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Adopting Innovations—Lessons Learned from a Peer-Based Hospital Diversion Program

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ABSTRACT: Moves to bridge the gap between research and practice have heightened interest in how service innovations are adopted. This paper reports on a peer-based hospital diversion program that provided short-term respite care, clinical monitoring, connection or re-connection to other mental health services, and peer support. The program was successful in providing services to the target population and was viewed as highly desirable by service recipients and clinical agencies. However, full adoption of this innovation was not realized and it closed barely a year after opening. Lessons learned from both the "life" and "death" of this program are offered.

KEY WORDS: peer-delivered; diversion; innovation; respite; crisis services.

A substantial number of persons with serious mental illness continue to utilize emergency room services and are subsequently hospitalized. Oftentimes persons in psychiatric crisis, yet not in need of hospitalization, turn to the emergency room because there is nowhere else to go when help is needed. Emergency room staff are confronted with a similar dilemma. They are not equipped to provide respite or connect persons to case management or other services and often have only two options when dealing with persons in acute crisis who are not considered a

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significant danger to themselves or others—hospitalize or release with minimal service and a referral for service elsewhere. The lack of options may, in fact, increase their propensity to hospitalize.

Many innovations in addressing the needs of persons in acute crisis have been developed. For example, day treatment and short-term acute residential programs produce slightly better clinical outcomes, are associated with slightly decreased costs, and likely lead to less psychological trauma compared with hospitalization (e.g., Dolnak, Rapaport, & Hawthorne, 1998; Fenton, Mosher, Herrell, & Blyler, 1998; Hawthorne, Green, Lohr, Hough, & Smith, 1999; Sledge, Tebes, Raakfeldt, Davidson, Lyons, & Druss, 1996). Another unique approach is the development of community-based acute psychiatric crisis treatment centers. Soteria House is one of the best known models of how acute psychiatric care can be provided in homelike settings (Mosher, 1995) and other examples of similar alternative community-based care programs can be found in Warner (1995).

In this brief report we describe CONNECTIONS, an innovative peer-based hospital diversion program that was called a model program by the National Mental Health Association. This is followed by a discussion of factors associated with CONNECTIONS demise, including policy, fiscal, and practice issues. Lessons learned from the failure to adopt such programs are useful to policymakers and program developers when initiating novel mental health services.

BIRTH OF CONNECTIONS

Policymakers and service providers in Philadelphia recognized a need for a short-term respite program that focuses on connecting or re-connecting a targeted group of persons who seek psychiatric emergency services with other community-based services rather than develop another long-term service program. CONNECTIONS was developed to meet this need and began operations in May 1998, and was open Wednesday through Sunday from 8pm to 8am. These "overnight" hours were viewed as necessary because other resources available to persons in crisis generally operate on a 9am to 5pm schedule with limited after-hours support. Each shift was staffed by Peer Support Counselors, a Master's level Mental Health Specialist, and Clerical Support staff. CONNECTIONS was based on a philosophy that people with mental illness and substance abuse issues can recover and minimize the negative impact of the illness on their lives, and that recovery is enhanced when people are actively engaged in decisions regarding their own treatment and their own rehabilitation activities. The CONNECTIONS service philosophy was embodied in the following principles: (1) staff respect of consumers each time they came to CONNECTIONS, (2) repeat visits were viewed as an opportunity to build relationships, and continue to engage the individual in discussions about life circumstances and treatment readiness and/or options, (3) teach new problem solving skills, (4) emphasize individual strengths, (5) think creatively, (6) encourage staff to be open to the possibility that they are not always correct, (7) actively work with current service providers (i.e., Intensive Case Management and other services), and (8) to help consumers access appropriate supports and services.

