hour observation beds
- Crisis urgent care centers/psychiatric emergency departments
- Crisis stabilization units/short-term crisis residential services
- Peer support and crisis services
- Critical time intervention
- Crisis intervention teams (CIT)
- Telehealth services
- Transportation



A Robust Continuum of Services



Adapted from Richard McKeon. Supercharge Crisis Services, National Council for Behavioral Health Annual Conference, 2015.

While the names of crisis services vary from community to community, they each have the goal of providing services to individuals to avoid hospitalization or involvement with the criminal justice system. Crisis services are commonly described as a continuum starting at *prevention*, moving to *early intervention*, then to *response*, and finally to *postvention*. Each step includes a collection of services designed to reduce the likelihood someone would need care in the most restrictive setting. This compendium provides more detail on many of the services in this continuum.

Behavioral health crisis services are a core component of Ohio's behavioral health system of care. As such, it is important for behavioral health authorities, providers and communities to understand what constitutes best or promising practices in the continuum of crisis services.

The following compendium provides brief summaries of some evidence-based or promising crisis services that are part of the continuum of crisis services offered in Ohio. Information on where to find further specifics about these evidence-based or promising practices in Ohio or elsewhere is also included where possible.

Crisis Services Values

The Substance Abuse and Mental Health Services Administration (SAMHSA) has developed practice guidelines for professionals who respond to mental health crises, and describes a set of values appropriate for a continuum of crisis services. These values are:

Safety for everyone involved. Interventions should avoid harm by considering the risks and benefits of specific interventions. The system should be designed to establish feelings of personal safety and security for the individual in crisis.

Active engagement of the individual in crisis. Interventions should be delivered in person-centered ways. Shared responsibility and active partnership should be established between the practitioner and the individual in crisis. The individual's strengths and abilities to assist in the resolution of the emergency must be recognized. The individual should be viewed as a credible source of information.

Holistic treatment. The whole person, not just the presenting psychiatric crisis, should be evaluated and considered. Interventions should be trauma-informed, addressing trauma from past experiences and the present crisis experience. Treatment should include a focus on prevention of a future crisis through individualized planning.

Recovery, resilience, and natural supports. Interventions should support the individual and contribute to his or her overall goals for recovery. Hope, engagement with natural supports, and the fostering of dignity are key components in any crisis system.

Crisis services should be developed using these values as guiding principles, while also working in partnership with people who have lived experiences, law enforcement, emergency departments, community treatment providers, hospitals, and local behavioral health authorities.



Prevention

Prevention includes resources and activities that help reduce or deter crises; the first-line defense in the promotion of well-being. Stable housing, employment, and access to health care provide a foundation for a stable recovery from serious mental illnesses. Crisis plans and Wellness Recovery Action Plans (WRAP) are self-designed prevention and wellness activities that anyone can use to determine the steps to be taken toward getting well and staying well.



Safety Planning

Intervention Description

The purpose of a safety planning intervention is to provide people who are experiencing suicidal ideation with a specific set of concrete strategies to use to decrease the risk of suicidal behavior. The safety plan includes coping strategies that may be used and individuals or agencies that may be contacted during a crisis. The safety planning intervention is a collaborative effort between a treatment provider and a patient and takes about 30 minutes to complete. The basic steps of a safety plan include: recognizing the warning signs of an impending suicidal crisis; using your own coping strategies; contacting others to distract from suicidal thoughts; contacting family members or friends who may help to resolve the crisis; contacting mental health professionals or agencies; and reducing the availability of means to complete suicide.

Ohio Program Examples

A. Heartland Behavioral Health Services

<https://heartlandbehavioral.com/treatments-programs/acute-hospitalization>

Evidence Supporting Practice

Research shows that individuals with higher-quality safety plans are less likely to be hospitalized in the year after safety planning. A recent study found that crisis planning reduced suicide attempts, reduced inpatient hospitalization, and was associated with a faster decline in suicidal ideation in high-risk active duty soldiers.

A “Safety Plan” Includes

- **Warning signs** — Recognition of the signs that immediately precede a suicidal crisis
- **Internal coping strategies** — Things patients can do to distract themselves without contacting anyone
- **Social situations that can help distract me** — Places patients can easily access to provide a safe environment (a library, mall, coffee shop, etc.)
- **People I can ask for help** — Identify at least three support persons who know local resources and are listed within the safety plan
- **Professionals or agencies I can contact during a crisis** — Maintain a list of nearby professionals and crisis support agencies, with hours and contact information. Memorize or have nearby to access 24/7 crisis support
- **Making the environment safe** — Strategies to limit or eliminate substance use, and any other strategies to maintain a safe environment

References

Safety Planning Intervention: A Brief Intervention to Mitigate Suicide Risk
http://www.suicidesafetyplan.com/uploads/Safety_Planning_-_Cog___Beh_Practice.pdf

Psychiatric Advanced Directives (PAD)

Intervention Description

A psychiatric advanced directive (PAD) is a document that specifies a person's future preferences for treatment, should he/she/they lose the ability to make competent choices for him/her/themselves. PADs are typically used in end-of-life situations, but can be applied to those in crisis as well. PADs come in two forms: instructional and proxy. Instructional directives describe preferences for treatment, such as hospitals, medication types, medication dosages, medication schedule, authorized or unauthorized visitors, and individuals who will care for children or pets. Proxy directives use a designated agent who will make decisions on behalf of the incapacitated patient. Typically, a directive uses both instructional and proxy directives in combination.

Additional Resources

National Resource Center on Psychiatric Advance Directives:

<https://www.nrc-pad.org>

Ohio Program Examples

- A. Disability Rights Ohio
<https://www.disabilityrightsohio.org/advance-directives-for-mental-health-treatment-ohio>
- B. Ohio Psychiatric Advance Directives Form
<https://www.nrc-pad.org/images/stories/PDFs/ohiopadform.pdf>

Evidence Supporting Practice

Research conducted on the use of psychiatric advance directives shows that it reduces the use of coercive treatment, lessens acts of violence, increases treatment that is consistent with patient preference, increases user alliance, and empowers patient autonomy.

