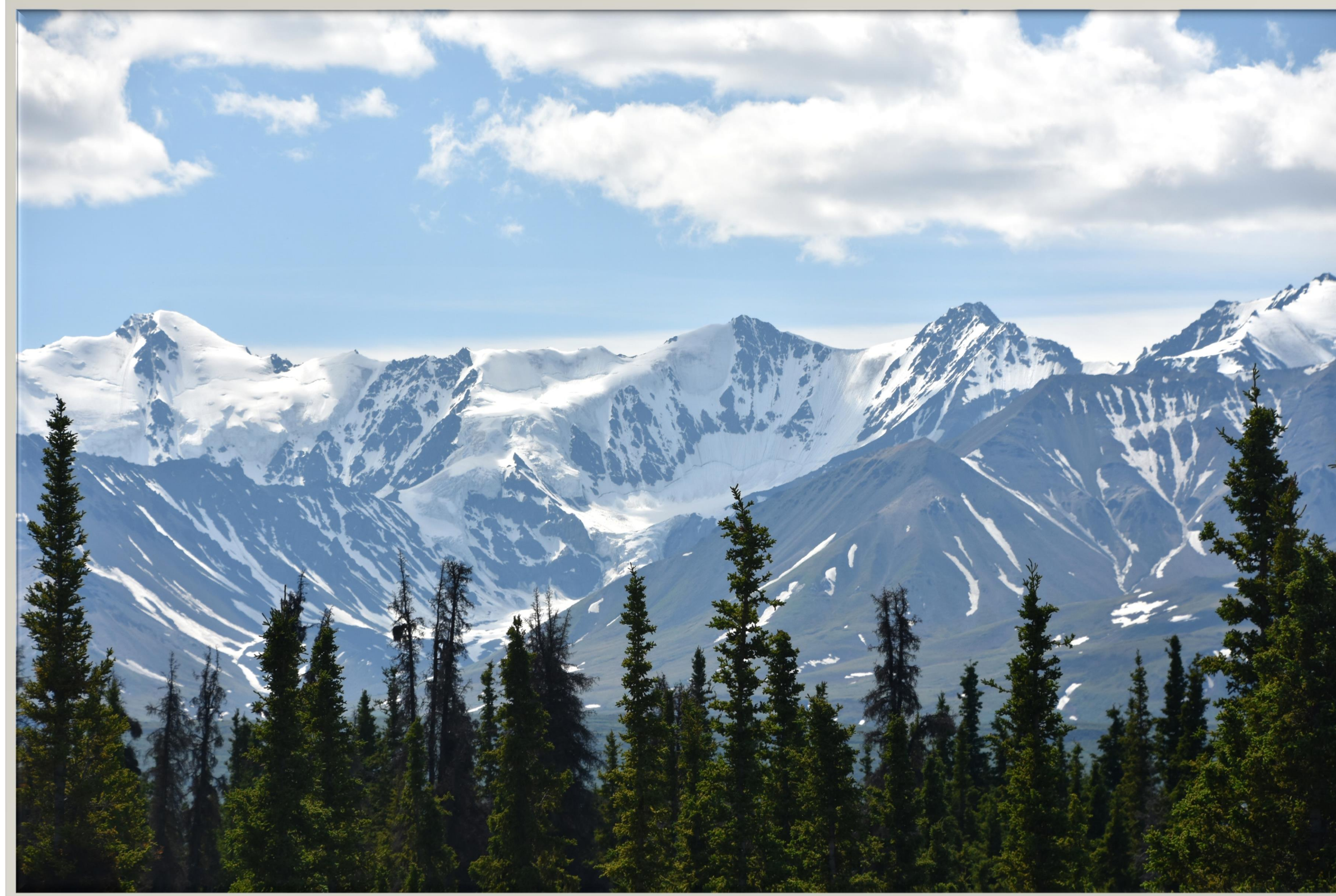




## Introduction

As discussed in the Crisis NOW Alaska Mental Health Trust Report, Fairbanks needs a comprehensive crisis response system, as the current system of care struggles to provide timely access to crisis services, is unable to meet individuals where they are experiencing the crisis, and often relies too heavily on law enforcement, the criminal justice system and hospital emergency rooms to respond to behavioral health crises.

As one part of the crisis continuum, the mobile crisis team will incorporate peers within the mobile crisis team (in collaboration with The Bridge); will respond where the person is and not restrict services to select locations within the North Star Borough or during particular days / times; and provide warm hand-offs and coordinating transportation when the situation warrants transition to other location



## Services

The essential functions of the mobile crisis team will include:

- triage and screening (explicit screening for suicidality);
- assessment;
- de-escalation/resolution;
- peer support (in collaboration with The Bridge);
- coordination with medical and behavioral health services;
- collaboration with families and natural supports, information and referrals;
- transportation;
- and crisis planning and follow-up.

