SUBJECT: *Mobile Crisis Teams*

DATE: *December 29, 2016*

TO: ABCGC: *Subcommittee on Crisis Services*

FROM: *UNM-ISR Staff*

**Problem Statement:**

A method is needed to connect and serve people in need of immediate acute mental health services in a familiar environment. People need acute mental health services in a familiar environment because of an inability or reluctance to seek outpatient services themselves.

**Executive Summary:**

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| --- | --- |
| Proposed Intervention: | Mobile Crisis Team (MCT) |
| Target Population:  | Currently the target population cannot be definitively established, but it can be estimated in a number of ways. The broadest population can be estimated using population estimates of all people in the community with mental health difficulties. SAMHSA estimates the prevalence of people in Bernalillo county with mental health problems in one year is approximately 136 people per 1,000 aged over 18 per one year (SAMHSA, 2014). Some portion of these individuals would be eligible for MCT services. More specific estimates can be derived from individuals contacting the NM Crisis Access Line (NMCAL) individuals who come in contact with APD’s Crisis Intervention Unit (CIU) and Crisis Outreach and Support Team (COAST), 911 calls that are for mental health that are not related to a crime, hospital emergency room and psychiatric emergency service contacts that do not require emergency treatment, and families and individuals who are seeking help. |
| Outcomes of Interest:  | MCT should address a series of questions:* Can MCTs help divert behavioral health clients away from jail?
* Does MCT reduce contacts with emergency hospital and psychiatric services?
* Does MCT impact the use and length of stay at inpatient mental facilities and jail?
* Does MCT decrease arrests and officer’s time involved with handling psychiatric emergency situations?
* Does MCT reduce client rates of participation in outpatient services pre and post MCT?
* Comparison of unexpected events after MCT contact, e.g., self-harm, violence to others, homelessness, further contact with the police,
* Changes in the client’s quality of life (i.e., measures through an assessment of coping strategies; reduction in utilization of emergency departments and higher levels of care; keeping people safe from suicide or other violence, or contacts with law enforcement or the criminal justice system; sustained participation in treatment),
* Measures of cost- effectiveness,
* Satisfaction among clients, families, and program staff.
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| Evidence Base:  | A co-responding police-mental health program collaborates specially trained police officers and mental healthcare workers to provide on-site services to people in the community. In a 2010 study by Forchuk, consistent themes emerged as to the strengths of mobile crisis services; a joint response is preferable as police are specialists in handling situations that involve violence and potential injury while mental health professionals are specialists in providing mental health consultation to officers and mental health care to individuals in crisis (Forchuk et al. 2010). These teams are based on the idea that the more police and mental health workers collaborate, the better the two systems can serve people and each other effectively (Rosenbaum, 2010). There are multiple objectives for the co-responding police-mental health program, including: de-escalating crises, preventing injuries to individuals in crisis and the response team, linking individuals who are experiencing psychiatric emergencies to appropriate services in the community, and reducing pressure on both the justice system (e.g. by decreasing arrests and officer’s time involved with handling psychiatric emergency situations) as well as the health care system (e.g. by decreasing unnecessary visits to the emergency department) (Borum, 2000; Matheson et al., 2005; Scott, 2000). Furthermore, these programs often aim to be accountable and cost effective.Connecting people in crisis with community services, rather than the justice system or acute care services, is thought to be the most appropriate way to support people and prevent reoccurrence of a crisis and ‘revolving-door’ recidivism (Lee et al., 2015; Kisely et al., 2010; Steadman et al., 2000).There is some evidence that the co-responding police-mental health programs are also cost effective (Scott 2000). |
| Description of Intended Program: | MCT is a community-based crisis intervention officer/civilian team providing immediate mobile crisis intervention services. Services are designed to improve an acute crisis episode and prevent inpatient psychiatric hospitalization or medical detoxification. Services are provided to adults, adolescents, and their families or support systems who have suffered a breakdown of their normal strategies or resources and who exhibit acute problems or disturbed thoughts, behaviors, or moods. These services are characterized by the need for highly coordinated services across a range of service systems. Crisis intervention services should be available on a 24–hour, 7-day a week basis. Services are provided by a mobile team. Crisis intervention services include: crisis prevention, primary assessment, secondary evaluation, acute crisis services, and support services. |
| Preliminary Budget: | $1,800,000 |

**Recommendation to the ABCGC:**

The ABCGC Subcommittee on *Crisis Services* recommends that Bernalillo County and the City of Albuquerque take steps to expand *services to people that have acute mental health needs* as described in this *Mobile Crisis Team (MCT)* Project Proposal.

Borum, R. (2000). Improving high risk encounters between people with mental illness and the police. Journal of the American Academy of Psychiatry and the Law, 28, 332–337.

Forchuk, C., Jensen, E., Martin, M. L., Csiernik, R., & Atyeo, H. (2010). Psychiatric crisis services in three communities. Canadian Journal of Community Mental Health, 29, 73–86.

Kisely, S., Campbell, L. A., Peddle, S., Hare, S., Pyche, M., Spicer, D., et al. (2010). A controlled before-and-after evaluation of a mobile crisis partnership between mental health and police services in Nova Scotia. Canadian Journal of Psychiatry, 55(10), 662–668.