Implementation Considerations

- Train physicians, mental health professionals, and patients in the use of PADs to facilitate positive relationships and experiences among all involved.
- Allow PADs to be designed, created, and negotiated by patients, their physicians, their surrogate decision-makers, and mental health professionals. This will increase alliance among those involved, encourage usage from both patients and health care professionals, and reduce refusal to honor the PAD.

References

- Nicaise, P., Lorant, V., & Dubois, V. (2013). Psychiatric Advance Directives as a complex and multistage intervention: a realist systematic review. *Health & Social Care in the Community*, 21(1), 1–14.
- Olsen, D. P. (2017). Increasing the use of psychiatric advance directives. *Nursing Ethics*, 24(3), 265–267.
- Sofer, D. (2019). Psychiatric Advance Directives. *AJN American Journal of Nursing*, 119(5), 16–17.

Assisted Outpatient Treatment (AOT)

Intervention Description

Assisted outpatient treatment (AOT) is court-supervised behavioral health treatment within the community. To be a candidate for AOT, a person must meet specific criteria, such as a prior history of repeated hospitalizations or arrests.

Also known as “involuntary outpatient treatment” or “outpatient commitment,” AOT commits local mental health systems to serve participants at the same time it commits participants to adhere to their treatment plans. Developed by patients with their health care providers, these plans are highly individualized, but typically include case management, personal therapy, medication, and other tools known to promote recovery. AOT participants receive due process protections and orders are made only after a hearing before a judge.

Additional Resources

http://adamhsc.org/pdf_adamhsc/en-US/OutpatientCommitment.pdf

Ohio Program Examples

A. Treatment Advocacy Center

<https://www.treatmentadvocacycenter.org/browse-by-state/ohio>

Evidence Supporting Practice

Past research has found that assisted outpatient treatment decreases hospitalization, arrests and incarceration, homelessness, and victimization. AOT also reduces length of stay in institutions, and results in better outcomes for subsequent outpatient care. The costs of related outpatient programs for individuals with serious mental illness were considerably lower than when compared with inpatient hospitalization. Participants in an assisted outpatient treatment program within Ohio also showed reduction in emergency department visits and hospital recidivism rates related to the treatment.

Implementation Considerations

- Most effective with individuals who need ongoing psychiatric treatment, but have difficulty adhering to treatment requirements.
- Court involvement, mandates are often triggered by a hospitalization.
- Treatment is mandated by the court; involuntary.
- Individual is released under ongoing supervision.
- Treatment providers play an active role in maintaining the individual’s treatment over time.
- Court order may include an emergency evaluation if behaviors change.

References

- Munetz, M. R., Ritter, C., Teller, J. L. S., & Bonfine, N. (2014). Mental health court and assisted outpatient treatment: Perceived coercion, procedural justice, and program impact. *Psychiatric Services*, 65:3, 352-358.
- Swanson, J. W., Van Dorn, R. A., Swartz, M. S., Robbins, P. C., Steadman, H. J., McGuire, T. G., & Monahan, J. (2013). The cost of assisted outpatient treatment: Can it save states money?. *American Journal of Psychiatry*, 170, 1432-1432.
- Swartz, M. S. & Swanson, J. W. (2004). Involuntary outpatient commitment, community treatment orders, and assisted outpatient treatment: What’s in the data?. *Canadian Journal of Psychiatry*, 49:9, 585-591.
- Swartz, M. S., Wilder, C. M., Swanson, J. W., Van Dorn, R. A., & Robbins, P. C. (2010). Assessing outcomes for consumers in New York’s assisted outpatient treatment program. *Psychiatric Services*, 61:10, 976-981.

Warm Lines

Intervention Description

Warm lines are phone numbers people with behavioral health conditions can call and talk to others in recovery. According to SAMHSA, a warm line is a direct service delivered by a peer that provides a person in distress with a confidential avenue to discuss his/her/their current status and needs. However, unlike crisis hotlines, warm lines are for non-emergency situations that, if left unaddressed, could escalate. Peers offer a non-judgmental, compassionate environment where they support callers and often offer their own experiences to help the caller address his/her/their concerns.

Ohio Program Examples

- A. The Peer Center
<https://thepeercenter.org>
- B. The Cincinnati Warm Line
<https://ohiocares.ohio.gov>
- C. The Nord Center Warm Line
<https://www.nordcenter.org/warmline>

Evidence Supporting Practice

While research on warm lines is just emerging, studies have shown that warm lines are effective at reducing feelings of isolation and loneliness. Additionally, research has found that warm lines are effective at decreasing the distress and increasing the hopefulness of callers. Studies have also found that warm lines are cost-avoidant, meaning they reduce the likelihood of using higher-cost services, such as inpatient hospitalization.

Implementation Considerations

- Warm lines can be run by a behavioral health provider or peer-run organization.
- Lines can be operated in a hub/distributed operator model.
- Telephone operators should be trained in intentional peer support.
- Diverse funding streams should be considered to ensure sustainability of the warm line.
- Many warm lines use paid peer support staff to operate the line.
- Warm lines have also been used for people with substance use disorders.

References

Larson, L., Malcolm, E., & Tikkanen, A. (2010). Warmline, Inc.: A Description of Services, Caller Voices, and Community Perspectives. Planning Council for Health and Human Services, Inc., Milwaukee, WI.

