Region 3a Mobile Crisis Team Proposal, Blue Ridge Behavioral Healthcare

Purpose and Background

Traditional "Mobile Crisis" teams provide timely assessment and intervention in cases of police involvement with individuals in the community. The purpose of such intervention is to provide law enforcement access to mental health experts on the scene, in real time, when they are involved with citizens who are experiencing crises such as suicidal ideation. Mobile crisis teams have existed for several decades around the country and Blue Ridge Behavioral Healthcare (BRBH) is making a proposal for funding to create a team in our area. The success of Mobile Crisis programs may be dependent on which components are provided. We believe a team that provides 1) "crisis intervention" on scene with police, 2) extended "crisis stabilization" after the initial law enforcement contact, and 3) the availability of an emergency psychiatrist to address immediate medication needs, will result in the most hospital and jail diversions.

One benefit of having a Mobile Crisis team is that mental health therapists can respond with law enforcement when they are dispatched on mental health related calls. This allows the therapists, rather than the officer alone, to assess the situation and potentially divert individuals from having to go to Emergency Departments, jails, or ultimately be hospitalized when an alternative safety plan can be put into place. More specifically, the Mobile Crisis therapist would assess the need for ECO (Emergency Custody Order), assist in de-escalation of the mental health related crisis, and potentially offer immediate therapeutic "crisis intervention." As in most traditional mobile crisis programs, staff would work in pairs when responding to scenes as requested by police, which helps with consultation and sound decision making for potentially high risk and complex cases.

After initial crisis intervention, for those that are appropriate, extended "crisis stabilization" services would be put into place. These services would begin immediately, last up to two weeks, and be in addition to other traditional services they may be receiving. Staff would be available to provide this additional support to the person, daily if needed, during that time frame. The benefit of the crisis stabilization component is that it helps the person stabilize over a longer period of time, potentially decreasing repeat law enforcement contact and provide better continuity of care.

An additional component proposed is the addition of an emergency psychiatrist to provide immediate evaluation and medication management until those in crisis could be seen for longer term psychiatric needs. The inclusion of a psychiatrist in traditional mobile crisis teams varies depending on funding levels and staffing availability, though their inclusion is deemed as ideal. The addition of a psychiatrist to our proposed team would also support hospital and jail diversion efforts for clients already open to BRBH, by making the doctor available to see same day walk-ins for those who may be unexpectedly in crisis or experiencing and escalation in symptoms.

It is expected that implementation of a Mobile Crisis team in our area would result in a decrease in ECOs and psychiatric hospital admissions. It would also help serve individuals experiencing mental health emergencies in a timelier manner and potentially decreasing the time law enforcement spends in the hospital and transporting clients. The team would also be available as requested to provide cross education to law enforcement agencies about mental health and substance abuse related topics.

Partnership

Four local law enforcement jurisdictions have expressed the desire to collaborate on this project—the police departments of Roanoke City, Roanoke County, City of Salem and town of Vinton. Two large hospital systems in the area are supportive of implementation of a Mobile Crisis team through BRBH. These efforts are also supported by our area's Mental Health and Criminal Justice Task Force and Catawba Regional Partnership. Mobile Crisis and CIT teams were recently noted as a priority area in a regional Criminal Justice and Opioid mini-cross systems mapping led by members of the Department of Behavioral Health and Human Services. This level of consensus among law enforcement, hospitals, and the Community Services Board (CSB) is expected to lend support to the success of the project. Mobile Crisis Teams are currently a part of the STEP-VA plan to be implemented in the future. Due to the experience of several in our catchment area with Mobile Crisis teams, BRBH would like to implement the project early and potentially be an example to others CSBS as needed.

Strategies

Key strategies include the availability of a mental health therapist to respond with police to a mental health related call. Additional psychiatric coverage to provide consultation and medication orders as needed is also an important component for the success of a mobile crisis team. Roanoke, Roanoke County, and Salem police departments have collected data on mental health related incidents from 2015-2017 which identified 4pm to 10pm as the peak hours of these calls and Thursdays typically having the highest volume. Many of the mental health related calls that police respond to are the result of an individual experiencing a significant external stressor, family conflict, or exacerbation of an already present mental illness. The therapist responding along with the police officer in these types of situations would provide an additional array of interventions, potential referral for immediate psychiatric services, and potential future outpatient services along with the sole police officer's ability to de-escalate, initiate an ECO, or arrest.