The involvement of peer providers was a central feature of this service philosophy. Peer/consumer providers have been the focus of much attention over the last decade (Davidson et al., 1999; Mowbray, Moxley, Jasper, & Howell, 1997; Sherman, & Porter, 1991). There is a growing literature base supporting the benefits of consumer-delivered services and increasing employment options available to consumers of mental health services (Mowbray, Moxley, Jasper, & Howell, 1997). Consumers are filling the employment rolls in a variety of positions including: case managers and case assistants on Assertive Community Treatment teams, vocational and employment coaches, peer support staff in drop-in centers and crisis residences and housing programs, street outreach, shelter and other homeless services, and as consumer advocates on service delivery monitoring teams. Benefits to employing consumers include increasing sensitivity to the needs of service recipients, increasing the trust and rapport developed with recipients, a more effective source of empowerment and role modeling, and an increase in the self-esteem of the consumer employee him or herself through the participation in meaningful work and potential career development (Mowbray et al., 1996; Salzer & Shear, in press).

PROGRAM DESCRIPTION

Service Contacts, Referrals, and Recipients

Service contacts refer to the number of consumers, referred and walk-in, who received CONNECTIONS services. CONNECTIONS had 416 service contacts over the one-year period of this study. Two hundred and seventy-one referrals were made to CONNECTIONS (58% of service

contacts). Referrals were fairly constant across the five days that CONNECTIONS was open. Forty-four of these referrals (16% of referrals) did not arrive at CONNECTIONS. A substantial number of service contacts were the result of walk-ins (N = 189, 42%). Service recipients are defined as the number of individual consumers (unique) for whom CONNECTIONS provided services. There were 220 unique consumers who received CONNECTIONS services. This figure, when compared to 416 service contacts, indicates that a substantial number of contacts were made by previous CONNECTIONS service recipients. One hundred and forty consumers visited CONNECTIONS once, 55 visited two to three times, and 25 consumers visited four or more times. Three consumers accounted for a total of 53 service contacts (29, 13, and 11 contacts). Demographic characteristics of service participants are presented in Table 1.

Services Provided and Dispositions

The number and types of services delivered by CONNECTIONS staff to consumers are presented in Table 2. Almost everyone received clinical monitoring and peer support, which were the basic services provided by CONNECTIONS. There were two significant services provided by CONNECTIONS that are not readily available in crisis emergency room settings—meals and overnight respite. Referrals and transportation were also frequently provided. Disposition data are presented in Table 3. It is important to note here that many consumers had more than one disposition. For example, one of the most frequent combined dispositions was referral to a housing shelter placement and referral to drug/alcohol treatment. CONNECTIONS also served an important function of reconnecting the person with their case manager or other service provider. Thirty consumers (7%) left CONNECTIONS without a formal disposition.

CONSUMER SURVEY

Consumers were asked to complete a six-item survey that was often administered just prior to the 8 A.M. closing. One hundred and forty-three consumers out of approximately two hundred and fifty consumers who received CONNECTIONS services during a six-month time period completed the survey. Almost all of those who were asked to complete the survey did so. Surveys were not completed by those who left the

TABLE 1

Characteristics of CONNECTIONS Service Recipients

Gender:	Male N = 151 (68%) Female N = 69 (32%)
Age:	Mean: 38.07 (SD ± 8.51), Range: 19–66
Race:	African American (N = 182; 82%), White (N = 29;13%), Latino (N = 8; 4%), Other (N = 2; 1%)
Veteran	(N = 26; 12%)
Currently Homeless	(N = 162; 73%)
Currently Employed	(N = 17; 9%)
Previously Arrested	(N = 101; 56%)
Previously in Incarcerated	(N = 76; 43%)
Primary Mental Health Dx	(N = 50; 23%)
Primary Drug/Alcohol Dx	(N = 62; 28%)
Dual Diagnosis Dx	(N = 95; 43%)
Previous Psych Hospitalizations	(N = 130; 70%)
Previous Psych Treatment	(N = 143; 75%)
Previous Medications	(N = 128; 68%)
Previous Suicide Attempts	(N = 84; 46%)
Previous Substance Treatment	(N = 120; 66%)
Current Psych Treatment	(N = 69; 37%)
Current Medications	(N = 72; 39%)
Current Substance Treatment	(N = 19; 10%)
Assigned to Case Management	(N = 47; 25%)

facility before it was administered, including a large number of consumers who received a formal disposition to another facility. It is plausible that the small number of persons who left without a formal disposition may have had less favorable impressions of the program, but that this would have been counterbalanced by the likely favorable impressions held by the larger group of consumers that left the program prior to completing the survey who obtained a formal disposition (e.g., shelter

TABLE 2

Services Provided by CONNECTIONS

Service Type	*N*	%
Peer Support	411	99%
Clinical Monitoring	402	97%
Meal	371	89%
Overnight Respite	320	77%
Transportation by Staff	252	61%
Referral	206	49%
Shower	173	41%
Laundry	132	32%
Clothing	72	17%
Transportation Tokens	67	16%
Other Services	28	7%

Note: The category "Other Services" consisted primarily of psychoeducation and time-limited case management services.

