Someone to Respond

A Toolkit for Implementing Mobile Behavioral Health Crisis Response in Alaska

Trust
Alaska Mental Health Trust Authority

AGNEW::BECK

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Section 1: Use of the Implementation Guide

Since 2018, the Alaska Mental Health Trust Authority, the Department of Health, the Department of Family and Community Services and many others have worked together to implement improvements to Alaska's system of behavioral health crisis care. (*Figure 1)* Implementing systemic change requires additional resources to guide, train and empower community and provider adaptation of approaches to behavioral health crisis response.

The *Mobile Crisis Team Implementation Guide* (*MCT Guide*) is intended as a resource to communities and organizations interested in expanding mobile response services to meet the needs of individuals in behavioral health crisis, or prevent future crisis, instead of solely relying on law enforcement, fire or EMS services.

The *MCT Guide* includes an overview of recommended early planning activities, the continuum of service model approaches, financing and reimbursement and considerations for partnerships and ongoing quality improvement.

These considerations and activities are based on experiences with developing MCT response in communities throughout Alaska, as well as national best practice guidance documents from SAMHSA. The *MCT Guide* describes five key considerations for local mobile crisis response planning in Alaska:

- Community Need
- Mobile Response Team Models
- Program Development
- Monitoring and Evaluation
- Community Partnership

Disclaimer

The *MCT Guide* does not constitute legal advice or supersede the practices, policies or procedures for any operator of mobile response services. This *MCT Guide* contains links to other third-party websites to provide convenience for the user; third-party links do not constitute an endorsement or guarantee that those sites will be operational or will contain the most current information. This resource is intended to provide context into why state and national resources have been dedicated to developing MCT response and share necessary considerations and steps for development and implementation of new services in alignment with lessons learned from other communities and national recommendations for best practice.

Alaska's Behavioral Health Crisis System Innovation Timeline

Key milestones in the implementation of a coordinated, connected system of behavioral health crisis care in Alaska.

2018

Federal approval (CMS) for SUD component of 1115 Medicaid Waiver

Initial conversations about Crisis Now framework in Alaska

Behavioral Health Improvement Project focuses on psychiatric boarding in emergency departments [Pub.A]

2019

Forensic Psychiatric Hospital Feasibility Study completed [Pub.B]

Federal approval (CMS) for behavioral health component of 1115 Medicaid Waiver

RI International conducts Crisis Now implementation readiness assessment in Anchorage, Mat-Su and Fairbanks [Pub.C]

Statewide convening on behavioral health crisis continuum

First site visit to Arizona to see Crisis Now in action

2020

Community planning workgroups convened in Anchorage, Fairbanks and Mat-Su

Concept-level pro formas developed for crisis services

SB 120 amends Title 47 to include crisis stabilization centers as locations for emergency detention

Settlement agreement with Disability Law Center identifies Crisis Now as a systems improvement initiative

2021

Crisis Now community coordinator positions funded in Fairbanks and Mat-Su

Mobile crisis teams launch in Anchorage and Fairbanks

2022

HB 172 signed into law

988 goes live nationwide

Mat-Su dispatch agency begins transferring behavioral health calls to Careline

Ketchikan Crisis Now community coordinator position funded and community planning begins

Five organizations across the state exploring 23-hour stabilization and/or short-term stabilization services

Planning begins in Kotzebue, Juneau, Copper Basin and Unalaska

Crisis Now Core Principles and Practices webinars begin

Child and Adolescent Behavioral Healthcare Improvement Project completed [Pub.D]

US Department of Justice report on Alaska's behavioral health system for children released [Pub.E]

2023

Careline launches law enforcement backline. Anchorage Police Department begins transferring calls

Mobile crisis team launches in Mat-Su

Ketchikan City Council approved positions for Mobile Integrated Healthcare program

Juneau community planning workgroup begins

Groundbreaking for Providence Crisis Stabilization Center

State of Alaska hosts Behavioral Health Roadmap meetings across the state

HB 172 Psychiatric Patient Rights Report submitted to the State Legislature [Pub.F]

2024

Groundbreaking for Southcentral Foundation Crisis Stabilization Center

Bartlett Regional Hospital and Capital City Fire and Rescue partner to launch MCT in Juneau

Trust hosts Crisis Now convening

Alaska Behavioral Health launches Mobile Outreach for Children and Families program in Fairbanks

Volunteers of America launches Rapid Response team

Anchorage Fire Department MCT pilots 24/7 response and is codified as an essential service

Milliman completes assessment of Alaska's behavioral health crisis continuum of care [Pub.G]

Ketchikan launches Mobile Integrated Health program

Central Peninsula Hospital begins mobile crisis response planning

Fairbanks MCT begins response to calls when requested by Alaska State Troopers

Department of Health begins Medicaid Rate Review project

Mat-Su MCT expands their service area

Publications

A. Behavioral Health Improvement Project
B. Forensic Psychiatric Hospital Feasibility Study
C. Crisis Now implementation readiness assessment
D. Child and Adolescent Behavioral Healthcare Improvement Project
E. US Department of Justice report on Alaska's behavioral health system for children
F. HB 172 Psychiatric Patient Rights Report
G. Assessment of Alaska's Behavioral Health Crisis Services Continuum of Care

