Alameda County Behavioral Health Care Services (ACBHCS)

CRISIS SERVICES DIVISION PRESENTATION ON PHASE ONE IMPLEMENTATION

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BACKGROUND

Need for crisis services:

• In 2010, 2.2 million hospitalizations and 5.3 million emergency department visits involved a diagnosis related to a mental health condition (AHRQ, 2010).

• Approximately one-fourth of adult Americans will have a mental disorder.

• About five percent of children aged 4–17 years have serious emotional distress.

• The California Legislature has found that “70% of people taken to emergency rooms for psychiatric evaluation can be stabilized and transferred to a less intensive level of crisis care.”

(National Center for Health Statistics, National Health Interview Survey, 2009).
BACKGROUND
Core crisis services can include:

- 23-hour crisis stabilization/observation beds
- Short term crisis residential services and crisis stabilization
- Mobile crisis services
- 24/7 crisis hotlines
- Warm lines
- Psychiatric advance directive statements
- Peer crisis services
Factors Affecting Crisis Services in Alameda County

• Geographically Large County
• Growing Population
• High Concentrations of Poverty
• Highest 5150 Rates in the State per capita
• Insufficient Diversion Capacity
• Large Homeless Population
• Money
OUTCOMES SOUGHT BY CRISIS SERVICES

- Divert individuals from unnecessary hospitalizations
- Ensure the least restrictive treatment option is available
- Assist in reducing costs for psychiatric hospitalization, without negatively impacting clinical outcomes
  - Reduce stigma and discrimination
  - User-friendly and recovery-oriented services
- Increase peer providers in crisis service provision
- Increase satisfaction and customer experience
- Culturally responsive (culturally linguistic and appropriate services)
  - Crisis services throughout the lifespan
OUTCOMES (continued)

- Improve quality of care
- Geographically distribute crisis services throughout the county
- Increase step down & step up capacity
- Increase diversion capacity
- Improve collaboration and connectivity efforts in the system
Types of Crisis Services
Crisis Stabilization Units (CSU)

- Direct service that provides individuals in severe distress with up to 23 consecutive hours of supervised care to assist with deescalating the severity of their crisis and/or need for urgent care.

- The primary objectives of this level of care are prompt assessments, stabilization, and/or a determination of the appropriate level of care.

- The main outcome of 23-hour observation beds is the avoidance of unnecessary hospitalizations for persons whose crisis may resolve with time and observation (SAMHSA, 2012).

Outcomes: need more study
Crisis Residential Services (CRS)

- “Designed to prevent or ameliorate a behavioral health crisis and/or reduce acute symptoms of mental illness by providing continuous 24-hour observation and supervision for persons who do not require inpatient services” (SAMHSA 2012)

- Core attributes of residential crisis services include providing housing during a crisis with services that are short term, serving individuals or small groups of clients, and are used to avoid hospitalization (Stroul, 1988)
Crisis Residential Outcomes

• The current literature generally supports that crisis residential care is as effective as other longer psychiatric inpatient care at improving symptoms and functioning.
  • Satisfaction of these services is strong
• Overall costs for residential crisis services are less than traditional inpatient care (SAMHSA 2012)
Mobile Crisis Teams

• “Capacity to go out into the community to begin the process of assessment and definitive treatment outside of a hospital or health care facility”

• “A psychiatrist available by phone or for in-person assessment as needed and clinically indicated” (Allen et al., 2002)

• Provide rapid response, assess the individual, and resolve crisis situations that involve children and adults who are presumed or known to have a behavioral health disorder (Allen et al., 2002; Fisher, Geller, and Wirth-Cauchon, 1990; Geller, Fisher, and McDermeit, 1995).

• Linking people to needed services and finding hard-to-reach individuals
Mobile Outcomes

Reduce psychiatric hospitalizations, including hospitalizations that follow psychiatric ED admission, and reducing arrests of mentally ill

Studies suggest that mobile crisis services are effective at:
- Diverting people in crisis from psychiatric hospitalization
- Effective at linking suicidal individuals discharged from the emergency department to services
- Better than hospitalization at linking people in crisis to outpatient services (SAMHSA, 2014)
WHO, What, Where, When

Crisis Service Utilization
JGP CSU Utilization

Totals for highest utilization of JGP CSU for the last two years per city (above 500 units)