## Impact in the Community

The implementation of a mobile crisis team will mean that individuals experiencing a behavioral health crisis will get the ***right care, in the right setting, when they need it.***

This will lead to a decrease in use and interaction with emergency departments, jails, and police.

## Population

The Fairbanks mobile crisis team will provide crisis services to any person in the North Star Borough in their home, workplace, or any other community-based location.

Based on the Mental Health Trust Authority's Crisis NOW report, there could be approximately 200 crisis episodes per 100,000 North Star Borough residents with 1,021 annual episodes for the mobile crisis team per year.







## Admission Criteria

Criteria for activating the mobile crisis team:

1. Individual must be in an active state of crisis that has not been able to be resolved by phone or other community interventions.
2. Individual must be able to vocalize and participate in planning.
3. Immediate intervention is necessary to attempt to stabilize the individual's condition safely.
4. Situation does not require an immediate public safety response.
5. The intervention is expected to improve the individual's condition/stabilize the individual in the community.
6. The individual demonstrates at least one of the following:
  - a) Suicidal/ assaultive/destructive ideas, threats, plans or actions that represent a risk to self or others.
  - b) Impairment in mood/thought/behavior disruptive to home, school, or the community.
  - c) Behavior is escalating to the extent that a higher intensity of services may be required.

## Discharge Criteria

Criteria for discharging an individual from the mobile crisis team:

1. Crisis assessment and other relevant information indicate that individual needs another level of care, either more or less intensive.
2. The individual is released or transferred to an appropriate treatment setting based on crisis screening, evaluation, and resolution.
3. Individual's physical condition necessitates transfer to an inpatient medical facility and the provider has communicated the crisis assessment information and safety plan to the receiving provider.
4. Consent for treatment is withdrawn and there is no court order requiring such treatment.







## Essential Functions – *Triage/Screening*

### Mobile Crisis Dispatch

Level 1	Law Enforcement Leads (with MCT accompanying or following behind) - <i>The MCT must heed police instructions and respond to the scene once it is deemed safe for entry.</i>	<p>This level indicates situations that are too dangerous to deploy without the environment first being secured by law enforcement. It is also key in these situations to have a response within the shortest amount of time possible.</p> <p>Dispatch will not dispatch the MCT as the sole responder if the caller is in imminent danger to self-and/or others (as evidenced by any of the following):</p> <ul style="list-style-type: none"><li>• “Likely” or “very likely” intent for suicide attempt (more than desire/ideations and capability alone)</li><li>• “Likely” or “very likely” intent for homicide attempt</li><li>• Threat to staff</li><li>• Possession of a weapon and unwilling to reduce access (e.g., put away in safe, closet, etc.).</li></ul>
Level 2	MCT Lead (with law enforcement in the background or following behind but on the scene)	<p>Caller reports any of one of the following:</p> <ul style="list-style-type: none"><li>• History of aggression</li><li>• Recent acts of aggression</li><li>• Self-injury</li></ul> <p>This level indicates situations where MCT staff enter the environment first, but law enforcement is immediately available if needed.</p>
Level 3	MCT Lifeline (Law enforcement on standby via phone)	<ul style="list-style-type: none"><li>• Active psychosis</li><li>• Disorganized thinking or reporting hallucinations which may result in harm to self/others</li><li>• Unable to care for self</li></ul>
Level 4	MCT Alone (no law enforcement)	<ul style="list-style-type: none"><li>• No suicidal/homicidal intent and denies suicidal plan/means/capability but expresses hopelessness, helplessness, sense of burdensomeness, disconnectedness, or anger.</li><li>• May develop suicidal intent without immediate help</li><li>• Potential to progress to need for emergent services</li><li>• May express distress/impairments that compromise functioning, judgment, and/or impulse control</li></ul>
Level 5	Secure Location (hospital, jail, social service agency, etc.)	<p>These cases are in a safe location so a clinician may respond alone without a peer support specialist. Calls to residences (apartments, homes, etc.) are not “safe sites”. With supervisory permission, a clinician may be sent alone if another mental health or social service professional is already onsite (e.g., OCS, teacher, etc.).</p>







