Creating and Sustaining High Quality Crisis Services: A Systemic Approach

Margie Balfour, MD, PhD
Connections Health Solutions
Chief of Quality & Clinical Innovation
Associate Professor of Psychiatry, University of Arizona
• Friday. 4:30 PM. The phone rings.
• Your spouse’s boss needs help with his brother.
• He’s been texting family members about how he would be better off dead.
• They’re afraid he might hurt himself.
• He might also have a drinking problem and need detox.

What do you advise?
CALL THE PSYCHIATRIST/THERAPIST/CLINIC

CALL 911
GO TO THE **EMERGENCY** ROOM

GO TO THE **CRISIS** CENTER

GO TO THE **DETOX** CENTER
“It’s easier to get into heaven than access psychiatric care.”

A behavioral health crisis is an emergency. It requires a systemic response with the same quality and consistency as the response to heart attack, stroke, fire, and other emergencies.
I’m having chest pain.

I’m suicidal.
Officer-involved shootings

One quarter of officer involved shootings were linked to mental illness\(^1\)

“Suicide by Cop”

Studies range from 10% - 49% depending on the study sample and methodology used\(^2-6\)

Prevalence of Mental Illness

<table>
<thead>
<tr>
<th></th>
<th>US Adults</th>
<th>Jail</th>
</tr>
</thead>
<tbody>
<tr>
<td>SMI</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-Men</td>
<td>4%</td>
<td>17.1%</td>
</tr>
<tr>
<td>-Women</td>
<td></td>
<td>34.3%</td>
</tr>
<tr>
<td>Any mental disorder</td>
<td>18%</td>
<td>76%</td>
</tr>
<tr>
<td>+ Co-occurring SUD</td>
<td>3.3%</td>
<td>49%</td>
</tr>
</tbody>
</table>

**What about kids?**
The National Center for Mental Health and Juvenile Justice found that **70.4%** of youth in the juvenile justice system have been **diagnosed with at least one mental health disorder**.

High-risk youth are estimated to cost society **$1.2 to 2 million each** in rehabilitation, incarceration, and costs to victims.


There are over **2 million jail bookings** of people with serious mental illness each year.¹

Nearly **half** of people with SMI have been arrested at least once.²
Impact of incarceration

- Offenders with mental illness are
  - Incarcerated twice as long
  - Three times more likely to be sexually assaulted while incarcerated
  - More likely to be in solitary confinement which exacerbates psychiatric symptoms
- Adverse effects post-release include
  - Interruption in Medicaid and other benefits
  - Difficulty finding employment
  - More likely to become homeless
  - More likely to be rearrested
- At twice the cost to taxpayers.

Jails and prisons lack the policies and trained staff to meet the needs of this population.

MYTH

“They’ll get the treatment they need in jail.”

Only one quarter of men and 14% of women receive formal substance abuse treatment while incarcerated.

3. Office of National Drug Control Policy
If they do make it to an ED...

- 84% of EDs report boarding of psychiatric patients for hours
- Increased risk
  - Assaults, injuries, self-harm
- Increased cost
  - Sitters, lost revenue ($2300/day)
  - Unnecessary inpatient admits
- Poor patient experience
  - Nontherapeutic environment with untrained staff

Psychiatric boarding = long waits for inpatient psychiatric beds with little/no treatment, for hours or sometimes even days.

What we need:

- A SYSTEMIC response to behavioral health crisis
- that delivers EVIDENCE-BASED care to people who need it
- with MEASURABLE OUTCOMES
- in the LEAST-RESTRICTIVE setting that can safely meet the person’s needs
- (and by the way, the least-restrictive settings also tend to be the LEAST-COSTLY)
Why isn’t there a national standard for crisis services?

• No standard nomenclature
  – For example: a “crisis stabilization unit” can be many things

• Crisis services fly under the federal radar
  – Primarily financed by Medicaid, which is regulated at the state level

• Stigma?

