Crisis Mobile

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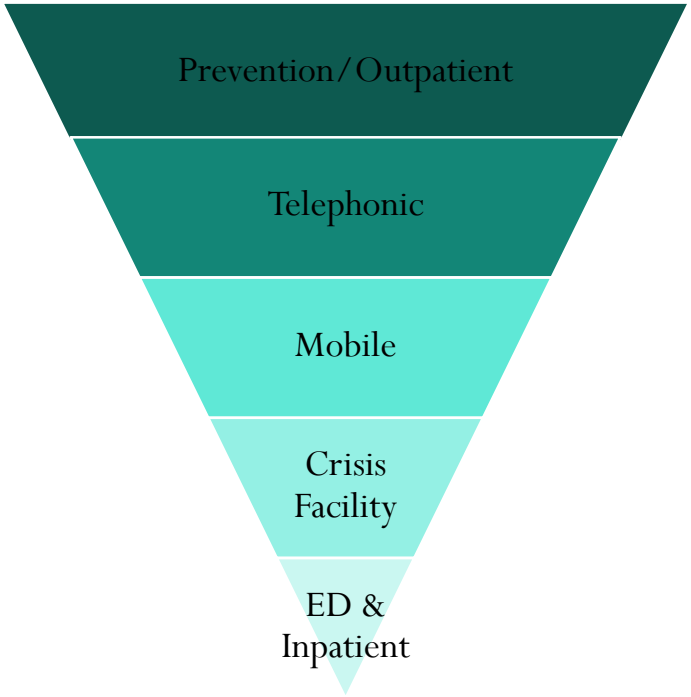
How Mobile Crisis Fits in the "Crisis Now" Model



Key "Precepts"

- **Ideal precepts of a mobile team – *how to get there can differ***
  - Community Based-not hospital
  - Stabilization vs. assessment
  - 24/7 "Quick" Response
  - 2 Person Responses
  - ED/Jail Diversion are key to key program and fiscal goals
  - Centrally Deployed "ATC" Model
  - Majority of responses do not require a law-enforcement response

What Does a Mobile Crisis Team "Do"

- **Provide Crisis Assessment, including a comprehensive Risk Assessment**
- **Crisis Intervention and de-escalation**
- **Safety plan with family/friends/supports involved;**
- **Arrange for HLOC if necessary (Detox, Crisis Facility)**
- **Transport When Necessary & Appropriate rather than using law-enforcement**
- **Set up follow up services; coordinate care for individual;**
- **Emergent petition/Non-emergent petition process**

"Goals"

- **Community stabilization**
  - Individuals tend do better in their natural environment: builds confidence for future crisis
- **Reduce Costs:**
  - Prevent over-use and misuse of emergency departments, psychiatric hospitalizations, and unnecessary law enforcement involvement
- **Reduce trauma**
- **Facilitate referrals**
- **Removes barriers to seeking mental health crisis care**
- **Collaboration with key partners (in the community at key intercept points)**

"Process"

- **Respond via central dispatch, that does initial safety triage and coordination**
  - Can respond without L.E. to DTS, STO, etc. based on certain parameters
- **Two-Person Responses…several variations i.e.**
  - Masters Level Clinician and Bachelors/BHT staff
  - Two BHT Staff
  - Peer Staff Partnered with other BH Staff
- **On-Scene Assessment & Risk Considerations**
  - Typically MT requests a L.E. Response less than 5% of all responses
  - If police already on-scene, focus is on releasing L.E. from scene as soon as possible.
- **Level-of Care Determination & Transport**
- **Coordination and Referrals**

Why Collaboration is Important

- Law Enforcement is often first to encounter individuals with mental health issues.
  - Can be Nexus to BH System & Treatment
- Does behavioral health really want individuals with mental health/substance abuse issues in the criminal justice system?
- Help Achieve BH System Goals
  - Reduce Suicide
  - Improved Client Outcomes
  - Efficiency
- Reconnections & Recovery Opportunities
- Early Intercepts are key to healthy communities, reducing suicide, reducing use jail, ER, crime, etc.

