Literature Review: Crisis Services (Mobile Crisis Teams)

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Definition: Mobile Crisis Teams (MCTs) are mobile services that provide psychiatric emergency care to individuals experiencing a behavioral health crisis in the community.

Target Population: The target population consists of persons of any age, who are experiencing a behavioral health crisis.

Description: According to the Community Partners, Inc. (CPI) Behavioral Health Business Plan, MCTs are described as an additional resource for the community and law enforcement for providing clinical response to anyone experiencing or at risk of a behavioral health crisis (CPI, 2015). MCTs are also described as mobile services that provide care in the patient's natural environment, making it easier to get a full sense of the environmental and social sources of an emergency. They also allow outreach to individuals who do not meet criteria for involuntary detention, but need psychiatric treatment services (Allen et al., 2002). The goals of MCTs are providing community-based services to stabilize persons experiencing emergencies in the least restrictive environment, to decrease arrests of mentally ill people in crisis, and to reduce police officers' time handling psychiatric emergency situations (Scott, 2000). Similarly, MCTs are expected to reduce hospitalization rates by diverting patients from hospital admission into community-based treatment (Guo et al., 2001). The role of MCTs within the crisis services continuum begins with the "Front Door" services of the existing components of the triage continuum. The crisis response referrals effected by the introduction of MCTs will mainly be the Mental Health Psychiatric Emergency Services (MHPES) and the UNM Emergency Department. The "Front Doors" are explained in the Wertheimer Report as entry points to crisis and stabilization services utilized in order to maximize the 'reach' of the continuum into the community (Wertheimer, 2004). The "Front Door" that the MCTs provide will potentially stream-line psychiatric patients to the proper systems that they need to enter. The stabilization services provide a short respite period for patients before they are released and then given the opportunity for "Back Door" services. The "Back Door" services include the connection of patients to follow-up services and community-based services.

In summary, the general goals of the MCTs are to provide on-site crisis intervention services to the community and diversion from jail and Psychiatric Emergency Services (PES). Most frequently, MCTs are dispatched by service calls from 911 or emergency crisis lines (NMCAL) as the highest level response for psychiatric emergencies. MCTs are an additional entry point into the Crisis Services triage, which includes crisis respite and transportation services.

Research Summary: In order for MCTs to be the most effective, smooth communication and collaboration is necessary between the crisis services (Hollander et al., 2011; Wertheimer, 2004). MCTs need to be able to deal effectively and quickly with psychiatric crises of any form. MCTs more frequently deal 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 (Lamb et al, 1995). Effective treatment is dependent on accurate assessment that directly translates into focusing treatment when it is needed. MCTs are designed to deal with situations effectively and as safely as possible. To do this, MCT staff must be skilled in crisis triage stabilization services. These practices help ensure an effective crisis services triage continuum.

The CPI business plan states that MCTs should consist of civilian responders in the form of a social worker and a mental health professional. The term "civilian responders" pertains to all psychiatric crisis intervention specialists such as psychiatric nurses, social workers, psychiatrists, etc. who are not police officers. On the other hand, the proposal for MCTs "A Regional Approach" states that MCTs consist of an officer/civilian mix of an Enhanced Crisis Intervention Trained (ECIT) officer and a mental health professional (BCBHI Crisis Services Committee, 2016). Research evidence shows both models of MCTs have

worked effectively, but with slightly different structures than the previously mentioned models. There were fewer articles studying the use of a civilian responder team, and more articles studying the use of officer/civilian teams. The two models are described in greater detail below.

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. In addition, 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 (back door) services. These programs can be effective alternatives to EDs that provide in-patient type services in a home-like or residential setting. Crisis stabilization and respite services will be described in more detail in another review.

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