Matheson, F. I., Creatore, M. I., Gozdyra, P., Moineddin, R., Rourke, S. B., & Glazier, R. H. (2005). Assessment of police calls for suicidal behavior in a concentrated urban setting. Psychiatric Services, 56(12), 1606–1609.

Rosenbaum, N. (2010). Street-level psychiatry-a psychiatrist’s role with the Albuquerque police department’s crisis outreach and support team. Journal of Police Crisis Negotiations, 10(1), 175–181.

Scott, R. L. (2000). Evaluation of a mobile crisis program: Effectiveness, efficiency, and consumer satisfaction. Psychiatric Services, 51(9), 1153–1156.

Steadman, H. J., Stainbrook, K. A., Griffin, P., Draine, J., Dupont, R., & Horey, C. (2001). A specialized crisis response site as a core element of police- based diversion programs. Psychiatric Services, 52, 219–222.

**SECTION 1: Problem Identification**

Problem Statement:

A method is needed to connect and serve people in need of immediate acute mental health services in a familiar environment. People need acute mental health services in a familiar environment because of an inability or reluctance to seek outpatient services themselves.

Problem Description:

In a business plan prepared in 2015 by Community Partners, Inc. (CPI) for the Bernalillo County Board of County Commissioners, it is noted that the New Mexico struggles to keep up with the growing demand for behavioral health professionals. According to the October 2015 report of the NM Health Care Workforce Committee, New Mexico has fewer psychiatrists per 100,000 population than the national average (13.8 vs. 14.2 nationwide) and fewer psychologists (32.4 vs. 33.9).

Another consideration pointed out by CPI was the availability of and access to physicians. The national physician search and consulting firm Merritt Hawkins recently issued a report ranking states in this area, based on 33 related factors that included physicians per 100,000 population, the percentage of state residents without health insurance, and federal poverty rates. New Mexico was ranked among the 10 states with the lowest access to physicians, at 48th out of 50 states. New Mexico has other workforce challenges including:

* High turnover among clinicians in public behavioral health settings, compared to primary- care settings;
* Limited number of providers specializing in child and adolescent psychiatry; and
* Limited access to independently licensed, master’s-level clinicians.

Due to the lack of qualified behavioral health professionals, the work of handling behavioral health crisis situations oftentimes falls to local law enforcement agencies. Law enforcement officers struggle to address the needs of people experiencing a behavioral health crisis. Law enforcement officers do not receive the level of training necessary to respond to a person exhibiting signs of a behavioral health disorder or significant emotional distress. Nor do officers have an adequate amount of time to devote to handling such calls. Diverting behavioral health calls to a team of behavioral health professionals and specially trained officers would free up officers and deputies to attend to other calls more appropriate to their level of training and interest. This would make the most of valuable resources and address appropriate needs by appropriate service providers.

CPI provided an initial assessment of gaps in the county’s behavioral health continuum of services. Services that could impact a person accessing care or continuing care as part of their recovery process. An effective crisis continuum would require key components that merge with existing services. Existing services may be limited in scope or have budget or jurisdictional limitations that restrict it from meeting the broader need of the community.

CPI calculated an average call volume of up to 128 calls per month were being responded to currently by law enforcement or fire fighters, calls that should be diverted to a special mobile crisis response team.

In their business plan, CPI recommended that the County establish six new services, of which mobile crisis teams were one necessary component that was missing from the County’s crisis continuum.

**SECTION 2: System Linkage Identification**

Currently in Bernalillo County the majority of mental health services offer outpatient care, case management, and recovery oriented services. Fewer services are available for crisis care, residential services, intensive outpatient services, and housing. Currently mental health services outside of the inpatient setting connect with people at the point of a crisis or most often in an emergency situation. The majority of services offered to outpatients deal with substance abuse problems. Private services are available but are expensive while public service providers are less costly but generally have a waiting list (UNM Dept. of Psychiatry et al.,2014).

Public providers such as the UNM Psychiatric Center Psychiatric Emergency Services (PES) offer psychiatric services in a 24-hour facility. Providers such as Assertive Community Teams (ACT) offer intensive outpatient services for extended periods of time. Other team providers especially those associated with the Albuquerque Police Department (i.e., Crisis Intervention Team “CIT”, and Crisis Outreach and Support Team “COAST”) fill a need for early responses in emergency situations. Providers located in facilities and mobile police crisis teams reach specific segments of the population that is either willing to go to a mental health facility for services or are involved in an emergency mental health situation, sometimes including law enforcement. Yet another portion of the population is unable or reluctant to seek acute mental health treatment. These people are not willing to go to a facility such as PES and they are acute in terms of the urgency of their mental health crisis. Thus they do not take advantage of the PES services. They may not come to the attention of the CIT or COAST or in some cases they do not reach the point of an emergency. Sometimes these individuals may contact the N.M. Crisis Access Line (NMCAL).

Funding for intensive outpatient programs is expensive and consistent funding is difficult to acquire and difficult to maintain. Consistent funding for innovative team concepts is difficult to obtain and keep. Most programs are financed with public funds. Some programs are piloted using limited funding from grants-in-aid and later may acquire recurring government funding if they are shown to be successful or politically popular.

