Webinar #5: Mobile Crisis Teams
Meeting Notes
Tuesday, July 14, 2020
9:00-10:30am

The fifth session in the Nevada Crisis Response System Virtual Summit webinar series drew more than 90 participants representing all of Nevada's 17 counties. The following panelists participated in the Webinar: Wendy Philpot, EMPACT-Suicide Prevention Center; Mary Hoefler and Megan Lee, Colorado Office of Behavioral Health; Christy Butler, Washoe County Human Services Agency MOST Team; and Laura Yanez, NAMI Western Nevada.

Kelly Marschall with Social Entrepreneurs, Inc. (SEI), welcomed participants to the fifth session in the webinar series and shared the objectives for the webinar, which included to review the mobile crisis team models in Colorado and Maricopa County, and to highlight opportunities and challenges and discuss optimal staffing and operations for mobile crisis teams. The final objective was to discuss mobile crisis team interaction with crisis call centers and crisis stabilization facilities.

The first panelist, Wendy Philpot, reviewed the different layers of the Crisis Now model and described how mobile crisis fits in the model. She outlined the ideal precepts of a mobile team, which include that they are: community based, have a focus on community stabilization, provide a 24/7 "quick" response with two people, include jail and emergency room diversion as key program and fiscal goals, include a centrally deployed air traffic control (ATC model, and have a majority of responses that do not require a law enforcement response.

Ms. Philpot described what a mobile crisis team does, explaining that they provide a crisis assessment, including a comprehensive risk assessment, connect with the client, and identify what led to the involvement of the mobile crisis team. They are able to provide therapy and assist with the connection to what the client needs, such as reviewing what services their insurance pays for, assisting with connecting the client to a therapist to set up an intake, calling a friend who can help support them, or making a safety plan so they can safely remain in their community. If necessary, the mobile crisis team arranges for a higher level of care, such as a detox or crisis facility. The mobile teams provide transportation when necessary and appropriate, and Ms. Philpot explained that they will call law enforcement if someone becomes unsafe.

Ms. Philpot emphasized that community stabilization is one of the primary goals of the mobile crisis teams, because the research says this is healthier and less traumatic for the individual. Their funder requires that they stabilize at least 75% of the clients they see in the community. She described how the crisis transition navigator program helps get people connected to services the next day.

Webinar participant Travis Atkinson asked if peer supports are used on the mobile team. Ms. Philpot answered that they were, and they are required to utilize 35% of crisis services with peer support. She noted that peers are a large portion of the mobile team structure, where the specialist or therapist has identified as a peer and work in the peer capacity and are able to use their skill and relatability to defuse the crisis situation.

Webinar participant Dorothy Edwards asked, “Where do you get referrals and how do you guarantee your safety if there is an individual who has significant mental health issues and may be displaying violent or potentially violent actions?” Ms. Philpot answered that they get referrals from third party calls and explained that there is a lot of training on the difference between “scary” and unsafe. She emphasized that safety is the number one goal, and the staff are very resilient and competent in what they do. Mobile crisis teams call law enforcement if they feel a situation is dangerous. Out of the 1,600-1,800 mobile crisis calls a month, they only reach out to law enforcement for about 60 of those calls, on average, because of the way staff are trained to recognize dangerous situations. Ms. Edwards later asked, “What about the mental health calls that come to law enforcement through dispatch? Do you have a relationship with law enforcement that allows them to reach out to you to respond to the call as necessary/appropriate?” Ms. Philpot answered that this is a huge component, explaining that 911 has a lot of training and relationships regarding when calls are mental health calls, so they divert people to the crisis line to provide the support. There is also a specific telephone number for law enforcement. If a law enforcement call is received, then there are no questions asked, and a mobile team is dispatched immediately. Their commitment is to get there within 30 minutes, on average, which can be tough since Maricopa County is large and very spread out.

Webinar participant David Robeck asked: “You referenced that some Master’s-Level “clinicians” do not have licenses. Then you mentioned that your group does provide therapy in the field. How does that work?” Ms. Philpot answered that crisis intervention in Maricopa County is a little different from outpatient therapy, explaining that in a crisis capacity they can provide therapy with a client as long as there is a licensed individual with oversight responsibilities. She noted that until recently, crisis services hours couldn’t be counted toward the hours needed to acquire clinical licensure.

Webinar participant Travis Atkinson asked about measurable outcomes and if there are cost savings from emergency department, jail and psychological hospital diversions that are reinvested into mobile crisis services. Ms. Philpot answered that on average, 78% of clients are stabilized in the community and 16% enter a higher level of care, and that there is significant reinvestment back into the crisis system.

