2018

Mobile Response Teams Framework

OFFICE OF SUBSTANCE ABUSE AND MENTAL HEALTH

MYFLFAMILIES.COM

Department of Children and Families

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EXECUTIVE SUMMARY

This framework serves as the basis for the development and expansion of mobile response teams to improve behavioral health services for Florida's children, youth and young adults ages 25 and under. The intent is to establish expectations for operational components and provide tools for implementation, while allowing ample flexibility for regional needs and practice innovation. This framework outlines the goals, guiding principles, service components, implementation models, best practices, roles and responsibilities, metrics and resources recommended for Mobile Response Teams (MRTs).

Options are often limited when children or youth experience a behavioral health crisis. Families and caregivers often turn to law enforcement, hospital emergency departments and inpatient treatment for help. MRTs provide meaningful alternatives to inpatient treatment when appropriate. They serve as part of a "no wrong door" model because they go to where the acute situation or crisis is taking place and provide intervention irrespective of the individual or system seeking assistance. MRTs provide readily available crisis care in a community-based setting and increase opportunities to stabilize individuals in the least restrictive setting to avoid the need for jail or hospital/emergency department utilization.

MRTs provide on-demand crisis intervention services in any setting in which a behavioral health crisis is occurring, including homes, schools and emergency departments. Mobile response services are available 24/7 by a team of professionals and paraprofessionals, who are trained in crisis intervention skills to ensure timely access to supports and services. In addition to helping resolve the crisis, teams work with the individual and their families to identify and develop strategies for effectively dealing with potential future crises. MRT providers are responsible for working with stakeholders to develop a community plan for immediate response and de-escalation, but also crisis and safety planning. Stakeholder collaboration must include law enforcement and school superintendents, but may also include other areas within education, emergency responders, businesses, other health and human service related providers, family advocacy groups, peer organizations, and emergency dispatchers (i.e., 211 and 911 lines).

Services include evaluation and assessment, development of safety or crisis plans, providing or facilitating stabilization services, supportive crisis counseling, education, development of coping skills, and linkage to appropriate resources.

This framework provides a "no one size fits all" approach. Proposals for MRTs should consider a variety of models designed to meet the needs of the local community. Managing Entities (MEs) and providers should leverage existing resources in their program design when proposing models such as a satellite team or a partnership with local law enforcement and schools. Depending upon geography, population, community needs and resources, MEs are expected to integrate MRTs into their existing behavioral health receiving system plans and county transportation plans for crisis services to achieve statewide coverage for all Florida counties with an optimal array of services. Although this document provides information about promising practices, innovative approaches and models to consider when creating MRTs, the following minimum requirements for competitive procurements are included in the ME contacts:

- Be conducted with the collaboration of local Sherriff's Offices and public schools in the procurement planning, development, evaluation, and selection process;
- Be designed to ensure reasonable access to services among all counties in the Managing Entity's service region, taking into consideration the geographic location of existing mobile crisis teams;
- Require services be available 24 hours per day, seven days per week with on-site response time to the location of referred crises within 60 minutes of the request for services;

- Require the Network Service Provider to establish formalized written agreements to establish response protocols with local law enforcement agencies and local school districts or superintendents;
- Require access to a board-certified or board-eligible Psychiatrist or Psychiatric Nurse Practitioner;
- Provide for an array of crisis response services that are responsive to the individual and family needs, including screening, standardized assessments, early identification, or linkage to community services as necessary to address the immediate crisis event.

BACKGROUND

The 2017 Legislature enacted HB 1121, which created a Task Force within the Department of Children and Families (Department) that was required to submit a report of its findings by November 15, 2017, to the Governor and the Legislature.[1] The Task Force was required to address four areas related to the involuntary examination of minors age 17 years and younger as follows:

- Analyze relevant data;
- Research the root causes of trends;
- Identify and evaluate options for expediting involuntary examinations; and
- Recommend alternatives to the Baker Act.

The Task Force found that involuntary examinations via the Baker Act for children under the age of 18, have increased 86% from fiscal year 2000-2001 to fiscal year 2015-2016. The Task Force made several recommendations for consideration by the 2018 Legislature including to provide funds for the Department to contract for additional mobile crisis teams and expand coverage statewide.

