

State Mental Health Agency Support for Mobile Crisis Teams, 2022

NRI's 2022 State Profiles

Updated April 18, 2023

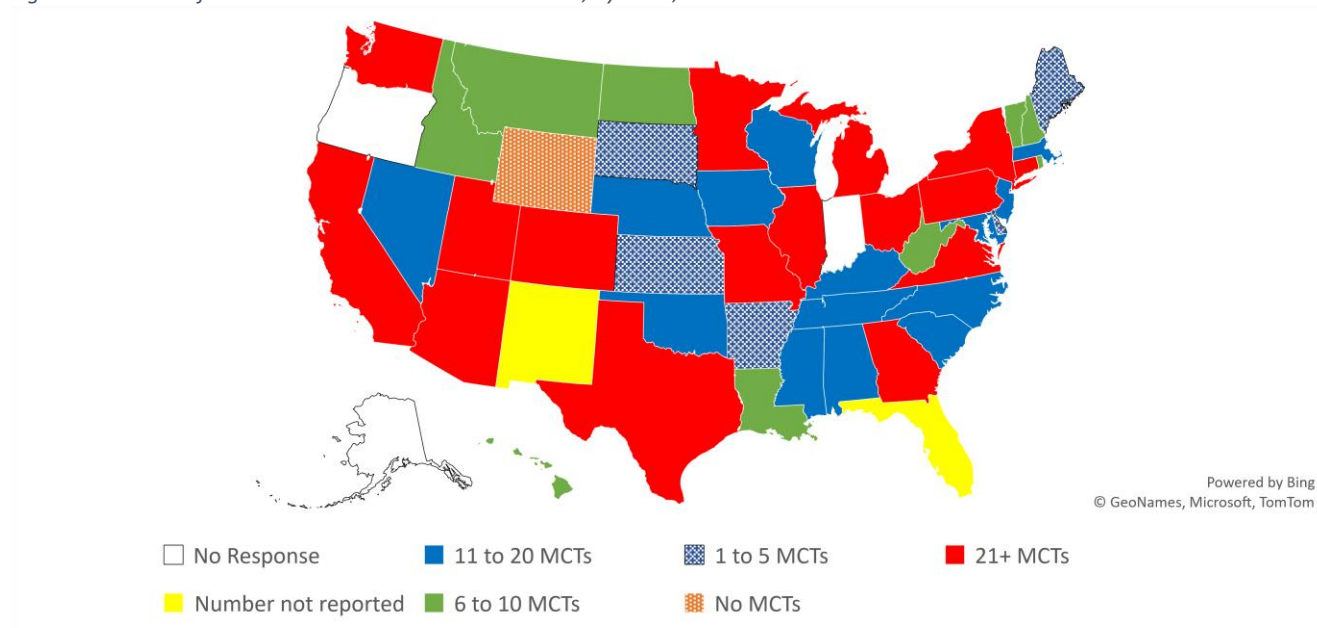
Highlights Based on 48 States Responding to the Crisis Component of NRI's 2022 State Profiles

Note: although 48 states responded to the Crisis Component, not all states provided answers to all questions; therefore, some of the information presented in this report is based on responses from fewer than the total number of reporting states

Mobile Crisis Teams: Someone to Respond

Mobile Crisis Teams (MCTs) are a critical component of the behavioral health crisis care continuum. MCTs are designed to travel to meet face-to-face with an individual experiencing a behavioral health crisis and have demonstrated effectiveness in helping address crises and reduce use of emergency rooms, psychiatric hospitalizations, and adverse criminal justice system interactions.

Figure 1: Number of Behavioral Health Mobile Crisis Teams, by State, 2022



MCTs are currently operating in 96% of responding states (46 out of 48 States). Most (41) states have staffed and funded their MCTs to respond to both mental health and substance use crises, while in four states MCTs are staffed and organized to only respond to mental health crises (two states did not respond to this question). Five states (Georgia, Massachusetts, Mississippi, Ohio, and Texas) also have MCTs staffed to respond to crises of individuals with intellectual disabilities.

