

# Change Is Underway

The Core Elements of Crisis Now are changing the way we treat mental health crises

LEARN MORE

# CrisisNow.com

*David W. Covington, LPC, MBA*

Young people who have a first psychosis and their families should be supported to achieve an ordinary life and quickly move beyond a diagnosis to recovery

New Castle Declaration, UK (2001)

2005

## Police

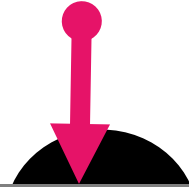
- The untrained MH workforce.
- Typically escalated crisis initially



## Individuals, Friends, Family Walk-In



## Primary Care & Social Services



## Crisis Call Lines

## Mobile Outreach

- Few locations
- Limited timeframes
- Inconsistent responses



## ACUTE SERVICES

- Extreme cases only where capacity exists
- Interminable waits common



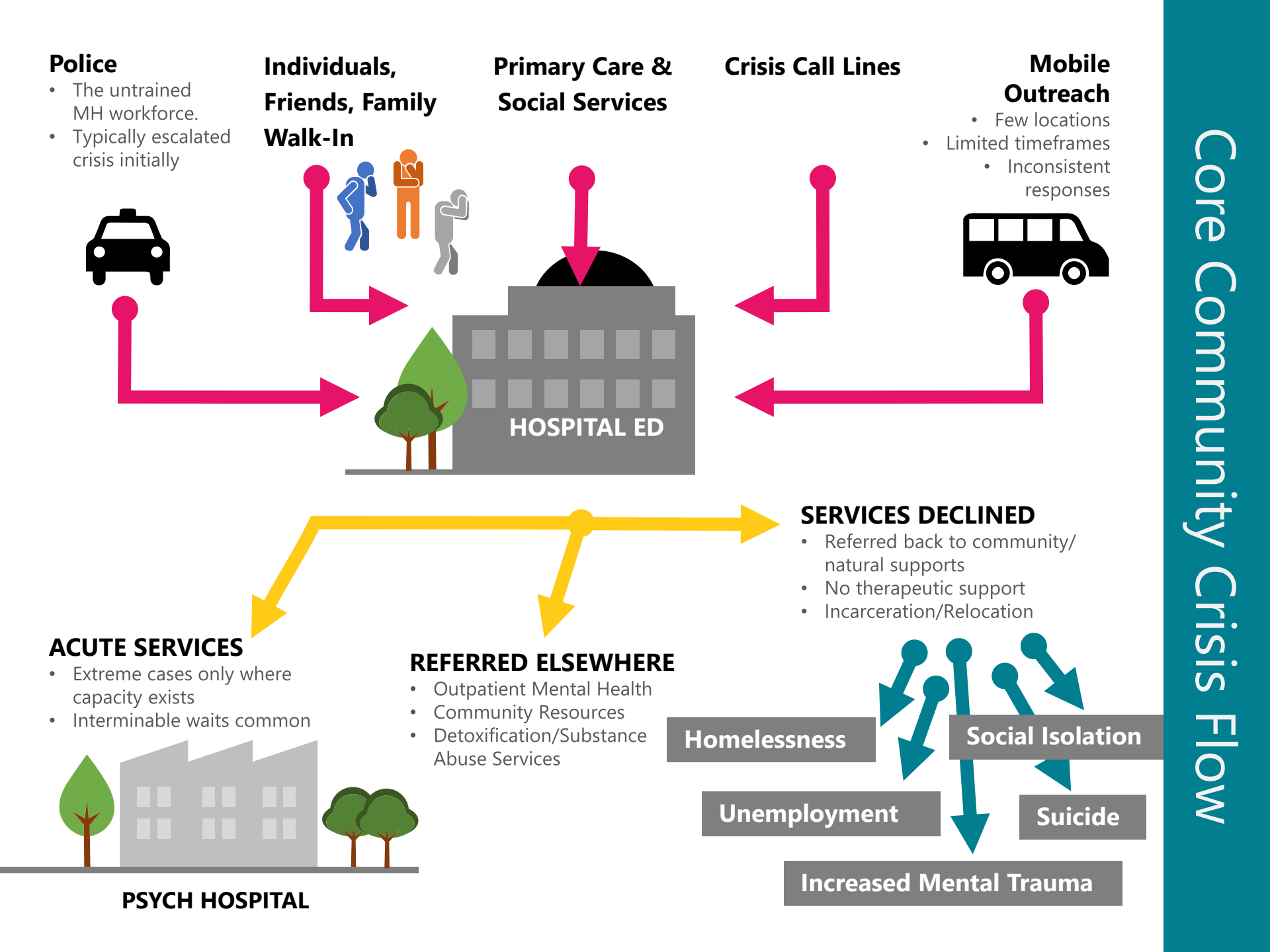
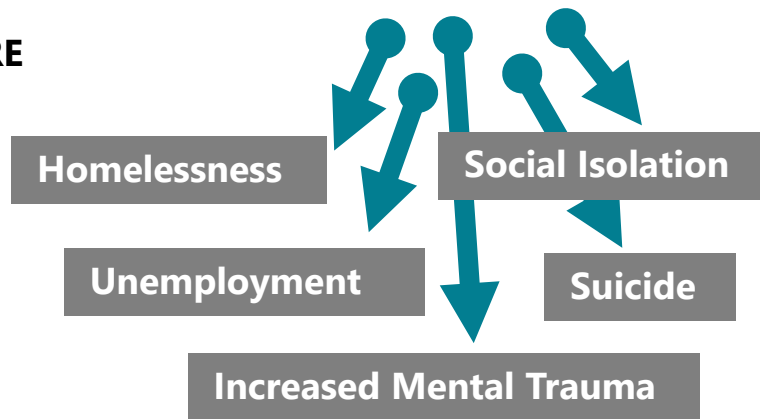
**PSYCH HOSPITAL**