Activities

Mental Health related calls would be identified by the participating police jurisdictions and the mobile crisis team therapist working or on-call would be notified to meet the officer at the location of the individual in crisis. Police would assess the situation for safety, and when deemed appropriate, would invite the mobile crisis therapist to assist. The therapist would conduct a basic mental health screening, including assessment of risk, mental status, history of mental illness, and current and previous services. The therapist would provide crisis intervention with motivational interviewing skills to de-escalate the crisis, make a safety plan if

needed, and a plan for follow-up services. The individual might be referred to the Same Day Access Center the follow day for intake or, if needed, plans could be made to provide crisis stabilization services for up to the next 15 days. If there was a need for psychiatric services, the psychiatrist could meet the individual at their home or somewhere else in the community to provide assessment and intervention. In the event that the individual was a danger to themselves or others, the police officer could initiate an ECO and the individual would be taken to the hospital emergency room for assessment.

Supporting Data

There is data to support mobile crisis teams reducing psychiatric hospitalizations. A paper by Roger Scott in 2000 provided data on the success of a mobile crisis team working with police in Dekalb County, Georgia. Fifty-five percent of the emergencies handled by the mobile crisis team were managed without psychiatric hospitalization of the person in crisis, compared with 28 percent of the emergencies handled by regular police intervention. A study in 2010 by Kisely, Campbell, and Peddle found that time spent on the scene by police officers was significantly lower with the use of mobile crisis. A 2001 study by Guo, Biegel, Johnson, and Dyches found that an individual receiving hospital based crisis services was 51 percent more likely to be hospitalized within 30 days of the crisis compared to an individual receiving interventions from a mobile crisis team. In 2013, Las Vegas, Nevada began a pilot of utilizing a mobile crisis outreach team with their paramedics to divert low medical acuity psychiatric patients from unnecessary transport to the emergency room and was able to increase the percentage of diversions by 11%. Evaluation of a Mobile Crisis Program: Effectiveness, Efficiency, and Consumer Satisfaction. Roger L. Scott, L.C.S.W., Psychiatric Services, Volume 1, Issue 9, September, 2000.

A Controlled Before-and-after Evaluation of a Mobile Crisis Partnership between Mental Health and Police Services in Nova Scotia. Stephen Kisely, MD, PhD, Leslie Anne Campbell, MSc, Sarah Peddle, MSc, Psychiatric Services, Volume 52, Issue 2, February, 2001.

Guo, S., Biegel, D.E., Johnsen, J.A, & Dyches, H. Assessing the Impact of Community-Based Mobile Crisis Services on Preventing Hospitalization. Psychiatric Services, Volume 52, Issue 2, February 2001

Diverting Psychiatric Patients to Least Restrictive Environment of Care. Presented at: The National Council for Behavioral Health Conference, March 7-9, 2016, Las Vegas.

Costs

There are a variety of potential service availability plans providing differing levels of mental health staff availability. A plan to assist mental health police calls with additional on-call coverage for all other times appears to be the most cost and recruiting effective strategy.

Day Time and on-call Coverage, Therapists

A plan for day time coverage provides at least 3 staff on shifts of 9am to 7pm at all times Monday through Friday, and the remaining time will be covered by on-call personnel available

for response within 1 hour. Costs for the 4 therapist positions and 1 supervisor to cover the proposed program, including salary, fringe, management and overhead, equipment and supplies is approximately $360,000. This staffing level also provides for good coverage for when staff may be on leave or in the event a position is vacant for a short period of time. On-call expenses for the remaining 118 hours per week would cost approximately $38,350 annually. On-call staff working in the community after-hours and on weekends would be paid the typical time and a half of their hourly rate. For an average of 4 after-hours calls daily, at an estimated 3 hours for each call, costs would be approximately $120,450.

Total personnel costs for Therapist = approximately $518,800.

Psychiatrist Coverage

Psychiatric services is a key component of a successful mobile crisis team. The psychiatrist would respond to police involved mental health crisis calls with assessment and needed medication orders to accomplish de-escalation and stabilization in the community. Additionally, when not called out to the community on a mental health call, the psychiatrist could see individuals on an emergency walk in basis with a goal of preventing a potential crisis from escalating to the level of police involvement.

The cost for a full time emergency psychiatrist (including salary, fringe, management and overhead, equipment and supplies) is approximately $375,000. This position would provide coverage for 40 hours a week, with schedule and availability optimally based on the hours of peak mental health calls. Considering the increased need during daytime hours for both Mobile Crisis in the community, and walk-in emergency appointments, and the cost of additional staff to sit with the client during telepsychiatry appointments as required by regulations, the most cost effective means for coverage is a hiring a full time psychiatrist.