In 2022, 44 states reported having 1,287 operating MCTs. States have a median of 14 MCTs, with a range from a high of 245 MCTs (in California) to a low of two MCTs in two states. Thirty-one states are currently working to open over 173 additional MCTs in 2023 (several report the actual number of new MCTs will depend on funding and workforce). In 15 states a total of 110 dedicated MCTs have been established to respond exclusively to children and adolescents in crisis, but in most states the same MCTs work with both children and adults.

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96%

Of States Have Mobile Crisis Teams Operating

512,305

Individuals Were Served by a Mobile Crisis Team Last Year

1,287

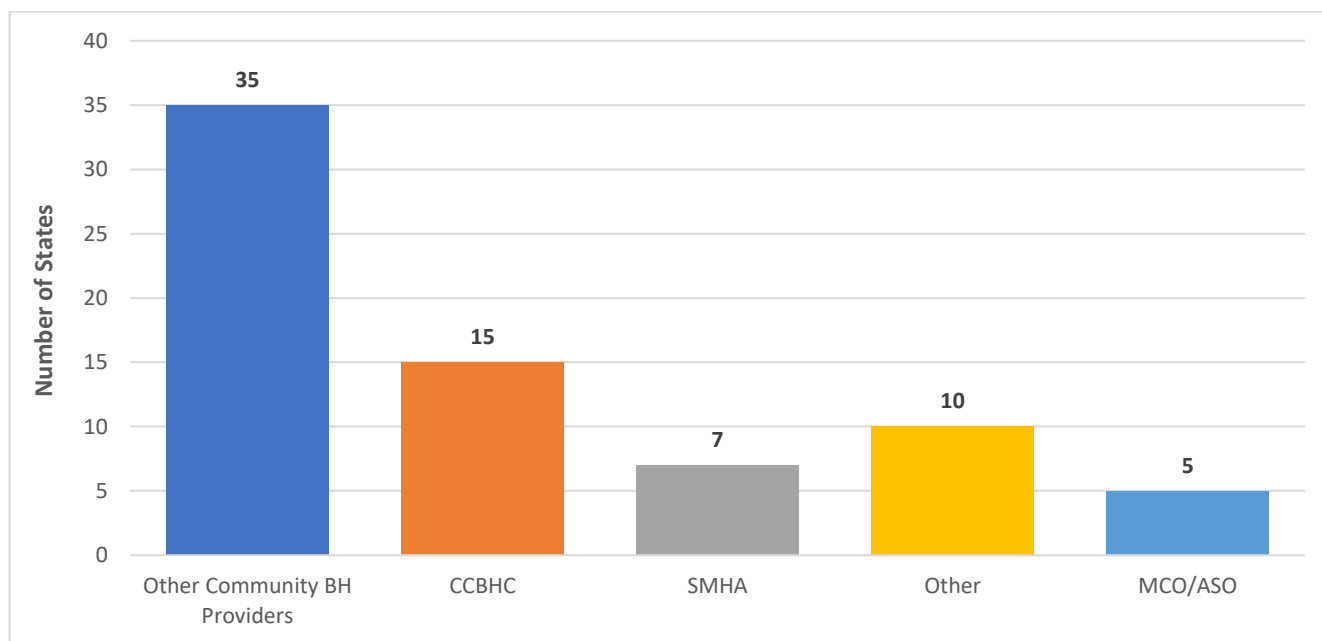
Number of Mobile Crisis Teams Operating (44 States reporting)

Mobile crisis is a relatively new service in many states and several states with MCTs are not able to report how many clients received MCT services in the past year. The 28 states able to report the number of individuals who received an MCT service during the last year reported 512,305 persons served. States averaged 18,297 individuals served by MCTs, ranging from a high of 108,581 in Massachusetts to a low of 77 in Kansas (which is in the process of implementing MCTs), with a median of 8,506 served by MCTs. In the 21 states able to report MCT clients served by age, 35% were under age 18 and 65% were age 18 and over.

