FORMATIVE EVALUATION OF THE RESPONSE SYSTEM —QUALITATIVE ANALYSES OF THE IMPLEMENTATION OF MOBILE CRISIS TEAMS

Report to the Behavioral Health Commission 2.0

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Irsay Institute
INDIANA UNIVERSITY

WISE INDIANA

This report was prepared by Experts from Indiana University alongside the Irsay Institute and WISE Indiana

AUTHOR

Bernice A. Pescosolido,, PhD, Director of the Irsay Institute for Sociomedical Sciences Research & Distinguished Professor of Sociology, Indiana University

CONTRIBUTING AUTHORS

Ashlyn B. Burns, PhD, MPH, Postdoctoral Fellow, Psychiatry, IU School of Medicine

Alejandra Laszlo Capshew, MA, Chief of Staff, Irsay Institute for Sociomedical Sciences Research

Lauren A. Magee, PhD, Assistant Professor, O'Neill School of Public and Environmental Affairs, IU Indianapolis

Emily Meanwell, PhD, Clinical Associate Professor, Sociology & Director, Social Science Research Commons

RESEARCH SUPPORT

Ekaterina Baldina, Graduate Research Assistant, Sociology, Indiana University

Emily Ekl, PhD Candidate, Sociology, Indiana University

Haleigh Kampman, PhD Student, Health Policy and Management, Fairbanks School of Public Health, IU Indianapolis

Luis Lopez, Graduate Research Assistant, Sociology, Indiana University

LeeAnn Sell, Study Director, Center for Survey Research, Indiana University

Brandy Smith, Graduate Research Assistant, Sociology, Indiana University

Mary Ellen Van Booven, Study Coordinator & Data Collection Supervisor, Center for Survey Research, Indiana University

Jassen Yep, Graduate Research Assistant, Sociology, Indiana University

WISE INDIANA STAFF CONTRIBUTORS

Makayla Pearson, MS, Project Management Specialist

Aaron Zych, MPH, Lead Project Management Specialist

Justin Blackburn, PhD, Scientific Director

Table of Contents

PART I: THE BRIEF

PART II: APPENDICES

Background

In the first regular session of Indiana's General Assembly in 2023, Senate Bill 1 (Senate Enrolled Act No.1, SEA1) was passed. SEA 1 reauthorized the Behavioral Health Commission (BHC) with a charge to deliver data and analyses, primarily involving the crisis response system, by October 2024. In accordance with SEA 1, the Division of Mental Health and Addiction (DMHA) funded 18 new initiatives to increase the number and coverage of crisis mobile teams operating in Indiana. DMHA collaborated with Wellbeing Informed by Science and Evidence (WISE), a partnership between the Indiana Clinical and Translational Sciences Institute's Monon Collaborative and the Indiana Family and Social Services Administration (FSSA) for the evaluation of the new crisis mobile teams. The Irsay Institute at Indiana University was engaged for this project, given its central research foci on mental health and mental health services. Specifically, serving as expert leads, scientists at the Irsay Institute would:

- Provide information required under SEA 1 relevant to the implementation of new crisis mobile teams
- Assemble and lead the team of researchers, interviewers, staff and consultants required to carry out the research
- Develop and carry out Phase 1 interview components
- Develop the ethnographic components of embedded observation in the initial three to five research sites
- Monitor research progress, data file creation and use of the data
- Outline major analyses required for the final Report
- Prepare a final report and subsequent papers, presentations, and scientific papers with the scientific team.
- Provide and organize presentations for the State on requested information and results

The Approach

Research in Three Phases

The Evidence Base. A set of mixed methods approaches to data collection provide overall and detailed data on the plan and early operation of the CMTs. This began with individuals working for the State in prevention roles (Phase 1) who, along with the individuals listed as agency contacts, comprised an initial list of individuals to be interviewed. Interview topics included agency approach, progress, concerns and successes of CMT implementation (Phase 2). Agency personnel were able to provide a list of the key members of the CMTs (Phase 2.5). Key CMT members were interviewed and contacted in the final phase (Phase 3), where researchers conducted on site observations and, when possible, ride-alongs to crisis calls.

Phase 1: Regional Prevention Coordinators

- In 2019, Indiana implemented a statewide Regional Prevention System (RPS) focused on systems change to promote mental health and prevent substance misuse.
- A semi-structured interview guide was developed to collect insights about the RPS implementation and sustainability. Participants were identified based on their role as an active regional coordinator.
- Qualitative interviews were conducted with all 9 regional coordinators in Indiana. The 10th Indiana regional coordinator position was not filled.
- Interview recordings were transcribed and coded for key themes.
- A scientific paper has been produced and is under peer review ("Implementation and sustainability of systems change for mental health promotion and substance misuse prevention", Co-Investigator Ashlyn Burns, lead author).

Phase 2: Interviews with agency points of contact for MCTs

- Pre-interview informational calls were conducted by the Principal Investigator, Bernice Pescosolido, with individuals listed as the agency contact. This was necessary to provide a quality sample listing for individuals at the agencies who were CMT leads, or who oversaw the CMT. For some agencies, a financial officer may have been listed on the contract who was not involved in service provision. The pre-interview call was also designed to explain the study and gauge interest to be part of the observational phase (Phase 3).

- All individuals named in the pre-interview, or whose name was later provided, comprised the sample list for Phase 2. This included agency CEOs, CMT leads, or others who expressed an interest. These interviews were conducted by the three Co-Investigators Ashlyn Burns, Lauren Magee, and Emily Meanwell.
- 30 interviews were conducted on Microsoft Teams, along with REDCap survey administration, with the identified individuals for this phase. (see Appendix III).
- Interviews were machine transcribed, then cleaned, summarized, and de-identified by the research assistants.
- Qualitative data were coded by a seasoned qualitative researcher using MAXQDA. In particular, stories were indexed and extracted.

Phase 2.5: Interviews with MCT members including peer support specialists

- These interviews paralleled the Phase 2 interviews but were targeted for members of the MCTs. Interviews were conducted by the Co-Investigators and Research Assistants.
- The MCT member interviews were intended for on site, face-to-face administration. However, the Indiana University Human Subjects Institutional Review Board required more information for the on-site observations. , Many of interviews were completed on Microsoft Teams with Redcap administration for the sake of efficiency.
- 51 interviews were completed.
- Interviews were sent to a professional research support services company approved by IU's Institutional Review Board for human transcription.
- Interview data were coded by a seasoned qualitative researcher, using MAXQDA software.

Phase 3: Observational data from site visits and interviews with community partners

- To date, four sites have allowed on-site visits.
- Teams of two to three ethnographers composed of Co-Investigators and research assistants have logged over 100 hours of observation with more site visits scheduled.
- Detailed fieldnotes are submitted within 24-48 hours of the completed observations time.
- 21 additional interviews were collected on site and sent out for human transcription.

Overall Results, Themes & Stories from the Community:

The interviews and observations provided a wealth of data on the current operation of the new CMTs. Respondents represent many different roles and positions, and with that, provided a variety of viewpoints on what is working, what challenges they face, and what changes they would make to improve the system.

Overwhelmingly, the data support the finding that the CMTs are successfully filling a gap – fewer individuals are "falling through the cracks" in receiving help from mental health, legal and social service organizations that have never comprised a true system of aid during crises. In this report we provide a listing of the major themes that our data produced: 1) The positive aspects of the CMTs and the successes that individuals in other agencies, individuals within the CMTs, and especially the peer workers, have experienced during this period; 2) The more troublesome aspects of the operation of CMTs, including the challenges that providers, collaborators, and people in the community still face; and 3) Recommendations that people within the CMTs and the larger crisis system see as potentially moving the success of the CMTs and the goal of crisis response forward in the State of Indiana.

