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Launching Crisis Care In Northern Virginia:

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Immediate Access to Focused Crisis Care and Justice System/ED Diversion

Emergency/Crisis?

1. Someone to talk to

2. Someone to come to you

3. A place to go

The Outcome of this Approach-911

- 21% of total law enforcement staff time was used to respond to and transport individuals with mental illness in 2017 (TAC Road Runners Report);
- More than half of LA County inmates who have a mental illness don't need to be in jail according to a recent Rand study (2020); *and,*
- 80 percent of hospital ED medical directors reported that their hospital "boards" psychiatric patients and boarding can often last for over 24 hours, if not days/weeks (Abid et al, 2014).

Mental Health and/or Substance Use Crisis

1. Someone to call

Coming July 16th, 2022!

2. Someone to come to you

3. A place to go

The Crisis Now Difference

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CRISIS NOW ACADEMY

Arizona invests $110 million per year in Phoenix Metro in crisis care to serve anyone, anywhere, anytime. Local law enforcement engages 23,000 each year and connects them directly to crisis facilities and mobile teams without visiting a hospital emergency department or jail.

Aetna/Mercy Care 2017 report

WHAT DIFFERENCE DOES THIS MAKE?

6x better Crisis Clinical Fit to Need*

* simply, services that match a person's need

37+ FTE police officers now engaged in public safety**

** vs. transporting and attending in hospitals

45 yrs less total hospital detention

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

$260m lower overall health spend

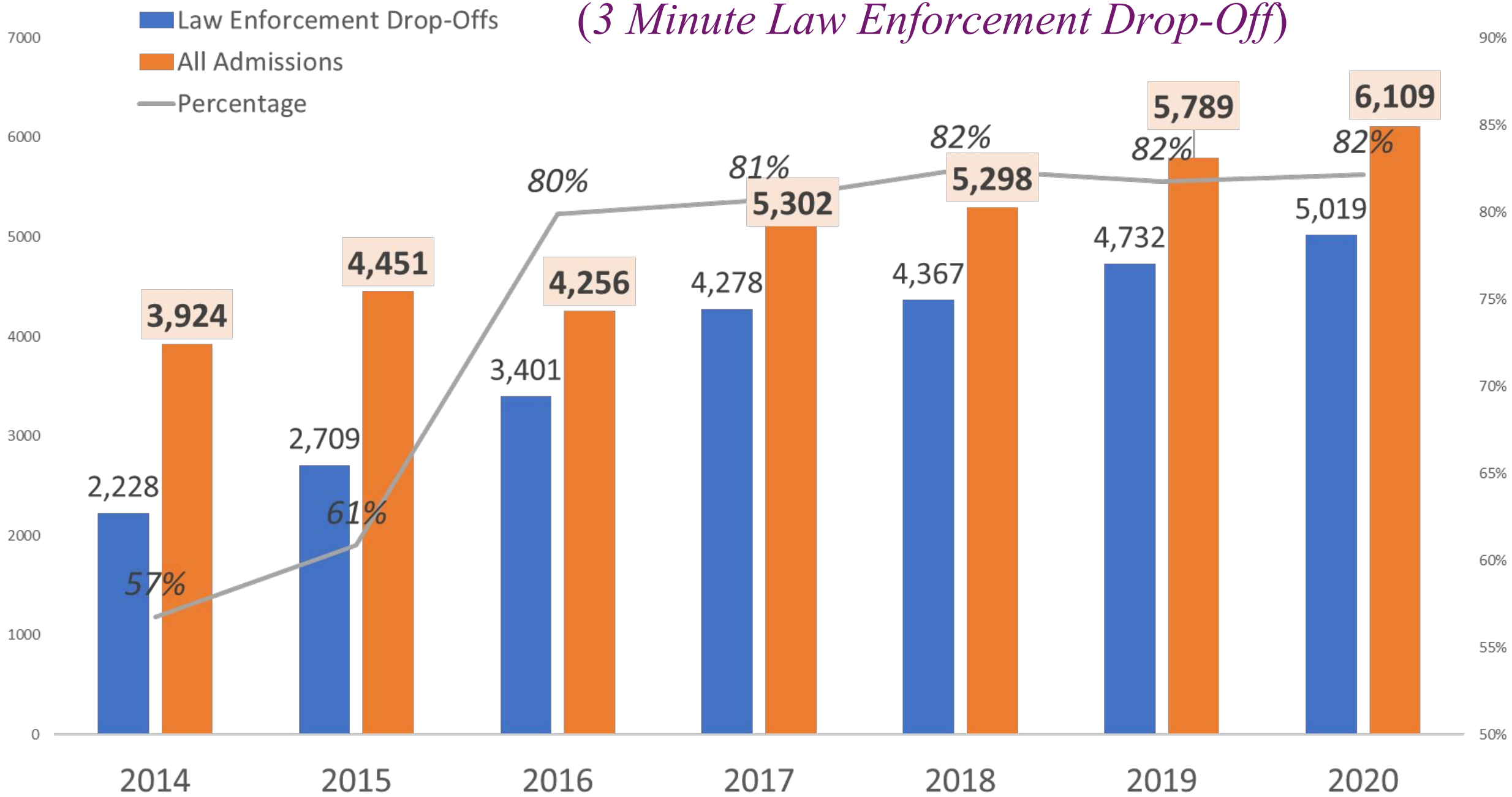
$37m avoided cost & losses in hospitals

priceless care that feels like care

Learn more at CrisisNow.com

Peoria AZ Referrals

(3 Minute Law Enforcement Drop-Off)