The Wellness Recovery Action Plan (WRAP)

Intervention Description

The Wellness Recovery Action Plan (WRAP) is a self-designed prevention and wellness process that anyone can use to get well and maintain his/her/their recovery. It was developed in 1997 by a group of people who were searching for ways to overcome their own mental health issues and move on to fulfilling their life dreams and goals. WRAP consists of a number of tools including a wellness toolbox, a daily plan, identification of stressors, identification of triggers and early warning signs, a crisis plan, and a post-crisis plan.

Evidence Supporting Practice

Controlled studies conducted in several Ohio communities found that training in mental illness self-management reduced depression and anxiety and improved participants' self-perceived recovery over time. Results confirmed the importance of WRAP as part of a group of evidence-based, recovery-oriented interventions.

References

- A Randomized Controlled Trial of Effects of Wellness Recovery Action Planning on Depression, Anxiety, and Recovery, *Psychiatry Online, Psychiatric Services in Advance: A Journal of the American Psychiatric Association*.
- Outcomes of an Illness Self-Management Group Using Wellness Recovery Action Planning Starnino VR1, Mariscal S, Holter MC, Davidson LJ, Cook KS, Fukui S, Rapp CA. *Psychiatric Rehabilitation Journal* Issue: Volume 34, Number 1 / Summer 2010.
- Effect of Wellness Recovery Action Plan (WRAP) Participation on Psychiatric Symptoms, *Sense of Hope, and Recovery Psychiatric Rehabilitation Journal* Issue: Volume 34, Number 3 / Winter 2011.

Early Intervention

Early intervention services and supports are designed to identify and address the onset of mental health crises. Outpatient providers offer access to services that promote recovery, while family and community supports help patients maintain stability in the least restrictive setting. Crisis phone lines provide resources and support to people in distress. Finally, respite programs provide temporary relief when caregivers need assistance with their responsibilities.



Mental Health First Aid

Intervention Description

Mental health first aid is an eight-hour course that teaches participants how to identify, understand, and respond to signs of mental illnesses and substance use disorders. The training gives the participant the skills needed to reach out and provide initial help and support to someone who may be developing a mental health or substance use problem or experiencing a crisis.

Additional Resources

<https://www.mentalhealthfirstaid.org>

Ohio Program Examples

- A. Mental Health First Aid, Franklin County
<https://mhafc.org/get-help/workplace-community-program/mental-health-first-aid>
- B. NAMI of Greater Cleveland
<https://namigreatercleveland.org/mental-health-first-aid>
- C. The Ohio State University Center for Public Health
<https://u.osu.edu/cphp/organizational-support-services/mental-health-first-aid-2>

Evidence Supporting Practice

Recent applications of the training have shown positive impacts upon participants, including increased recognition of schizophrenia and related mental illness, increased knowledge of adolescent mental health issues, and decreased stigmatization of individuals with mental illness. The mental health first aid training has also been shown to be effective within the workplace.

Course Objectives

- Teaches participants to identify individuals at risk of suicide or with depression
- Helps participants to identify and assist individuals currently struggling with a mental health crisis
- Increases overall knowledge of applicable community services
- Helps trainees to identify a person who has overdosed, or has experienced trauma

References

- Kelly, C. M., Mithen, J. M., Fischer, J. A., Kitchener, B. A., Jorm, A. F., Lowe, A. & Scanlan, C. (2011). Youth mental health first aid: A description of the program and an initial evaluation. *International Journal of Mental Health Systems*, 5:4.
- Kitchener, B. A. & Jorm, A. F. (2006). Mental health first aid training: A review of evaluation studies. *Australian and New Zealand Journal of Psychiatry*, 40:6-8.
- Kitchener, B. A. & Jorm, A. F. (2004). Mental health first aid training in a workplace training: A randomized controlled trial. *BMC Psychiatry*, 4:23 .
- Kitchener, B. A. & Jorm, A. F. (2002). Mental health first aid training for the public: Evaluation of effects on knowledge, attitudes and helping behavior. *BMC Psychiatry*, 2:10.

24-Hour Crisis Hotline or Text Line

Intervention Description

A crisis hotline or text line is a phone number people can call or text to get immediate crisis assistance and referral, usually by trained volunteers or paid staff. The confidential service provides immediate support to decrease hopelessness, promote problem-solving and coping skills, and facilitate referral to needed services.

Crisis hotlines provide a critical connection between people in crisis and community behavioral health treatment and social-service resources. Some crisis hotlines specialize in helping people in specific circumstances, such as sexual assault victims, runaway youth, human trafficking victims, veterans, the elderly, and people who identify as LGBTQ+.

Ohio Program Examples

- A. Crisis Text Line
https://www.oacbha.org/crisis_text_line.php
- B. Ohio Cares
<https://ohiocares.ohio.gov>
- C. Ohio Suicide Prevention Foundation
<http://www.ohiospf.org>

Evidence Supporting Practice

Several studies have found that the mental status of callers improves during and after calls to a crisis hotline. Studies show that hotlines are particularly helpful in assisting people with depression who are experiencing suicidal ideation. Other studies have found that hotlines are effective at reducing the suicidality of callers, improving symptoms of psychological distress, and enhancing hopefulness. Finally, psychosocial programs that incorporate hotlines are associated with reductions in the use of inpatient hospitalizations and overall treatment costs.

Implementation Considerations

- Crisis hotlines should have a working relationship with the police or other mobile and short-term crisis services in the community.
- Crisis hotlines should have comprehensive communication plans in place so they are widely known to members of the community.
- Crisis hotlines should be a part of the community's overall suicide prevention framework.

References

- Gould, M., Kalafat, J., Munfakh, J., & Kleinman, M. (2007). An evaluation of crisis hotline outcomes. Part 1: Suicidal Callers. *Suicide and Life-Threatening Behavior*, 37(3), 322-337.
- Gould, M., Kalafat, J., Munfakh, J., & Kleinman, M. (2007). An evaluation of crisis hotline outcomes. Part 2: Suicidal Callers. *Suicide and Life-Threatening Behavior*, 37(3), 338-352.
- Stein, D.M., & Lambert, M.J. (1984). Telephone counseling and crisis intervention: A review. *American Journal of Community Psychology*, 12(1), 101-126.

