Rethinking our Response to Behavioral Health Crisis Management

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Changing Paradigms and Models of Mental Illness and Treatment

1950’s Asylum Psychodynamic
1960’s De-institutionalization
1970’s Comm. Mental Health Bio-psychosocial
1980’s “Revolving Door” Neurobiological
1990’s Managed Care
2000’s Recovery? Holistic?
Changing Paradigms and Average Hospital Length of Stay

- **Ave LOS**
  - 1950’s: Asylum
    - Decades
  - 1960’s: De-institutionalization
    - Years
  - 1970’s: Comm. Mental Health
    - Months
  - 1980’s: Revolving Door
    - Weeks
  - 1990’s: Managed Care
    - Days
  - 2000’s: Recovery?
    - Hours
Some kinds of changes are easier and quicker to make than others
Systems that don’t work

- Massively and rapidly changing attitudes about mental illness, ideas about where care is delivered, what that care should be, how it should be paid for, who should direct care, …but...

- We mostly do what we do, because that’s what we’ve been doing

- Much of what we do was based on an environment that no longer exists.
UIHC Emergency Room Psychiatric Visits in one month (January) 2006-2009
Over-reliance on Emergency Rooms and Acute Hospitalization

- We have taught people to come to ER’s when they are in crisis
- ER’s are well equipped to deal with many physical crises
- ER’s are poorly equipped to deal with many MH and SA crises
What kinds of behavioral health issues do we see in the ER?

- People in crisis – not necessarily people with serious mental illness
  - People who have multiple, co-occurring problems including:
    - Substance abuse
    - Criminal justice issues
    - Trauma (often cumulative)
    - Homelessness
    - Joblessness
    - Lifelessness
Hitting the wall

- When they “hit the wall”, they go to the emergency room.
- From there, basically two choices:
  - Acute care hospital
  - Back to wherever they came from
Crisis Emergency Room

Family / Natural Supports
CMHC
PCP
Law Enforcement

Homeless Shelter
Substance Abuse Tx / Detox

Acute Psychiatric Hospitalization
Access Center - Many Questions

- Who should run it?
- Where should it be?
- What kind of staffing?
- Primary functions?
- How would it be financed?
Opportunities

- Magellan RFP?
  - Probably directed towards crisis stabilization units
- Others?
Short-term residential units: Acute crisis stabilization beds

- i.e., for people who really don’t need acute hospitalization but don’t have any place else to go (e.g., just kicked out of their house, or just left jail – shelters won’t take them);
- many states are investing heavily in this model – as a way to deal with the inflow, or front-door issues.
Crisis Stabilization Units

- Mary Greeley – Story County Project
  - 6 bed - “little white house” (TLP – transitional living project)
    - Staffed 24/7 – by “entry level” – type person
      - Not licensed (bachelor’s level)
    - $150 / day
    - Intake from ER, county
    - Average LOS – 2 weeks – range (a few days to a month)
    - Also – step down (from hospital)
    - Licensure – SCL at one time; now?
These are not new ideas

- “Crisis and emergency services are critical elements of a service system, ensuring timely care to stabilize acute episodes of mental illness at the least restrictive level appropriate to the need”.

- “These should include residential stabilization services for adults and for children that provide a non-institutional setting that can appropriately stabilize known clients who don’t need the medical services provided by a hospital”.

Source: Quick Fixes or Structural Reform: TAC, 1998
Next Steps

- This can not move forward without meaningful partnering between
  - Mental health
  - Substance abuse
  - Criminal Justice

- Identifying lead organizations

- Identifying opportunities for pilot project and funding