Following the February 2018 shooting at Marjory Stoneman Douglas High School in Parkland, Florida, Governor Scott held roundtable discussions with members of law enforcement, school administrators, teachers, mental health experts, and state agency leadership to discuss ways to keep Florida students safe. The mental health and child welfare roundtable examined ways to expand mental health services for Floridians, especially students, and improve coordination between state, local and private behavioral health partners. Part of those discussions revolved around the need to improve and expand the mobile crisis response for youth with behavioral health challenges.

Subsequently, the Marjory Stoneman Douglas High School Public Safety Act, (Ch. 2018-3, Laws of Florida) was passed during the 2018 Legislative session. Section 48 of the law provides intent for the creation of a statewide network of mobile response teams through a competitive procurement process. This process only applies to new teams. Existing teams can use funding to expand or enhance services without being competitively procured. The legislation authorized the Department to establish new teams where they are most needed, to ensure reasonable access among all counties. Currently, there are twelve (12) MRTs operating in ten (10) Florida Counties due to the innovative efforts of providers, counties, local governments, and managing entities to blend funding sources and make the resource available. The Task Force found that areas with MRTs serving children had lower rates of involuntary examinations via the Baker Act. However, there has not been a strategic, statewide approach to these efforts and as a result, the teams vary in size, capacity, coverage area, target population, funding sources, and hours of operation. The intent of this legislation is to ensure MRTs are available statewide.

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[1] The report is available at: http://www.myflfamilies.com/service-programs/substance-abuse/publications.

PROGRAM GOALS

The primary goals of MRTs are to lessen trauma, divert from emergency departments or juvenile/criminal justice, and prevent unnecessary psychiatric hospitalizations. MRTs must be designed to be accessible in the community at any time. According to the Task Force Report, many of the families who use mobile response team services are parents of children and adolescents. MRTs funded with this specific allocation are available to individuals 25 years of age and under, regardless of their ability to pay, and must be ready to respond to any mental health emergency.

A mental health crisis can be an extremely frightening and difficult experience for both the individual in crisis and those around him/her. Loved ones and caregivers are often ill-equipped to handle these situations and need the assistance and support of professionals. Frequently, law enforcement or emergency medical technicians are called to respond to mental health crises and they often lack the training and experience to effectively handle the situation.

Emergency departments are generally considered inadequate settings for children and young adults experiencing behavioral health crisis as they lack the specialized expertise necessary to effectively respond to psychiatric issues. Wait time may be excessive and individuals may be held for long periods of time while waiting for psychiatric beds to become available. While inpatient psychiatric treatment is an important component of a behavioral health system (particularly when an individual is experiencing suicidality or psychosis), it is often used where community-based interventions may be more appropriate, but are not available. MRTs have the training and know-how to help resolve mental health crises, make clinical decisions regarding the individual's immediate safety needs, and connect them to the necessary level of services.

The Baker Act Task Force Report found that numerous and complex factors have led to the increasing use of involuntary examinations amongst minors. The Task Force members unanimously agreed to several factors that are relevant to the implementation of MRTs: prevention and early intervention services are critical to reducing involuntary examinations in minors and there are areas across the state where options short of involuntary examination via the Baker Act are limited or nonexistent.

It is imperative that MRTs operate as an integral part of the behavioral health system of care. They will be more effective if they understand their role and where they fit in the continuum relative to other providers, services, and the community at large. By intervening early, MRTs can help prevent costly and unnecessary stays in hospitals, crisis stabilization units, and correctional facilities. If inpatient services are needed, they facilitate that connection. They are also effective in connecting people with the community mental health system who had not accessed treatment and services before.

GUIDING PRINCIPLES

The System of Care values and principles are the foundation of MRTs. These values and principles are the driving force behind systemic change. The core principles include:

- **Strength-based** – move the focus from the deficits of the individual and family to focusing on their strengths and resources related to the goal of recovery. This includes viewing the individual and family as resourceful and resilient.
- **Family-driven and youth-guided** – recognize that families have the primary decision-making role in the care of their children. The individual's and family's preferences should guide care.
- **Community based with an optimal service array** – provide services in the least restrictive setting possible, ideally in the community. Individuals should be able to obtain any behavioral health service they need in their home community. Peer support is an important component of services.
- **Trauma sensitive** – respond to the impact of trauma, emphasizing physical, psychological, and emotional safety for both service providers and individuals; and create opportunities for individuals to rebuild a sense of control and empowerment.
- **Culturally and linguistically competent** – be respectful of, and responsive to, the health, beliefs, practices, and cultural and linguistic needs of diverse individuals. "Culture" is a term that goes beyond race and ethnicity to include characteristics such as age, gender, sexual orientation, disability, religion, income level, education, geographical location. Cultural competence applies to organizations as well as individuals. Cultural Competence is a set of behaviors, attitudes, and policies that come together in a system to work effectively in multicultural situations. Linguistic competence is the ability to communicate effectively in a way that can be easily understood by diverse audiences.
- **Coordinated** – provide care coordination for individuals with serious behavioral health conditions with an emphasis on individualized services across providers and systems. At the system level, leverage resources by analyzing funding gaps, assessing the use of existing resources from all funding streams, and identifying strategies to close the funding gaps, including the options of blending and braiding of funding sources.
- **Outcome-focused** – ensure that programmatic outcome data is accessible to mangers, stakeholders, and decision makers, and that the data is meaningful and useful to those individuals. Collect feedback from each individual and family regarding the service delivery to improve outcomes of care that inform, individualize, and improve provider service delivery.

> **System of Care
> Values and Principles**
> - Strength-based
> - Family-driven and youth-guided
> - Community based with an optimal service array
> - Trauma sensitive
> - Culturally and linguistically competent
> - Coordinated
> - Outcome-focused

Section 394.4523(1)(d), F.S., defines the "no-wrong-door" model as the model for the delivery of acute care services to persons who have mental health or substance use disorders, or both, which optimizes access to care, regardless of the entry point to the behavioral health care system."

MRTs serve in this capacity as they are available at any place where the acute situation or crisis is occurring. MRTs are designed to address a wide variety of situations, including suicidal and homicidal behaviors, individuals displaying hallucinations, family/peer conflicts and disruptive behaviors. The MRT can be the first on the scene or they may be called in by law enforcement or other professionals (school personnel, adult and child protection staff, other medical personnel). MRTs are dispatched to the location of a crisis with a target response time of one hour from the time of the call. MRTs coordinate in-person services with law enforcement to provide additional safety, when appropriate and necessary.

Further supporting the "no wrong door" model", the MRT provides warm hand-offs and referrals to other services in the community to meet the ongoing needs of the individual and will follow-up to determine that the appropriate linkage is made. When the situation warrants, they will assist with the individual being admitted to a designated receiving facility or an inpatient detoxification facility, depending on the behaviors displayed by the individual.

SERVICE COMPONENTS

MRTs provide on-demand crisis intervention services in any setting in which a behavioral health crisis is occurring, including homes, schools and emergency rooms. MRTs are multi-disciplinary teams of behavioral health professionals and paraprofessionals with specialized crisis intervention and operations training.

Mobile response services are *available 24/7 with the ability to respond within 60 minutes* to new requests. MRT staff are expected to triage calls in order to determine the level of severity and prioritize calls that meet the clinical threshold required for an in-person response. Research suggests that best practice is to provide continued crisis stabilization and care coordination services as indicated for up to 72 hours. In addition to helping resolve the crisis, teams work with the individual and their families to identify and develop strategies for effectively dealing with potential future crises.

MRTs must include access to a board-certified or board-eligible psychiatrist or psychiatric nurse practitioner. Best practice suggests these professionals play a vital role to stabilize the crisis until the individual is connected to a behavioral health services provider for ongoing services, if necessary. For example, these professionals can provide:

- Phone consultation to the team within 15 minutes or shortly after a request from an MRT, and
- Face-to-face or telehealth appointments with the individual within 48 hours of a request if the individual has no existing behavioral health services provider.

Services include evaluation and assessment, development of safety or crisis plans, providing or facilitating stabilization services, supportive crisis counseling, education, development of coping skills, linkage to appropriate resources and connecting those individuals who need more intensive mental health and substance abuse services. They facilitate "warm handoffs" to community services, and other supports.