Peer Respite Services

Intervention Description

A peer respite program is a voluntary, short-term, overnight program that provides community-based, non-clinical crisis support to help people find new understanding and ways to move forward. It operates 24-hours a day in a home-like environment. Peer respite is staffed and operated by people with psychiatric histories. They are designed as psychiatric hospital diversion programs to support individuals experiencing or at-risk of a psychiatric crisis. The idea behind peer respite programs is that psychiatric emergency services can be avoided if less-coercive or intrusive supports are available in the community.

Additional Resources

<https://mha.ohio.gov/Families-Children-and-Adults/For-Adults/Connecting-with-Peer-Support>

<http://www.peerrespite.net>

Ohio Program Examples

A. Foundations

<http://www.foundationscanton.org>

Evidence Supporting Practice

Several comparison/control studies of peer respite services have found that those involved in these services are significantly less likely to use emergency room or inpatient care compared to others. Further, research has found that participants have higher rates of self-reported empowerment, satisfaction, self-esteem, social connectedness, recovery, and improved mental health symptoms compared to other crisis services. Peer respite services have also been found to be cost-effective, with treatment for individuals receiving the service costing about two-thirds less than those who did not receive the service.

Implementation Considerations

- Peer respite organizational features have critical implications for financing and sustainability, and careful consideration is needed to align financing with program mission.
- Peer-operated services within traditional provider organizations or well-established peer-run organizations may have more access to financial resources and infrastructure, including information technology and third-party billing capacity.
- Peer respite services must interact with the traditional mental health treatment and billing structure, and should understand how to interact with the rest of the mental health system to be successfully sustained in the community.
- Psychiatrists who provide consultation for respite must have a commitment to recovery principles and offered training in shared and supported decision-making.
- Peer respite needs to have a clear protocol for outreach and education activities to increase program access. This includes establishing guidelines with traditional providers regarding whether and how they provide outreach to potential guests through formal referrals and through raising community awareness.

References

- Ostrow, L., Croft, B. (2015). Peer Respite: A Research and Practice Agenda. *Psychiatric Services*, 66(6) 638-640.
- Croft, B., Nilufer, I., (2015). Impact of the 2nd Story Peer Respite Program on Use of Inpatient and Emergency Services. *Psychiatric Services*, 66(6): 632-637.
- Human Services Research Institute (2016). Mixed Methods Evaluation of a Peer Respite Program.

Children's Respite Services

Intervention Description

Respite is the temporary relief for family caregivers from the ongoing responsibility of caring for an individual of any age with special needs. While definitions vary, all share the premise that respite care allows family caregivers to take a short pause in their caregiving responsibilities. Respite can be planned or emergency care. These services have been found to be beneficial, meaningful, and enjoyable to both the caregiver and the care recipient.

Additional Resources

<https://mha.ohio.gov/Families-Children-and-Adults/Family-Supports/Strong-Families-Safe-Communities>

Ohio Respite Locator Service:
<https://archrespite.org/respite-locator-service-state-information/167-ohio-info>

Ohio Program Examples

- A. Ohio Guidestone
<https://ohioguidestone.org>
- B. CareSource
<https://www.caresource.com/plans/medicaid/benefits-services/behavioral-health>
<https://www.caresource.com/documents/behavioral-health-respite-care-services-for-children>

Evidence Supporting Practice

Respite is an evidence-based practice with many studies concluding that receiving respite care, regardless of model, leads to reductions in family caregiver stress and burden, improved quality of life and well-being for both caregivers and care recipients, reduced need for out-of-home placements, and reduced risk for abuse and neglect. Further, new studies have found that respite is cost-effective when compared to more costly institution-based care.

Implementation Considerations

- Ongoing technical-assistance should be received for respite providers.
- Promote the exchange of information and coordination among local governments, community respite services programs, agencies serving children, families, and respite care advocates to promote service referral, and efficient use of services.
- Obtain diversified funding sources to ensure sustainability of this community resource.
- Respite services should be diverse and include a variety of models.

References

- Mullins, L.L., Aniol, K., Boyd, M. L., Page, M.C., and Chaney, J.M. (2004). The influence of respite care on psychological distress in parents of children with developmental disabilities: a longitudinal study. *Children's Services: Social Policy, Research, And Practice*, 5 (2): 123-138.
- Owens-Kane, S. (2007). Respite Care: Outcomes for Kinship and Non-Kinship Caregivers. *Journal of Health & Social Policy*, 22 (3/4): 85-99.
- Madden, E.E., Chanmugam, A., McRoy, R.G., Kaufman, L., Ayers-Lopez, S., Boo, M., and Ledesma, K. J. (2016). The impact of formal and informal respite care on foster, adoptive, and kinship parents caring for children involved in the child welfare system. *Child Adolesc Soc Work J*, 33: 523-534.
4. Remedios, C., Willenberg, L., Zordan, R., Murphy, A., Hessel, G. and Philip, J. (2015). A pre-test and post-test study of the physical and psychological effects of out-of-home respite care on caregivers of children with life-threatening conditions. *Palliative Medicine*, 29 (3): 223-230.

Response

Programs and practices designed to respond to people experiencing a behavioral health crisis range from walk-in clinics, 23-hour stabilization beds, mobile teams, specially trained police officers, and hospital emergency departments encompass the response practices. Regardless of the approach taken, the goals of mental health crisis response are to ensure the patient's safety and stability.