We punctuate each of these three counts with the words and the stories of the individuals in the community who have experienced crisis and those who serve to help them through.

Responses: Successes

An analysis of the multiple sources of data revealed several clearcut themes that were reported by respondents, often from across the different sectors of interviews – other social service agency personnel, CEOs or supervisors of CMTs, law enforcement, health care providers, and of course, the CMT members themselves. However, we begin by providing one of many in-depth stories which provides a textured sense of how the CMTs are working, how they are received by people in crisis and what their successes look like.

Voices of People and Providers on CMTs:

...the police officers who responded to that event brought him to [the crisis center] because they knew that he needed support...he finally made the call on a Saturday where he said, "mobile crisis get here now, I'm ready." Funny thing is when we got there, he took off and ran, [both laugh] which is funny. We, he and I can joke about it now. [both laugh] ...But, guess who didn't give up? The peer in recovery that got there first. She started following him on foot. And guess who else didn't give up? The mobile crisis team lead, who was in the car, who was communicating with the peer in recovery that knew where he was walking to and what he was about to do next, OK? ...We worked together with that, and we got him in the car. He finally started working on more of a harm reduction plan with us instead of a treatment plan, and we shifted our focus with this client to meet him where he was at, and then we were able to successfully reach the point where he was ready to go to detox by kind of reframing things and setting up different goals with him and his input.

The day after the death of his friend, he recognized us as we were [walking around the area with a community partner], he recognized us and he ran to the [crisis center] staff member and myself because he recognized me as helping him on mobile crisis and he just needed to talk it out, he needed to get it out. And [one of our community partners] did such a phenomenal job of supporting him in that moment along with the [crisis center] team lead and myself.... I think that really translated to him, that people do really care about me still. They're not blaming me for this even though I might be blaming myself a little bit. And ultimately, we ended up working on a plan with him to attend treatment out of state and...he called us a couple, about a month ago and said, "I am 78 days clean and sober from heroin for the first time in my life, and I am calling you to tell you, thank you, and to tell [the crisis center] thank you, and to tell everybody thank you for not giving up on me."

Themes

1) **Saving Lives, Protecting Families, and Appropriate Care**

Nearly all the individuals we interviewed reported that the CMTs were critical for the people in the State of Indiana. These comments ran from simple statements about statistics on record, as that from one of the CMT leaders (Ex.1) to very detailed stories of how and where the CMTs can provide crisis care when the lines between options are blurry at best.

In Ex.2, a police officer relates the case of a young boy whose situation was critical. Over a two-year period, the boy was clearly ill, the family was trying their best, and the time of the local police was being used. It was only the CMT that had the knowledge and the resources to find what the boy needed. In the end, the situation turned out to be a biological problem in the structure of the boy's brain. This was not a mental illness in the traditional sense. Finding the medical solution not only resulted in appropriate care for the boy, but it saved the stressors on his family, and reduced the efforts of the local police.

Voices of Providers on CMTs (Ex.1):

Well, I mean one thing we just keep reminding our team of is, there's about 15 individuals who are alive because our team exists in our community. And that's huge.

Voices of Community Partners – Police – on CMTs (Ex.2):

....a juvenile down in [Town]...We had been called there. I don't know how many times, dozens and dozens of times within a year and a half or two years....He had outbursts—more than one occasion harmed his mother; tried to kill her one time; tried to stab her—just all kinds of things. He was just 12 years old. It was obvious there was some issue going on....Of course, there was a situation where the DCS and the juvenile probation were doing this: "Well, it's not a DCS problem because Mom's trying to do everything she can. It's not a neglect issue." Juvenile probation's like, "Well, it's not really—we don't want him 'cause he's only 12...It's a parental problem. Of course, again, when the call comes in, we go down, but we're the police. There's only so much we can do. If you're telling me—and if you're saying that we can't arrest him—we don't arrest him 'cause it's not a crime—or it's not a juvenile probation matter 'cause he's so young, but it's not a DCS problem, either because his mom is trying to do everything, she can do to take care of him, who's gonna help this kid? Yeah, well, mobile crisis center, mobile crisis team. They came in. They started working with him. They got involved. That reduced our calls a little bit because they were calling them directly. Anyway, long story short, because of their work and involvement and really trying to drill down to see what the problem is, they finally had the kid—they finally did a CT scan—or no, an MRI on his brain—something.

2) **Confronting the Public Mental Health Crisis in the Community NOW**

Perhaps not surprisingly, community representatives from the police to social service agencies, to the CEOs of contracting agencies, to the mental health workers in the trenches, reported that they understood the growing problems of mental health and substance use. Community-based services, universally, have been underdeveloped, underfunded, and stigmatized. The community partner in Ex.3 clearly states the need for such services and the abysmal state before the CMTs. Similarly, the police official in Ex.4 not only indicates that CMTs are making a difference, but, in his/her professional judgment will need to be supported given his/her anticipated trajectory of the mental health-related problems in the community.

3) **Meeting People Where They Are and Increasing Continuity of Care**

CMTs address the well-known problems of the mental health system – wait times that go past the crisis point leading to individuals not showing up for the scheduled appointment, unaddressed minor problems that turn into major needs for hospitalization, and complaints that both of these problems prevent any kind of continuity of care for individuals with chronic mental health and addiction issues. Many respondents noted that the CMTs go a long way to eliminate these problems. As the CMT member in Ex.5 indicated, the community-based approach has resulted in being able to handle many calls and to address issues "in the moment", in a way that matches the situation of individuals in the community "where they are". Similarly, for the other organizations in the community (Ex.6), the CMTs have become the solution for dealing with "just a small barrier" that, traditionally, would have translated into a potentially serious situation. From the perspective of our mental health professionals, these represent a "huge success" or a "huge win".

Voices of Community Partners on CMTs (Ex.3):

Well, I know drug and alcohol addiction and mental health don't care about what county you're in or if it's a cornfield or the inside the city limits. It's a thing, it's real, it's out there and it needs to be addressed and prior to them, there was nothing.

Voices of Community Partners – Police – on CMTs (Ex.4):

That the crisis teams are a good idea. At least from our perspective, they're working. They're a benefit to us and in turn, a benefit to the community, and so I think that all resources should be allocated to 'em so they can expand and meet the demand for dealing with mental health-related calls, 'cause I don't believe they're going down. I believe they're going up.

Voices of Providers on CMTs (Ex.5):

And so, you know, through those partnerships, we're able to respond to, I think we average about 120, 130 calls a month for our crisis teams. They're able to respond to those folks and, you know ….and we can respond wherever the crisis is happening. And I just think that's, you know, meeting people in the moment, and where they are, I think is…a huge success.

Voices of Community Partner on CMTs (Ex.6):

He went to his appointment, was able to get those filled, but then he couldn't navigate going to that pharmacy and getting it picked up. …It wasn't a situation that he met inpatient criteria. I was able to contact the mobile crisis unit. They know him, just because they're at the [lower-barrier homeless shelter] a lot, and he goes there, especially during the day when it's hot. We were able to help facilitate getting him picked up from the emergency room. He didn't he didn't need to have a stay. He got out, he was able to then go straight to the pharmacy, pick up his medicines that were no cost to him, but was what he was needing….It was a huge win, because we were able to tap into outpatient resources and meet that patient where they were, and it was just a small barrier, which was transportation, essentially, and just trying to navigate it all.