Established programs and services such as PES, ACT, CIT, and COAST have found a niche in the community. They have access to funding, an adequate number of clients, and have been functioning long enough to be established in the community. New programs attempting to reach a segment of the population that is not being served by PES, ACT, CIT, or COAST, need to connect and communicate with these established programs to prevent overlapping services.

UNM Department of Psychiatry and Behavioral Sciences, UNM Center for Education on Policy and Research, and RWJF Center for Health Policy at UNM. (2014) Landscape of Behavioral Health in Albuquerque. Online at https://www.cabq.gov/council/documents/task-force-on-mental-health-documents/BHTF\_20141028CityProjectReportFinal.pdf

**SECTION 3: Target Population**

Mobile Crisis Teams (MCTs) are mobile services that provide psychiatric emergency care to individuals experiencing a behavioral health crisis in the community. The target population consists of persons of any age, who are experiencing a behavioral health crisis.

Currently the target population cannot be definitively established, but it can be estimated in a number of ways. The broadest population can be estimated using population estimates of all people in the community with mental health difficulties. SAMHSA estimates the prevalence of people in Bernalillo county with mental health problems in one year is approximately 136 people per 1,000 aged over 18 per one year (SAMHSA, 2014). Some portion of these individuals would be eligible for MCT services. Further, the NM Department of Health measures the frequency of mental distress. Using data from the NM Behavioral Risk Factor Surveillance System (BRFSS) the NMDOH estimated between 2012 – 2014 18.3% of Bernalillo County adults experienced frequent mental distress (<https://ibis.health.state.nm.us/community/highlight/report/GeoCnty/1.html>).

Because the goals of MCTs primarily focus on providing community-based services to stabilize persons experiencing emergencies in the least restrictive environment, to decrease arrests of mentally ill people in crisis, to reduce police officers’ time handling psychiatric emergency situations (Scott, 2000), and to reduce hospitalization rates by diverting patients from hospital admission into community-based treatment (Guo et al., 2001) more narrow estimates can be derived.

More specific estimates can be derived from individuals contacting the NM Crisis Access Line (NMCAL)individuals who come in contact with APD’s Crisis Intervention Unit (CIU) and Crisis Outreach and Support Team (COAST), 911 calls that are for mental health that are not related to a crime, hospital emergency room and psychiatric emergency service contacts that do not require emergency treatment, and families and individuals who are seeking help. Currently data from all these sources either is not available or does not exist to provide an estimate. NMCAL handles approximately 1,400 calls per month statewide and approximately 35% of these calls originate in Bernalillo County. CET could respond to “emergent calls” and likely handle more serious “urgent calls.”[[1]](#footnote-1) We estimate this to be an average of 90 calls per month for individuals 18 years of age and older. People from both call levels may possibly seek a rapid response to an event from the CET.

Preliminary data from the UNM Psychiatric Center Psychiatric Emergency Services (PES) suggests that a segment of individuals who present to the PES or Psychiatric Urgent Care Center (PUCC), who are referred by APD may be eligible for MCT services. This primarily includes individuals who have a higher acuity level upon arrival. In discussions with PES staff individuals who present with a Level III or Level IV acuity level and who are not eligible for PES services may be eligible. Table 1 provides a monthly estimate for Level III and Level IV clients.

The estimate shown in Table 1 is the average number of individuals by each time period (calendar year 2015 and January 2016 – October 2016) and the average number of individuals for the entire time period who were assessed by PES as being Acuity Level III and Acuity Level IV. Based on our review, for the time period of January 2015 through October 2016 there were an average of 95.7 individuals per month assessed as Acuity Level III and 237.3 individuals per month assessed as Acuity Level IV. Recall only a portion of individuals in both Acuity Levels will be eligible for MCT and currently we cannot estimate this number.

Table 1 – PES Acuity Level

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| --- | --- | --- | --- |
| **Acuity Level** | **2015** | **2016 (thru October)** | **Total** |
| Level III | 85.8 | 95.7 | 95.7 |
| Level IV | 247.3 | 225.5 | 237.3 |
| Total | 333.1 | 321.2 |  |

Some preliminary data is also available using APD CIT related data. These data provided by APD showed that between January 2016 and October 2016 of 2,064 CIT related incidents reported by APD field officers 1,606 (51.6%) were transported to area hospitals that includes UNM’s PES. It is not known what portion of these calls would be eligible for MCT services. APD CIT trained officers also come into contact with individuals who might be eligible for MCT services. We currently do not have an estimate of how many of these individuals might be eligible for MCT services.

SAMHSA. (2014). Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2012, 2013, and 2014.

Note: The formula for this calculation multiplies the 2014 US Census population for Bernalillo county (671,429) by SAMHSA’s estimate of the average yearly percentage of adults in Bernalillo county with a serious mental illness between 2012 and 2014 (20.24%). (671,429\*20.24% =135,897)

**SECTION 4: Outcome Identification**

A resource that meets the needs of people at the acute mental health level must deliver measureable services and achieve specific performance measures and outcomes. In general, the resource should address a series of questions:

* Can MCTs help divert behavioral health clients away from jail?
* Does MCT reduce contacts with emergency hospital and psychiatric services?
* Does MCT impact the use and length of stay at inpatient mental facilities and jail?
* Does MCT decrease arrests and officer’s time involved with handling psychiatric emergency situations?
* Does MCT reduce client rates of participation in outpatient services pre and post MCT?
* Comparison of unexpected events after MCT contact, e.g., self-harm, violence to others, homelessness, further contact with the police,
* Changes in the client’s quality of life (i.e., measures through an assessment of coping strategies; reduction in utilization of emergency departments and higher levels of care; keeping people safe from suicide or other violence, or contacts with law enforcement or the criminal justice system; sustained participation in treatment),
* Measures of cost- effectiveness,
* Satisfaction among clients, families, and program staff.

