

The Case for a Psychiatric Emergency Center (PEC) Pilot Project

From the first meeting of the SJ 47 Joint Subcommittee's Expert Advisory Panel on Mental Health Crisis Response and Emergency Services in the spring of 2016, creation of regional Psychiatric Emergency Centers (PECs) has been the top recommendation of the panel for improving Virginia's crisis response system. The PEC in its most robust form is a facility built and operated to accept all individuals experiencing mental health crisis, whether coming on their own, brought by family, friends or law enforcement officers, or referred by hospital Emergency Departments or other providers. It provides a calm and supportive setting in which these individuals can be assisted in addressing their crisis, usually within a 24 hour period, and at the end of that 24 hours they can return home, with a plan for community-based care, or be transitioned to a community-based residential care program, or be admitted to an acute care psychiatric facility. Ideally, these PECs are open on a 24/7 basis, have both medical and mental health staff and immediate pharmacy access, and on-site security that enables law enforcement officers to transfer individuals in crisis to the care of these PECs and quickly return to their duties in the community. The PECs also give a prominent role to trained peer recovery specialists who are able to engage with individuals coming to the PEC and provide support and reassurance to them.

The consensus endorsement of the PEC as the panel's highest priority arose out of several observations shared by the panel members, including the following: that the hospital Emergency Department (ED), where most individuals in mental health crisis go or are taken or referred, is a poor environment for individuals in mental health crisis and extended time in the ED can actually make a person's crisis worse and can degrade the ED environment for other patients as well; that for many people in mental health crisis, especially those whose crisis is fueled in part by alcohol or drugs as well as by acute stress events in their lives, the most important service they can receive is time in a supportive setting, and giving people such time in such a setting often enables them to reduce or resolve their crisis without resort to hospitalization; and that psychiatric hospitalization can actually be counterproductive for a number of individuals in crisis, who end up occupying beds they do not need and denying those beds to persons who do need them.

This view from the panel is fully supported by the National Association of State Mental Health Program Directors (NASMHPD). In an August 2018 report entitled *A Comprehensive Crisis System: Ending Unnecessary Emergency Room Admissions and Jail Bookings Associated with Mental Illness*, the NASMHPD wrote that three of the essential components of an effective mental health crisis response system are: (1) a regional or statewide crisis call center, (2) centrally deployable mobile crisis on a 24/7 basis, and (3) residential crisis stabilization. In describing the residential crisis stabilization component of this system, the report states:

Design of these facility-based programs may vary but ideally will include a medically staffed flexible observation/stabilization area (often limited to 24 hours of care) that implements a no referral refused process in which walk-in, law

enforcement and other first responder referrals are immediately accepted without requiring any form of screening prior to acceptance. These observation/stabilization programs are often paired with some form of subacute short-term (2-5 day) facility-based crisis program (could be inpatient, respite or residential) to offer more than 24 hours of care without escalating to more costly acute inpatient options that would result in longer lengths of stay and higher per diem costs than programs with specific mental health crisis resolution expertise.

The NASMHPD report goes on to note that many people who are currently hospitalized to address their mental health crisis would be better served in a PEC/crisis-stabilization setting. Because crisis stabilization units have limited availability in Virginia, and PECs do not exist at all, many people likely are being unnecessarily hospitalized only because a less restrictive alternative is not (but could be) available. As noted in the presentation on mental health crisis services made to the SJ 47 Joint Subcommittee at its November 5, 2018 meeting, the demand on public and private psychiatric hospital beds, for both voluntary and involuntary admissions, continues to rise. The absence of the PEC from the continuum of crisis care will result in increasing demand for hospital beds.

The regional meetings held with public and private mental health providers and other stakeholders over several months in 2018 produced several specific proposals for improving mental health crisis services in almost every region, and proposals for PECs were among them. A proposal from Region 4 (see Appendix B of the October 1, 2018 report on mental health crisis services submitted to the SJ 47 Joint Subcommittee) documents the efforts made there to both build local psychiatric hospital capacity and to reduce demand on hospital care, and the limited success of those efforts. In response, Region 4 has proposed a PEC model based on facilities developed by RI International that are currently operating in 5 different states. Often referred to as the “Living Room” model, this facility is the most robust PEC model, operating on a “no refusal” basis in regard to individuals coming or being brought to the facility due to crisis. The proposed Region 4 PEC would serve up to 16 individuals at a time and would be staffed with a psychiatrist and/or psychiatric nurse practitioner (with supplemental tele-psychiatric services), nursing staff, LCSWs, qualified mental health professionals, peer recovery specialists and off-duty police for 24/7 coverage. Notably, Region 4’s proposal would also develop a mobile crisis center, with services available 24/7, to assist in both preventing hospitalization and providing “step down” services from the PEC. A full budget for the construction and operation of such a program has not yet been developed.

Regional CSB staff in Region 2 have also identified this model as filling a key need in the array of crisis services available in Region 4. A specific concept proposal has not yet been developed there.

