

Mobile Crisis Management Teams as Part of an Effective Crisis Management System for Rural Communities

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Mobile crisis management teams provide crisis prevention and intervention services in community settings. The Appalachian Community Services crisis management program shows how such teams can be used to effectively serve rural communities.

In 2007, North Carolina appropriated funds for the support of mobile crisis management teams across the state. Mobile crisis management is a Medicaid-billable service involving "all support, services and treatments necessary to provide integrated crisis response, crisis stabilization interventions, and crisis prevention activities" [1]. Mobile crisis management teams are staffed with a mix of clinicians and unlicensed qualified professionals. They respond to all ages and disability groups in community settings (including residences, schools, offices and emergency departments) and have around-the-clock access to a psychiatrist for consultation. The Appalachian Community Services (ACS) crisis management system, originally developed by the region's Local Management Entity (LME), Smoky Mountain Center, serves as an example of the effective use of mobile crisis teams to serve rural communities as part of a comprehensive crisis management system that includes emergency dispatch, facility-based crisis intervention services, and walk-in clinics. This effective rural model features assessment by licensed clinicians, linkage with inpatient resources, and close collaboration with community partners to prevent and diffuse crises, avoid unnecessary use of emergency departments (EDs), and achieve positive outcomes for clients.

Delivering mobile crisis services in a rural area presents unique challenges. ACS serves 7 rural counties in Western North Carolina with populations ranging from 10,587 to 59,036. Approximately 120 miles long, the region includes the Eastern Band of the Cherokee Nation and several small municipalities, and is served by 7 small community hospitals and 7 sheriff's departments. Unlike hospitals in urban centers, which typically employ their own behavioral health staff, hospitals in this region must rely on mobile crisis management teams to provide a behavioral health response when one is required by individuals visiting the emergency department (ED). This necessitates credentialing of mobile

crisis clinicians. With such a large service area, it is critical that deployment and management of staff be highly effective.

The majority of crisis calls come directly to ACS emergency dispatch rather than to the LME. In fiscal year 2010-2011, ACS had 3,945 calls to the crisis line, of which 2,469 resulted in a face-to-face intervention. Of these, 68% were performed in EDs; the rest were performed in client homes and other safe community settings. The high percentage of assessments conducted in the ED is due to two factors. Many individuals present to the ED before calling mobile crisis. ACS marketing efforts, and the walk-in centers, are beginning to reduce this trend. A second factor is that individuals who require inpatient treatment must be medically cleared prior to being accepted by the receiving facility. Many individuals could receive this medical clearance through an alternative treatment provider, such as an urgent care, and ACS has encouraged the development of such alternatives.

Crisis calls typically come from individuals seeking services, family members of those in crisis, service providers, law enforcement officers, and EDs. Calls are received through a toll-free line by trained support staff, logged into custom tracking software, linked with an available mobile crisis clinician, and triaged. At that point, callers who do not require emergency medical assessment and treatment may be scheduled to be seen in the community, avoiding an unnecessary ED visit. Some callers simply require information, and others may have needs that can be adequately addressed by referral to a walk-in center the following business day. A face-to-face mobile crisis assessment is performed when triage determines that a comprehensive clinical assessment is necessary to ensure someone's safety. The mobile crisis clinician who takes the crisis call works the case from initial triage to disposition. Disposition may

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Crisis Intervention Teams and Mobile Crisis Management

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The Crisis Intervention Team (CIT) model is a law enforcement-based jail-diversion program for those experiencing crisis as a result of mental health problems. The use of crisis intervention teams is growing across North Carolina. According to an email message from Bob Kurtz, PhD, of the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services in the North Carolina Department of Health and Human Services, in February 2011, more than 4,000 (about 18%) of the state's law enforcement officers were CIT-certified at that time.

The first CIT initiative was developed in Memphis, Tennessee, in 1988 in the wake of a tragedy there. The Memphis CIT program now serves as a national model for taking a proactive approach to assisting individuals in crisis who might otherwise serve jail time [1]. To become CIT-certified, law-enforcement officers undergo 40 hours of training in which they are taught the signs of a mental health crisis and de-escalation skills; officers are also provided with resources for diverting people in crisis from jail by linking them to treatment when this can be done at little risk to public safety [2]. In many instances those in crisis are connected to treatment through the mobile crisis management system.