## Essential Functions – *Assessment*

- MCT will assess the person in crisis and consult with available collateral persons on scene or, if necessary, via phone. MCT will also collaborate with the individual in crisis to create a plan for crisis intervention and arrange for appropriate continuing crisis intervention at the lowest appropriate level of care. If the MCT determines that involuntary hospitalization is appropriate, the clinician will call Fairbanks Police Department. The MCT may transport an individual to the hospital if, based on their assessment of safety, and after consultation with a clinical supervisor or the CMO, it is deemed safe to transport and the client is agreeing to go voluntarily.
- If an individual is too intoxicated to meaningfully participate in an assessment, the MCT will immediately stop the assessment and reach out to the supervisor on call. After consulting with the supervisor on call, the MCT may call EMS or refer the individual to services more appropriate for their needs.
- MCT clinician is responsible for completing an assessment that addresses the information below:
  1. Causes leading to the crisis event; including psychiatric, substance abuse, social, familial, legal factors and substance use;
  2. Safety and risk for the individual and others involved; including an explicit assessment of suicide risk;
  3. Strengths and resources of the person experiencing the crisis, as well as those of family members and other natural supports;
  4. Recent inpatient hospitalizations and/or any current relationship with a mental health provider;
  5. Medications prescribed as well as information on the individual's compliance with the medication regimen; and
  6. Medical history as it may relate to the crisis.
- All crisis assessments must be documented immediately following a crisis assessment but by no later than the end of their shift.
- The clinician should also complete the Level of Care Utilization System for Psychiatric and Addiction Services (LOCUS) in order to assess immediate service needs and inform the treatment planning process in addition to the Columbia Suicide Severity Rating Scale (C-SSRS) and the PHQ-9.





ALASKA  
BEHAVIORAL  
HEALTH

# Fairbanks Mobile Crisis Team

*Christine Alvarez, LPC, Chief Clinical Officer of Adult Services*  
calvarez@akbh.org - (907) 744-1333

## Essential Functions – *Peer Support, De-escalation, Coordination, Crisis Planning, and Follow-up*

**Peer Support:** The peer support specialist does not reduplicate the role of the clinician but, instead, should establish rapport, share experiences, and strengthen engagement with the individual experiencing the crisis. Peers may also engage with the family members of (or other persons significant to) those in crisis to educate them about self-care and ways to provide support.

**De-escalation/Resolution:** MCT will engage individuals in counseling throughout the encounter and intervene to de-escalate the crisis in order to prevent, if possible, a higher level of care.

**Coordination w/ Medical and Behavioral Health Services:** The MCT, as part of an integrated crisis system of care, will focus on linking individuals in crisis to all necessary medical and behavioral health services that can help resolve the situation and prevent future crises. These services may include crisis stabilization or acute inpatient hospitalization and treatment in the community (e.g., community mental health clinics, in-home therapy, family support services, crisis stabilization facility, etc.).

**Crisis Planning and Follow-Up:** During a mobile crisis intervention, the MCT should engage the individual in a crisis planning process resulting in the creation or update of a range of planning tools including a safety plan. Follow-up contact between the MCT and the individual in crisis, service providers and identified supports will be initiated within 24 hours of the initial crisis.



## Training

### **AKBH Orientation**

Orientation for all AKBH MCT staff will include privacy and HIPAA overview; safety overview; incident reports; legal requests and holds; screening for suicide risk, wellness plan & safety plan; billing; documentation; community resources; ECR general training; golden thread and treatment planning; DLA-20; trauma informed care; and ARC/Wiley Qualifacts treatment plan.

### **Crisis Responder Training (30 hrs.)**

- Mental Health Crisis Services Definitions and Goals
- Early Intervention and Prevention
- Harm Assessment and Suicide Prevention
- Alaska Mental Health Law
- Less Restrictive Referral Alternatives
- Cultural Identity Impact on Crisis Intervention
- Crisis Intervention with Specific Populations (e.g., SPMI, SED, children/adolescence, older adults, SUD, etc.)
- Law Enforcement as Partners
- Collaboration with Service Providers and Others
- Crisis Services Provider Boundaries and Self Care





## Training

### Online Training (14.5 hours)

- **The Suicide Prevention Resource Center - Counseling on Access to Lethal Means** : Covers why reducing access to lethal means of self-harm saves lives. Teaches practical skills on when and how to ask suicidal clients about their access to lethal means and how to work with them and their families to reduce that access.
- **Zero Suicide Institute - Assessing and Managing Suicide Risk**: Assessing and Managing Suicide Risk (AMSR) is a one-day training that expands the clinical skills of providers and offers a clear and descriptive suicide risk formulation model to inform long-term treatment planning. Teaching and skills-building methods include video demonstrations, group discussion, written and paired practice, case review, and expert teaching.
- **The Columbia Lighthouse Project Training for Communities and Healthcare in the Columbia Suicide-Severity Rating Scale (C-SSRS) Interactive Training Module**: The Columbia Protocol, also known as the Columbia-Suicide Severity Rating Scale (C-SSRS), supports suicide risk assessment through a series of simple, plain-language questions that anyone can ask. The answers help users identify whether someone is at risk for suicide, assess the severity and immediacy of that risk, and gauge the level of support that the person needs. Users of the tool ask people: Whether and when they have thought about suicide (ideation); What actions they have taken — and when — to prepare for suicide: Whether and when they attempted suicide or began a suicide attempt that was either interrupted by another person or stopped of their own volition.
- **CAMS-Care, LLC's Collaborative Assessment and Management of Suicidality**: Teaches the Collaborative Assessment and Management of Suicidality (CAMS), an evidence-based, therapeutic framework emphasizing collaborative assessment and treatment planning. Consists of CAMS Book, "Managing Suicidal Risk, A Collaborative Approach, 2nd Edition & 3-hour CAMS Online Video Course