Facilitating a warm handoff means actively connecting an individual to another service provider. This process goes beyond simply providing a referral name, phone number, and appointment time. Particularly for individuals in crisis, it has been shown that a referral alone is not adequate. Warm handoffs are a transfer of care between two providers in the presence of the individual and their family. This can involve an introduction to the new service provider during a short meeting with the crisis counselor. It is important to explain the process the individual should follow, what to expect during their first appointment, and allow them to ask questions. For additional information and resources to implement or improve the use of warm handoffs, the Agency for Healthcare Research & Quality provide resources for clinicians, staff, and a Quick Start Guide[2].

Once this occurs, it is expected that either the crisis has resolved naturally, the individual is connected to a community-based provider who will engage the individual in services, or the individual was assisted

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[2] https://www.ahrq.gov/professionals/quality-patient-safety/patient-family-engagement/pfeprimarycare/interventions/warmhandoff.html.

with admission to a designated receiving facility. MRTs will need to establish protocols for working with existing care coordination teams for individuals who are not already connected to behavioral health services, for those that are eligible.

To meet community needs, MEs and their partners will develop the delivery system and process for MRT response. MRTs are designed to provide immediate intervention to attempt to stabilize the individual's condition safely in situations that do not require an immediate public safety response, prevent unnecessary hospitalizations, manage appropriate levels of risk and provide timely access to assessment and evaluation in a wide array of settings. Intervention is warranted when a crisis significantly interferes with the ability to function and is severe enough to place the individual at a risk of disruption of services or living environment.

The clinical threshold for crisis may include aggressive behaviors; suicide attempts/ideation; drug and alcohol overdose or abuse; or disruptive symptoms related to thought, mood and anxiety disorders (e.g., panic, hopelessness, anger, depression), escalating behavior(s) and, without immediate intervention, the individual is likely to require a higher intensity of services. It may also present as an overt change in functioning, or be prompted by traumatic life events. Mobile Response Teams must coordinate in-person services with law enforcement to provide additional safety, when appropriate and necessary.

MRT providers will need to be well connected to the local behavioral health system of care. This includes being familiar with the community resources, services, and supports available to the individuals they serve. When the crisis assessment indicates a need for additional services, MRTs need to be positioned to facilitate a warm handoff to the right service at the right time. This can range from case management to Community Action Treatment teams and anything in between. MRT providers will need to be connected to local multi-disciplinary/family service planning teams as they are able to assist in identifying supports and service planning for the family.

Telehealth is an important asset for increasing the capacity of MRTs especially in rural areas, geographically large counties, or urban areas where congested traffic patterns make meeting the 60-minute response time a challenge. Telehealth can be used to provide direct services to individuals via video-teleconferencing systems, mobile phones, and remote monitoring. It can also be used to provide assessments and follow-up consultation as well as initial triage to determine if an in-person visit is needed to respond to the crisis call.

ROLES AND RESPONSIBILITIES

Collaboration is key for successful mobile response teams and the coordination of services. The following delineates the roles and responsibilities of MEs, providers and MRTs:

- Managing Entities
    - Facilitate the competitive procurement process
    - Identify and develop directory of community resources
    - Monitor the system of care
    - Monitor care coordination
    - Engage in community networking and support to build relationships with law enforcement, community resource organizations, behavioral health organizations, and local agencies
    - Identify and create MOUs for required partnerships identified in the "Key Partners" section.

- o Develop a process to monitor and evaluate providers and MRTs to ensure the quality of data, MRT response process, customer satisfaction (see Attachment 1), community collaboration and warm hand-offs to community service providers
- o Ensure network adequacy and manage resources
- o Assess and address quality of care issues based on established standards of care
- o Develop cross-system partnerships and agreements for information sharing and coordination
- o Ensure MRT process is addressed in future county transportation plans and Behavioral Health Receiving System plans
- o Assist in eliminating barriers at the systems level to expand regional and local behavioral health resources.