Crisis Intervention Team (CIT)

Intervention Description

A crisis intervention team is a multi-faceted method in police training that teaches officers diverse attitudes towards mental health. CIT helps reduce the stigma towards mental illness or crisis, improves police response to persons with mental illness or experiencing a crisis, and reduces unnecessary arrests. Most commonly, it is a 40-hour training course in which select officers learn the necessary skills to have better interaction with these individuals and guide them to appropriate assistance. Skills gained include de-escalation of the situation, ability to recognize opportunities for referral to treatment rather than arrest and recognizing the signs and symptoms of mental illness.

Additional Resources

<https://www.nami.org/Get-Involved/Law-Enforcement-and-Mental-Health>

<http://www.citinternational.org/Learn-About-CIT>

Ohio Program Examples

- A. NEOMED
<https://www.neomed.edu/cjccoe/cit>
- B. NAMI Franklin County
<http://www.namifranklincounty.org/cit.html>
- C. Summit County Alcohol, Drug Addiction & Mental Health Services Board
<https://www.admboard.org/crisis-intervention-team-cit.aspx>

Evidence Supporting Practice

Multiple studies have been conducted on the effectiveness of crisis intervention teams. CIT has been found to be an effective strategy for preventing unnecessary arrest, reducing the time taken on mental disturbance calls, and increasing preparedness of officers who encounter persons with mental illness. CIT also has been found to be an effective method to prepare police officers to be informal liaisons to the mental health care system; thereby facilitating connections between the person in crisis and needed treatment services.

Implementation Considerations

- Police officers and community treatment providers should be well-connected and have continuous communication.
- Police officers should be allowed to take CIT as a part of their continuing education requirements.
- Police departments that have CIT trained officers should track the outcomes of their calls for individuals with mental illness for quality-improvement purposes.

References

- Franz, S., & Borum, R. (2011). Crisis Intervention Teams may prevent arrests of people with mental illnesses. *Police Practice & Research*, 12(3), 265–272.
- McGuire, A. B., & Bond, G. R. (2011). Critical elements of the crisis intervention team model of jail diversion: An expert survey. *Behavioral Sciences & the Law*, 29(1), 81–94.
- Taheri, S. A. (2016). Do Crisis Intervention Teams Reduce Arrests and Improve Officer Safety? A Systematic Review and Meta-Analysis. *Criminal Justice Policy Review*, 27(1), 76–96.
- Watson, A. C., Compton, M. T., & Draine, J. N. (2017). The crisis intervention team (CIT) model: An evidence-based policing practice? *Behavioral Sciences & the Law*, 35(5/6), 431–441.

Mobile Crisis Team

Intervention Description

Mobile crisis services have the capacity to go out into the community to begin the process of assessment and definitive treatment outside of a hospital or health care facility. Mobile crisis services provide acute mental health crisis stabilization and psychiatric assessment services to individuals within their own homes and in other sites outside a traditional clinical setting. The objectives of mobile crisis services can vary, but often include reducing unnecessary psychiatric emergency department admissions, reducing arrests, reducing suicidality, and behavioral health and social service resource linkage.

Ohio Program Examples

- A. Netcare
<http://www.netcareaccess.org>
- B. Frontline Service
<https://www.frontlineservice.org>
- C. Samaritan Behavioral Health
<http://sbhihelp.org/crisiscare-montgomery>

Evidence Supporting Practice

Several quasi-experimental studies provide empirical evidence on the effectiveness of mobile crisis services. These studies have found that mobile crisis services are effective at diverting people in crisis from psychiatric hospitalization, effective at linking suicidal individuals discharged from emergency department to community services, and more effective than hospitals at linking individuals with outpatient services. Recent studies have also found that these teams are effective at providing Naloxone services to persons suffering from opioid use disorders.

Implementation Considerations

- Community resources and treatment services are in place to successfully refer clients to needed services.
- Ongoing and streamlined communication among participating agencies and the local health care community is necessary.
- Ongoing agency collaboration, information sharing between agencies, and team-building can facilitate implementation of the model in local communities.

References

- Fisher, W.H., Geller, J.L., & Wirth-Cauchon, J. (1990). Empirically assessing the impact of mobile crisis capacity on state hospital admissions. *Community Mental Health Journal*, 26 (3), 245-253.
- Geller, J.L., Fisher, W.H., & McDermeit, M. (1995). A national survey of mobile crisis services and their evaluation. *Psychiatric Services*, 46, 893-897.
- Guo, S., Biefel, D., Johnsen, J., & Dyches, H. (2001). Assessing the impact of community-based mobile crisis services on preventing hospitalization. *Psychiatric Services*, 52, 223-228.

Psychiatric Emergency Department/ Urgent Care

Intervention Description

Psychiatric emergency departments (ED) are dedicated treatment environments set apart from the hospital's main ED. A psychiatric ED is custom-designed to meet the needs of behavioral health patients. For example, patients may be placed in recliners rather than on gurneys and privacy is ensured through the design of treatment stations. A wide variety of behavioral health staff (psychiatrists, nurses, social workers, peers) may interact with the patients, ensuring immediate assessment and intervention, with the goal of transitioning to a less-restrictive environment or facilitating a timely transition to hospitalization.

Ohio Program Examples

- A. St. Vincent Charity Medical Center
Psychiatric Emergency Department, (216) 363-2538
- B. University of Cincinnati Medical Center
Ridgeway Pavilion, (513) 584-8577
- C. University of Cincinnati Children's Psychiatric Intake
Response Center
<https://www.cincinnatichildrens.org/service/p/psychiatry/programs/intake-response>
- D. Akron Children's Hospital Psychiatric Intake Response Center
<https://www.akronchildrens.org/locations/Psychiatric-Intake-Response-Center.html>

Evidence Supporting Practice

Psychiatric urgent care centers and psychiatric emergency departments report substantial improvements in symptom severity, distress, psychosocial functioning, mental health-related quality of life, and patient satisfaction, while dramatically reducing the need for coercive measures, decreasing episodes of agitation and physical restraint, and diverting unnecessary psychiatric hospitalization, all at substantially lower costs. Dedicated psychiatric EDs have also been shown to reduce the length of stay for behavioral health patients in emergency care.

