CRISIS STABILIZATION CENTER

Problem/ Issue

- Currently UNM-PSYCHIATRIC Emergency Room, other emergency rooms provide acute emergency crisis support. However, this treatment is extremely short-term in scope and service, with no access to "step down" therapeutic services. Emergency rooms are expensive and designed for handling the emergency but not the support.

- People who receive service from the emergency room have no place to go once the emergency is resolved.

- Eligibility for "in-patient" beds is, by design, limited to persons who are in "danger to themselves or others."

- There is little or no service for persons who are experiencing "sub-acute" (non emergency) but nevertheless debilitating mental or behavioral conditions or symptoms (e.g. major depression, personality disorders, mental conditions not endangering themselves or others).

Background

- The idea of crisis triage /stabilization centers was first introduced ten years ago by a study commissioned by the City of Albuquerque (hereinafter "Wertheimer Report").

- House Joint Memorial 17 also identified crisis stabilization as a major gap in the behavioral health continuum.

- Other jurisdictions Tucson, San Antonio, Pierce County, WA have utilized crisis triage stabilization centers as key components to successful behavioral health continuums.

- These jurisdictions have found that the creation of lower level service models create more opportunities for patients to control symptoms without the cycle of crisis-to-crisis emergency room visits. These centers generally can see patients sooner - without long wait times.

- Not only does the stabilization center provide a more clinically appropriate environment for long term maintenance, but other jurisdictions have shown significant cost savings.

Recommendations

1. The center should be a short term (no longer than 5 days) transitional center for:

    1. persons who were diagnosed and treated at UNM Psychiatric Emergency and are in need of short term stabilization ("step-down services").

    2. Persons who are suffering from "sub-acute" mental illness or conditions who are not a danger to themselves or others but are still in need of immediate services. These clients could be persons in need of services but who have not committed an arrestable crime. ("drop in services")

2. Should the center be based on a "social model" rather than a "medical model?"

    1. As Rep. Miera noted in his report "medical models" are generally more expensive to run and maintain.

    2. Medical model stabilization emphasizes the "triage" aspects of the center and on medical stabilization, less on the social aspects of stabilization such as connecting people to resources in the community.

    3. Currently, UNM Psychiatric Emergency room (as well as other emergency rooms through city) does most of the "triage" components (i.e: diagnosis, prescriptions, more complex therapies).

    4. "Medical model" centers usually see increased regulation and licensure requirements, and increased infrastructure and liability costs.

    5. A "social model" would have medical personnel at the center that would consistently interact with the diagnostician or other physicians in the community, and provide some feedback on the patient's condition, but would not make a diagnosis nor prescribe.

    6. A "social model" facility would be primarily concerned with stabilizing a patient with an eye toward connecting them to services in the community.

    7. While there are some services that can provide the "triage" aspects of the center, primarily UNM Psychiatric Emergency, Kaseman, ect., there are no facilities that provide "step down" stabilization services.

    8. By diverting people that need stabilization out of the emergency room or in-

patient beds, makes more efficient use of scarce resources and fills a need that is not currently being met in the community.

9. If a social model is utilized and full medical services are not available on site, tele-health and close co-location near UNM's Psychiatric Emergency Room would be beneficial.

10. Social model creates a safe welcoming environment that could contain case management functions such as:
    1. assisting with signing up the “newly eligible” for Medicaid.
    2. For persons with Medicaid: coordinating with the client's MCO “care coordinators.”
    3. peer to peer support.
    4. Non-drug therapy support
    5. connecting persons with housing resources.
    6. This center could be the mechanisms to provide for more comprehensive case management for the persons with mental and behavioral health issues.
    7. This center could be a central “resource center” to provide information about connecting people to resources as recommended by the case management sub-group.

3. The center should be open 24⁄7, seven days a week.

4. The center should not be based on any “eligibility requirements” but rather based on “need.” Anybody in the community, regardless of income, should have access to the center.

5. Whether the center is a medical or social model, protocols should be established so that patients can be transferred to the appropriate level of care for the symptoms they are experiencing, and that drop off procedures be streamlined so that law enforcement and first responders are able to drop a person off at an emergency room or the crisis stabilization center quickly and efficiently.

Funding

1. Other jurisdictions have funded stabilization centers through grants (public and private), local governments and through state funding mechanisms. It is generally seen that most centers utilize “blended funding” from a variety of sources.

2. The success of such a center would hinge on the ability to link clients to more

permanent support services in the community, after or concurrent to step down medical stabilization. Given that federal and state funding mechanisms are limited in scope by eligibility requirements, local government funding could provide a “needs based” funding allowing case workers to address a clients' individualized needs without regard to reimbursement issues with Medicaid.