Mobile Crisis Team Operation:

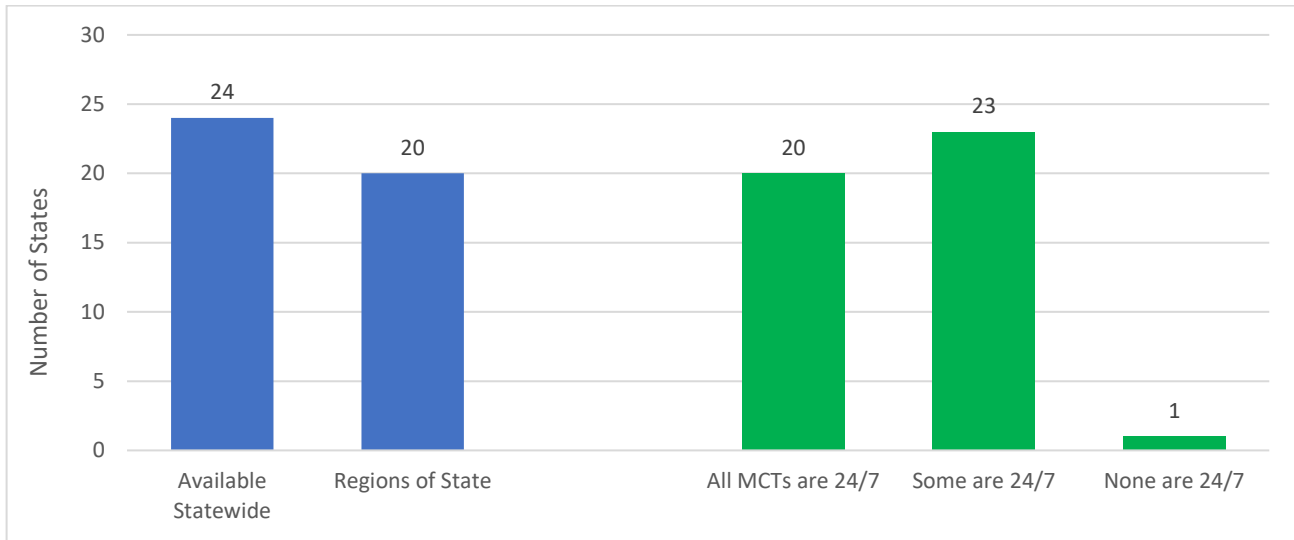
States may use multiple types of organizations to operate MCTs. As shown in Figure 2, community behavioral health providers such as community mental health centers (CMHCs) are the most common type of organization, operating MCTs in most (35) states. Certified Community Behavioral Health Centers (CCBHCS) (15 states), and State Mental Health Authorities (SMHAs) operating their own MCTs are the next most common, with seven states. Other organizations that operate MCTs include Managed Care Organizations/Administrative Service Organizations in five states, and a variety of other organizations such as county/local governments and local hospitals (10 states).

Figure 2: Number of States Funding Mobile Crisis Teams, by Type of Organization Operating MCT, 2022



The goal of states is to have MCTs available to all individuals experiencing a crisis anywhere in a state, at any time of day or night. However, as states expand their MCT services, not all states have statewide or 24-hours-a-day, seven-days-a-week (24/7) availability of MCT services. In 24 states, MCTs are available statewide wherever in a state an individual is experiencing a crisis. As shown in Figure 3, fewer than half of the states (20) have MCTs available (24/7). States described the major barriers to expanding coverage include workforce/staffing shortages (33 states), transportation issues in rural/remote areas, and funding to sustain MCT services.