Implementation Considerations

Planning for a psychiatric ED requires consideration of operational processes, staffing models, use of technology, and facility design.

- Key processes to consider are immediate triage and identification of behavioral health emergencies, rapid medical clearance, early psychiatric assessment and stabilization, and quick transfer to an appropriate care setting.
- Staffing models can range from on-call crisis response teams to dedicated on-site psychiatric emergency personnel.
- Psychiatric telemedicine services can be integrated into ED settings where there is limited availability of behavioral health practitioners.
- Facility design should aim at reducing potential harm to patients, visitors and staff, reduce agitation, and facilitate de-escalation.

References

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23-Hour Observation Level of Care

Intervention Description

Extended observation units (EOUs) and 23-hour beds are designed for consumers who may need short, fairly intensive treatment in a safe environment that is less restrictive than a hospital, and when it is expected that the acute crisis can be resolved in less than 24 hours. Services include medication, meeting with extended family or significant others, and referral to more appropriate services. Additionally, these facilities may be suitable for patients in substance-induced states, while they return to sobriety.

Ohio Program Examples

- A. Portage Path Behavioral Health
<https://www.portagepath.org>
- B. Coleman Professional Services
<http://www.colemanservices.org>
- C. Ravenwood Health
<https://www.ravenwoodhealth.org>

Evidence Supporting Practice

Repeated research and evaluation has found that observational care, or 23-hour observation programs, result in cost-savings compared to inpatient treatment, reduced use of the emergency department and inpatient psychiatric treatment, and no increases in suicide gestures or other self-harm behavior when compared to other programs. Further, studies have found that observational care reduces expensive psychiatric boarding, or the holding of patients until a bed or service is made available, reduces length of stay, and improves patient flow in hospital emergency and psychiatric departments.

Implementation Considerations

- Facilities should have a separate entrance, a lobby with waiting room, and interview rooms.
- The program must have strong collaborative partners in the hospital and community behavioral health system.
- The unit must be adequately staffed 24/7 by psychiatrists.
- The setting should be comfortable and calming.
- Treatment should be delivered promptly.
- Staff should be part of the environment and not behind enclosures.

References

- San, D., Kuswanto, C., Sum, M., Chai, S., Sok, H., Xu, C. (2015). The 23-Hour Observation Unit Admissions Within the Emergency Service at a National Tertiary Psychiatric Hospital: Clarifying Clinical Profiles, Outcomes, and Predictors of Subsequent Hospitalization. *Primary Care Companion CNS Disorders*, 17(4): 10.
- Francis, E., Marchand, W., Hart, M., Carter, A., Schinka, J., Feldman, A., Ordorica, P. (2000). Utilization and Outcome in an Overnight Psychiatric Observation Program at a Veterans Affairs Medical Center. *Psychiatric Services*, 51(1): 92-95.
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Short-term Acute Residential Treatment

Intervention Description

Short-term residential treatment serves individuals experiencing a mental health emergency in a community-based setting. Short-term residential treatment programs are a critical component of Ohio's behavioral health system and have similar results when compared to inpatient hospitalization. These programs offer services in a recovery-focused, community-based, home-like environment that focuses on person-centered psychosocial and psychiatric care, multi-day lengths of stay, and encourages autonomy and accountability.

Ohio Program Examples

- A. Becket Springs Hospital
<https://beckettsprings.com>
- B. Access Ohio
<http://www.accessoh.com/Home.aspx>
- C. Rescue Mental Health and Addiction Services
<http://www.rescuemhs.com>

Evidence Supporting Practice

Short-term residential treatment is an evidence-based practice with many randomized controlled trial research studies that have found it effective for use with persons who have mental health or substance use challenges. Research has found that short-term residential treatment is comparable to or better than inpatient psychiatric treatment in terms of symptom improvement, reductions in suicidality, improved client satisfaction, enhancing social skills, and linkage with community resources. Studies have consistently found that short-term residential programming is a safe, cost-effective alternative to inpatient psychiatric treatment for those experiencing an acute psychiatric crisis. Further, short-term residential treatment has been found to be highly effective with persons across the lifespan.

Implementation Considerations

- A broad spectrum of stakeholders should be involved in the planning process.
- Services should seek ongoing feedback from stakeholders and consumers to ensure services are meeting the needs of the community.
- A needs-assessment should be conducted where the community has identified gaps where short-term residential crisis services assist in meeting the needs of residents.
- There are sufficient referral sources.
- The facility has adequate connectivity to services in the community.

References

- Lloyd-Evans, B., Slade, M., Jagielska, D., & Johnson, S. (2009). Residential alternatives to acute psychiatric hospital admission: systematic review. *British Journal of Psychiatry*, 195, 109–117.
- Stroul BA. Residential crisis services: a review. *Hospital Community Psychiatry* (1988) 39: 1095–1099.
- Hawthorne WB, Green EE, Gilmer T, Garcia P, Hough RL, Lee M, et al. (2005). A randomized trial of short-term acute residential treatment for veterans. *Psychiatric Services*, 56: 1379–86.
- Fenton WS, Mosher LR, Herrell JM, Blyler CR. (1998). Randomized trial of general hospital and residential alternative care for patients with severe and persistent mental illness. *American Journal of Psychiatry*, 155: 516–22.

