INDIANA UNIVERSITY
PUBLIC POLICY INSTITUTE
Center for Health and Justice Research

OCTOBER 2020 | ISSUE 20-C33

21ST CENTURY CURES MOBILE CRISIS TEAMS

BACKGROUND

The United States is in the midst of an overdose epidemic. More than 67,000 drug overdoses occurred in 2018. Of those, more than two-thirds involved opioids.[1] Indiana has used funds from the 2016 21st Century Cures Act (Cures) and the State Opioid Response (SOR) to address this issue and create mobile crisis teams, spearheaded by Choices Recovery and Centerstone Behavioral Health Services in southeastern Indiana (Table 1).[2] These programs partner clinicians with peer recovery staff and nurses to enhance access to and engagement with evidence-based substance use disorder (SUD) treatment, particularly for opioid use disorder.

Existing research on mobile crisis teams has mostly focused on teams that respond to mental health crises. Therefore, in collaboration with the Indiana Division of Mental Health and Addiction (DMHA), the Center for Health and Justice Research (CHJR) designed a developmental evaluation to study the substance use-focused mobile crisis teams created by Cures and SOR funds and identify barriers and facilitators to their operations. This brief reviews findings from the evaluation and provides recommendations for jurisdictions implementing similar teams elsewhere.

KEY FINDINGS

- Despite several barriers to program implementation and operations, the mobile crisis teams known as CERT and OCRT engaged hundreds of individuals throughout rural Indiana in evidence-based treatment services for substance use disorder.
- The most persistent barriers described by CERT and OCRT are a high volume of clients, narrow window of engagement, and shortage of evidence-based treatment providers.
- The most important facilitators described by CERT and OCRT were socializing programs, emphasizing team communication, implementing harm reduction strategies, and utilizing technology.
- Best practice recommendations for implementing similar mobile crisis teams include socializing the program to individual agencies, locating evidence-based treatment providers, preparing to meet client basic needs, embracing a harm reduction philosophy, and integrating technology into team operations.

TABLE 1. Mobile crisis teams funded through 21st Century Cures Act

MOBILE CRISIS TEAM	MANAGEMENT	LOCATION	TEAM COMPOSITION
Choices Emergency Response Team (CERT)	Choices	• Greensburg, Indiana • Serves Dearborn, Decatur, Franklin, Jefferson, Ohio, Ripley, and Switzerland counties	• Three recovery support specialists with lived SUD experience who focus on client mentoring and engagement • Three clinicians responsible for screening clients for appropriate treatment • One clinical director in charge of day-to-day operations and reporting
Opioid Crisis Response Team (OCRT)	Centerstone	• Bloomington, Indiana • Serves Morgan, Monroe, Brown, Bartholomew, Jennings, Lawrence, and Jackson counties	• Two recovery coaches focused on connecting clients to needed resources • One clinician responsible for screening clients for appropriate treatment • One program manager responsible for team supervision, reporting, and socializing the program

FINDINGS

BARRIERS TO MOBILE CRISIS TEAM OPERATIONS

Barriers are obstacles that mobile crisis teams struggled with during either implementation or operation of the program.

High volume of clients, narrow window of engagement, and shortage of evidence-based treatment providers

CERT and OCRT described the most persistent barrier throughout the duration of the Cures grant as a high volume of clients, some of whom have severe addiction issues. This reflects the ongoing overdose epidemic that Indiana is experiencing. CERT leadership is hopeful that the addition of more team members will ease this difficulty by lightening team member caseloads.

Additionally, teams may have only a narrow window of time to engage clients in treatment services, as individuals who reach out to these organizations are in a very specific frame of mind and place in their lives in terms of readiness to pursue treatment. If the individual or team encounter barriers in pursuit of treatment, this window of willingness or ability to engage may be missed. One team estimates that they missed that window for 40 percent of their referrals.

Compounding these issues is a shortage of evidence-based SUD treatment providers in the geographical areas served, including detox services and medication-assisted treatment providers. The closure of these types of facilities has made treatment more difficult. Crisis teams have tried to supplement these service losses with hospitals, but hospitals often have their own set of barriers.