4) **Providing for Needs of the Whole Person, Including Community Belonging**

CMTs serve as the connective tissue between many sources of care for the patient and for the service/treatment organizations. As the CMT member in Ex.7 indicates, the CMTs deal with problems in daily life (e.g., food, clothing), and most importantly, connection to primary care providers, which research has documented is a serious problem of access for individuals with mental health and addiction problems (Coombs et al. 2021).

CMTs cultivate the sense of belonging, continuity of concern, and simple human connection in the community, and, even to their own peer workers (Ex.8). A number of respondents noted that because the CMTs are out in the community and not behind organizational walls, they are a visible sign of a continuous network of care. The CMTs appear to be critical in filling the role of a support system for some individuals in the community (Ex.9).

Voices of Providers on CMTs (Ex.7):

Respondent: Yeah, I mean, we've been able to connect them with social service agencies that provide clothing and food. We've been able to connect them to health resources. You know, primary care providers, getting them connected to those providers outside of mental health services, so. You know, we have been able to provide lists of resources for support groups, those types of things.

Voices of Peer Client on CMTs (Ex.8.):

And so, and still today he's still inquiring about what is going on in my child's life and how we can be of service and how, what his team can do to help the matters that are going on.

Voices of Providers on CMTs (Ex.9) :

Like I said, I have the one client that I still follow up with about twice or three times a week even. That's made a big difference in his life. He feels like someone cares about him. He actually, is very happy when I get a hold of him, and I'm helping him because I do genuinely care and want to help this guy get to where he doesn't have to live in the woods anymore. It's hard for me to know my client's living outside, and it is for anybody, but I just want to make sure we can get him a better life 'cause it's no way to live like that. Living with your mental health untreated, addiction untreated, it doesn't look—it's not gonna end in a good way.

5) **Improving Efficiency and Effectiveness, Reducing Barriers to Treatment**

Respondents, especially those in law enforcement and in crisis agencies, often mentioned that the CMTs offer a more effective and efficient way of dealing with crises in the community. One respondent indicated (Ex.10) that the de facto response before CMTs, relied on the police and the criminal justice system which benefited neither the individual nor the judicial system. The situation before CMTs took invaluable time away from policing, clogged the docket for the judges, and resulted in delayed treatment for the individual. The time for all parties involved in the old approach, especially in de-escalating the mental health or addiction crisis, was particularly ineffective for the individual needing care. As a health care provider in one of the treatment centers we interviewed noted (Ex.11), the potential costs of care are well known to individuals in the community, and CMT patients do not incur these costs. Further, as research has documented, the typical ER does not provide an alternative given its mission and the stigma that potential mental health and addiction patients face because they are seen as inappropriate users (Sacre et al. 2022).

Voices of Community Partners on CMTs (Ex.10):

...now they don't have to come up, take them from downtown, lock them up, you know, go through all that process in the next four days because why go through the judicial system to eventually get to us? Right. We can cut out the judicial system and get an individual into, a stable environment and get a foundation started ...

Voices of Providers on CMTs (Ex.11):

The responses to people that when someone's experience a mental health crisis, they know that they can call us and they're not gonna get an ambulance bill and they're not gonna have to go sit in an emergency room for four or five hours and then be sent away feeling just as bad as when they started.

6) **Raising the Status and Understanding of the Importance of Peer Workers as Part of the Team**

Data overwhelmingly revealed the acceptance, and acknowledged value, of having trained peers on the CMTs. Though not without challenges (see next section), both CMT members (Ex.12) and those who supervise, see peers as the "primary responders" (Ex.13) because they can open a dialogue with people in crisis. The peers' personal experience, combined with their professional training, offers added value to CMT work and the community.

7) **Increasing the Community Safety Net Interorganizational Connectedness**

One of the basic points that nearly every respondent mentioned during their interviews is the "added value" of the CMTs in building a unified system. They indicated that this was not just about filling a gap in the system; rather they pointed to how having the "connective tissue" that the CMTs provided in the system, spilled over into "community engagement" in the broader sense (Ex.14). This is something that the CMT providers themselves see as one of their major successes. Going beyond formal contractual arrangements, the providers often indicated that they formed network ties that they count on, and that they were pleased to reciprocate when they could be of service as well. The idea of partnerships in the response to crisis appears to have become the central contribution that enables longer term planning for individuals with mental illness and substance use disorders (Ex.15).

Voices of Providers on CMTs (Ex.12):

I think peers as the primary responder is very successful. I see and I hear a lot of great feedback from them being able to respond to situations, relate to clients, empathize, you know, all of, listen and all of that. I think there's been great success with them as you know, that, that primary responder. I think for the clients that we've interacted with, we've had like a really positive significant impact on their lives.

Voices of Providers – Supervisors – on CMTs (Ex.13):

I think I enjoyed that they shared some personal experiences and their personal walk, and then how, how they've overcome and they're in recovery, and now that they're learning things they can put the principles that they're learning and their live experience together.... It made me a lot more comfortable for their safety. Because of course, I mean, sitting here in my position, I want all my employees to be safe.... they just bring such a value to our team. And that's the purpose of them, but they just bring such a value.

Voices of Community Partners on CMTs (Ex.14):

We work with them both receiving referrals from them into our emergency room, but then we also help with that disposition where we're trying to find a safe disposition that really, they don't—they're not safe to be in the shelter for the night, and maybe would benefit them to stay on the crisis unit and then get connected to the next level of care or outpatient resources. We utilize them a lot in that aspect, too, but I'll tell you, the mobile crisis team, they do so much more. They're on a lot of community engagement teams when it comes to helping with the homeless population. They're on a lot of teams when it comes to those that when we're trying to train law enforcement officers for CIT, they play a big role in that as well because we're just trying to work as a community, a collaborative effort to get a better understanding of what mental health is.

Voices of Providers on CMTs (Ex.15):

What's been most successful is building the partnerships with the different organizations because we have to have a plan for folks when their initial crisis is settled down. So being able to have that, "hey, can I call you if I have a lady in front of me that needs a bed and if you can help her get in, get like plan and, and take into there," because they know that if they have someone who's in a mental health crisis, that's a shelter, they can call us and we'll come out and we'll help them directly without needing to involve the police or that person having to be exited from their bed. So that's been especially helpful building those partnerships more than just surface level, but actually how we help each other in those things.

8) Increasing System Trust and Performance Outcomes

Our respondents told us that partnerships were successful only if they were built on trust. Trust was neither granted immediately nor because of an official system change; rather, as Ex.16, Ex.17 and Ex.18 reveal, the dynamics have changed. This is reflected in case outcomes with fewer individuals in crisis in jail, the emergency room, or hospitals (Ex.17).

9) Enhancing the Tacit and Emotional Work of Others in the Crisis System

One unanticipated success of the CMTs has been awareness and concern for professionals across the system. The CMTs told us they had a better understanding of the bottlenecks in the crisis system and the dilemmas that other professionals and peers face in their work. (Ex.19)

10) Raising Awareness and Action across All Community Sectors

A few respondents expressed their perception that, overall, the community was in a better position because of the CMTs and their new collaborations. In Ex.20, the respondent provided an important story of how a political official made contact to dispatch an MCT, and how this indicates critical support for their work.

Voices of Providers on CMTs (Ex.16):

They were skeptical. They were really skeptical at first, you know, they were like, no, like this is not... you're not the police, you know, because when we kind of presented the idea, they kind of took it as well, you know, that's kind of our jobs, you know. But I think that they were very skeptical. But now that we have gone out with them and we have done this work for almost a year, they have really begun to trust us.

