

National Survey of

Mobile Crisis Teams

PREPARED FOR:

Vibrant Emotional Health
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(SAMHSA)

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National Survey of Mobile Crisis Teams – Summary Report

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1. INTRODUCTION

Mobile Crisis Teams (MCTs) have received increased interest and attention prior to and since the national launch of the 988 Suicide & Crisis Lifeline in July 2022. MCTs are the “someone to respond” component of the three pillars of the crisis continuum, as defined by the Substance Abuse and Mental Health Services Administration (SAMHSA): “someone to call, someone to respond, and someplace to go.” In this context, policies related to MCTs in the form of guidelines (1–3), regulations and financing (4,5) have surged and will likely continue. However, these initiatives and investments have occurred in the absence of a clear picture of the reach, operational configurations, and clinical best practices currently in place among MCTs across the US.

This National Survey of MCTs is the most comprehensive national survey of MCTs to date. This survey was intended to describe the national landscape of MCTs to inform the development of local, state, and federal roadmaps for crisis care systems. By describing a baseline of MCT characteristics and identifying gaps, crisis system administrators will be better equipped to develop policies, refine funding priorities, and optimize implementation planning. This survey further aims to serve as a stepping stone to a national platform that can be used to identify and contact MCTs by referring agencies such as 988 contact centers, behavioral health providers, first responders, and others. Question sections in the survey included service areas and partnerships, program and team structure, clinical scope, technology use, financing/billing/revenue, quality, and incentives (see Appendix for a complete list of survey questions).

First developed in the 1970s, MCTs have been prioritized by policymakers as a way of addressing Emergency Department (ED) boarding of psychiatric patients and inadequate psychiatric inpatient bed capacity (6–9). MCTs have a unique ability to respond rapidly in a less restrictive environment and to coordinate with community partners such as Law Enforcement, Criminal Justice Systems and EDs to divert people from those settings (10–12). Over the years, MCT programs have been implemented to supplement existing emergency response systems as a way of reaching high-risk individuals who may not otherwise access specialty behavioral health care. Single-site research studies have shown that MCTs can decrease emergency department utilization and psychiatric hospitalization among people in crisis, thus reducing costs while simultaneously increasing engagement in community-based care (13–18). MCTs are more favorably perceived by people who receive these services than a law enforcement response (12).

Despite this modest body of research supporting the effectiveness of these programs, there remains a large gap in our knowledge of what constitutes MCTs across the United States. Though there is broad consensus that evidence should inform both policymaking and program operations, without a better understanding of what factors facilitate versus impede the effectiveness and long-term impacts of these programs, it is challenging to develop guidance that can be consistently applied across various unique contexts.

Given that national 988 crisis line implementation includes MCT dispatch as a high priority of a well-functioning crisis system, there has been a significant increase in interest in MCTs including new legislation, significant funding opportunities, and a proliferation of models (e.g., civilian vs. police co-

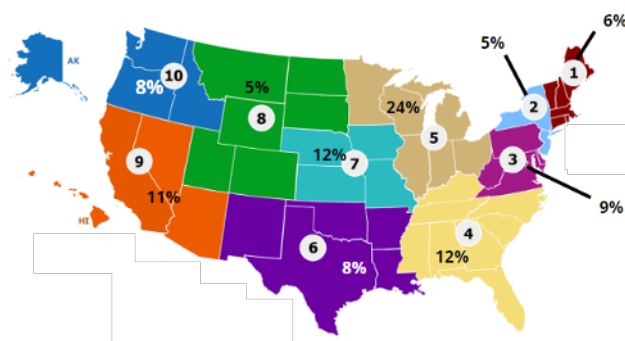
responder, solo response vs. 2- to 3-person teams, paramedic vs. law enforcement first responder partnerships, peer involvement, self-dispatch vs. hotline or 911 dispatch, and others). Our intent with the National Survey of MCTs is to be inclusive and survey all typologies. This initial landscape analysis lays out a path to begin standardizing nomenclature, setting the foundation for comparison analyses, and improving the quality and outcomes of MCT services nationally.

2. METHODS

The National MCT survey is a 51-question tool developed by the authors of this report in collaboration with leadership of Vibrant Emotional Health, the Substance Abuse and Mental Health Services Administration (SAMHSA), and the National Association of State Mental Health Program Directors (NASMHPD); see appendix for complete survey questions. The survey was open between January 12 and March 31, 2022. A convenience sampling strategy was used to disseminate the survey directly to a list of email addresses associated with MCT programs (see Appendix for a definition of MCT program), as well as email listservs and newsletters for national crisis services stakeholder groups such as SAMHSA, NASMHPD, the National Council for Mental Wellbeing, and others (see Appendix for a complete list of dissemination activities). United States territories were not recruited for the survey.

To encourage as many responses as possible, all questions were made optional, so the total number of responses to each question varies depending on the responses received. Furthermore, programs were encouraged to share contact information but were given the option to respond to this survey anonymously to mitigate potential reporting bias. Study procedures were approved by the University of California, San Francisco, Human Research Protection Program’s Internal Review Board as exempt and requiring limited review (IRB #22-36148).

A total of 1,290 responses were completed by MCT programs, however, only the responses that provided their state (N=562) were included due to significant missingness of data among respondents who did not provide a state (728 respondents, which answered on average fewer than 3 questions). Of those 562 responses, 153 respondents indicated a preference for anonymity. Duplicate responses (n=8) among identified responses were excluded for a final total of 554 responses. Out of the 51 total questions, a mean of 39 and median of 46 questions had complete responses in the final sample.



Respondent roles included MCT Program Director/Manager (43%), Front-Line MCT Clinician (19%), MCT Clinical Supervisor (12%), and Executive Director or CEO of the organization that oversees the MCT program (10%).

45 states included at least one response, except for Rhode Island, Washington DC, Minnesota, North Dakota, Wyoming, and Hawai’i.

3. RESULTS

FINDING #1: MCT Geographic Distribution, Areas Served, and Contexts are Diverse

MCTs across the US states are serving incredibly diverse regions in terms of geographic unit (county, region, city, state, etc.), population served (number of persons residing in the catchment area), and population density (urban, suburban, rural, and frontier¹).

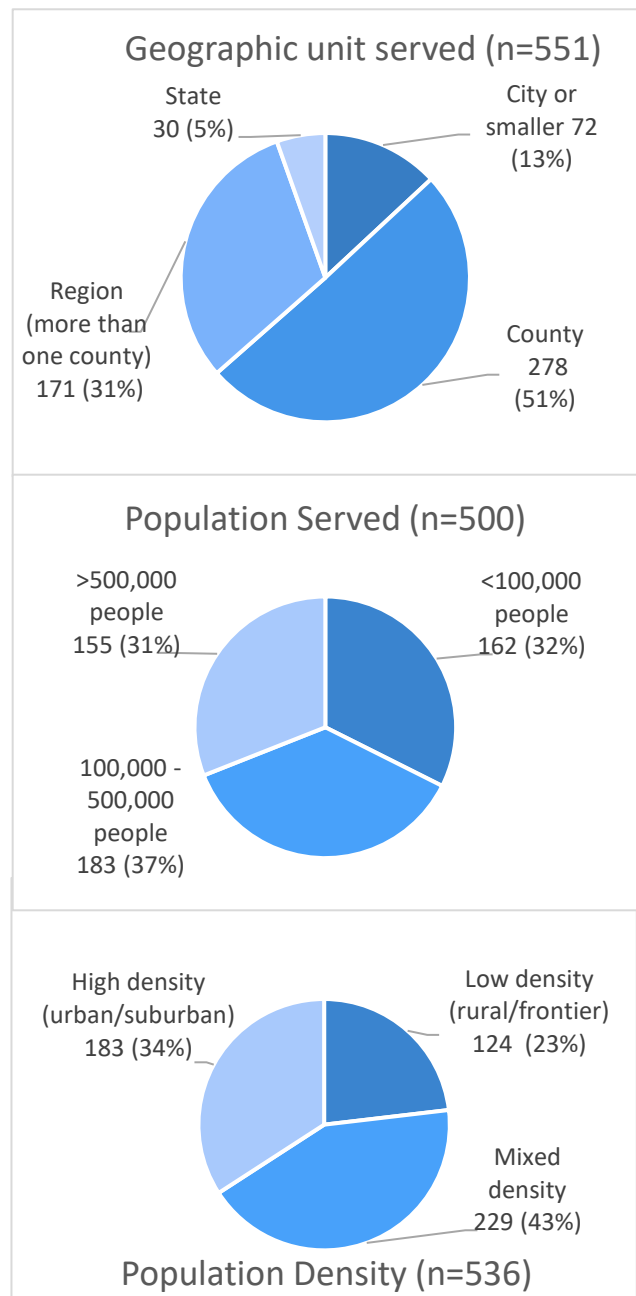
SUMMARY OF FINDINGS

The majority of MCTs provide services for a county or region (multiple counties), 51% and 31% respectively. The minority provide services for a city or entire state, 8% combined. MCTs are evenly distributed (approximately 1/3rd each) based upon population served (<100,000, 100,000-500,000, and >500,000). Mixed population density (both rural/frontier and urban/suburban) was more common (43%) than only high or low density. The most common factors reported as barriers to providing MCT services were long distances, poor Wi-Fi/cellular connectivity, snow, and traffic.

TAKEAWAYS

MCTs operate in a wide range of service areas and population sizes/densities. Three natural cohorts were identified based on the population of the service area (<100,000, 100,000-500,000, and >500,000); we will use these groupings while presenting subsequent findings given that these cohorts may be leveraged to guide program design, implementation, technical assistance, and learning collaborative groupings. Variations across frontier, rural, suburban, and urban settings suggest that MCT programs will need to emphasize different competencies to address different population needs and presentation patterns.

One size will not fit all. MCT program design and reality-based implementation will require balancing standards, best practices, and local-regional context.



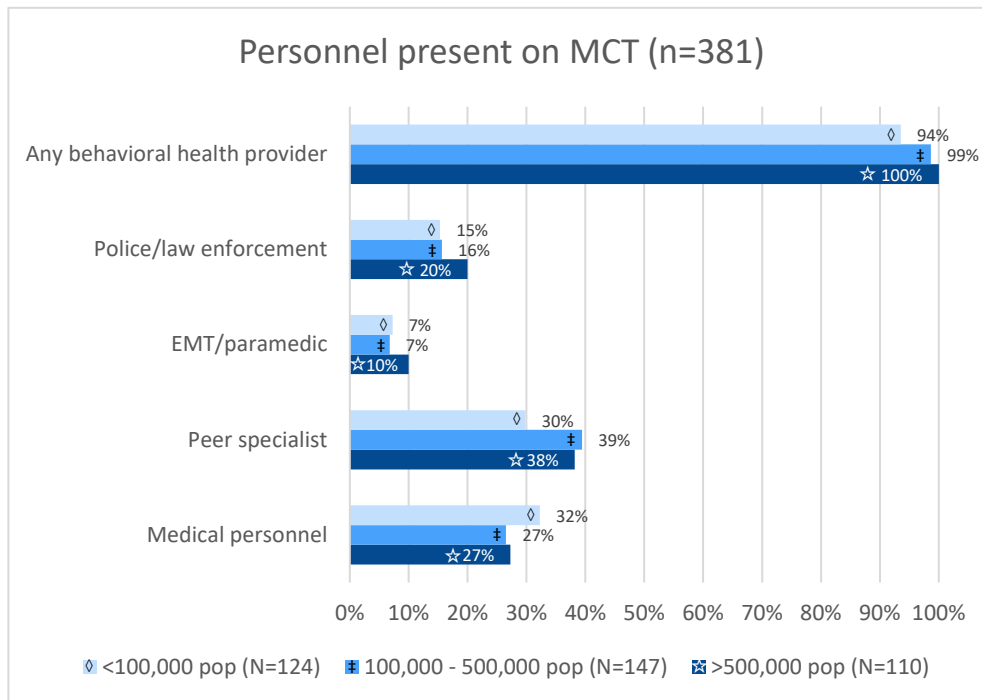
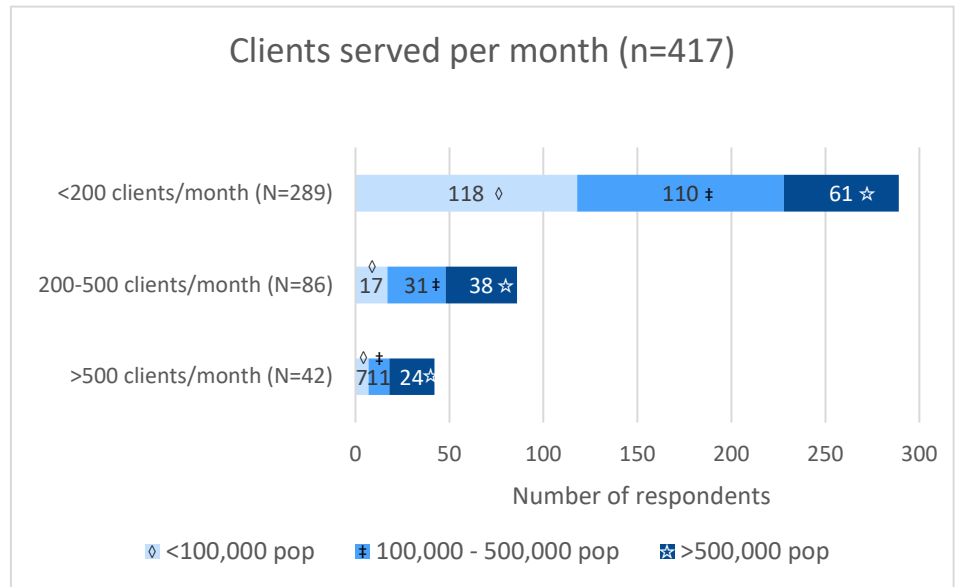
¹ The authors acknowledge that “frontier” is no longer the preferred term based on feedback from indigenous populations and regret its use in this survey; the decision was made to keep this term in this report to prioritize transparent and accurate reporting given that this was the option made available to survey respondents.

FINDING #2: MCTs Themselves are Diverse Operationally and Administratively

Given the regional diversity that shapes the service areas of MCTs, it is to be expected that there is considerable variability in how MCTs themselves are structured. The national survey identified a wide range of operational and administrative approaches.

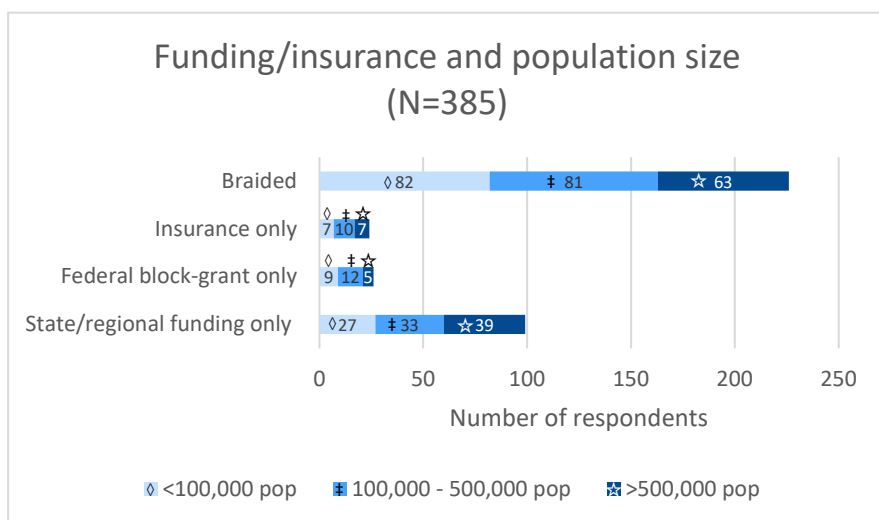
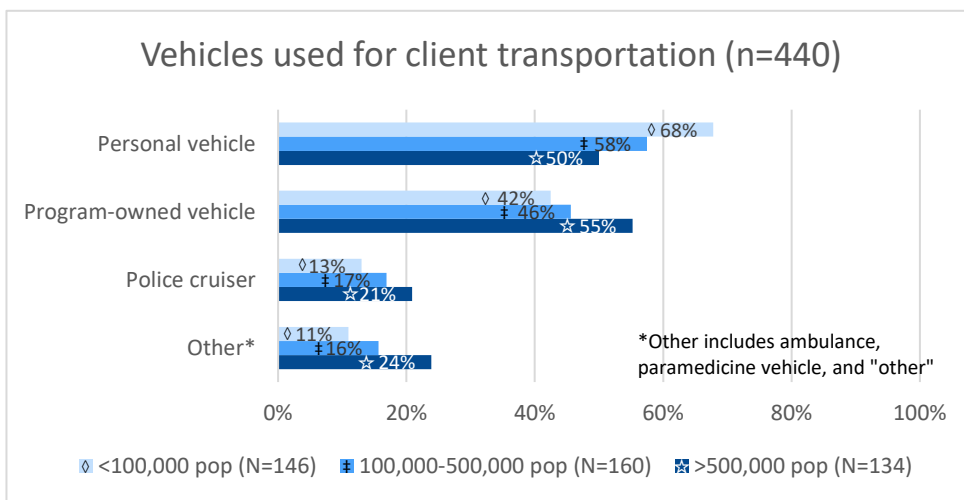
SUMMARY OF FINDINGS

Nearly 70% of MCT programs serve fewer than 200 clients per month, and just 10% serve more than 500 clients per month. MCTs serving smaller populations more often serve fewer clients, and programs serving larger populations serve more clients monthly, but this trend is not absolute—nearly half of MCT programs in catchment areas larger than 500,000 people are reaching fewer than 200 clients per month.



Regarding MCT staffing composition, 98% of programs that responded to the survey include a behavioral health provider, which indicates that respondents are truly mobile crisis and co-responder programs. Law enforcement and EMTs are more often a part of MCT staff in larger service areas, whereas there are fewer peers and more medical personnel in smaller service areas.

Another key issue is how MCTs provide transportation when needed. MCT programs in smaller service areas use personal vehicles more often, whereas program-owned vehicles, police cruisers, and ambulances are more often used in larger service areas.



Finally, financing of MCT services is highly variable. Most MCTs are supported by braided funding sources, meaning they receive a combination of insurance, federal block grants, and/or state or local general funds. MCT programs in smaller service areas more often rely on only federal block grants, whereas larger service areas more often rely on only state/regional funding.

TAKEAWAYS

MCTs vary in their administrative oversight, workflow and dispatch processes, team composition, and justification for payment. This finding is unsurprising given the variability of service areas large and small, rural and urban, highly resourced and under-resourced. However, the need for local adaptation may present a challenge to the goal of eventually setting quality standards and communicating to the public about what to expect with an MCT response. By contrast, when someone feels chest pain and calls an ambulance, there is a reasonably consistent understanding across the US that an emergency medical response will assist with evaluation, triage, and transportation. The variability of survey responses suggests that no such consistent understanding currently exists for MCTs.

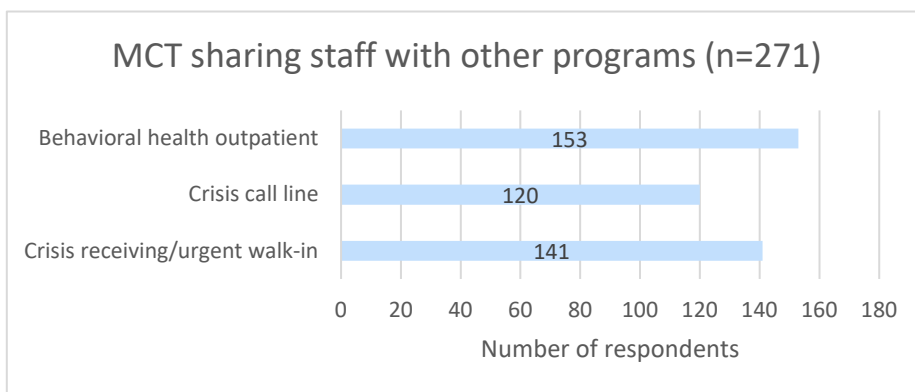
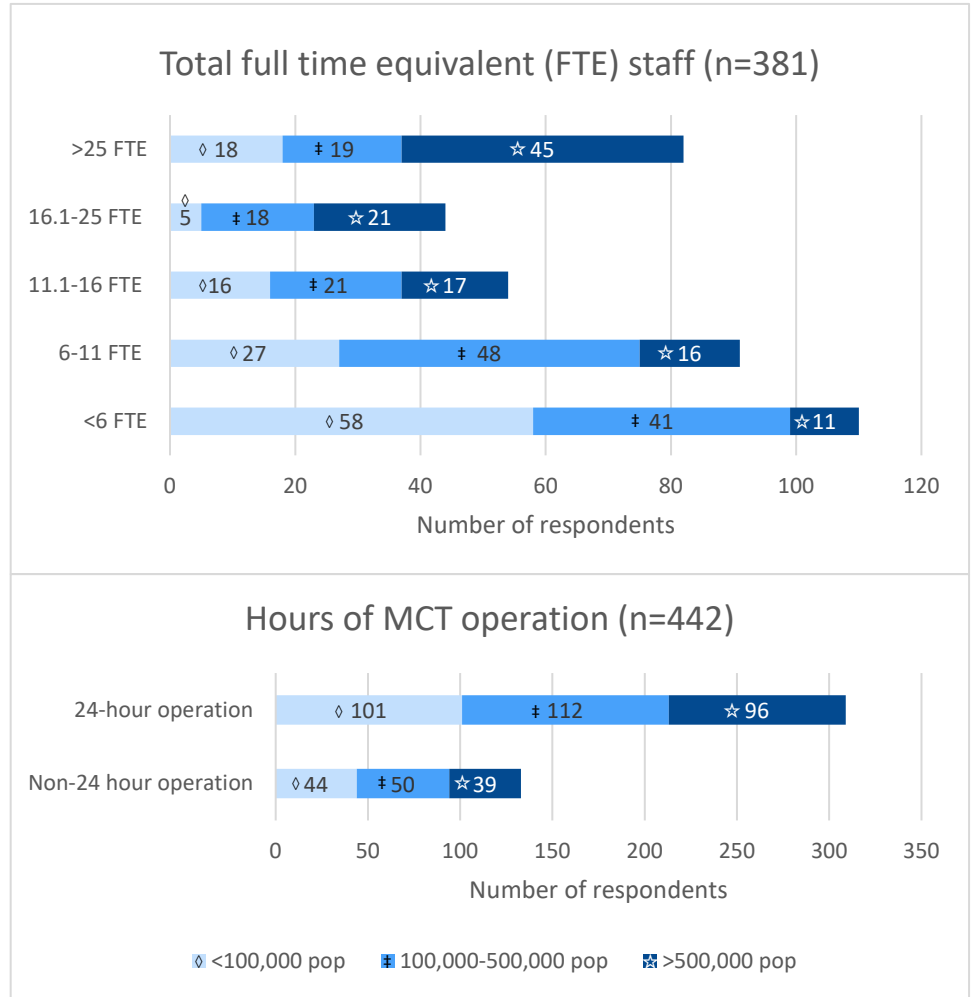
To move towards the goal of defining and ensuring high-quality standards among MCTs, there is a need for technical assistance for MCT programs to support local tailoring while still meeting public and quality expectations. There is also a lack of clear evidence or guidelines regarding optimal team compositions, transportation policies, dispatch and triage protocols, and productivity expectations—all areas that will benefit from continued research as MCTs are implemented and studied across the US. Though operational variation may present a challenge to standardization, there is a clear need to define expectations and achieve minimum standards in MCT service delivery across the nation.

FINDING #3: There is a Gap Between the Vision and Reality for MCT Scale and Reach

The vision of nationwide availability of MCT services that operate 24/7/365 and demonstrate high capacity and responsiveness is laudable. Results of this national survey suggest a significant gap between this vision and reality.

SUMMARY OF FINDINGS

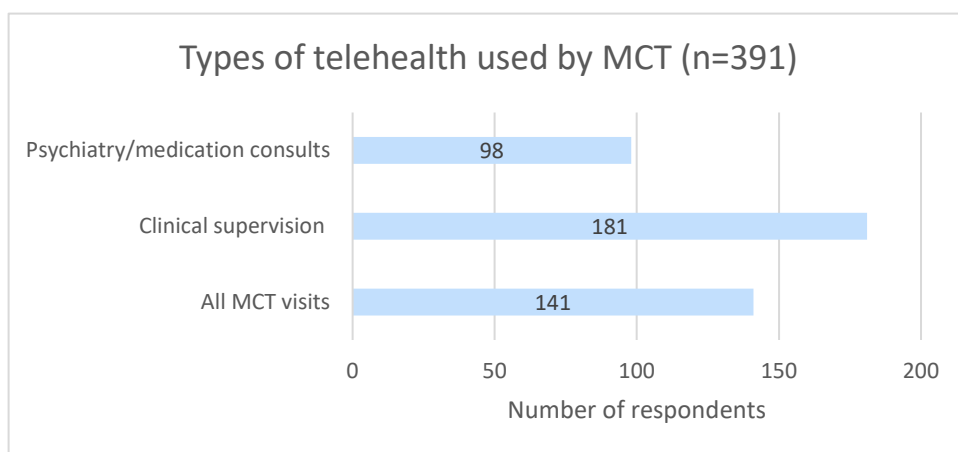
MCT staffing in full-time equivalents (FTEs) revealed that 52.7% of MCTs reported <11 FTEs, 14.2% of MCTs reported 11.1-16 FTEs, and 33.0% of MCTs reported >16 FTEs. 70% of MCTs reported 24/7 availability, yet only 40% of MCTs reported both 24/7 availability and >11 FTEs (minimum capacity for 2-person, on-duty teams operating 24/7), suggesting that MCTs with <11 FTE may not be optimally operating 24/7 with a 2-person team. FTE count demonstrated a positive correlation with population size: as the service area population increased, so did the proportion of larger teams.



Capacity enhancers, such as shared staffing with affiliated programs and use of telehealth, are widely used across MCTs. The most frequently reported staff sharing arrangements were with behavioral outpatient providers, crisis hotlines, and

crisis receiving facilities. MCTs serving smaller populations (<500,000) reported greater utilization of capacity enhancers.

The most frequently reported modalities for use of telehealth included clinical supervision, MCT visits, and psychiatry or medication consults. Utilization of these telehealth modalities demonstrated minimal variation based on population size served.



TAKEAWAYS

SAMHSA guidelines (1) describe the vision of connectivity between crisis hotlines and a national network of 24/7 MCTs as a consistent, universal behavioral health crisis response. However, the scale and reach of MCT programs in present day are far from meeting this vision. Specifically, whereas 70% of MCTs report 24/7 availability, when compared with the minimum staffing required for 24/7, on-duty, 2-person teams, only 40% truly meet this threshold.

Workforce shortages and funding limitations loom large in terms of achieving the necessary scale and capacity for a nationwide network of MCT programs that are 24/7, on-demand, and provide timely crisis response. Crisis service staffing requires scale to achieve the necessary backfill, redundancy, and workforce retention needed to meet the expectations and reliability of crisis response. These challenges are greater for MCTs programs serving less populated and population dense service areas. Additionally, staff retention is more difficult when programs are minimally staffed for 24/7 availability, given the increased stresses and demands on the skeleton crews covering all shifts.

To expand access to MCTs, we believe there is a need for greater adoption of scale enhancers like shared staffing, telehealth solutions, and hybrid on-duty/on-call staffing models. Regulatory and financing mechanisms are also needed to support such approaches. Our experience suggests that scale enhancers have greater impact when augmenting an already strong foundation of staffing for 24/7 coverage, rather than being used as strategies to achieve minimum capacity for 24/7 availability.

