



Behavioral Health Crisis Study - Crisis System Overview and Exemplary Models

With a renewed attention and energy focused on improving public behavioral health systems of care. Comprehensive crisis response and stabilization services have long been considered a crucial element of public behavioral health systems. There is a considerable body of evidence suggesting that comprehensive crisis services can improve outcomes for consumers, reduce inpatient hospital stays and costs, and facilitate access to other necessary behavioral health services and supports. In many communities, crisis response services also perform important public health, public safety, and community well-being functions.

Access and availability to behavioral health crisis services continues to be a complex gap in Colorado's behavioral health system. The goals of crisis services are to improve access to the most appropriate treatment resources and to decrease the utilization of hospital emergency departments, jails, prisons and homeless programs for behavioral health emergencies. Through improved crisis services we can ultimately provide crisis intervention, with the goal of creating a seamless integrated behavioral health care system, where consumers will receive appropriate, timely, and quality care.

Purpose of a Behavioral Health Crisis System

For persons experiencing behavioral health crises, a competent crisis response service system should be able to:

- Provide timely and accessible aid;
- Provide access to a wide range of crisis stabilization options;
- Stabilize them as quickly as possible and assist them to return to their pre-crisis level of functioning;
- Increase and maintain their community tenure;
- Increase their ability to recognize and deal with situations that may otherwise result in crises; and
- Increase or improve their network of community and natural supports, as well as their use of these supports for crisis prevention.

In order to fulfill the operational capabilities listed above, a crisis response system **must** be able to:

- Resolve crises for persons with serious behavioral health issues, 24 hours a day, seven days a week;
- Recruit and retain appropriately skilled and trained, linguistically and culturally competent staff that are capable of serving adults, children, adolescents, and families;
- Serve as a community resource for crisis response, stabilization, and referral of individuals, including children and adolescents, who are in crisis;
- Provide appropriate linkages and arrangements that alleviate the use of law enforcement as the primary responder to individuals in crisis, thus, minimizing the criminalization of persons with behavioral health issues;
- Provide services that are adequate for individuals with multiple service needs, specifically individuals with co-occurring disorders and/or accompanying medical conditions;
- Provide a range of crisis services that divert people from inpatient psychiatric hospitalization, emergency rooms to less costly service alternatives;
- Directly transport and/or arrange for the transport of individuals in crisis for treatment;
- Establish links with healthcare resources to provide and/or arrange for medical clearance, toxicology screens, and lab work, as well as medical and non-medical detoxification services;
- Coordinate with the consumer's primary behavioral health provider for follow-up and post-crisis care; and
- Incorporate evaluation protocols to measure the effectiveness of the crisis services.

Examples of crisis program components might include:

-  Telephone crisis services staffed by skilled professionals to assess, make appropriate referrals, and dispatch mobile teams;
-  Mobile crisis units with the ability to respond within one hour to a behavioral health crisis in the community (e.g., homes, schools, or hospital emergency rooms);
-  A range of short-term crisis residential services (e.g., supervised apartments/houses, foster homes, and crisis stabilization services); and
-  Urgent care services with the capacity for immediate clinical intervention, triage, and stabilization.

Crisis Services as an Integral Part of the Health Care System

There is growing recognition that behavioral health crisis services cannot and do not operate on the fringe of the health care system, but rather are mainstream activities necessary to complete the health care continuum. Crisis services cut across many different systems, including:

- **Social services:** Housing, medical benefits, child welfare, etc.;
- **Legal:** Involuntary confinement or detention for the purpose of treatment and evaluation;
- **Health:** Medical services; and
- **Community and personal safety:** Law enforcement assessment of danger to self or the community.

Due to this multi-system involvement in delivering crisis services, a psychosocial rehabilitation framework is promoted through the application of a “systems” approach to crisis service intervention. Such an approach ensures that no aspect of the life of the individual with mental illness is ignored or denied the necessary assessment or intervention.

For the purpose of this document, **crisis services are defined as:**

A collection of integrated services that is available 24 hours a day, seven days a week to respond to and assist individuals in a behavioral health emergency. These services are provided to persons who are in an emergency condition or crisis situation. The person’s need may be such that they require treatment to reduce the likelihood of death, harm to themselves or someone else, serious injury or deterioration of a physical condition or a major setback in their condition or illness. Examples of these services include but are not limited to: crisis hotlines, crisis residential and respite services, crisis/mobile outreach, short-term crisis counseling, crisis walk-in clinics, and crisis stabilization services to name just a few.