Trust Investments: Fiscal Years 2021—2024

Contact Center
Total investment (FY21-24): $468,519

Mobile Response
Total investment (FY21-24): $4,894,486

Center-Based Crisis Services
Total investment (FY20-24): $3,664,269

Community Coordination
Total investment (FY21-24): $1,540,800

System Support
Total investment (FY21-24): $901,339

Additionally, Trust funding supports Alaska partner participation in crisis system immersion trips to Arizona, with 15 trips supported between 2018-2024.

Figure 1. Timeline of highlighted efforts and reports leading to system transformations in behavioral health care.

Section 2: Background

A new approach to behavioral health crisis care is needed across Alaska

Our current systems of care are challenged to provide timely access to behavioral health crisis services. People in crisis are often unable to receive care where they are, delaying care and oftentimes creating a cycle of crises. Communities often rely on law enforcement, the criminal justice system and hospital emergency rooms to respond to behavioral health crisis, and Alaska facilities that provide inpatient psychiatric care are often at capacity with waitlists.

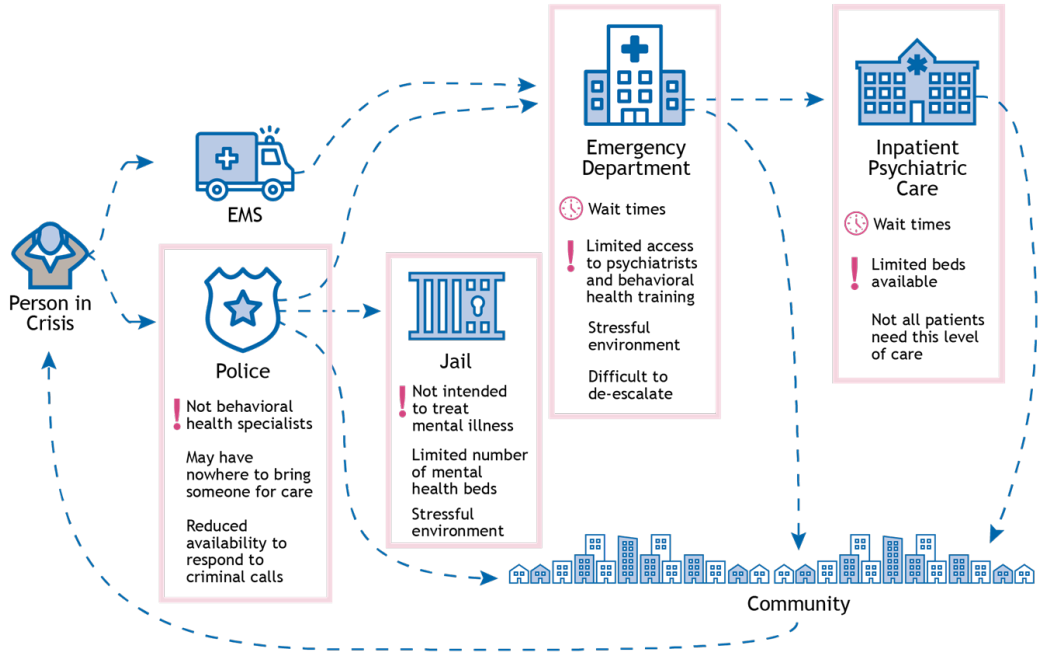


Figure 2. Current flow of behavioral health crisis response

To address these statewide challenges, partners have the goal to *Design and implement a behavioral health crisis response system analogous to the physical health system*. 'Behavioral health crisis' in this document includes mental distress, mental health conditions and conditions related to substance misuse. Mobile crisis response is an important part of the behavioral health continuum- people in behavioral health crisis should receive the appropriate level and type of care based on their need(s).[1]

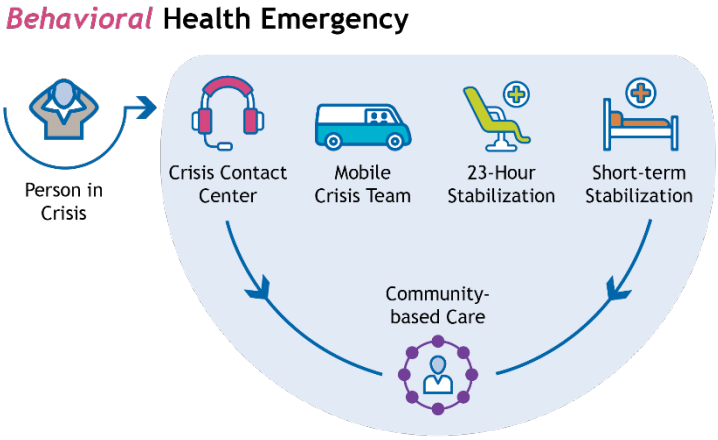


Figure 3. Behavioral health emergency response should parallel physical health emergency responses

[1] Communities across the nation are developing innovative prevention and outreach services that can prevent crises, if 24/7, on-demand behavioral health crisis services are not feasible.