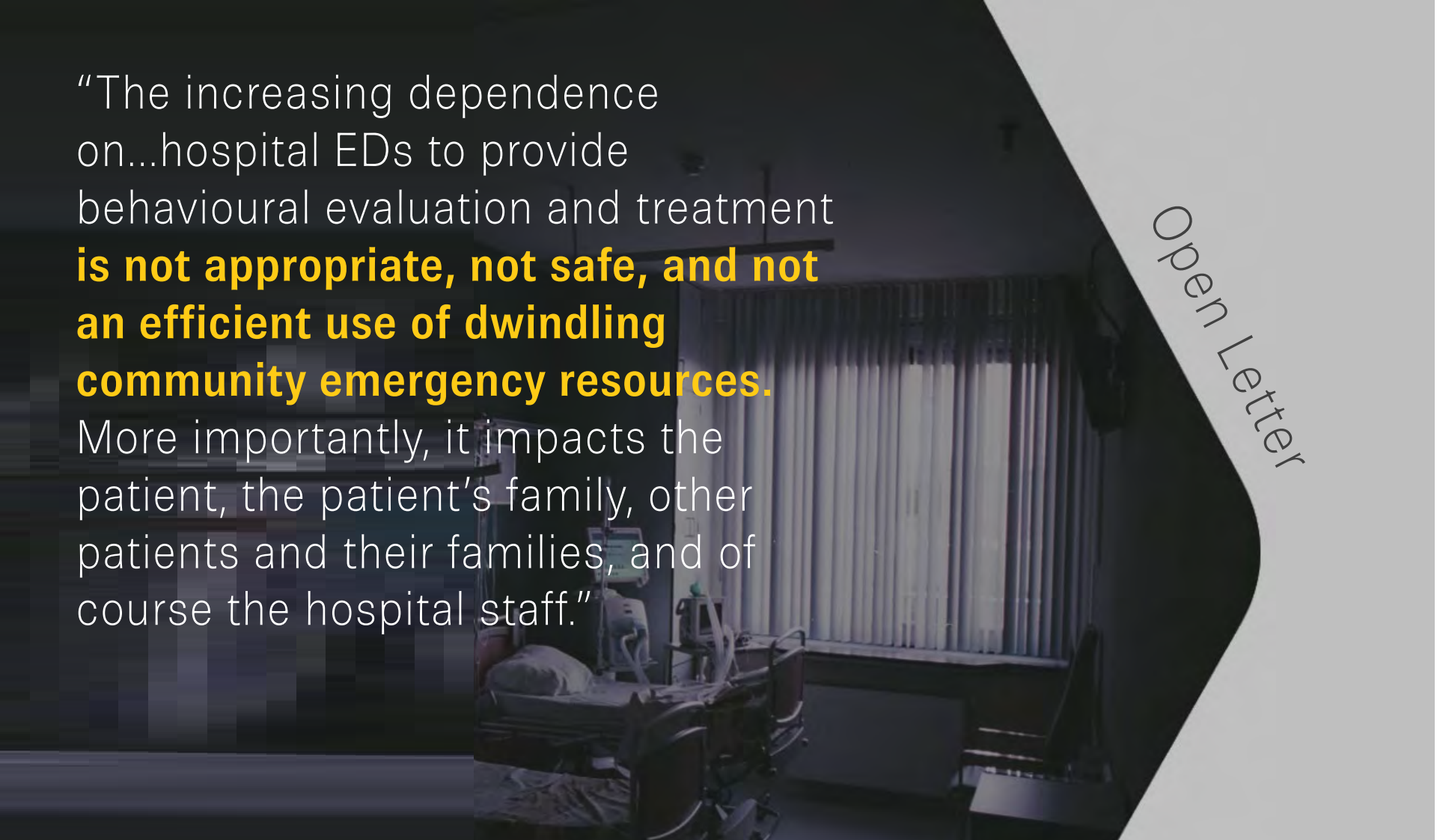
## SERVICES DECLINED

- Referred back to community/natural supports
- No therapeutic support
- Incarceration/Relocation

## REFERRED ELSEWHERE

- Outpatient Mental Health
- Community Resources
- Detoxification/Substance Abuse Services





“The increasing dependence on...hospital EDs to provide behavioural evaluation and treatment **is not appropriate, not safe, and not an efficient use of dwindling community emergency resources.**

More importantly, it impacts the patient, the patient’s family, other patients and their families, and of course the hospital staff.”

Open Letter

Sheree (Kruckenber) Lowe, VP of Behavioral Health for the California Hospital Association, representing 400 hospitals and health systems

## Seattle Times 2013.

Lack of space forced those involuntarily detained in EDs to wait on average 3 days.