Service Components

A comprehensive crisis system (CCS) is designed to address and overcome many of the constraints inherent in a hospital-based setting, including time, space, and a lack of community treatment orientation.

Community-based crisis services, when well coordinated and implemented, are an effective and humane approach to service delivery for persons in psychiatric crisis. Rather than a single service response, a CCS encompasses a range of timely services that are integrated across multiple providers. A well-designed CCS can provide backup to community providers, perform outreach by connecting first-time users to appropriate services, and improve community relations by reassuring that persons with severe behavioral health issues will be supported during crises.

Of equal importance, a CCS must have the ability to address the needs of individuals with **co-occurring mental illness and substance abuse disorders**. Such co-occurring disorders are remarkably common. An estimated 10 to 12 million people live with co-occurring mental and addictive disorders nationwide.¹⁶ According to a paper written by Sciacca, 50 – 75 percent of those with severe mental illness also have a substance related problem. Research suggests that the mental health problems often predate the substance abuse problems by 4-6 years; alcohol or other drugs may be used as a form of self-medication

to alleviate the symptoms of the mental disorder. The capacity to address co-occurring disorders should be viewed as a **fundamental feature** of an effective CCS based upon the prevalence of co-occurring disorders in the population served.

The information in this section of the report will provide a general description of the core components of a comprehensive crisis system. The core components of a CCS system include:

- 24-Hour Crisis Telephone Lines (including Warm Lines)
- Walk-In Crisis Services
- Mobile Crisis Services
- Crisis Residential/Crisis Respite Services
- Crisis Stabilization Units

Although the names of the particular services may differ from system to system, their function is the same or very similar



24-Hour Crisis Telephone Lines

The telephone is often the first point of contact with the crisis system for a person in crisis or a member of his/her support system. Telephone crisis services should be available 24 hours per day to provide assessment, screening, triage, preliminary counseling, information, and referral services. A primary role of telephone crisis personnel is to assess the need for face-to-face crisis intervention services and to arrange for such services when and if indicated.



Warm-Lines

Warm lines are designed to provide social support to callers in emerging, but not necessarily urgent, crisis situations. Peer-run warm lines are a relatively new pre- and post-crisis service. Peers are current or former consumers of services who are trained to provide non-crisis supportive counseling to callers.

Warm lines focus on the following:

- (1) Building peer support networks and establishing relationships,
- (2) Active listening and respect for consumer boundaries, and
- (3) Making sure callers are safe for the night.¹⁹



Walk-in Crisis Services

Walk-in crisis services are provided through Urgent Care Centers in some communities. Services typically include:

- (1) Screening and assessment;
- (2) Crisis stabilization (including medication);
- (3) Brief treatment; and
- (4) Linking with services.

Single or multiple community agencies may be identified to address walk-in crisis and "urgent" situations on a 24-hour basis or through extended service hours.



Mobile Crisis Outreach

Mobile crisis teams are one of the most innovative components of a CCS. Mobile teams have the capacity to intervene quickly, day or night, wherever the crisis is occurring (e.g., homes, emergency rooms, police stations, outpatient mental health settings, schools, etc.). These teams can serve persons unknown to the system and often work closely with the police, crisis hotlines, and hospital emergency services personnel. Mobile teams can operate out of a wide variety of locations, either centralized or distributed throughout the community. Although some mobile crisis teams may specialize in serving adults or children exclusively, it is important to note that these teams often become involved in treating the entire family or other support system. Thus, an "extended intervention," which can include short-term counseling, may be necessary. In this instance, a mobile team member may act as the primary care provider until it is appropriate to transition the family into mainstream services.

Some mobile teams may have broad authority and responsibilities for service management that include, but are not limited to:

- (1) Providing pre-screening assessments or acting as gatekeepers for inpatient hospitalization of consumers utilizing public services; and
- (2) Managing and controlling access to crisis diversionary services.

In designing mobile crisis teams, it is critical to remember that what these teams do is far more important than the specific logistics of their operation. Some mobile teams operate 24 hours a day, whereas others operate only during nights and weekends, relying on community agencies or walk-in centers to handle crises during regular working hours. In some systems, mobile teams provide preventive support in the form of “wellness checks” for persons felt to be fragile or at risk.

While one of the goals of a mobile crisis team is to link consumers to community support services, teams vary in their capacity to accomplish this task. Clear channels of access that are established between the team and community programs prior to team operations greatly enhance this effort.