Voices of Providers on CMTs (Ex.17):

What's worked well has been our, our partnership with the local law enforcement, as we've learned to trust each other and naturally it hasn't been perfect and we've had speed bumps, but it's worked really, really well. And it just has the aspect of it. Here's what's going on is this and you know, it's just changed the dynamic of people getting thrown in jail for stuff that they shouldn't probably get thrown in jail for and also diverting and easing averting on officers and even our community and not filling up our emergency room at the hospital when the officers are out, and they don't know what else to do. So, they just take somebody to the hospital because yeah, I don't know what to do with this, so that's worked really well.

Voices of Providers on CMTs (Ex.18):

Um...I think what's been very successful about it is the connection with other organizations that are already up and running and getting an idea of how their process was and being able to connect with them and get that extra support. Ok, this is what's working for us and it is not what's working for us. So, you know, kind of read back—but so getting the heads up of another organization that's up and running that has helped a lot, because then it would steer me to go another direction or kind of implement a different way.

Voices of Providers on CMTs (Ex.19):

...police department tell me that it's really helped the mental health of their law enforcement because we're getting people to, in, to outpatient and they're getting into services. It reduced some of their calls...with law enforcement, they, they go out and see somebody with mental health and there's nothing they, of there's nothing they can do, and they can't convince me to go anywhere, then they leave. Ok. What do you think happens when they go to lay their heads on the pillow at night? They wonder what happened with that person. Right. But when they pass them off to us, they know that we're finding them the resource, they know that they completed the process, and they know we're gonna follow up with them the next day.

Voices of Providers on CMTs (Ex.20):

But when you have like those right people involved, they're able just to kind of spread the message and the benefit of this new service and it's something that can catch on with just through other parts of the organization.... I remember one time we had the, like the mayor of our city actually called us to go on a mobile crisis. So, when you have the level of awareness where people all the way up to the mayor know oh, ok, well, let's call [Agency], because they have that service, that is something that's powerful where there's an understanding that the service does have a way to benefit.

Responses: Challenges

Along with the positive responses detailed above, respondents shared ideas that would improve the roll out, operation, and sustainability of the CMTs. These recommendations affect the ultimate goal of getting people into care, improving their mental health and addiction status, and increasing inclusion and well-being in the community.

Themes

1) The Need for Improved or Novel Destinations for People in Crisis

While the CMTs provide the necessary connective tissue for more seamlessly responding to individuals' crises in the community, respondents often raised concerns about the availability and adequacy of treatment and social service places to bring people to – the "chink in the armor" of the crisis systems from the point of the view of one of our respondents from law enforcement (Ex. 21). This included, but was not limited to what the CMT members believed, since community partners mentioned as well. In particular, issues of housing (Ex. 22) represent perennial problems, as does sufficient wrap around services. Perennial problems, as does sufficient wrap around services.

Voices of Community Partners on CMTs (Ex.21):

Yeah. I think it would be nice to have places to take them. I think right now, at least in our area, that's the chink in the armor. We're really good at—we're really good at dealing with them. We have resources such as the mobile crisis team that can come up and deal with them. We have laws in place that allows us to deal with them without taking them to jail. We can actually take 'em somewhere. The problem is we don't have very many places to take them, especially local (ly).

Voices of Community Partners on CMTs (Ex.22):

Il wish we had a longer-term housing, right? The mobile crisis unit and their crisis stabilization team do a fantastic job, and they have the unit that can house that patient, but it's not a long-term resolution. I think a longer-term outpatient stay, as far as transition and things to help navigate some of those things would help. Our homeless population continues to grow indefinitely, because we have a lot of great resources. What's happening is a lot of those great resources are getting extended, because now the need is growing. That's something that I, just housing, and then having those wraparound services matched with that housing would be really beneficial for our patients.

2) The Need for Greater Consistency in Policies Across the Safety Net

In the early stages of implementation, the articulation of policies that ease collaboration across the local systems is difficult (Ex.23).

3) The Scarcity of Trained Peer Workers and Training Opportunities

There is little question about what the most frequently mentioned challenge is – i.e., staffing. There is a general problem because of the shift hours (in particular late-night shifts) and the nature of the work (Ex.24, 25). But the most serious shortage surrounds certified peer specialists, with respondents indicating a shortage of training opportunities (Ex.26, 27). The shortage of peer specialists is compounded by the State's training requirements for certification and six months of crisis experience for reimbursement. In our observations, we have found that the CMTs that have yet to deploy are the ones who cannot meet these requirements. Finally, respondents raised important and specific issues regarding the strain on peer workers given their history and potential triggers on the job (Ex.28).

Voices of Providers on CMTs (Ex.23):

…. getting consistent referrals has been a challenge. So, every system that like we work with has different policies and practices kind of already in place, as far as crises. And so like, for example, we work with, you know, some schools and their practices are to call 911, you know, for these specific situations, and that's true like, of just so many entities, like even mental health providers, like when they get, you know, specific information from clients. And so, it's just gonna take a lot of time, I think, to be able to change some of the policies and practices in place for a lot of systems that are already in place to be able to kind of change from 911 to like, a 988 call, or a direct call like, to our mobile crisis team.

Voices of Providers on CMTs (Ex.24):

Well, if you talk with the state, they're gonna—so they've heard this from multiple people. So, like with the new state requirements, which we understand why they are there, it creates a very high demand for certified peers, and then you also have certified peers they also have the six months of experience in crisis before, you know, like it officially can be counted towards reimbursement. And we know all the reasons that that's there, but that is a challenge because there's not, there's not a deep pool of existing certified peers that meet that criteria. So then, you know, even when you do find the individual that is certified and they're passionate about it, there is a significant amount of time getting that person ready, you know, to scale up and perform the services. So that is a challenge that we're just working through and we're just gonna keep doing it.

Voices of Supervisors on CMTs (Ex.25):

Staffing. It's hands down been, you know, finding people who want, finding a peer that wants to work overnight on the weekend or a therapist that wants to work overnight on the weekend to be able to assess folks. I mean, that's challenging.

Voices of Providers on CMTs (Ex. 26):

Respondent: I think training has been an issue getting them trained because there's not a lot of training opportunities. So, I know they've had to wait on some training across the state. I can't tell you just what the specifics of that, but I know that that's been a challenge. Some of the trainings have been full, or we've had to drive a ways, just to get them all their training done...and we're just gonna keep ***doing it****.*

Voices of Providers on CMTs (Ex.27):

So, challenges have been hiring [laughs] work—workforce. It's, it's a specialty population and type of job to want to do, so it has not been easy to even get applicants, or keep applicants, because the training aspect is even really intense because we wanna make sure everyone is comfortable and ready for the work. So, and, and mostly it has been individuals who have started doing the training for mobile crisis and then realize, this might not be what I want, but I wanna stay within [Agency] and then they're finding other opportunities within [Agency] to fit more of what they're interested in. So that's been a huge challenge. At the very beginning, also getting peers certified and trained was a major issue that has definitely gotten better more recently, there's more availability for training, which is great because peer is such a major aspect of mobile crisis.