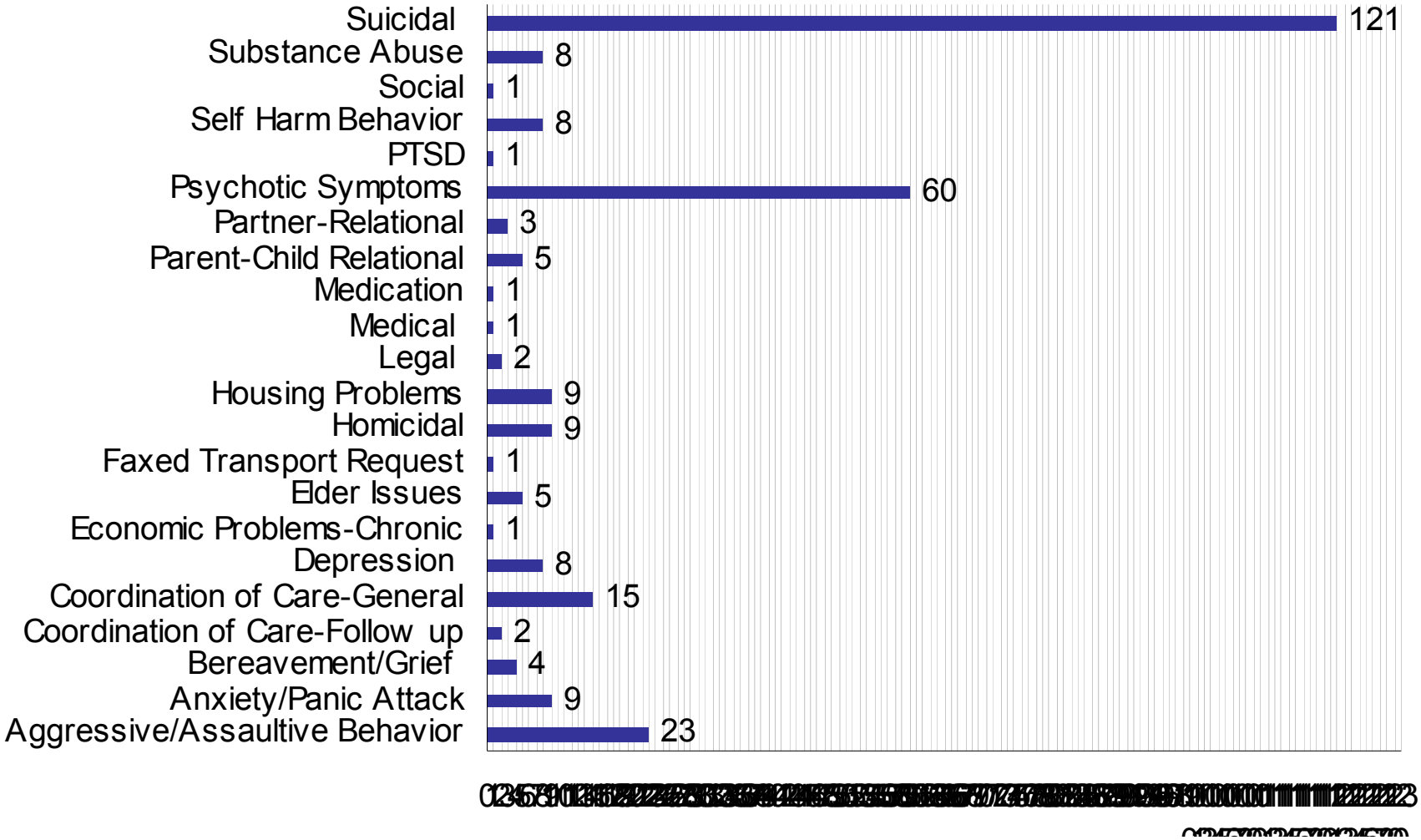
Law-Enforcement "Considerations"