- Dublin= 519
- San Leandro = 3,253 served (all zip codes)
- Hayward=2,670 (all zips)
- Oakland= 9,917 (all zips)
- Berk/Albany= 1,339 (all zips)
- Fremont=710
## EMS Utilization for 2016

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Ethnicity of PES Clients

- African American: 37%
- Caucasian: 35%
- Latino: 12%
- Asian/Pacific Islander: 9%
- Native American: 2%
- Other/Unknown: 6%
Medi-Cal Recipients Alameda Cty
Proposed Plan: Phase 1
What We Have Now

**Crisis Receiving Centers**
- Walk-in crisis clinic (Sausal Creek*)
- Crisis Stabilization Unit/Psychiatric Emergency Services (John George, Willow Rock, Sausal Creek)
- Sobering Center (Cherry Hill)

**Hospitalization/Alternatives**

**Locked:**
- Inpatient/Psychiatric Health Facility (John George, Willow Rock)

**Locked Step Downs:**
- Mental Health Rehabilitation Center (Villa Fairmont, Gladman,MBC)

**Unlocked Step Downs:**
- Crisis Residential Treatment (Woodroe Place, Jay Mahler Recovery Center)

**Short-Term Crisis Field-Based Outreach**
- In-Home Outreach Teams (IHOT)
- Crisis Triage Outreach Team (Hope Intervention Program for TAY)
- Mobile Crisis Team (one team)
- Mobile Evaluation Team (one team)
Where We’re Heading
Crisis Service Delivery Plan
Phase 1
Mobile Evaluation Team (bhcs)*

- Imminent need
- OutReach
- 5150 capable telepsych/teleinterpreter
- 911 Triggered
- 7a-11p 7days/wk
- O/C staff
- Goal: field evaluations

Mobile Crisis (bhcs)*

- Urgent need
- 5150 capable w/ telepsych/teleinterpreter
- InReach: B&Cs, SUD providers, shelters, other...
- Peer Provider
- N, Mid, S Cty teams run simultaneously
- o/c staff
- M-Sun10a - 8p

Crisis Support & Triage (CST) (bhcs)

- MET/Mobile contacts w/in 24 hr
- Crisis Advisement & Warm Line
- Peer Providers: welcoming & advisor
- Triage ACCESS/CSS/school/Community calls

Referral
Where We’re Heading
Crisis Service Delivery Plan
Phase 1

Crisis Stabilization Units (CSU):
Locked CSU @ John George-AHS
Willow Rock CSU
Amber House (11/2017)

Crisis Residential Treatment (CRT):
Woodroe Place
Jay Mahler Recovery Center
Amber House (11/2017)
Where We’re Heading
Crisis Service Delivery Plan
Phase 1

Adult Hope Intervention Program: AdHIP (BHCS)*
- 18 yo and up
- Fidelity to HIP model (90 days)
- InReach: PES/Cherry Hill, Highland ED?
- Peer Provider
- Census: 30-40
- Warm hand off

Community Treatment and Transition Team (CT3)
- MHSA Innovations Pilot
- Short term treatment (up to 18 mos.)
- Components of Whole Person Care (WPC): RN, PA/NP, MD, Voc/IPs, Telehealth detox, housing navigation capable
- Population Served: Unconnected individuals w/SUD & JIMH & homeless w physical health dx
- Referrals: BACS HIP, FREE, IHOT, MDFT, ACCESS
- Peer Specialist and Family Advocate MHA
- Family involvement and reconnection
  - Census: 30-40
- CT3 may refer to long term tx if appropriate

*Exploring transportation partnership with EMS
Staff Training & Practices

**Proposed Best Practices:**

- Trauma Sensitive Services
- Culturally Responsive Crisis Intervention
  - Stages of Change
  - CBT for Psychosis
  - DBT (three states of mind)
- SBIRT (Screening, Brief Intervention, Referral to Treatment)
- CIT (Crisis Intervention Training)
  - Differential Diagnosis
  - Children/TAY/Older Adult
  - Working with Families
    - Client Rights
    - CPI- Crisis Intervention

Outcome: ABI & PCOMS Anxiety-based analyst hired to measure all programs
Timeline for Phase 1

- Mobile Crisis/Mobile Evaluation Teams: Goal of July 1, 2017
- CSU/CRT Programs: November 1, 2017 (Amber)
- AdHIP: April 1, 2017
- CT3: July 1, 2017
- Peer Respite: TBD
- Wellness Center: Berkeley Wellness Center, Summer 2017
Questions/Feedback