Voices of Providers on CMTs (Ex.28):

Once we get peers, we're putting them in situations that could be triggering. So, the amount of oversight, supervision and support that they need is also an increase from our professional staff. Our most, you know, passionate, wonderful engaging peers that we have don't have any behavioral health experience as far as being in this workforce. So, there are a lot of, you know, training boundaries, basic things that, you know, some of the professional workforce comes in with. So, yeah, definitely a lot of oversight to keep them supported and over the ***position****.*

4) The Child/Adolescent Service Gap

Respondents were concerned about special populations that might require tailored approaches (Ex.29). Children and adolescents were mentioned primarily, but others included veterans. This went beyond what the CMTs might offer to the availability of tailored services in the area (Ex.30).

5) The Growing Pains of Start-Up & Need for Awareness Efforts

Two issues were raised regarding program start-up and community awareness. The first issue targeted the variability of emergency work, especially before staffing is complete and the hours of operation are limited in the start-up stages (Ex.31). There are limits on marketing time and resources, causing confusion among the public about the mission of CMTs (Ex. 32, 33). The second issue is the tension between having a one-size-fits-all, perhaps evidence-based model (Ex. 34), and having little guidance about how the model should be tailored to the area demographics, problem profiles, or treatment landscape (Ex.35).

Voices of Providers on CMTs (Ex.29):

Kids—challenges is the kids with behaviors. That's the biggest challenge because the resources aren't there to help them. with this, so that's worked really well.

Voices of Providers on CMTs (Ex.30):

We're trying to figure out, we have a no-wrong-door approach for our unit. But that's been a challenge when it's mobile crisis because you're gonna respond regardless of the age. We don't necessarily have the resources to link those kids to. If we respond to an adult mobile crisis, and they need a higher level of care, we have inpatient in town, we have our unit, things like that. If it's a kid, we're very limited. Any inpatient is going to be at least an hour away from here if not longer. There are just all different components. Trying to figure out how to build systems in place. Peers, the way they're trained, don't get a ton of training around how to deal with children and adolescents.

Voices of Providers on CMTs (Ex.31):

Honestly, staff boredom [slight laughter]. Yeah, we literally can go all day and not get a call. We go 24 hours and not get a call. And then the next day we've got four or five calls, and the staff's all excited, they've been dealing with calls. We can have two deployments in a day, and they're all excited, and then we won't deploy for another four or five days. Again, we really started out with a very soft opening, and until we can have crisis receiving and stabilization operating 24 hours a day, we are keeping it kind of soft. We don't want to advertise, you know, hey, bring us your people, but only [during certain days and hours]. We have had our marketing meetings with the first responders, and we did tell they, they are aware that they can bring them in for crisis receiving, just during the day, but that mobile team is available at any time. And once we get that full staffing to where, you know, we can just cut loose, then we start more of the mass marketing campaign.

Voices of Providers on CMTs (Ex.32):

And a lot of it just comes down to marketing, you know, it's me and a few people. We have crises 24/7 and really no time for marketing versus [another mobile crisis team that has] a fully set up team of 10, 12 folks…and so, [one of the people on the team] markets and does community events and community affairs, not going out on the mobile crises. So. Yeah. Exposure. I guess they say that exposure. Yes.

Voices of Providers on CMTs (Ex.33):

I think a general misunderstanding of what we don't do. We will not come out to your home and just come get your kid and take them somewhere. This is an hours long process to find a hospital for your child.

Voices of Providers on CMTs (Ex.34):

The state knows we need something, and there are models out there like the Crisis Now model and try to figure out what's gonna stick for Indiana. We're all doing it differently, so I can't say ours is any better than anyone else's. We're not having any major challenges that make us scared we can't continue this in the long run. Sustainability will be a factor.

Voices of Providers on CMTs (Ex.35):

I would say, I mean, I talked about the data and all of that. There's not a whole lot of direction, or like, I feel like [a colleague] and I kind of built this…the way we thought would be the best way to build it, set it up. But I don't feel like there was a lot of, here, this is how you're gonna build this, this is how you're gonna set this up, it was just kind of run with it. And so, we did, and I think we did a great job, but I think that a lot of mobile crisis teams probably have different processes and probably function—like each one probably functions completely different than we do. Just because they weren't given any direction either. So, I don't know, that could be an issue down the road, if there's not a lot of continuity in the service, like across the board. But yeah, I think it's been a lot of—like [my colleague] always says, it's building the plane while you fly it [laugh]. Yeah, which definitely feels accurate a lot of the time. So, yeah, I think that would probably be one of the, one of the big things that is a struggle.

6) Billing and Sustainability

Inevitably the issue of billing, given the nature of crisis work (Ex.36, 38), insurance coverage (Ex.37), and sustainability past the funding from SEA 1, is a concern among CMT members, leaders, and agency CEOs.

Voices of Providers on CMTs (Ex.36):

I think funding is gonna be a big issue. I'm foreseeing the mobile crisis billing codes, the Medicaid mobile crisis billing codes, won't be sufficient for the actual response. For instance, if we get called out by a family member, friend, or law enforcement to assist and the person chooses not to engage with us, we can't bill for that.

Voices of Providers on CMTs (Ex.37):

a crisis call over the phone, that is not billable. But even reimbursement for the mobile crisis portion isn't, you know, now some, like Medicaid, they do a great job. But other insurance companies, private Medicare, they all are, and I know everybody's cinching their belts. I get it. But at the same time, if you're not healthy in your mind, you're not gonna be healthy in your body, you're not gonna be contributing to society, and we're just causing a spiral of more situations to come.

Voices of Providers on CMTs (Ex.38):

…. grant or contract funding. There's a lot of downtime…we can go hours or days without a single call. How do you pay for something that may never get a call or may get four calls in a day? The state knew they were paying us to figure out the ebbs and flows of all the crisis and the downtime for the mobile crisis teams. Sustainability will be an ongoing challenge. Our funding ends in [about 10 months], and we're all waiting to see what kind of support there will be after that. Billing specifically for mobile crisis does not cover the actual costs. It costs more to keep a unit open and maintain mobile crisis teams with all the resources you have than what you actually get paid for. That will be an ongoing challenge.

Responses: Direct Advice to the State

We specifically asked respondents what they would like to tell the DMHA and the State Legislature. Few respondents provided responses to this, perhaps a result of interview fatigue or because they had done so in response to questions already asked. Here we provide a few unique responses.

Voices of Providers on CMTs:

....back to that thing about being decisive, continue to be decisive. Expect the best from our group. Our group, while I've watched over [my career]...there tends to be a lot of excuses why things can't happen. And I just want them to know, we like the pushing for the best to help where it's needed. Don't give up. There are agencies that support what they're doing, support how they're doing it, applaud their boldness and keep going. So, I think it—one, is just saying, you know, you have fans out here for the changes they're making.

Voices of Providers on CMTs:

The data is a challenge. There's a lot of data to track. We got this spreadsheet about a month ago with all the things we need to track, and it doesn't interface with DARMHA, the state system for data collection. For all our other systems, you just put the data in the EHR and it automatically submits, but it doesn't for this. We'll have to manually put all that data in. Building the functionality in the EHR has also been a challenge.

Voices of Providers on CMTs:

I don't know if the state would agree, but I think going from a grant to a contract has been helpful. Sometimes when you're on a grant and outline everything very specifically, and then the needs change, it's hard to adapt...

Responses: Regional Prevention Coordinators–The Larger View

Background: Because we began the search for a sample list with the Regional Prevention Coordinators (RPC), we decided that their input would be useful, even as this model is being abandoned by the State. The Regional Prevention System (RPS) was an approach for engaging community members throughout Indiana in mental health promotion and substance misuse prevention efforts. The RPS was first implemented in 2019 in response to feedback provided by community members and stakeholders at DMHA's Annual Congress. The roll out of the RPS started in Region 1, and then expanded to other regions. Each Regional Prevention Coordinator facilitated 9-12 Client Consultation Boards (CCBs) throughout their region (typically one in each county) and maintained a Regional Council with one representative from each CCB.