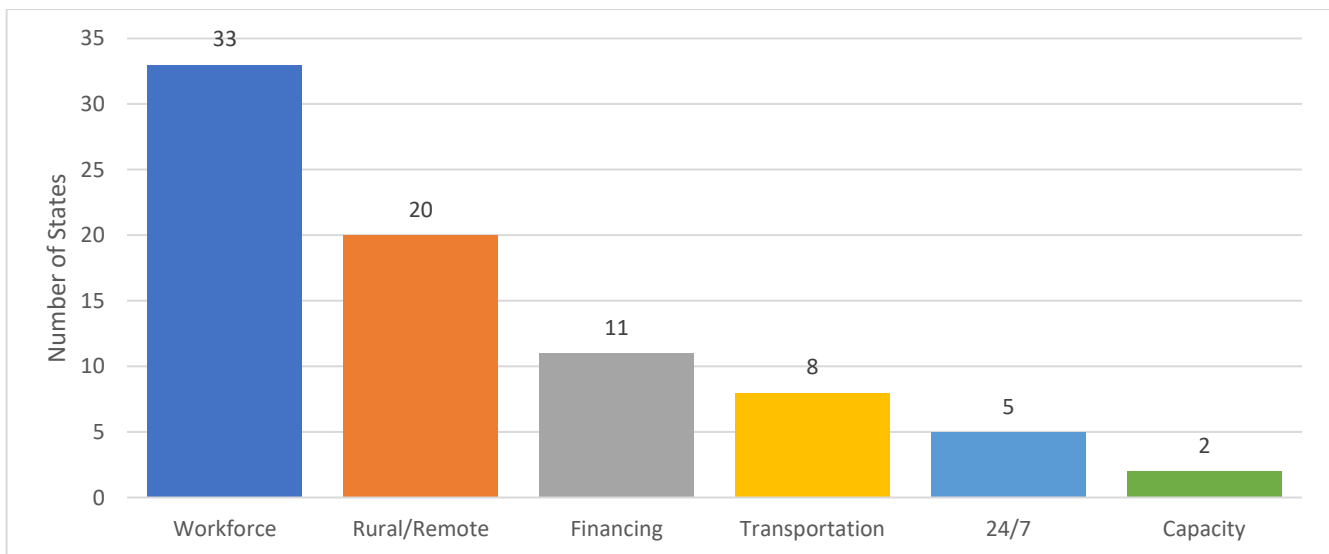
Figure 3: Number of States with Mobile Crisis Teams Available State-wide and 24/7, 2022



Challenges to Having MCTs available 24/7 to all Clients (all Regions):

Most (78%) SMHAs report difficulties establishing and providing Mobile Crisis services that are available at any place (region) of a state and that are available any time of any day or night. The most frequently identified barriers to providing 24/7 MCT across all regions of a state were the lack of available skilled workers (33 states), followed by issues of operating MCTs in rural parts of states (20 states), other challenges include financing MCT services, transportation, and capacity to meet demand (See Figure 4).

Figure 4: Barriers to Provision of MCT Services 24/7 Statewide, 2022



States often described particular difficulties with MCT staffing for evenings/overnight and weekend shifts. Workforce issues are particularly acute in rural areas and geographically isolated areas:

- “Hiring and retention of staff has been the most significant challenge. It has been particularly difficult to hire Licensed Clinical Social Workers for second and third shifts.”
- “Hiring and retaining staff who are willing to work the overnight shift is difficult. This is particularly noted in rural counties across the state.”
- One state noted that “some regions are geographically isolated and require unique transportation arrangements (e.g. helicopter, mule) should a MCT be indicated.”

Efforts to Address Challenges to MCT 24/7 availability:

Most of the states are working to expand the number of MCTs that are available 24/7. Approaches to expand include increasing the use of Medicaid, increased state funding, supporting growing and training the workforce to work in MCTs, changing credential requirements to staff MCTs, and increasing the use of technology and telehealth in remote areas. Sample state initiatives to expand MCT services include:

- Arkansas: Funding for pilot programs and utilizing teams with clinical support virtually
- Arizona: Established statewide response time standards within contracts and policies and continues to collaborate with providers and system partners on system performance. Increased use of peers in MCTs may also help to reduce workforce shortages in areas with limited crisis responders available.
- California: Working on implementing the statewide Medicaid mobile crisis benefit; stakeholder engagement, training/technical assistance, etc., encouraging regional partnerships.
- Connecticut: Some private non-profit mobile crisis providers are looking to adjust work schedules to be more flexible (e.g., four 10-hour day work weeks, triaging calls from home instead of the office but will go out if a mobile response is needed). Legislation was just recently passed that will allow for Licensed Professional Counselors (LPCs) and Licensed Marriage and Family Therapists (LMFTs) working on a state-funded or state-operated mobile crisis team to issue an emergency certificate. The state is hoping that this will increase the pool of applicants to more than just LCSWs.
- Illinois: The SMHA has developed a statewide plan for addressing the workforce shortages.
- Kentucky: Providing technical assistance to providers to support increased workforce; identifying alternative response options and/or increased safety mechanisms that can be put in place for the response process.
- Louisiana: The state is working with providers to address education and experience requirements that may prohibit hiring otherwise qualified staff. Mobile Crisis Response is a new service for the state, implemented as recently as April 2022. In the initial phase of implementation, MCTs are expected to implement a “soft launch” of services, allowing them to build up to 24/7 availability as new teams are staffed, trained, and engaged with local community stakeholders to build effective relationships and referral bases. During this initial phase all providers are rendering services a minimum of 40 hours a week. The specific hours of operation vary by region.
- Maryland: The State is utilizing Federal, state, and local grant funds to address workforce issues. Maryland was recently awarded federal grant dollars to expand the use of peers in the crisis system.
- Maine: The State has increased funding to the contracted MCTs in order to increase staffing, and is engaging in a rate study process to assess whether Medicaid rates are sufficient or need to be increased. The state is taking part in the Mobile CMS Technical Assistance Grant in order to achieve federal best practices and is exploring the implementation of CCBHC.