Crisis Respite/Residential Services

On occasion, resolution of a crisis may require the temporary removal of a consumer from his or her current environment. The purpose of crisis respite/residential services is to provide the individual in crisis with support in a calm, protected, and supervised non-hospital setting. During this period, the person can stabilize, resolve problems, and link with possible sources of ongoing support. A range of settings for residential/respite crisis support should be available to meet the varying needs and desires of individuals. Residential supports can be classified as either individual or group

Individual Residential Supports

Individual approaches serve one or two persons in a particular setting.

Examples include **family-based crisis homes** where the person in crisis lives with a screened and trained “professional family.” In addition to practical and emotional support from “family” members, professional providers visit the home daily to help the consumer develop a self-management treatment plan and connect with needed services.

A **crisis apartment** is another model of providing individual support. In a crisis apartment, a roster of crisis workers or trained volunteer staff provide 24-hour observation, support, and assistance to the person in crisis who remains in the apartment until stabilized and linked with other supports. In a **peer support** model, groups of consumers look after the person in crisis in the home of one of their members providing encouragement, support, assistance, and role models in a non-threatening atmosphere.

Finally, an **in-home support** approach, similar to a crisis apartment but in the person’s own residence, can be considered if separation from the natural environment is not felt to be necessary. A similar range of services as described in the family-based peer model above are available to consumers in their own home.

Group Residential Supports

Group respite/residential approaches have the capacity to serve more than two consumers at a time. These services are generally provided through crisis residences that combine two types of assistance – crisis intervention and residential treatment. **Crisis residences** offer short-term treatment, structure, and supervision in a protective environment. Services depend on the program philosophy, but can include physical and psychiatric assessment, daily living skills training, and social activities, as well as counseling, treatment planning, and service linking. Crisis residential services are used primarily as an alternative to hospitalization, but can also shorten hospital stays by acting as a step-down resource upon hospital discharge.

Crisis Stabilization Units (CSUs)

Crisis Stabilization Unit services are provided to individuals who are in behavioral health crisis whose needs cannot be accommodated safely in the residential service settings previously discussed. CSUs can be designed for both voluntary and involuntary consumers who are in need of a safe, secure environment that is still less restrictive than a hospital. The goal of the CSU is to stabilize the consumer and re-integrate him or her back into the community quickly. The typical length of stay in a CSU is less than five days. Consumers in CSUs receive medication, counseling, referrals, and linkage to ongoing services. Multi-disciplinary teams of behavioral health professionals staff CSUs, which generally cost two-thirds the amount of a daily inpatient stay.

23-Hour Beds

Twenty-three hour beds, also known as Extended Observation Units (EOUs), may be found in some communities as a stand-alone service or embedded within a CSU. Twenty-three hour beds and EOUs are designed for consumers who may need short, fairly intensive treatment in a safe environment that is less restrictive than hospitalization. This level of service is appropriate for individuals who require protection when overwhelmed by thoughts of suicide or whose ability to cope in the community is severely compromised. Admission to 23-hour beds is desirable when it is expected that the acute crisis can be resolved in less than 24 hours. Services provided include administering medication, meeting with extended family or significant others, and referral to more appropriate services.

Transportation

Transportation is an essential ingredient of the crisis system that ties all the service components together. The ability to transport individuals in need of crisis services in a safe, timely, and cost effective manner is critical to operations. The requirements for individuals who are authorized to transport persons in crisis vary between communities and may be determined by the legal status (voluntary versus involuntary) of the individual in need of treatment.

In some circumstances, mobile teams will coordinate transport with local law enforcement or emergency medical vehicles to assist individuals in receiving necessary care. Transportation within a crisis service system may also take other, less expensive forms. For example, crisis systems may arrange with private commercial entities, such as taxi companies, to transport individuals who are willing and able to be transported for treatment, but who lack resources to make the trip. Regardless of how a crisis system decides to provide transportation, there are several key factors for consideration in arranging or providing transportation for individuals seeking crisis services. These factors include:

- (1) Reliability;
- (2) Availability; and
- (3) Skill level of those involved in the transport.

Overview adapted from "A Community-Based Comprehensive Psychiatric Crisis Response Service" Prepared by the Technical Assistance Collaborative, Inc. April 2005

State Examples

Texas Crisis Services Redesign

The Texas Legislature appropriated \$82 million for the FY 08-09. This appropriation was specifically for a redesigned crisis service system. The first phase of implementation will focus on enabling statewide access to competent rapid response services, avoiding hospitalizations and reducing transportation issues.