*Every time a psychiatric boarding occurs, the hospital experiences a cost/loss of \$2,264*





# Crisis Now Continuum

Individual, Primary Friends, Family Walk-In Services Police Crisis Line & Mobile

# How Does Your Crisis System Flow?

% whose assessed need matched their linked crisis service

Most all community crisis referrals flow through the hospital ED.

STEP 1



## Community Crisis Flow

Compute your crisis system flow.

Hospital ED 200 persons in crisis per 100,000 persons in your community on a monthly basis.

Greater Phoenix Community

4m Total Pop.

Divide by 100k and multiply by 200

8,000 Monthly Crisis Flow

What do they look like clinically?

STEP 2

STEP 3

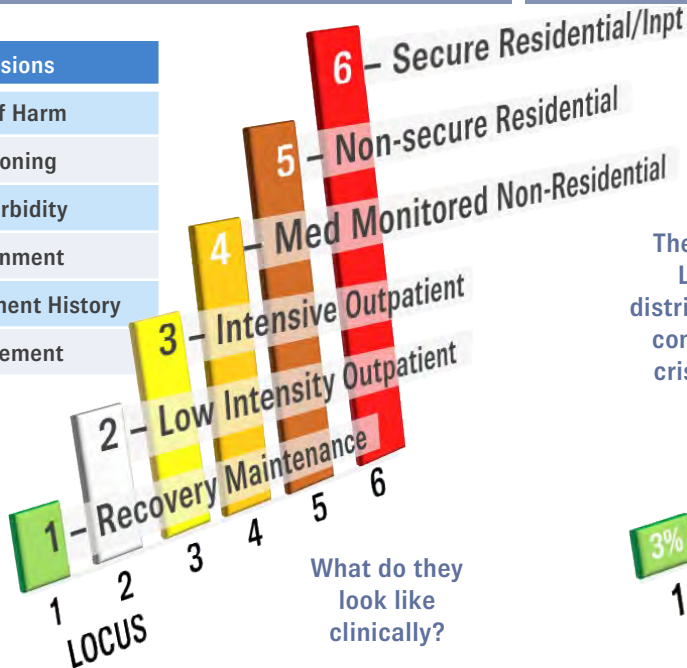
STEP 4

## LOCUS Levels of Care

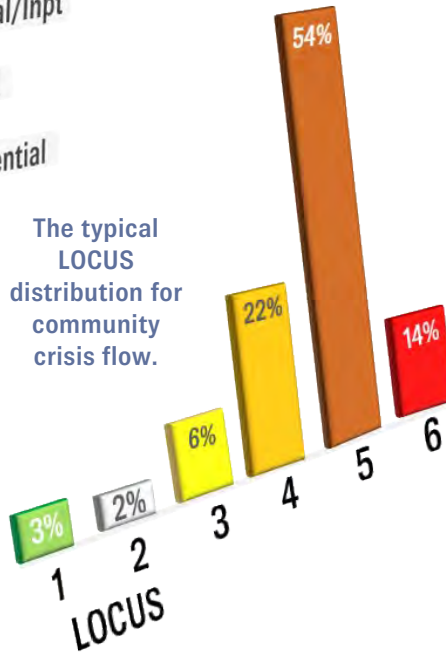
## Stratified Crisis Need

## Clinically Matched Care

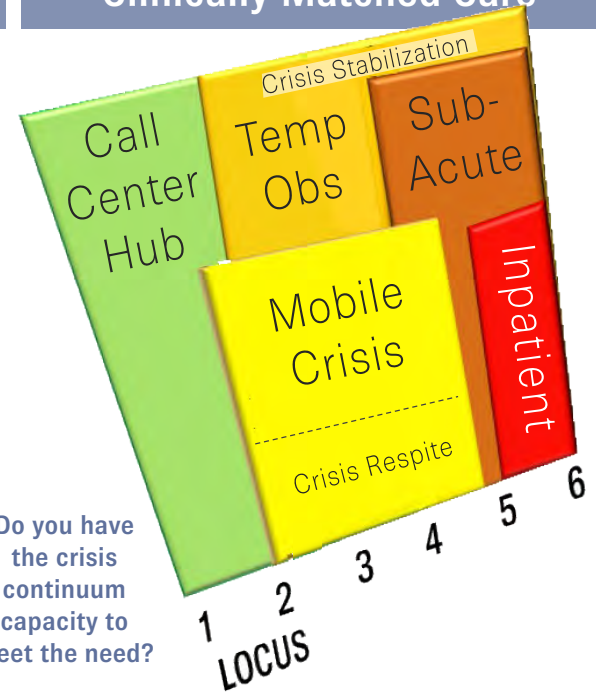
Dimensions
Risk of Harm
Functioning
Co-Morbidity
Environment
Treatment History
Engagement



What do they look like clinically?



Do you have the crisis continuum capacity to meet the need?



# How Does Your Crisis System Flow?

% whose assessed need matched their linked crisis service

Individual, Primary Friends, Care & Family Social Walk-In Services Police Crisis Line & Mobile



Most all community crisis referrals flow through the hospital ED.

Compute your crisis system flow.

Hospital ED





# How Does Your Crisis System Flow?

% whose assessed need matched their linked crisis service

Individual, Primary  
Friends, Care &  
Family Social  
Walk-In Services  
Police  
Crisis Line  
& Mobile



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STEP



## Community Crisis Flow



Hospital ED

Compute your crisis system flow.