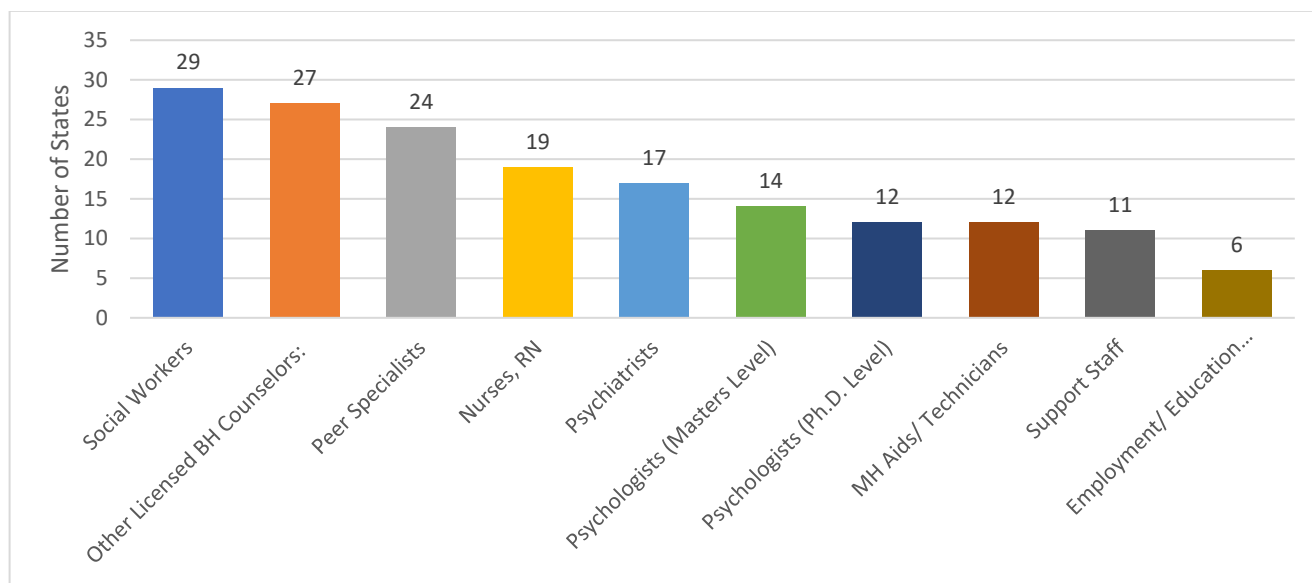
- Minnesota: Minnesota received FMAP and COVID funding to focus on enhancing or expanding mobile crisis services. The funding could be directed to recruit and maintain staff. In addition, telehealth services have enabled MCT to use two-way interactive video and audio communication to deliver services.
- Missouri: The SMHA conducted a needs assessment to assess gaps and barriers to 24/7 mobile crisis and determine some recommendations and next steps to improve. The SMHA has also secured additional funding for up to 65 mobile crisis teams in Missouri.
- Mississippi: DMH is providing Mobile Crisis Response Teams with an additional \$100,000 per team beginning in July 2022 to assist with staffing challenges.
- Montana: The state is working collaboratively with frontier, rural, tribal, and urban communities to develop models that integrate telehealth responses to meet their specific needs.
- North Carolina: The North Carolina State Medicaid office (Division of Health Benefits) has contracted with Recovery International for an assessment of our MCT and recommendations.
- Nebraska: Exploring how to utilize technology and/or telehealth options.
- New Hampshire: Recruitment, retention, evaluation process is currently underway with Dartmouth College.
- New Mexico: The SMHA is working with an actuarial firm to develop a sustainable rate for MCT so that staff will be well compensated. Pilot sites are utilizing recruiting firms and signing bonuses in order to secure staff for MCTs. Rural and remote areas have been a focus for pilot sites. They have been intentionally included in all planning efforts to ensure that services are tailored to their unique geographic areas.
- Nevada: A CMS Mobile Crisis Planning Grant will establish standards for staffing, mechanisms for reimbursement, define catchment areas, and the 988-contract vendor will have a centralized MCT dispatch
- New York: Assessing community need, program development based on need.
- Ohio: Launched a workforce development strategy that gives the state an opportunity to make education more attainable and affordable for students committed to behavioral healthcare careers. The funding will be dedicated to enhancing paid internship and scholarship opportunities for students working to achieve behavioral health certifications and degrees at Ohio's two- and four-year colleges and universities and other educational career development settings. It will also help remove financial barriers from obtaining licenses, certifications, and exams necessary for employment in these careers; support providers in their ability to supervise and offer internships and work experiences; and establish a Technical Assistance Center to help students navigate the federal and state funding opportunities available to them. This investment will also fund recruitment and retention bonuses for students who commit to employment with Ohio's community mental health and addiction centers which provide care, treatment, and services to Ohio's Medicaid-eligible population.
- Pennsylvania: Working on funding which will help and looking at establishing a training program.
- South Dakota: Implemented a program to offer virtual crisis care within rural communities. Virtual Crisis Care provides law enforcement with 24/7 access to behavioral health professionals utilizing tablet technology. This service offers de-escalation, stabilization, safety assessments and connections to local mental health resources for follow-up care.
- Texas: HHSC is looking into providing direction on the credentialing process to clarify who can be credentialed as a Qualified Mental Health Professional-Community Services.

- Utah: Worked to develop the crisis response workforce through the State’s crisis worker certification program and is working with local universities to encourage and support crisis track development.
- Virginia: Additional funding, gathering data to assist with predictive staffing, potential integration of private providers.
- Washington: Passed legislation that established a Crisis Response Improvement Strategy Committee and steering committee to make recommendations to legislature on crisis system enhancements to include improving services, building a workforce, and improving funding stability.
- Wisconsin: To address the MCT barriers statewide the SMHA is working with colleagues in the Department of Medicaid to promote mobile crisis teaming statewide by expanding the benefit to include teaming options and higher reimbursement rates for Medicaid recipients.
- West Virginia: Children’s Mobile Crisis teams have received supplemental funding. The state is working generally to increase its behavioral health workforce with a statewide therapist loan repayment (STLR, <https://dhr.wv.gov/BBH/data/STLR/Pages/default.aspx>) program and other initiatives in collaboration with the WV Higher Education Policy Commission (<https://www.wvhepc.edu/inside-the-commission/offices-and-affiliates/health-sciences/behavioral-health/behavioral-health-initiative/>)

Mobile Crisis Team Workforce Shortages

Thirty-three SMHAs reported that MCTs in their state were experiencing workforce shortages. Masters-level Social Workers, Other Licensed Behavioral Health Counselors, and Peer Specialists are the types of staff with the most states reporting shortages (see Figure 5).