Description of Crisis Services

Crisis redesign funds will be used to support an array of services recommended by the Crisis Redesign Committee, and the outpatient competency restoration services dictated under Senate Bill 867, Texas Legislature. This overall effort is associated with transforming the mental health system in Texas. The

Crisis redesign services will integrate many community organizations that play significant roles in the mental health and state's larger public health care system.

Additionally, Local Mental Health Authorities (LMHAs) may use some of the funds to defray transportation costs related to behavioral health crises incurred by local law enforcement agencies.

Two processes will distribute crisis redesign funds:

- 1) a majority of the funds will be divided among the state's LMHAs, added to existing contracts to fund enhanced crisis services.
- 2) A portion designated as Community Investment Incentive funding will be awarded on a competitive basis to communities willing to contribute at least 25% in matching resources. Funds will be available for the following services:

Initial crisis services. The first priority for funds allocated directly to Local Mental Health Authorities (LMHAs) will be ensuring a minimum level of the critical crisis services that provide rapid and mobile response to crisis situations: Crisis Hotline and Mobile Outreach Services. This will provide every county with basic crisis response capabilities, including identification, screening and stabilization of patients who can be safely treated in the community.

- **Hotline.** Crisis hotlines are a critical gateway to behavioral health services, offering toll-free telephone service 24 hours a day, 7 days per week to the public of all ages. Hotlines will be staffed by trained paraprofessionals that may answer the hotline and provide information and non-crisis referrals; however, trained Qualified Mental Health Professionals (QMHP-CSs) will provide screening and assessment of the call, to determine the nature and seriousness the contact. As part of crisis redesign, the American Association of Suicidology (AAS) will accredit all hotlines.
- **Mobile Outreach.** Mobile outreach services operate in conjunction with crisis hotlines, providing emergency care, urgent care, and crisis follow-up in the child, adolescent, or adult's natural environment. Mobile services allow immediate access to assessment and crisis resolution, regardless of the time and place of the precipitating event or the individual's transportation resources. A mobile crisis outreach team may also provide temporary services in the community to individuals who need psychiatric treatment, but refuses the traditional system to access care. Often these individuals have urgent needs, but do not meet criteria for involuntary detention. Mobile crisis outreach teams work closely with law enforcement and other local crisis responders.

Enhanced local crisis services. Once the minimum level of initial services has been achieved, local communities come together to develop a plan to use their funds to establish or expand additional crisis services recommended by the committee. This allows communities to enhance crisis service infrastructure for more extensive response and stabilization options, such as:

- **Crisis Outpatient Services.** Office-based outpatient services for adults, children and adolescents provide immediate screening and assessment and brief, intensive interventions focused on resolving a crisis and preventing admission to a more restrictive level of care. These services serve two purposes: 1) ready access to psychiatric assessment and treatment for new patients with urgent needs, and 2) access to same day psychiatric assessment and treatment for existing clients. Additionally, these services provide treatment for patients who are currently unlikely to hurt themselves or others, but who might develop an emergency if they do not receive same-day services. Clinicians are available during (Note: either use "all" or "business" to replace the word "appropriate") hours to treat individuals with fairly severe needs if a brief, moderately intensive, intervention might reduce the need for a more intensive level of care. Available services may include brief therapy, pharmacotherapy, and case management services.
- **Children's Outpatient Crisis Services.** Children's outpatient crisis services provide flexible, multi-faceted, and immediately accessible services when children and adolescents are at higher risk for hospitalization or out-of-home placement. These specialized services are provided in the child's living environment or in other settings, primarily in the home, and are designed to be family-focused, intensive, and time-limited.
- **Extended Observation Units.** Extended observation is an essential component of the crisis service array that can reduce unnecessary incarceration and inpatient psychiatric interventions. It

includes provision of comprehensive psychiatric emergency services with the goal of comprehensive assessment, rapid stabilization, and appropriate aftercare planning, and can include up to 23-48 hours of observation and treatment. These services provide immediate access to emergency care at all times and have the ability to safely and appropriately manage the most severely ill psychiatric clients. Services are delivered in a secure and protected environment generally co-located with a DSHS-licensed hospital or crisis stabilization unit.