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Community

Total Pop.

Divide by 100k and multiply by 200

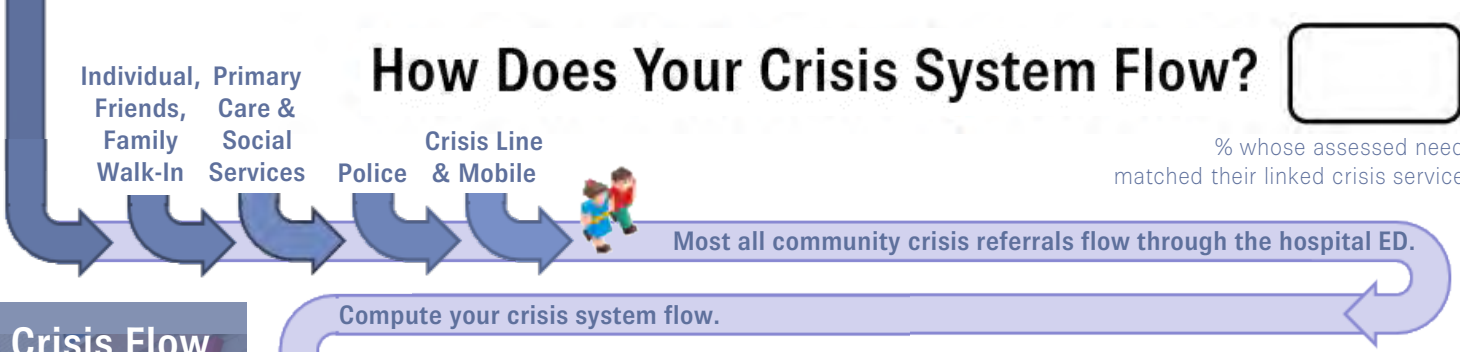
Monthly Crisis Flow

What do they look like clinically?

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**Greater Phoenix**

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Hospital ED

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**Greater Phoenix**

Community

**4m**

Total Pop.

Divide by 100k and multiply by 200

**8,000**

Monthly Crisis Flow

What do they look like clinically?

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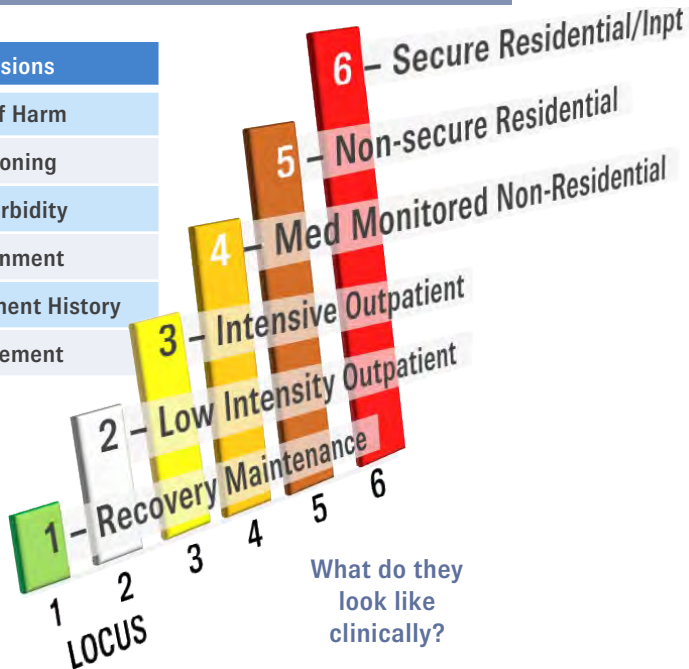
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What do they look like clinically?

STEP 2

## LOCUS Levels of Care

Dimensions
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What do they look like clinically?

# AnyBigCity, USA

Pop. 4m

## Dimensions

Risk of Harm

Functioning

Co-Morbidity

Environment

Treatment

History

Engagement



# How Does Your Crisis System Flow?



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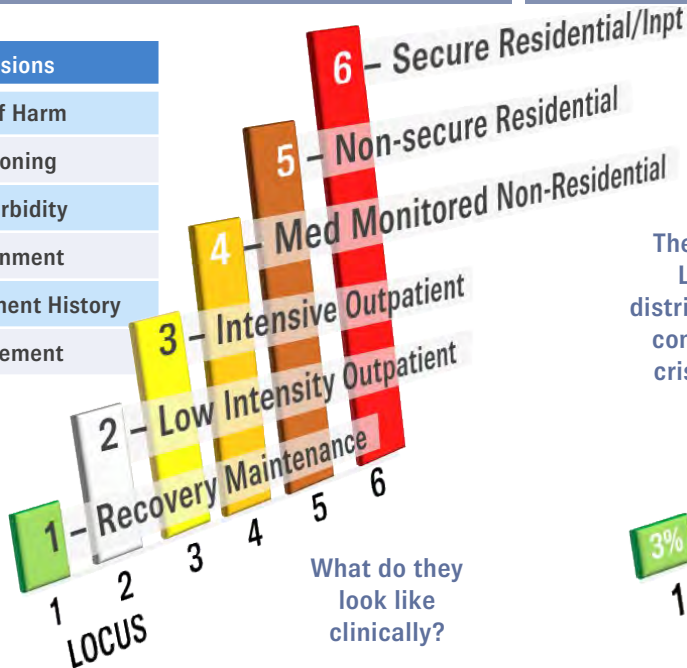
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STEP