Southeastern Center for Mental Health, Developmental Disabilities, and Substance Abuse Services facilitates CIT training in Brunswick, New Hanover and Pender counties. In southeastern North Carolina, the relationship of law enforcement officers to the local mobile crisis management system is integral to the CIT program and starts during training. A representative of the mobile crisis system attends CIT trainings to discuss the partnership between mobile crisis clinicians and officers and to explain how to contact mobile crisis dispatch and to access mobile crisis services.

Calls received from CIT officers differ somewhat from other calls to mobile crisis dispatch. Heather Strickland, the mobile crisis management supervisor for RHA Behavioral Health Services in Wilmington, North Carolina, notes that these calls are generally about emergency situations and that specific information about the person in crisis is often not available. "We always have clinicians on call, so that these calls are responded to immediately," says Strickland. A mobile crisis management clinician will meet the person in crisis and the CIT officer wherever they are for a face-to-face assessment. If involuntary commitment is not needed, the clinician can assist in transporting the person in crisis to an appropriate location for other assistance.

Corporal Greta Mallard, CIT Coordinator for the Wilmington Police Department, says, "The development of the mobile crisis team has been a great asset to the officers of the Wilmington Police Department. Having the capability of getting a person in crisis assistance, without having to automatically take out involuntary commitment papers,

benefits both the police department and the individual."

The success of the CIT and mobile crisis management programs is reflected in a number of outcomes. Success in Southeastern Center's catchment area is particularly evident in a decrease in admissions of local residents to Cherry Hospital, the region's state psychiatric hospital. Local admissions to Cherry Hospital have dropped: 65 people were admitted in the first quarter of 2011, but only 27 in the first quarter of 2012.

Officer Lonnie Waddell of the Wilmington Police Department, who received the National Alliance on Mental Illness—Wilmington's "CIT Officer of the Year" award for 2011, remembers one instance in which involuntary commitment was prevented. A man with suicidal ideation had contacted his mother in Ohio, who then contacted Wilmington police. When Officer Waddell arrived at the man's home, he spent some time talking with him, gathering his medical history and learning that he had not been taking his medication. Concluding that there was no need for an arrest or involuntary commitment, Waddell then called mobile crisis dispatch. "Mobile crisis clinicians have resources that I don't have," he says. "Some people don't need to go to the hospital or jail; the issue can be handled in their home, where they feel safe and comfortable."

Sergeant Mike Howell, CIT Coordinator for the New Hanover County Sheriff's Office, summarizes the importance of the relationship between the mobile crisis management system and CIT officers: "Mobile crisis is a great resource for officers when assisting someone in crisis. Because mobile crisis can more appropriately respond to these types of calls, the relationship with law enforcement results in a better outcome for the consumers and the community at large." **NCMJ**

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include diversion from 24-hour psychiatric care with a safety plan, referral to a walk-in clinic or service provider, and voluntary or involuntary referral to facility-based crisis services for drug or alcohol detoxification or for inpatient treatment. Safety plans include items such as arranging for care and supervision with safe friends or family members, removing weapons from the environment, follow up by mobile crisis, psychiatric evaluation, or next working day follow up with the primary provider. The majority of individuals needing 24-hour psychiatric care are admitted to a local or regional crisis or inpatient unit within 24 hours. However, individuals who require a hospital bed at a state institution or some other specialized treatment resource often wait days for treatment. ACS sends a daily report to the LME that lists all individuals awaiting inpatient placement.

In fiscal year 2010-2011, a high proportion (46%) of clients served by the ACS mobile crisis system had no health insurance; 26% of clients served had Medicaid only, 7% had Medicare only, 7% had both Medicaid and Medicare, 11% had third-party insurance, and 3% had tribal insurance. Half of clients served had a primary or secondary diagnosis of substance abuse. For 16% of clients, substance abuse was their primary disability; another 34% of clients had both mental health and substance abuse problems; for 48% of clients, a mental health problem was the primary disability; and for 2% of clients, an intellectual or developmental disability was their primary problem.