“If you’ve seen one state mental health system, you’ve seen ONE state mental health system.”
Simply building more inpatient beds won’t solve the problem of access to MH care. Systemic approaches are needed, including crisis care.

Defines crisis system essential services: crisis line with “air traffic control” capability, mobile crisis teams, crisis stabilization, crisis best practices (e.g. recovery-focused and trauma informed)

Review of national best practices in crisis services with a focus on improving crisis systems through the standardization of outcome measures.

More in-depth toolkit from SAMHSA to assist in the implementation of crisis services.
A National Standard for Crisis Systems?

- Interdepartmental SMI Coordinating Committee (ISMICC)
- Created by 21st Century Cures Act
- 45 recommendations in 5 focus areas
- 2.1 Define and implement a national standard for crisis care

In response, the Group for the Advancement of Psychiatry is developing a comprehensive report defining elements of the ideal crisis system.

Measurable Performance Standards
in the following areas

- Governance & Finance
- Crisis Continuum: Essential Services & Program Capabilities
- Clinical Best Practices & Competencies
A crisis system is more than a collection of services. Crisis services must all work together as a coordinated system to achieve common goals. And be more than the sum of its parts.

Adapted from: Richard McKeon (Chief, Suicide Prevention Branch, SAMHSA). Supercharge Crisis Services, National Council for Behavioral Health Annual Conference, 2015.
# 3 Key Ingredients for a SYSTEM

## Accountability
- Who is responsible for the system?
- Governance and financing structure
- System values and outcomes
- Holding providers accountable

## Collaboration
- Broad inclusion of potential customers, partners, & stakeholders
- Alignment of operational processes & training towards common goals
- Culture of communication & problem solving

## Data
- Are we achieving desired outcomes?
- Performance targets & financial incentives
- Continuous quality improvement
- Data driven decision making
Arizona Crisis System Structure

Southern Arizona Region:
- 8 counties
- 38,542 mi² (3 Marylands)
- 1.8 million people
- 6 Tribal Nations
- 378 mi of international border

Tucson: 530,000
Pima County: 1 million
Similar size and pop as NH

The financing & governance structure supports organization, accountability, & oversight of the system.
What this means for the crisis system

- Centralized **planning**
- Centralized **accountability**
- **Alignment** of clinical & financial goals

Performance metrics and payment systems that **promote common goals**

**Decrease**
- ED & hospital use
- Justice involvement

**Increase**
- Community stabilization
- Engagement in care

*These goals represent both good clinical care & fiscal responsibility.*
What is the Sequential Intercept Model?

- Every person follows a path through the justice system: Arrest, detention, arraignment, pre-trial, etc.
- At every point along this path, there is an opportunity for the behavioral health system to “intercept” the person and either
  - Stop them from progressing further (diversion)
  - Mitigate the effects of justice involvement
- Crisis services are focused on Intercept 1:
  - Interactions with law enforcement to prevent unnecessary arrest

Example of strategic service design

**State** says: Reduce criminal justice costs for people with SMI.

**AHCCCS** contracts with regional Medicaid MCOs/RBHAs and includes requirements targeted at reducing criminal justice involvement.

**RBHA** (which is at risk) uses contract requirements/VBP with its subcontracted providers to create services and processes targeted at reducing justice involvement.

**Targeted Services and Processes:**

**Law Enforcement as a “preferred customer”**

**CRISIS LINE**
- Some 911 calls are warm-transferred to the crisis line
- Dedicated LE number goes directly to a supervisor

**MOBILE TEAMS**
- **30 minute response time** for LE calls (vs. 60 min routine)
- Some teams assigned as **co-responders** (cop + clinician)

**CRISIS CENTERS**
- **24/7** crisis facility
- **Quick & easy drop-off** for law enforcement
- **No wrong door** – LE is never turned away

**connections HEALTH SOLUTIONS**
The Crisis Continuum

- **Person in Crisis**
  - Crisis Line
  - Mobile Crisis Teams
  - Crisis Facility
  - Post-Crisis Wraparound