Ms Philpot reviewed the mobile team’s process, describing how a crisis team will respond via central dispatch, and who does the initial safety triage and coordination. The mobile teams are made up of two person responses with several variations, such as a Masters Level Clinician and Bachelors/BHT staff, two BHT staff, or a peer staff partnered with other behavioral health staff. She emphasized that if police call, the focus is on releasing law enforcement from the scene as soon as possible, noting that it’s often only a two-minute conversation to make that hand-off. Ms. Philpot emphasized that collaboration with law enforcement is important, explaining that police are often the first to encounter individuals with mental health issues and can help achieve behavioral health system goals.

Mary Hoefler and Megan Lee presented on mobile crisis team operations and practices in Colorado. Ms. Hoefler explained that Colorado is moving toward centralized dispatch through the statewide call center, and that many of the calls continue to go to local crisis numbers. They are trying to have more standardized responses. Ms. Hoefler described how in Colorado’s current system, the statewide call center does a good job screening and deciding if mobile crisis teams will be dispatched. Since March, new screening protocols related to COVID-19 have been added and there has been an increase in the

use of telehealth. She noted that the mobile teams work with law enforcement and will go wherever they are called. She explained that if someone is intoxicated or needs to be restrained, it's not appropriate for a mobile response.

Ms. Hoefler reviewed the challenges Colorado has faced with their mobile teams, noting that unlike Maricopa County, Colorado doesn't have any vans, and emphasized that transportation is a statewide challenge. There is a one-hour response time in urban areas and a two-hour response time in rural/frontier areas. Another challenge for Colorado is their workforce; Ms. Hoefler noted that in many parts of the state it is very difficult to find peers or master's level clinicians. She described how a lack of broadband/wireless coverage is difficult for the mobile teams and the people they serve and explained that another issue is the geographic distance and terrain of the state.

Ms. Lee presented on Colorado's innovation, including finding alternative providers, and spacing them geographically so they are closer to where the community need is. Telehealth is something Colorado had been exploring, and due to the pandemic, telehealth utilization has greatly increased. Ms. Lee described another idea in Colorado which consists of putting up a kiosk at a hospital and deploying behavioral health workers with a tablet to connect clients immediately to a mobile team via telehealth, rather than waiting for the mobile team to get there. She explained that one team has only a behavioral health crisis focus and they do some responses on their own or with a tablet, and they are thinking through other types of paired response.

Ms. Hoefler reviewed Colorado's crisis services data and explained that the data was a bit skewed because providers were given a six-month waiting period for data submission but that data indicated positive outcomes including fewer callers being taken to the emergency department.

Christy Butler described Washoe County's MOST teams, explaining that they have five clinicians and one case manager. The clinicians are all fully licensed mental health counselors. They ride with patrol for ten-hour shifts and are available seven days a week. The majority of their calls come through dispatch. There is only one MOST worker on at a time for the entire county, which means that there could be three or four officers waiting for them to complete one crisis call and move to the next.

Ms. Butler explained that the MOST team is able to refer calls to a case manager to get the client the follow-up services they need. She noted that law enforcement is receiving crisis intervention training from the teams as well, which includes role playing so they can learn how to best handle crisis situations. She emphasized that the relationship they have with law enforcement is extremely important.

Webinar participant Sheila Leslie asked: "Are there other collateral benefits to being embedded with law enforcement in terms of 'teaching' them by example how to handle a crisis mental health situation?": Ms. Butler answered that the "main thing is law enforcement hears how we talk to individuals in crisis," explaining that officers will pick up on that, see how that works and learn about the programs that exist so they have that as a resource for the next call.

Webinar participant Hal Wyrick explained that he is with the Crisis Response Team in Las Vegas and that they are in their third year of operation. He noted that they are the result of a collaboration between

Las Vegas Fire and Rescue, Southern Nevada CHIPS, and American Medical Response and detailed how they run multiple Advanced Life Support (ALS) units with Masters Level Clinicians on their trucks responding to mental health and behavioral health emergencies in real time through the 911 system. He indicated that they also have 100 percent case management follow up on every patient their units come in contact with, and that their goal is to provide the right care at the right time in a patient's moment of crisis.

Ms. Marschall commented that Nevada is unique because of the many different mobile crisis models, and asked Laura Yanez about the benefits of having access to a peer. Ms. Yanez explained that having a clinician and a peer respond to a crisis can help to ease anxiety for the client. She emphasized that there is a power in the peer being able to say, "I've been there before and I've experienced that, and this is what helped me." This makes the person feel less alone and that they can reach out for help. An anonymous webinar participant commented that: a "peer with me would have benefited me during my crisis," and that "you don't know what it's like, until you know what it's like."