TABLE 3

Dispositions

Disposition	*N*	%
Shelter Placement	151	36%
Notify/Re-Connect with Case Management or Other Service Provider	127	31%
Drug/Alcohol Treatment	94	23%
Other Disposition	63	15%
Return Home	51	12%
Consumer Left without Formal Disposition	30	7%
Outpatient Mental Health Treatment	20	5%
Crisis Emergency Services	16	4%
Emergency Evaluation Center	13	3%
Emergency Room for Medical Reasons	7	2%
Inpatient Mental Health Treatment	3	1%

Note: The information reported here refer to the number and percentage of dispositions in each category out of the 416 service contacts. The category "Other" refers to DPA referrals and other social service and medical referrals.

placement, return to home). CONNECTIONS staff also failed to administer the surveys on a few occasions.

Ninety-seven consumers (68%) reported that their needs were completely met and 33 (23%) reported that nearly all needs were met. One hundred and sixteen respondents (82%) reported that they were extremely or very satisfied with the services they received (96% reported being satisfied to some degree). One hundred and fourteen respondents (80%) reported that they would definitely return to CONNECTIONS if they were in need of help in the future and another 26 (18%) reported they would probably return in the future. The four most important services that consumers reported receiving were: overnight shelter (N = 103, 72%), support or counseling (n = 60, 42%), meal/beverages (N = 28, 20%), and referral (N = 22, 15%).

PROVIDER SURVEY

A survey of service agencies was conducted in February of 1999. A total of twenty-two out of forty-six mailed surveys were returned (a 48% completion rate). All providers indicated that CONNECTIONS was a needed service in the crisis response system. Thirteen of the 22 respondents (58%) stated that the program was highly needed. Respondents were also very satisfied (>90%) with the program environment, professionalism of CONNECTIONS staff, and staff ability to help consumers with their immediate problems.

DISCUSSION

CONNECTIONS served its intended population of those who were at-risk for inpatient hospitalizations. It filled a gap in services by offering services to individuals who are in crisis but do not require psychiatric hospitalization. These persons are oftentimes:

- given the least amount of attention in the ER
- the last to be seen
- sent home with little more than a recommendation to contact a mental health agency in the morning.

CONNECTIONS was viewed as extremely helpful and needed by consumers and community providers alike. Moreover, CONNECTIONS

likely resulted in significant cost savings due to the high number of walk-ins who would have likely sought crisis services. Assuming a very conservative cost of $200 for each crisis contact, it might be argued that the presence of CONNECTIONS saved at least $37,800 (189 walk-ins × $200 per assumed contact at CRC). So what happened to this model program?

The number of individuals served by CONNECTIONS never came close to the 100 to 120 consumers per month that was reasonably expected by the Philadelphia Office of Mental Health (OMH). Therefore, the program closed at the end of its funding cycle in June 1999. Few articles have discussed the inadequate adoption of apparently successful programs (e.g., Diamond, 1995; Reding & Raphelson, 1995). CONNECTIONS story is an important addition to our understanding of this topic. At least three factors appear to have played a role.

First, Philadelphia has an abundance of psychiatric hospital beds and there is currently no system in place other than pre-authorization for limiting the use of these beds. CRCs do not have incentives to pursue alternative crisis services for persons who are not in obvious need for hospitalization. Data reported by OMH indicated that 68% of consumers coming to CRCs were ultimately referred to inpatient care during the latter stages of CONNECTIONS existence. The CRCs, Oversight Committee agencies, and the other community-based referral sources for CONNECTIONS did not have financial incentive to refer or encourage the use of CONNECTIONS to their consumers. A successful set of alternative crisis services can only be built around a treatment philosophy committed to decreasing the number of referrals for hospitalization even further and ultimately the number of psychiatric inpatient beds available in the system.