RI Approach / Crisis Now National Best Practice Model, with fidelity

1. **CRISIS CALL TRIAGE: Transition / transfer applicable calls directly to the crisis line**
   - 80-90% of all calls are resolved by phone and fewer than 1% are connected to 911 due to public safety or medical acuity concerns
2. **MCOT: Dispatch two-person mobile crisis teams to community locations as indicated**
   - Teams resolve 70-80% of calls in the community
   - Prioritize dispatch to law enforcement requests for support to shorten response time
   - Accept warm-hand off from law enforcement if they are first to respond to scene
   - **Only engage law enforcement** when there are immediate safety concerns (3% of mobile responses in AZ and 2% in GA)
3. **CRCs: Operate crisis receiving centers that accept ALL referrals in real-time**
   - RI International's Peoria AZ facility accepts over 400 law enforcement drop-offs monthly in an average of 3 minutes; have not declined a referral in 7 years.

RI Approach / Crisis Now National Best Practice Model for N. VA

The Critical Relationship between a CRC and a Short-Stay Crisis Unit when operated with fidelity.

- **The Crisis Receiving Center is a 24/7/365 acute crisis service that is a hybrid between a psychiatric ED/Inpatient level of care. Purpose is to provide rapid assessment/stabilization and diversion from EDs/jails/state hospitals. Will accept ECOs.** ***Highest level of behavioral health acuity.***
- **The co-located Short-Stay Stabilization Center will provide 3-5 day stays for people who require more time to resolve the crisis, detox. Will accept TDOs under 72-hour orders and attempt to resolve crisis or convert to voluntary status.** ***This service is = inpatient level of care***

Experience and Expertise… RI Team:

- Co-led the development of the National Action Alliance ***Crisis Now*** paper (2016) that has shaped much of the service design of the last five years;
- Were lead writers of the SAMHSA ***National Guidelines for Behavioral Health Crisis Care*** (2020);
- Co-Hosts the national **988 Crisis Jam** with leaders from all 50 states and federal partners on a weekly basis for support implementation efforts (Wed, noon EDT);
- Contracted for crisis services in 10 states;
- Support CIT training in multiple states and CIT International is a listed partner in the Crisis Now efforts (www.crisisnow.com);
- Are consultants on crisis system design in several states / counties throughout the nation (including California, Oregon, Alaska, Louisiana, Wisconsin and New Mexico) over the past two years; *and*
- Contributed language to national legislation, including the *National Suicide Hotline Designation Act* and *CAHOOTS*.

Crisis Now-Essential Principles and Practices pioneered by RI

- **The principles that provide the foundation of the "Crisis Now" model direct our practices. These include:**

1. *Safety for All*. We believe in "NO FORCE FIRST" and rarely use restraint or seclusion.
2. *Recovery Orientation* (Guest is full partner in care)
3. *Engagement* focus is Immediate (first goal for everyone/excellent customer services)
4. *Peer-powered* (peers employed 50%, real peer roles in milieu every day)
5. *Trauma-informed* (staff training, environments, values)
6. *Zero Suicide*
7. *Full Inclusion of all Partners* (funders, family, advocates, community, LE, EDs)

Our ASKS of the VA Legislature to Launch Crisis Now In Region Two.

IN SUMMARY:

- **The Primary Goals in the Crisis Now Model include:**

1. **Diverting people** in behavioral health crisis (MH/ SUD) from ED's, Jails, and EMS involvement
2. **Reducing expensive, unnecessary hospital stays** in state and community hospitals
3. **Avoiding delays** in providing timely, appropriate and targeted BH care to people in crisis to see better outcomes
4. **Getting Law Enforcement** back to their jobs (Public Safety) ≤ 5 minutes
5. **Avoiding ED-based medical clearance** processes (expensive, unnecessary)
6. **Help states reduce taxpayer burden** by leveraging federal Medicaid match & Commercial insurance.

Our ASKS of the VA Legislature to Launch Crisis Now in Region Two.

- **To see these outcomes, we need to be able to run Crisis Now services with fidelity to the model:**

1. **Understand that Crisis Now is a new evidence-based practice, not a current VA CSU, and requires a different set of licensure standards.**
2. **Need support to clarify Board of Pharmacy rules to allow for onsite stock medication access and storage for 24/7 use by MDs, NPs, and RNs as done in other states.**
3. **Help with DBHDS for access to a seclusion room, just like an inpatient facility or state hospital.**
4. **Legislative Code revisions to allow up to 23-hours to assess a new guest under an ECO, esp. if intoxicated or unable to engage.**
5. **General fund availability to open the 23-hour CRC: $ 2.8 Million.**
6. **Review Medicaid reimbursement rates to meet ongoing costs for this level of care and require commercial insurance providers to cover these new crisis services so tax payers are not having to fund insured people.**

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Questions?

Thank you!