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I am a retired Licensed Psychologist and program administrator now providing consultation and training services for both traditional and Peer mental health organizations. I have worked in administrative and clinical capacities for mental health organizations and alcoholism and drug abuse treatment programs in Oregon, Washington, Colorado, New Mexico, and Michigan over a 40+ year career. My work has included: the provision of crisis intervention services and evaluations for involuntary commitment: the fiscal and operational management of crisis intervention departments in community mental health programs; and the training and supervision of those providing such services.

I am testifying in support of SB 816, requiring hospitals to submit emergency department abstract records to the Oregon Health Authority. My interest in this bill is how the boarding of mental health patients in emergency departments is contributing to the detriment of individuals, families, and the mental health provider and payer systems.

Much data has been gathered nationally at federal and state levels. To quote from the 2015 "Behavioral Health Patient Boarding in the ED" report by the International Association for Healthcare Security and Safety – Foundation (IAHSS – Foundation):

The additional wait in an Emergency Department before receiving the deemed mental health services coupled with overcrowding can further deteriorate the health of the patient and can lead to life threatening circumstances.

According to the Agency for Healthcare Research and Quality (AHRQ), many factors contribute to inferior health outcomes:

1. *Compromised quality of care - Emergency Department is a high stress work environment and extra demand due to overcrowding can surge the error rates.*
2. *Quality measures by Institute of Medicine (IOM) that is safety, effectiveness, patient-centeredness, efficiency, timeliness, and equity are all compromised in overcrowded Emergency Departments due to long waits and diversion of the ambulance away from the hospital closest to the patients. This results in a 5 percent increase in likeliness for the patient to die as compared to less crowed emergency units. 2006 IOM report states that the "Future of Emergency Care: Hospital-Based Emergency Care at the Breaking Point," due to overcrowded Emergency Departments.*
3. *Timely treatment of the patient is a growing issue. It helps prevent patient pain and suffering along with delays in diagnosis and treatment.*

Additionally, given our current State's budget shortfall, solutions to emergency department boarding of mental health patients should also require the adoption of evidence-based but lower cost resources for post-acute treatment. Emerging now in states are more affordable and evidence-based Peer services, with Peer Crisis Respite programs being a prime example. Such Recovery-oriented services have been shown to be effective and less expensive, and also have the advantage of being more attractive to patients in need, thus helping reduce the problems of treatment elopement, treatment resistance, and

general demoralization more commonly experienced by patients in a traditionally structured treatment environment.

Many states have begun addressing the emergency department boarding problem, and Oregon should proceed to systematically do so now as well. SB 816 is a good first step toward a proactive solution.

Thank you.

However, a closer look at the results suggests a complex relationship between respite and inpatient & emergency service use. Respite guests with longer stays at Second Story had a higher likelihood of using inpatient or emergency services than guests with shorter stays. Similarly, the longer the stay, the more hours of inpatient and emergency services that guests were likely to use. In fact, those who stayed at Second Story for about two weeks or more used inpatient and emergency services at approximately the same rate as those in the comparison group—that is, those who had not used peer respite services. These dynamics may be a reflection of pre-existing factors that we could not capture in our study. We expect that our future analyses—including work that uses recovery surveys and in-depth interviews with guests and staff—will help us to understand more about these findings.

Conclusions. Peer respites may be a viable and person-centered alternative for people in crisis. Programs like Second Story may decrease the behavioral health system's reliance on costly inpatient or emergency services. Future research should focus on understanding peer respites' impact on other important outcomes, such as quality of life and community integration. Future research can build on our findings to guide peer respites in making important program design and implementation decisions.

For more information. See "Impact of the 2nd Story Peer Respite Program on use of Inpatient and Emergency Services" in the June 2015 issue of Psychiatric Services and available online at http://ps.psychiatryonline.org/doi/full/10.1176/appi.ps.201400266.

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Human Services
Research Institute

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A short summary of research findings from the Human Services Research Institute

Can peer respites reduce the need for more traditional (and costly) psychiatric emergency services?

Peer respites are emerging as an alternative model of support for people at risk for or experiencing a mental health crisis. They offer a safe, temporary stay at a residence staffed by specially trained peers—people who have lived through similar crises of their own and have previously received services through the mental health system. But what type of impact will peer respites have on the behavioral health system in general, particularly inpatient and emergency services? The evaluation of Second Story, one of the nation's first peer respites, yields some initial data.

Second Story is located in Santa Cruz, California. It's financed through the combination of a Mental Health Transformation Grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) and funding from the behavioral health department of Santa Cruz County. All Second Story staff identify as peers who have previously received services through the mental health system. Staff are trained in Intentional Peer Support, a service delivery program that emphasizes mutuality, reciprocity, and growth through the development of peer-to-peer relationships.

The Study. We looked at the data on 139 people who were guests at Second Story between May 2011 and June 2013, and we compared their data to a group of people with similar characteristics who hadn't used peer respite services. That is to say, we used propensity score matching to establish a comparison group of 139 individuals who did not use the respite but had similar clinical, demographic, and behavioral health service use characteristics. The similarities between the two groups allow us to draw some conclusions about Second Story's effect on the use of emergency psychiatric services.

First, we examined the likelihood of using inpatient or emergency services after the respite start date. Next, we looked at total hours of inpatient and emergency service use for the 98 individuals who used any of those services. In all of our analyses, we took individuals' clinical, demographic, and behavioral health service use histories into account.

Results. The probability of using any inpatient or emergency services after the respite start date was about 70% lower among respite users than non-respite users. For those who used any inpatient or emergency services during the study period, a longer stay in respite was associated with fewer hours of inpatient and emergency service use.