Performance measures should be evaluated as well as outcomes. Measures associated with the performance of an acute service could be: is the service utilized at the anticipated rate of use, at what percentage do women and adolescents use the service, are acute mental health hospital beds used inappropriately and does the new resource affect this situation?

In addition to outcomes and performance measures, client and staff satisfaction should be measured. Questions such as: what were clients particularly happy with and found useful, what was the effectiveness of the help they received, what are the benefits of emergency intervention at home, what is the benefit of having staff available at any time of the day or night, what is the importance of the frequency of visits and a quick response from the MCT, does assistance with practical help such as help with benefits, and referral services impact clients. Staff satisfaction includes – job satisfaction, emotional exhaustion, personal accomplishment, team role clarity, and personal role clarity (MHCA, 2011).

**SECTION 5: Best Practice Identification**

The interaction between police officers and individuals who experience a mental health crisis is high and increasing in North America (Coleman and Cotton 2010). Between 7 and 31% of police calls involve a person with mental illness (Abbot 2011; Baess 2005; Wilson-Bates 2008). The increase in police involvement with mental illness is reported to be due to a number of factors including de-institutionalization (i.e. more individuals with psychiatric issues residing within the community), fewer psychiatric hospitals and hospital beds, decreased hospitalization, and changes in mental health laws (Cotton and Coleman 2006; Fisher et al. 2006; Lamb et al. 2002).

A co-responding police-mental health program involves a collaboration of specially trained police officers and mental healthcare workers that provide on-site services to consumers in the community. In a 2010 study by Forchuk, consistent themes emerged as to the strengths of mobile crisis services; a joint response is preferable as police are specialists in handling situations that involve violence and potential injury while mental health professionals are specialists in providing mental health consultation to officers and mental health care to individuals in crisis (Forchuk et al. 2010). As Rosenbaum (2010) explains: these teams are based on the idea that the more police and mental health workers collaborate, the better the two systems can serve consumers and each other effectively. There are multiple objectives for the co-responding police-mental health program, including: de-escalating crises, preventing injuries to individuals in crisis and the response team, linking individuals who are experiencing psychiatric emergencies to appropriate services in the community, and reducing pressure on both the justice system (e.g. by decreasing arrests and officer’s time involved with handling psychiatric emergency situations) as well as the health care system (e.g. by decreasing unnecessary visits to the emergency department) (Borum 2000; Matheson et al. 2005; Scott 2000). Furthermore, these programs often aim to be accountable and cost effective.

Connecting individuals in crisis with community services, rather than the justice system or acute care services, is thought to be the most appropriate way to support consumers and prevent reoccurrence of a crisis and ‘revolving-door’ recidivism. Some research has evaluated this claim. Steadman et al. (2000) examined three sites’ dispatch calls and found that in situations where a specialized response was present, the co-responding police mental health program in Knoxville had the largest proportion of referrals to treatment services compared to the other models (36%, compared to 0% in Memphis’s CIT model, and 3% in Birmingham’s program whereby civilian officers assist police officers in mental health crises). When the co-responding police- mental health program in Knoxville responded to a mental health crisis, they were more likely to refer an individual to case managers, mental health centers, or outpatient treatment, compared to the other two specialized models. This is not an isolated finding. In 2010, Kisely et al. found that individuals who had been in contact with the co-responding police-mental health program in Halifax showed greater service engagement than control subjects, as demonstrated by increased outpatient contacts. A study done by Lee et al. (2015) conducted an evaluation of an Australian joint police-mental health mobile response unit (A-PACER), that aimed to improve the delivery of a community-based crisis response. Activity data were audited to demonstrate utilization and outcomes for referred people. Police officers and mental health clinicians in the catchment area were also surveyed to measure the unit’s perceived impact. During the 6-month pilot, 296 contacts involving the unit occurred. Threatened suicide (33%), welfare concerns (22%) and psychotic episodes (18%) were the most common reasons for referral. The responses comprised direct admission to a psychiatric unit for 11% of contacts, transportation to a hospital emergency department for 32% of contacts, and community management for the remainder (57%). Police officers were highly supportive of the model and reported having observed benefits of the unit for consumers and police and improved collaboration between services (Lee et al. 2015). Findings of this study revealed that the majority of contacts were successfully responded to in the community, with only 32% of contacts requiring transportation to a hospital emergency department for care. A further 11% of contacts were directly admitted to a psychiatric inpatient unit (following completion of a mental health assessment by the A-PACER clinician), enabling more rapid access to specialist (specialized) care. With other contacts resulting in referral to local housing, welfare or drug treatment services, the underlying cause of mental health crisis was made more readily known (Lee et al, 2015). Multiple perceived benefits were also reported, summarized by four themes: enhanced outcomes for consumers (e.g. more sensitive and timely response to health issue for consumer), more efficient use of police resources (e.g. can free up police to respond to other jobs), enhanced outcomes for police (e.g. get help from a mental health expert or unit), and improved collaboration between services (e.g. better communication, feedback, and access to information) (Lee et al., 2015).