**80%** resolved on the phone
**71%** resolved in the field
**68%** discharged to the community
**85%** remain stable in community-based care

**Easy Access for Law Enforcement = Pre-Arrest Diversion**

**Decreased Use of jail, ED, inpatient**

**LEAST Restrictive = LEAST Costly**

Schematic designed by Margie Balfour, Connections Health Solutions.
Data courtesy Johnnie Gaspar, Arizona Complete Health and applies to southern Arizona geographical service area.
Many options for law enforcement to divert people to treatment instead of jail all with a culture of NO WRONG DOOR

Crisis Hotline
- Info, care coordination
- Direct line for LE
- Some co-located at 911

Mobile Crisis Teams
- Masters level clinicians
- On-site crisis intervention
- 30-min response time for LE

Mental Health Support Teams (MHST)
- In addition to CIT
- Unique specialized team specializing in civil commitment, challenging cases, and follow-up
- Officers/Deputies & Detectives

Law Enforcement Training
- Supported by RBHA & multiple community partners
- Tucson PD and Pima Co Sheriff are 100% MHFA & 80% CIT trained

Access Point
- 24/7 Detox/Crisis for Voluntary Adults
- <10 minute LE drop-off time
- Transitions to substance use tx/MAT

Regional Behavioral Health Authority
- First Responder Liaisons
- Responsible for the network of programs and clinics

Crisis Response Center
- 24/7 Crisis Center for Adults and Youth
- <10 minute LE drop-off time
- Law enforcement never turned away
- Adjacent to ED, Court, Inpatient psych
- Clinic, 23 hour obs, initiation of Opiate MAT

Co-Responder Teams
- MHST Detective
- Mobile Team Clinician

Crisis Response Canine
“LEO”

BH Services at the Jail
- Instant data exchange with MH history
- Risk screening
- Diversion programs, specialty courts, etc.
The Crisis Response Center

• Built with Pima County bond funds in 2011
  - Alternative to jail, ED, hospitals
  - Serving 12,000 adults + 2,400 youth per year
  - Managed by Connections since 2014
• Law enforcement receiving center with NO WRONG DOOR
  (no exclusions for acuity, agitation, intoxication, payer, etc.)
• Services include
  • 24/7 urgent care clinic (adult length of stay 2 hours, youth 3 hours)
  • 23-hour observation (adult capacity 34, youth 10),
  • Short-term subacute inpatient (adults only, 15 beds, 3-5 days)
• Space for co-located community programs
  - peer-run post-crisis wraparound program, pet therapy, etc.
• Adjacent to
  - Crisis Call Center
  - Banner University Medical Center Emergency Department
  - 66-bed Inpatient psych hospital
  - Mental health court
Connections Model
“We address any behavioral health need at any time.”

• “No wrong door”
• We take everyone:
  - No such thing as “too agitated” or “too violent”
  - Can be highly intoxicated
  - Can be involuntary or voluntary
• Fewer medical exclusionary criteria than many inpatient psych hospitals
• Law enforcement is never ever turned away
• Studies show this model:
  - Critical for pre-arrest diversion
  - Reduces ED boarding
  - Reduces hospitalization

CIT Recommendations for Mental Health Receiving Facilities

1. Single Source of Entry
2. On Demand Access 24/7
3. No Clinical Barriers to Care
4. Minimal Law Enforcement Turnaround Time
5. Access to Wide Range of Disposition Options
6. Community Interface: Feedback and Problem Solving Capacity

These 2 are the hardest to do well

1. Dupont R et al. (2007). Crisis Intervention Team Core Elements. The University of Memphis School of Urban Affairs and Public Policy
Easy Access for Law Enforcement so we are the preferred alternative to drop off at jail or ED
The locked 23h obs unit provides a safe, secure, and therapeutic environment:

- Continuous observation
- Lack of means to hurt oneself or others
- Therapeutic milieu: Open area for therapeutic interactions with others
- As welcoming as possible