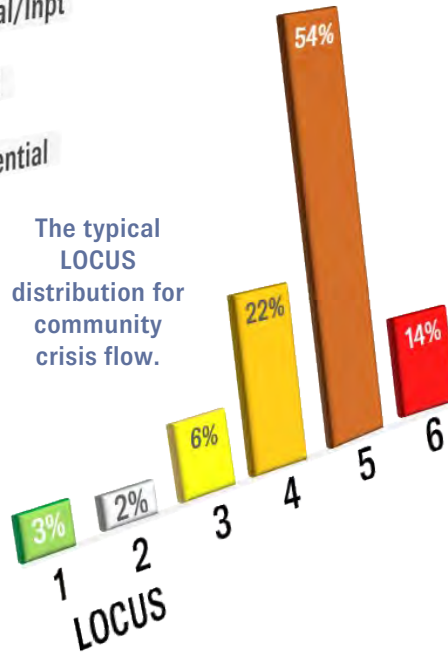
## LOCUS Levels of Care

## Stratified Crisis Need

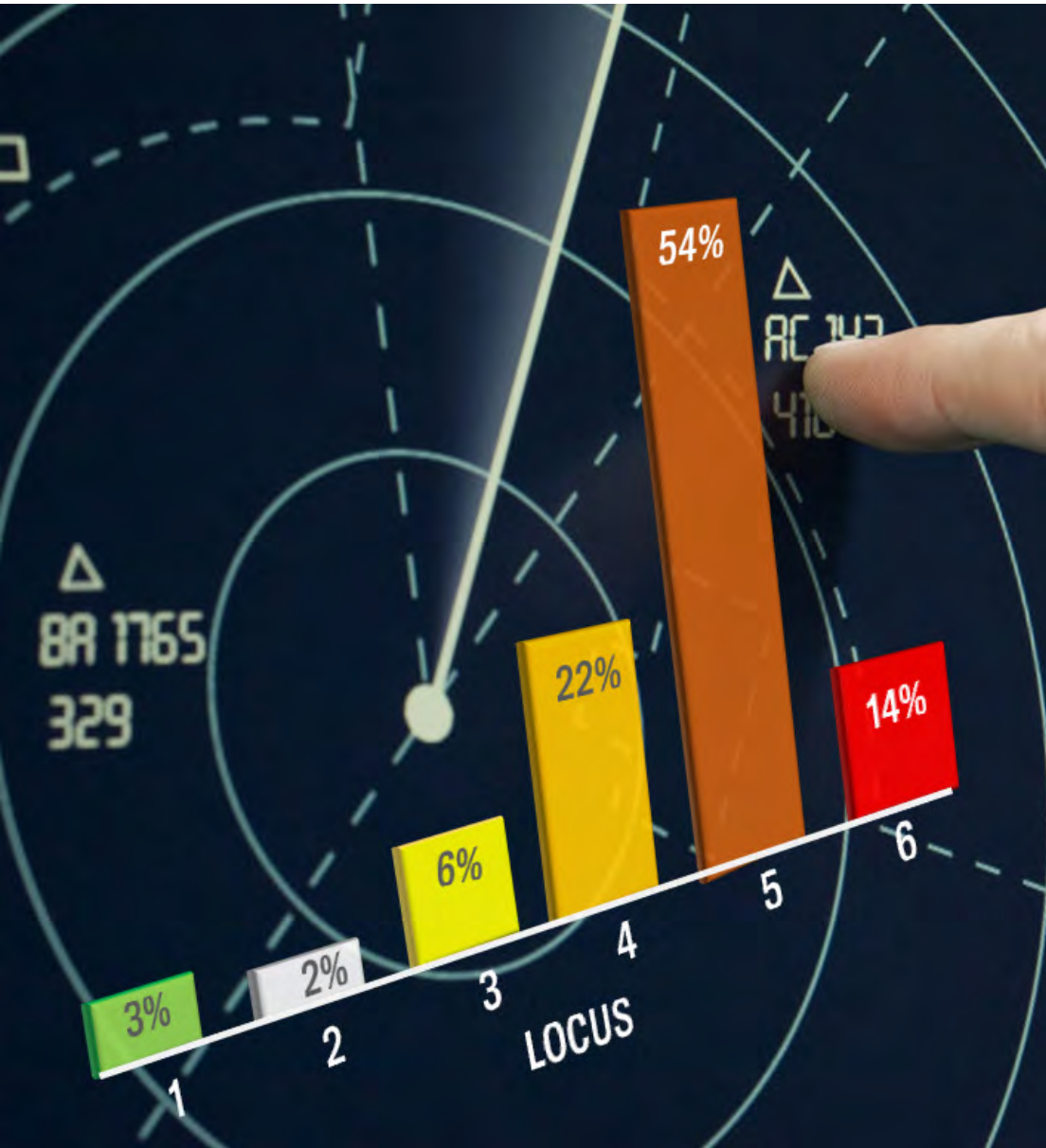
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What do they look like clinically?



We utilized more than a decade of statewide crisis data to produce the analysis in this report.