*Cost Benefit*

The goals of the crisis teams are presented as humanitarian rather than economic; however, there is some evidence that the co-responding police-mental health programs are also cost effective (Scott, 2000). A mobile response program in Georgia in the US, had the aims of reducing the number of hospitalizations, delivering a more effective and efficient response, and reducing costs (Scott, 2000). Compared to a traditional police response, a joint police and mental health response resulted in a 23% reduction in the average cost per case and an increase in the proportion of cases avoiding psychiatric hospitalization (55% with a joint response; 28% with traditional police response) (Scott, 2000). According to the supervisor in San Diego County’s second district, their corresponding police-mental health program potentially saves more than $2,000,000 a year in the western division of the San Diego Police Department through decreasing jail costs and officer savings by as much as $2,200 per contact (Rosenbaum, 2010). In Melbourne, the operation of PACER was found to be less costly, reducing the time to assessment and resulted in fewer consumers being transported to hospital ED for care (19% of cases with PACER; 82% of cases with usual care) (Lee et al., 2015).

The literature clearly shows that linking individuals in crisis with community mental health services is a particularly important aspect to be emphasized in the co-responding police-mental health programs.

**Model 1:** Civilian Team

A study using an interdisciplinary team composed of crisis intervention specialists, registered nurses, and psychiatrists managed by a community mental health agency indicated that community-based MCTs resulted in lower rates of hospitalization than hospital-based interventions. The study showed that a consumer in the hospital-based intervention group was 51 percent more likely to be hospitalized than a consumer in the community-based mobile crisis intervention group (Guo et al., 2001). Case management services in addition to their crisis intervention duties was made possible by the number and interdisciplinary group of mental health professionals making up the MCTs (Guo et al., 2001). The study did not describe how the MCTs reacted to violent and potentially violent clients. In another study (Alexander & Zealberg, 1999), a Mobile Crisis Program implemented in Charleston, South Carolina had a staff that consisted of attending psychiatrists, psychiatric residents, nurses, master’s level clinicians, and administrative personnel. Additionally, third or fourth year medical students also served as part of the team with post-doctoral fellows in psychology, graduate students in social work or nursing, pharmacy students, and paramedics. All cases for assistance in critical incidents involving law enforcement agencies (i.e. bridge jumpers, or suicidal or homicidal people barricaded in houses) are responded to not only in Charleston County, but in the two adjacent counties as well. This mobile crisis program, however, does not respond only to law enforcement referrals, they also respond to community callers. The article concluded that not only did this MCT model prove advantageous to EMS and law enforcement authorities, but it also offered psychiatric residents and professional students exposure to community psychiatry in its truest sense. Overall, the studies conclude that civilian MCTs are effective in diversion from hospitals and jail. Civilian MCTs are able to take referrals and calls from the community, not exclusively from the police force.

**Model 2:** Officer/Civilian Team

Studies on officer/civilian MCTs provide suggest that an MCT must have a licensed mental health professional on the team for best results in hospital diversion. One study found that when a mobile psychiatrist was added to a Crisis Intervention Unit, the number of hospital admissions decreased greatly in comparison to the Crisis Intervention Unit lacking a mobile psychiatrist (Reding & Raphelson, 1995). The number of the members on the MCT can vary, but our review found teams typically contain no more than 2 to 3 members. A study of a program in DeKalb County, Georgia noted the program was staffed with four police officers and two psychiatric nurses who rotated work hours in teams of two officers and one nurse. The teams operated from 3 p.m. to 10:30 p.m. seven days a week and had a psychiatrist available for telephone consultation at all times (Scott, 2000). Another study (Lamb et al., 1995) followed one hundred and one consecutive referrals to law enforcement-mental health teams in Los Angeles to see if an outreach team comprised of a mental health professional and a police officer could assess and make correct dispositions for psychiatric emergency cases in the community. Both studies came to similar conclusions concerning the proper treatment of persons experiencing a mental health crisis. The DeKalb County, GA study found MCTs can decrease hospitalization rates for persons in crisis and can provide cost-effective psychiatric emergency services that are favorably perceived by consumers and police officers (Scott, 2000). The Los Angeles, CA study concluded that outreach emergency teams composed of a police officer and a mental health professional were able to deal appropriately with persons who have acute and severe mental illness, a high potential for violence, a high incidence of substance abuse, and long histories with both the criminal justice and mental health systems, while avoiding criminalization of those in crisis.

Both models of civilian MCTs and officer/civilian MCTs are effective in fulfilling the main goals of diversion and on-site crisis stabilization/intervention. Civilian MCTs are more equipped to deal with on-site treatment and swift evaluation, but may not have the training and resources to deal with potentially violent situations. On the other hand, officer/civilian MCTs are more equipped to deal with potentially violent situations but have less on-site treatment options because of the composition of the team. Civilian MCTs are proven to be able to take calls from law enforcement and respond to crises and stabilize/intervene and divert citizens. If violent calls are received by civilian MCTs they are most likely from law enforcement; but if the calls are from the community civilian MCTs can make contact with law enforcement. The officer/civilian MCTs are proven to effectively deal with persons who have acute and severe mental illness, and a high potential of violence. The research for civilian MCTs has not conclusively shown how they deal or can deal effectively with persons of violent potential or if they even need to deal with violent individuals at all. After the crisis is stabilized, MCTs are designed to route patients to appropriate treatment which includes crisis stabilization and respite services. In an extreme case, MCTs can take patients to psychiatric emergency departments (PED). Crisis stabilization and respite services are effective alternatives to a hospital emergency department (ED) or an inpatient setting, providing 23-hour crisis stabilization care and proper step-down services. These programs can be effective alternatives to EDs that provide in-patient type services in a home-like or residential setting.