If these gaps in funding and workforce cannot be closed, it raises the question if MCTs are truly a viable or appropriate solution for every community, particularly in low density population areas that are likely to be more expensive per capita. If not, then alternative solutions need to be developed to meet the needs of people in crisis.

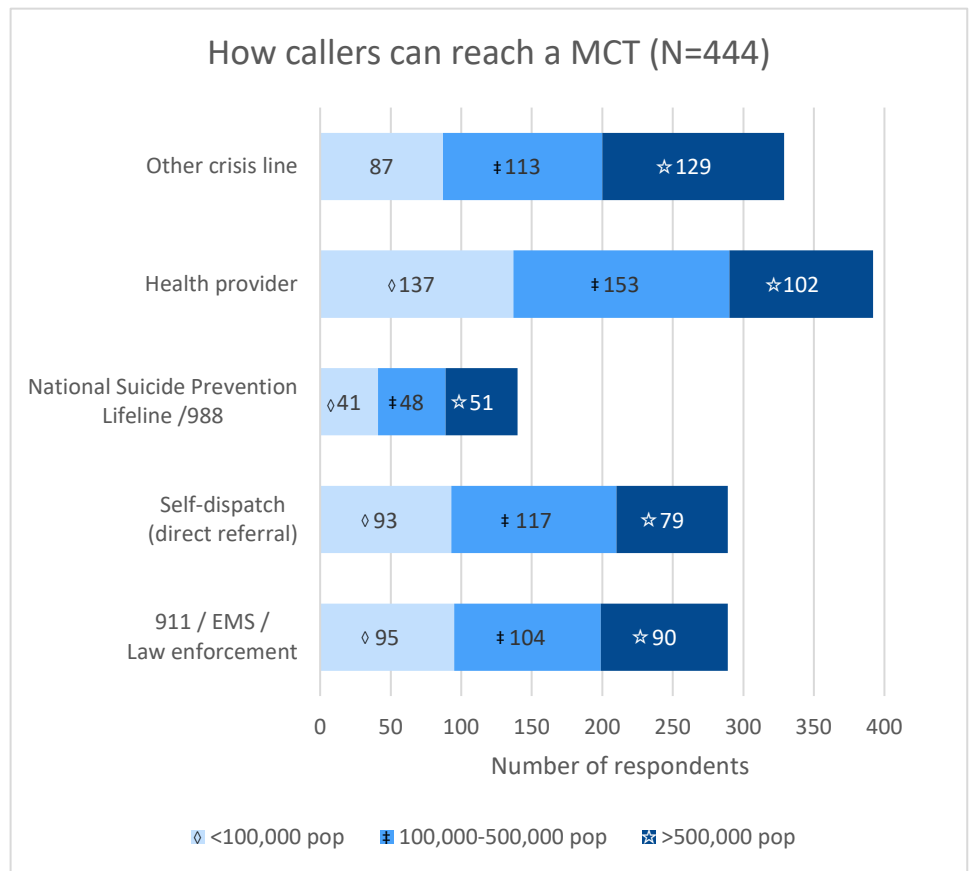
FINDING #4: Operational Integration Between MCTs and the Crisis Continuum is Limited

SAMHSA’s National Guidelines for Behavioral Health Crisis Care describe a continuum of services composed of call centers, mobile teams, stabilization facilities, and follow-up care. At the front end, this means MCTs should be integrated with crisis call centers, 911 providers, and other first responders such as law enforcement and emergency medical services (EMS).

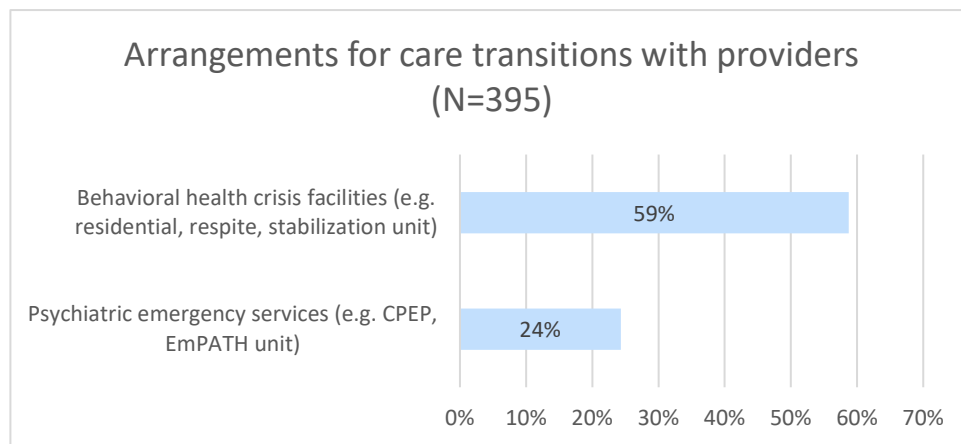
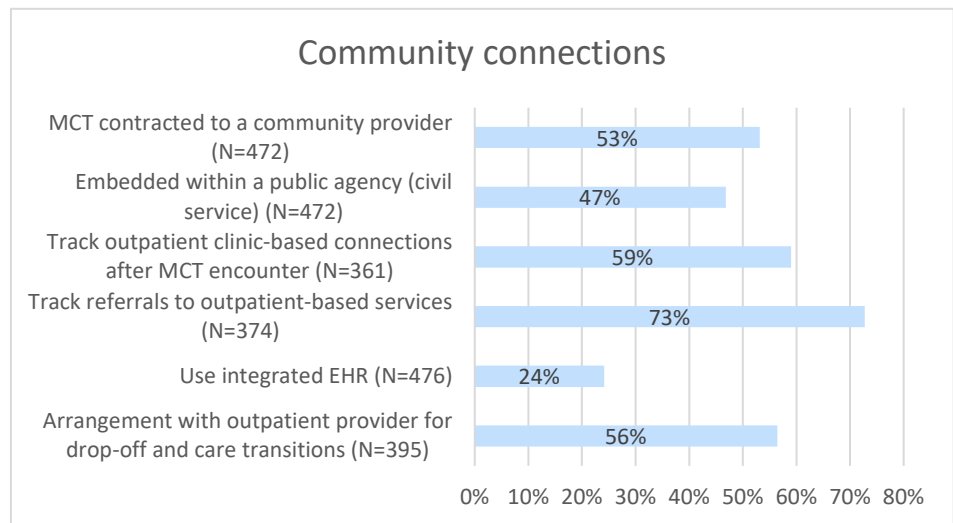
They also need to be well linked with after care settings to facilitate care transitions, including crisis facilities for those who need further stabilization and outpatient services for those who can safely remain in the community. It is therefore of interest to what degree MCTs report integration with these other components of the crisis continuum.

SUMMARY OF FINDINGS

MCTs primarily interface with call centers that receive behavioral health crisis calls (e.g., non-NSPL, NSPL, and 911) regarding requests for service and/or dispatch. MCTs reported that the way callers can reach them is variable, with most reporting they receive calls either from health providers, internal or self-dispatch, and 911 or other first responder agencies. Whereas only 32% of MCTs reported being reached via the National Suicide Prevention Lifeline (NSPL) (surveys were collected prior to launch of the 988 Suicide & Crisis Lifeline), more than twice as many can be reached by other non-NSPL crisis lines.



Community connections to facilitate post-crisis care were reported by 56% of MCTs that had arrangements with outpatient providers for drop-offs and care transitions. Only 24% of MCTs report using integrated electronic health records (EHRs) with systems that might be used for information sharing during care transitions.



Regarding arrangements for care transitions, 59% of MCTs reported such arrangements with behavioral health crisis facilities, and 24% with psychiatric emergency services.

A higher number of MCTs reported collecting metrics on post-crisis care follow-up, including 73% tracking referrals to outpatient-based services and 59% tracking outpatient clinic-based connections that followed the face-to-face MCT encounter.

TAKEAWAYS

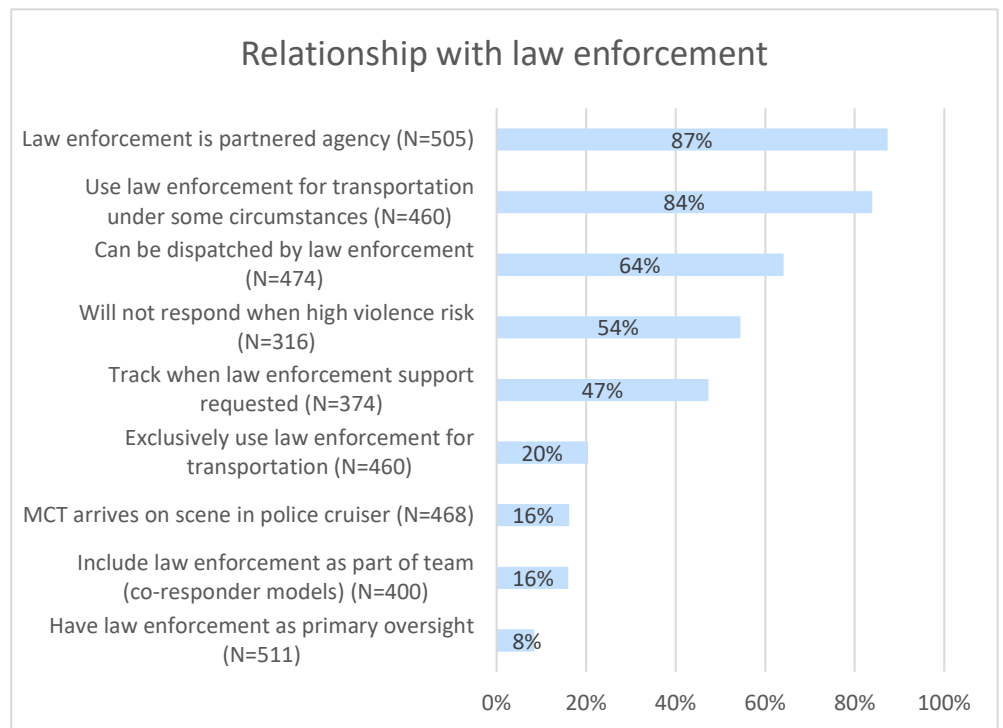
To meet the vision of SAMHSA’s crisis continuum guidelines, there is a critical need for coordination between MCTs and other continuum components, yet MCTs across the US states report continued silos and fragmentation. With so many different care systems involved, there is a need for centralized leadership, often at the county or regional level, to engage partners across the crisis continuum and develop operational workflows and written agreements that facilitate integration. Finally, the ability of MCTs to connect people to care may be limited by the inadequate availability and capacity of crisis facilities and outpatient services, which suggests a need for investments in and expansions of post-crisis care at a scale commensurate with the crisis services themselves.

FINDING #5: MCTs Collaborate with Law Enforcement on Multiple Key Functions

The role of law enforcement in mobile crisis response has taken many forms across the US. (11) In some cases, law enforcement agencies sought and received additional funding to add behavioral health clinicians to join their officers on mental health-related calls, termed “co-response” programs. In others, communities sought MCTs as a clinical alternative to having armed officers respond to crisis calls unless absolutely necessary for the safety of the person in crisis or the public.

SUMMARY OF FINDINGS

Law enforcement was the most reported partner agency among MCTs at 87% of respondents. Law enforcement is a common provider of transportation, with 84% of MCTs reporting some transportation by law enforcement. 64% of MCTs can be dispatched by law enforcement. 16% of MCTs reported including a law enforcement officer as part of the team in a co-responder model, and the same portion reported arriving on scene in a police cruiser.



TAKEAWAYS

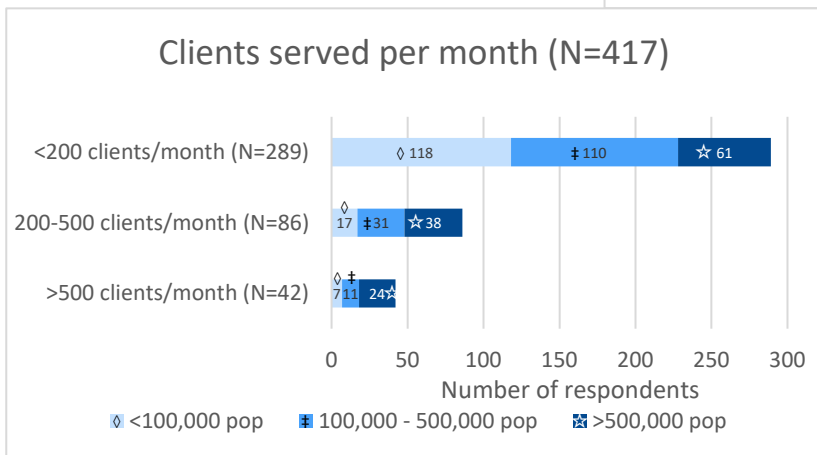
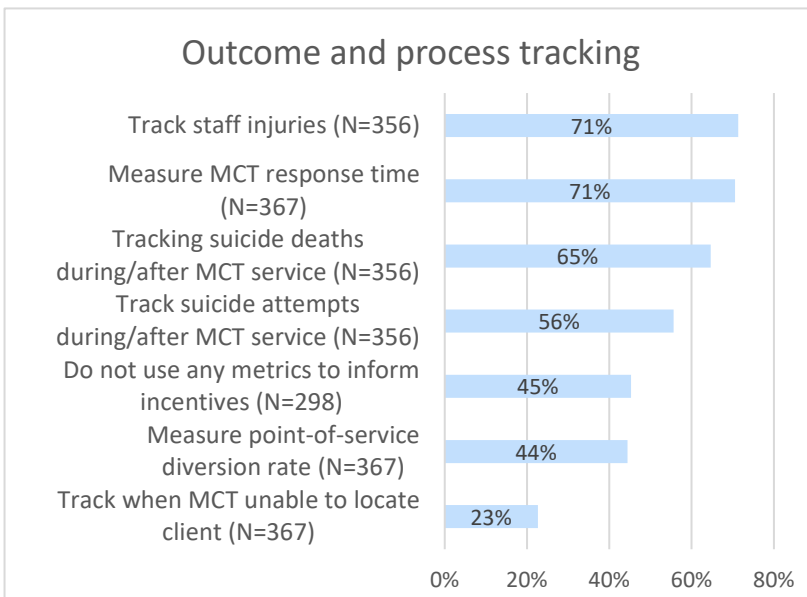
This landscape analysis indicates that law enforcement is the primary MCT collaboration partner across the nation and remains involved in multiple aspects of MCT work. This finding may reflect the common experience among MCT providers that there is a need to ensure safety for all—including providers, the public, and person in crisis—and that law enforcement officers provide security during response. However, many communities, especially minoritized and historically oppressed communities and others who have frequently experienced trauma during police interactions, have described feeling unsafe when law enforcement are present as part of a mental health response. While there may be consensus that certain cases such as extreme active violence or use of a loaded firearm may warrant law enforcement involvement, there remains significant gray area regarding the appropriateness and safety for MCT-only first response vs. when law enforcement support is needed for co-response. Localities should aim to develop a range of MCT options, including both civilian and police co-responder models, that limit law enforcement’s role only when necessary, with clearly defined triage criteria that can be transparently communicated to the public. Crisis system administrators should increase engagement with communities to better understand local preferences and tailor these criteria to meet local needs.

FINDING #6: Metrics Tracked by MCTs are Incomplete

Quality metrics are foundational for monitoring attainment of programmatic objectives, demonstrating contractual compliance, justifying revenue, validating value-based payments, and comparing programs across jurisdictions. Core measures of MCTs include performance metrics (e.g., service volumes by encounter type, response time), process metrics (e.g., use of clinical best practices, downstream connection to community-based services, post-MCT follow-up rates), and outcome metrics (e.g., diversion from higher levels of care, symptom reduction, rates of suicide attempts and deaths) (19).

SUMMARY OF FINDINGS

When asked about the collection of metrics, 45% of MCTs reported not using any metrics to inform incentives or payments. As it relates to critical incidents, 71% of MCTs track staff injuries, 65% of MCTs track suicide deaths during and after MCT services, and 56% of MCTs track suicide attempts during and after MCT services. For point-of-service outcomes, 44% of MCTs measure diversion rates and 23% of MCTs track when they are unable to locate clients.



In terms of productivity, 69% of MCTs would be considered small (<200 clients served per month), and the minority would be considered medium (200-500 clients per month) or large (>500 clients per month), with 20% and 10%, respectively. 69% of MCTs reported using stand-alone EHRs, and 26% of MCTs reporting using Word, Excel, or fillable PDFs for documentation (see Appendix, figure 37).

TAKEAWAYS

The ability to demonstrate program performance, measure outcomes and perform continuous quality improvement is dependent upon adequate collection of metrics. MCTs have a unique vantage point to serve as a system of care barometer that informs ongoing transformation efforts. Yet many MCTs lack both the capacity and technological infrastructure to collect or report metrics, which suggests that metrics in MCTs are minimally developed or disseminated and may mean that best practices are not being utilized. Without collecting metrics, many MCTs are ill-equipped to prove their value or objectively advocate for adequate funding, and it is very challenging to compare analogous MCT programs across jurisdictions. MCTs would benefit from alignment with quality improvement activities.

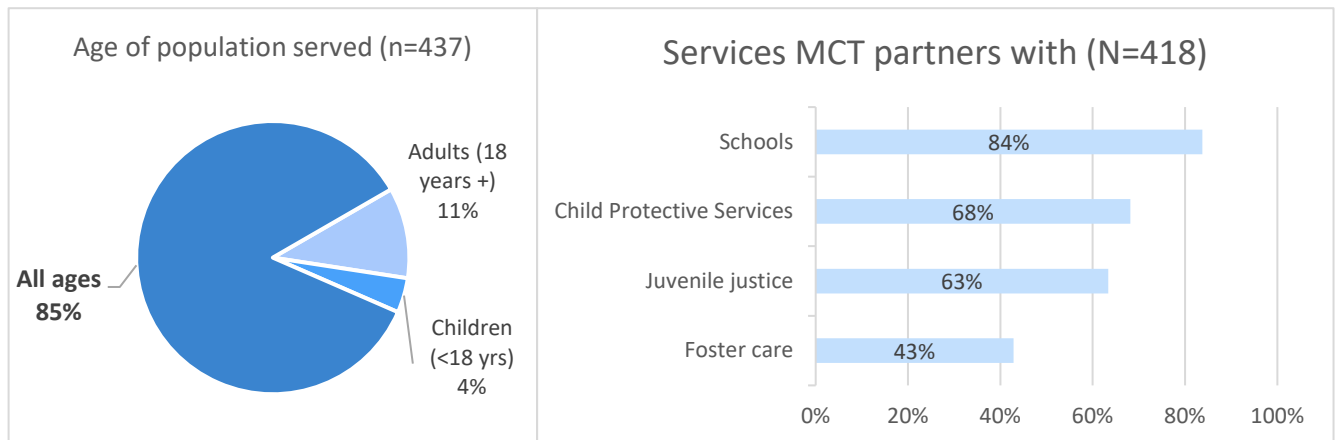
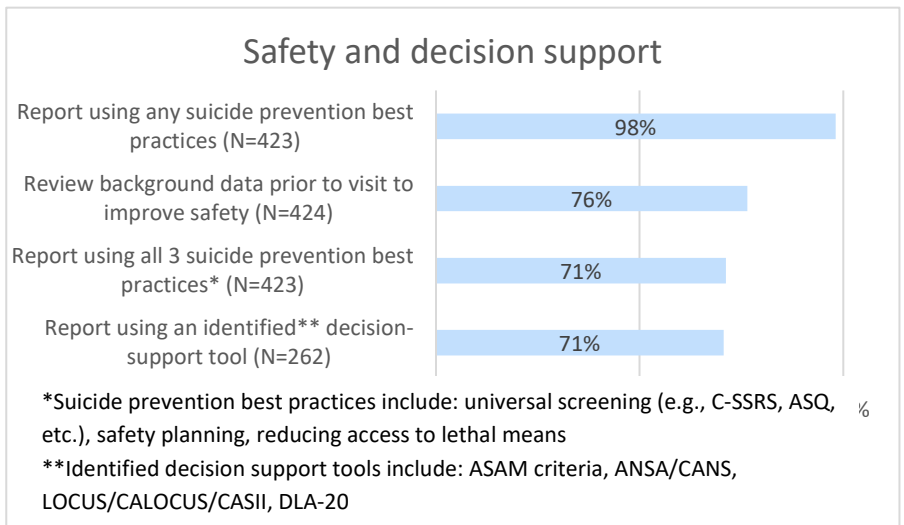
FINDING #7: Clinical Best Practices and Partnerships are Unevenly Adopted Across MCTs

Although MCTs have been studied for service outcomes, there is very little literature on clinical best practices in MCT settings. Clinical approaches in MCTs are therefore guided primarily by experts with experience in crisis service settings who are tasked with adapting general best practices to the unique context of MCTs. MCTs were queried about best practice adoption for suicide prevention, decision support, and field safety.

SUMMARY OF FINDINGS

For the three main suicide prevention best practices (universal screening, safety planning, and reducing access to lethal means), 98% of MCTs reported utilizing any of these best practices, and 71% reported using all three.

The most frequently reported field safety strategies included reviewing available background data before meeting with the client (76%), requiring 2-person teams (59%), and attempting a phone call with the client or family before entering the scene (58%). 71% of MCTs reported using a decision support tool for level of care decision-making with the most frequent including the American Society of Addiction Medicine (ASAM) criteria, the Adult Needs and Strengths Assessment (ANSA) or Child and Adolescent Needs and Strengths (CANS), the Level of Care Utilization System (LOCUS) or its related instruments for children and adolescents (CA-LOCUS/CASII), and the DLA-20 Functional Assessment.



The vast majority of MCTs serve all ages (85%), whereas 11% only serve adults and 4% serve only children. Among MCTs that serve children (89%), the most frequently reported collaboration partners include schools (84%), child protective services (68%), juvenile justice (63%), and foster care (43%).

TAKEAWAYS

Clinical best practices in the areas of suicide prevention, field-based safety tactics, and the use of level of care decision support tools are unevenly adopted across MCTs. Although the majority of MCTs report serving children, partnerships with child system providers are unevenly adopted.

There are few tailored, evidence-informed practices studied in the context of MCTs, thus leaving MCTs to adopt practices based on existing evidence to improve quality of care. There is a need to better define core competencies, continued training, and dissemination of best practices. Children and adolescents have distinct needs from adults, and MCTs serving children benefit from collaboration with specialized pediatric systems and providers. There is a need for an MCT convening to identify promising clinical approaches to guide development of MCT-based best practices and guidelines.

4. DISCUSSION

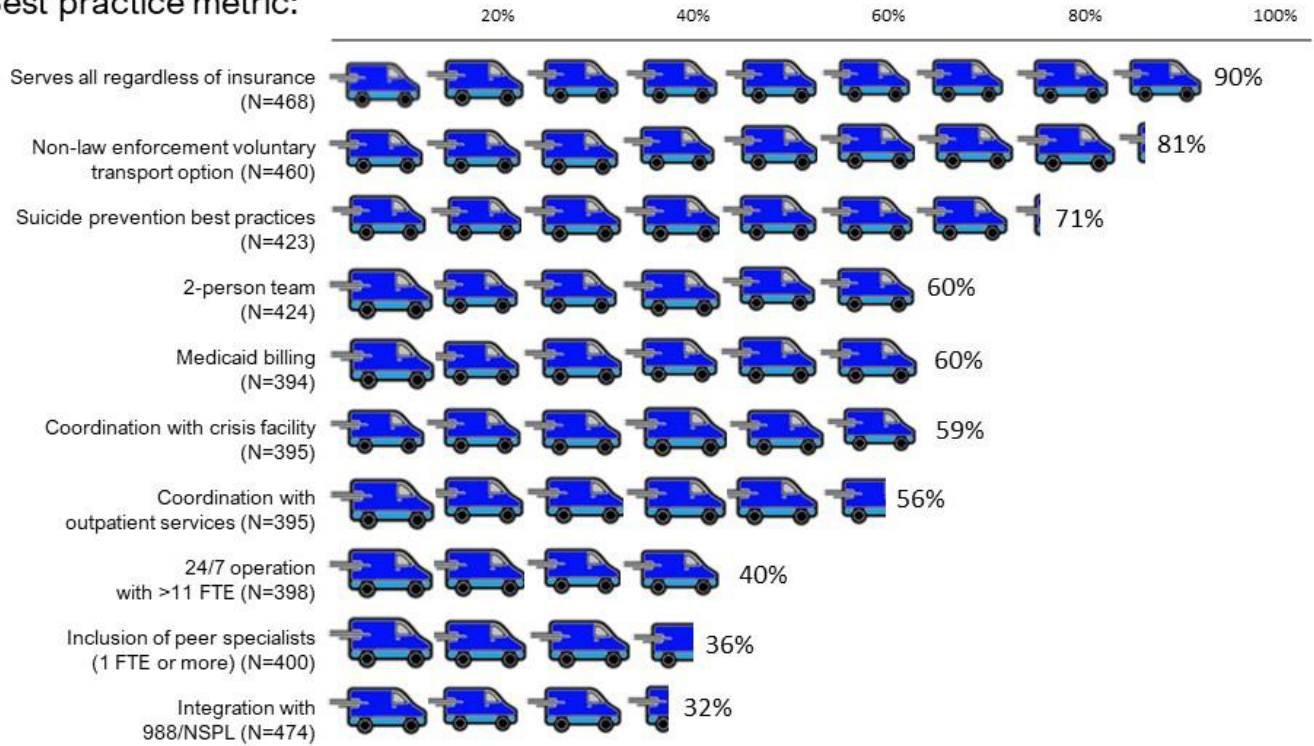
This national MCT survey provides a first look into the landscape of mobile crisis response across the US. These programs are now ubiquitous and serving millions of Americans. The key takeaways described above highlight both the significant accomplishments of a nascent component of the crisis continuum as well as the major challenges ahead.

There is a potential reckoning looming on the horizon for MCT services in the US. Given the significant gaps between the current state of MCT implementation and the vision for nationwide 24/7 coverage, including major structural barriers such as workforce shortages and inadequate insurance reimbursements, the question must be considered: is it feasible to have full MCT coverage across the entire US? If so, what steps need to be taken to optimize the MCT workforce and streamline best practices? If not, what alternatives exist and how should communities without MCTs provide services to people in crisis?