Blue Ridge Behavioral Healthcare (BRBH) currently has a contract with Insight Telepsychiatry to provide psychiatric consultation and medication orders after-hours by phone with the capability of video assessments if needed. This contract could be used to provide either psychiatric coverage during the remaining hours of the week when the full time psychiatrist is not scheduled, or, less optimally, as a replacement of the full time psychiatrist position. The cost of this contract is currently a $3900 monthly fixed availability fee with $50 for each phone consult up to 50 consults per month. (An additional availability fee of $3545 is charged for calls exceeding 50 per month.) Video assessments are an additional $250 each. Currently BRBH is averaging 25-30 consults per month. The Insight representative has confirmed that we could utilize the remaining monthly call availability on the current contract for mobile crisis. There would be an additional one time set up fee of approximately $1500 to set up the doctor availability. Insight is currently providing this service to a mobile crisis unit in another state and estimates that 20 percent of calls request video assessment. The potential number of cases needing phone review is estimated at 20 monthly with a projection of about 5 monthly needing video assessment.

Total costs for a full time emergency psychiatrist and after-hours telepsychiatry services= approximately $402,000. And additional one time $1500 set up fee for telepsychiatry.

Revenue

Police data indicate approximately 10-12 mental health related calls daily between the five participating police jurisdictions. Of those, about 40% are ECOs which the CSB Emergency Services staff are already responding to in the local hospital emergency rooms. The remainder would be the calls directed to the mobile crisis team.

Crisis Intervention services could be billed for individuals with Medicaid for time spent on the initial crisis call. Crisis Stabilization services could be billed for individuals with Medicaid for daily follow-up services of up to 15 days. Considering a projected Medicaid rate of 30% of all individuals seen through mobile crisis, the following amounts are projected revenue sources:

Average of 3 hours per call billed to Crisis Intervention at $125/hour and estimated 6 calls daily=$2250 daily or $821,250. Average of 30% Medicaid clients=$246,375 in yearly Medicaid billing for Crisis Intervention.

Projection of 5 hours daily in additional Crisis Stabilization billing at $89/hour =$445 daily or $162,425 yearly. Average of 30% Medicaid clients=$48,727 in yearly Medicaid billing for Crisis Stabilization.

There would be a total projected yearly Medicaid billing to offset therapist's expenses of $295,102.

A full time psychiatrist could also bill Medicaid for evaluations and consultations with medication orders. **The potential Medicaid billing for psychiatric services is estimated at $87,000**. **Telephone consultations through Insight Telepsychiatry would not be billable.**

TOTAL ONGOING COSTS FOR MOBILE CRISIS TEAM PER YEAR

4 Therapists and 1 supervisor	$360,000
Therapist On-call and Paid Worked Time	$158,800.00
Full Time Emergency Psychiatrist	$375,000.00
Insight Telepsychiatry after hours coverage	$27,000.00
Total Staffing Cost	$920,800
ESTIMATED POTENTIAL TOTAL MEDICAID REVENUE	$382,102.00
TOTAL PROJECTED ONGOING FUNDING NEEDED	**$538,698.00**
Plus one time telepsychiatry set up fee	**$1500.00**

Outcomes

Based on empirical data, a regional mobile crisis team should result in a decreased number of psychiatric hospital admissions across the participating jurisdictions. This could in turn have a positive impact on the current high census in state hospitals. With a corresponding decrease in the number of ECOs, time spent by police officers maintaining custody during the ECO/TDO process should be significantly reduced. Local hospital emergency rooms would benefit with a decrease in number of ECOs and individuals arriving by police transport after a police call deemed mental health related. Additionally, individuals in the community would be receiving the least restrictive level of service at a time when escalation into ECO, hospitalization, and even possible arrest could exacerbate previous trauma, increase acuity, and reinforce negative perceptions of police and mental health staff. Providing services and support in the community during a time of crisis is best for the individual, their involved family, and the community.

Data planned to be collected during the project include:
Mobile Crisis calls from law enforcement and their jurisdiction
Mobile Crisis contacts
resulting in diversion/safety plan
going to Emergency Department after contact
hospitalized after contact
going to jail after contact
referred to extended ambulatory crisis stabilization
engaging in extended ambulatory crisis stabilization
entering residential crisis stabilization
with co-occurring mental health and substance use
Continue track regional hospitalization numbers

Impact

Both police and mental health staff attempt to provide solutions and support to individuals in a mental health crisis, but in traditionally very different ways. A program of mobile crisis would expand and solidify the relationships between the two types of agencies, forge better understanding of how crisis situations are perceived by the other, and provide a much more comprehensive and supportive response in these cases. As a regional program, police relationships across jurisdictions would be strengthened. State hospital bed utilization is expected to decrease, and most importantly, the community and its citizens would benefit from a program that could better meet the emergent needs of those with mental health and co-occurring disorders and help connect them to the right treatment at the right time.