Nationally, 'as is' models of crisis response have unfairly relied solely on law enforcement intervention.

The Department of Justice and Department of Health and Human Services recognize many people with behavioral health conditions interact with the criminal justice system when in crisis- instead of receiving necessary behavioral health care.[2]

Models of crisis care that rely solely on law enforcement, are increasingly viewed as insufficient and may violate civil rights under the Americans with Disabilities Act (ADA) and *Olmstead*.

Multiple litigation and federal investigations into violations of the ADA and *Olmstead*, including crisis response.[3]

> *"The ADA also applies to public entities' emergency response and law enforcement systems… Equal opportunity requires that people with behavioral health disabilities receive a health response in circumstances where others would receive a health response- for example, if call centers would dispatch an ambulance or a medic rather than law enforcement to respond to a person experiencing a heart attack or a diabetic crisis, equal opportunity would entail dispatching a health response in similar circumstances involving a person with a behavioral health disability."*[2] pp 3-4; emphasis added

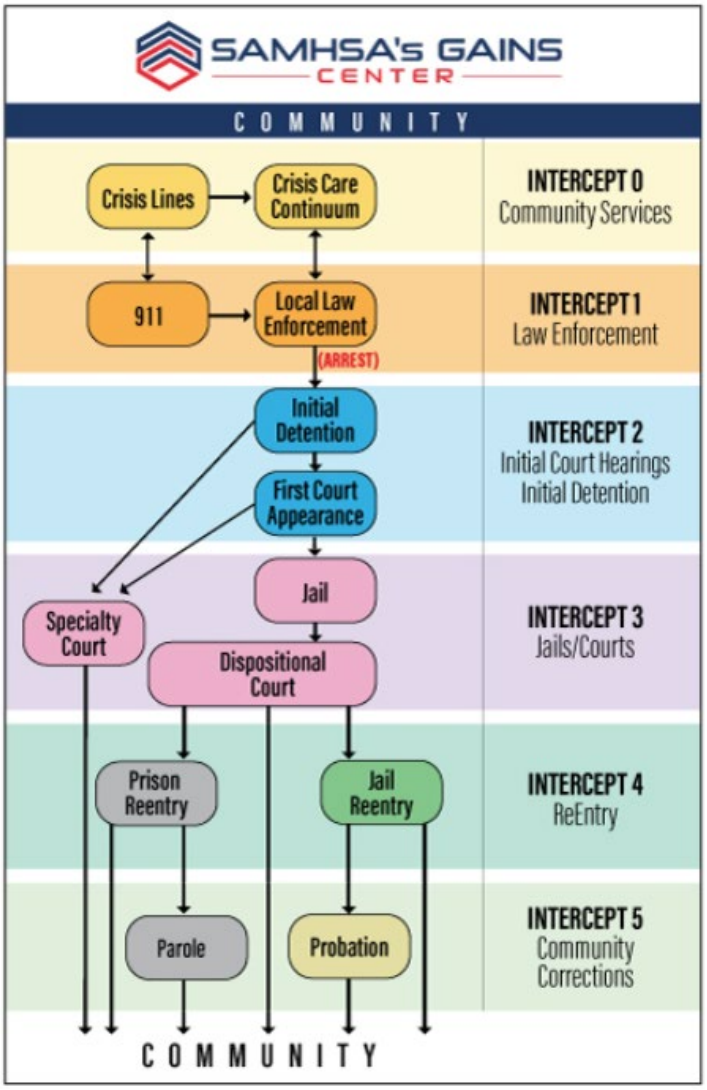


Figure 4. Sequential Intercept Model (SIM).

Mobile Crisis Teams (MCT) can be an essential part of efforts to divert unnecessary law enforcement response to individuals experiencing a behavioral health crisis. These diversion- or intercept- efforts have been a long priority of efforts detailed within the Sequential Intercept Model (SIM). The SIM details "how individuals with mental and substance use disorders come into contact with and move through the criminal justice system", and "helps communities identify resources and gaps in services at each intercept and develop… strategies to divert people with mental and substance use disorders away from the justice system into treatment."[4] Mobile crisis response teams with law enforcement officers would fall under 'Intercept 1'.

[2] Department of Justice and Department of Health & Human Services Guidance for Emergency Responses to People with Behavioral Health or Other Disabilities https://www.justice.gov/d9/2023-05/Sec.%2014%28a%29%20-%20DOJ%20and%20HHS%20Guidance%20on%20Emergency%20Responses%20to%20Individuals%20with%20Behavioral%20Health%20or%20Other%20Disabilities_FINAL.pdf

[3] Substance Abuse and Mental Health Services Administration: Update on Olmstead Litigation. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2023.

[4] Sequential Intercept Model https://www.samhsa.gov/criminal-juvenile-justice/sim-overview

In addition to diverting law enforcement response, improving the behavioral health crisis care continuum increases the options for crisis services at less intensive levels of care. As illustrated in Figure *5*, if more people have access to call-based or mobile crisis response services, they are anticipated to have less need for care at place-based settings like the emergency department or specialized behavioral health stabilization settings.

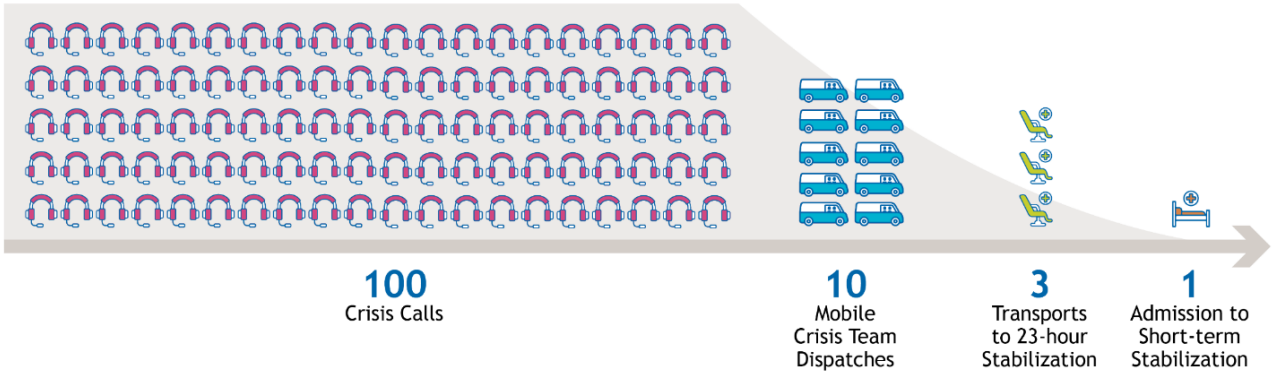


Figure 5. *National estimates are that a fully accessible behavioral health crisis continuum can divert individuals from higher levels of care. For every 100 crisis calls, only 10 may need in-person mobile response and 1 admission to short-term treatment.*

Section 3: Community Need

Understanding existing mobile response services, demand, and potential to adapt existing or start new services is a community effort. No single individual or entity can independently understand a community's mobile response needs. Meetings to explore community or regional needs should include, at minimum: people with lived experience with mental health and substance use conditions, behavioral health providers, healthcare providers, social service providers, and first responders – including law enforcement and fire/emergency medical services (EMS). Think about who in your community is impacted by behavioral health emergencies, and ensure they have a meaningful chance to participate or provide feedback as part of the exploration and planning process.

Figure 6. Essential components of mobile crisis team implementation.

Estimating Mobile Crisis Team Demand

It is important to estimate the annual number of crisis events in the community or region where you would like to implement a behavioral health focused mobile response. The Crisis Resource Need Calculator is a great resource to help estimate demand.

It will also be beneficial to work with your local Public Safety Answering Point (PSAP), law enforcement, and/or emergency medical service provider to identify the approximate volume of monthly or annual first responder dispatches that are primarily for a behavioral health crisis (including substance misuse or incapacitation, suicidal calls without imminent risk of danger to others, etc.). Table 1 below provides guiding questions for meetings, interviews or data requests from existing teams that respond to community members where they are at.

Existing Services

Table 1. Sample comparison table and questions to evaluate existing services. *Note: estimations for behavioral health crisis response volumes should include situations where an individual is in crisis related to mental health conditions and/or substance misuse or incapacitation.*

	Current Team	*Current Team*	*Current Team*	*Current Team*
Serves which population(s)?				
Responds to what kinds of behavioral health presentations?				
Response area?				
Availability?				
How are we reached?				
What are dispatch criteria?				
Estimated behavioral health crisis response volume? (monthly)				

Community and Partner Discussion

- Do the existing services experience behavioral health crises call volumes close to demand estimates?
- What constraints do current mobile response services experience?
    - Staffing, availability, training, etc.
- How do existing services align or differ from best practice recommendations suggested by SAMHSA's 2025 National Guidelines?[5]
- What is our community vision for mobile response?
    - What would change, or stay the same, based on existing services?
    - What outcomes do we want to see (ex. reduced law enforcement or EMS response to individuals with behavioral health needs)?
- What opportunities are there to build upon or align existing services with best practice to meet community behavioral health needs?
    - Can clinical and/or peer support be added to existing mobile response teams to expand service to include behavioral health crisis care? Who is interested or able to support this?
    - If clinical and/or peer support is added to existing mobile response, does this seem sufficient to meet community needs? And local workforce availability or capacity?
- Who are potential coordinators or facilitators in our community for mobile crisis response efforts?

[5] 2025 National Guidelines for a Behavioral Health Coordinated System of Crisis Care

Section 4: Mobile Response Team Models – Someone to Respond

Once you understand community needs and potential demand for mobile crisis teams (MCT), community partners should explore the MCT composition(s) that best fits your community needs and community capacity. Smaller, rural communities with a limited behavioral health workforce and a small volume of annual crisis events may need to adapt desired mobile response team type and composition to fit the local context while also striving to meet national guidelines for best practices.

Crisis Response Teams

SAMHSA identifies three distinct types of behavioral health mobile crisis response teams:

- **Behavioral health practitioner-only (BHP) team**: a team comprised *exclusively of behavioral health practitioners*. In addition to at least one licensed or credentialed behavioral health practitioner, the team may include unlicensed or uncredentialed behavioral health practitioners and/or peer support providers.
- **Co-responder team:** generally a team that pairs specially trained (e.g., crisis-intervention trained) law enforcement officers or other public health first responders with behavioral health practitioners.
- **Mobile response and stabilization services (MRSS):** developmentally appropriate BHP-only MCT response and time-limited community-based stabilization services focused on preventing unnecessary out-of-home placements for youth.

SAMHSA recommendations for best practice are clear that while MCT configurations vary, to be considered an MCT, teams must be:

1. **On-demand and rapid.** MCT response begins upon the acceptance of a dispatch request that is initiated by a crisis contact (call, electronic message, or chat).
2. **Mobile.** The MCT goes to the individual in crisis at any community-based location (i.e., the response is not limited to specific locations such as EDs or settings that are secure and/or staffed by behavioral health crisis clinicians).
3. **In-person.** At least one crisis staff person must meet face-to-face with the individual in crisis (i.e., not a 100% telephonic, online, or telehealth interaction).
4. **Inclusive of a licensed or credentialed provider**. An MCT response must include engagement by a licensed or credentialed behavioral health clinician who participates in a clinical assessment of the needs of the individual in crisis. If necessary, the clinical assessment can be done by telehealth if at least one other MCT staff member is on scene and interacting with the individual face-to-face.

Mobile crisis team services also ideally have the capacity to support the following scope of services: [6]

- Triage and screening
- Clinical assessment with the support of evidence-based screening and assessment, and decision support tools
- De-escalation/conflict resolution
- Peer support
- Harm reduction
- Coordinated care for needed follow-up services
- Crisis planning, stabilization and follow-up
- Operate independently from law enforcement staff but coordinate with them and other responders when necessary.
- Conduct follow-up after the crisis episode, timed according to the level of care needed by the patient.

Non-Crisis Mobile Response Teams

SAMHSA recommendations identify **community outreach teams** as teams that work to prevent crises and provide wraparound supports to those in need. These teams are prevention-oriented and work to connect individuals to needed services and supports such as behavioral health, physical care, housing, benefits, education, and employment.

While not included in SAMHSA's Model Definitions, **Mobile Integrated Health** teams are another approach Alaskan communities are using for preventative and post-crisis stabilization services. These teams may provide support for chronic disease management, preventative or post-discharge follow-up care or transportation services for a wide range of health and behavioral health needs.

Unless these teams also meet SAMHSA's four MCT criteria identified in the table above, these teams should not be identified as 'crisis' or 'emergency' services.

Community and Partner Discussion

The "Overview of the Mobile Response Continuum" (Table 2*),* summarizes the SAMHSA-identified options for mobile crisis and non-crisis response and pairs this information with a summary of Alaska-based program examples.

Questions for Consideration

- Which of these service models best suits our community needs?
    - Do we have capacity, or need, to add a mobile crisis response team?
    - If not, does our community need to expand or create non-crisis response services?
- Which of these teams is most realistic for our workforce capacity?

Potential Conversation Partners

- Law Enforcement
- Fire/EMS
- MCT Operator(s)
- Public Safety Answering Point (PSAP)
- Peer advocacy and support programs
- Behavioral health providers
- Case management or care navigation programs
- Social service agencies
- Domestic violence and sexual assault programs
- Tribes and Tribal Organizations
- Local government

[6] SAMHSA Mobile Crisis Team Toolkit: Draft. 2025

Table 2. Overview of the Mobile Response Team Continuum

	Crisis Response			Non-Crisis Response	
Mobile Response Type	**Behavioral Health Practitioner (BHP)-Only Mobile Crisis Team**	**Co-Responder Mobile Crisis Team**	**Mobile Response and Stabilization Services (MRSS)**	**Community Outreach Teams (COTs)**	**Mobile Integrated Health (MIH)[7]** *(not included in SAMHSA guidelines)*
SAMHSA Definition[8]	MCTs can vary in configuration, but must be: - On-demand and rapid - Mobile: Goes to the person in crisis at any community-based location - In-person: At least one staff must meet face-to-face - Inclusive of a licensed or credentialed behavioral health practitioner			Not crisis responders, COTs can work effectively alongside or in a complimentary manner to MCTs to prevent crises and provide wraparound supports to those in need.	MIH is the provision of healthcare using patient-centered, mobile resources in the out-of-hospital environment.
SAMHSA Service Description[9]	- BHP-only MCTs is a rapid, on-demand, community-based response provided by a team comprised exclusively of behavioral health practitioners. - Active treatment and prevention efforts. - Provides 24/7/365 service when possible. - Responds within one-hour for urban settings and two hours for rural - Provides post-crisis follow-up within 72 hours of initial crisis episode	- Leverage the skills of both behavioral health practitioners and law enforcement officers or other public safety-first responders - Tend not to provide 24/7/365 coverage - Active treatment and prevention efforts. - Follow-up occurs in-person, telephonically or virtually	- Timely, time-limited, intensive, home- and community-based crisis services designed to support children, youth, and their families/caregivers through a systems-based approach with the goal of preventing unnecessary out-of-home placements. - Provides a BHP-only MCT response and time-limited community-based stabilization services (up to 8 weeks) that are more robust than the typical follow-up provided by the other two MCT models - Provides 24/7/365 service when possible.	- Engages in outreach to support community needs including behavioral health, physical care, housing, benefits, education, and employment. - Prevention oriented	It may include, but is not limited to: - Telephone advice to 9-1-1 callers instead of resource dispatch - Community paramedicine care - Chronic disease management - Preventive care or post-discharge follow-up visits - Transport or referral to a broad spectrum of appropriate care

[7] ACEP. Vision Statement on Mobile Integrated Health and Community Paramedicine. Accessed at: https://www.acep.org/siteassets/uploads/uploaded-files/acep/clinical-and-practice-management/ems-and-disaster-preparedness/mih-vision-statement.pdf

[8] 2025 National Guidelines for a Behavioral Health Coordinated System of Crisis Care

[9] 2025 National Guidelines for a Behavioral Health Coordinated System of Crisis Care

	Crisis Response			Non-Crisis Response	
Mobile Response Type	**Behavioral Health Practitioner (BHP)-Only Mobile Crisis Team**	**Co-Responder Mobile Crisis Team**	**Mobile Response and Stabilization Services (MRSS)**	**Community Outreach Teams (COTs)**	**Mobile Integrated Health (MIH)[7]** *(not included in SAMHSA guidelines)*
SAMHSA Staffing[10]	Should be paired. Pair should include at least one licensed or credentialed behavioral health practitioner and another responder such as an unlicensed or uncredentialed behavioral health practitioner and/or a peer support provider. Although an in-person response by at least one member of the MCT is necessary to meet the service definition, a one-person response should be provided judiciously.	Co-response MCTs are most commonly staffed by both behavioral health professionals and law enforcement officers or EMS staff.	- Master's level licensed BHP and another responder that may be an unlicensed provider and/or a peer - May include peer/family advocate, consulting psychiatrist or ANP.	At minimum, COTs should be staffed by individuals qualified to perform the functions of the team. Depending on the function of the team, COTs may be staffed by the following: Licensed Practitioner of the Healing Arts (LPHA), Mental Health Professional (MHP), Qualified Mental Health Professional (QMHP), Rehabilitative Services Associate (RSA), Certified Peer Support Specialist, Community Health Worker, paraprofessional, or a Crisis Worker. Depending on the model, COTs may include medical and psychiatric staff.	MIH programs are typically staffed by EMTs or paramedics.
Alaska Mobile Response Program Examples	True North Recovery (Mat-Su) Alaska Behavioral Health (Fairbanks)	-BHP + EMS: Anchorage Fire Department, Capital City Fire and Rescue (Juneau) -BHP + Law Enforcement: Anchorage Police Department	Volunteers of America Rapid Response (Anchorage)	Anchorage Police Department HOPE Team	Anchorage Fire Department CORE Team Ketchikan Fire Department Capital City Fire and Rescue (Juneau)

[10] 2025 National Guidelines for a Behavioral Health Coordinated System of Crisis Care

Section 5: Billing and Financial Sustainability

Current Funding Landscape

All crisis and non-crisis response teams in Alaska currently rely on grant funding and/or municipal organizational budgets. Medicaid reimbursement does not cover full-service costs for beneficiaries. Private insurers generally do not pay for mobile crisis services. The State of Alaska does not currently reimburse Mobile Integrated Health teams for triage to alternate destinations or treatment in place.

Alaska Medicaid

The Division of Behavioral Health is exploring opportunities to modify the existing 1115 Medicaid Waiver to support service sustainability.

The State of Alaska also received a Certified Community Behavioral Health Center (CCBHCs) Medicaid Demonstration Planning Grant in 2025. This grant is the first step towards exploring enhanced crisis service models and reimbursement.

There are national and state-level conversations in progress related to payment equity for behavioral health services from private insurers.

Financial Planning Resources

For providers unfamiliar with Alaska Medicaid, the Alaska Behavioral Health Association created the *Alaska Behavioral Health Provider Toolkit* as a resource for delivering Medicaid behavioral health services in Alaska.

See *Table 3* for mobile response models, billing potential and regulatory references. Table *4* provides a comparison of crisis services billing options currently available within the State plan and 1115 waivers. For detailed financial modeling, refer to the *Billing and Financial Modeling Tools* section.

Billing and Financial Modeling Tools

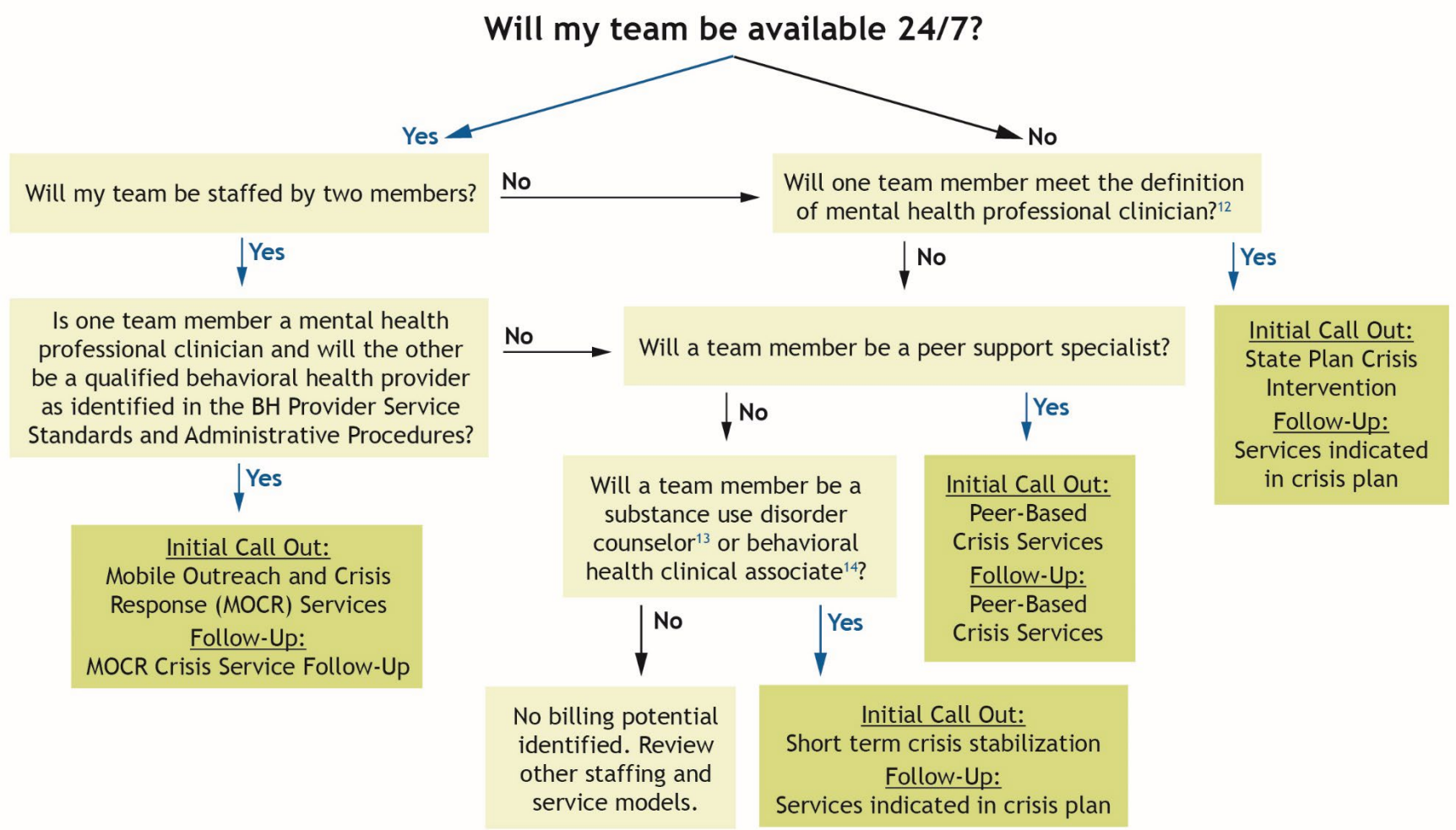
Understanding the financial realities for billing, staffing, operations and revenue for your mobile crisis response program is central to operations and sustainability planning. Upon request, Agnew::Beck Consulting can provide a concept-level modeling tool and assistance orienting to use of the Excel spreadsheet to estimate potential revenue from your program. Contact becky@agnewbeck.com for more information or to request the Excel file.

Table 3. Mobile crisis billing landscape

	Crisis Response			Non-Crisis Response	
Mobile Response Type	**Behavioral Health Practitioner (BHP)-Only Mobile Crisis Team**	**Co-Responder Mobile Crisis Team**	**Mobile Response and Stabilization Services**	**Community Outreach Teams (COTs)**	**Mobile Integrated Health (MIH)[11]** *(not in SAMHSA guidelines)*
Alaska Medicaid Billing	- 1115 Waiver Mobile Outreach and Crisis Response - State Plan Crisis Intervention - State Plan Crisis Stabilization - 1115 Waiver Peer-Based Crisis Services	Depending on team composition: • State Plan Crisis Intervention • State Plan Crisis Stabilization • 1115 Waiver Peer-Based Crisis Services	Various State Plan or 1115 Waiver services, depending on program.	Team/program dependent	None; MIH teams are not eligible for reimbursement for triage to alternate destinations (TAD) or treatment in place.
Alaska Billing Notes	- 1115 Waiver per call-out rate does not cover the cost to provide the services - Private insurance may not cover mobile crisis services	- MCD per 15-min service rates for crisis intervention and crisis stabilization will not cover the cost to provide these services as part of a mobile response - Private insurance will typically only cover if services provided by a licensed clinician	*This is not a specific service in Alaska MCD's current service array.* If providers bill for these services, they may bill through a combination of MOCR, crisis intervention, peer-based crisis or other services billed in 15-minute increments	*This is not a specific service in Alaska MCD's current service array.* Likely unbillable unless a specific service is ordered in a crisis treatment plan and delivered by this type of team.	*This is not a specific service in Alaska MCD's current service array.* Medical components likely unbillable without regulatory change. Behavioral health components potentially billable if ordered in a crisis treatment plan and delivered by qualified team members.
Alaska Regulation and Service Descriptions	7 AAC 135 – Medicaid Coverage; Behavioral Health Services 7 AAC 136 – Alaksa SUD and BH Program: 1115 Demonstration Waiver 7 AAC 138 – 1115 SUD Waiver Services 7 AAC 139 – 1115 BH Waiver Services			Not applicable	7 AAC 26 Emergency Medical Services

[11] ACEP. Vision Statement on Mobile Integrated Health and Community Paramedicine. Accessed at: https://www.acep.org/siteassets/uploads/uploaded-files/acep/clinical-and-practice-management/ems-and-disaster-preparedness/mih-vision-statement.pdf

Medicaid Billing Options Decision Tree



[12], [13], [14]

[12] See 7 AAC 160.990(49) https://www.akleg.gov/basis/aac.asp#7.160.990

[13] See 7 AAC 70.990(32) https://www.akleg.gov/basis/aac.asp#7.70.990

[14] See 7 AAC 160.990(86) https://www.akleg.gov/basis/aac.asp#7.160.990

Table 4. Comparison of Crisis Services Billing Options

	Mobile Crisis Outreach and Response (1115 Waiver)	Crisis Intervention (State Plan)	Crisis Stabilization (State Plan)	Peer-Based Crisis Services (1115 Waiver)
Regulation	• 7 AAC 138.450 for SUD • 7 AAC 139.350 for MH • 7 ACC 135.370 • Provider Services Standards and Administrative Procedures for Behavioral Health Provider Services *SUD and BH manuals have identical Mobile Crisis sections, except that the SUD manual requires enrollment as a QAP or PSS.*	7 AAC 135.160	7 AAC 135.170	• 7 AAC 138.450 for SUD • 7 AAC 139.350 for MH • 7 ACC 135.370 • Provider Services Standards and Administrative Procedures for Behavioral Health Provider Services *SUD and BH manuals have identical Peer Crisis sections, except:* - *SUD manual requires enrollment as a QAP or PSS.* - *SUD manual requires services be identified in a crisis plan by a mental health professional clinician (7 AAC 138.450(1))*
Staffing	Mental health professional clinician (7 AAC 160.990(49)) and another qualified professional *Peer support is a service component but not an explicit staffing requirement*	Mental health professional clinician (7 AAC 160.990(49))	SUD counselor (7 AAC 70.990(32)) or BH clinical associate (7 AAC 160.990(86))	Peer support specialist (7 AAC 138.400)
Purpose	• Prevent a crisis from escalating • Stabilize during or after a crisis • Refer and connect to appropriate services to resolve crisis	• Reduce symptoms • Prevent harm to self or others • Prevent relapse or deterioration • Stabilize family system	• To return the recipient to the recipient's mental, emotional, and behavioral level of functioning before the crisis occurred	• To help an individual avoid the need for hospital emergency department services or the need for psychiatric hospitalization

	Mobile Crisis Outreach and Response (1115 Waiver)	Crisis Intervention (State Plan)	Crisis Stabilization (State Plan)	Peer-Based Crisis Services (1115 Waiver)

Requirements	• 24/7 availability
	• Delivered in the community
	• Follow-up to ensure connection and stabilization
	• Initial assessment
	• Short-term crisis stabilization plan
	• Documentation of follow-up disposition and services provided
		• