

# Planning for Mental Health Inpatient Alternatives

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The process of planning for acute care services in a community is often made more complicated by the fact that there are multiple definitions in use for inpatient alternatives, so planners use the same words but mean different things. The intent of this article is to support local planning processes by providing commonly understood descriptions for:

- √ Triage/23-hour observation beds
- √ Crisis stabilization/sub-acute beds
- √ Crisis respite/residential beds

These are key system components that may serve as alternatives to an inpatient stay. The following discussion summarizes each component. Definitions and examples are from site visits, public documents and regulations, in Arizona, California, Oregon and Washington. The descriptions have been grouped by “like focus” rather than what they are locally named (for example, “stabilization” has been used to describe each of these components of an acute care system). For most components, examples are also provided of staffing levels and/or costs.

## Triage Function/23-Hour Observation Beds

Two general approaches have emerged related to acute care ( triage and observation functions). One model is like a psychiatric emergency room, that can keep patients up to 23 hours, but tends to serve them more rapidly, focusing on medical/psychiatric/chemical dependency evaluation and then triaging to the most appropriate care facility. The other model focuses on using the time to provide a low stimulus environment and medications as well as evaluation, using more time to stabilize the individual prior to referral to the next level of care.

### Site Examples

#### ***Crisis Triage Center (CTC) 1:***

This CTC serves a county with a population of about 687,000 who live in urban, suburban and rural settings. The CTC evaluates and treats individuals experiencing mental health, chemical dependency or developmental disabilities crises. It is a short-term psychiatric observation and treatment unit for individuals experiencing crisis, combining the mental health and chemical dependency expertise of a community mental health center and a chemical dependency provider to offer an effective clinical alternative to jails or more expensive medical services. The Center offers: a quiet and safe environment to stabilize individuals experiencing episodes of crisis; medical supervision at all times; observation areas for older adults and youth; accommodations for individuals

with physical disabilities, and discharge planning for community transition. For some individuals who are engaged in ongoing services, use of the Center may be a part of a personal crisis plan. The CTC is located in a free standing facility that also houses the countywide crisis telephone service, the mental health center's mobile crisis team, the county mental health professionals (who initiate civil commitment procedures), and the detoxification unit operated by the chemical dependency provider. The facility is licensed as an outpatient evaluation and treatment facility under the emergency services component of state licensure for community mental health centers.

The system design is to have emergency inpatient admissions for the public mental health system come to the CTC prior to admission. The CTC also serves the criminal justice system by making it easy for police to bring individuals for observation rather than placing them in jail. In addition to providing direct stabilization services, this role allows the public mental health system to diagnose system problems, as the gaps in the system tend to result in admissions to the CTC. There is a cross-system advisory committee that meets regularly, looks at data from the CTC and recommends system improvements.

The following describes the CTC component operated by the mental health center. It does not include detoxification statistics or staffing. The CTC started four years ago with seven to eight admissions a day; it now sees ten to twelve admissions a day. Patients are brought in by the police (21%), mental health center staff and/or mobile crisis staff (27%); transferred from an emergency room (ER) (25%); or referred by other community resources. Transfer to an ER for medical clearance occurs about once a week; medical backup is within blocks. The CTC is written into the protocols of the emergency medical system (EMS). If the EMS field staff declare a patient medically stable in the field and obtain approval from their base, they can bring a person directly to the CTC rather than going to an ER.

Children under 18 represent slightly over ten percent of the population served by the CTC. The youngest child seen to date was four. It is the police who bring in these youngsters in crisis. The "swing" rooms are used for children, who are often coming from chaotic situations. If they are already being served by the system and have case aides, the aides are asked to accompany them; if they are under the age of 12, parents are asked to accompany them.

Individuals who are intoxicated are brought to the CTC because they also appear to have a mental health issue, usually related to suicidality. Sobering beds are not available in the community, so by default this occurs in the CTC unit; patients requiring detoxification (medical or social) are transferred across the hall to the co-located detoxification program. The two programs provide constant informal consultation to one another regarding patient status and discharge planning. Restraints are used infrequently (for about one percent of admissions, usually methamphetamine-related). There are ten resting rooms with beds, and two observation rooms in the mental health component of the CTC. Using couches and extra mattresses, occupancy has been as high as 21; policy is not divert unless seclusion or restraint is required, or if there is a question of medical stability.

The average length of stay is just under 20 hours, but some patients stay up to 72 hours. Ten percent of admissions to the center result in a subsequent voluntary inpatient admission, three percent in an involuntary inpatient admission. The remaining admissions are referred to follow-up services through the mental health system or a variety of community resources.

Nurse practitioners are on call twenty-four hours a day, seven days a week; a consulting psychiatrist rounds three hours a week and consults with staff; each shift is staffed with an RN with two years of psychiatric experience; and five psychiatric technicians. The operating budget is \$1.5 million.

The physical design of the CTC creates a calming milieu; although not licensed as an inpatient or residential facility, it was built to residential treatment facility standards, with a large day room directly observed by staff, and rooms with permanently installed beds on the other side of the staff station. By design, there is no television, radio, or reading material; it is a low stimulus environment. The staff has created a team environment with a shared philosophy regarding this low stimulus approach.

There is a close working relationship with the community providers of public mental health services: the expectation is that if the CTC calls regarding a client active in services, there will be a response from either the case manager or supervisor. Discharge summaries are faxed to providers when the consumer leaves. A more complete discharge summary is prepared for transfer to inpatient units.

***Crisis Triage Center (CTC) 2:***

This CTC is located in a city sitting at the intersection of three counties. The population base is 1.5 million. The CTC is co-located with a sub-acute unit as well as a telephone crisis service that serves two counties and several health plans. A staff member from the CTC also provides mobile crisis services, accompanied by police, generally when it is necessary to initiate a civil commitment proceeding. This CTC functions as the major intake facility for psychiatric emergencies, and acts as the intake facility for all police holds for the county. However, it is not the public system gatekeeper, and patients seeking an inpatient stay can and do present to other facilities in the service area.

The center provides mental health assessment for adults, adolescents and children, serving all socioeconomic groups. Patients' individual acute mental health needs are assessed and they are referred to the appropriate level of intervention. The CTC works closely with inpatient psychiatric units, emergency rooms, primary care providers, outpatient mental health providers, county mental health clinics and police. It refers to all the psychiatric inpatient units in the county; these facilities have a contractual obligation to prioritize care for civil commitment patients.

Approximately 26 patients per day pass through the CTC; about two-thirds of them are involuntary, one-third voluntary. About 13% of those seen are under the age of 18. The police account for 25% of admissions, some patients are transferred from ERs following

evaluation, and many are advised to come to the CTC by telephone crisis staff. Following an assessment, about ten percent of patients may be admitted to the sub-acute unit, another 15-20% may be transferred to an inpatient unit, and the remaining patients are referred back to their ongoing care provider or offered follow up stabilization services in a clinic operated by the CTC (up to three visits). The CTC average length of stay is one to four hours, although some patients stay as long as ten hours.

The CTC is located on the campus of a large health system, with a full service ER and psychiatric inpatient unit as backup. If there is a concern about medical stability, the patient is sent to the emergency room for screening and then returned to the CTC for psychiatric assessment. The CTC has three state-certified holding rooms to assist in management of patients who require seclusion intervention. If holding rooms are unavailable, the CTC diverts to ERs. The total active service capacity is ten, although additional patients may be in the waiting area adjacent to the triage center.

All patients are triaged by a nurse as a first step and are then placed (along with any family/significant others that have accompanied them) in assessment rooms furnished with couches and chairs. There is a designated assessment room for children. The emphasis is on assessment, access to medications and referral. Patients are seen by a mental health therapist and a psychiatrist/nurse practitioner for assessment, development of a treatment plan and initiation of appropriate intervention, including medications. Those patients presenting with what is principally a substance abuse issue are transferred to the detoxification center, where both sobering and detoxification services are available.