Figure 5: Number of States Experiencing Workforce Shortages for Mobile Crisis Teams, by Type of Staff, 2022



Twenty-two SMHAs have developed special training to prepare peer specialists to work as part of an MCT or at a Crisis Stabilization Center. For example, Oklahoma developed Peer Specialist Crisis Training. A webinar about the Oklahoma Peer Recovery Support Specialist Training program is available online: <https://www.nasmhpd.org/content/presentation/ta-coalition-webinar-oklahomas-peer-recovery-support-specialist-crisis-track>

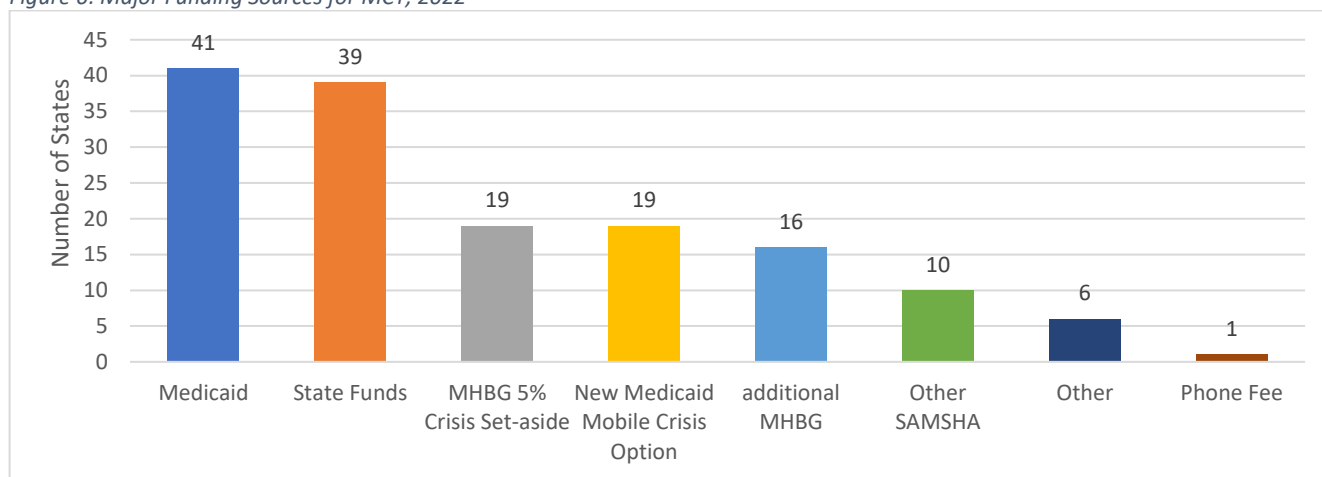
Financing Mobile Crisis Services

Twenty-four States reported expending \$405.4 million for MCTs last year, an average of \$16.9 million per state, ranging from a high of \$71 million in Illinois (with 83 MCTs averaging \$855,422 per team) to a low of \$1.8 million in Nebraska (with 13 teams). States reported that the median cost to operate an MCT was \$570,493 and the median cost to start a new MCT was \$500,000 (11 states reporting costs to operate and start MCTs).

States are paying for MCTs through a variety of funding sources, including state, federal, and local government funds. As Figure 6 shows, most states are using state general and special funds, but Medicaid and the Mental Health Block Grant (MHBG) 5% set-aside for Crisis Services are being used by many states.