Crisis Response Center, Tucson AZ

Urgent Psychiatric Center Phoenix, AZ
23-Hour Observation

- **Culture shift: Assumption that the crisis can be resolved**
- **Interdisciplinary Teamwork**
  - 24/7 psychiatric provider coverage (MD, NP, PAs)
  - Peers with lived experience, nurses, techs, case managers, therapists, unit coordinators
- **Early Intervention**
  - Median door to doc time is ~90 min
  - Interventions include medication, detox/MAT, groups, peer support, safety planning, crisis counseling, mindfulness
- **Proactive discharge planning**
  - Collaboration and coordination with community & family partners

Peers with lived experience are an important part of the interdisciplinary team.

“I came in 100% sure I was going to kill myself but now after group I’m hopeful that it will change. Thank you, RSS (recovery support specialist) members!”

Most are discharged to the community the following day
Avoiding preventable inpatient admission, even though they met medical necessity criteria when they first presented.
Research shows\textsuperscript{1,2} that CIT is \textit{most effective} when the training is VOLUNTARY and the Tucson Model strongly supports this philosophy. The Tucson Model mandates basic training for everyone, while more advanced training is voluntary. High rates of training are achieved through culture change and by creating incentives to make the training desirable.

\textbf{ALL officers receive basic mental health training (MHFA – 8 hrs)}

- Mental health basics and community resources
- De-escalation and crisis intervention tools

\textbf{SOME officers receive Intermediate training (CIT – 40 hours)}

- Voluntary participation
- Aptitude for the population

\textbf{SPECIALIZED Units receive CIT + Advanced Training}

- SWAT & Hostage Negotiators
- MHST Teams (specialized Mental Health teams)

\textbf{100% of the force is MHFA trained}

\textbf{70% of first responders & 911 call-takers are CIT trained}

\textbf{Specialty units are 100% CIT trained & receive ongoing Advanced CIT refreshers}


Tucson MHST Model: A Preventative Approach
Dedicated Mental Health Support Team

MHST officers focus on **service & transport**.
- Locate over 95% of patients with civil commitment pickup orders
- Hundreds of patients transported to treatment without uses of force
- Develop relationships and recognize patterns
- Helps with CIT calls when needed

MHST detectives focus on **prevention & safety**.
- Investigate calls that otherwise wouldn’t be looked at (e.g. “I’m concerned about my neighbor”)
- Prevent people from falling through the cracks
- Connect people to treatment instead
- Focus on public safety but avoid criminal justice involvement whenever possible

MHST officers wear plainclothes because it decreases the anxiety of the person receiving services and also has an effect on the officer’s attitude.

The “weird stuff” detectives
Cops like quick turnaround time (10 min) so that it’s easier to bring people to treatment instead of jail.

Most drops are voluntary (light bars), meaning the officers are engaging people into treatment.
... and LESS Justice Involvement

Fewer calls for low-level crimes that tend to land our people in jail.

Culture change in how law enforcement responds to mental health crisis.

More LE-MH Collaborations = better community stabilization

**Co-Responder Teams**
- Mobile crisis clinician assigned to MHST detectives
- Investigations & follow-up for high-risk individuals

Percent of calls resulting in *involuntary hospitalization* decreased from 60% to 20%

**Deflection Program**
- Peer co-responders focused on SUD and overdoses
- Option not to arrest for possession of small amounts

In the first 18 months, **1,500 people** were connected to treatment instead of arrest.

**Homeless Outreach**
- Identify and engage people needing services instead of arresting them
- Lots of collaboration with community stakeholders

**200 people** housed in the first year of the program
Next...

Using Data to Improve Care
Outcome metrics for facility-based crisis services

- **Timely**
  - Door to Diagnostic Evaluation (Door to Doc)
  - Left Without Being Seen
  - Median Time from ED Arrival to ED Departure for ED Patients: Discharged, Admitted, Transferred
  - Admit Decision Time to ED Departure Time for ED Patients: Admitted, Transferred

