The Friendly Front Door: An Effective, Community-Based Crisis Service System

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CEO
Community Partnership of Southern Arizona
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- 35 years of experience in behavioral health in southern Arizona
- President and CEO of Community Partnership of Southern Arizona (CPSA) and Community Partners, Inc. (CPI)
- Member of the National Leadership Forum on Behavioral Health/Criminal Justice Services of the National GAINS Center
- Tenured board member of the National Council for Community Behavioral Healthcare
What is Community Partnership of Southern Arizona (CPSA)?

CPSA is a community-based 501(c)(3) Regional Behavioral Health Authority for Pima County (GSA 5) since 1995. CPSA administers public behavioral health care in Pima County. 54,862 members served in FY12-13. +221% since FY95-96 (Includes both continuous care and crisis) Funded through the Arizona Department of Health Services/Division of Behavioral Health Services, Arizona Health Care Cost Containment System and SAMHSA.
Systemic Approach to Managing a System of Care

- Network Sufficiency
- Quality Oversight
- Fiscal Integrity
- Comparability of Care
- Strategic Planning
- System Initiatives
  - Child/Family Team
  - Adult Recovery Team
  - Criminal Justice Liaisons and Team
System Transformation

New Freedom Commission Report – Goals
(July 2003)

• Americans Understand Mental Health Essential to Overall Health
• Mental Health Care Consumer/Family Driven
• Eliminate Disparities in Mental Health Services
• Early Mental Health Screening
• Excellent Mental Health Care Delivered and Research Accelerated
• Technology Used to Access Mental Health Care

Framework for moving forward with a Crisis Service Network
Building the Crisis Response Center (CRC)
## Crisis System Timeline

<table>
<thead>
<tr>
<th>Year</th>
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<td>2011</td>
<td>2012</td>
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</table>
Crisis System Timeline

2005

- Economy booming
- Tucson growing
- Economic development
- More businesses being developed
- Lack of mental health infrastructure
Crisis System Timeline

2005

- Gaps in mental health crisis system
- Issues around inadequate funding
- Dramatic increase in the use of crystal meth/polydrug use
- Higher activity and greater complexity of cases
- Greater awareness of the intersection of mental illness/substance abuse and the justice system.
“... the effects of Aaron Swyers’ paranoid schizophrenia grew stronger and more terrifying as Wednesday wore on, leading to a tragic accident that claimed his life and the lives of Pima County Sheriff’s Deputy Timothy Graham and taxi driver Dawud Isa Abusida.”

- Arizona Daily Star, 8/13/2005
Bond Election - May 2006

• How could we focus attention on creating a psychiatric urgent care center?
• Developing better infrastructure for crisis services
• Creating better strategies managing community risks
Convening a Process Improvement Initiative

Importance of cross-system collaboration between criminal justice and behavioral health

Implementing philosophical/mindset change in both behavioral health & criminal justice

Developing a criminal justice team

Cross-training the overall behavioral health workforce
Key System Partners

- Community based service providers
- Hospital Emergency Rooms
- Law Enforcement (police and jail)
- Courts
- Fire Departments
- Primary Care and Health Plans
- Social services, including homeless resources
- Schools
- Child-serving agencies (DCS, etc.)
- Military and Veterans Administration
- Consumers and families
Crisis System Assessment

• Interview the stakeholders
• Interview the community
• Pull crisis system data
• Conduct a literature review on crisis systems
• Perform site surveys within the behavioral health system and the crisis system
“The Commitment”

- Decompress hospital Emergency Departments
- Safe and quick ‘drop off’ for law enforcement (diversion from jail)
- Alternative to juvenile detention
- Quick crisis mediation and return to community with service plan
Critical Components of a Crisis System

• 24-hour crisis telephone line (call and command center)
• Warmlines (pre- and post-crisis intervention)
• Community mobile response
• Walk-in crisis services (urgent care)
• Crisis stabilization (23-hour stabilization)
• Short term sub-acute (few days)
• Transportation
• Peer support and advocacy services
• Transition back into communities
Overarching Goals

Improve outcomes for CPSA members and their families

Improve public safety

Save taxpayer dollars
Crisis System Timeline

2006

- Ballot initiatives and bonds
- Funding for Psychiatric Urgent Care Facilities
- Funding for Psychiatric Inpatient Hospital Facilities
- Competing initiatives
  (Regional Transportation Authority concerns with sharing a ballot initiative with behavioral health)
- Board of Supervisors approval
Crisis System Timeline

2006

- Both bonds passed
- Steering committee formed
- Outreach to community partners
Initial Challenges

2007

• Challenge with turnover of key stakeholders
• Change management
• Alignment, realignment
• Building design
The Great Recession

- The economy crashes
- Budget cuts
- Benefit redesign
Impact of Recession

2009-2010

- Crisis System plans on hold
- Bond money unavailable due to unknown state budget
- When budget was set, the cuts added to the difficulty of building the CRC
Increased Demand, Fewer Resources

Due to the state of the economy, easily accessible crisis services became more necessary. Also due the state of the economy, the CRC became more difficult to build.
Shovel Ready