ACS operates three mobile crisis teams which are each assigned to cover specific counties. However, because demand for crisis services is often uneven, mobile crisis clinicians can respond to any location as needed. The ACS mobile crisis management system relies primarily on active-duty (rather than on-call) staff to ensure a timely professional response. A dispatcher and 2-5 clinicians licensed at the master's or doctoral degree level are on active duty at all times; clinicians at the master's degree level must be licensed clinical social workers (LCSW), licensed personal counselors (LPC), licensed clinical addiction specialists (LCAS), or licensed psychological practitioners (LPP). Clinicians receive extensive training in clinical and risk assessment, medical risk factors, and involuntary commitment procedures, and all eligible staff are credentialed to complete the first exam for involuntary commitment. A psychiatrist is on call at all times and is frequently consulted. Qualified professionals and other unlicensed staff are used effectively for intervention, follow-up, and engagement with individuals judged not to be in need of 24-hour psychiatric care. The crisis director, clinical director, and medical director at ACS are all actively involved in oversight of all crisis programs. Each mobile crisis team has a team leader, and a supervisor is on-call for consultation at all times. Having rapid access to walk-in services, follow-up care provided by qualified professionals, and psychiatric evaluation the next business day makes it possible for mobile crisis clinicians to divert many cases from 24-hour psychiatric care. This

structure strengthens safety plans and saves clients from having to spend a long time in the ED awaiting inpatient placement.

The success of mobile crisis teams in a rural setting is predicated on developing positive relationships with community stakeholders, including the LME, hospitals, law enforcement officers, the departments of social services, magistrates, primary care doctors, indigent-care clinics, homeless shelters, urgent-care clinics and other providers of behavioral health care. Mobile crisis team leaders regularly reach out to these stakeholders, marketing their services by attending meetings, making educational presentations, and facilitating stakeholder meetings between mobile crisis, the LME and the local hospital. As many as 70 such marketing events have taken place during a quarter. The goal is to ensure that all parties are in communication regarding systemic challenges and that they are working on developing ways of addressing the needs of high-acuity clients proactively in community settings. High acuity clients include those at substantial risk of harm to self or others, or those who have challenging psychiatric, substance abuse, or medical needs.

Stakeholders are encouraged to call emergency dispatch at the first sign of a behavioral health crisis rather than using the ED. Every effort is made to perform assessments outside of the ED environment and to stabilize the crisis in the least restrictive setting. Prior to responding in a community location, mobile clinicians triage the medical and safety risks to ensure the well-being of staff members and those served. Mobile crisis team members respond in pairs when necessary and are encouraged to seek psychiatric or administrative consultation as necessary. If a determination is made that the client needs emergency medical assessment or 24-hour psychiatric care, only then is he or she referred to the ED. One benefit of performing assessments in a community setting is that if there is imminent need of inpatient placement, the search for a bed can begin immediately. Despite extensive efforts to educate members of the community to call mobile crisis management first, many individuals present to their local ED without having contacted mobile crisis. In these cases, a mobile crisis team will respond after the client has been medically cleared. Inpatient psychiatric facilities will not consider admitting a patient without medical clearance. The mobile crisis clinician can assist in resolving a crisis quickly and can recommend that the patient be discharged from the ED to outpatient services in the community. ACS was the first approved involuntary commitment waiver site in North Carolina. This allows credentialed mobile crisis staff to complete the first exam for involuntary commitment. The disposition of 41% of the nearly 2,500 crises handled by mobile crisis teams in fiscal year 2010-2011 was that a safety plan was devised and follow-up care and outpatient treatment were arranged. In the remaining cases, it was determined that inpatient care was needed. In 67% of these 2,500 events, someone (eg, a friend or family mem-

TABLE 1.
Average Wait Times to Get a Bed at Broughton State Hospital or in a Local Behavioral Health Inpatient Psychiatric Unit or a Local Crisis Stabilization Unit in Western North Carolina

Six-Month Time Period	Average Wait Time to Get a Bed		
	Broughton State Hospital	Local inpatient psychiatric unit	Local crisis stabilization unit
July – December 2010	1.5 days	13.9 hours	7.9 hours
January – June 2011	2.67 days	14.9 hours	6.5 hours
July – December 2011	4.125 days	15.2 hours	7.2 hours

ber) signed a petition stating that an individual needed to be committed involuntarily for inpatient mental health treatment, but in 15% of such cases, it was possible to have the petition terminated and to initiate outpatient services with safety plans.