The CTC is a multidisciplinary program staffed by psychiatrists, nurse practitioners, masters-level mental health therapists, nurses, and psychiatric assistants. Operating in supportive roles are security officers and registrars. The staffing pattern provides for a registered nurse, mental health therapist and psychiatrist twenty-four hours a day, seven days a week, with additional RNs, a nurse practitioner, therapists, and psychiatric assistants scheduled for high-volume times. The budget for the entire facility (telephone crisis, sub-acute, mobile and CTC) is about seven million dollars.

Based on three years' experience, this CTC is being remodeled to improve the physical layout of the facility. The issues of organizing physical flow, patient care areas, staff workspace, bed boards, mailboxes, and forms bins are critical to the effectiveness of staff in a high intensity setting that must see patients as rapidly as possible.

### ***Crisis Triage Center (CTC) 3:***

This CTC is in a county with a mixture of rural, suburban and small cities, with a total population of about 357,000 people. It is on the edge of a major metropolitan area. The CTC is operated as a part of the public mental health system's crisis services, and is co-located with the telephone crisis service and walk-in crisis services. In the same facility are an outpatient social model detoxification facility and a psychiatric health facility (PHF, a free standing inpatient facility).

The facility receives its referrals from ERs, police, mental health staff, and community providers. It is not used as a first step prior to inpatient authorization, but as an alternative to inpatient services. Patients who are assessed as requiring an inpatient stay will be referred directly to the PHF, or a community hospital. The focus of the CTC is to provide a low stimulus and supportive environment where patients can regain functioning level, add coping skills and return to their home environment. Some admissions are specifically for medication administration and stabilization.

The CTC is the receiving center for police who are initiating a civil commitment hold, so a subset of the patient population arrives involuntarily. After initial screening, a determination is made as to whether this less restrictive alternative will be appropriate. If not, the patient is transferred to the inpatient unit. The maximum stay in the CTC is 23 hours; data is not available on average length of stay.

Staffing includes an RN on every shift, with physician back-up available through the physician on duty/on call to the PHF. An on call pool provides additional staffing to support increased volumes.

The center's physical facility includes two rooms, each with two fixed beds; there is audio but not video surveillance of these rooms. Another room with video and observation window serves as an observation area for both walk-in crisis services and the 23-hour CTC service. A day room has television, educational and relaxation tapes and reading materials. There is access to a kitchen. The day room may also be used as an overflow area if all beds are full.

About ten percent of the patients seen are children. They are accommodated in a separate interview room. At present there is no data regarding the characteristics of the population or their disposition. Anecdotally, staff report that only a small proportion of their patients subsequently require an inpatient stay. A new information system is in the design phase; in future, this center will be able to track the sources of referrals, length of stay and dispositions.

#### ***Crisis Triage Center (CTC) 4:***

This CTC serves a large urban county of 1.7 million people. It is hospital-based, located within the region's largest emergency room and trauma center. A waiting room is located between the two units. The CTC is a psychiatric ER model, with six observation rooms (camera observation) and four hallway gurneys. The observation rooms are used for those requiring a secure environment or those who have medical issues to be assessed. The average stay is between five and six hours, but can be up to 23 hours and 59 minutes. The CTC is staffed with nurses, social workers and psychiatrists, including psychiatric residents. The region's largest psychiatric inpatient facility is located in this hospital, which is part of an academic medical center.

This CTC sees some older adolescents in addition to adults, but most children are seen at the emergency room of the regional children's hospital. Up to 70% of the patients seen in this facility have co-occurring disorders (mental health, substance abuse,

developmental disabilities), and a subset represents a very disabled population that is extremely difficult to place appropriately. The facility is focused on provision of a single entry point into multiple treatment systems, with linkage to those systems; it provides pre-booking diversion for law enforcement throughout the county. The intent is to facilitate placement of the patient to the most appropriate treatment agency and least restrictive environment.

The facility is full at least several times during any given week. Last year it had over 7,000 visits. The police account for about 30% of referrals; another major source is walk-in and self-referrals. Not all public inpatient admissions flow through this unit; some admissions to the inpatient floors of this hospital are direct admissions, and there are a number of other inpatient psychiatric units serving the region.