**Model 3:** Peer Support Services

Peer Support Service is an individualized, recovery focused approach that promotes the development of wellness self-management, personal recovery, natural supports, coping skills, and self-advocacy skills and development of independent living skills for housing, employment and full community inclusion (Alliance Behavioral Healthcare). Peer supporters are people who use their experience of recovery from mental health disorders to support others in recovery. Combined with skills often learned in formal training, their experience and institutional knowledge put them in a unique position to offer support (Mental Health America). In both mutual support groups and consumer-run programs, the relationships that peers have with each other are valued for their reciprocity; they give an opportunity for sharing experiences, both giving and receiving support and for building up a mutual and synergistic understanding that benefits both parties (Mead, Hilton, & Curtis, 2001). In contrast, where peers are employed to provide support in services, the peer employed in the support role is generally considered to be further along their road to recovery (Davidson, Chinman, Sells, & Rowe, 2006). Peers use their own experience of overcoming mental distress to support others who are currently in crisis or struggling. This shift in emphasis from reciprocal relationship to a less symmetrical relationship of ‘giver’ and ‘receiver’ of care appears to support the differing role of peer support in naturally occurring and mutual support groups and peer support workers employed in mental health systems.

The literature demonstrates that peer support workers can lead to a reduction in psychiatric hospital admissions among those with whom they work. Additionally, associated improvements have been reported on numerous issues that can impact the lives of people with mental health problems (Repper, 2011). According to the literature, some benefits for consumers from peer support services are admission rates to psychiatric hospitals and community tenure, empowerment, social support and social functioning, empathy and acceptance, and reducing stigma. Some randomized controlled trials comparing the employment of peer support workers with care as usual or other case management conditions report either improved outcomes or no change. Solomon and Draine (1995) in a 2-year outcome study reported no differences in the impact of care provided by peers and care as usual on hospital admission rates or length of stay. Similarly, O’Donnell et al. (1999) reported no significant difference in admission rates when comparing three case management conditions; standard case management, client-focused case management, and client-focused case management with the addition of peer support. It is important to note that a result of no difference demonstrates that people in recovery are able to offer support that maintains admission rates (relapse rates) at a comparable level to professionally trained staff. However, Clarke et al. (2000) found that when assigned to either all peer support worker or all non-consumer community teams that those under the care of peer support workers tended to have longer community tenure before their first psychiatric hospitalization. This study was based on following two Assertive Community Treatment (ACT) teams in Oregon, one comprised of peers (case workers with a mental health diagnosis) and one with no peers. Furthermore, in a longitudinal comparison group study, Min, Whitecraft, Rothband, and Salzer (2007) found that consumers involved in a peer support program demonstrated longer community tenure and had significantly less re-hospitalizations over a three-year period. In regards to social support and social functioning, a longitudinal study, Nelson, Ochocka, Janzen, and Trainor (2006) reported that at three-year follow-up, consumers continuously involved in peer support programs scored significantly higher than comparison groups on a measure of ‘community integration’, which was assessed using the meaningful activity scale.

According to SAMHSA (2009), effective roles of peer supported services are providing mentoring and coaching, connecting people to needed services and community supports, and helping in the process of establishing new social networks supportive of recovery. Currently there are many forms of peer support services offered. As mentioned before, the ACT team is a SAMHSA evidence-based model that provides comprehensive treatment and support services to individuals who are diagnosed with serious mental illness. This is achieved through continued care provided at the consumers’ home or in the community. Most of the time, ACT teams are multidisciplinary teams made up of clinicians, nurses, case managers, substance abuse specialists and peer support specialists. Target populations are identified by referrals, post-psychiatric hospitalizations, and post-incarcerations.

Also, many current peer supported services are respite based. Peer-run crisis respites are usually located in a house in a residential neighborhood. They provide a safe, homelike environment for people to overcome crisis. The intended outcomes are diverting hospitalization by building mutual, trusting relationships between staff members and users of services, which facilitate resilience and personal growth (Ostrow, 2011). The National Coalition for Mental Health Recovery (NCMHR), a driving force behind the establishment of peer-run crisis respite services nationwide, has described PRCRs as a place for people in crisis to process stress, explore new options for short-term solutions, increase living and coping skills, and reduce susceptibilities to crisis in an environment that provides support and social connectedness. Evidence is still being compiled for peer-run crisis respites, but one randomized controlled trial of a PRCR has been conducted (Greenfield et al.,2008). This study found that the average rate of improvement in symptom ratings was greater in the alternative than in the hospital comparison group, and that the peer-run alternative group had much greater service satisfaction. The cost was significantly less: $211 per day versus $665 per day for hospitalization. The study authors concluded that this alternative was “at least as effective as standard care” and a “promising and viable alternative” (Greenfield et al., 2008).