Mobile crisis supervisory staff members work closely with the LME staff members who provide care coordination. Mobile crisis supervisors are uniquely positioned to identify individuals who are repeatedly presenting in crisis. It is often the case that those who find themselves in crisis repeatedly have not engaged with a primary provider of behavioral health services or lack access to needed services. When the mobile crisis supervisors communicate daily with the LME to let them know how many people are actively waiting in an ED for inpatient placement, they highlight specific cases that are cycling through the crisis system. Mobile crisis team leaders initiate meetings with the LME and any other agencies involved to identify and address the challenges that such cases present. The LME can assist with these cases by initiating disability applications, guardianship proceedings, or authorization for needed care.

In accordance with North Carolina statute, a magistrate must approve petitions for involuntary treatment and issue custody orders for individuals who have a mental illness or a substance abuse problem and are believed to be a danger to themselves or to others. Although involuntary commitment is sometimes necessary, it can be traumatic for clients and is very expensive for local law enforcement and for the hospital. Mobile crisis team members work with magistrates to avoid unnecessary petitions for involuntary commitment. Magistrates are encouraged to contact mobile crisis dispatch before approving such a petition and issuing a custody order, to determine whether that course of action can be avoided. A mobile crisis team can often facilitate a voluntary admission to a facility-based crisis unit or an adult inpatient unit. Most admissions to either type of unit are on a voluntary basis. The mobile crisis management team provides emergency transportation to safely get voluntary clients where they need to go. In one community where mobile crisis team members worked with local magistrates intensively, the number of crisis assessments that took place in a community setting rather than in the ED increased by 50% over a 1-year period.

The mental health system in North Carolina has been transformed over the past decade. Challenges associated with these changes have been well documented. The implementation of mobile crisis management in North Carolina may be seen as one success of mental health reform, but significant problems remain.

In the far western part of the state, by far the most significant challenge for hospitals, law enforcement, and the mobile crisis system is the lack of sufficient inpatient capacity for adults, children, and adolescents whose care needs are such that they would be considered “high acuity” patients. Although in recent years the state has made more private psychiatric beds available through state contracts with community hospitals, wait times for some clients continue to grow. Although a mobile crisis team can resolve many crises, and can facilitate local admission for most adults, the wait time for some populations places a severe strain on hospital EDs, law enforcement (who often wait in the emergency department until a disposition is found), clients and families. For children and adolescents, geriatric patients, individuals who require admission to a state hospital, and those with unstable medical conditions that may complicate treatment such as high blood pressure or diabetes, wait times range from a few days to up to 3 weeks. (In the ACS region, the average wait time for a bed in a state hospital more than doubled over the past 18 months, increasing from 1.5 to 4.1 days; that increase is consistent with trends across the state [2]; see Table 1.) These individuals, whose needs as patients are too great for them to be served by a local private facility, wait in an ED, where they do not have access to the treatment they require. Some individuals cannot be served locally because the services they need are unavailable (such as child crisis stabilization, child inpatient, geriatric, medical/psych inpatient), or because their acuity is too high to be served in local facilities. There is a critical need for a facility-based crisis unit to serve children and adolescents, who currently must be transported to an inpatient unit several hours away from their families.

A rural mobile crisis system also faces transportation and funding challenges. The distance to psychiatric facilities, including Broughton State Hospital, is a significant barrier. Our LME, Smoky Mountain Center, provides some funding for emergency transportation, which helps clients access

care on a voluntary basis. Fortunately, Smoky Mountain Center, has long made funding for crisis services a priority; without that funding, the ACS crisis management system would not be possible. Commercial insurance and Medicare do not reimburse for mobile crisis services. Only 26% of those served have Medicaid coverage, and nearly 50% have no insurance of any kind. North Carolina may experience significant cuts in Medicaid mental health funding in the coming years [3]. Further cuts to a system that is already inadequately funded will place additional burdens on local systems of care.

Mobile crisis management, as part of an integrated crisis system, can have a significant positive impact on clients, families and communities by making crisis prevention and crisis intervention readily available. The ACS model, which provides licensed clinicians, emergency dispatch, ED response, facility-based crisis services, and walk-in centers, provides a robust crisis response in a challenging rural setting. This program has proved effective over time in meeting community needs with available resources. With the continued support of policymakers, funders and community part-

ners, we can work together to provide the best crisis care possible to our community. **NCMJ**

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