- **Crisis Stabilization Units (CSU).** CSUs provide short-term residential treatment designed to reduce acute symptoms of mental illness. Services are provided in a secure and protected environment that is licensed under Chapter 577 of the Texas Health and Safety Code and Title 25, Part 1, Chapter 411, Subchapter M of the Texas Administrative Code (relating to Standards of Care and Treatment in Crisis Stabilization Units). CSUs are clinically staffed and psychiatrically supervised, and provide immediate access to emergency care.
- **Crisis Residential Services for Adults and Children.** Crisis residential services provide short-term, community-based residential, crisis treatment to adults, adolescents, and children with some risk of harm to self or others who may have fairly severe functional impairment. These facilities provide a safe environment with clinical staff on site at all times, however they are not designed to prevent elopement. Individuals must have at least a minimal level of engagement to be served in this environment. Utilization of these services is managed by the Local Mental Health Authority (LMHA) and is based on medical necessity. The recommended length of stay is 1 to 14 days. Adults, adolescents and children must be served in separate environments of care in the event services are provided.
- **Crisis Respite for Adults and Children.** In contrast to crisis residential services, crisis respite services provide short-term, community-based residential crisis treatment to individuals who have low risk of harm to self or others. Individuals may have some functional impairment requiring direct supervision and care, but do not require hospitalization. These services can occur in houses, apartments, or other community living situations. Generally, these services are for individuals who have housing challenges, or caretakers who need short-term housing assistance supervising individuals with mental health issues. The LMHA manages the utilization of these services based on medical necessity. Crisis respite services may occur over a relatively brief period, such as a 2-hour service to allow a caretaker to complete necessary tasks, or on a full day basis.

Community Investment Incentive

- **Psychiatric Emergency Service Center with Extended Observation services.** A portion of the Community Investment Incentive funds will be used for Psychiatric Emergency Service Centers that provide intensive crisis services for one or more counties or local service areas. These sites will be co-located with a licensed hospital or CSU and equipped to treat severely ill children, adolescents and adults. They will provide emergency psychiatric services with extended observation and, for individuals who cannot be stabilized within 23 to 48 hours, treatment in an inpatient hospital unit or CSU for up to 14 days. Establishing these facilities will substantially increase the number of communities and individuals with access to such services. It will also encourage communities to pool their resources to achieve economies of scale, ensuring the most efficient capacity utilization.
- **Projects for jail diversion or alternatives to State hospitalization.** Community Investment incentive funds will be used to develop other community-based projects that focus on diverting individuals from incarceration or providing alternatives to state hospitalization. These projects include crisis residential services, Crisis Stabilization Units, extended observation, crisis respite, the purchase of local hospital beds and associated services that provide residential alternatives to incarceration or state hospitalization.
- **Outpatient Competency Restoration Services.** Community Investment Incentive funds will support outpatient competency restoration services. DSHS proposed to extend its ability to provide competency restoration services beyond State Mental Health Hospital (SMHH) based programs. This is done through the development and enhancement of the mental health crisis system. A successful outpatient competency restoration program will enhance the communities' ability to provide effective treatments to individuals with mental illness involved in the legal system. This can be accomplished while reducing the burden on jails and state psychiatric

hospitals. Competency restoration services provide psychiatric stabilization in conjunction with any needed training in courtroom skills and behavior. Outpatient competency restoration programs established under this initiative will have an adapted curriculum from the inpatient competency restoration curriculum used at Florida State Hospital and North Texas State Hospital-Vernon Campus. Also adapted is the outpatient curriculum from DSHS's community mental health Resiliency and Disease Management system. The model will require strong collaborative efforts among local judges, jail officials, community mental health systems, and community-based organizations providing support services. DSHS is working with providers of outpatient competency restoration programs in other states to incorporate effective and successful strategies into the Texas model.

Pima County Arizona

Community Partnership of Southern Arizona (CPSA) is the state Regional Behavioral Health Authority that since 1995 has administered publicly funded mental health and substance use services for children, adults and their families in Pima County.

In 2005, members of the behavioral health, medical and criminal justice communities and local government recognized the need for expanded and coordinated psychiatric crisis services in fast-growing Pima County. Since that time, increased demand in the public health care system and reductions in the state's behavioral health funding have made the need for a cost-effective, responsive crisis system even more critical.

CPSA and its partners have worked to make its crisis-care system even more responsive, coordinated and comprehensive, with convenient and complementary locations for services. Crisis services are available to anyone in the community, regardless of income or whether they have insurance.

To aid coordination of services, **individuals having a behavioral health crisis are asked to call the free, 24/7 Community-Wide Crisis Line at (520) 622-6000 or 1-800- 796-6762.** Crisis line staff will have the latest information on immediately available services.