About 25% of those seen in the CTC go on to an inpatient stay (half voluntarily, half involuntarily). Another five to seven percent go to detoxification or the county's long-term substance abuse treatment facility. Twenty respite beds in the community back up the CTC. If the CTC is seeing a patient who is active in the public mental health system, the current clinician/case manager is contacted and must respond to participate in aftercare planning. If a "high utilizer" is identified (seen four times in three months), a multi-agency team meeting is convened to put together a plan that will be more effective. The CTC has three staff members who focus on the "back door", assuring that patients are transferred to the appropriate system and engaged in services.

#### ***Crisis Triage Center (CTC) 5:***

These planned CTCs are in an urban setting, spread over a large geographic area with a total population of 2.9 million. Acute care services are distributed into three regions, each with between 900,000 and 1,000,000 population. Urgent Care Centers are being developed for each of the regions. Each will co-locate mobile crisis services, observation beds and crisis stabilization beds. Each Urgent Care Center will convene a cross-system advisory committee to provide feedback to the CTC and to the system as a whole. The system design envisions that all patients (with appropriate exceptions for medically complex situations) will be seen in CTCs prior to an inpatient stay.

Mobile crisis services are provided in any community setting where staff safety can be assured, including but not limited to home, hospital, school, residential settings, jail, juvenile detention, shelter or other public setting. Service components include crisis and behavioral health emergency level of care assessment, crisis intervention, crisis resolution, crisis disposition (assist with access to needed services including arranging or providing transportation), community education and consultation, critical incident management, crisis episode-of-care management including follow-up (including suicide watch and behavior management in residential or home settings) for up to two weeks after first intervention/contact, and risk management assessment.

The Centers are jointly projecting over 10,000 visits (each up to 23 hours) or 27 visits per day. Each center will be staffed with a minimum of five staff (RN, mental health counselor, technicians) at all times; CTC and mobile crisis staff will be cross trained and

can assist in coverage at peak times. Two of the CTCs are free-standing, one is in what was an unused wing of an inpatient setting, with a full service ER and inpatient unit as backup. There is a blended prescriber model with a mix of full time psychiatrists, psychiatric nurse practitioners and on-call psychiatrists, all three centers being supported by a single psychiatry group. The psychiatry group has the staff that will initiate the civil commitment process. The operating budget for each regional CTC is \$2.2 million inclusive of medical providers and exclusive of capital costs. The twenty-four hours a day, seven days a week mobile crisis services in one region (clinical and administrative support) are projected at 28 FTEs, at a cost of approximately \$1.2 million for each regional team.

Alternative Care Beds (also co-located with the CTC in each of three regions) will provide sub-acute care as defined below. They are for short-term stabilization and voluntary diversion for consumers into less restrictive levels of service, as much as possible replacing voluntary inpatient admissions. Patients will move from the CTC observation beds into alternative care beds if they cannot be safely placed back into the community at the end of 23 hours.

The following definitions provide further context for this triage/23-hour function.

## **Definitions**

*California Code of Regulations: Crisis Stabilization means a service lasting less than 24 hours, to or on behalf of a beneficiary for a condition which requires more timely response than a regularly scheduled visit. Service activities may include but are not limited to assessment, collateral and therapy. Crisis stabilization must be provided on site at a 24-hour health facility or hospital-based outpatient program or at other provider sites that have been certified by the department to provide crisis stabilization services.*

- Medical backup services must be available either on site or by written contract or agreement with a hospital. Medications must be available on an as-needed basis and the staffing pattern must reflect this availability. All beneficiaries receiving Crisis Stabilization shall receive an assessment of their physical and mental health.
- A physician shall be on call at all times; there shall be a minimum of one RN, psychiatric technician or licensed vocational nurse on site at all times; at a minimum, there shall be a ratio of at least one licensed or registered mental health professional on site for every four patients.
- If crisis stabilization services are co-located with other specialty mental health services, persons providing crisis stabilization must be separate and distinct from persons providing other services.