ALASKA  
BEHAVIORAL  
HEALTH

# Fairbanks Mobile Crisis Team

*Christine Alvarez, LPC, Chief Clinical Officer of Adult Services*  
calvarez@akbh.org - (907) 744-1333

## Safety & Supervision

**Safety:** Ensuring safety for both the individual in crisis and MCT staff is essential for effective crisis care.

The keys to safety and security for home visits by the MCT include:

1. No member of the MCT will be required to conduct home visits alone.
2. AKBH and/or The Bridge will equip MCT staff who engage in home visits with a communication device.
3. MCT staff dispatched on crisis outreach visits will have prompt access to any information available on history of dangerousness or potential dangerousness on the individual they are visiting.
4. MCT staff will use GPS enabled technology and will check in at least once per hour with dispatch.

**Supervision:** The MCT staff will always have direct access to a licensed clinical supervisor. During business hours, the MCT staff may contact the director of adult services, the chief clinical officer of adult services, and/or the AKBH psychiatric provider, if they are a current client. After hours, the MCT staff may call the on-call clinical supervisor or the chief medical officer or delegate.





ALASKA  
BEHAVIORAL  
HEALTH

# Fairbanks Mobile Crisis Team

*Christine Alvarez, LPC, Chief Clinical Officer of Adult Services*

calvarez@akbh.org - (907) 744-1333

## Funding

Research found that the economic impact of crisis services resulted in a 23 percent lower average cost per case than police intervention. In another study analyzing the cost impact of mobile crisis intervention, they found that mobile crisis intervention services could reduce costs associated with inpatient hospitalization by approximately 79 percent in a six-month follow-up period after the crisis episode.

Collaborative funding to support crisis care in the future will be important. Crisis services will be funded through an individual's insurance coverage, but no one will be turned away from crisis care, regardless of the funding that will be used to pay for the service. This means if an individual receives crisis services and has Medicaid or private insurance, the respective payers will cover the service but those who are uninsured will receive services funded by a grant (from the state or other source).

As of right now, our budget outlines the cost for the clinical aspects of the crisis team to be \$638,327. We anticipate, based on Agnew-Beck's numbers and the RI Report, to have 1032 crisis episodes. The 1115 Waiver provides \$175.64 per call out which could result in \$181,260 in revenue. Additionally, there is an option to bill short-term crisis intervention services (STCIS) instead of the mobile crisis code, which is a time-based code (15 minutes - \$31.44) so if a crisis takes 3 hours to resolve we could potentially bill the STCIS (\$377.28) instead of billing the mobile crisis code (\$175.64).

Follow-up can be billed under the STCIS (get 22 hours) or 1115 peer-based crisis services (15 minutes - \$20.46)





## References

- **Tennessee Department of Mental health and Substance Abuse Services (2012)** *Behavioral Health Crisis Services & Crisis Training.*
- **Beacon Health Options (2016)** *Medical Necessity National Criteria Set: Mobile Crisis*
- **SAMHSA (2020)** *National Guidelines for Behavioral Health Crisis Care: A Best Practice Toolkit*
- **Spokane County Community Services, Housing, and Community Development Department, Spokane County Regional Behavioral Health Division (2020)** *Crisis Response Services.*
- **Santa Barbara County Department of Behavioral Wellness (2021)** *Crisis Systems: Crisis Assessment Procedures*
- **Santa Barbara County Department of Behavioral Wellness (2019)** *Crisis Systems: Crisis Triage*
- **Alameda County Behavioral Health Mental Health and Substance Use Services (2019)** *Crisis Services Division: Mobile Crisis Team Services Policy and Procedure*
- **Center For Applied Research and Analysis at The Institute for Social Research at the University of Next Mexico (2020)** *Mobile Crisis Team Screening and Assessment Tools and Procedures*
- **The New York Office of Mental Health (2019)** *Mobile Crisis Program Guidelines*
- **Georgia Department of Behavioral Health and Developmental Disabilities (Unknown)** *Guide: Using Mobile Crisis Services in lieu of an Order to Apprehend*