Successes of CMTs:

- In areas with crisis stabilization centers, RPCs commented on the value of having a place where people can go for respite, hygiene needs, and get connected to other resources.
- Mobile integrated response teams are present in several counties.
- Several communities are launching training to prepare more people to respond to crisis situations.

Barriers to CMT Success:

- Long waiting time when services are not in the county
- Remaining lack of awareness of CMTs in some areas

Voices of RPCs on CMTs:

Everyone seems to have the same opinion so far, which is oh, thank goodness for [the mobile crisis team]. If it hadn't been for them, you know, that kind of thing. An example of that would be last spring they had a really unusual thing happen on the edge of [the county]. They had a fella that was holed up in his apartment and he had a gun and was shooting it out. There were schools nearby. There was a park nearby. It was at the time of day where people were moving around and a lot of area law enforcement did go to help. But, [the mobile crisis team] showed up there and you know, between everyone who came to the aid of that, they had it under control. No bystanders or pedestrians or kids were hurt."

Example of Real World Change: Informing Community Leaders from the RPCs

One county held a symposium that was organized by the RPC in collaboration with other community members, a symposium included presentations from leaders of an organization with MCTs, including the peer support specialist. While raising awareness of these services, the well-attended symposium also included presentations on 988 and other community resource.

Successes of Crisis Prevention:

- Communities and organizations that had never received state funding before were able to apply and receive funds. Information gathered through the RPS was used to inform the development of RFFs during the COVID-19 pandemic, resulting in a focus on grassroots organizations and BIPOC/LGBTQ+ populations.
- CCBs facilitated a number of partnership connections between schools, case managers, social workers, community foundations, and in some regions, between mental health treatment facilities.
- RPCs often heard from community members that they were thankful for having someone who showed that they cared about the community and that they now could connect them to DMHA.
- Over time, communication between members of the community and the RPCs increased and relationships were strengthened throughout the community. As more people became engaged, this increased diversity of thought and the groups started to gain more momentum.
- Identifying a champion who was willing to reach out to others and connect the RPC with their network facilitated growth and increased engagement in the CCB.

Barriers to Crisis Prevention:

- Compared to those who had been in field of mental health and substance use for a longer period, engagement with community members from sectors outside of mental health and substance misuse prevention was easier as they were receptive to idea of prevention.
- RPCs also discussed encountering stigma as a barrier. Some communities were unwilling to discuss issues around mental health and substance misuse but became more open to the topic over time.
- Community members expressed confusion about the RPS and how it differs from other systems/organizations focused on mental health/substance use, such as Drug Free Coalitions (DFCs), Local Coordinating Councils (LCCs), and Systems of Care (SOCs).
- Sustainability about community engagement gains represent a major concern, especially in rural areas where other existing coalitions do not exist and where community members expressed concerns of not being heard.

Example of Real World Change: Increased Cross-County Collaboration from the RPCs

An RPC in a county with an existing Quick Response Team facilitated connection to another county hoping to implement a QRT. Collaboration has been ongoing and successful, with the established team providing guidance on developing the CMT under SEA 1

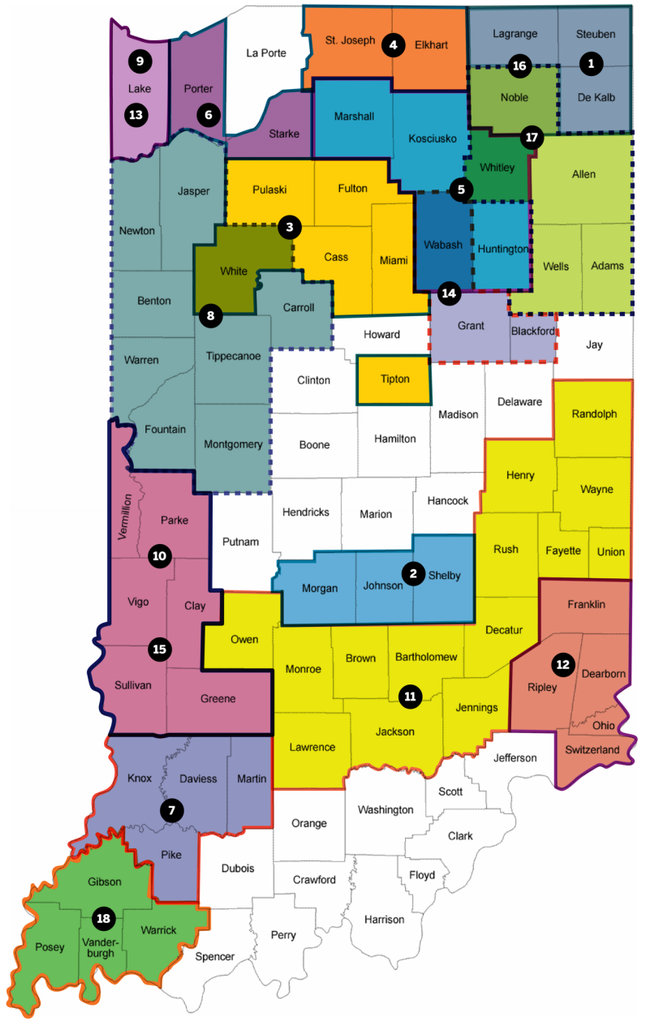
References:

Coombs, Nicholas C., Wyatt E. Meriwether, James Caringi, and Sophia R. Newcomer. "Barriers to healthcare access among US adults with mental health challenges: A population-based study." *SSM-population health* 15 (2021): 100847.

Sacre, Maya, Rikke Albert, and Juanita Hoe. "What are the experiences and the perceptions of service users attending Emergency Department for a mental health crisis? A systematic review." I*nternational Journal of Mental Health Nursing* 31, no. 2 (2022): 400-423.

Appendix I:

Indiana Counties Covered and Overlaps



Provider

1 Benchmark Services (non-CMHC)
LaGrange, Steuben, & Dekalb

2 Choices (non-CMHC)
Morgan, Johnson, & Shelby

3 4C Health
White, Pulaski, Fulton, Cass, Miami, & Tipton

4 Oaklawn Psychiatric Services
St. Joseph & Elkhart

5 Otis R. Bowen Center for Human Services, Inc.
Kosciusko, **Huntington**, Marshall, **Whitley**, & **Wabash**

6 Porter-Starke Services Inc.
Porter & Starke

7 Samaritan Center/Good Samaritan Hospital
Knox, Daviess, Pike, & Martin

8 Valley Oaks Health
Benton, Carroll, Fountain, Jasper, Montgomery, Newton, Tippecanoe, Warren, & **White**

9 Southlake Community Mental Health Center Inc.dba Regional Health Systems
Lake

10 Aspire Indiana, Inc.
Vermillion, Parke, Vigo, Clay, Sullivan, & Greene

11 Centerstone of Indiana, Inc.
Bartholomew, Brown, Decatur, Fayette, Henry, Jackson, Jennings, Johnson, Lawrence, Monroe, Morgan, Owen, Randolph, Rush, Union, & Wayne

12 Community Mental Health Center, Inc.
Dearborn, Franklin, Ohio, Ripley, & Switzerland

13 Edgewater Health
Lake

14 Grant Blackford Mental Health
Grant, Blackford, & **Wabash**

15 Hamilton Center, Inc.
Vermillion, Parke, Vigo, Clay, Sullivan, & Greene

16 Northeastern Center (NEC) Community Mental Health Center
DeKalb, LaGrange, **Noble**, & Steuben

17 Park Center
Allen, Wells, Adams, Huntington, **Whitley, & Noble**

18 Southwestern Behavioral Healthcare, Inc.
Vanderburgh, Warrick, Posey, & Gibson

Bold text denotes counties covered by more than one provider.