Crisis Stabilization Centers

Intervention Description

Crisis stabilization centers are home-like environments that address behavioral health crises in a community-based behavioral health or hospital setting. They are bedded units that range from six to 16 beds and are staffed by licensed and unlicensed peer supporters, as well as clinical and non-clinical professionals who hold masters and bachelor degrees. Services may consist of assessment, diagnosis, abbreviated treatment planning, observation, case management, individual and group counseling, skills training, prescribing and monitoring of psychotropic medication, referral, and linkage. Service delivery is offered on a 24-hour basis to address the client's immediate safety needs, develop resilience and create a plan to address the cyclical nature of behavioral health challenges and future behavioral health crises for adults and children. Crisis stabilization centers offer services to individuals whose needs cannot be met in the community. The environment is safe and secure and less restrictive than a hospital setting.

Additional Resources

<https://www.nami.org/Learn-More/Treatment/Getting-Treatment-During-a-Crisis>

Ohio Program Examples

- A. Rescue Mental Health and Addiction Services
<http://www.rescuemhs.com/adult-services>
- B. Netcare
<http://www.netcareaccess.org/services/help-in-a-crisis-adult-youth/crisis-stabilization>
- C. The NORD Center
<https://www.nordcenter.org/emergency-crisis-center>

Evidence Supporting Practice

Studies on crisis stabilization centers have found that they are effective at lowering the length of stay in the emergency department and are cost-effective when compared to inpatient treatment. One study found that implementation of one crisis stabilization unit saved \$4 million in Medicaid costs. Another study found that providing the psychiatric services in a community-based crisis stabilization unit was significantly less expensive than inpatient psychiatric treatment with comparable outcomes. Research has also found that these units result in significant reductions in use of inpatient psychiatric resources and are effective at diverting individuals from the criminal justice system.

Implementation Considerations

- Collaboration across multiple community service sectors is needed to successfully implement a crisis stabilization center. Service sectors can include police, child welfare, hospitals, community mental health centers, substance use disorder treatment facilities, legal services, peer support providers, Medicaid, private insurance, health departments, among others.
- Financing should include blending multiple sources and resources to address the various unique needs of the individuals that the crisis stabilization center serves.

References

- Saxon, V., Mukherjee, D., Thomas, D. (2018). Behavioral Health Crisis Stabilization Centers: A New Normal. *Journal of Mental Health and Clinical Psychology*, 2(3): 23-26.
- Frances, E., Marhand, W., Hart, M. (2000). Utilization and outcome in an overnight psychiatric observation program at a Veterans Medical Center. *Psychiatric Services*, 51(1): 92-95.
- Heyland, M., Johnson, M. (2017). Evaluating an alternative to the emergency department for adults in mental health crisis. *Issues in Mental Health Nursing*, 38 (7): 557-561.

Children: Mobile Response Stabilization Services

Intervention Description

Children’s mobile response and stabilization services (MRSS) are aimed at ensuring the safety and well-being of children, youth and their families/caregivers facing crisis situations because of escalating behaviors that may risk disruption of a child or youth’s current living arrangements. MRSS provides immediate crisis response on-site, and coordinates subsequent stabilization services to children, youth, their families, and caregivers.

Additional Resources

<https://www.wraparoundohio.org/mobile-crisis-response-and-stabilization-services>

What is New Jersey’s Mobile Response and Stabilization Services intervention
<https://www.casey.org/nj-mobile-response-stabilization-services>

New Jersey Mobile Response and Stabilization Services
https://www.state.nj.us/dcf/policy_manuals/mobile-response-serv-72-hrs.pdf

Ohio Program Examples

- A. Coleman Professional Services:
<http://www.colemanservices.org/our-services/behavioral-health/crisis-intervention.aspx>
- B. Family Resource Center
<http://www.frcoho.com/crisis-intervention>
- C. Butler Behavioral Health
<https://www.bbhs.org/what-we-do/community-based-services>

Evidence Supporting Practice

While MRSS is a relatively new crisis-intervention service offered to children and adolescents, it is commonly viewed as a component of a comprehensive children’s behavioral health system of care. Recent studies and local program evaluation reports suggest that MRSS reduces suicidality of clients, reduces emergency department usage, and improves access to needed services. MRSS is currently endorsed by the Substance Abuse and Mental Health Administration, the National Association of State Mental Health Program Directors, and the Association of Children’s Residential Centers.

Implementation Considerations

- Develop contracts with key model specifications and performance expectations.
- Institute a culture of “crisis defined by caller.”
- Institute a culture of “just go.”
- Single statewide call center is easier for families/enhances access.
- Use a standardized practice model for all sites. Promote access, quality, and outcomes using performance data analysis and reporting, workforce development, and data transparency.
- Mobile crisis creates an important linkage to EDs — Divert youth from EDs (by responding to schools, homes); help connect youth and families in the ED back to the community.
- Programs are kept fiscally viable by combining grant funds and third-party reimbursement.
- Adapt and leverage the model to link and integrate with other services and systems.

References

- Mann, C. & Hyde, P. (2013). Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions. Joint CMCS and SAMHSA Informational Bulletin.
- Child Health and Development Institute of Connecticut. Mobile Crisis Intervention Services: Performance Improvement Center (PIC)

Postvention

Postvention services refer to efforts that are directed toward helping an individual get back to his/her/their pre-crisis level of functioning and assisting in the development of new skills for dealing with challenges in the future.



Withdrawal Management

Intervention Description

Medical withdrawal management safely manages the acute physical symptoms of withdrawal associated with stopping drug use. Medical detoxification is typically considered the first stage of addiction treatment and by itself does little to change long-term drug use. Although withdrawal management alone is rarely sufficient to help individuals with an addiction achieve long-term abstinence, for some individuals it is a strongly indicated precursor to effective drug addiction treatment (National Institute on Drug Abuse, 2018).

The goal of withdrawal management, also called detoxification or “detox,” is to enable a person to stop taking the addictive substance as quickly and safely as possible. For some, withdrawal therapy can be done on an outpatient basis. For others, withdrawal therapy may include admission to a hospital or a residential treatment center.