The facility proposed by Region 3b (Appendix C of the report dated October 1), and developed in partnership with Sovah Health, would serve a maximum of 10 people at any one time. It shares many of the characteristics of the Living Room model proposed by Region 4, but would not be “no refusal facility”. Instead, individuals would be screened first by CSB staff in other settings (the Crisis Intervention Team Assessment Center [which would be co-located with the

PEC], hospital ED, or CSB) and then would be referred to the PEC if that screening indicated that the needs of those individuals could be met within the 24-hour time frame for care. Region 3b has identified a building with an unfinished interior as the location for its PEC, and anticipates a cost of just under \$800,000.00 to build out and furnish the facility. An annual facility budget is not yet available. The costs of additional CSB staff (including peer support specialists and administrative/support specialists to add to existing CSB clinical pre-screeners) and the costs of medical services staff provided by Sovah Health (registered nurses, technicians and a site manager) would amount to approximately \$775,000.00 annually.

The facility proposed by New River Valley Community Services (NRVCS), is also based on the Living Room model, and will have a “no refusal” policy for individuals coming to it. If funded, it would consist of a “common area with comfortable seating and soothing décor” to support the “de-escalation” of a person’s crisis, and 3 semi-private rooms equipped with recliners where individuals could rest during their stay. Significantly, it would be co-located with an existing Crisis Intervention Team Assessment Center (CITAC) and the offices of the NRVCS mobile crisis team, and would be a 10-minute drive from a Crisis Stabilization Unit (CSU) that is certified for both detoxification services and for acceptance of individuals under a TDO. Staffing would include peer recovery specialists, a triage technician and a registered nurse. The co-location with, and ready availability of, a variety of other crisis services, would enable the NRVCS center to respond to whatever level of acuity was presented by individuals arriving there, moving those individuals to other settings, and involving higher levels of intervention, if an individual’s condition and behaviors warranted it. In addition, the center would be able to utilize these same co-located and nearby services to help a person “step down” to another level of community-based care – for example, returning home with mobile service involvement and arrangements made for appointments in outpatient care, or transferring to the CSU for additional residential services before returning home.

Unlike the other proposals, the NRVCS center would not begin as a 24/7 facility. Instead, its hours of operation “will be based on call volume and initially include night and weekend hours to accommodate the known needs of the community, with current trends in emergency services indicate the living room would best serve the community from 1:00pm to 9:00pm Tuesday through Saturday.” Hours, staffing and treatment capacity could grow as the demands for services dictate.

The budget for the NRVCS center includes a one-time set up cost of \$108,000.00 (to build out and equip a portion of the NRVCS-owned building where the CITAC and mobile crisis program are already located), annual staff costs of just under \$390,000.00 (for a clinical program supervisor, registered nurse, 2 intensive care clinicians and 3 peer recovery specialists) and annual operating expenses of under \$2,000.00.

All of the PEC proposals are consistent with current recommendations nationally for mental health crisis services, as reflected in the report from the NASMHPD (which is attached). The PEC provides a critically important temporary environment of care and support for individuals in crisis, reducing the demand on the hospital ED on the one hand and reducing the need for the psychiatric hospital on the other. As the NRVCS proposal notes, approximately 50 to 75 percent

of individuals seen in mental health crisis at the LewisGale Hospital Montgomery ED (located in Blacksburg) between June and August of 2018 ended up being psychiatrically hospitalized. Many of those who came to the ED voluntarily waited many hours, and sometimes days, before a hospital bed became available. The data from existing PEC programs in other states shows that those waits, and those hospitalizations, can be dramatically reduced if a PEC was available as a temporary refuge and place of support during a crisis.

Discussions within the Statewide TDO Task Force have noted the importance of ensuring funding for full implementation of STEP-VA, to ensure that community-based services that can help to prevent crises are more available to persons with serious mental illness. There is a concern that attention given to separate funding requests for projects like the PEC will deflect attention from full funding for STEP-VA implementation. Additionally, while “crisis services” are included as one of the core services to be provided by CSBs under STEP-VA, the PEC has not been specifically identified as a necessary part of “crisis services” (though “mobile crisis services” have been so identified). The response, reflected in the current regional proposals, is that while the PEC is absent from Virginia’s current vision of the needed array of crisis services, it is a centerpiece of the needed array of crisis services identified by the National Association of State Mental Health Program Directors (NASMHPD), and the efficacy of the PEC model has been demonstrated in the states that have adopted them. (The NVRCS proposal cites several studies showing the efficacy of the PEC.) Many of the CSBs share the view of the NASMHPD. The proposals cited above involve modest costs when compared with the costs of the current system, including long hospital ED waits endured by patients, the overcrowding of state hospitals, and long hours spent by law enforcement in holding individuals in custody in the hospital ED and elsewhere and transporting them across the state to available hospital beds.

The NRVCS proposal in particular, with its co-located CITAC, mobile crisis team and proposed PEC, and its nearby TDO-capable CSU, offers a possible model of full integration of key crisis services. While the NRVCS proposal does not include all of the services, or hours of operation, included in the other proposals, it reflects that region’s understanding of its current need. Those additional hours and staff can be added if the experience of the facility demonstrates the need for more.

Establishing pilot projects helps to increase understanding of what the community’s mental health service needs are, and what responses most effectively address those needs. Given the national consensus on the significance of the PEC as a key component of the needed array of mental health crisis services, it would be a mistake to decline funding for at least one of the PEC proposals submitted from the regional meetings. We need the experience of such pilots to guide future service decisions to better help those who are in crisis.

Also needed is a review of current insurance compensation for these services. These proposals are currently asking for near-full government funding for the PEC operations because of the lack of appropriate insurance compensation. Since these facilities are helping people resolve their crises in less restrictive ways, and without the current high costs of hospital ED waits and over-hospitalization, medical insurance should cover them. An effort to ensure such coverage needs to be made.