Appendix II:

Mobile Teams Included in Report

Provider	Contact Name	Email Address	Status of Mobile Crisis	Counties
4C Health	Nicole Hiatt Drang	NHiattDrang@fourcounty.org	Yes	White, Pulaski, Fulton, Cass, Miami, Tipton
Aspire Indiana, Inc.	Kevin Sheward	kevin.sheward@aspireindiana.org	None currently, has been awarded grant to develop mobile crisis	Vermillion, Parke, Vigo, Clay, Sullivan, Greene
Benchmark Services (nonCMHC)	Brian Gill	bgill@benchmarkhs.com	Yes	LaGrange, Steuben, Dekalb
Centerstone of Indiana, Inc.	Chelsea Stripe Linda Grove-Paul Tammie Eppley Brit Vincent	chelsea.stripe@centerstone.org Linda.Grove-Paul@centerstone.org Tammie.Eppley@centerstone.org Brit.Vincent@centerstone.org	Yes	Bartholomew, Brown, Decatur, Fayette, Henry, Jackson, Jennings, Johnson, Lawrence, Monroe, Morgan, Owen, Randolph, Rush, Union, Wayne
Choices (non-CMHC)	Jessica Krause	jkrause@choicesccs.org	Yes	Morgan, Johnson, Shelby
Community Mental Health Center, Inc.	Shelbi Tedeschi Tracy Mock	shelbi.tedeschi@cmhcinc.org Tracy.Mock@cmhcinc.org	Yes	Dearborn, Franklin, Ohio, Ripley, Switzerland
Edgewater Health	Tanya Rogers Danita Johnson	trogers@edgewaterhealth.org danitajohnson@edgewaterhealth.org	None currently, has been awarded grant to develop mobile crisis	Lake
Grant Blackford Mental Health	Chelsie Matchette Stacey Lohse Susan Miller Lisa Dominisse	cmatchette@getradiant.org slohse@getradiant.org smiller@getradiant.org ldominisse@getradiant.org	Yes	Grant, Blackford, Wabash
Hamilton Center, Inc.	Art Fuller	afuller@hamiltoncenter.org	Yes	Vermillion, Parke, Vigo, Clay, Sullivan, Greene
Northeastern Center (NEC) CMHC	Steve Howell	steve.howell@nec.org	None currently, has been awarded grant to develop mobile crisis	DeKalb, LaGrange, Noble, Steuben
Oaklawn Psychiatric Services	Kelli Liechty	kelli.liechty@oaklawn.org	Yes	St. Joseph, Elkhart
Otis R. Bowen Center for Human Services, Inc.	Tess Ottenweller	tess.ottenweller@bowencenter.org	None currently, has been awarded grant to develop mobile crisis	Kosciusko, Huntington, Marshall, Whitley, Wabash
Park Center	Kelly Sickafoose Justin Hull	kelly.sickafoose@parkview.com justin.hull@parkview.com	Yes	Allen, Wells, Adams, Huntington, Whitley, Noble
Porter-Starke Services Inc	Mike Weaver	mweaver@porterstarke.org tbuskirk@porterstarke.org	Yes	Porter, Starke
Samaritan Center/ Good Samaritan Hospital	Kimberly Everett	keverett@gshvin.org	None currently, has been awarded grant to develop mobile crisis	Knox, Daviess, Pike, Martin
Southlake Community Mental Health Center Inc.dba Regional Health Systems	Rachel Bakaitis	rachel.bakaitis@regionalgroup.care	None currently, has been awarded grant to develop mobile crisis	Lake
Southwestern Behavioral Healthcare, Inc.	Katy Adams	adamsk@southwestern.org	Yes	Vanderburgh, Warrick, Posey, Gibson
Valley Oaks Health	Jade Schluttenhofer	jschluttenhofer@valleyoaks.org	None currently, has been awarded grant to develop mobile crisis	Benton, Carroll, Fountain, Jasper, Montgomery, Newton, Tippecanoe, Warren, White

Appendix III:

Number of Interviews by Agency and by Phase

Agency	Completed Phase 2 interviews	Completed MCT 2.5 Interviews	Phase 3 Interviews
Anthony Wayne/Benchmark	1	3 (includes 2 LE)	6
Aspire Indiana Health	2	2	
Bowen Center	2		
Centerstone	2	3	15
Choices	1	3	
Edgewater	1		
Family Health Center	2	4	
Four County	1		
Hamilton Center	3	4	
Incompass Health Care	2	1 (LE)	
Lifespring	1	3	
Northeastern Center	1		
Oaklawn	1	9	
Park Center	1	8	
Porter- Starke	2	4	
Radiant Health	2		
Regional Care Group	1	1	
Southwestern Behavioral Healthcare	2	6 (includes 1 LE)	
Valley Oaks Health	2		
Total	**30**	**51**	**21**

Appendix IV:

Study Information Sheet for Respondents

INDIANA UNIVERSITY STUDY INFORMATION SHEET FOR RESEARCH

1 MOBILE-CRISIS TEAM EVALUATION (MTE) STUDY

You are being asked to participate in a research study. Scientists do research to answer important questions that might help change or improve the way we do things in the future. This document will give you information about the study to help you decide whether you want to participate. Please read this form, and ask any questions you have, before agreeing to be in the study.

All research is voluntary. You can choose not to take part in this study. If you decide to participate, you can change your mind later and leave the study at any time. You will not be penalized or lose any benefits if you decide not to participate or choose to leave the study later.

The purpose of this study is to understand and improve mobile crisis services in Indiana.

We are asking you if you want to be in this study because you are a Regional Prevention Coordinator in

Indiana. The study is being conducted by Bernice A. Pescosolido, Distinguished Professor of Sociology and Director of the Irsay Institute for the Sociomedical Sciences, Justin Blackburn, Science Director, WISE Indiana, and Ashlyn Burns, Research Associate and PhD Candidate, Richard M. Fairbanks School of Public Health. It is funded by the Indiana Division of Mental Health and Addiction.

If you agree to be in the study, you will do the following things.

- Participate in a recorded online interview using Microsoft Teams • The interview will take approximately 45 minutes

Your study participation concludes at the end of this interview.

Before agreeing to participate, please consider the risks and potential benefits of taking part in this study.

You may be uncomfortable while answering the interview questions. While completing the interview, you can skip any questions that make you uncomfortable or that you do not want to answer.

There is a risk someone outside the study team could get access to your research information from this study. More information about how we will protect your information to reduce this risk is below.

We don't think you will have any personal benefits from taking part in this study, but we hope to learn things that will help researchers and policymakers in the future.

You will be paid for participating in this study. You will receive a $50 Amazon e-gift card to thank you for your time. **There is no cost to participate in the study.**

We will protect your information and make every effort to keep your personal information confidential, but we cannot guarantee absolute confidentiality. All information provided during the interview will be captured, managed, and stored using strict data security protocols in place for university research data. All interview notes, video, and audio recordings linked to your personal information will be stored for ten years behind a password-protected firewall on highly secure servers using Microsoft Teams at Indiana University via Secure Storage, REDCap, and other user-restricted locations, which are managed by CSR and University Information Technology Services at IU. All example quotes from interviews will be de-identified to the greatest extent possible, so they cannot be linked to you or your organization.

No one except the researchers listed and other key personnel at Indiana University will have access to interview recordings, transcriptions, notes, or contact information. However, your personal information may be shared outside the research study if required by law. We also may need to share your research records with other groups for quality assurance or data analysis. These groups include the Indiana University

Institutional Review Board or its designees, and state or federal agencies who may need to access the research records (as allowed by law). We will inform you if that is the case.

If you have questions about the study or encounter a problem with the research, contact the researcher, Ashlyn Burns at ashbburn@iu.edu or Bernice Pescosolido at 812-855-6256.

For questions about your rights as a research participant, to discuss problems, complaints, or concerns about a research study, or to obtain information or to offer input, please contact the IU Human Research Protection Program office at 800-696-2949 or at irb@iu.edu.

IU IRB SIS Template – Exempt v12.19.2023

Appendix V:

MCT Instrument

INTERVIEW QUESTIONS- CRISIS TEAM MEMBERS

Thank you for taking the time to complete this interview. We have been asked to get a picture of how mobile crisis teams are working and changing the ways that Indiana is dealing with mental health crises. Since you are part of a mobile crisis team, we would like to know more about your experiences. But before we start, do I have your permission to record this discussion?

Recording the interview ensures that my notes are complete. Recordings will be confidential and only shared within the research team. All stories and names will have names and places removed, that is, they will be de-identified, so they cannot be linked to you or your organization. If you would like us to turn off the recorder at any point, just let me know. Do you have any questions before we start?

[NOTE TO INTERVIEWERS: Proceed through the interview asking the yellow-highlighted questions first, then if there is time remaining, go back to the top of the guide and ask the blue-highlighted questions.]

Context/Background Questions: I would like to start by asking some questions about your role and how you became involved in mobile crisis services.

1. What is your current role and what are your responsibilities related to mobile crisis?
    a. How long have you been in this role?
2. Can you walk me through your career trajectory, starting with school?
3. What motivated you to do this kind of work?
4. What does your role on the team mean to you?
    a. Have you faced any challenges integrating as part of the team?
        i. If so, follow .up: Can you tell me more? What has been the biggest challenge?

The Innovation: I would like to learn a little bit more about your mobile crisis team.

5. Can you tell me about your mobile crisis team? How is your mobile crisis team composed?
    a. How do your team members' roles differ by background position? (i.e., what is the role of peer supports vs. other team members)
    b. Do you feel that your team has the full scope of expertise needed to de-escalate a crisis?
    c. **If the team existed/respondent was involved in the team prior to last year:** Did you have peers involved on your teams prior to the state requiring peer involvement?
    d. How do you determine who takes the lead on a call? (i.e., is it always the peer, is it the EMT, is it a therapist, is it someone else, etc.)
6. We are really interested in hearing about your stories and experiences. To start off, can you tell me about a recent call that you responded to involving a person experiencing a mental health crisis?
    a. Probe: Can you walk me through how you approached the situation?
    b. Probe: Did you encounter any difficulties in de-escalating the person in crisis?
    c. How was the crisis resolved? (i.e., was the person taken to a hospital, crisis facility, or other location?)
        i. How would this call have been handled if your community did not have a mobile crisis team to respond?
        ii. Were you able to link the person to additional services for ongoing care? What services did you link them to?

Sociocultural Norms and Perceptions:

7. How do you think your mobile crisis services are perceived by members of the community who do not work in this field?

8. Does your organization partner with other organizations in the community to deliver services or refer patients? [NOTE TO INTERVIEWERS: If there is time and your respondent has mentioned working with law enforcement, this community partner question could be used to elicit more details, and especially get the name of a liaison.]
    a. Have other organizations in the community been supportive of this initiative?
    b. Have you faced any challenges building partnerships with other community organizations needed to effectively implement services?
    c. How about any challenges navigating patients to additional resources in the community?
        i. Are there resources the individuals you serve need that are not currently available in your community?

Innovation Effectiveness

9. In your opinion, do you think mobile crisis services have had an impact on the community? How so?
10. Are there any more examples you can share of how mobile crisis has impacted the individuals you have served?
11. Does your organization track outcomes?
    a. Probe: If so, what outcomes do you track?
    b. Probe: If not, why not? What outcomes would you like to track?
    c. Have you seen any changes in patient/community outcomes since beginning services?
12. In your opinion, what does success of a mobile crisis team look like to you?

Organizational/System Readiness for Change: Thank you. Next, I have some questions about how things have been going.

13. Can you walk me through the process of delivering crisis care services (including both mobile crisis and other services the site may have such as a crisis stabilization unit)?
    a. How do you feel about existing practices?
    b. What are the advantages or disadvantages of the approach your team uses?
14. Do you feel that your organization was prepared to make changes needed to deliver mobile crisis services?
    a. Why or why not?
    b. Are there additional changes you think are needed to improve service delivery?

Innovation Efficacy and Implementation Effectiveness:

15. Overall, what would you say has been working well about your mobile crisis team?
    a. Probe: What successes have you had?
16. What challenges have you faced?
    b. Probe: What would you say has been the biggest challenge?
    c. Probe: Are there any current challenges you are working through?
17. What aspects of de-escalating a crisis do you find most challenging?
    a. Can you give any examples of challenging situations you have encountered?
    b. Have you engaged in any training to prepare for responding to crisis calls?
    c. Do you follow a specific model or use any tools to guide your approach?
    d. Are there areas you think your team could use additional training in?
18. Do you believe your organization/team members can make additional changes needed to effectively deliver mobile crisis services?
    a. What supports or resources could enhance your teams' ability to do so?

Implementation Policies, Practices, and Laws: Now, I want to talk about your perception of mobile crisis services, the value of these services to the community, and any supports that have helped with service implementation.

19. What policies have impacted your ability to deliver mobile crisis services (ex., inability to get reimbursed for services if a person refuses transportation)? [Probe: This could be rules internal to your organization or county, state or federal policies that may affect delivery of services.]

20. What has been the most helpful supports in place that have helped you deliver mobile crisis services?
21. What federal/state laws or local regulations have impacted your ability to deliver services?

Implementation Climate:

22. How supportive do you feel that your organization has been in undertaking and participating in the delivery of mobile crisis services?
23. What efforts has your organization taken to strengthen or expand services?
24. Is there anything you feel has weakened your ability to deliver crisis services?

Innovation-Values Fit:

25. Do you believe that your organizational leaders value mobile crisis services?
    a. If so, how have your organizational leaders demonstrated that they value these services?
    b. If not, what is more highly valued by your organizational leaders?
26. Have any competing priorities impacted the progress of implementing mobile crisis services (e.g., staffing of onsite services being prioritized over mobile team)?
27. Are there any reasons why your organization does not support mobile crisis services?
28. Those are all of the questions I have for you. Thank you so much for your time. Is there anything we haven't talked about in relation to your experiences or mobile crisis that you think would be important for us to know?

Closing

Thank you for your time and valuable input.

We would like to email you a $50 Amazon gift card for participating in this interview. You will receive the gift card via email in the next 3-4 weeks from csr@indiana.edu.

We have your email down as janedoe@gmail.com. Is this where you would like us to send your gift card?

Yes

No, enter new email address

No, doesn't want an incentive

Admin: Possible People to Contact

Do you want to add contact information for anyone who was mentioned in the interview that may be relevant to the study?

Yes

No