*Standards (Maricopa County Arizona, Value Options Request for Proposals): Observation Beds are a 24-hour secure and protected, medically staffed, psychiatrically supervised treatment environment, designed specifically for those individuals who, as a*

*result of a psychiatric disorder, are an acute danger to themselves or others, or who are acutely disabled, and require temporary evaluation and crisis stabilization in order to determine the most appropriate level of service. An individual stay may be as little as 23 hours or up to 72 hours. Operates 24 hours a day, seven days a week.*

- Admission criteria: The individual presents with symptoms consistent with a DSM-IV diagnosis (AXIS I-V) which require, and can reasonably be expected to respond to, therapeutic intervention AND, the individual exhibits substance intoxication with suicidal/homicidal ideation OR the individual exhibits an inability to function safely in a non-hospital setting due to a known or probable DSM-IV disorder.
- Services include: walk-in and drop-off capacity, staff for preparation of petitions for court ordered evaluations, nursing services [recording and evaluating vital signs and assessing the need for emergent medical interventions], provision of transportation to a medical facility for persons identified as requiring medical clearance [if not located in a general medical facility], crisis intervention and resolution, a discharge plan for each consumer and follow up with the consumer within 24 hours of discharge, coordination with other emergency service providers.

## **Crisis Stabilization/Sub-acute Beds**

Crisis stabilization or sub-acute beds are co-located in some of the sites described above. The following site examples and definitions illustrate how the level of care is of greater duration and intensity than that of a 23-hour unit.

### **Site Examples**

#### ***Crisis Triage Center (CTC) 2:***

The sub-acute beds are located on another floor in the same building. There are 24 beds, roughly divided in half between crisis stabilization services and chemical dependency (CD) services. Those using the sub-acute beds for crisis stabilization have an average stay of four days, ranging up to ten days. Some patients may go on to an inpatient stay, although this is infrequent. There is CD programming for the patients admitted for CD services, and crisis stabilization patients may also attend those sessions. The psychiatrist also working in the CTC assessment area provides prescriber coverage.

#### ***Crisis Triage Center (CTC) 5:***

The Alternative Care Beds (co-located with the CTC in each of three regions) provide sub-acute care, short-term stabilization and voluntary diversion for consumers into less restrictive levels of service. Both voluntary and involuntary patients will be served in this setting. A stay in an alternative care bed will precede almost all inpatient stays. It is

anticipated that an inpatient stay that follows an alternative bed stay will likely be for the next phase of the civil commitment process.

These sub-acute beds will be staffed with an RN and a Technician at all times and a Masters Level Counselor ten hours per day for a total of twelve FTEs at each site. The three centers are jointly projecting over 10,000 bed days. The psychiatry group described above will provide the medical/prescribing services. The operating budget for each region's alternative care beds is approximately \$850,000 inclusive of medical providers and exclusive of capital costs.

## **Definitions**

*Standards (Maricopa County Arizona, Value Options Request for Proposals): Crisis Stabilization Beds are a facility or community based program where patients in urgent/emergent need can receive crisis stabilization services, including nursing care, observation, supervision, and medication management in a safe, structured setting. Treatment interventions are focused on mobilizing support and resources so that the patient can be managed in a less restrictive setting. This level of care is appropriate for individuals in crisis who do not require the intensive medical treatment of hospital care. Programs should be designed for lengths of stay of two to four days, although some stays can be less than 24 hours. Operates 24 hours a day, 7 days a week.*

- Admission Criteria: The individual presents with symptoms consistent with a DSM-IV diagnosis (AXIS I-V) which require, and can reasonably be expected to respond to, therapeutic intervention AND one of the following: a clinical evaluation of the individual's condition indicates sudden decompensation with a strong potential for danger to self or others and the individual has no available or appropriate supports to provide continuous monitoring, a clinical evaluation suggest that the individual can be effectively treated with short-term intensive crisis intervention services and returned to a less intensive level of care within a brief time frame, a less intensive or restrictive level of service has been considered or tried, a clinical evaluation indicates the onset of an incapacitating psychiatric condition but there is insufficient information to determine the appropriate level of service
- Staff Credentials: Board Certified/Eligible Psychiatrist or Nurse Practitioner with experience in Psychiatry under the supervision of a psychiatrist; RN with behavioral health experience, Master's Level Certified Behavioral Health Professional, combination of mental health workers and other appropriately trained staff. Staff level: staff to patient ratio of 1:3, at least two staff at facility at all times, one of which must be a registered nurse, all patients evaluated within 24 hours of admission by psychiatrist or nurse practitioner, psychiatrist or nurse practitioner available twenty-four hours per day, seven days a week by telephone or on site.
- Setting may be a stand-alone unit in a hospital, an urgent care center, a psychiatric health facility, or a residential setting. Services include: comprehensive