# A Fully Informed Model

Our team compared the outcomes of a traditional inpatient beds model alone versus a Crisis Now continuum model in a metropolitan population of 4 million.



Individual, Primary Friends, Family Walk-In Services Police Crisis Line & Mobile

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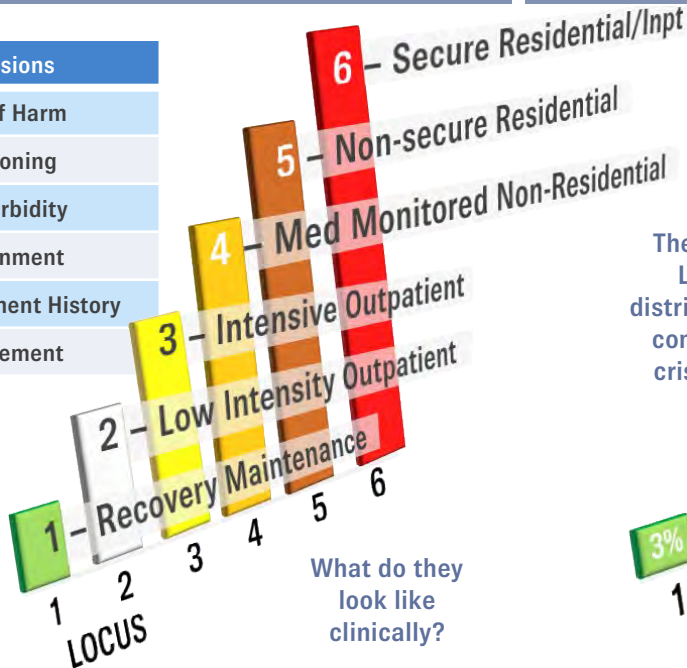
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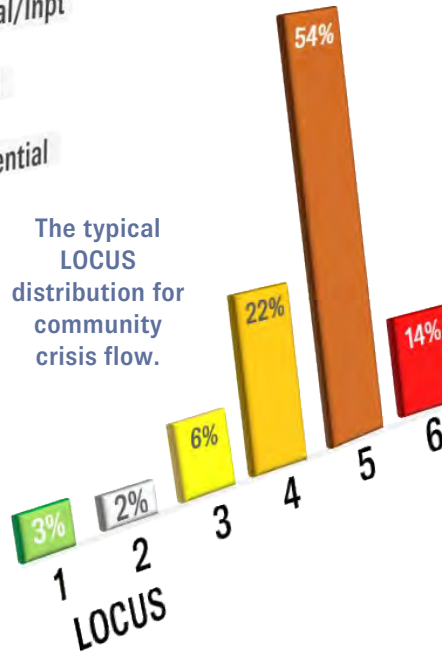
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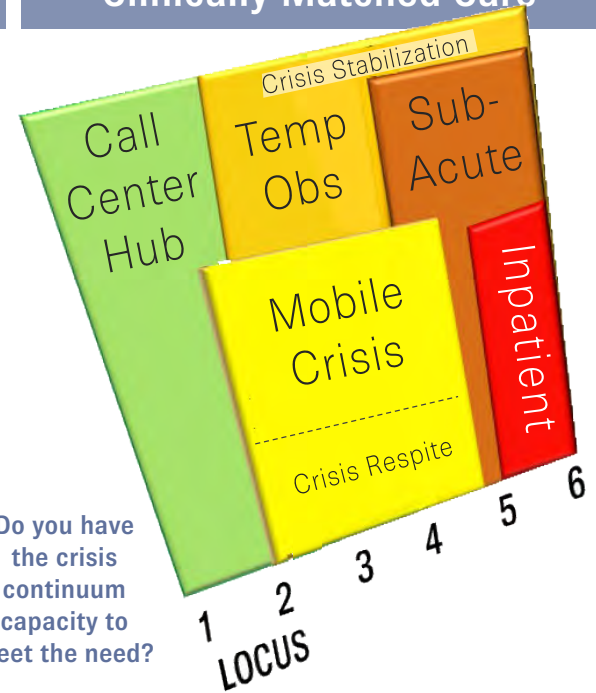


What do they look like clinically?



The typical LOCUS distribution for community crisis flow.

Do you have the crisis continuum capacity to meet the need?



# Crisis Now System

In the **Third Model**, fully deploy the principle practices of the Crisis Now System and add Crisis Navigator and a 24/7 Outpatient Clinic

# What is the Crisis Now model?

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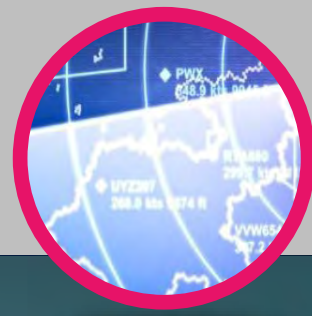
**Call Center Hub**



**Mobile Crisis**



**Crisis Facilities**



**“Air Traffic Control”  
Crisis Call Center Hub  
Connects and Ensures  
Timely Access and Data**



**Law Enforcement Bypasses the Emergency Room and Proceeds Directly to Crisis**

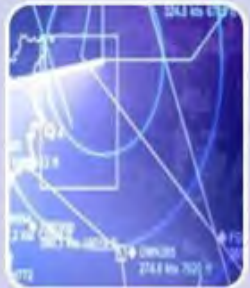
**5 to 7 Minute Turn-Around Police Drop Off. No Call. No Referral. No Rejection. Simple.**