Client basic needs

Another critical barrier to providing treatment services is that many clients' basic needs—such as safe and affordable housing, food, transportation, and learning general life skills—are not being met. One team member explained, "Just treating substance use disorder can't be your only priority; you must help meet their basic needs." This sentiment is backed up by social science research on motivation.[3] This means CERT and ORCT have had to link clients to community resources that can provide wraparound and support services. This includes connecting individuals to homeless shelters and food banks, providing transportation to and from treatment, and helping clients secure insurance coverage.

Difficulty working with other agencies

Another barrier identified by both teams is difficulty working with external agencies to coordinate client treatment. This difficulty is two-fold.

First, many clients struggle with more issues than just an SUD, including physical or mental health concerns, criminal justice involvement, or child custody issues. These types of issues put clients into contact with several agencies which may not be cognizant of the client's SUD or SUD best treatment practices. This may make it difficult for CERT and OCRT to reach some individuals or obtain information that could facilitate treatment.

Second, CERT and OCRT team members explained that there is a lack of professional recognition for their teams' treatment staff by other agencies' staff. Team members have reported instances where their professional certifications for SUD treatment were not recognized by other agencies, making them reluctant to collaborate with treatment teams.

FACILITATORS TO MOBILE CRISIS TEAM OPERATIONS

Facilitators are people, events, and/or infrastructure identified by mobile crisis teams as being essential to the success or sustainability of the program.

Educating outside agencies

The most critical facilitator common across both mobile crisis teams was the targeted socialization of—or education about—their programs to agencies within each county. Introducing these programs to individual agencies has required three years of "hustling," as one team member put it—spreading the word about the programs, building relationships with local agencies, and building infrastructure for referrals. Each team serves at least seven different counties, and each county has different stakeholders and levels of community buy-in, which require different strategies for socialization.

Successful engagement strategies include attending Local Coordinating Council (LCC) meetings, providing education on treatment and harm reduction strategies, distributing literature to agencies, and meeting with local judges and jail staff. According to CERT, the key to building these

relationships lies in meeting the community where they are—as one team member put it, asking, "How can we help you?" instead of saying, "This is what we can do for you."

Another socialization strategy has been to identify crisis team staff members familiar with a community and use them to gain community buy-in and establish trust. Leadership believes this is successful because of the local, personal connection between the team members and community stakeholders, stating it has been difficult to obtain buy-in without these connections. Establishing this type of rapport may be especially important in rural communities.

A final strategy for socialization is identifying the appropriate level of clinical support for the community teams are serving. Because rural areas often have struggling or nonexistent recovery infrastructure, more clinicians may be needed than in urban areas.

Team characteristics and communication

Another facilitator identified by both teams was specific team characteristics and policies that promote cohesiveness and improve workflow. One team described themselves as tight-knit, passionate, and diverse in terms of professional and life experience. They stated that they interview prospective team members as a group to ensure this positive work environment is maintained. Both teams also emphasized the importance of integrating recovery resource specialists, stating their lived experience has been essential to supporting clients and securing community buy-in.

CERT and OCRT stressed the importance of communication among team members. Promoting self-care in their work environment is an explicit priority, and team members often check in with each other, encourage breaks when needed, and remain mindful of their own triggers so they know when to ask other team members for help. The importance of team characteristics and open communication has been emphasized in other literature about mobile crisis teams.[4]

Harm reduction

Both teams identified the use of harm reduction strategies that meet people where they are in terms of readiness for recovery as a critical facilitator to operations. They recognize that not every individual they engage with will be ready for traditional treatment, and consequently one team asks all their clients upfront, "What are you willing to do today for your recovery?" Intervention for individuals who are not ready to engage in treatment often include harm reduction components, such as naloxone provision or referral to a syringe exchange service. Meanwhile, intervention for individuals who are more prepared for treatment do not require sobriety to receive services, unlike many other treatment providers.