- **Accessible and expedient hand offs to mobile crisis**
  - Quick and Certain Response Times
  - "We got this" attitude
  - Get Officers of-scene as soon as possible

- **Behavioral health only calling PD when safety concern exist**
  - Builds trust between law enforcement and behavioral health
  - Reduces belief about "dumping"
  - Individuals in Crisis may be escalated by PD presence; mobile team looks like 2 people coming to visit in an unmarked mini van

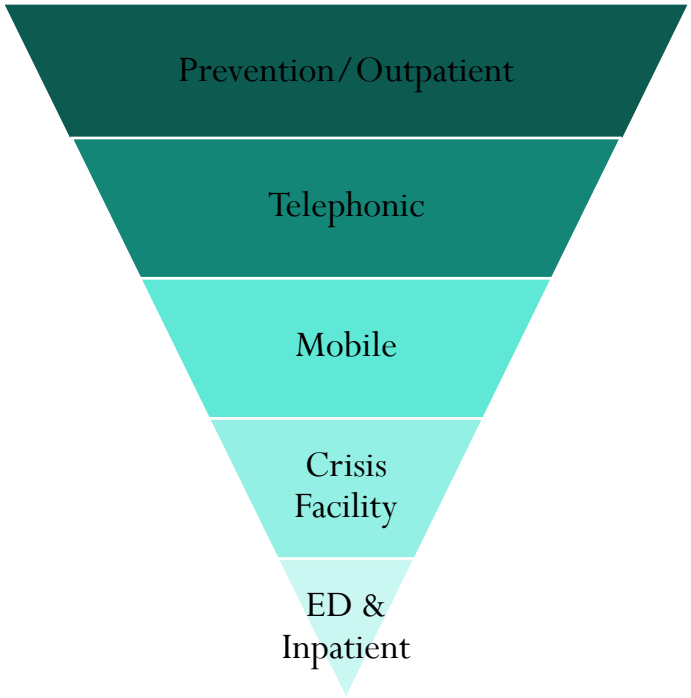
- **Law-Enforcement Requested Mobile Teams**
  - I.e. 3,000 Times a Year. Of the 18,000 MT Responses, less than 1,800 required any Police Response).
  - Vast majority Stabilized in their Community, only about 15% Transported to Psychiatric/Substance Community Based Receiving Center by Mobile Team.
  - Less than 3% Transported to Med/Surge E.D.

No. of PD Calls by Purpose



Examples

- **20,000 Crisis Calls a Month**
  - Less than 10% result in Crisis Mobile Dispatch
  - Less than 1% result in a Police Response Requested
- **1,600 Mobile Team Responses a Month**
  - Less than 10% of Mobile Team Responses required a Police Response
  - Roughly 75% Of all Mobile Team Responses Stabilize individuals in their "Community"
  - Of those that needed a HLOC, less than 3% transported to Med/Surge E.D. (i.e. minimal use of Ambo)
- **Crisis Observation Admissions**
  - Approximately 70-80% Stabilized and Discharged to Community
- **Involuntary Admissions**
  - About 70% do not "complete" the involuntary process (i.e. community stabilized, convert to voluntary, other levels of care, etc.)



Implementation & "Lessons Learned"

- **Staffing**:
  - Outpatient "perspective"
  - Shift-Work/Work Force
  - Funder Expectations
  - Perceptions:
    - Has "schizophrenia", don't go alone, keep cops on, etc
    - Nights are scary
- **Core measures…response time, time to release, community stabilization, etc.**
- **Roles of Peers**

Implementation & "Lessons Learned"

- **Rural Considerations**
- **Different culture & Language barriers**
- **L.E. More likely to use Crisis System when easy to navigate and faith that service will be fast and reliable**
  - ✓ MT responds quickly
  - ✓ Not a lot of "U.M." or Triage
  - ✓ Get officers off-scene early as possible

Questions?????