## How Does Your Crisis System Rate?



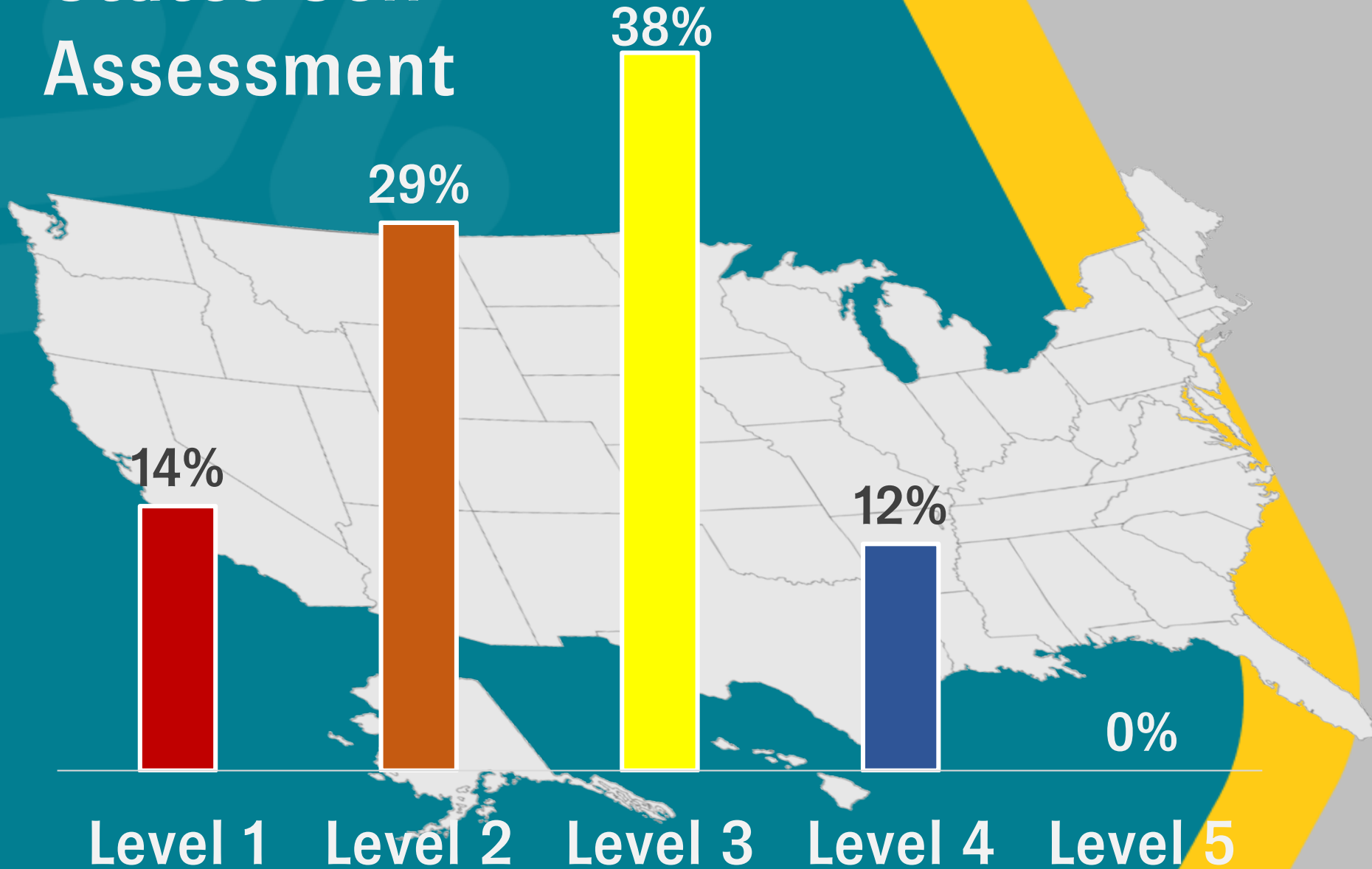
A Framework for State/Regional Self-Assessment

For more info see <http://crisisnow.com>



	① Call Center Hub	② Mobile Outreach	③ Sub-acute Stabilization	Crisis Now System	Level 5 System Also Conforms to 4 Modern Principles
<b>What makes Level 5 different?</b>	Real Time Access Valve Mgmt	Meets Person at Home/Apt/Street	Direct LE Drop Off <10 Min	Equal Partners 1 <sup>st</sup> Responders	
<b>Level 5: FULLY INTEGRATED</b>	Air Traffic Control Connectivity	Adequate Access Statewide	Adequate Access Statewide	Adequate Access Statewide Plus →	① Priority Focus on Safety/Security
Level 4: CLOSE	Data Sharing (Not 24/7 or Real Time)	Statewide Access but Reliant on ED	Statewide Access but Reliant on ED	Integrated System w/ Diversion Power	② <b>Suicide Care Best Practices</b> , e.g. Systematic Screening, Safety Planning and Follow-up
Level 3: PROGRESSING	Formal Partnerships	Adequate Access <1 Hr Response	Adequate Access >50% Bed Available	Adequate Access Major Payers Included	③ Trauma-Informed, Recovery Model
Level 2: BASIC	Shared MOU/ Protocols	Some Availability Limited to Urban	Some Availability Limited to Urban	Limited State/ County Support	④ Significant Role for Peers
Level 1: MINIMAL	Agency Relationships	None or Very Limited Availability	None or Very Limited Availability	Fragmented Status Quo	