- **Safe**
  - Rate of Self-directed Violence with Moderate or Severe Injury
  - Rate of Other-directed Violence with Moderate or Severe Injury
  - Incidence of Workplace Violence with Injury

- **Accessible**
  - Volume/visits
  - Denied Referrals Rate

- **Least Restrictive**
  - Community Dispositions
  - Conversion to Voluntary Status
  - Hours of Physical Restraint Use & Hours of Seclusion Use
  - Rate of Seclusion and Restraint Use

- **Effective**
  - Unscheduled Return Visits – Admitted, Not Admitted

- **Consumer Family Centered**
  - Consumer Satisfaction (Likelihood to Recommend)
  - Family Involvement

- **Partnership**
  - Law Enforcement Drop-off Interval
  - Hours on Divert
  - Provisional: Median Time From ED Referral to Acceptance for Transfer
  - Post Discharge Continuing Care Plan Transmitted to Next Level of Care Provider Upon Discharge
  - Provisional: Post Discharge Continuing Care Plan Transmitted to Primary Care Provider Upon Discharge

---

The Regional Behavioral Health Authority requires the other 23h crisis facilities to use this framework.

- Consistent outcome measurement across the Southern AZ network
- Monthly data reviews to monitor system performance across the region
  - Insight into volume trends
  - Bed capacity and throughput
  - Community acuity and engagement
  - Ensure accountability and proper discharge planning
“Maybe stories are just data with a soul.”

- Brené Brown

Systems Approach: How can crisis data help improve the whole behavioral health system?

Every crisis visit is a story about how someone couldn't get their needs met in the community.

If we turn the stories into data, it can reveal trends about things that need improving in the overall behavioral health system.
The Canary in the Coal Mine for what’s NOT working in the community

Crisis Center

“I couldn’t get in to see my doctor at my clinic.”

“These meds aren’t working.”

“I couldn’t get my case manager on the phone.”

“I missed my appointment because I don’t have transportation.”

“What are you in for?”

“There was a problem at the pharmacy and I couldn’t get my meds filled.”

“I don’t have a safe place to stay.”

“I got kicked out of my group home... AGAIN.”

“My mom can’t handle me at home by herself.”

“I couldn’t get my case manager on the phone.”
CRC-Payer Data/QI Partnership

Crisis Response Center

Daily Data Feed and other reports

Regional Behavioral Health Authority

Analysis

System-wide Quality Improvement

Monthly Joint Data/QI Meeting

The Power of Crisis-Payer Collaboration

Percent of each clinic’s adult population that had a CRC visit

Maybe this clinic needs some help?

CRC has the NUMERATOR
RBHA has the DENOMINATOR
“Familiar Faces” QI Plan

1. **DATA REPORTING:** The CRC sends a monthly rolling frequent utilizer report to the RBHA.

<table>
<thead>
<tr>
<th>Last name</th>
<th>First name</th>
<th>dob</th>
<th>ICC</th>
<th>T19 status</th>
<th>rbha</th>
<th>payer</th>
<th>Clinic Only</th>
<th>Obs</th>
<th>Total</th>
<th>Visit this month?</th>
</tr>
</thead>
<tbody>
<tr>
<td>LA FRONTERA</td>
<td>SMI T19</td>
<td></td>
<td></td>
<td></td>
<td>Cenpatico</td>
<td>AHCCCS only</td>
<td>9</td>
<td>10</td>
<td>19</td>
<td>Y</td>
</tr>
<tr>
<td>LA FRONTERA</td>
<td>SMI T19</td>
<td></td>
<td></td>
<td></td>
<td>Cenpatico</td>
<td>AHCCCS only</td>
<td>0</td>
<td>4</td>
<td>4</td>
<td>Y</td>
</tr>
<tr>
<td>COPE</td>
<td>SMI T19</td>
<td></td>
<td></td>
<td></td>
<td>Cenpatico</td>
<td>AHCCCS &amp; Medicare</td>
<td>0</td>
<td>4</td>
<td>4</td>
<td>Y</td>
</tr>
<tr>
<td>LA FRONTERA</td>
<td>SMI T19</td>
<td></td>
<td></td>
<td></td>
<td>Cenpatico</td>
<td>AHCCCS only</td>
<td>0</td>
<td>6</td>
<td>6</td>
<td>Y</td>
</tr>
<tr>
<td>LA FRONTERA</td>
<td>SMI T19</td>
<td></td>
<td></td>
<td></td>
<td>Cenpatico</td>
<td>AHCCCS only</td>
<td>1</td>
<td>4</td>
<td>5</td>
<td>Y</td>
</tr>
</tbody>
</table>