- Providers
  - o Create, and update as needed, an implementation plan for delivering Mobile Response Team services
  - o Engage in community networking and support to build relationships with law enforcement, community resource organizations, behavioral health organizations, and local agencies
  - o Identify and create Memoranda of Understanding
  - o Increase community awareness about Mobile Response Teams and behavioral health needs through community education and outreach
  - o Provide training for workforce development that focuses on areas such as crisis assessment, strengths-based crisis planning, intervention, care coordination
  - o Ensure cross-training in Crisis Intervention Training (CIT) and Mental Health First Aid, help build behavioral health literacy and awareness of resources, develop and distribute educational materials
  - o Ensure process for informed consent and HIPPA compliance measures
  - o Promote information sharing and use of innovative technology – mobile applications, tele-psychiatry
  - o Manage all administrative functions, including: purchasing, human resources, training, and quality assurance and reporting requirements

- Mobile Response Teams
  - o Respond to new requests within 60 minutes
  - o Provide behavioral health crisis-oriented services that are responsive to the individual and family needs
  - o Respond to the crisis where the crisis is occurring (e.g., schools, homes, community locations, etc.)
  - o Provide screening, standardized assessments, early identification and linkage to community services
  - o Whenever possible include family members
  - o Develop a Care Plan
  - o Provide care coordination by facilitating the transition to ongoing services through a warm hand-off, including psychiatric evaluation and medication management
  - o Ensure process for informed consent and HIPPA compliance measures
  - o Promote information sharing and use of innovative technology – Mobile applications, tele-psychiatry

KEY PARTNERS

The success of MRTs depends heavily on community collaborations. The MEs must ensure that the provider enters into formalized written agreements to establish response protocols with local law enforcement agencies and local school districts or superintendents. Formal partnerships should include Memorandum of Agreements (MOAs) or Memorandum of Understanding (MOUs). Beyond this requirement, to maximize resources, MEs are responsible for ensuring that each of their MRTs establish informal partnerships with key stakeholders such as Medicaid managed care plans, Community Based Care lead agencies, 211-United Way, Central Receiving Facilities, Community Health Departments, Department of Education, Department of Health, Department of Juvenile Justice and Florida Department of Law Enforcement.   Interdependent system partners work together to create community capacity.

- Managing Entities- support utilization management, quality management and information management for their regional system of care.
- Mobile Response Teams- provide timely response and intervention to individuals in crisis in order for them to remain in the community when appropriate and to link them to community resources.
- Local School Districts or Superintendents- coordinate with School Safety Specialist, District Crisis Intervention Team and/or Threat Assessment Team and notify them when a student in the district's K-12 system has an interaction with one of these teams.
- Law Enforcement- Communication patterns should be established between MRTs and local law enforcement partners.
- Medicaid managed care plans, including the child welfare specialty plan, can be approved by the Agency for Health Care Administration to pay for mobile crisis services.
    - The following health plans are approved (or approval is pending) to provide mobile crisis services as an "in lieu" of service: Aetna, Best Care, Florida Community Care, Humana, Lighthouse (pending approval), Miami Children's (pending approval), Prestige, Sunshine, and Staywell.
    - MEs and health plans are discussing finance strategies to increase the statewide capacity for MRT services.
    - All health plans can coordinate with providers in their network to connect an individual to primary care or other types of needed medical and dental services.

IMPLEMENTATION MODELS

This framework provides a flexible "no one size fits all" approach. Proposals for MRTs will consider a variety of models designed to meet the needs of the local community. MEs and providers should leverage existing resources in their program design when proposing models such as a satellite team or a partnership with local law enforcement and schools. Depending upon geography, population, community needs and resources, MEs are expected to integrate MRTs into their existing behavioral health receiving system plans and county transportation plans for crisis services to achieve statewide coverage for all Florida counties with an optimal array of services. There are currently twelve (12) publicly-funded MRTs in Florida. These MRTs vary in composition, design and location depending upon the local community. To achieve statewide access to MRT services, MEs and their partners, may consider a variety of service models which are integrated into existing behavioral health receiving system plans. Teams may be designed with a full team of five or more professionals and paraprofessionals based in a behavioral health center. An alternative model might consist of a licensed mental health professional based in a law enforcement office or county public health unit. In Texas, MRTs include a crisis-trained law enforcement officer or deputy who partners with licensed mental

health clinicians, provides first response and follow-up in the community and call in an MRT team when required.

Services may be designed to include contracting with a telehealth services company for psychiatric care. Again, partnerships are key along with leveraging existing community resources. Regardless of service model or design, MRTs must be available 24/7 with staffing sufficient to respond within 60 minutes to provide crisis stabilization and warm hand-offs. The goals are to ensure individuals receive appropriate referrals, telehealth or face-to-face appointments as determined by an assessment and safety or crisis plan. Models might include recovery support specialists and peer-run groups to provide one-on-one interactions with families, conduct phone follow-up and lead families through treatment process.