psychiatric evaluation, psychosocial assessment, medication administration and management, individual and family counseling treatment and discharge planning, risk management assessment, multiagency coordination

## **Crisis Respite/Crisis Residential**

There is great variation in respite services. Services may be offered in the individual's home, in a residential setting, in a motel, or anywhere that is a safe and comfortable place. Crisis respite is the larger category, encompassing all of the variation.

The staff providing crisis respite may be certified/licensed clinicians, behavioral health technicians, or peer counselors. Prescribing services may be a part of the “wrapped around” services. In order to effectively use home or community-based respite services, the system may need to change where the first contact occurs. In the *CTC 5* example described above, the clinical philosophy is based on the belief that the best chance of successful respite is when the patient is not removed from a familiar setting. It is very difficult to use these alternatives in a system that depends on emergency rooms as the principal site for managing the acute episode. Once a patient is in an ER, the medical/legal risk environment dictates conservative practice that is more likely to lead to an inpatient stay.

Crisis residential is a form of respite offered in a residential setting (e.g., the staff is only available in the physical facility). The staffing level ranges from having staff on duty and awake 24 hours a day, seven days a week to having staff on duty, but not awake 24 hours a day, seven days a week. Access to prescribers may be included or be provided by the outpatient service system. The length of stay may be truly respite or crisis focused (less than two weeks), or may become transitional housing with stays of three to six months.

Service systems that have been unable to develop sufficient shelter and housing capacity may find they are using these crisis residential services for residential crises rather than clinical crises. The unavailability of shelter beds as well as safe and affordable housing for public mental health consumers can lead to “clogging” of precious system resources targeted for consumers experiencing an acute episode of care.

### **Definitions**

*Washington State Contract Definitions: Stabilization Services mean services provided to persons who are experiencing a mental health emergency or crisis. This service is to be provided in the person's own home or another homelike setting. Stabilization services shall include short-term (less than two weeks per episode) face-to-face assistance with self-care, meals and medication monitoring.*

*California Code of Regulations: Crisis Residential Treatment Service means therapeutic or rehabilitative services provided in a non-institutional residential setting which provides a structured program for beneficiaries as an alternative to hospitalization for beneficiaries experiencing an acute psychiatric episode or crisis who do not present medical complications requiring nursing care. The service supports beneficiaries in their*

*efforts to restore, maintain and apply interpersonal and independent living skills and to access community support systems. The service is available 24 hours a day, seven days a week. Service activities may include assessment, plan development, therapy, rehabilitation, collateral, and crisis intervention.*

## **Conclusion**

As public mental health systems assume financial risk for inpatient services to the Medicaid population, there has been growing focus on the development of a range of alternatives that are expected to reduce demand for inpatient services. Those communities that have put alternate services in place have experienced a decline in both the absolute number of admissions and the rate of admissions per 1000 in their population. One of the lessons learned as elements of this acute care system have been developed is that no single solution is enough. There are several levels of acuity that need differing levels of support in order to provide a safe stabilization experience. In addition, if there are not adequate shelter, housing, or residential options for stable patients to move on to, the system can become gridlocked and unable to serve new patients at the front door. This lesson regarding aftercare services and a safe and affordable place to go to has also been key to reducing length of stay for inpatients.

Some regions of the country have been working on building housing capacity that is controlled by the mental health system, as an adjunct to Section 8 and other housing authority programs. Housing development that assures long term stable housing, with variable to minimal staff supports, is the next great frontier for public mental health and is a critical component of an effective acute care system!