2. **MULTI-AGENCY TEAM MEETINGS** with CRC, RBHA, clinic staff to discuss the patient’s needs and develop improved crisis and service plans. The goal is at least 3 staffings per patient regardless of whether they are at the CRC that day.

3. **CHARTS FLAGGED** at the CRC with information about the new crisis plan and who to contact so that the new plan can be implemented.

---

**Warnings**

- Event Date: 1/9/2017
- DO NOT DISCHARGE before ART with HOPE DRC, Jerry D ☐, 990- ☐, per consultation with Cenpatico ☑

Balfour ME, Zinn T, Cason K, Fox J, Morales M, Berdeja C, Gray J; Provider-Payer Partnerships as an Engine for Continuous Quality Improvement; Psychiatric Services; 2018;69(6):623-625; [https://doi.org/10.1176/appi.ps.201700533](https://doi.org/10.1176/appi.ps.201700533)
Results: Fewer “Familiar Faces”

Case Example: Ms. X becomes lonely during the weekend, which is a trigger for feeling overwhelmed and suicidal and coming to the CRC. She has a partner who is also enrolled in services.

Individualized Plan:
- The outpatient provider will proactively do welfare checks on nights and weekends to help plan for triggers that historically result in CRC visits.
- The team will explore working with her partner’s team (with consent) in order to assist both in recovery together.
- The CRC will call her clinic Peer Support Specialist immediately upon arrival to reinforce the relationship with her outpatient team and help connect her more quickly with outpatient support.

Results: CRC visits decreased from 14 in Q1 2016 to 1 in Q1 2017.

Clinical Approach: “Be a detective, not a bouncer.”

- Don’t end at “They don’t need to be here”
- Figure out what they ACTUALLY need
- Explore reasons for using the crisis center to meet their needs
  - What do they need?
  - Why haven’t they been able to get it?
  - What is reinforcing their repeat visits?
  - What do we want to reinforce instead? (Replacing the behavior)
- Partner with patient and “the system” to get their actual needs met
Youth Trends

Members per Week at the CRC

How can we address proactively?

Week before Winter Break

Return from Spring Break + Testing

Return from Summer Break
Which schools need the most help?

The RBHA took a deeper dive to target communities for a pilot program.

Compared mobile team response by county in relation to number of schools.

This allowed us to find outliers to target for a pilot program.

Courtesy Johnnie Gaspar, Arizona Complete Health
# New School Based Programs

Goal is to identify & enroll members in need of ongoing support

<table>
<thead>
<tr>
<th>Behavioral Health Co-Location</th>
<th>Medicaid Funding for School Service Provision</th>
<th>Youth Engagement Specialist Program Y.E.S.</th>
</tr>
</thead>
</table>
| • Outpatient Behavioral Health and School partnership  
  • Block Funded | • Direct funding for the school based provision of Behavioral Health Services  
  • Fee for Service | • School Resource Officer and Counselor Partnership  
  • Block Funded |

Responsibilities
• Rotates between five schools 1 day per week  
• Provides outreach and engagement  
• Conducts eligibility screening  
• Coordinates enrollment  

Responsibilities
• Rotates between the same five schools 1 day per week (off day)  
• Provide direct service provision  
• Therapy, Case Management, School based behavioral support  

Responsibilities
• On call 8-5 to respond as a Subject Matter Expert at the request of school staff  
• Attend Individual Education Plan meetings (IEP)  
• Train on Mental Health First Aid

Courtesy Johnnie Gaspar, Arizona Complete Health
Reduced Readmissions on Youth Unit

Youth CSU (23 hour obs) Return visits within 72 hours

- 2016: 1.6%
- 2017: 1.1%

*p < 0.03

It took a LONG time and LOTS of collaboration to get where we are today.