Medicaid is used to pay for some MCT services in most (41) states, while in seven states MCTs cannot yet bill Medicaid. All MCTs can bill Medicaid for services in 29 states and only some of the MCTs operated can bill Medicaid in 12 states. In 2022, Congress included in the American Rescue Plan a provision to enhance the ability of Medicaid to reimburse for MCT services and 19 states reported working with their State Medicaid Agency to use this new Medicaid option. The Medicaid Rehabilitation option is currently being used by 17 states and an 1115 Medicaid waiver is used by six states to support MCT services.

Figure 6: Major Funding Sources for MCT, 2022



Relationship of Crisis Call Centers and Mobile Crisis Teams

Every state funds and supports operation of Behavioral Health Crisis Call Centers with staff trained to address behavioral health crises. In July of 2022, with federal support, a national three-digit (988) behavioral health crisis call system launched with over 200 local Lifeline/988 call centers across the United States. In addition to the 988 call centers, SMHAs support over 344 state or local behavioral health call centers that operate separately from the Lifeline/988 system. Some individuals experiencing a behavioral health crisis who contact a call center (either a 988/Lifeline or non-lifeline call center) require a face-to-face response after talking (or chat or texting) with the crisis call center staff. The SAMHSA Crisis Now guidelines recommend MCTs as the preferred response for individuals requiring contact beyond what a call center provides. In 23 states either all MCTs (13 states) or some MCTs (10 states) have written agreements in place between Call Centers and MCTs. In 20 states, no written agreement are yet in place, but all 20 states described efforts to establish working agreements (including Memorandums of Understanding, decision trees/dispatch protocols, etc.) between call centers and MCTs.

Data/Outcomes from MCTs

Several states are starting to collect and report data about how MCTs are helping individuals experiencing a behavioral health crisis. Table 1 below shows that nearly half of MCT dispatches were resolved by the MCT team meeting with the individual in crisis. About 13% required further care at either a Crisis Stabilization Program (where available) or at an Emergency Room (14%). In addition, 39% of clients that MCTs met with needed a follow-up outpatient behavioral health visit.

Table 1: Mobile Crisis Team Data on Outcome Of Dispatches, 2022

MCT Metrics being Measured	Number of States Reporting	Average	Median	Low	Max
Percentage of MCT dispatches that are successfully resolved during the initial encounter with the individual in crisis:	15	49%	54%	10%	82%
Percentage of MCT dispatches with an individual needing care at a Crisis Stabilization Program	15	13%	9%	0.0%*	54%
Percentage of MCT dispatches that end with an individual going to an Emergency Department	15	14%	15%	0.1%	38%
Percentage of MCT dispatches that end with an individual needing additional care at an outpatient behavioral health provider	16	39%	31%	1%	78%
Other Outcomes	10				

* State did not have Crisis Stabilization Programs at the time of reporting

Ten states reported collecting additional information to monitor what happens to individuals after MCTs are dispatched. Two states reported on the percentage of dispatches that result in an individual going to jail—both states reported about 1% of dispatches resulted in transport to jail. Other measures states monitor included referral to psychiatric hospitals, to residential respite or residential crisis beds, to substance use services, and connecting individual to social services (such as housing, food stamps, TANF, etc.).

Other 2022 NRI State Profile Reports on Crisis Services

This report on Mobile Crisis Teams is one of a series of reports that NRI is producing for states during the fall of 2022. Other Profile Highlight reports focus on:

- SMHA Support for the Behavioral Health Crisis Continuum (Call Centers, Mobile Crisis Teams, and <24-Hour Crisis Receiving and Stabilization Facilities)
- SMHA Support for Crisis Call Centers (988 and other call centers)
- SMHA Support for < 24 Hour Crisis Stabilization Programs
- Crisis Workforce Issues
- Technology and Outcomes in Crisis Services
- Funding Behavioral Health Crisis Services
- Alternatives for Transportation in Crisis Services

**All 2022 State Profile reports are available on-line at www.nri-inc.org.
For Additional Information About this Report, or the SMHA Profiles Project,
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National Association of State Mental Health Program Directors Research Institute (NRI)