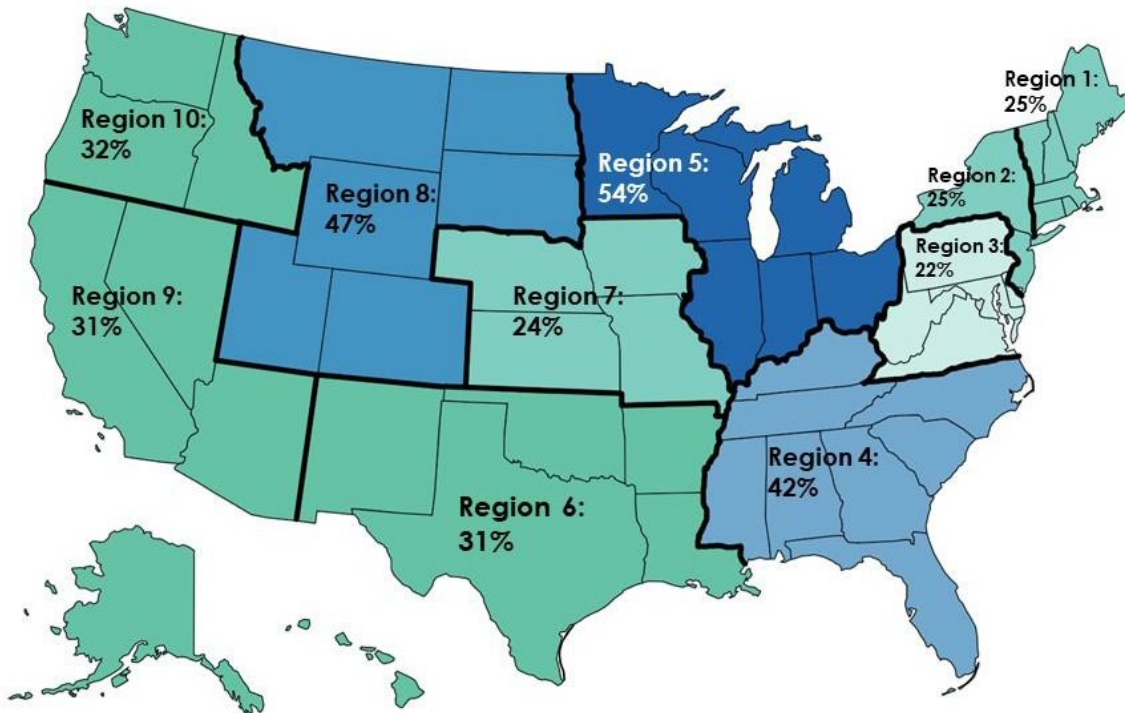
Another major theme in the survey results is the need for standards in the face of contextual variability. MCT programs need to have flexibility to adapt their services to best fit their population's needs, physical environment, system components, financing mechanisms, and many other factors. At the same time, there is a need for a shared understanding of what to expect when a mobile crisis team responds to a person in crisis, similar to how most people know what services are provided by an ambulance. To meet the vision of a future state in which all populations have equitable access to high quality MCT services, there will need to be a process in place to map out MCT catchment areas, to describe the services and characteristics of the MCT program, and to make it easy to locate and contact MCTs.

Drawing on recent federal and local legislative and regulatory definitions of MCTs, we propose that a key step towards this objective is to develop a dashboard that can track uptake of MCT best practices. Drawing on questions from the survey as an initial iteration of this approach, we demonstrate how many respondents are currently meeting each of the following best practices, and how regions across the US states are performing in terms of the number of MCT programs that report implementing 7 or more of these 10 best practices.

Best practice metric:



Percentage of respondents in each SAMHSA region that report implementing 7 or more of the 10 best practices (n=398)



We envision that this national best practice adoption and implementation dashboard will drive funding gap estimates, prioritization of focus for system transformation and technical assistance, and as a repeat measure barometer to determine the impact of various systemic interventions.

POLICY IMPLICATIONS

MCTs evidence a high level of diversity across multiple dimensions, and there are many unanswered questions about what models are best for what contexts. There remain broad needs for expanding the MCT workforce and peer specialist trainings, increasing insurance reimbursement for MCT services, and investing in rigorous research and evaluation of ongoing implementation activities to expand the evidence base to better inform MCT clinical best practices.

Multiple entities including crisis hotlines, crisis receiving facilities, 911 Public Safety Answering Points (PSAPs), outpatient mental health clinics, emergency departments, and others need a simple way to contact MCTs and request services. Respondent contact information gathered in this survey can set the foundation for the creation of a registry of MCTs across the US states and territories to drive the creation of an “MCT Finder” search engine to be used by referring agencies, including the potential for 988 crisis hotlines to “dispatch” MCTs. Such a registry could further enable outreach to MCT programs for participation in convenings, technical assistance opportunities, funding opportunities, and creation of learning communities.

MCTs need to achieve scale to provide 24/7 availability and on demand capacity. However, over 50% of MCTs lack the scale and reach to meet these expectations. MCTs need adequate technology to support program evaluation, operational integration with collaboration partners, and comparisons across jurisdictions, yet only 26% of MCT are utilizing a modern digital platform that integrates with other behavioral health providers. Workforce challenges and funding limitations are additional structural barriers to achieving such scale, inter-operability, and reporting capabilities. Dedicated efforts to modernize MCT platforms are needed to achieve these critical objectives.

These national MCT survey results represent a baseline for MCTs across the US that was obtained contemporaneously to policy and funding surges and prior to the national launch of 988. This context creates a unique opportunity for repeated surveys to evaluate the ongoing impact of such guidelines, roadmaps, and policy-funding. We are hopeful that these survey results and the additional research that follows will propel the field of mobile crisis to a place of evidence-based policy making.

LIMITATIONS

There are some limitations to survey methods that should be acknowledged. The survey responses are limited to those MCT programs that could be reached via a convenience sample of MCTs in the US and may not be representative of all MCT programs. Incomplete responses may have underreported certain questions based on respondent type, further impacting representativeness of the responses. Some duplicate responses may not have been detected as a result of allowing anonymous responses. Variability in respondent roles may further contribute to disparate responses to survey questions based on information available to respondents.

5. CONCLUSION

We set out to answer the question, “What is an MCT?” The answer is complex; it depends, and numerous unanswered questions remain. Context matters a great deal. While workforce and funding are key structural barriers, MCTs operating in different contexts have different needs for technical assistance to achieve the vision of a nation-wide network of 24/7, on demand, high performing MCTs that are integrated with crisis hotlines and crisis receiving facilities. We hope that these survey results will influence further research, evidence-based policy, and funding methodologies.

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APPENDIX A: Definition of MCT Program vs. Team

The National Survey of Mobile Crisis Teams (MCTs) was administered at the level of the MCT program, meaning a single entity with potentially multiple team components.

To define and calculate a mobile crisis "team":

- Ask about the following per program (program should be base unit of measure):
 - Total FTE of front-line responders (also good to know supervisors/consultants but not counted towards teams)
 - Hours of operation per week (i.e., 24/7, 40-hours per week, etc.)
 - # of staff responding (i.e., 1- or 2- or 3-person teams)
- To calculate actual teams per program:
 - $(\text{responder FTE} \times 40 \text{ hours} / 1.3 \times \text{modifier for staff vacation/sick}) / (\# \text{ hours of operation per week}) / (\# \text{ staff responding})$
 - For example, a program with 16 responder FTE working on 2-person teams 24/7: $16 \times 40 / 1.3 / 168 / 2 = 1.5$ teams available 24/7, i.e. 2 teams available half the time (during peak hours) and 1 team available the rest of the time (low demand hours)
 - Or, a program with 6 responder FTE working on 1-person teams M-F 7am-7pm: $6 \times 40 / 1.3 / 60 / 1 = 3$ teams available during business hours
- Additional info that can be factored in:
 - Hours per shift and shifts per week (not needed but can matter operationally)
 - Downtime, travel time, response duration, contact rate, etc. (can help inform response capacity as comparison point to actual population needs in the program's service area)

APPENDIX B: Table of recruitment activities

Dissemination Partner	Recipients at the time the survey was shared
American Association of Community Psychiatry (AACCP)	General membership listserv with 1,154 members
American Association of Emergency Psychiatry (AAEP)	Listserv with 282 active addresses
Crisis Community Jam	Listserv of approximately 2,300 subscribers
Crisis Intervention Teams (CIT) International	Contact list had 7,945 addresses
Crisis Residential Association	Listserv of about 250 people
Mental Health Liaison Group (MHLG)	80+ mental health organizations
National Association for Behavioral Health (NABH)	Weekly member newsletter with 1,547 email addresses
National Association of Mental Illness (NAMI)	988 State Crisis Response Advocates listserv with 551 recipients; state policy and advocacy network with 130 recipients (potential overlap)
National Association of State Mental Health Program Directors (NASMHPD)	Newsletter to 1,400 subscribers, additional listservs, and discussed at state calls
National Council for Mental Wellbeing (NCMW)	Newsletter mailing list of 42,000 subscribers
One Million Moms (1M4)	1M4 listserv has 240 subscribers
The Counsel of State Governments (CSG) listserv	Distribution list with approximately 6,000 members
Vibrant Emotional Health	Emailed to 892 email addresses

APPENDIX C: Table of respondents' states

State	Survey respondents
Alabama	3
Alaska	1
Arizona	19
Arkansas	1
California	21
Colorado	16
Connecticut	5
Delaware	6
District of Columbia	0
Florida	7
Georgia	10
Hawaii	0
Idaho	1
Illinois	37
Indiana	5
Iowa	13
Kansas	20
Kentucky	9
Louisiana	2
Maine	2
Maryland	16
Massachusetts	11
Michigan	17
Minnesota	0
Mississippi	18
Missouri	26
Montana	1
Nebraska	6
Nevada	20
New Hampshire	2
New Jersey	3
New Mexico	4
New York	23
North Carolina	6
North Dakota	0
Ohio	38
Oklahoma	5
Oregon	22
Pennsylvania	14
South Carolina	6
South Dakota	1
Tennessee	10
Texas	30
Utah	8
Vermont	12
Virginia	8
Washington	22
West Virginia	8
Wisconsin	39
Wyoming	0
Total	554

APPENDIX D: Summary figures for all survey questions

Figure 1

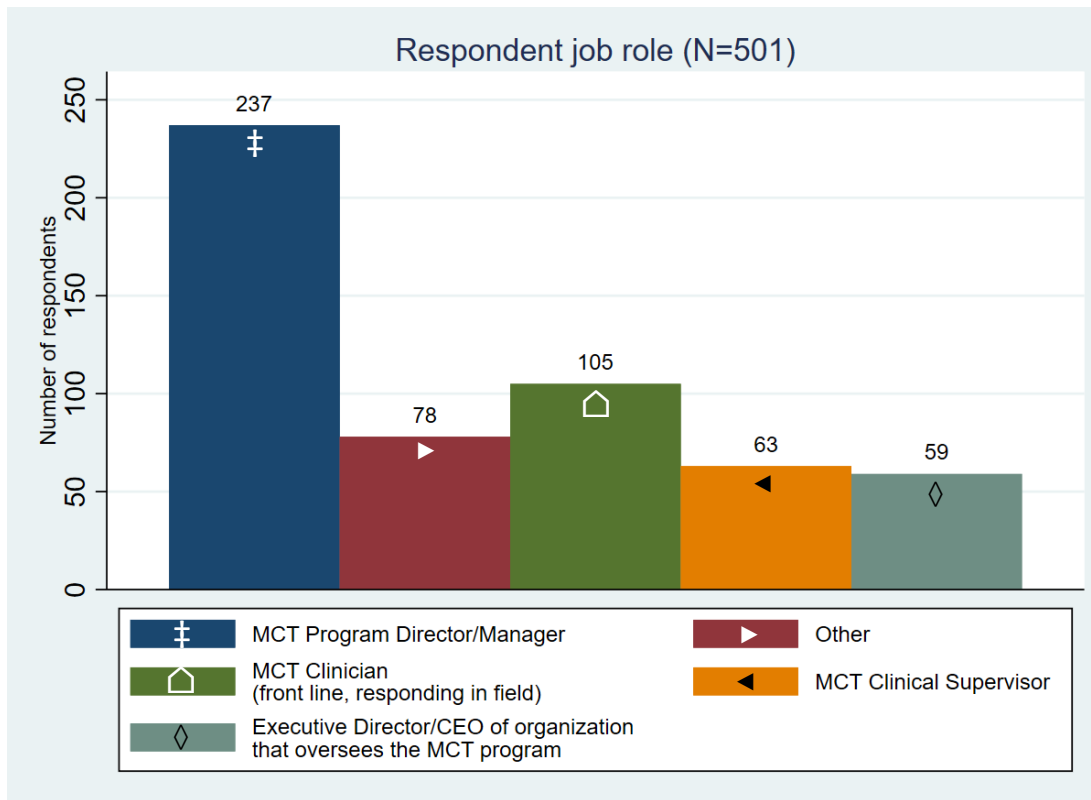


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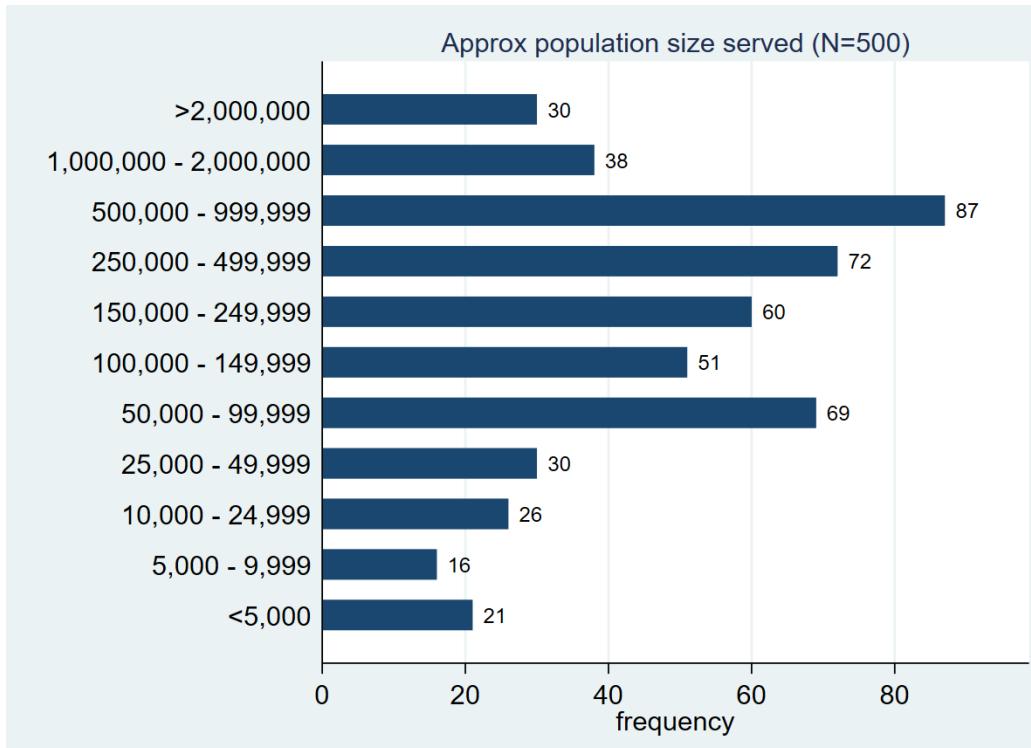


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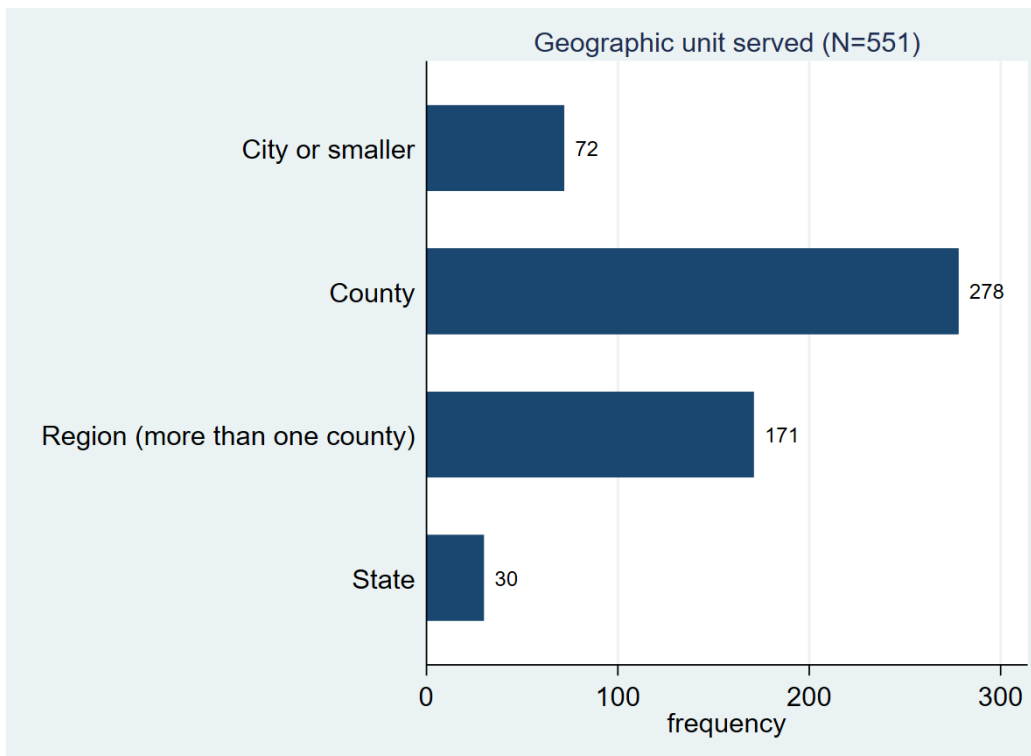


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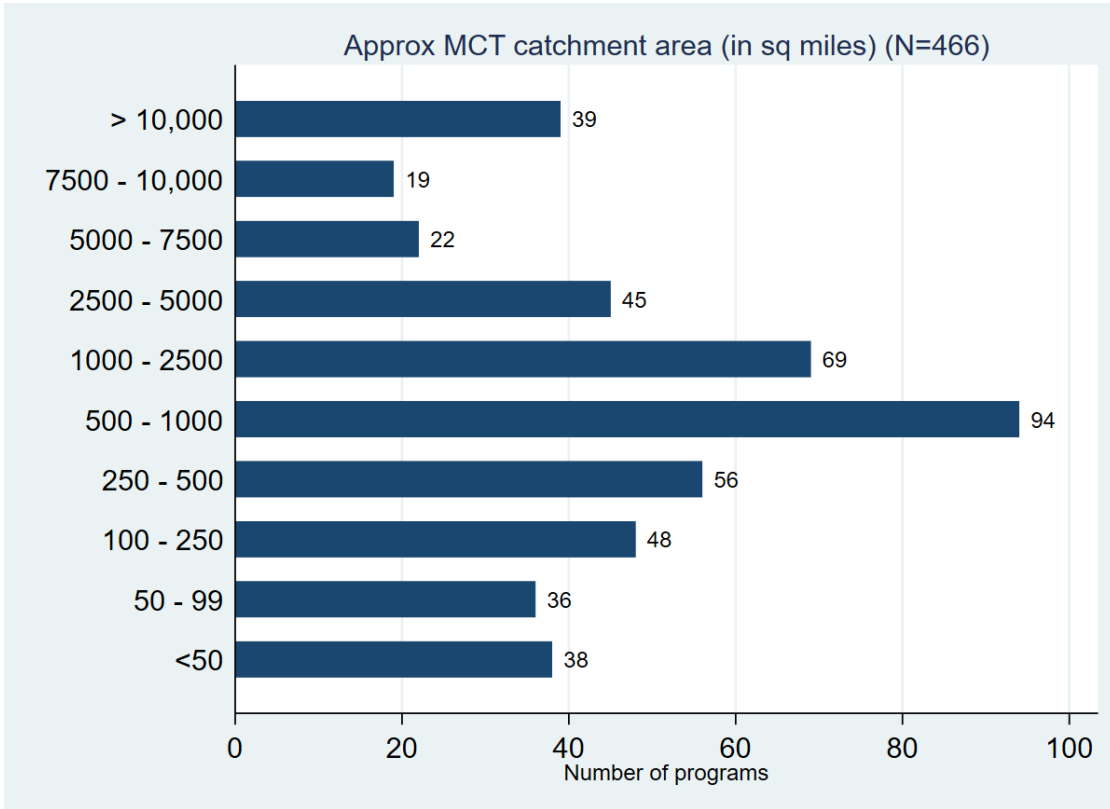


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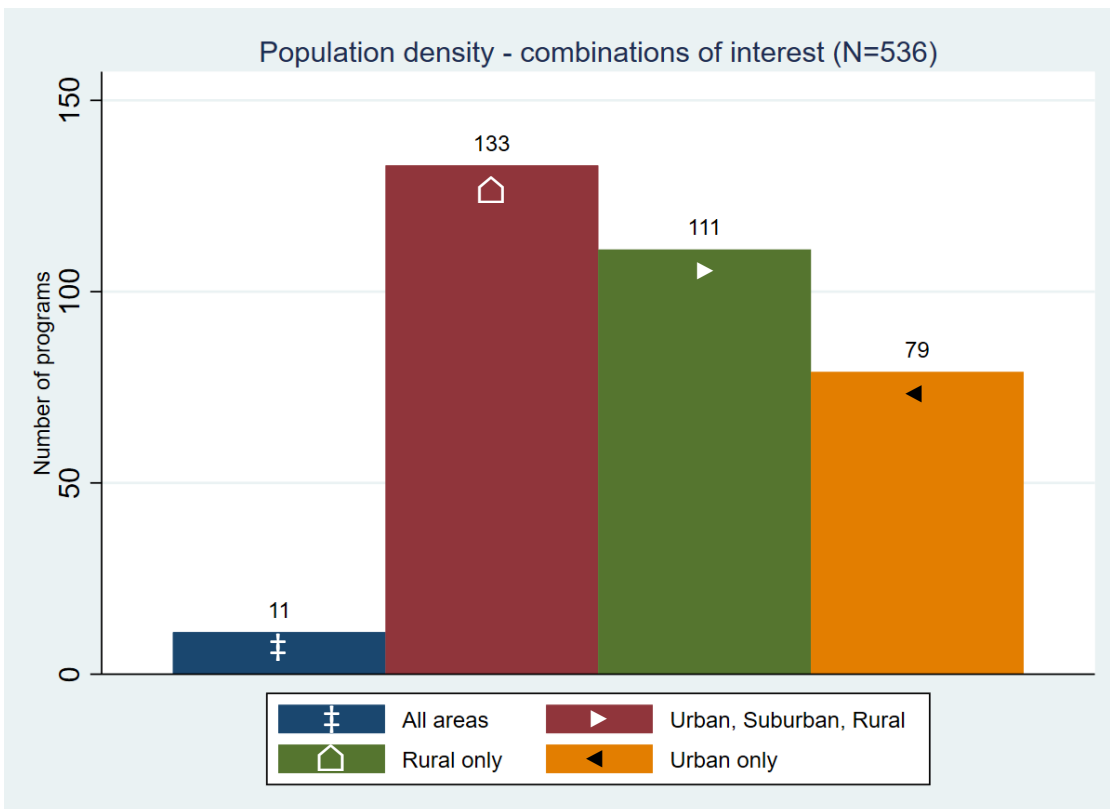


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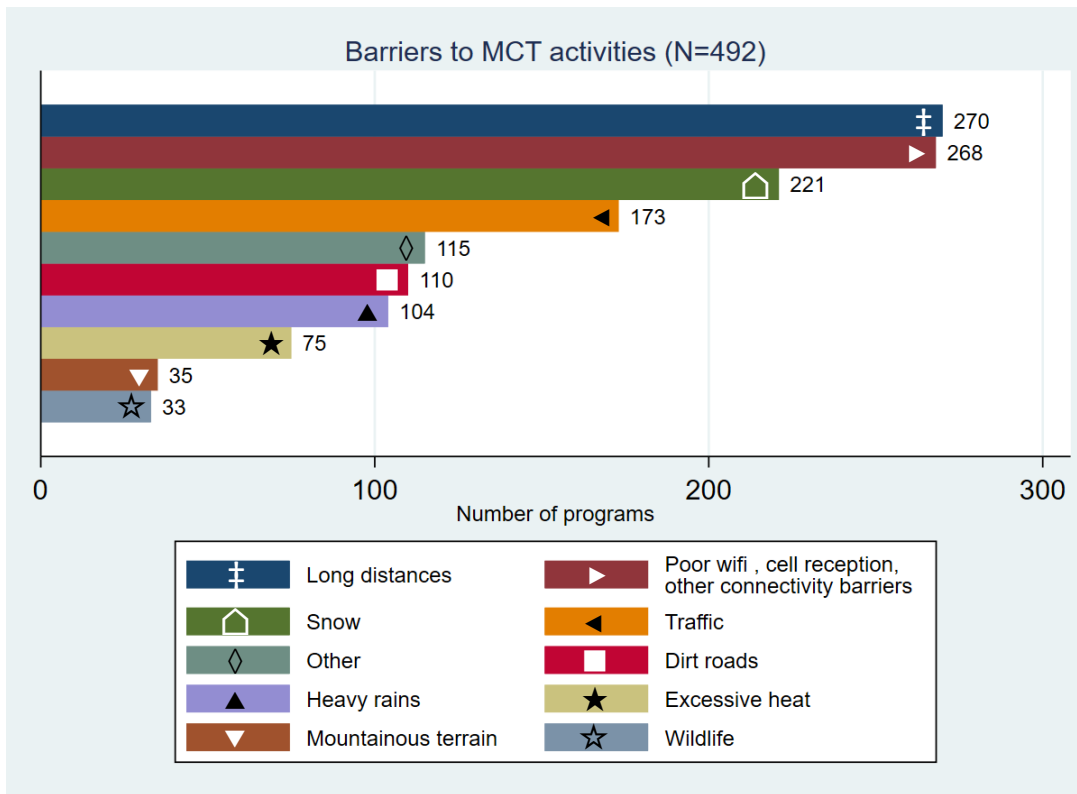


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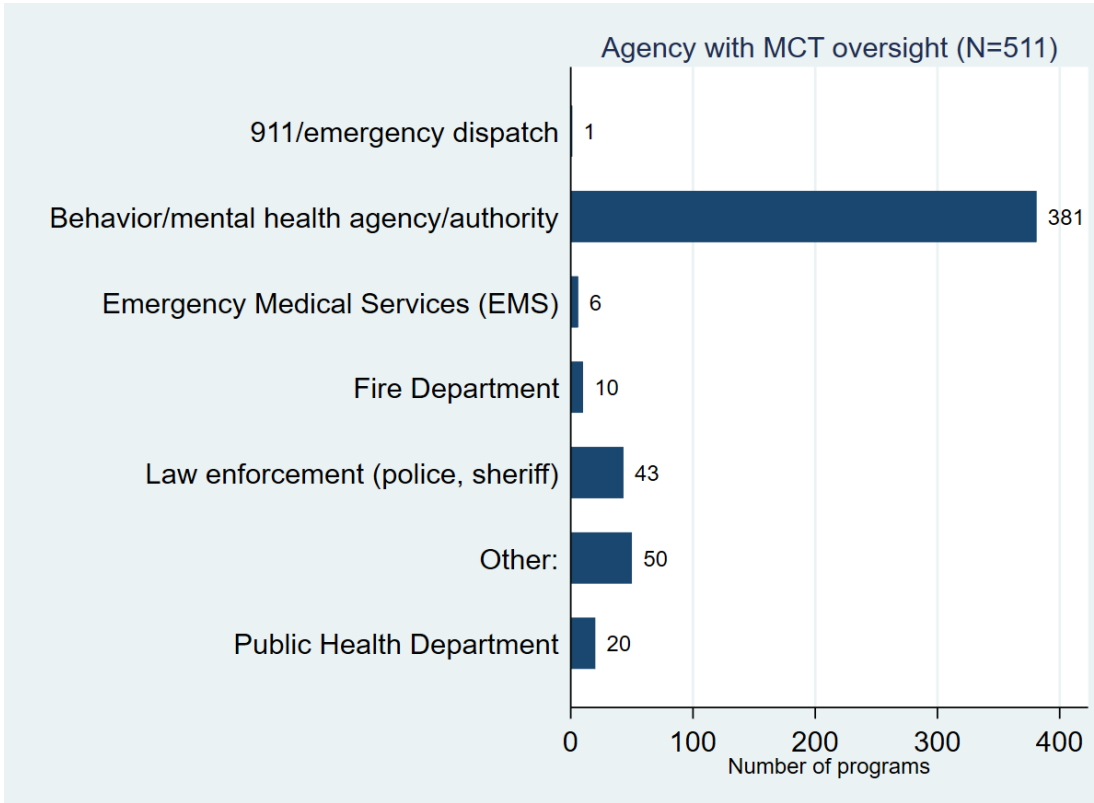


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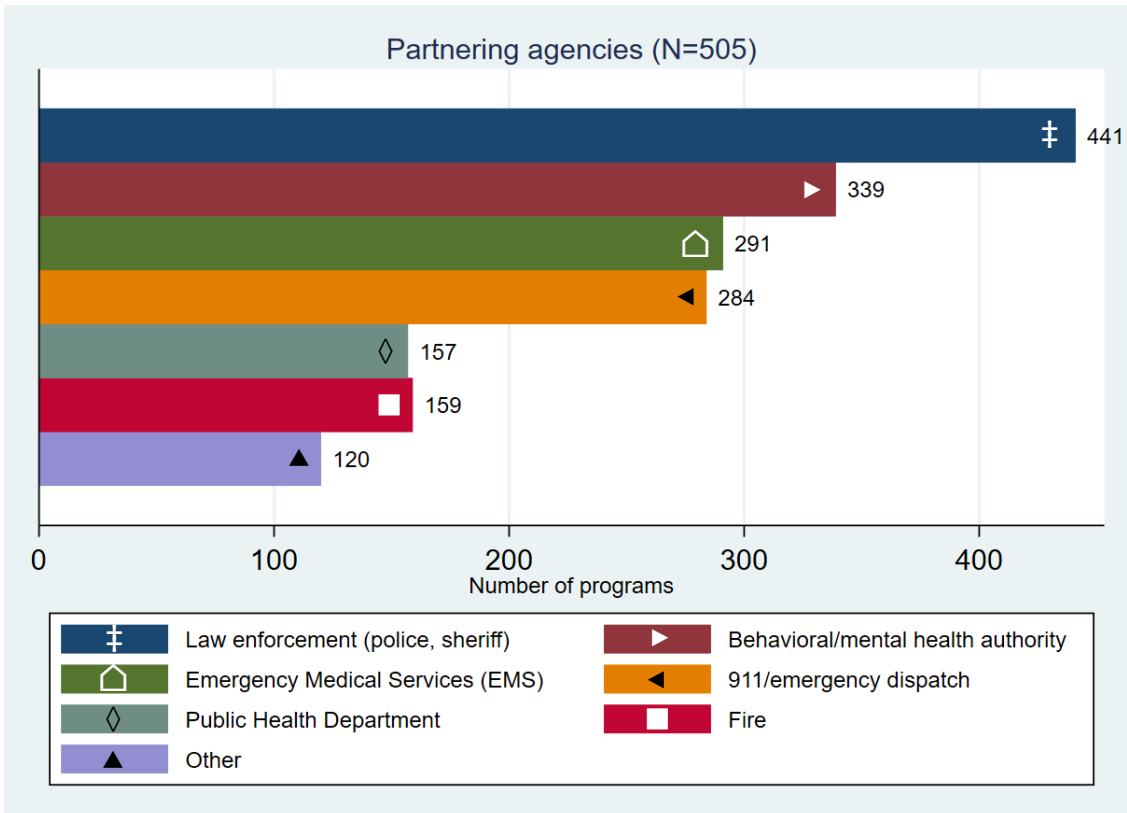


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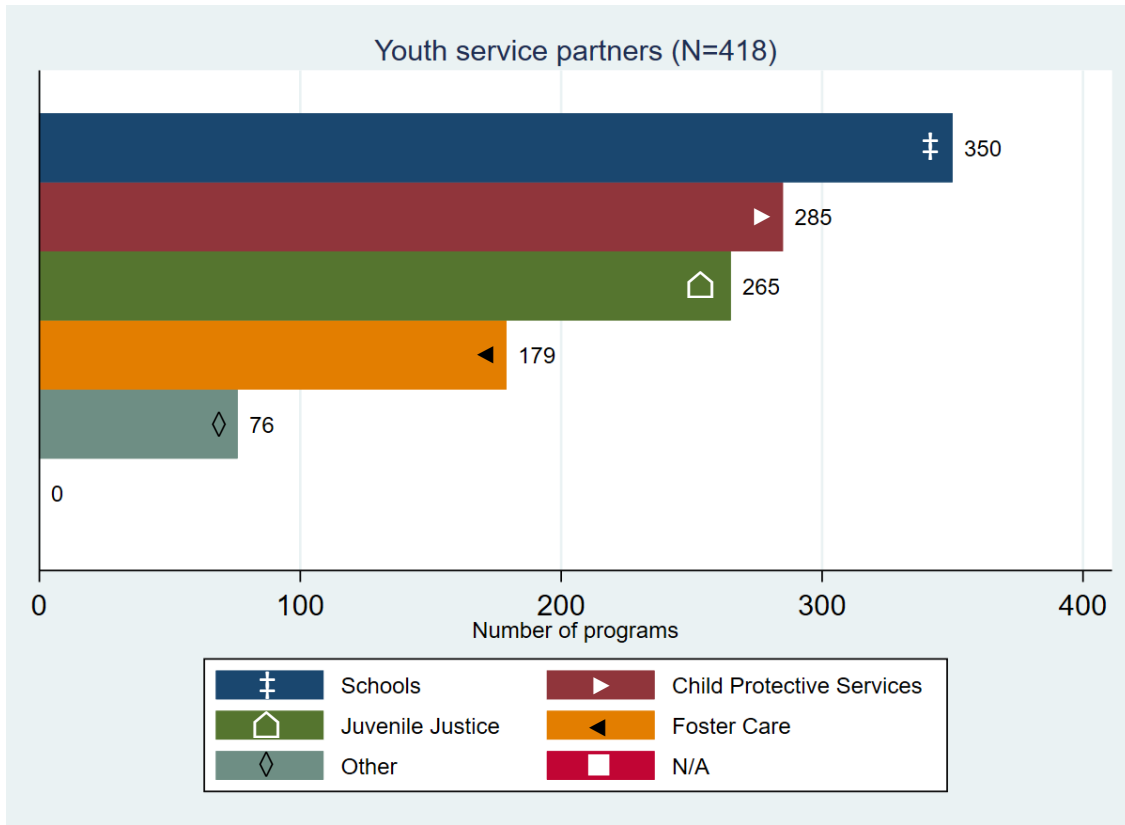


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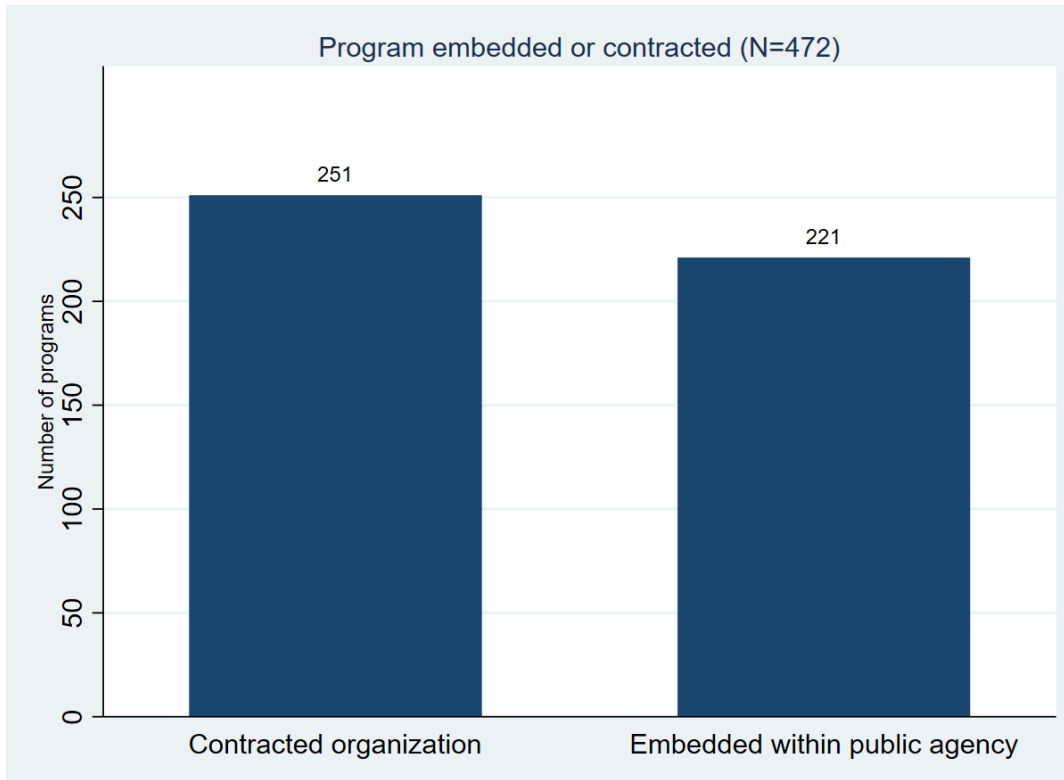


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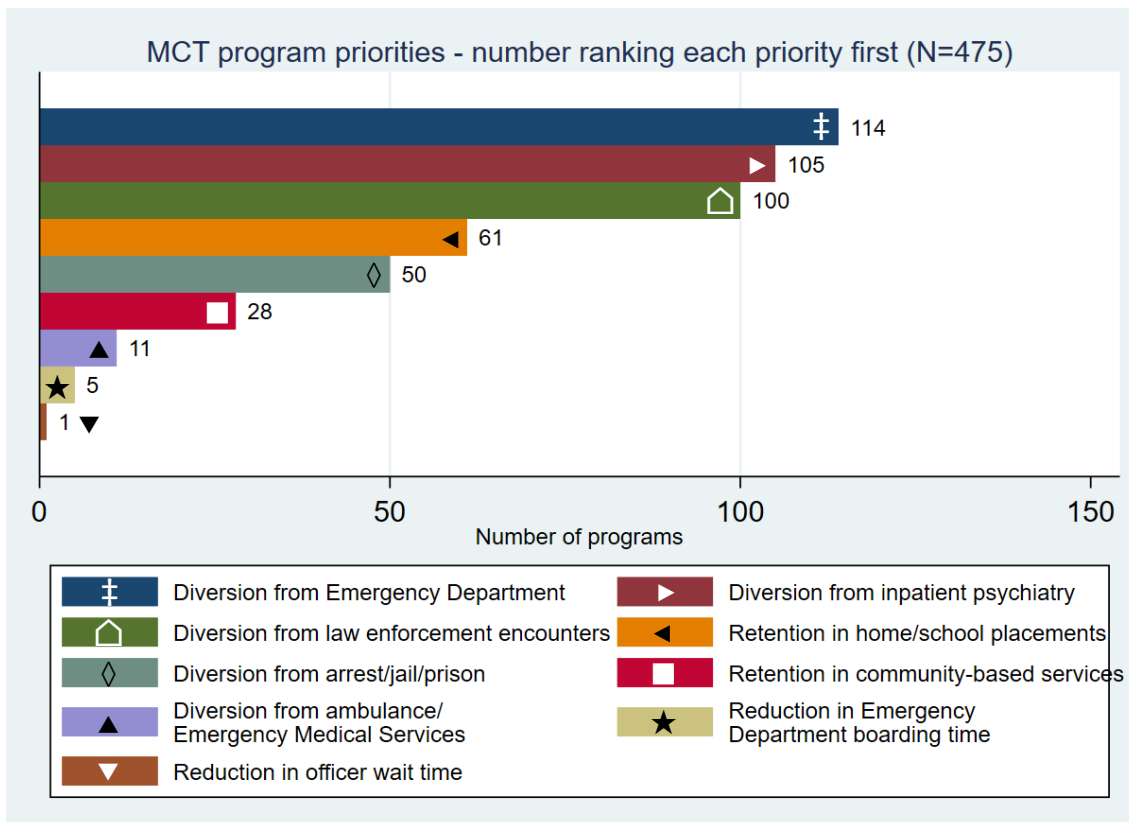


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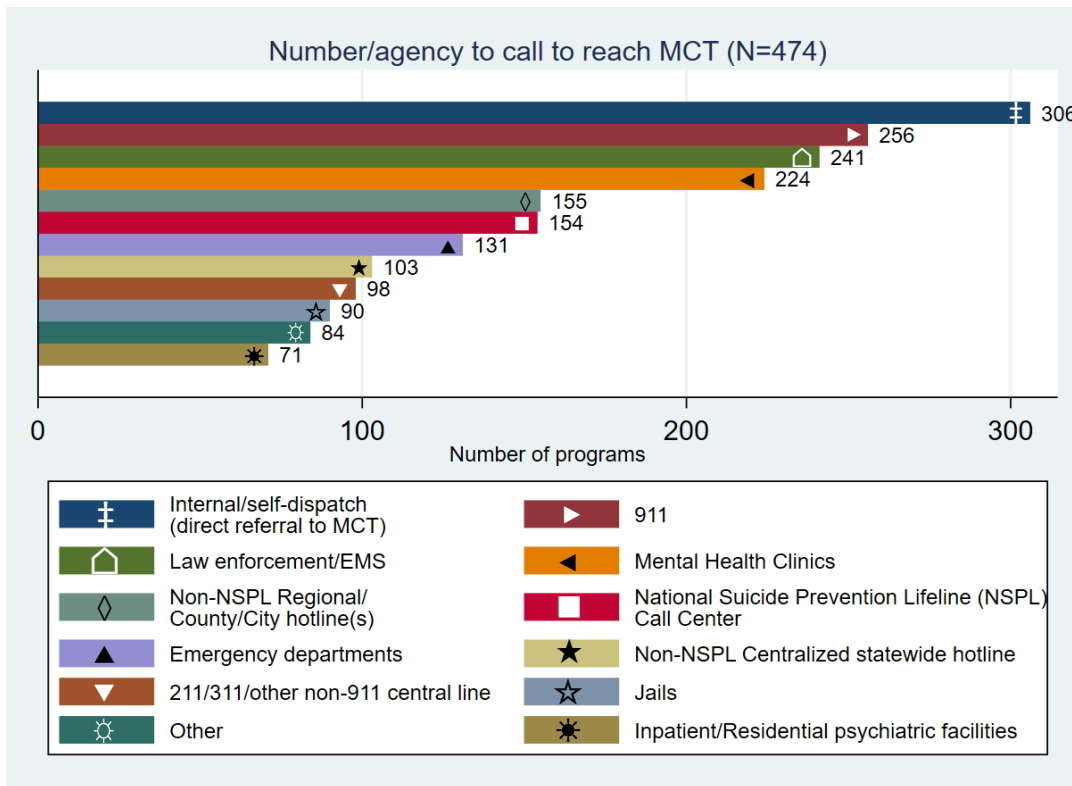


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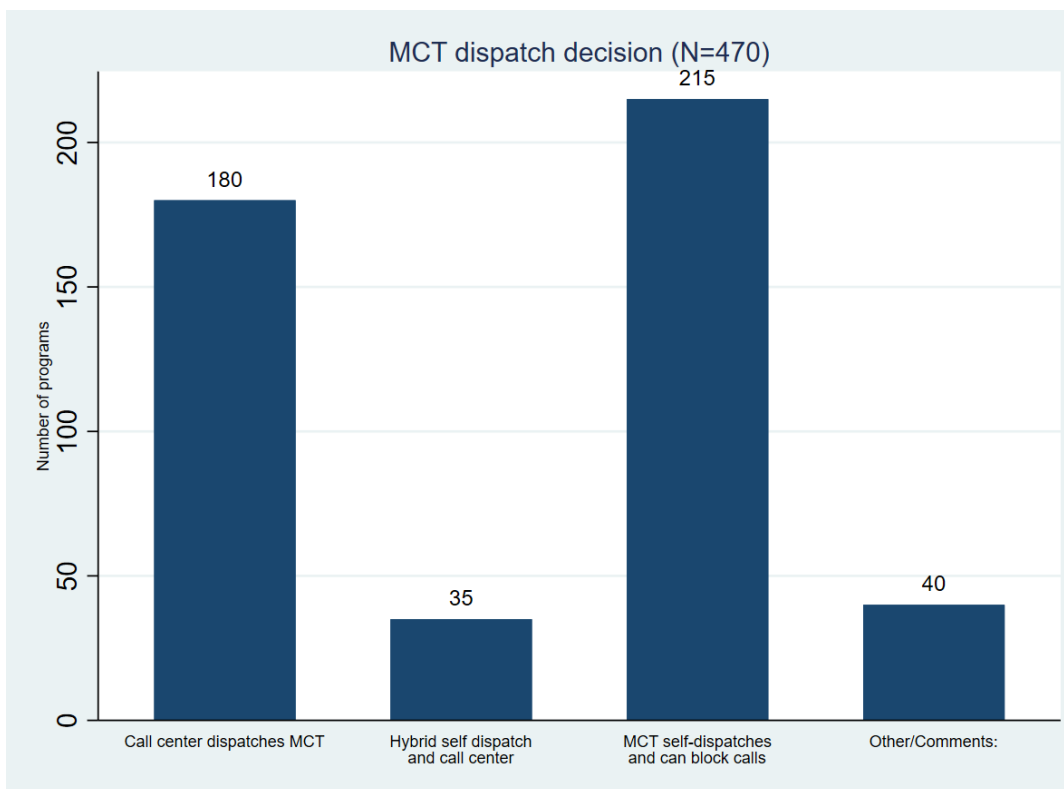


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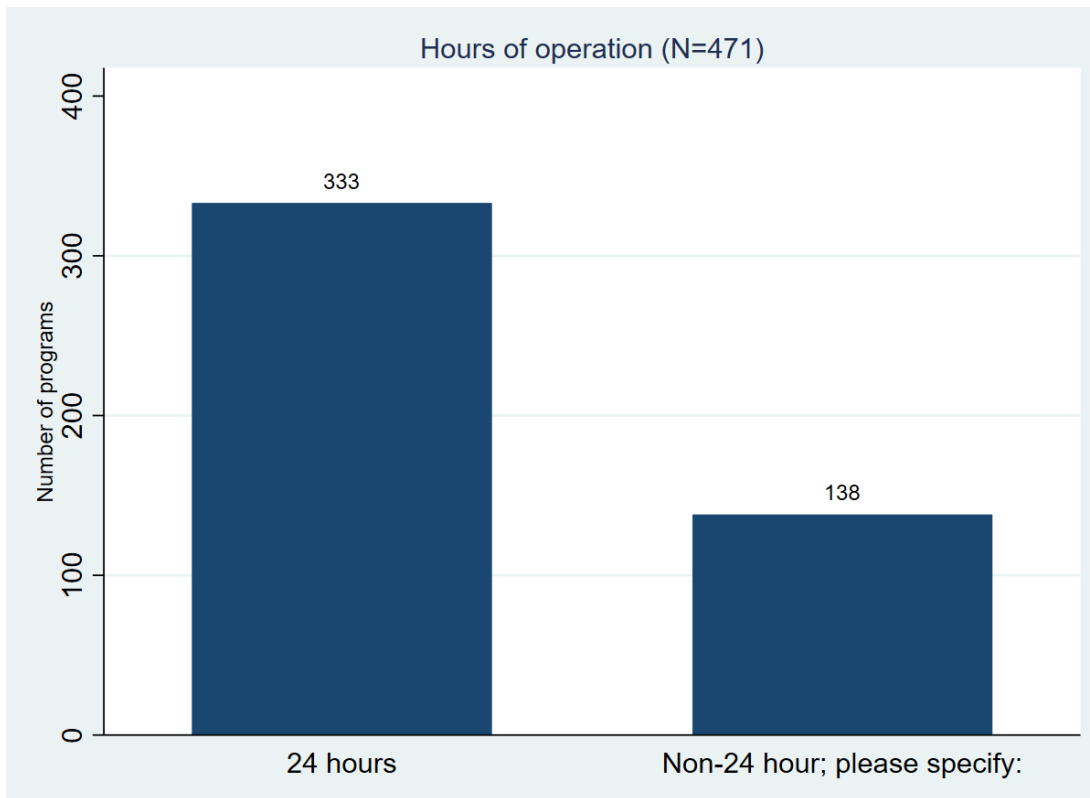


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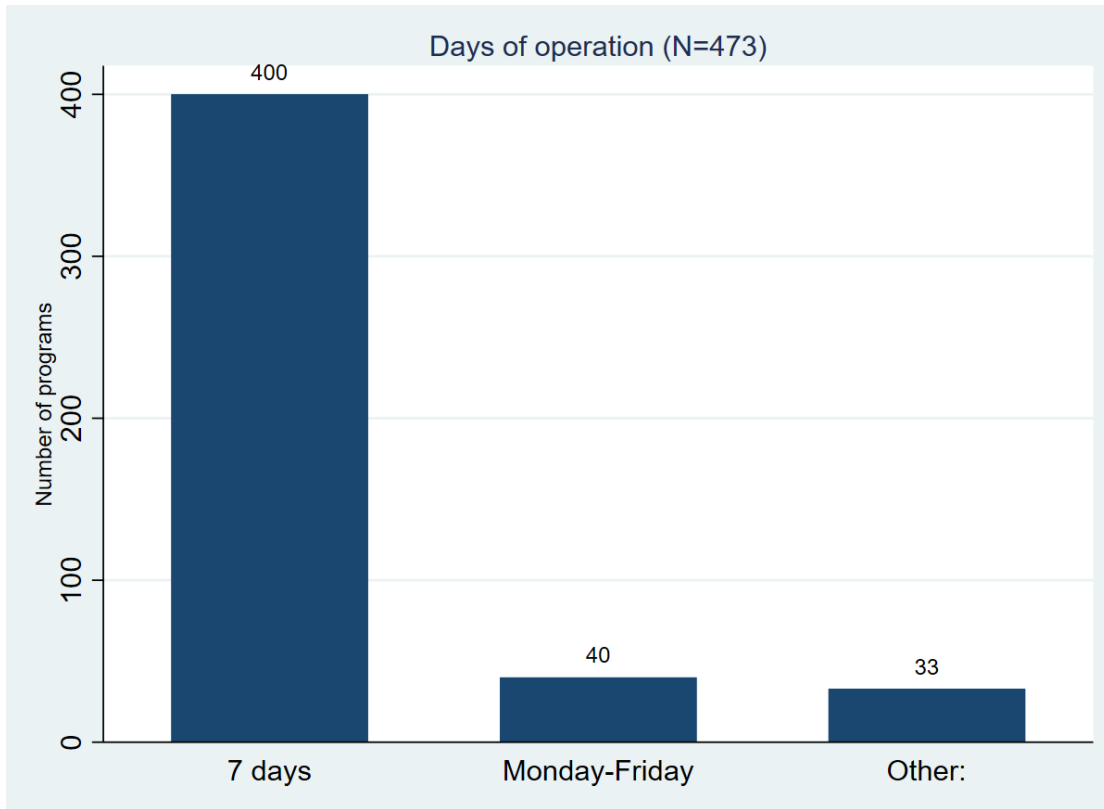


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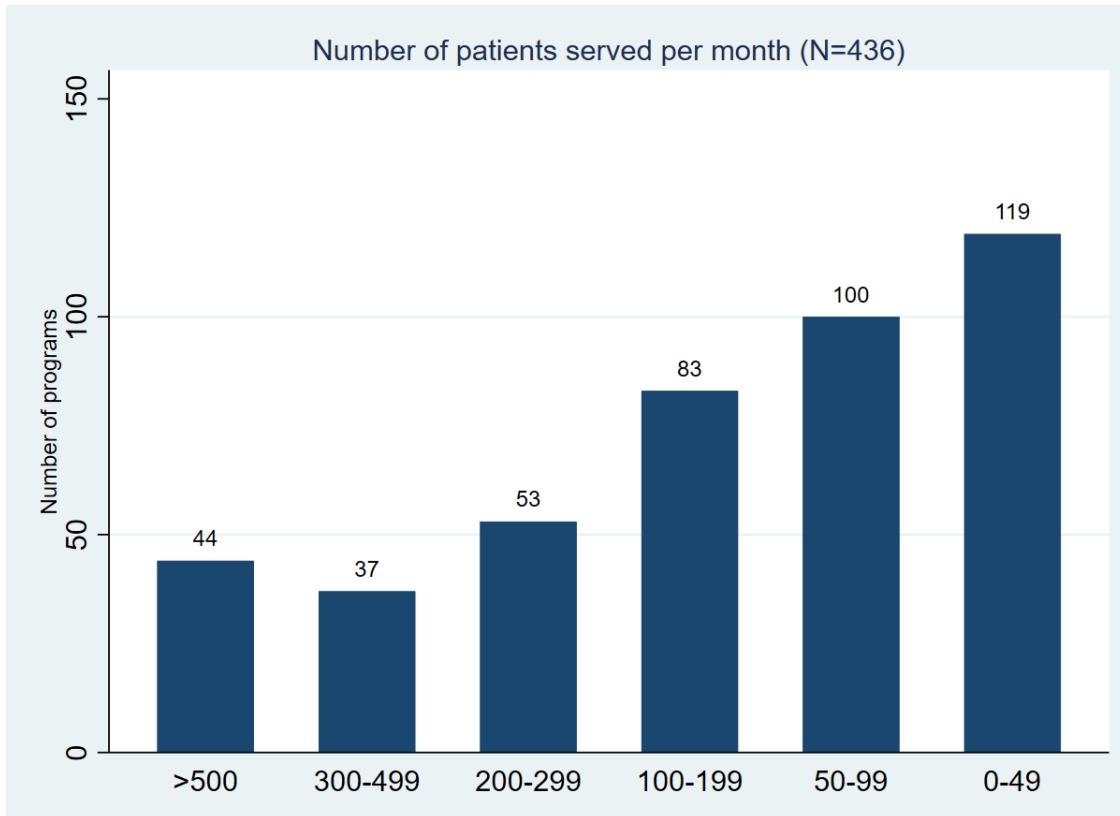


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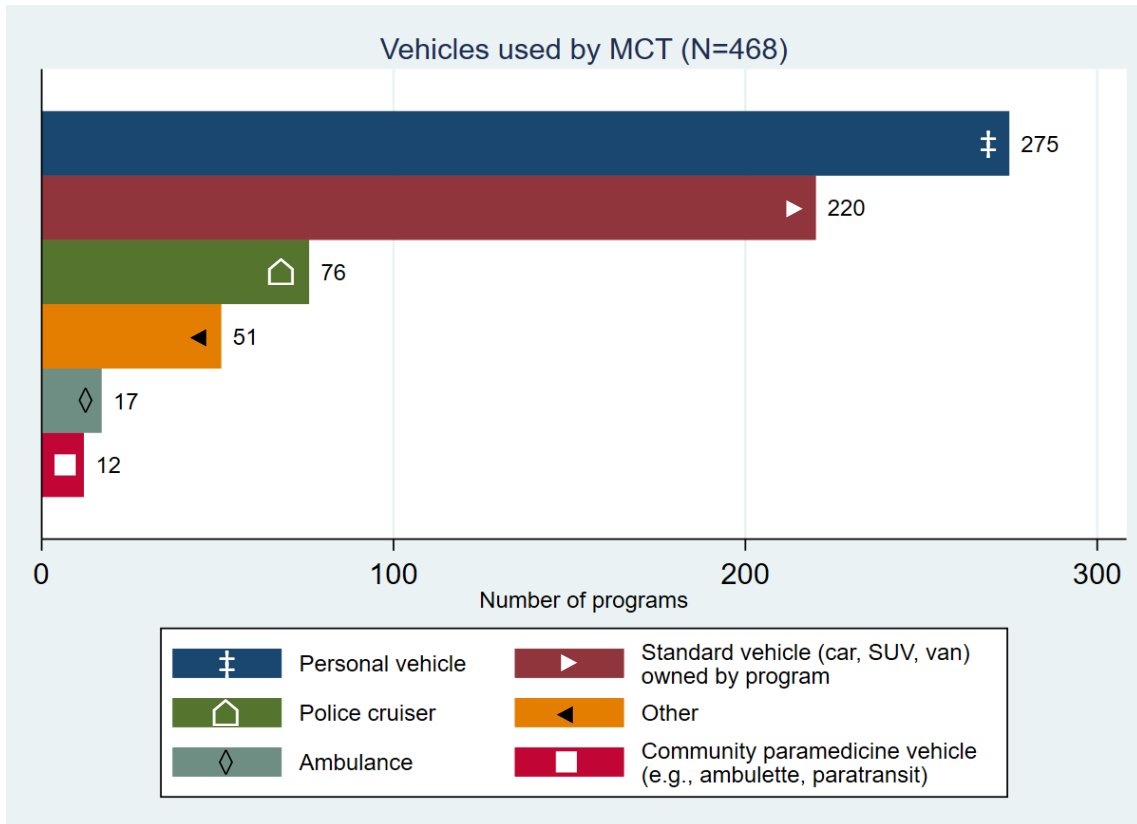


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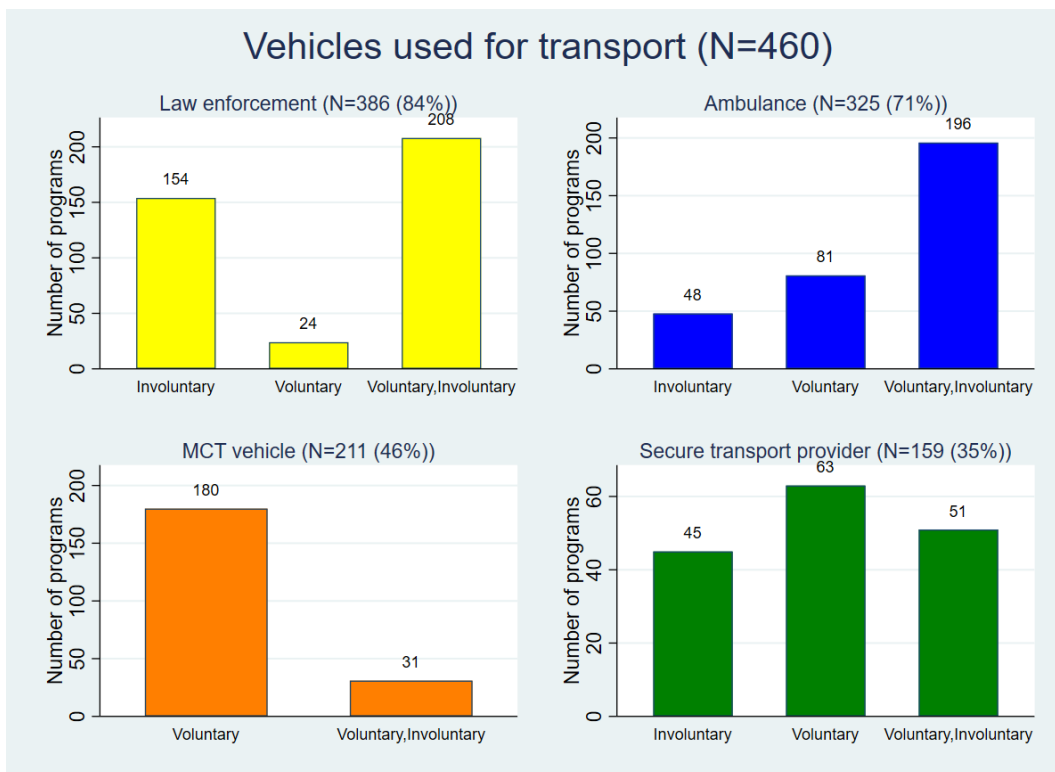


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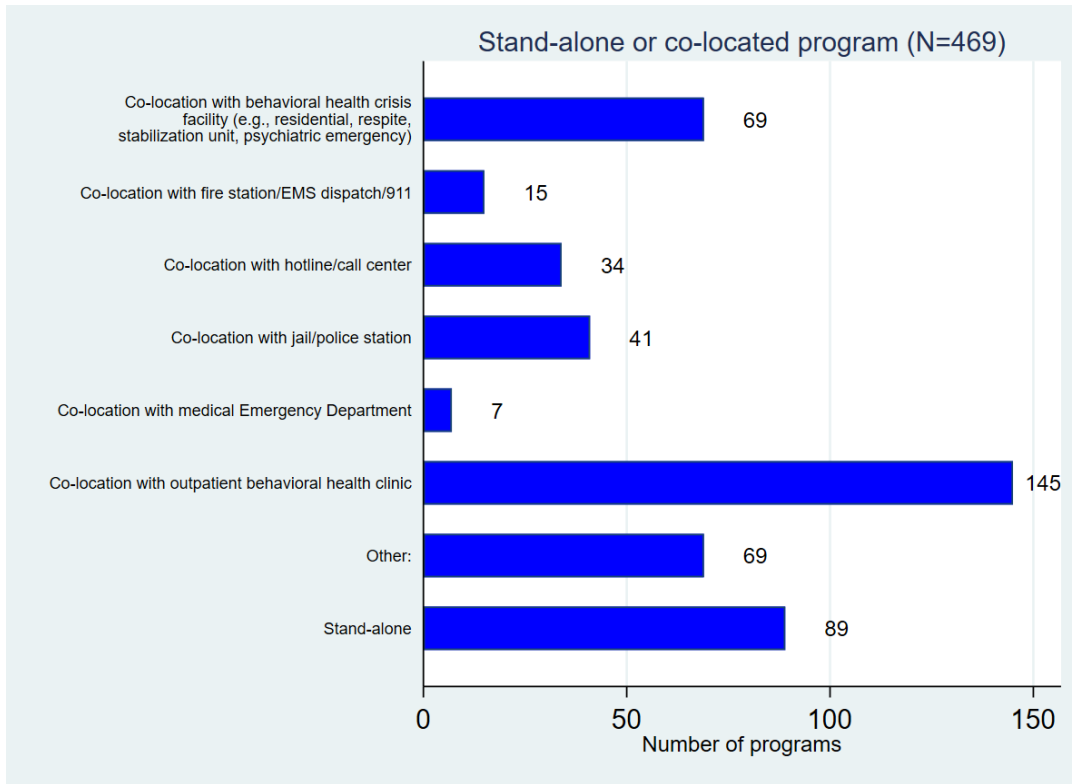


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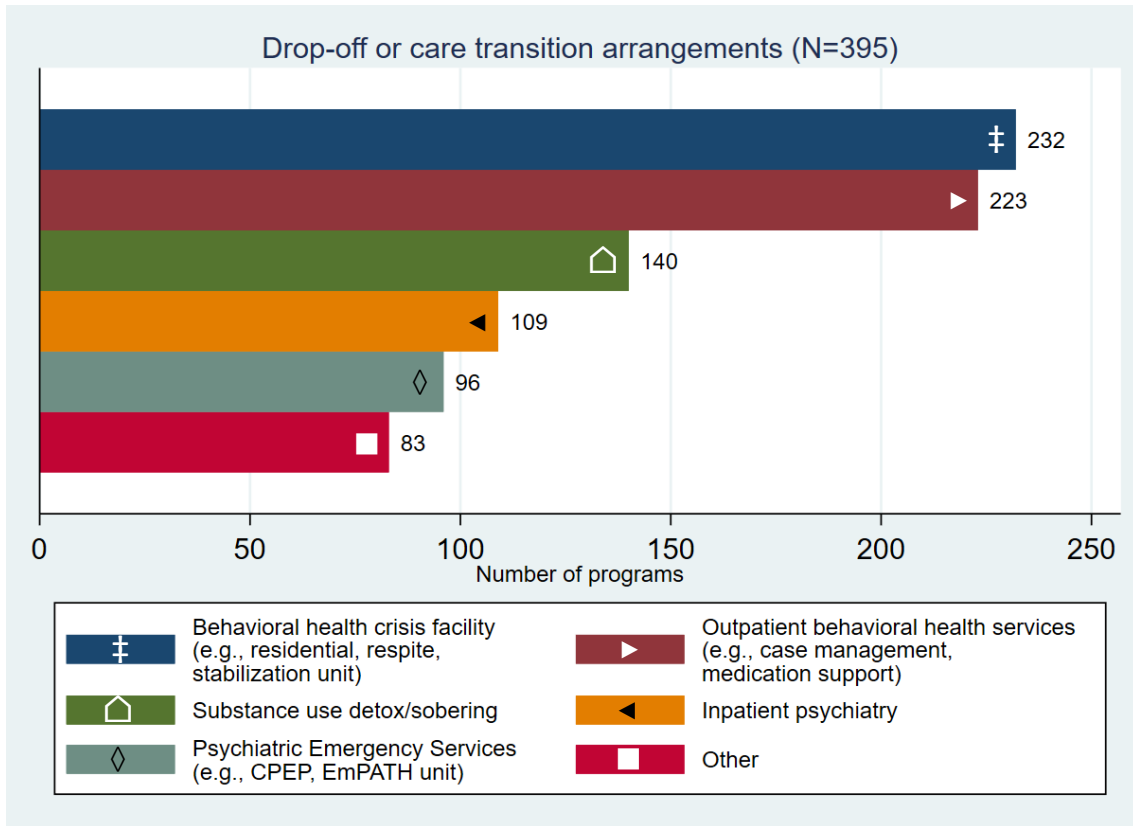


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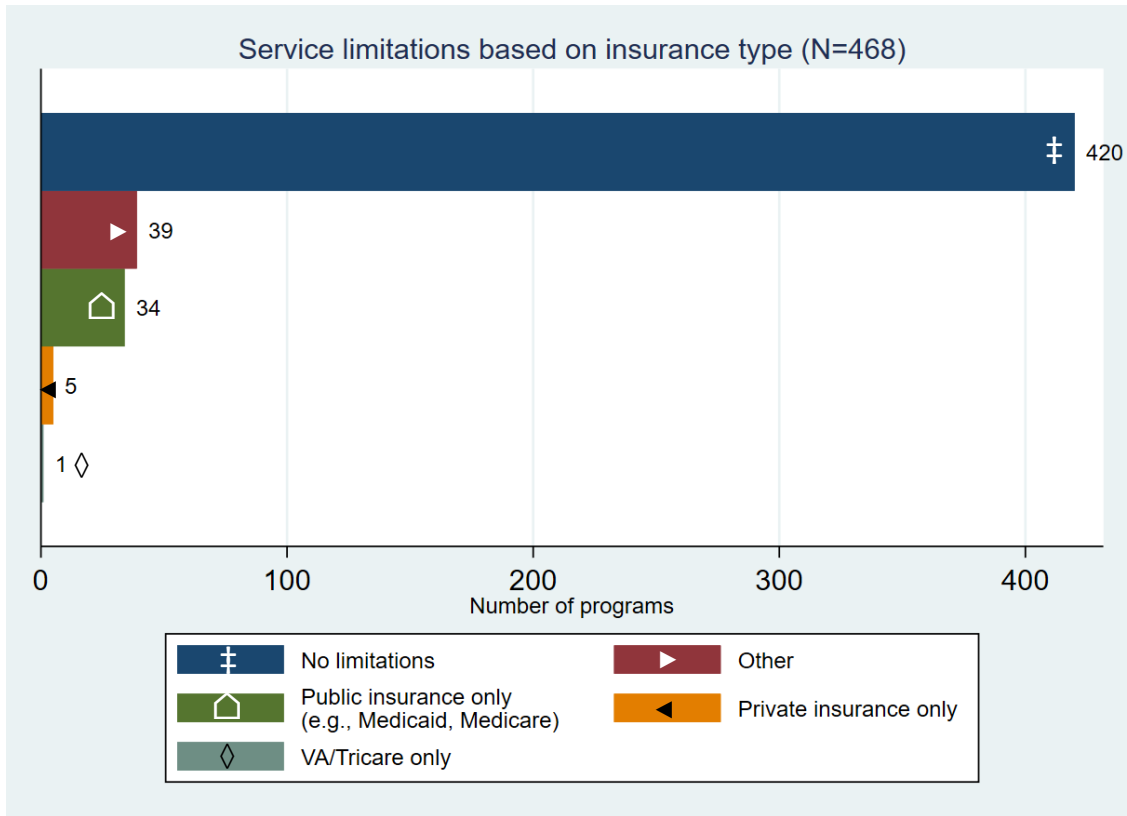


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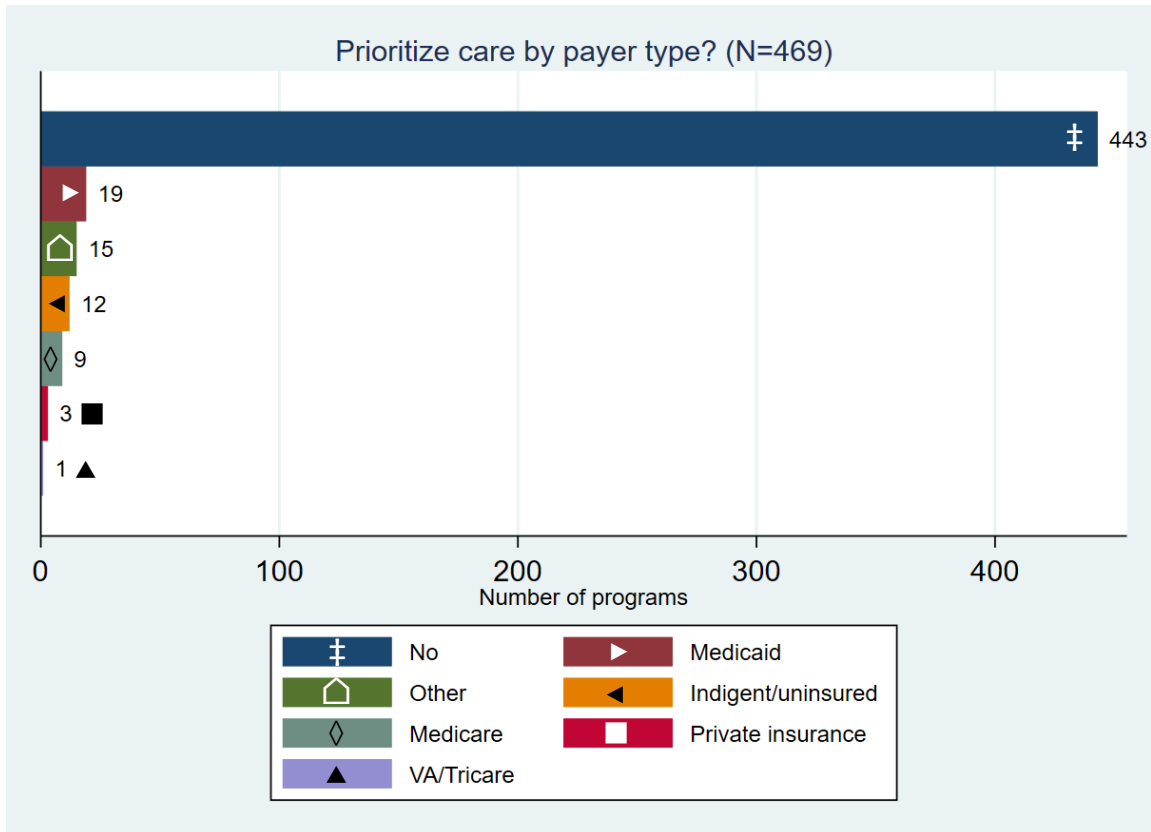


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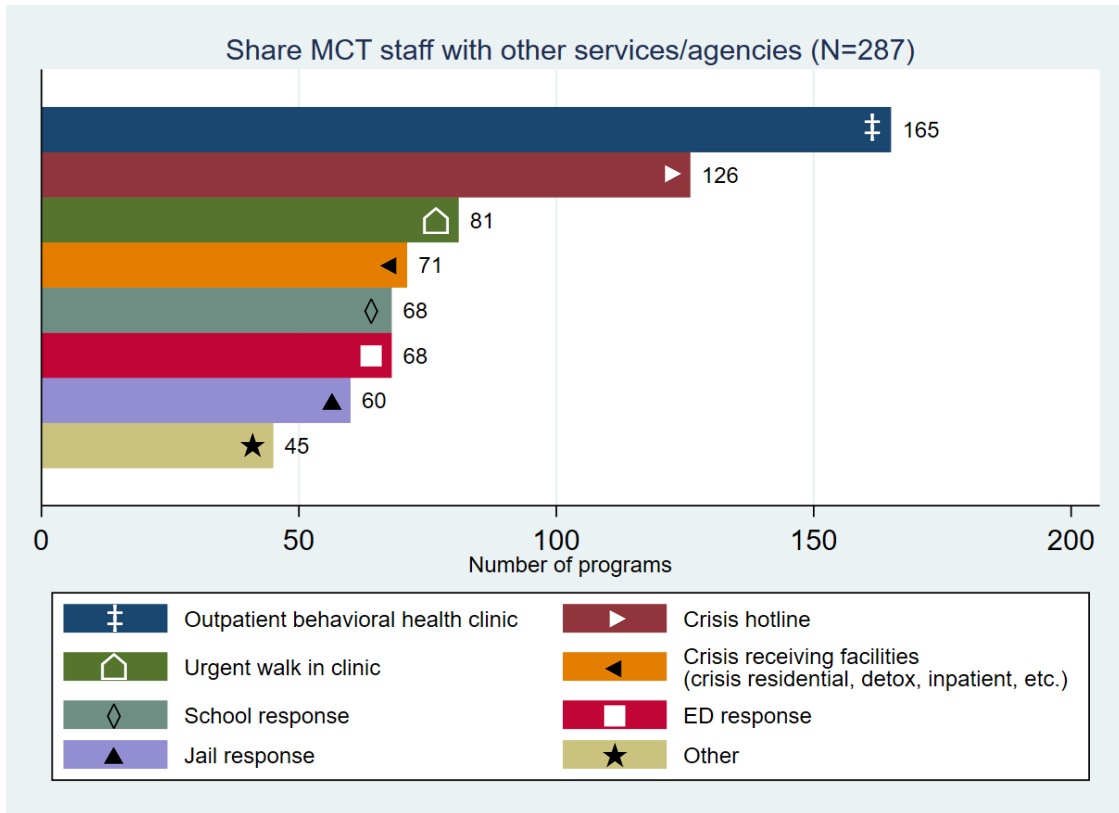


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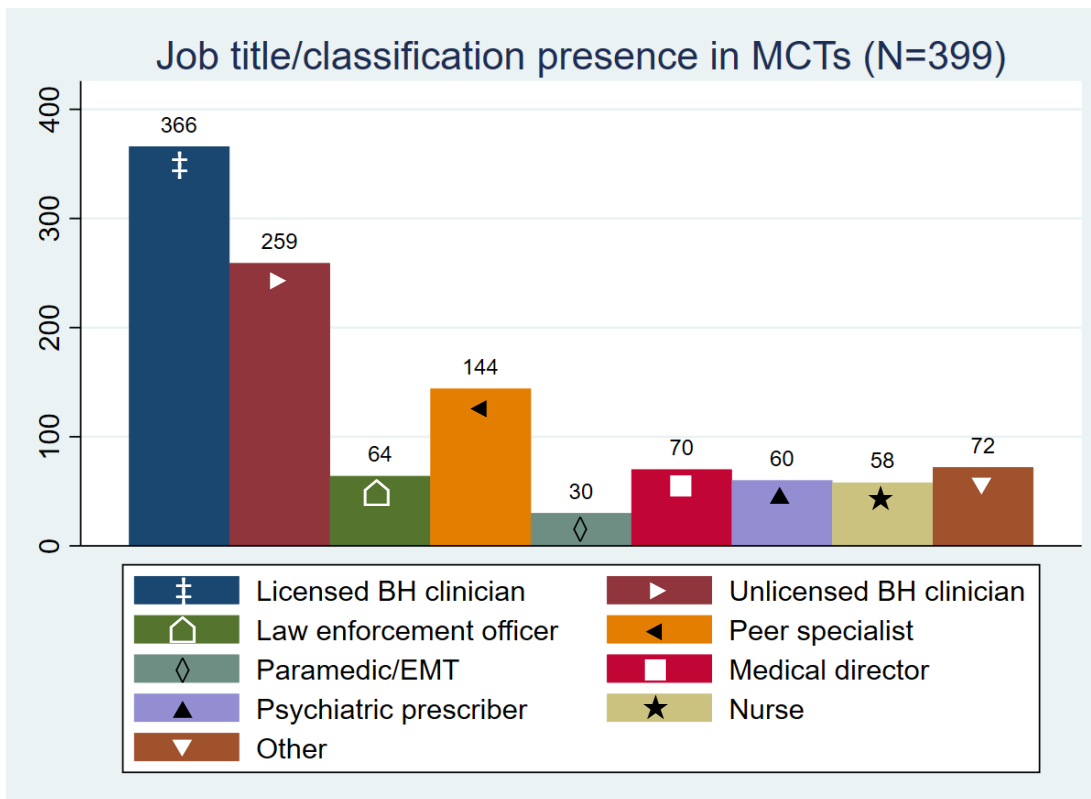


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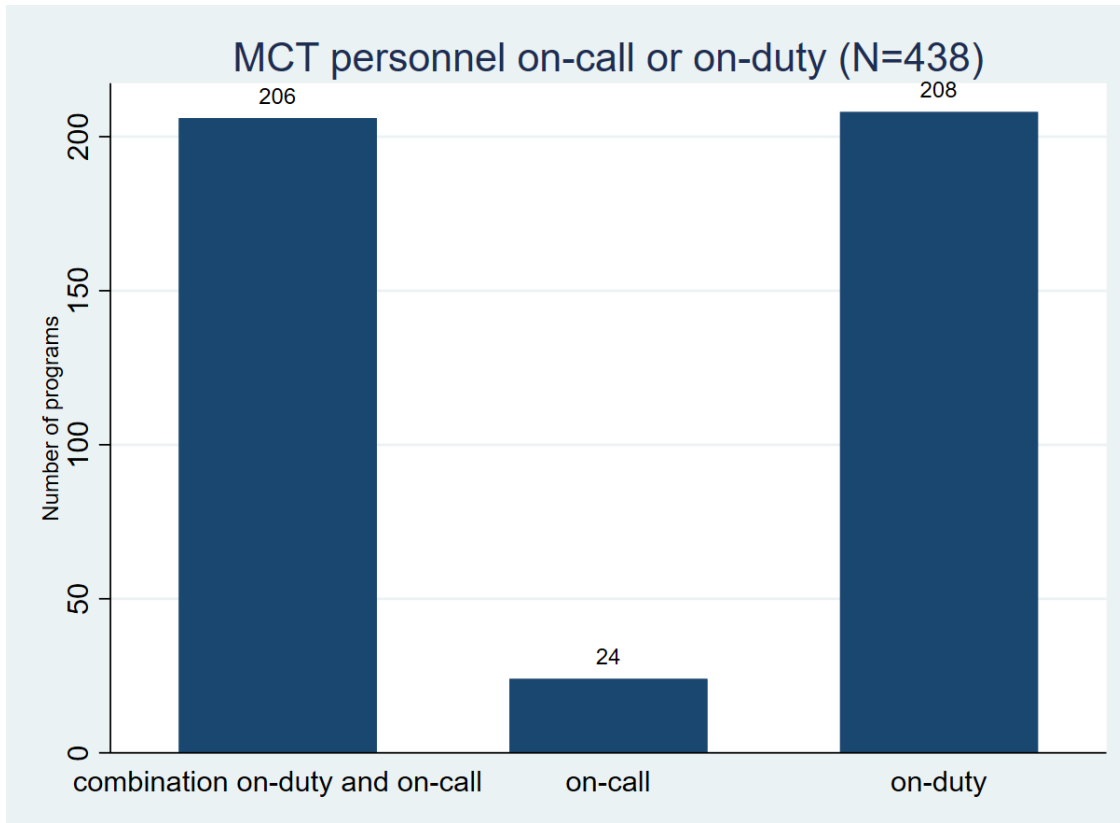


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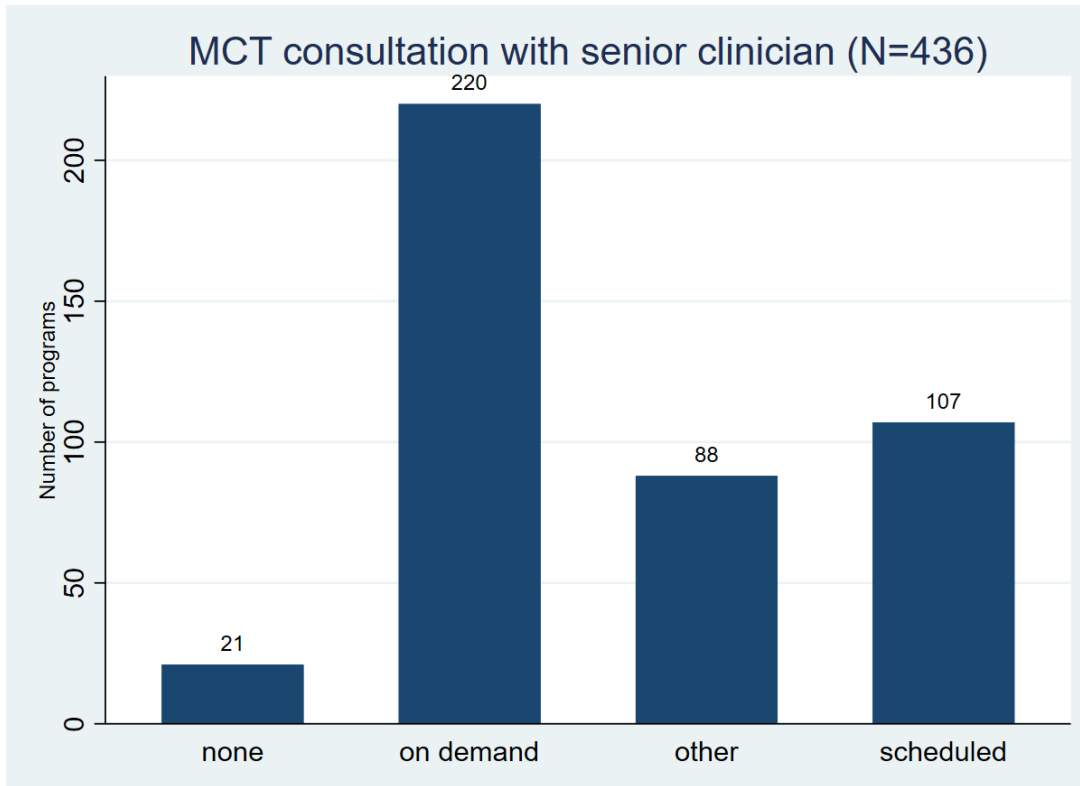


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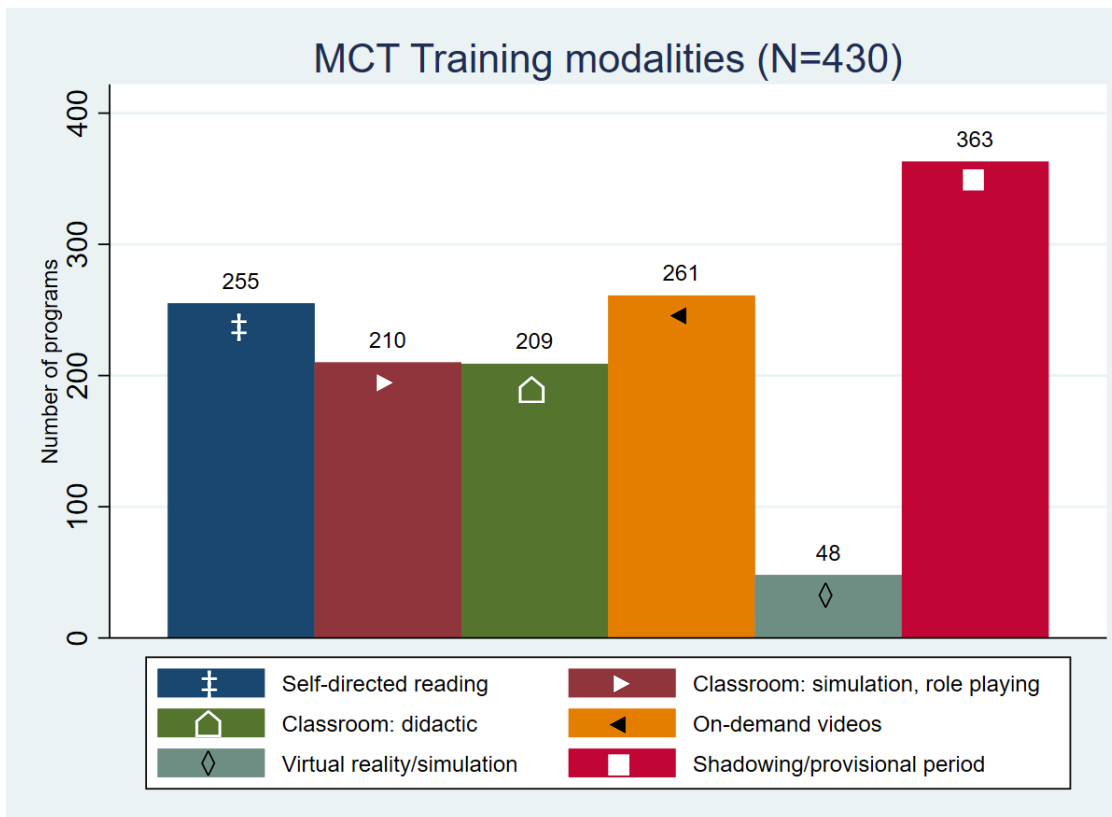


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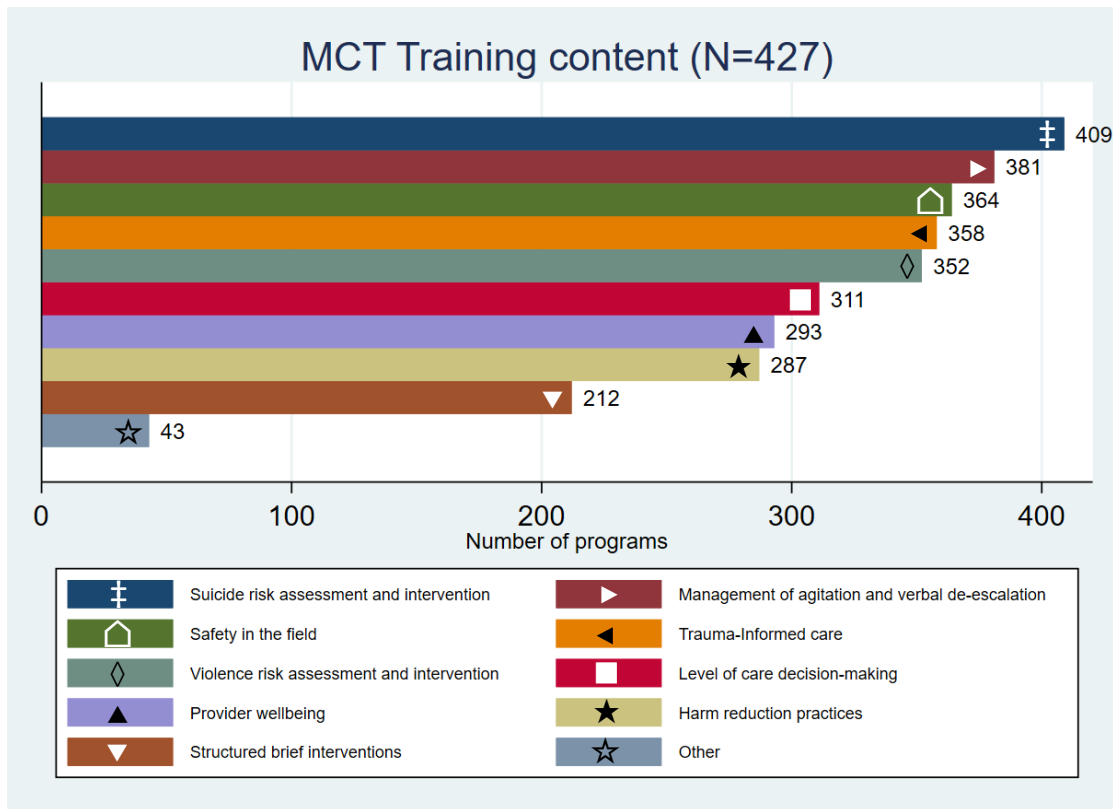


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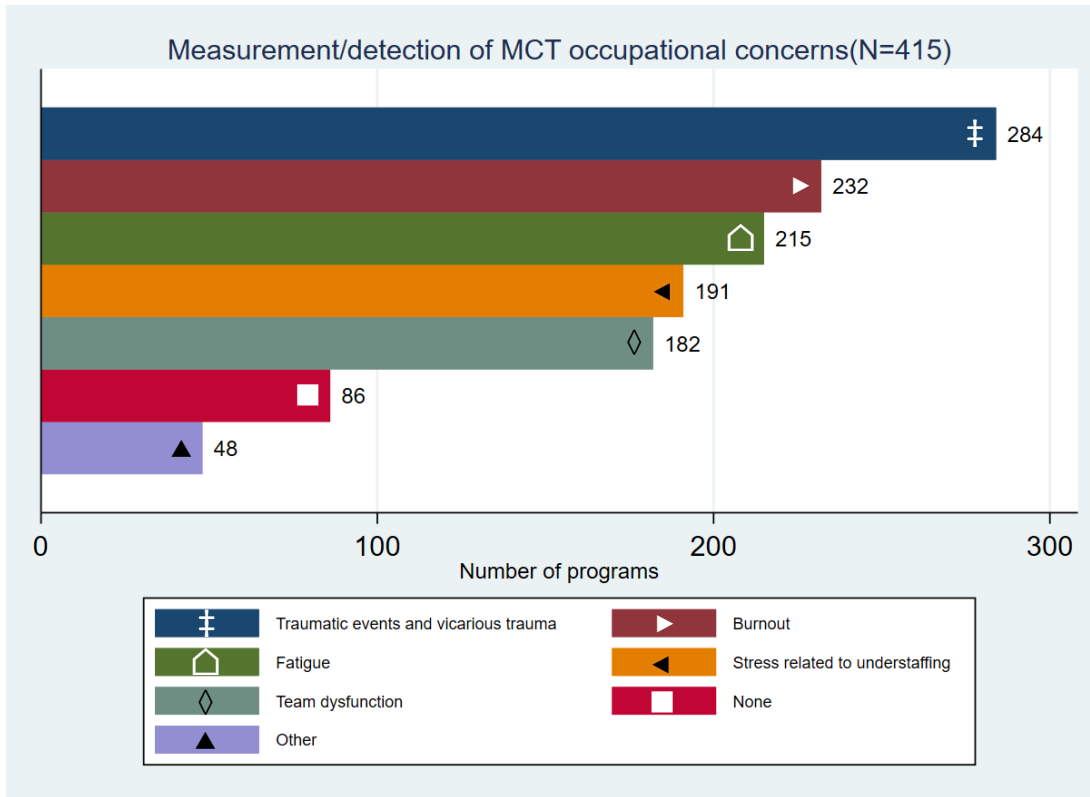


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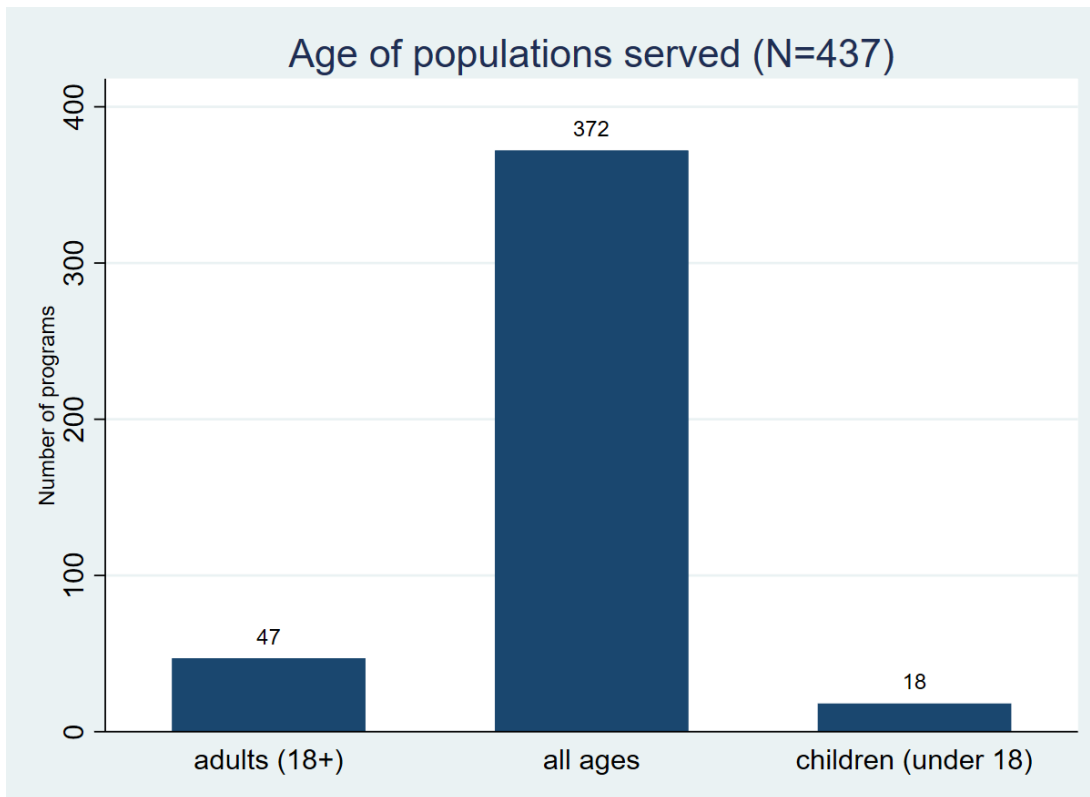


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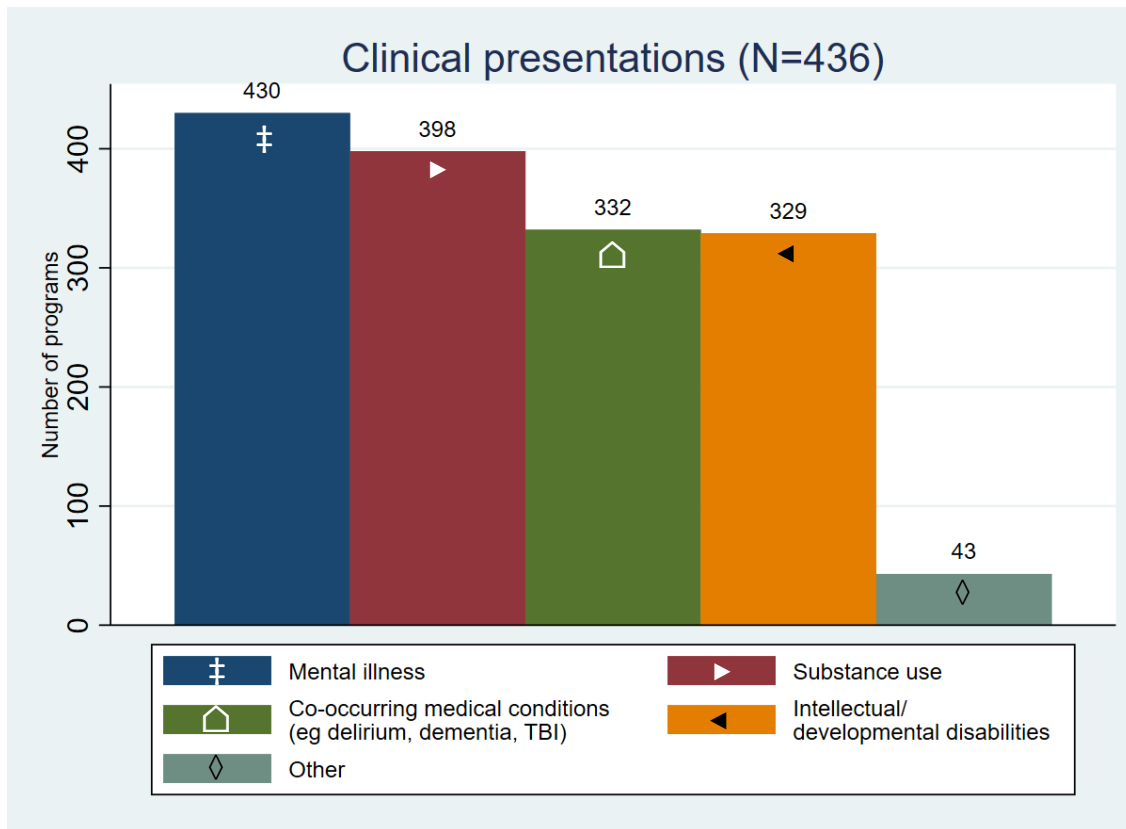


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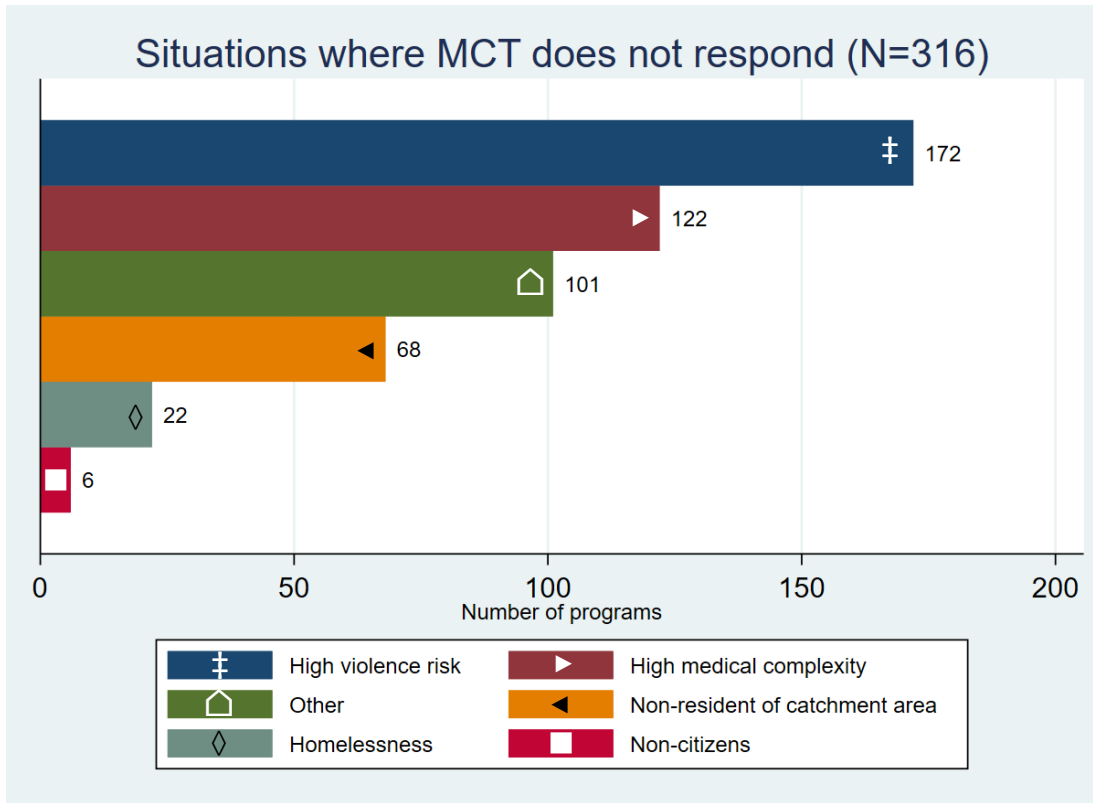


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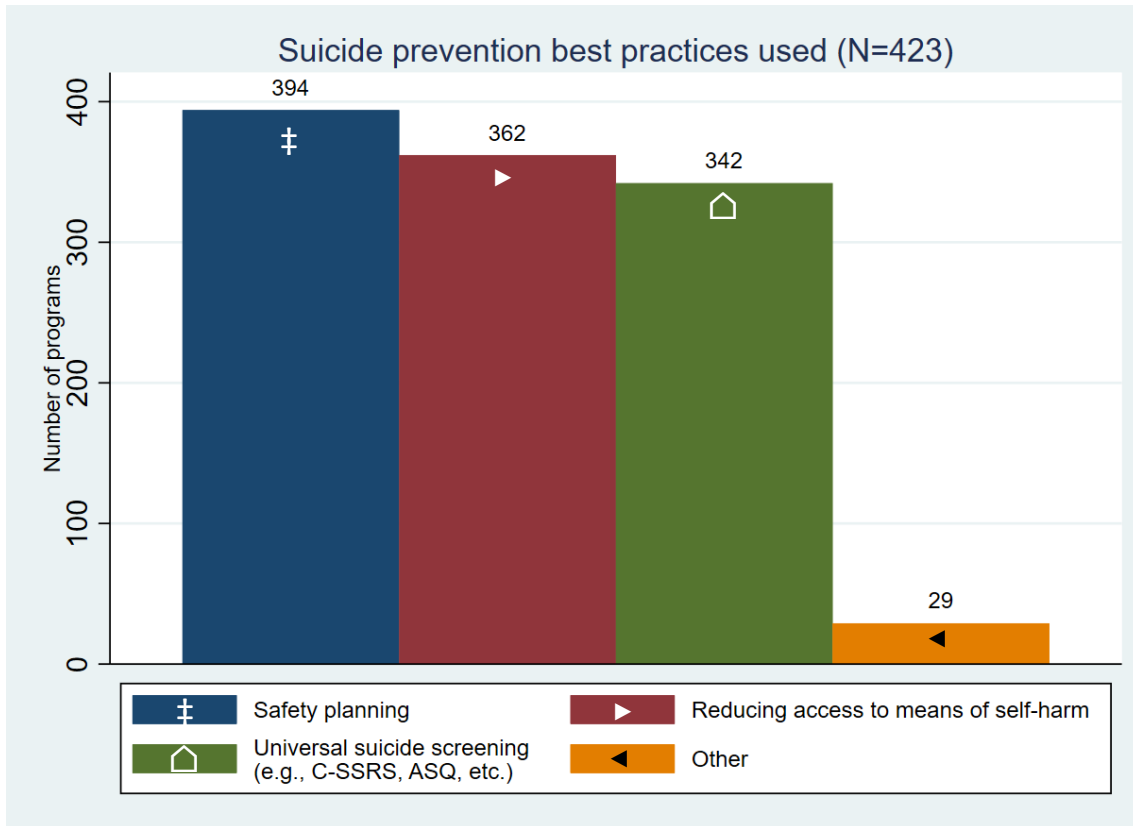


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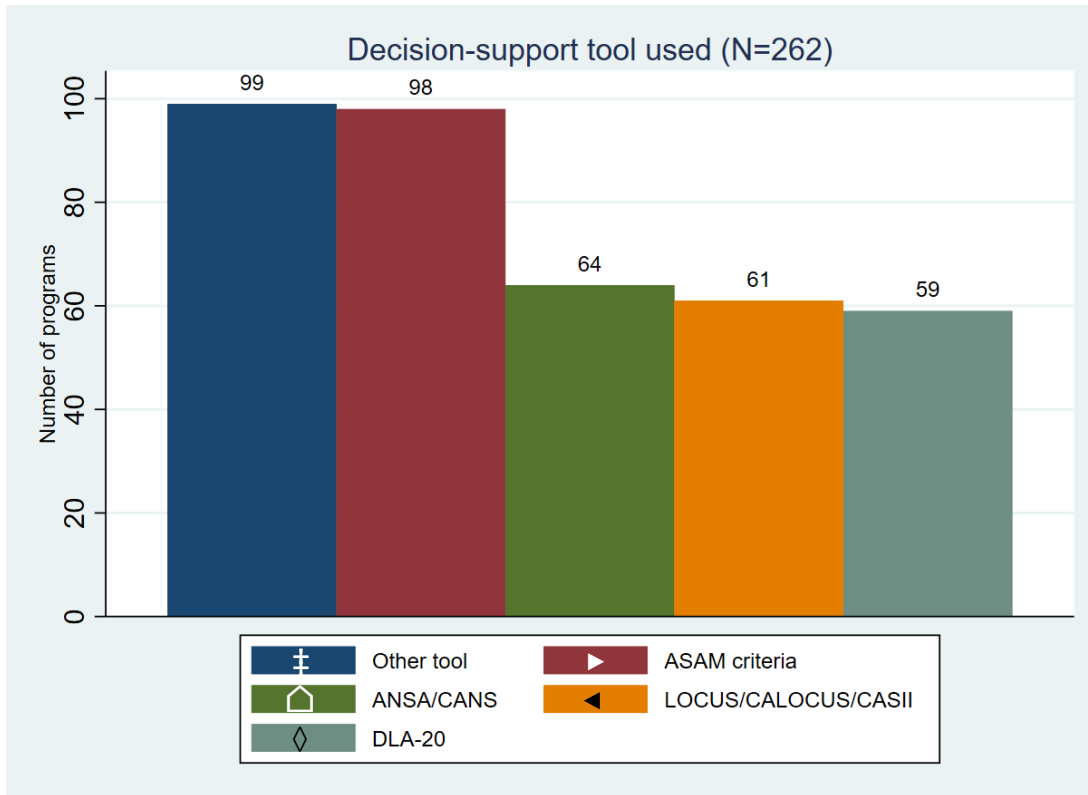


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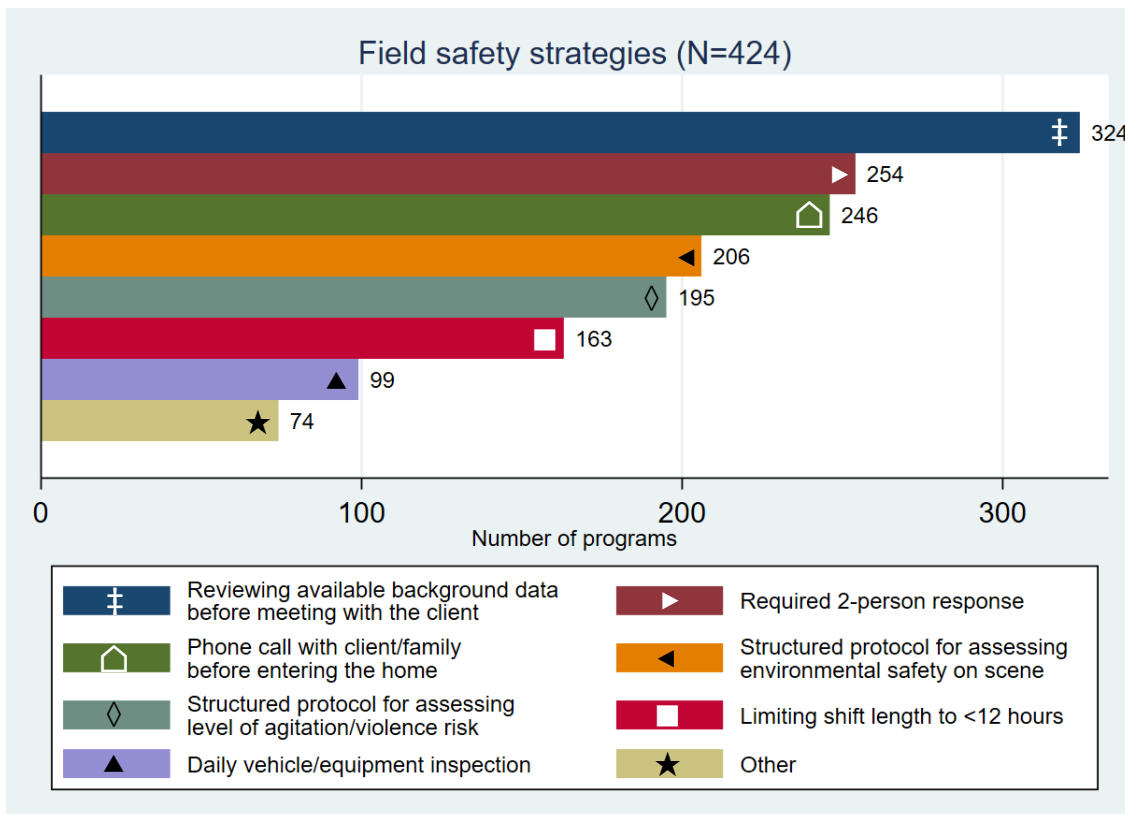


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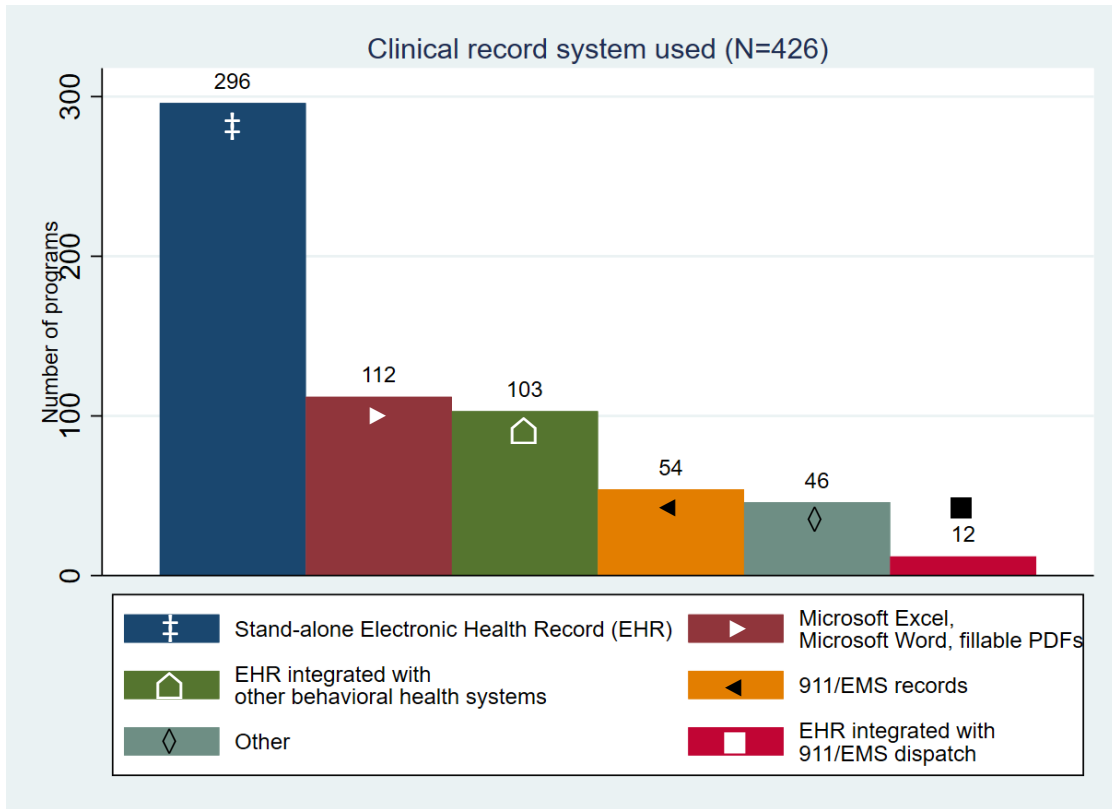


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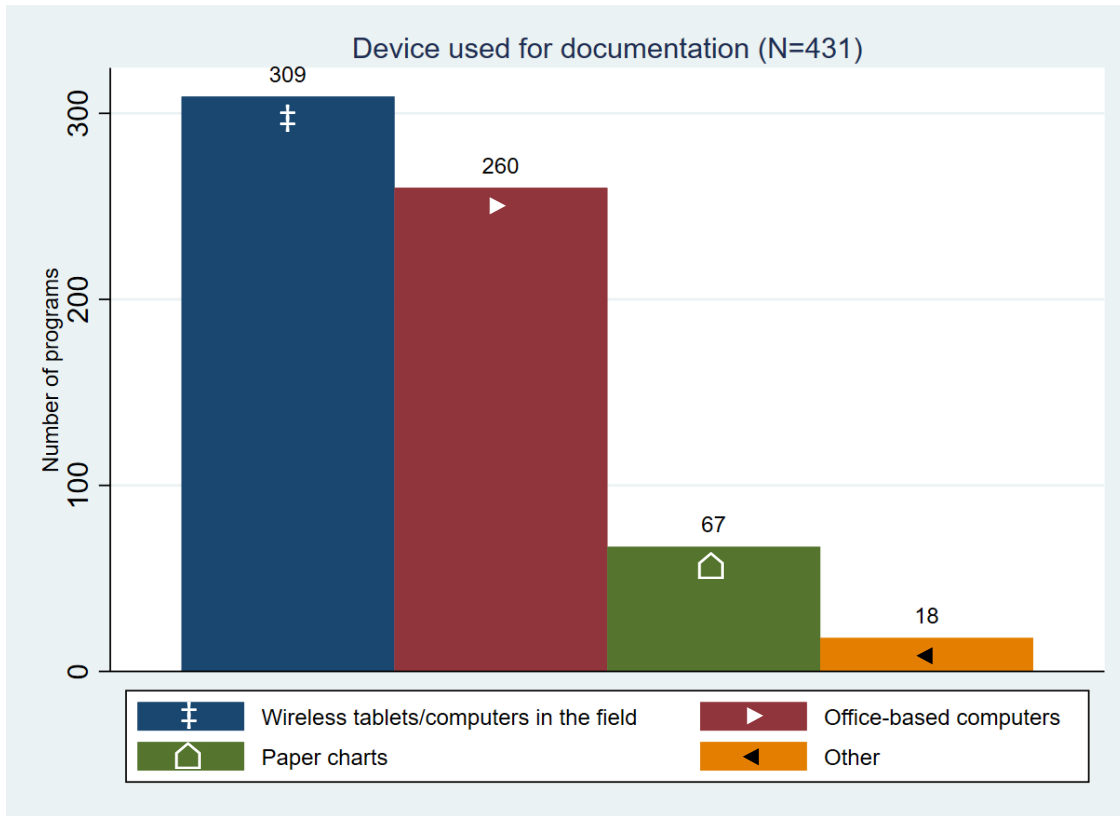


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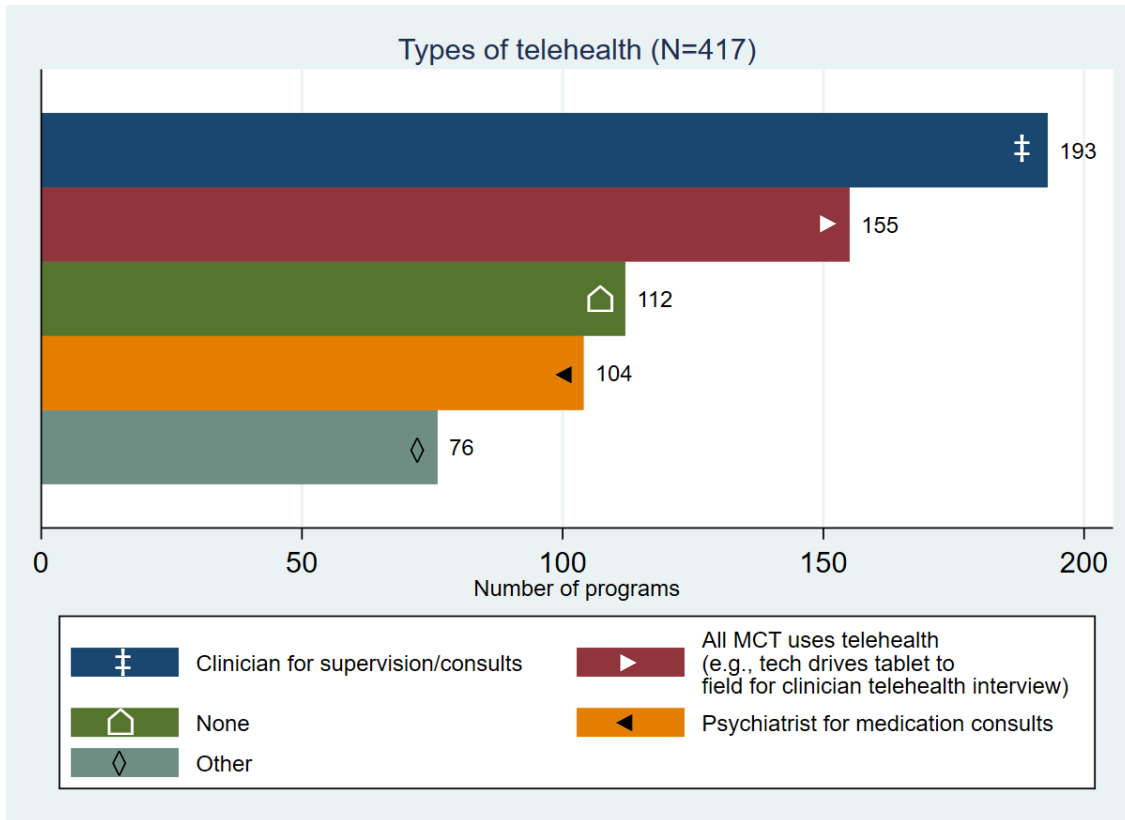


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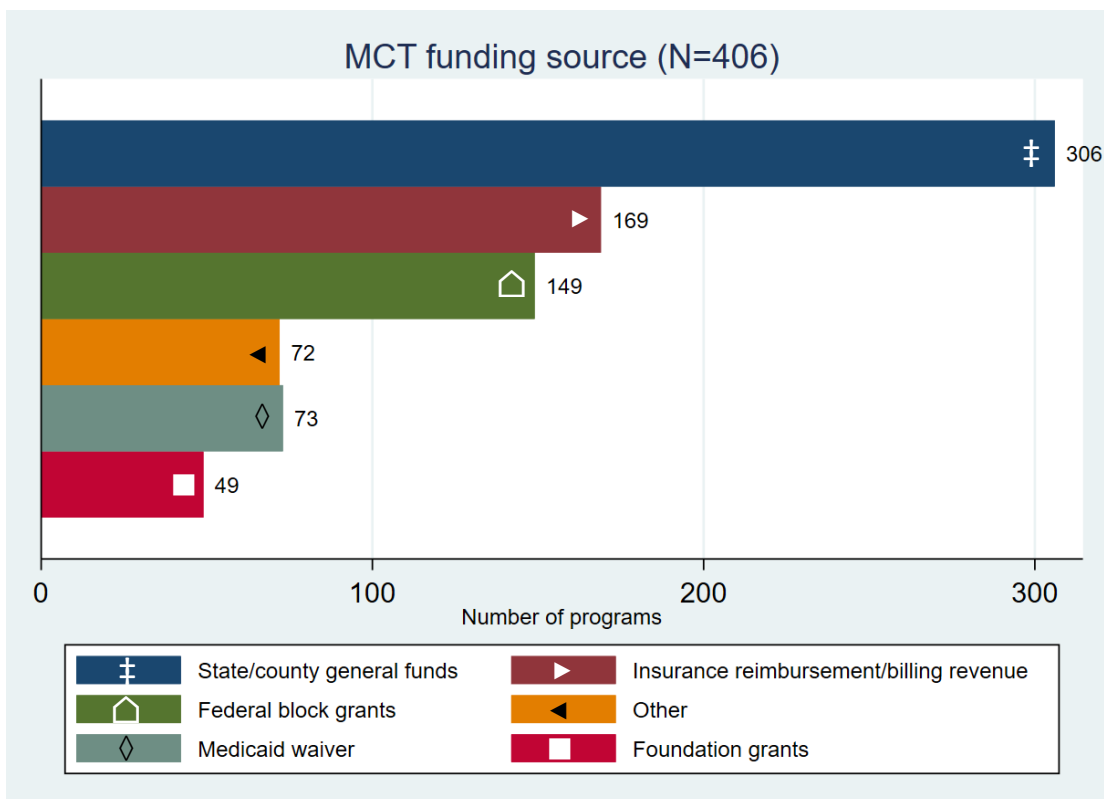


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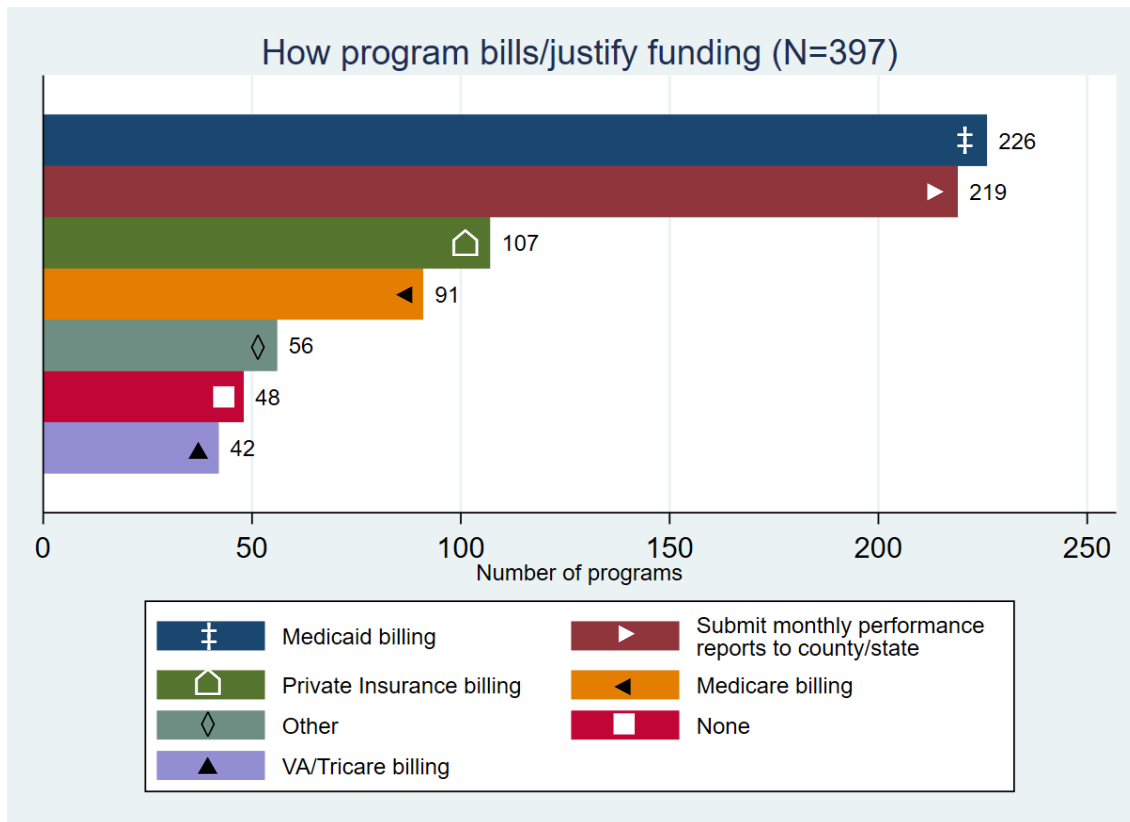


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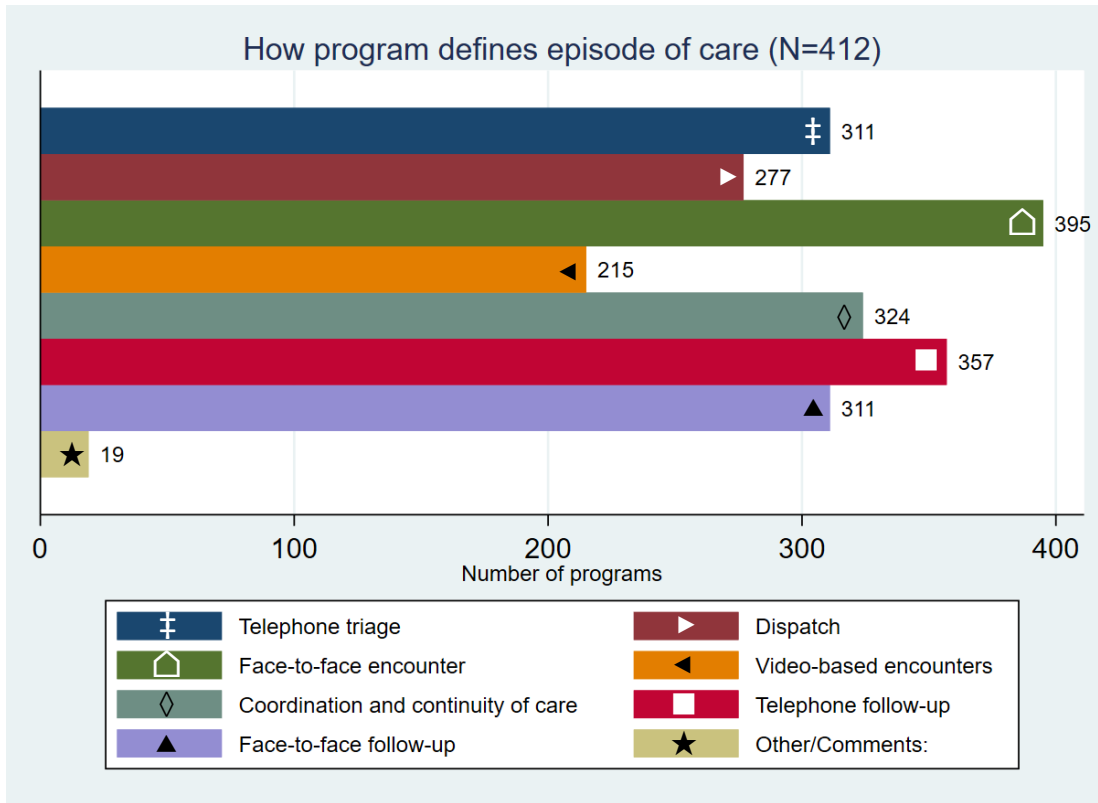


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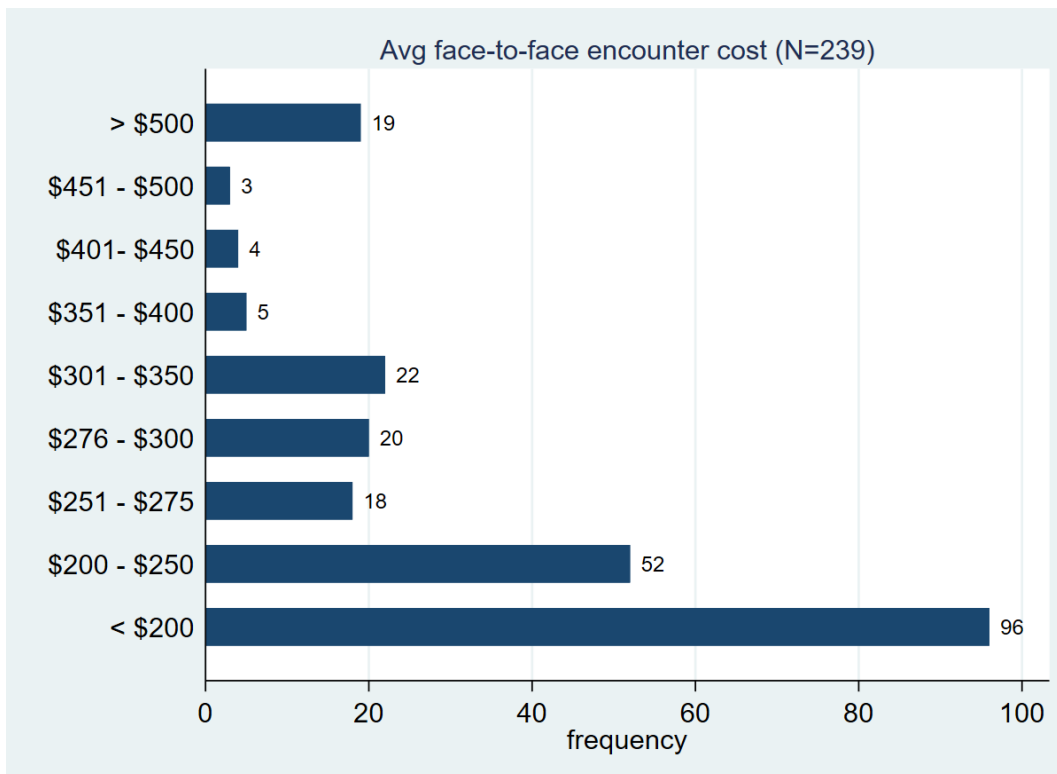


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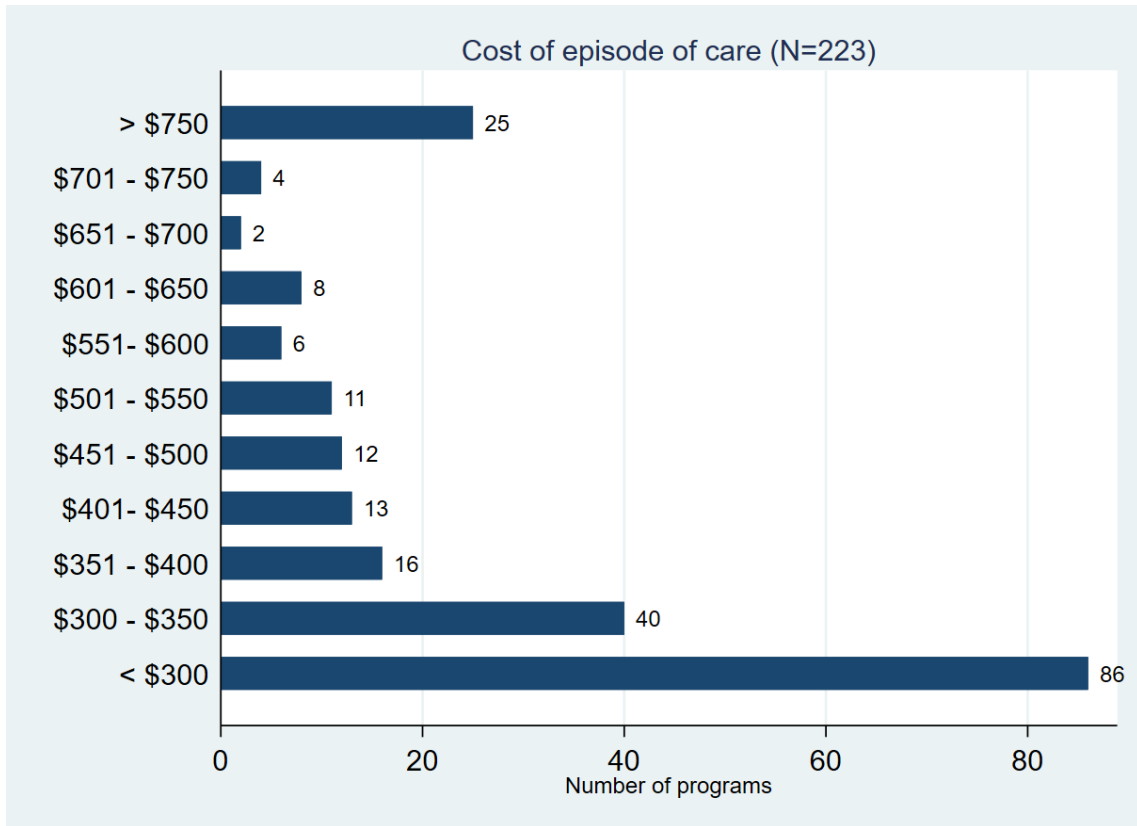


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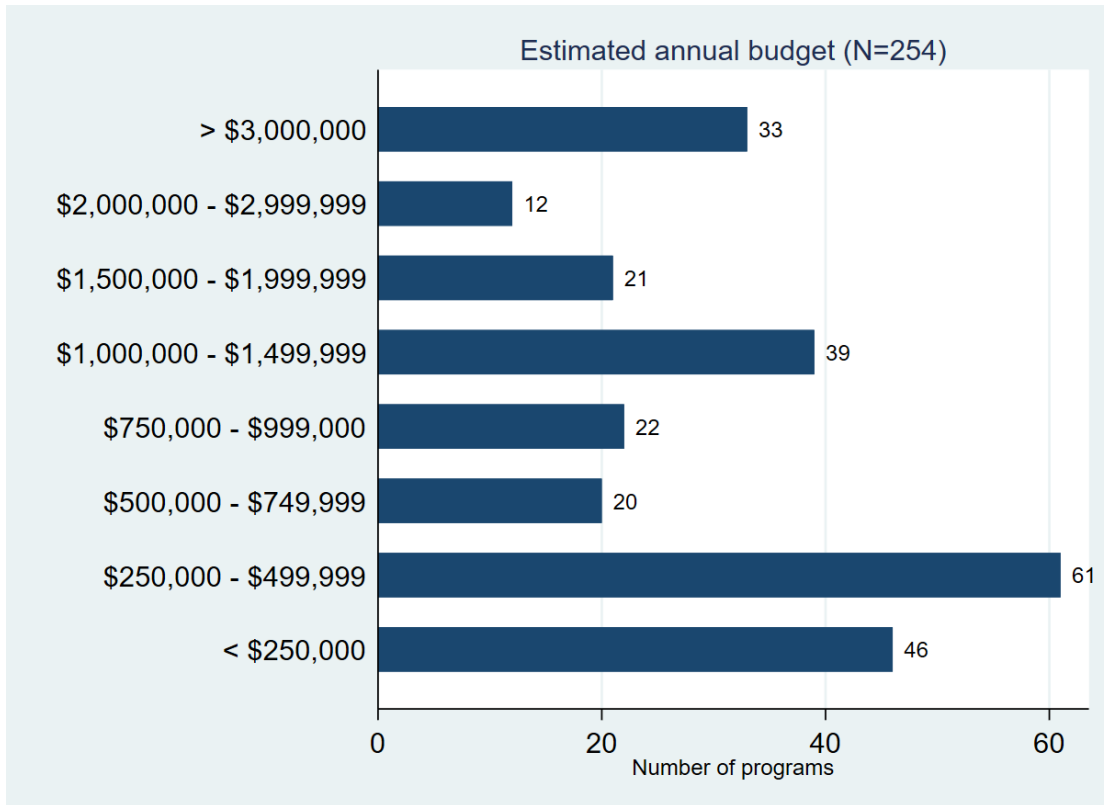


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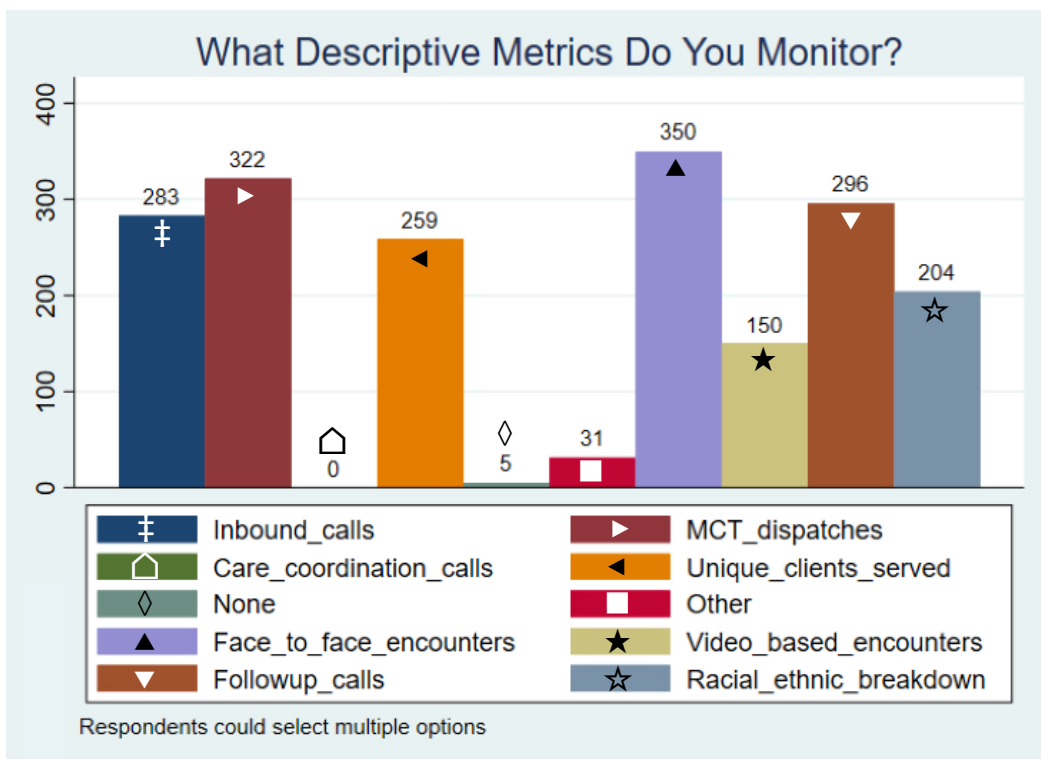


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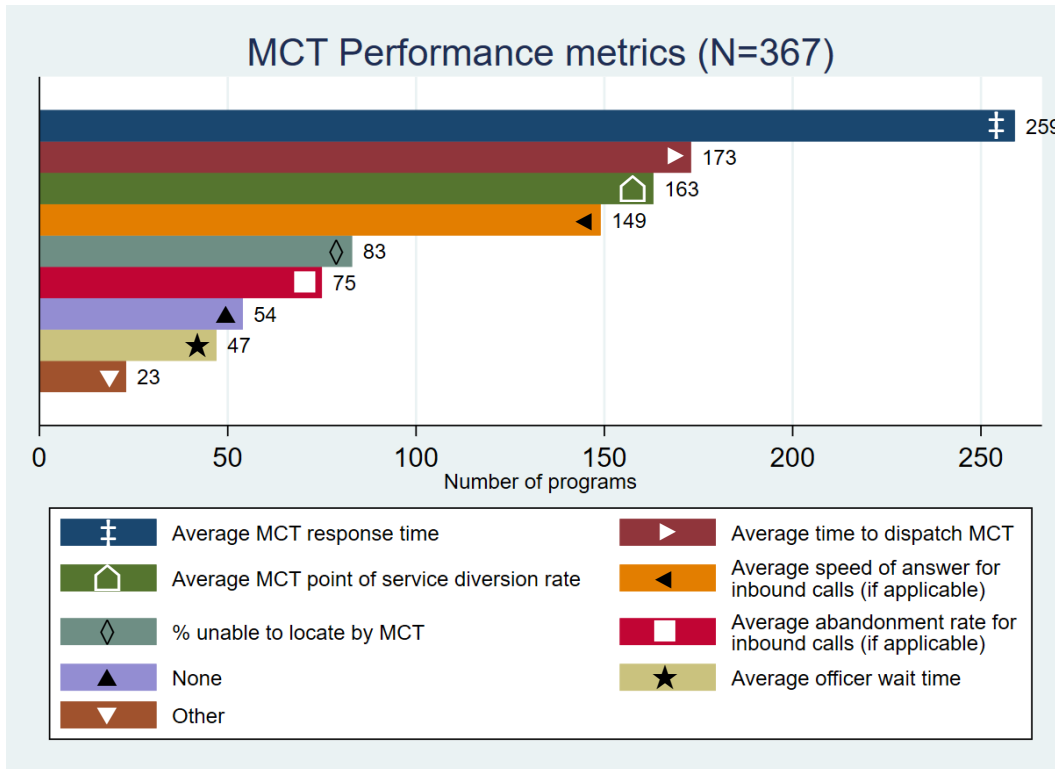


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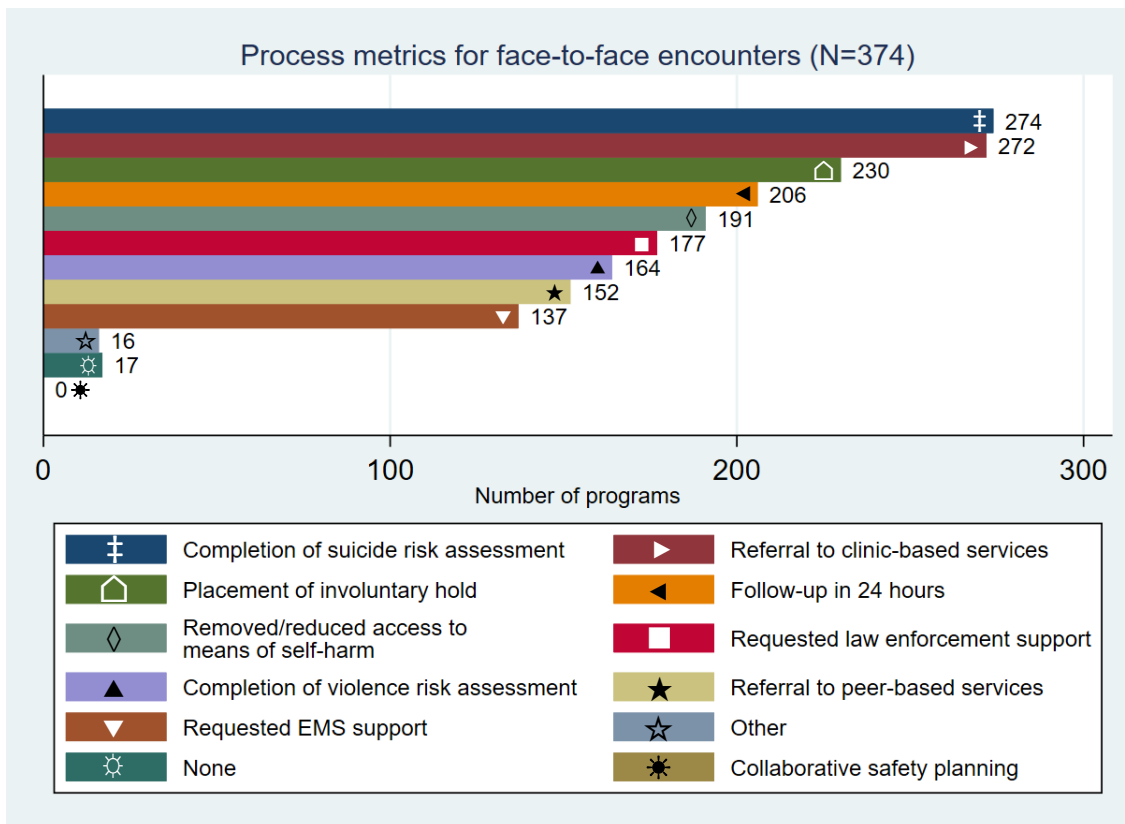


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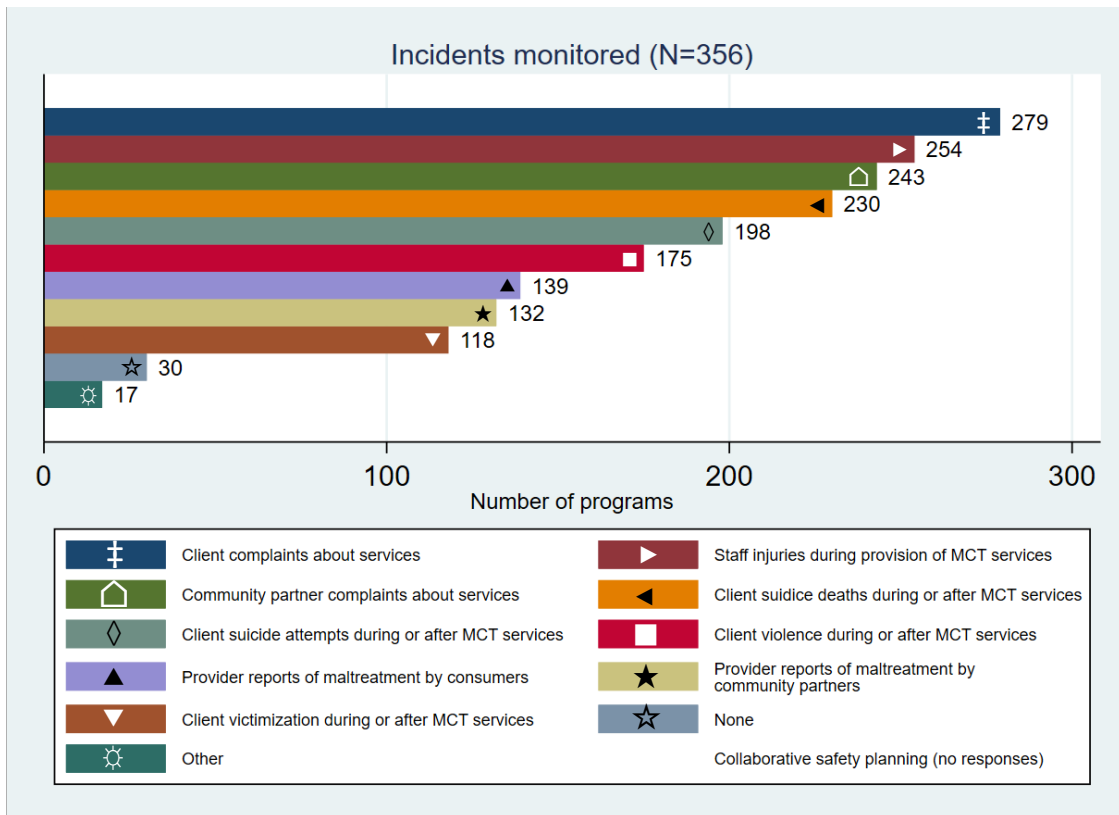


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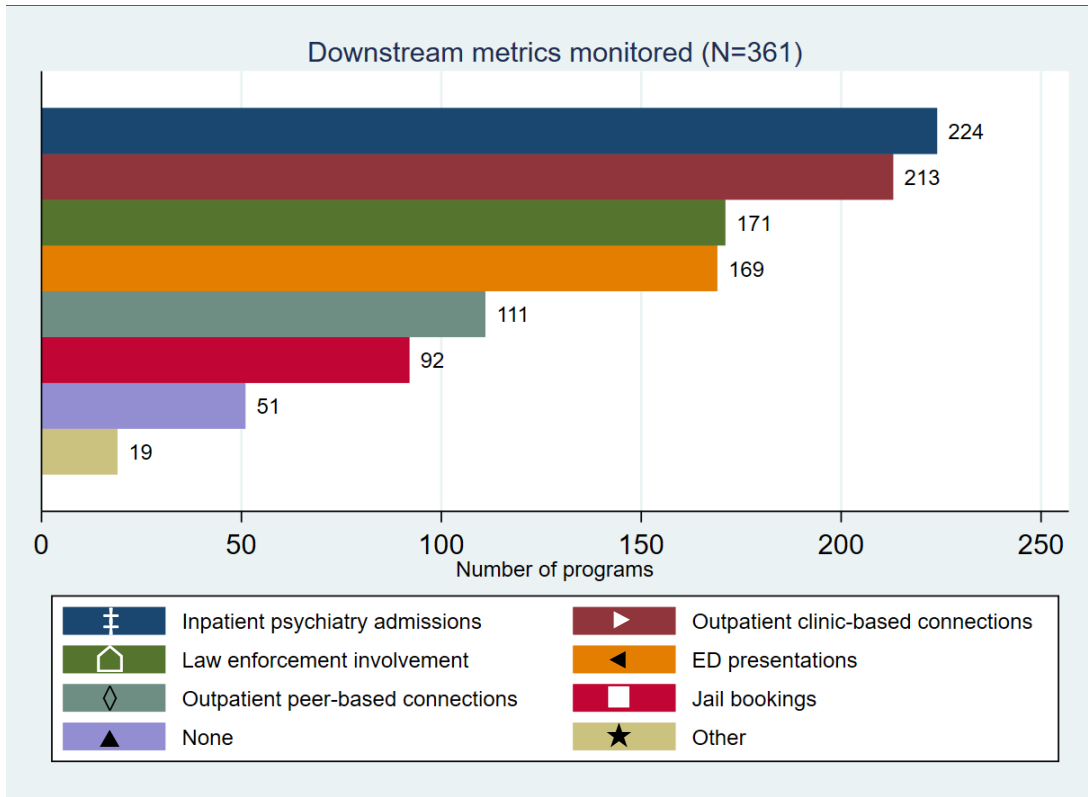
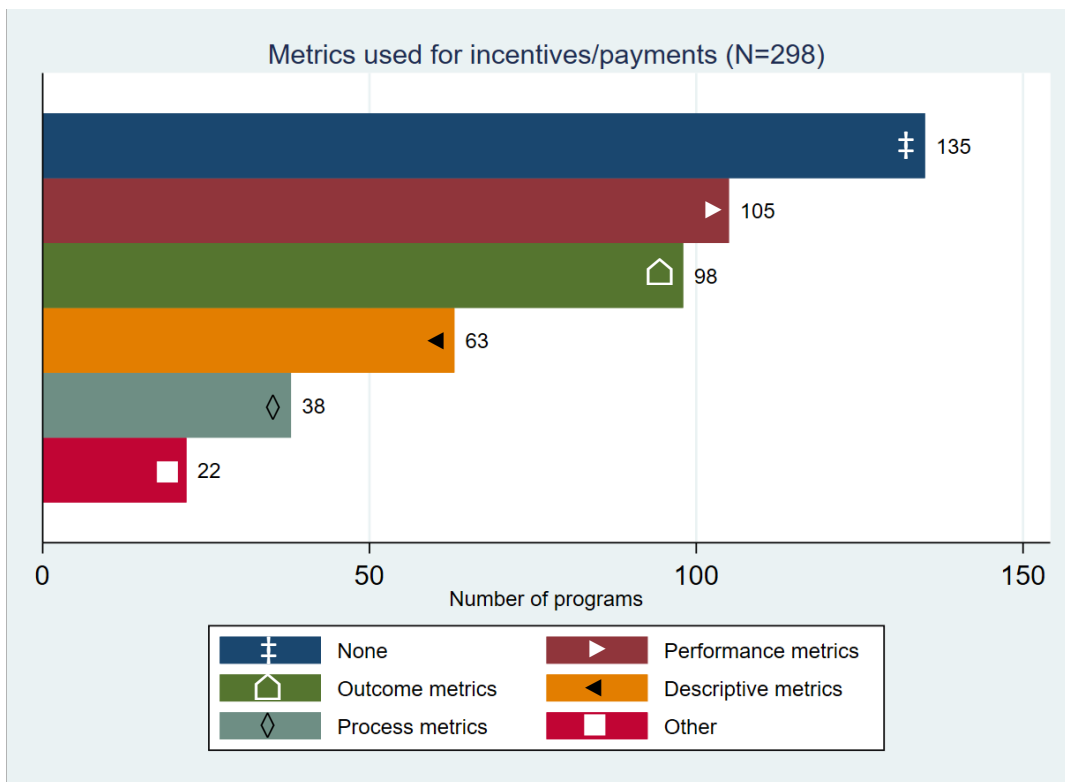


Figure 50



APPENDIX D: National Survey of Mobile Crisis Teams Questionnaire

National Survey of Mobile Crisis Teams

We are pleased to announce the launch of this National Survey of Mobile Crisis Teams (MCTs). In the context of 988 implementation, efforts to reduce unnecessary involvement of law enforcement in crisis response, and wide scale organization around high-functioning crisis systems, MCTs (including co-responder teams) have proliferated and been the focus of new legislation and funding. And yet, there remains a large gap in our knowledge of what constitutes MCTs. To better understand the organization, operation, and financing of MCTs, we are pleased to announce the launch of the first-ever National Survey of MCTs in the United States, in collaboration with Vibrant, SAMHSA, NASMHPD, and others.

Confidentiality: Programs are encouraged to share contact information in order to remain connected to important and timely national updates on MCT funding opportunities, training and technical assistance, and additional information. Your contact information will be kept separate from your response to this survey, unless you consent below to have your responses identified. Data from this survey will only be reported publicly in aggregate. You have the option to respond to this survey anonymously.

Do you agree to have your program identifying information linked with your survey responses?

- Yes, I agree
- No, I prefer to keep my identifying information separate from my confidential survey response

Do you agree to share your program information or would you rather remain anonymous?

- Agree to identify program
- Prefer to remain anonymous

Please provide your reasons for preferring to stay anonymous. We are hoping to engage MCT programs as much as possible and would appreciate any feedback about your concerns with identifying your program for this national survey. (free text)

Respondent Information

- A. Name of MCT program (optional)
- B. MCT program phone number (optional)
- C. MCT program contact email (optional)
- D. MCT program website URL (optional)
- E. Name of respondent (optional)
- F. Respondent role with MCT program (optional)
 - MCT Program Director/Manager
 - MCT Clinical Supervisor
 - MCT Clinician (front line, responding in field)
 - Executive Director/CEO of organization that oversees the MCT program
 - Other

- G. Respondent phone number (optional)
- H. Respondent email address (optional)
- I. How did you hear about this National Survey of Mobile Crisis Teams? (Select all that apply.)
 - Contacted directly by study team
 - National Suicide Prevention Lifeline Network/Vibrant Emotional Health
 - Weekly National Crisis Learning Collaborative / Crisis Jam
 - National Association of State Mental Health Program Directors (NASMHPD)
 - National Council for Mental Wellbeing
 - American Association of Emergency Psychiatry
 - American Association of Community Psychiatry
 - CIT International
 - Crisis Residential Association
 - LinkedIn
 - Twitter
 - Facebook
 - Other

A. Service area

1. In what state does your MCT operate?
2. What geographic unit does your MCT serve?
 - State
 - Region (more than one county)
 - County
 - City or smaller
3. In what counties and/or cities does your MCT operate?
4. What is the approximate size of the population served by your MCT?
5. Approximately how many square miles is your MCT catchment area?
6. What is the population density in your catchment area? (Select all that apply.)
 - Urban
 - Suburban
 - Rural
 - Frontier
7. What types of barriers frequently impede your MCT's activities? (Select all that apply.)
 - Snow
 - Heavy rains
 - Excessive heat
 - Dirt roads
 - Long distances
 - Traffic
 - Mountainous terrain

- Wildlife
- Poor wifi, cell reception, other connectivity barriers
- Other/Comments:

B. Partnerships

- 8. What agency has primary oversight over the operations of your MCT?**
- Public Health Department Behavior/mental health agency/authority Law enforcement (police, sheriff) Emergency Medical Services (EMS)
 - Fire Department
 - 911/emergency dispatch
 - Other:
- 9. What agencies does your MCT partner with? (Select all that apply.)**
- Public Health Department
 - Behavioral/mental health authority
 - Law enforcement (police, sheriff)
 - Emergency Medical Services (EMS)
 - Fire
 - 911/emergency dispatch
 - Other/Comments:
- 10. What youth services does your MCT partner with? (Select all that apply.)**
- Schools
 - Juvenile Justice
 - Child Protective Services Foster Care
 - N/A
 - Other/Comments:
- 11. Is your program embedded within a public agency (civil service) or contracted to a community provider?**
- Embedded within public agency
 - Contracted organization
- 12. Please rank your MCT program's priorities from most to least important. (Drag options from highest to lowest priority.)**
- Diversion from law enforcement encounters
 - Diversion from Emergency Department
 - Diversion from arrest/jail/prison
 - Diversion from inpatient psychiatry
 - Diversion from ambulance/Emergency Medical Services
 - Reduction in Emergency Department boarding time
 - Reduction in officer wait time
 - Retention in community-based services Retention in home/school placements

C. Program Structure

- 13. What number can someone call to access your MCT services? (Select all that apply.)**
- Internal/self-dispatch (direct referral to MCT)

- National Suicide Prevention Lifeline (NSPL) Call Center
- Non-NSPL Centralized statewide hotline
- Non-NSPL Regional/County/City hotline(s)
- 911
- 211/311/other non-911 central line
- Law enforcement/EMS
- Emergency departments
- Inpatient/Residential psychiatric facilities
- Jails
- Mental Health Clinics
- Other/Comments:

14. Who is responsible for making the decision about whether your MCT team is dispatched to a call (i.e., can your MCT program block a call if needed)?

- Call center dispatches MCT
- MCT self-dispatches and can block calls if needed
- Other/Comments:

15. What are your hours of operation?

- 24 hours
- Non-24 hour; please specify:

16. What days do you operate?

- 7 days
- Monday-Friday
- Other:

17. Approximately how many patients does your MCT program serve per month?

18. What vehicles do you use to arrive on scene? (Select all that apply.)

- Personal vehicle
- Standard vehicle (car, SUV, van) owned by program
- Ambulance
- Community paramedicine vehicle (e.g., ambulette, paratransit)
- Police cruiser
- Other/Comments:

19. Which of the following are used for voluntary and/or involuntary transport? (Select Voluntary and/or Involuntary for all that apply.)

- Law enforcement
- Ambulance
- MCT vehicle
- Secure transport provider
- Voluntary
- Involuntary
- Other:

20. Is your program stand-alone or co-located at a site?

- Stand-alone

- Co-location with hotline/call center
- Co-location with outpatient behavioral health clinic
- Co-location with behavioral health crisis facility (e.g., residential, respite, stabilization unit, psychiatric emergency)
- Co-location with medical Emergency Department
- Co-location with jail/police station
- Co-location with fire station/EMS dispatch/911
- Other:

21. With which local services does your MCT have formal arrangements for expedited drop-off and care transitions? (Select all that apply.)

- Outpatient behavioral health services (e.g., case management, medication support)
- Behavioral health crisis facility (e.g., residential, respite, stabilization unit)
- Substance use detox/sobering
- Psychiatric Emergency Services (e.g., CPEP, EmPATH unit)
- Inpatient psychiatry
- Other/Comments:

22. Is your MCT service limited to certain insurance carriers? (Select all that apply.)

- No limitations
- Private insurance only
- Public insurance only (e.g., Medicaid, Medicare)
- VA/Tricare only
- Other/Comments:

23. Does your program prioritize care by payer type? (Select all that apply.)

- No Indigent/uninsured Medicaid
- Medicare VA/Tricare
- Private insurance
- Other/Comments:

24. Does your program share MCT staff with related behavioral health and crisis/emergency services? (Select all that apply.)

- Outpatient behavioral health clinic
- Crisis hotline
- Urgent walk in clinic
- Crisis receiving facilities (crisis residential, detox, inpatient, etc.)
- ED response
- School response
- Jail response
- N/A
- Other/Comments:

D. Team Structure

25. Please describe the Full Time Equivalents (FTEs) for each member of your team. (Estimates are acceptable; enter numbers only.)

- Licensed BH clinician (e.g., psychologist, LPC, LCSW, LMFT, etc.)
- Unlicensed BH clinician

- Paramedic/EMT
- Law enforcement officer
- Peer specialist
- Psychiatric Medical Director
- Psychiatric prescriber (e.g., MD/DO, NP, PA)
- Nursing (e.g., BSN, RN, LPT)
- Other
- FTEs

26. Are your MCT members working full-time during hours of operation or are they on-call as needed?

- On duty
- On call
- Combination of on duty/on call (Comments optional):

27. Do you have a supervision structure for MCT members to consult with a senior clinician?

- Scheduled
- On demand
- None
- Other/Comments:

28. What type of training modalities do you utilize to train MCT providers? (Select all that apply.)

- On-demand videos
- Self-directed reading
- Classroom: didactic
- Classroom simulation: vignettes, role plays, etc.
- Virtual reality/simulator
- Shadowing/provisional period <1 month
- Shadowing/provisional period 1-3 months
- Shadowing/provisional period >3 months
- Other/Comments:

29. Which of the following topics are covered in your MCT training curriculum? (Select all that apply.)

- Suicide risk assessment and intervention
- Violence risk assessment and intervention
- Management of agitation and verbal de-escalation
- Structured brief interventions: SBIRT, CALM, SPI, etc
- Level of care decision-making
- Trauma-Informed Care
- Harm reduction practices
- Safety in the field
- Provider wellbeing
- Other/Comments:

30. Does your program have effective mechanisms in place to prevent, detect, and respond to the following experiences among providers? (Select all that apply.)

- Fatigue Burnout
- Traumatic events and vicarious trauma Team dysfunction
- Stress related to understaffing
- None

- Other/Comments:

E. Clinical

31. What populations do you serve?

- Children (<18 years old)
- Adults (≥18 years old)
- All ages

32. What types of clinical presentations do you respond to? (Select all that apply.)

- Mental illness
- Substance use
- Intellectual/developmental disabilities
- Co-occurring medical conditions (e.g., delirium, dementia, TBI)
- Other/Comments:

33. Are there any types of cases that your MCT will not respond to? (Select all that apply.)

- High medical complexity
- High violence risk
- Homelessness
- Non-resident of catchment area
- Non-citizens
- Other/Comments:

34. What suicide prevention best practices are used in >70% of appropriate cases? (Select all that apply.)

- Universal suicide screening (e.g., C-SSRS, ASQ, etc.)
- Safety planning
- Reducing access to means of self-harm
- Other/Comments:

35. Do you use a decision-support tool to assess for service intensity need and level of care? (Select all that apply.)

- LOCUS/CALOCUS/CASII
- ASAM Criteria
- ANSA/CANS
- DLA-20
- Other/Comments:

36. What strategies does your MCT use to increase safety during field visits? (Select all that apply.)

- Limiting shift length to <12 hours
- Required 2-person response
- Daily vehicle/equipment inspection
- Reviewing available background data before meeting with the client
- Phone call with client/family before entering the home
- Structured protocol for assessing environmental safety on scene
- Structured protocol for assessing level of agitation/violence risk
- None
- Other/Comments:

F. Technology

37. What type of clinical record system do you use? (Select all that apply.)

- Stand-alone Electronic Health Record (EHR)
- EHR integrated with other behavioral health systems
- 911/EMS records
- EHR integrated with 911/EMS dispatch
- Microsoft Excel, Microsoft Word, fillable PDFs
- Other/Comments:

38. What type of devices does your MCT primarily use for documentation?

- Wireless tablets/computers in the field
- Office-based computers
- Paper charts
- Other/Comments:

39. What types of telehealth does your MCT provide? (Select all that apply.)

- All MCT uses telehealth (e.g., tech drives tablet to field for clinician telehealth interview)
- Clinician for supervision/consults
- Psychiatrist for medication consults
- None
- Other/Comments:

G. Financing

40. What types of funding supports your MCT program? (Select all that apply.)

- Federal block grants
- State/county general funds
- Foundation grants
- Medicaid waiver
- Insurance reimbursement/billing revenue
- Other/Comments:

41. How do you bill for and/or justify funding for services? (Select all that apply.)

- Submit monthly performance reports to county/state
- Medicaid billing
- Medicare billing
- VA/Tricare billing
- Private Insurance billing
- None
- Other/Comments:

42. What activities comprise an episode of care for your organization? (Select all that apply.)

- Telephone triage
- Dispatch
- Face-to-face encounter
- Video-based encounters
- Coordination and continuity of care
- Telephone follow-up

- Face-to-face follow-up
- Other/Comments:

43. What is your average face-to-face encounter cost?

44. Average episode cost

45. What is your total annual budget estimate for MCT?

H. Quality and Incentives

46. Which of the following descriptive metrics do you monitor? (Select all that apply.)

- # Inbound calls (if applicable)
- # MCT dispatches
- # Face-to-face encounters
- # Video-based encounters
- # Care coordination calls
- # Follow-up calls
- # Unique clients served
- Racial/ethnic breakdown of clients served
- None
- Other/Comments:

47. Which of the following performance metrics do you monitor? (Select all that apply.)

- Average speed of answer for inbound calls (if applicable)
- Average abandonment rate for inbound calls (if applicable)
- Average time to dispatch MCT
- Average MCT response time
- Average MCT point of service diversion rate
- % unable to locate by MCT
- Average officer wait time
- None
- Other/Comments:

48. Which of the following process metrics do you monitor for face-to-face encounters? (Select all that apply.)

- Completion of suicide risk assessment
- Completion of violence risk assessment
- Collaborative safety planning
- Removed/reduced access to means of self-harm
- Follow-up in 24 hours
- Referral to clinic-based services
- Referral to peer-based services
- Requested law enforcement support
- Requested EMS support
- Placement of involuntary hold None
- Other/Comments:

49. Which of the following incident types do you monitor? (Select all that apply.)

- Staff injuries during provision of MCT services
- Client suicide attempts during or after MCT services
- Client suicide deaths during or after MCT services
- Client violence during or after MCT services
- Client victimization during or after MCT services
- Client complaints about services
- Community partner complaints about services
- Provider reports of maltreatment by consumers
- Provider reports of maltreatment by community partners
- None
- Other/Comments:

50. Which of the following downstream outcome metrics do you monitor following face-to-face encounters? (Select all that apply.)

- Outpatient clinic-based connections
- Outpatient peer-based connections
- ED presentations
- Inpatient psychiatry admissions
- Law enforcement involvement
- Jail bookings
- None
- Other/Comments:

51. Which of the following metric types described above are used to inform incentives and/or payments? (Select all that apply.)

- Descriptive metrics
- Performance metrics
- Process metrics
- Outcome metrics
- None