- **2000**: City (Tucson) MH Court
- **2001**: CIT Program started
- **2002**: Mobile Crisis Teams
- **2004**: Felony MH Court
- **2006**: Bond passes to build crisis facility
- **2007**: Jail Based Restoration to Competency
- **2011**: Jan 8 2011 shooting at Congress On Your Corner
- **2014**: MacArthur Grant awarded to Pima County
- **2016**: Jail + MH Data Exchange
- **2017**: Co-responders (cop + clinician)
- **2018**: Learning Site designation by DOJ/BJA
- **2019**: 911/crisis line co-location
- **2020**: CoMPaSS Court Consolidated misd. problem-solving court
- **2021**: Drug Deflection UMATTER program
Lessons Learned & Key Ingredients

• The solution is **not** always more inpatient beds!
• Stabilize crisis in the **least-restrictive** setting possible (which also tends to be the **least-costly**)
• **Governance and payment structures** to incentivize these programs and services
• **Data-driven and values-based** decision-making and continuous quality improvement
• Stakeholder **collaboration** across silos
• **Culture of:**
  – **NO WRONG DOOR**
  – “Figure out how to say YES instead of looking for reasons to say no.”
Questions?

Margie Balfour, MD, PhD
Connections Health Solutions
Chief of Quality & Clinical Innovation
Associate Professor of Psychiatry, University of Arizona
margie.balfour@connectionshs.com

Tucson is one of the DOJ’s Learning Sites for Mental Health Law Enforcement Collaboration. Funding for a visit may be available.

# Models of Crisis Stabilization

Nomenclature varies by state, but as a general guide:

<table>
<thead>
<tr>
<th>Model</th>
<th>Description</th>
<th>Level of Care</th>
<th>Acuity</th>
<th>Locked</th>
<th>Police drops</th>
<th>Use of peers</th>
</tr>
</thead>
<tbody>
<tr>
<td>23 hr. obs</td>
<td>Short-term (&lt; 24 hrs.) assessment and stabilization with hospital level staffing and safety protocols</td>
<td>LOCUS 6 “Medically Managed” with 24/7 nursing and medical coverage</td>
<td>Can take both low and high acuity/violent patients</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Living Rooms</td>
<td>Short-term (&lt; 24 hrs.) stabilization in a home-like environment with mostly peer staffing</td>
<td>LOCUS 5 “Medically Monitored” with medical/nursing staff available but not on-site 24/7</td>
<td>Lower acuity patients not at imminent risk of harm to self/other, not agitated or violent</td>
<td>No</td>
<td>Sometimes</td>
<td>Yes</td>
</tr>
<tr>
<td>Sobering Centers &amp; “Social Detox”</td>
<td>Short-term (&lt; 24 hrs.) stabilization for patients with substance use needs, typically not using meds</td>
<td>LOCUS 5 “Medically Monitored” with medical/nursing staff available but not on-site 24/7</td>
<td>Lower acuity patients not at imminent risk of harm to self/other, not agitated or violent</td>
<td>No</td>
<td>Sometimes</td>
<td>Yes</td>
</tr>
<tr>
<td>Crisis Residential</td>
<td>Intermediate term (days to a couple weeks) crisis stabilization in a residential setting</td>
<td>LOCUS 6 “Medically Managed” with 24/7 nursing and medical coverage</td>
<td>Can take both low and high acuity/violent patients</td>
<td>No</td>
<td>Usually not</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Programs may also have niche specializations depending on other affiliated community services. For example: San Antonio’s program is located on a housing campus and focuses heavily on homelessness recovery. Tucson’s center is attached to an emergency room and collaborates closely with the ED to reduce ED boarding.