Providers need to consider what MRT staff will be doing when not out in the community responding to a call. It is recommended that to the extent possible, staff not have other duties and responsibilities within the provider agency. The success of MRT's ability to divert unnecessary inpatient admissions will depend on the knowledge of the service by the community. Staff who are not responding to a call or providing a follow-up visit should be outreaching to community partners, key stakeholders, and the general public to ensure that they are aware of how to access the MRT and that the service is available.

BEST PRACTICES
Department staff researched best practices for the operation of MRTs and information was synthesized from SAMHSA technical assistance briefs and practice guidelines, National Council and AHRQ reports. Below are some exemplary models of MRTs developed in other states.

State of New Jersey
The Mobile Response and Stabilization Services (MRSS) System delivers mobile response services to children/youth/young adults experiencing escalating emotional and/or behavioral reactions and symptoms that impact the youth's ability to function typically (at baseline) within their family, living situation, school and/or community environments. Mobile response services are available 24 hours per day, 7 days a week, year-round, are delivered by MRSS staff and include both initial (within 1 hour) face-to-face intervention wherever the youth's need presents, and follow-up interventions, services and coordination for up to 72 hours subsequent to the initial intervention. If at the end of initial mobile response services, a youth continues to exhibit patterns of behavioral and emotional needs that require continued intervention and coordination to maintain typical functioning and prevent continued crisis reaction, a child/youth may be transitioned to Mobile Response Stabilization Management Services that can continue to serve the individual for up to eight weeks.

State of Massachusetts
In Massachusetts, Mobile Crisis Intervention (MCI) is provided to youth (under the age of 21) by all emergency service program (ESP) providers. MCI provides a short-term service that is a mobile, on- site, face-to-face therapeutic response to a youth experiencing a behavioral health crisis for the purpose of identifying, assessing, treating and stabilizing the situation and reducing immediate risk of danger to the youth or others consistent with the youth's risk management/safety plan, where one exists. This service is provided 24 hours a day, 7 days a week and includes: A crisis assessment; engagement in a crisis planning process that may result in the development/update of one or more crisis planning tools (e.g., Safety Plan; Advance Communication to Treatment Providers; Supplements to Advance Communication and Safety Plan, Companion Guide for Providers on the Crisis Planning Tools for Families) that contain information relevant to and chosen by the youth and family; up to 7 days of crisis intervention and stabilization services including on-site face-to-face therapeutic response, psychiatric consultation and

urgent psychopharmacology intervention, as needed; and referrals and linkages to all medically necessary behavioral health services and supports, including access to appropriate services along the behavioral health continuum of care.

Milwaukee County, Wisconsin

Milwaukee County in Wisconsin has a nationally respected and effective crisis response model for children in their region. The program is called the Mobile Urgent Treatment Team (MUTT) and its primary focus is to keep children at home with families and out of hospitals. MUTT provides MRSS services for children and adolescents (up to age 18), and addresses a family's immediate concerns about their child by phone or by responding to them in the community or in their home. Services are available 24 hours a day, seven days a week. Once called, the MUTT team immediately travels to the location where a crisis may be occurring. The team assesses the situation, including the potential for danger that the child poses to himself or others. Based on the assessment, the team weighs intervention options, including keeping the child home (with adequate support services), temporary placement in a crisis group home or other emergency setting, or hospitalization in a psychiatric facility. The team can provide short-term case management services as necessary and frequently acts as a liaison between the family and available community services.

King County, Washington

The Children's Crisis Outreach Response System (CCORS) in King County, Washington provides crisis outreach and stabilization services 24 hours a day, 7 days a week to all residents of King County regardless of income. Specific services include mobile crisis outreach, which consists of specially trained teams available to respond in the child or youth's natural environment to de-escalate the situation. The team conducts mental health and suicide risk assessments and works with the family to implement ongoing services and supports to prevent future crises. CCORS also provides non-emergency outreach appointments, available within 24-48 hours for families who are not in immediate crisis but require timely support and linkages to services. Crisis stabilization services in the form of in-home support are available for up to 8 weeks following the initial acute crisis. Intensive crisis stabilization services (90-day in-home support) and crisis stabilization beds are also available to specialty populations.