Second, referrals agencies did not realize the potential of CONNECTIONS as an option to hospitalization. To do so would have required a change in service philosophy from a traditional medical approach involving a decision about hospitalizing a person in crisis, to a peer based diversion model based on a continuum of service options for a person in crisis. The need to change service philosophies may have been compounded by the involvement of consumers in the delivery of CONNECTIONS services. Previous research suggests that mental health professionals view consumer-delivered services as helpful, but less helpful than professionally-delivered services (Salzer, McFadden, & Rappaport, 1994). These views were found to impact referrals and other forms of support for these services (Salzer, Rappaport, & Segre, 2001).

Finally, any demonstration requires a sufficient amount of start up time. Obviously, the definition of sufficient is always a difficult one. In hindsight, it seems logical that new services representing a new perspective in how services might be offered, compared to, for example, a start-up of a fairly traditional service program (i.e., a new partial hospitalization program, community clinic, etc.), requires relatively more time to become imbedded into the service structure. CONNECTIONS represented a new type of program, differing in terms of the involvement of consumer-providers and as an alternative acute crisis service. Extensive efforts were made early on to ensure adequate referrals, but CONNECTIONS administrators remained confident about potential referrals based on the total numbers of persons seeking services at the CRCs and staff statements that they could more than satisfy program capacity. A pipeline study examining the number of potential referrals was not conducted. Such a study may have demonstrated that reality is oftentimes far different from perception. The situation is similar to that found when conducting research, where expected research participant estimates based on clinical and other referral sources are often woefully over-optimistic. It seems obvious that one year was not enough time to address attitudinal and other referral barriers.

Financing and management of the behavioral healthcare needs for medical assistance recipients in Philadelphia County transitioned to a managed care environment in 1997. In retrospect, it is likely that a program like CONNECTIONS would have better flourished with a firm referral relationship with the behavioral healthcare entity managing medical assistance for Philadelphia County called Community Behavioral Health (CBH). The time and energy that went into building relationships with multiple referral sources could have been better spent engaging the holders of the "purse strings" and developing a solid relationship and referral protocol with the administration and behavioral healthcare care service managers operating the crisis admission line for CBH. Since all admissions to acute and subacute psychiatric levels of care are assessed and approved through the crisis line, this would have provided the CONNECTIONS program with a greater and more consistent pool of referrals and provided CBH with a less restrictive alternative to inpatient care and a consumer based/consumer empowered service alternative.

Alternative crisis services are a necessary component of a system of care for persons with serious mental illnesses. These services require the full support of all participants across the system if they are to be successfully integrated into the network of care. Consumer choice in treatment interventions and referrals should be incorporated across all

levels of mental health care, including the crisis service network. A peer based diversion program like CONNECTIONS provides options for addressing acute crises. However, the main lesson learned from this program is that as much attention should be paid to facilitating the adoption of such treatment innovations as spent in their design.

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Dual Diagnosis: HIV and Mental Illness, a Population-Based Study

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ABSTRACT: This is a cross-sectional, population-based (n = 378,710) study using hospital discharge abstract data to determine the relative risk associated with having a dual diagnosis of mental illness and HIV/AIDS. The analysis addresses issues of gender, race, and age, as well as types of mental illness. Persons with a mental illness are 1.44 times more likely to have HIV/AIDS. Women are at increased risk of being dually diagnosed. There are no risk differences by race. Those with a specific diagnosis of substance abuse or a depressive disorder are more likely to have a diagnosis of HIV/AIDS.

KEY WORDS: HIV/AIDS; mental health.

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Anyone wishing to submit articles for consideration for this column should contact Wesley E. Sowers, M.D., St. Francis Medical Center, the Center for Addiction Services, 2 East 400-45th Street, Pittsburgh, PA 15201-1198.

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KEY WORDS: HIV/AIDS; mental health.

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Anyone wishing to submit articles for consideration for this column should contact Wesley E. Sowers, M.D., St. Francis Medical Center, the Center for Addiction Services, 2 East 400-45th Street, Pittsburgh, PA 15201-1198.

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