Withdrawal from different categories of drugs such as depressants, stimulants or opioids produces different side-effects and requires different approaches. Detox may involve gradually reducing the dose of the drug or temporarily substituting other substances, such as methadone, buprenorphine, or a combination of buprenorphine and naloxone (Mayo Clinic, 2018).

Ohio Program Examples

- A. Ohio Addiction Recovery Center
<https://www.ohioarc.com>
- B. Gateways Recovery Center
<http://www.gatewaysrecovery.com>
- C. Saint Vincent Charity Medical Center
<https://www.stvincentcharity.com/services-centers/behavioral-health-addiction-medicine/addiction-medicine-rosary-hall>

Evidence Supporting Practice

Numerous studies have been conducted on withdrawal management services for substance use disorders. Overall, studies have found that medication-assisted detoxification results in higher levels of successful withdrawal management and longer-term abstinence. Another study found that consistency in treatment providers (i.e., having the same doctor throughout the process) reduced the likelihood individuals would discharge against medical advice.

References

- Ling, D., Amass, L., Shoptaw, S. (2005) Multi-center randomized trial of buprenorphine–naloxone versus clonidine for opioid, detoxification: findings from the National Institute on Drug Abuse Clinical Trials Network Addiction, 100(8).
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- Blondell, R., Amadasu, A., Servoss, T., Smith, S. (2008). Differences Among Those who Complete and Fail to Complete Inpatient Detoxification. *Journal of Addictive Diseases*, 25(1): 95-104.

Transition Supports

Transition Supports refer to the purposeful, planned process of assisting people who are moving from one service to another, often between behavioral health services and other sectors or between hospital and community services. Providing transition supports can improve individual client level outcomes, including reducing likelihood of re-hospitalizations and emergency department use, and improving overall functioning.



Peer Crisis Support Services/ Peer Navigators

Intervention Description

Peer support workers or peer navigators are individuals with lived experience who connect individuals with behavioral health disorders and their families and caregivers to culturally relevant services. The peer navigator staff provide support through engagement and education on prevention, diagnosis, timely treatment, recovery management, and follow-up with other services. Connecting individuals with similar mental health or substance use disorders who are familiar with the health care network can often promote service utilization and continuity of care.

Additional Resources

<https://mha.ohio.gov/Health-Professionals/About-Mental-Health-and-Addiction-Treatment/Peer-Support>

Ohio Program Examples

- A. Turning Point Community Programs
<https://www.tpcp.org/programs/peer-navigators>
- B. Spectrum Health Systems Recovery Support Navigator Program
<https://www.spectrumhealthsystems.org/2015/spectrum-s-recovery-support-navigator-program-changes-lives>
- C. The Recovery Center
<http://www.therecoverycenter.org>

Evidence Supporting Practice

Peer support workers are increasingly being used in crisis services across the U.S. Research has found that routine contact with a peer navigator can help individuals with serious mental illness and substance use disorders access the health care system effectively, thereby improving physical and mental well-being. In addition, matching navigators and clients with similarities may also help to increase empathy and trust, particularly among individuals struggling with serious mental illness.

Implementation Considerations

- Obtain diversified funding sources to ensure sustainability.
- Identify whose buy-in and support is needed to implement peer support in your service setting. Also identify barriers to inclusion of peers in the service array.
- Peer support staff should be diverse and reflect the patient population they serve.
- Peer support staff receive broad training as the basis of their certification. To be effective, they need additional training in areas unique to crisis care.

References

- Corrigan, P. W., Kraus, D. J., Pickett, S. A., Schmidt, A., Stellon, E., Hantke, E., & Lara, J. L. (2017). Using peer navigators to address the integrated health care needs of homeless African Americans with serious mental illness. *Psychiatric Services*, 68:3, 264-270.
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Critical Time Intervention (CTI)

Intervention Description

Critical time intervention (CTI) attempts to assist individuals with mental illness when they are displaced from facilities and facing unstable housing or food insecurity. CTI is a time-limited case management model that focuses upon continuity of care and physical supports during the transition from hospitals, shelters, prisons, and other institutions to community living. CTI works by providing emotional and practical support during the critical time of transition and by strengthening the individual's long-term ties to services, family, and friends. Ideally, post-discharge assistance is delivered by workers who have established relationships with clients during their institutional stay.

Additional Resources

Coalition on Homelessness and Housing in Ohio
<https://cohhio.org>

Ohio Program Examples

- A. Cuyahoga Partnering for Family Success Program
<https://www.criticaltime.org/2015/03/02/new-program-in-cuyahoga-county-ohio-uses-cti-to-address-homelessness-and-child-welfare>
- B. Homeless Veterans
<https://www.va.gov/homeless>
- C. Homefull
<http://www.homefull.org>

Evidence Supporting Practice

Recent research supports the application of CTI upon discharge from psychiatric hospitals to reduce homelessness and food insecurity. CTI has demonstrated long-term impact for patients in transition. The model also has potential with the transition between prison and society.

Implementation Considerations

- Personalized case management aimed to fit the client's current needs and resources.
- Establish ongoing supports from contacts known to the individual from previous environment during transition months.
- Establish long-term ties to community and family resources during the time of transition.
- Maintain treatment engagement, motivational coaching and psychosocial development as environments and available resources change.
- Work with the client to establish and maintain a strong network of contacts within the community to promote stability over time.
- Gradually shift responsibilities to the client, family, and community supports.

References

- Draine, J. & Herman, D. B. (2007). Critical time intervention for reentry from prison for persons with mental illness. *Psychiatric Services*, 58:12, 1577-1581.
- Herman, D. B., Conover, S., Gorrochurn, P., Hinterland, K., Hoepner, L., & Susser, E. S. (2011). Randomized trial of critical time intervention to prevent homelessness after hospital discharge. *Psychiatric Services*, 62:7, 713-719.
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Notes



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