Groundbreaking occurred in October 2009

Partnership collaborated on:
- Construction
- Vendor selection
- Economic challenges
Events of January 2011

2005  2006  2007  2008  2009  2010  2011  2012
CPSA’s Role

Implementation of Disaster Plan

Alerted the crisis telephone response provider

Established Emergency Operations Center (EOC) Linked with County Administrator and Sherriff’s Department

Convened key behavioral health leaders

Collaborated with local, state, and national partners
CPSA’s Strategy

• To provide continuity of care for existing members
• To coordinate a response to tragedy-related mental health needs of the community
• Media messaging
Detox Component of Crisis Service Network

Opened Desert Hope

Streamlining Referrals - Aligning Procedure
- Land acquisition 2010
- Construction
- Opening and operation
  January 2011
Crisis Response Center (CRC) Grand Opening

- BHP completion
- CRC completion
- Move Community-wide Crisis line into CRC
- Sally Port collaboration with Law Enforcement
- CSP co-located staff
Crisis Response Center (CRC)

- Operates 24/7/365
- Adult 23-Hour Observation Chairs
- Juvenile 23-Hour Observation Chairs
- Adult Sub-acute wing
- Law enforcement sallyport
- Call Center Line is housed here
Crisis System and CIT

- Recovery starts at the crisis scene with the CIT officer
- Police transport is a vital first step
- Officers must:
  - Be reassuring
  - Reduce trauma
  - De-escalate the crisis
Criminal Justice Team (CJT) Outputs

CPSA’s Criminal Justice Team:

Monitor approximately 590 CPSA members in court-ordered treatment.

Facilitates almost 3,000 diversions from the justice system into treatment, avoiding more than 26,000 days in jail.

Provides Crisis Intervention Training to more than 150 law enforcement and corrections officers from 11 jurisdictions in Pima County. Excluding Tribal law enforcement, local agencies employ roughly 1,980 officers. For 2014, CPSA is on track to train more than 200 officers, or 10% of their workforce.
Arizona E/R Wait Time vs. CRC Wait Time
(April 2012 – April 2013)

Oro Valley: 169 minutes
St. Mary’s: 214 minutes
Tucson Medical Center: 211 minutes
Northwest Medical Center: 207 minutes
St. Joseph’s: 263 minutes
University of Arizona Medical Center: 309 minutes
University of Arizona Medical Center – South Campus: 357 minutes
Average: 246 minutes, or 3.06 hours

Average CRC wait time – 15 minutes
CRC Data
(FY 2014)

Number of crisis calls – 119,180
Total individuals served (face-to-face) – 13,852
Law enforcement transfers – 1,355
Emergency Department transfers - 600
### CRC Data

**Number of Adults Accessing Care**

(October 2013 – August 2014)

<table>
<thead>
<tr>
<th>Unit</th>
<th>Accessions</th>
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<tr>
<td>Adult Crisis Intervention Unit</td>
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<tr>
<td>Adult Crisis Stabilization Unit</td>
<td>4,751</td>
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<tr>
<td>Adult Short-term Inpatient Unit</td>
<td>1,258</td>
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</table>

The Adult CIC is the clinic where clients are first assessed. They can either be discharged from the CIC or sent to the CSU.

The Crisis Stabilization Unit is the 23-hour observation unit.

The Short-term Inpatient unit treats clients for over 24 hours, but usually only for a few days.
## Two-year Comparison of Individuals Seen & Services Delivered by the CRC

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<tr>
<th>Item</th>
<th>Totals for year</th>
<th>2012-13</th>
<th>2013-14</th>
<th>% increase</th>
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Adults Receiving Care at the CRC
(July 2013 – June 2014)

- Adult Crisis Intervention Clinic (Triage)
- Adult Crisis Stabilization Unit (23-hour observation)
- Adult Short Term Inpatient Unit (Subacute)
Children and Youth Receiving Care at the CRC
(July 2013 – June 2014)
Calls to the Community-Wide Crisis Line
(July 2013 – June 2014)
Mobile Acute Crisis (MAC) Team Dispatches (July 2013 – June 2014)
Average MAC Team Response Times (July 2013 – June 2014)

<table>
<thead>
<tr>
<th>Months</th>
<th>Minutes</th>
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<td>Mar.</td>
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<td>Apr.</td>
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<td>May</td>
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<tr>
<td>June</td>
<td>34</td>
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Non-emergency CRC Transports
(July 2013 – June 2014)
Law enforcement officers would have spent approximately 13,200 hours in ED wait-time vs. 660 hours in CRC drop-off time, saving 12,540 hours of law enforcement time.

The average cost to an ED to board a psychiatric patient has been estimated at $2,264 for the first day. Diverting 600 cases from the ED saves an estimated $1,358,400.

An average day in jail costs $80. CRC services avoided 26,000 jail days, saving $2,080,000.
Essential Elements for Creating an Effective, Community-Based Crisis Service System

• Shared Values
• Political Will
• Culture of Collaboration
• Leadership
• Community Inclusion
• Accountability
Questions?