

The Alameda Model: Using a Psychiatric Emergency Services (PES) Unit to Treat People in Mental Health Crisis

The claim: treating persons in mental health crisis in a psychiatric emergency services (PES) unit enables over 75% of them to achieve sufficient stability to be discharged to their home or to a community-based program within 24 hours, so that: (1) they are treated in the least restrictive setting; (2) disruption to their lives is minimized, (3) psychiatric boarding in hospital EDs is eliminated, (4) unnecessary psychiatric hospitalizations are prevented.

The structure: The PES unit is “typically a stand-alone program dedicated solely to the treatment of individuals in mental health crisis.” It can be locked, unlocked, or a combination; community-based or in-hospital; normally staffed with psychiatric nurses and other mental health professionals on a 24-hour basis; psychiatrists on-site or readily available. The unit can assess and treat people right away, “with the potential for patients to stabilize quickly.” It operates as an outpatient facility; timeline for treating and discharging patients is 23 hours, 59 minutes.

The process:

From the community - California law (WIC 5150-5155) gives police, as well as designated doctors, clinicians and facilities, the authority to detain, transport, and involuntarily hold an individual in acute mental health crisis for up to 72 hours. A police officer who places an individual under a “5150 hold” contacts an EMS ambulance service and transfers custody of the person to the ambulance crew, who perform a “field screening” of the person, “looking only for medical stability issues”. If the person is deemed medically stable, the person is brought directly to the PES unit. Patients may also “self-present” at the PES unit for care.

From the Emergency Department (ED) - When the ambulance crew find that a person in crisis is medically unstable and needs further evaluation and “medical clearance”, the person is taken to the ED. A “streamlined” medical clearance process, in which *no* specific laboratory tests are required, is in place (developed jointly by the area EDs and the PES unit) to facilitate transfer of these individuals (*and* those who self-present at the ED in mental health crisis) to the PES unit. (Experience has shown that lab tests are time-consuming and seldom identify conditions that preclude safe transfer to the PES unit.) On-site psychiatric consult in the ED *not* necessary, as the attending ED physician consults by phone with a psychiatrist at the PES unit. If the doctors agree that transfer is appropriate, the patient is accepted by the PES unit *without* regard to the person’s psychiatric diagnosis or history or whether the person has medical insurance or has access to a psychiatric hospital bed if hospitalization is ultimately found to be needed.

At the PES unit – On the person’s arrival, a triage nurse conducts an initial evaluation for medical stability and then [if appropriate] sends the patient to a triage psychiatrist, stationed by the ambulance bay, who again assesses and makes “a quick determination if some immediate medicines are needed prior to full evaluation”. Once cleared there, the person goes to “a large waiting-room type area where people can sit in chairs or lie down with a pillow or a blanket”. (There are no individual rooms because this is an outpatient service.) Intensive supportive services are provided over the next several hours, with an emphasis on gaining patient engagement and consent to treatment. Injectable medications are used only in extreme situations. Within 24 hours of a patient’s admission, a decision is made on whether the patient needs hospitalization or can return home or go to a placement less restrictive than an ED.

Outcomes in Alameda County: Persons in mental health crisis in EDs are transferred to the PES unit within (on average) 2 hours of ED admission; less than 25% of the persons admitted to the PES unit are psychiatrically hospitalized; over 75% are able to go home or to a community-based program (e.g. detox, crisis residential housing, or “a board and care arrangement”).