- **New Crisis Response Center (CRC)** provides services for anyone in Pima County experiencing a behavioral health crisis. It also serves as a central point for coordinating crisis services throughout the CPSA system, built with voter-approved (2006) Pima County bonds, will open in late summer 2011, as will the nearby Behavioral Health Pavilion operated by UPH Hospital. CPSA, Pima County, UPH Hospital and the University of Arizona College of Medicine have collaborated to create these state-of-the-art facilities behind UPH Hospital, on Pima County's Kino campus. Crisis Response Network of Southern Arizona (CRNSA) will operate the CRC for CPSA. In addition to providing recovery-focused crisis services for adults, children and their families when emergency medical care is not needed, the CRC will house a call center that will be the hub for CPSA's crisis system, providing telephone crisis-stabilization services and directing callers to community resources.

Highlights:

- Services available 24/7, including holidays.
- More than 60,000 square feet in total.
- A state-of-the-art facility with a contemporary look and a family-friendly setting.
- First floor highlights:
 - Comprehensive behavioral health crisis screening, triage and assessment for adults, children and youth who do not require emergency medical and/or acute psychiatric care.
 - 13 adult assessment and crisis stabilization areas for stays up to 24 hours.
 - 8 children and youth assessment and crisis stabilization areas for stays up to 24 hours.
- Second floor highlights:
 - 15 adult beds for crisis-stabilization stays of 24 hours or more.
 - State-of-the-art call center providing crisis telephone triage with mobile team dispatch.
 - Administrative offices and conference rooms with video conferencing capability.

- First responder entrance via a sally port that allows secure transfer of individuals in crisis.
- Front entrance and reception area separate from nearby Behavioral Health Pavilion.

Benefits to the Community:

- Improves available treatment alternatives, quality of service and coordination of care for vulnerable individuals in a behavioral health crisis.
 - Reduces demand on over-crowded hospital emergency departments.
 - Provides a one-stop drop-off point for law enforcement and other first responders, allowing them to more quickly return to the street.
 - Diverts non-violent mentally ill adult or youth offenders from jail or detention into the public behavioral health system.
 - Allow on-site behavioral healthcare providers to coordinate comprehensive care and quickly reintegrate individuals back to the community or home.
- **Southern Arizona Mental Health Center (SAMHC)**, which formerly operated the crisis line, now focuses on the delivery of face-to-face crisis services for walk-ins at 2502 N. Dodge Blvd., and provides expanded Mobile Acute Crisis (MAC) team capacity.
 - **Desert Hope**, a new substance abuse treatment center, opened in July 2011 across from UPH Hospital and the new CRC. Desert Hope is operated by Compass Behavioral Health Care and serves adults who are under the influence of alcohol and/or other drugs, many of them homeless, as well as individuals who need medically supervised detoxification services. Peer staff helps engage individuals in treatment and connect them with community resources. Coordination with local shelters and other organizations serving individuals who are homeless also will be increased. Desert Hope serves mostly individuals involved with law enforcement who otherwise might end up in emergency departments (EDs) or jail.
 - CPSA began coordinating **court-ordered evaluation services** for Pima County on Oct. 1, 2010. CPSA's approach is to divert individuals from hospital emergency departments to crisis services as clinically indicated and to reduce the number people admitted for court-ordered evaluation when less intense and less restrictive services would better serve the individual's needs.

How the Enhancements Benefit the Community

CPSA expects these changes to make the most of taxpayer dollars by:

- Reducing demand on over-crowded hospital EDs.
- Diverting people in crisis because of mental illness or substance use from more costly services such as jail or detention into treatment.
- Providing secure transfers for law enforcement and other first responders, allowing them to quickly return to the street.

Coordinated, cost-effective behavioral health crisis services in accessible, strategically located facilities will ensure that individuals in Pima County will receive appropriate crisis stabilization services and be able to return to the community in a timely manner.

State Statutory recognition of Behavioral Health Crisis Services

There are many examples of other state systems where behavioral health crisis services have been established and regulated in state statutes. These are just a few of the highlighted leading examples other examples do exist.

Established Behavioral Health Crisis Services

Minnesota – establishes a crisis system in statute and licensure requirements
 Maryland - establishes a crisis system in statute and licensure requirements
 Louisiana - establishes a crisis system in statute and licensure requirements

Crisis Stabilization Units - Defined recognized and oversight (licensing)

Florida
 Montana
 Arizona