# States Self-Assessment





**CRISIS NOW**  
Transforming Crisis Services

# Crisis Now – Exceptional Practices Lead to System’s Success in AZ

ARIZONA  
2017

**4.5**



## A Crisis Now Case Study

Roadmap to Level 5 Crisis Services

# The Crisis Now Difference

In 2016, according to Aetna/Mercy Maricopa, metropolitan area Phoenix law enforcement engaged 22,000 individuals that they transferred directly to crisis facilities and mobile crisis without visiting a hospital emergency department. *What difference did it make?*

**Improved Crisis Clinical Fit to Need (CCFN) by 6x**



**Saved hospital EDs \$37m in avoided costs/losses**

**Reduced total psychiatric boarding by 45 years**

Calculated from "Impact of psychiatric patient boarding in EDs" (2012) (Nicks and Manthey)

**Reduced potential state inpatient spend by \$260m**

Calculated from Arizona data, 2017



Firefighter savings not yet realized / quantified.

## Key references to the mathematics in this report:

“The Impact of Psychiatric Patient Boarding in Emergency Departments” (2012) (Nicks and Manthey):

- 35% of those consulted to psychiatry required inpatient care
- The average hospital ED length of stay was 1,089 minutes (18 hours)
- The hospital psychiatric patient boarding cost was \$2,264 per person

“Amazing Results of Team Work: 2016 Diversions” (2017) (Mercy Maricopa Integrated Care RBHA, Arizona):

- In 2016, 21,943 individuals with mental health and addiction challenges were handed off from Phoenix area police departments directly to crisis
- Reportedly, approx. 1,000 person directly connected through fire fighters, but these relationships are newer and the full potential is yet unknown

“Psychiatric Bed Supply Per Capita” (2016) Treatment Advocacy Center:

- The consensus opinion of an expert panel on psychiatric care estimated the need as around 50 public psychiatric beds per 100,000 population

“Georgia Crisis & Access Line LOCUS” (2006-2017) Behavioral Health Link

- 1.2m caller episodes of care evaluated for higher intensity cases in which emergency department, law enforcement or mobile crisis were involved
  - 54% were LOCUS Level 5, which warrants non-secure sub-acute crisis levels of care

“Crisis Now Business Case” (2017) David Covington presentation at the National Dialogues on Behavioral Health Conference (New Orleans)

- Crisis Now model improves “Crisis Clinical Fit to Need (CCFN)” by 6x (meaning the LOCUS assessment matches the connected service description)
- Psych inpatient expense reduced from potential \$485m to \$125m (savings of \$260 million after adding the \$100 million investment in crisis continuum)
  - Seattle Times reported avg. psychiatric boarding time in Washington State 3 days (2013)
- Carolinas Healthcare reported baseline psychiatric boarding 40 hours on average (Dr. John Santopietro presentation at the National Council for BH)
  - Average hospital ED waiting time for person without SMI 2 to 3 hours

“The Impact of Psychiatric Patient Boarding in Emergency Departments” (2012) (Nicks and Manthey):

- 35% of those consulted to psychiatry required inpatient care
- The average hospital ED length of stay was 1,089 minutes (just over 18 hours)

“Law Enforcement and Mental Health” (2017) Ruby Qazilbash Bureau Justice Assistance to Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC)

- In Madison, WI, law enforcement BH calls 3 hours versus 1.5-hour average contact
- By contrast, in the Arizona model BH calls 45 minutes to 1 hour (direct transport to sub-acute crisis urgent care with 5 to 7-minute turnaround, per Nick Margiotta)

2018 LONDON FIRST ANNUAL SUMMIT  
**URGENT** &  
EMERGENCY CARE





**2019**  
**WASHDC**

SECOND ANNUAL SUMMIT

**URGENT &**  
**EMERGENCY CARE**

# 4<sup>th</sup> International Zero Suicide Summit 2018: 'Moving beyond the tipping point'

September 3- & 4 - Rotterdam

**REGISTER NOW!**

[REGISTRATION FORM](#)

**Where?**

Rotterdam  
The Netherlands

**Who?**

70+ worldwide suicide  
prevention professionals

**What?**

Learning, sharing &  
working together

120  
Days

14  
Hours

38  
Minutes

24  
Seconds

## About the summit

Zero Suicide is a global movement that has mobilized professionals in the field of suicide prevention across the globe to cooperate in research and share prevention. "Beyond the Tipping Point" is the fourth international summit where we will come together to share our thoughts and knowledge in our belief that suicide is preventable. This year the summit will take place in The Netherlands. Zero Suicide will partner up with our Dutch colleagues from 113 to co-host the fourth global summit.

During this two day event, you will meet other suicide prevention experts and professionals from all over the world. In addition, you will have the opportunity to listen to a range of speakers sharing their valuable experience and providing inspiration. The intention is to be as interactive as possible to ensure we enable practitioners in the field to



**NASMHPD**

[Core Elements](#)

[The Report](#)

[The Video](#)

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[LEARN MORE](#)

# CrisisNow.com

*Thank you!*