Overall, peer support workers have the potential to drive through recovery-focused changes in services. However, many challenges are involved in the development of peer support such as boundaries, stress on peer support workers, and maintaining roles. Careful training, supervision, and management of all involved are required (Repper, 2011). Important to note, interventions for peer support services are evidence-based per the Consumer Operated Services Evidence Based Practices Toolkit (SAMHSA, 2011). Also important to note, peer support services are Medicaid reimbursable when using certified peer support workers.

Abbott, S.E. (2011). Evaluating the impact of a jail diversion program on police officer’s attitudes toward the mentally ill. (Doctoral dissertation).

Alexander, C., Zealberg, J. (1999). Mobile Crisis: Mobile Emergency Psychiatry Out of the Hospital Setting (pp. 93-99) *New Developments in emergency psychiatry: Medical, legal, and economic* [pdf]. San Francisco, CA, U.S. Jossey-Bass, 93-99.

Allen M., Forster P, Zealberg J, and Currier G (2002). Report and Recommendations Regarding Psychiatric Emergency and Crisis Services. A Review and Model Program Descriptions. APA Task Force on Psychiatric Emergency Services. American 140 A. J. Mitchell et al. Psychiatric Association (www.psych.org/edu/otherres/ libarchives/archives/tfr/tfr200201.pdf).

Baess, E.P. (2005). Integrated Mobile Crisis Response Team (IMCRT): Review of pairing police with mental health outreach services. Vancouver Island Health Authority.

Clarke, Gregory N., Heidi A. Herinckx, Ronald F. Kinney, Robert I. Paulson, David L. Cutler, Karen Lewis, and Evie Oxman. (2000). Psychiatric Hospitalizations, Arrests, Emergency Room Visits, and Homelessness of Clients with Serious and Persistent Mental Illness: Findings from a Randomized Trial of Two ACT Programs vs. Usual Care. *Mental Health Services Research*, Vol. 2, No. 3.

Coleman, T. G., & Cotton, D. (2010). Police interactions with persons with a mental illness: Police learning in the environment of contemporary policing. Calgary: Prepared for the Mental Health and the Law Advisory Committee, Mental Health Commission of Canada.

Community Partners, INC. (2015). Behavioral Health Business Plan (pp. 1-99) (Bernalillo County Behavioral Health Initiative, Bernalillo County Board of County Commissioners). Community Partners, INC.

Davidson, L., Chinman, M., Sells, D., & Rowe, M. (2006). Peer support among adults with serious mental illness: A report from the field. *Schizophrenia Bulletin*, 32(3), 443–445.

Fisher, W. H., Silver, E., & Wolff, N. (2006). Beyond criminalization: Toward a criminological informed framework for mental health policy and services research. Administration and Policy in Mental Health and Mental Health Services Research, 33, 544–557.

Forchuk, C., Jensen, E., Martin, M. L., Csiernik, R., & Atyeo, H. (2010). Psychiatric crisis services in three communities. *Canadian Journal of Community Mental Health*, 29, 73–86.

Greenfield, T. K., Stoneking, B. C., Humphreys, K., Sundby, E., & Bond, J. (2008). A randomized trial of a mental health consumer-managed alternative to civil commitment for acute psychiatric crisis. *American Journal of Community Psychology, 42*(1), 135-144.

Guo, S., Biegel, D., Johnsen, J., and Dyches, H. (2001). Assessing the Impact of Community-Based Mobile Crisis Services on Preventing Hospitalization. Psychiatric Services, 52(2), 223-228.

Lamb H., Shaner R, Elliott DM, et al. (1995). Outcome for psychiatric emergency patients seen by an outreach police–mental health team. Psychiatric Services 46:1267– 1271.

Lamb, H. R., Weinberger, Linda E., DeCuir, W. J, Jr, & Walter, J. (2002). The police and mental health. Psychiatric Services, 53(10), 1266–1271.

Lee, S., et al. (2015). Outcomes achieved by and police and clinician perspectives on a joint police officer and mental health clinician mobile response unit. International Journal of Mental Health Nursing, 24, 538-546.

Mead, S., Hilton, D., & Curtis, L. (2001). Peer support: A theoretical perspective. *Psychiatric Rehabilitation Journal*, 25(2), 134–141.

Min, S., Whitecraft, J., Rothband, A.B., & Salzer, M.S. (2007). Peer support for persons with co-occurring disorders and community tenure: A survival analysis. *Psychiatric Rehabilitation Journal*, 30(3), 207–213.

Nelson, G., Ochocka, J., Janzen, R., & Trainor, J. (2006). A longitudinal study of mental health consumer/survivor initiatives: Part 1 – Literature review and overview of the study. *Journal of Community Psychology*, 34(3), 247–260.

O’Donnell, M., Parker, G., & Proberts, M. (1999). A study of client-focused case management and consumer advocacy: The community and consumer service project. *Australian and New Zealand Journal of Psychiatry*, 33(5), 684–693.

Ostrow, L., Fisher, D. (2011). Peer-Run Crisis Respites: A Review of the Model and Opportunities for Future Developments in Research and Innovation.