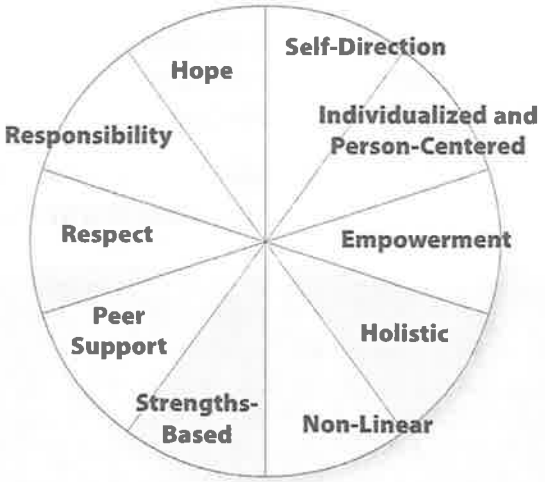
KEY DATA POINTS

- *Respite guests were **70% less likely to use inpatient or emergency services***
- *Respite days were associated with significantly **fewer inpatient and emergency service hours***

- **Strengths-Based:** Recovery focuses on valuing and building on the multiple capacities, resiliencies, talents, coping abilities, and inherent worth of individuals. By building on these strengths, consumers leave stymied life roles behind and engage in new life roles (e.g., partner, caregiver, friend, student, employee). The process of recovery moves forward through interaction with others in supportive, trust-based relationships.
- **Peer Support:** Mutual support—including the sharing of experiential knowledge and skills and social learning—plays an invaluable role in recovery. Consumers encourage and engage other consumers in recovery and provide each other with a sense of belonging, supportive relationships, valued roles, and community.
- **Respect:** Community, systems, and societal acceptance and appreciation of consumers —including protecting their rights and eliminating discrimination and stigma—are crucial in achieving recovery. Self-acceptance and regaining belief in one's self are particularly vital. Respect ensures the inclusion and full participation of consumers in all aspects of their lives.
- **Responsibility:** Consumers have a personal responsibility for their own self-care and journeys of recovery. Taking steps towards their goals may require great courage. Consumers must strive to understand and give meaning to their experiences and identify coping strategies and healing processes to promote their own wellness.
- **Hope:** Recovery provides the essential and motivating message of a better future—that people can and do overcome the barriers and obstacles that confront them. Hope is internalized; but can be fostered by peers, families, friends, providers, and others. Hope is the catalyst of the recovery process.

Mental health recovery not only benefits individuals with mental health disabilities by focusing on their abilities to live, work, learn, and fully participate in our society, but also enriches the texture of American community life. America reaps the benefits of the contributions individuals with mental disabilities can make, ultimately becoming a stronger and healthier Nation.

Components of Recovery



Resources
www.samhsa.gov
National Mental Health Information Center
1-800-789-2647, 1-866-889-2647 (TDD)

NATIONAL CONSENSUS STATEMENT ON MENTAL HEALTH RECOVERY

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Substance Abuse and Mental Health Services Administration
Center for Mental Health Services
www.samhsa.gov

Background

Recovery is cited, within *Transforming Mental Health Care in America, Federal Action Agenda: First Steps*, as the "single most important goal" for the mental health service delivery system.

To clearly define recovery, the Substance Abuse and Mental Health Services Administration within the U.S. Department of Health and Human Services and the Interagency Committee on Disability Research in partnership with six other Federal agencies convened the National Consensus Conference on Mental Health Recovery and Mental Health Systems Transformation on December 16-17, 2004.

Over 110 expert panelists participated, including mental health consumers, family members, providers, advocates, researchers, academicians, managed care representatives, accreditation organization representatives, State and local public officials, and others. A series of technical papers and reports were commissioned that examined topics such as recovery across the lifespan, definitions of recovery, recovery in cultural contexts, the intersection of mental health and addictions recovery, and the application of recovery at individual, family, community, provider, organizational, and systems levels. The following consensus statement was derived from expert panelist deliberations on the findings.

Mental health recovery is a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential.

The 10 Fundamental Components of Recovery

- **Self-Direction:** Consumers lead, control, exercise choice over, and determine their own path of recovery by optimizing autonomy, independence, and control of resources to achieve a self-determined life. By definition, the recovery process must be self-directed by the individual, who defines his or her own life goals and designs a unique path towards those goals.
- **Individualized and Person-Centered:** There are multiple pathways to recovery based on an individual's unique strengths and resiliencies as well as his or her needs, preferences, experiences (including past trauma), and cultural background in all of its diverse representations. Individuals also identify recovery as being an ongoing journey and an end result as well as an overall paradigm for achieving wellness and optimal mental health.
- **Empowerment:** Consumers have the authority to choose from a range of options and to participate in all decisions—including the allocation of resources—that will affect their lives, and are educated and supported in so doing. They have the ability to join with other consumers to collectively and effectively speak for themselves about their needs, wants, desires, and aspirations. Through empowerment, an individual gains control of his or her own destiny and influences the organizational and societal structures in his or her life.
- **Holistic:** Recovery encompasses an individual's whole life, including mind, body, spirit, and community. Recovery embraces all aspects of life, including housing, employment, education, mental health and healthcare treatment and services, complementary and naturalistic services, addictions treatment, spirituality, creativity, social networks, community participation, and family supports as determined by the person. Families, providers, organizations, systems, communities, and society play crucial roles in creating and maintaining meaningful opportunities for consumer access to these supports.
- **Non-Linear:** Recovery is not a step-by-step process but one based on continual growth, occasional setbacks, and learning from experience. Recovery begins with an initial stage of awareness in which a person recognizes that positive change is possible. This awareness enables the consumer to move on to fully engage in the work of recovery.