Technology

A final important facilitator for both teams has been technology, especially in wake of the COVID-19 pandemic. The teams have been using technology like Zoom to reduce in-person contact. For example, CERT partnered with its local recovery community to hold three Zoom meetings a day for individuals in recovery. These meetings were successful, with an estimated 270–400 attendees during the first month. The team has thus considered continuing these meetings post-social distancing and even implementing this model in jails. Team leadership explained that the pandemic has forced previously reluctant agencies to embrace new technologies like Zoom.

RECOMMENDATIONS

Overall, this evaluation had several findings. First, decades' worth of research on mobile crisis teams suggest that, although mental health-focused crisis teams show promising outcomes, teams focused on substance use are studied far less. This means evaluations like this one may serve as an invaluable resource to similar teams across the country. Second, despite several barriers that have persisted during the past three years of Cures funding, CERT and OCRT have garnered support for their programs and leveraged outside resources to serve hundreds of people in need of SUD treatment. Based on these findings, our team recommends the following best practices for organizations in other jurisdictions that are considering implementing or operating a mobile crisis team:

Socialize the program to local agencies

Obtaining buy-in from agencies the teams are trying to serve—like law enforcement and hospitals—within the community is critical to garnering program referrals. There is no one-size-fits-all approach to these efforts and, as such, efforts should be tailored to individual agencies in individual communities.

Locate evidence-based treatment providers in your area

Identifying and securing buy-in from adequate treatment providers in the area that use medication-assisted treatment and do not require sobriety for receipt of services is vital to a program's success.

Prepare to meet your clients' basic needs

Although a mobile crisis team's primary function is to connect individuals to treatment, teams should also be prepared to meet or make referrals for clients' basic needs—such as housing, transportation, and insurance—to facilitate successful treatment outcomes.

Embrace a harm reduction philosophy

Evidence-based SUD treatment acknowledges that not every individual is ready for traditional treatment. Mobile crisis teams should ask their clients, "What are you willing to do today for your recovery?" Interventions for individuals who are not ready to engage in treatment should include harm reduction components, such as naloxone provision or referrals to a syringe exchange service.

Integrate technology into team operations

Technology can increase communication with hard-to-reach clients, enhance recovery activities, and facilitate robust data collection to track clients and outcomes.

REFERENCES

1. CDC (2020). Centers for Disease Control & Prevention. Drug Overdose Deaths. https://www.cdc.gov/drugoverdose/data/statedeaths.html. Published March 19, 2020.
2. Beletsky, L. (2018). 21st Century Cures for the Opioid Crisis: Promise, Impact, and Missed Opportunities. *Am J Law Med, 44*(2-3),359-385.
3. Maslow, A. (1943). Abraham M. Maslow's Hierarchy of Needs, A Theory of Human Motivation. *Psychological Review, 50*, 370-396.
4. Bailey K., Paquet S.R., Ray B.R., Grommon E., Lowder E.M., Sightes E (2018). Barriers and facilitators to implementing an urban co-responding police-mental health team. *Health & Justice, 6*(1), 21.

The authors wish to thank the Indiana Division of Mental Health and Addiction for their support of this research.

INDIANA UNIVERSITY
PUBLIC POLICY INSTITUTE
Center for Health and Justice Research

The Center for Health and Justice Research (CHJR) works with public safety agencies, social service organizations, and residents to conduct impartial applied research on public and justice system policy choices. CHJR is housed within the IU Public Policy Institute (PPI), a multidisciplinary institute within the Paul H. O'Neill School of Public and Environmental Affairs. PPI also supports the Center for Research on Inclusion & Social Policy (CRISP), the Manufacturing Policy Initiative (MPI), and the Indiana Advisory Commission on Intergovernmental Relations (IACIR).

PREPARED BY

Beca Stockman, *CHJR Research Assistant*
Staci Rising, *CHJR Project Manager*
with assistance from **Karla Camacho-Reyes,** *CRISP Special Projects Coordinator*

101 W. Ohio Street, Suite 400
Indianapolis, IN 46204

Phone: (317) 278-1305
Email: iuppi@iu.edu
policyinstitute.iu.edu

Follow us on Twitter
@IUPublicPolicy

LinkedIn
Indiana University Public Policy Institute