Reding, G., and Raphelson, M. (1995). Around-the-clock mobile psychiatric crisis intervention: Another effective alternative to psychiatric hospitalization. Community Mental Health Journal, 31, 179–187.

Repper, J., Carter, T. (2011). A Review of the Literature on Peer Support in Mental Health Services. *Journal of Mental Health*, 20(4), 392-411.

Rosenbaum, N. (2010). Street-level psychiatry-a psychiatrist’s role with the Albuquerque police department’s crisis outreach and support team. *Journal of Police Crisis Negotiations*, 10(1), 175–181.

Scott, R. L. (2000). Evaluation of a mobile crisis program: Effectiveness, efficiency, and consumer satisfaction. *Psychiatric Services*, 51(9), 1153–1156.

Solomon, P., & Draine, J. (1995). The efficacy of a consumer case management team: Two-year outcomes of a randomized trial. *Journal of Mental Health Administration*, 22, 135–146.

Substance Abuse and Mental Health Services Administration/Recovery Community Services Program. (2009). What Are Peer Recovery Support Services? Rockville, MD: HHS Publication No. (SMA) 09-4454.

Substance Abuse and Mental Health Services Administration//Center for Mental Health Services. (2011). Consumer-Operated Services: The Evidence. Rockville, MD: HHS Pub. No. SMA-11-4633.

Wertheimer, D. (2004). Crisis Triage Services Continuum Recommendations Final Consultant Report (pp. 1-41, Consultant Report). (City of Albuquerque Behavioral Health Crisis Triage Planning Initiative). Seattle, WA: Kelly Point Partners.

Wilson-Bates, F. (2008). Lost in transition: How a lack of capacity in the mental health system is failing Vancouver’s mentally ill and draining policing resources. Vancouver.

Yitzchak H., Lee, J., Tahtalian S., Young, D. and Kulkarni, J. (2012). Challenges Relating to the Interface Between Crisis Mental Health Clinicians and Police When Engaging with People with a Mental Illness, Psychiatry, Psychology and Law, 19:3, 402-411, DOI: 10.1080/13218719.2011.585131

**SECTION 6: Description of Intended Intervention**

In addressing the stated problem, officials in Bernalillo determined to support an MCT program. Titled “Mobile Crisis Team” (MCT) the local program focuses on intervening with acute clients.

In Bernalillo county a Mobile Crisis Team is envisioned as having the following characteristics and providing the following services. Characteristics of the program match the service definition of the New Mexico Interagency Behavioral Health Guidelines as revised July 9, 2010, specifically mobile team Crisis Intervention Services. MCT will provide the following services.

* A community-based crisis intervention officer/civilian team.
* The team will provide immediate mobile crisis intervention services.
* Services are designed to improve an acute crisis episode and prevent inpatient psychiatric hospitalization or medical detoxification.
* Services are provided to adults, adolescents, and their families or support systems who have suffered a breakdown of their normal strategies or resources and who exhibit acute problems or disturbed thoughts, behaviors, or moods.
* These services are characterized by the need for highly coordinated services across a range of service systems.
* Crisis intervention services should be available on a 24–hour, 7-day a week basis.
* Services will be provided by a mobile team anywhere within the county, focusing primarily at the client’s location, i.e., home or residence.
* Crisis intervention services include: crisis prevention, primary assessment, secondary evaluation, acute crisis services, and support services.

Bernalillo County proposes that the composition of MCTs will be independently licensed behavioral health clinician and a specially trained law enforcement officer. The clinician will be employed by a 24-hour behavioral health facility. The clinician will complete mobile crisis team training, and be a contractor of Bernalillo County. The law enforcement officer will complete crisis intervention training, as well as enhanced crisis intervention training and mobile crisis team training. The County also expects that the law enforcement officer will be assigned specifically to the MCT and will only answer MCT designated calls for service.

CPI recommended the County establish four crisis response mobile teams to be strategically located in Bernalillo County. These teams would respond to people experiencing a psychiatric crisis. The teams would work independent or in concert with the Albuquerque Police Department’s Crisis Intervention Unit (CIU) or their Crisis Outreach and Support Teams (COAST).

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**SECTION 7: Cost & Budget Considerations**

**Preliminary Budget**

There are no budget documents available regarding the funding of the proposed MCT. CPI estimated an annual cost for four two-person mobile crisis teams at $1,800,000. CPI suggests that Medicaid would potentially reimburse the cost of MCT in appropriate cases.

**SECTION 8: ANTICIPATED TIMELINE**

Milestone and timeline information necessary to complete this portion of the proposal was not available.

Step #1: Draft Project Proposal Complete

Step #2: Project proposal reviewed & approved by appropriate ABCGC subcommittee

Step #3: Project proposal reviewed & approved by ABCGC steering committee

Step #4: Project proposal reviewed & approved by full ABCGC

Step #5: Project proposal reviewed & approved by the BCC

Step #6: Project proposal turned into RFP or other contracting scope of services

Step #7: Service provider(s) signs contract

Step #8: Services delivery begins

1. Routine Calls: Call is resolved with de-escalation of the caller. Caller is offered a referral to local resources. Caller initiates next steps. Urgent Calls:Call requires de-escalation. A determination is made, with consultation from clinical supervisor, that an outbound call will be scheduled to follow up with the caller. Emergent calls: require immediate emergency attention. [↑](#footnote-ref-1)