Santa Fe New Mexico Mobile Crisis Response Team

The crisis response team is a partnership between Santa Fe County and Presbyterian Medical Services (PMS), a licensed, qualified, integrated behavioral health and primary health care provider. The 24-hour, seven days-a-week toll-free crisis hotline has operated for almost two decades out of the Santa Fe Community Guidance Center. When law enforcement and first responders call the crisis line, "hot" calls go directly to the mobile response team. Two partner teams are dispatched and meet first responders to provide assessment and intervention, usually arriving within 20 minutes. While each situation is unique, real-time interaction with first responders in the field has been invaluable in de-escalating situations, educating first responders and preventing hospitalizations. While primarily used by law enforcement and first responders, the service is available to schools, the local National Alliance on Mental Illness chapter and people concerned about their loved ones.

Maine Behavioral Health Care Crisis Team

After police respond to a call involving a juvenile, the officer completes a police juvenile reporting form and sends it to the Maine Behavioral Healthcare crisis team. A clinician then calls the family to arrange an assessment, provide resources and services and provide later follow-up to ensure the family has engaged in referred services. The reporting form captures critical information for tracking and accountability. In addition, parents of juveniles in crisis use the form as a tool to convey concerns and

record problem behavior to mental health professionals. With parental consent, they use the information to inform the school system and help prepare an appropriate response to the child's needs. The result is a program that recognizes juveniles at risk at the earliest possible stage, captures relevant and useful information, secures an appropriate referral network and tracks results for mutual accountability. The results of the program were decisive—86 percent of the families reported that only one response was needed to receive the appropriate resources.

North Carolina
Carolinas Health Care System (CHS) service line for behavioral health conducts tele-psychiatry consults in rural emergency rooms. Small but strategic teams are deployed "virtually." This team – comprised of a small, rotating group of psychiatrists, nurses, social workers and a manager is located not in the medical emergency rooms but at the behavioral health headquarters. The team proactively "rounds" on patients in 19 medical emergency rooms by monitoring the electronic medical records and communicating via phone and video with emergency department staff and patients.

Central Ohio
Brings together crisis intervention specialists, therapists, case managers and other staff members who pair up to visit teens and young adults in schools, jails, hospital emergency rooms and other places to connect them with mental health services. Initially contacted though the community crisis hotline, the flow begins with a 2-1-1 call that is triaged and sent to a helpline. Appropriate calls are sent to the behavioral health provider crisis staff who again triages and respond in-person with a secondary staff person, who may be a therapist or case manager.

METRICS
It is important to measure the value and impact of MRTs. Consideration should be given to the following measures:
- Mobile Response Teams responding to a crisis in 60 minutes or less for at least 80% of mobile episodes.
- Mobile Response Teams submitting performance improvement plans each quarter with goals in service access, service quality, and outcomes, as well as goals relating to efficient and effective clinical and administrative practices.
- Children with SED and ED who improve their level of functioning.
- Decrease in admissions to the CSU
- Diverting individuals to community-based care when appropriate, lessening the debilitating symptoms of mental illness, addressing co-occurring disorders, reducing hospitalization
- Providers report the number of individuals successfully completing treatment (that were linked or referred by an MRT)
- Number of formal outreach activities annually by providers (or by MRTs when there is no provider partner).

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Attachment 1

Sample Client Satisfaction Survey

Mobile Response Customer Satisfaction Survey	RATINGS (Fill in Circles Completely)				
	Strongly Agree 1	Agree 2	Neutral 3	Disagree 4	Strongly Disagree 5
Mobile Response Team (MRT) Questions					
1. The MRT responded to the crisis within 60 minutes.	O	O	O	O	O
2. The MRT staff were respectful.	O	O	O	O	O
3. The MRT staff were knowledgeable.	O	O	O	O	O
4. The MRT staff talked with me in a way that I understood.	O	O	O	O	O
5. The MRT helped me/my child/ my family get the services needed or contacted my current service provider (if one existed at the time of the MRT intervention).	O	O	O	O	O
6. The services or resources my child/family or I received were right for us/me.	O	O	O	O	O
7. At the end of this process I knew what I needed to do for the next steps.	O	O	O	O	O
8. At the end of this process I felt that I knew about community resources I may need.	O	O	O	O	O
9. Overall, I am very satisfied with the way the Mobile Response Team responded to the crisis	O	O	O	O	O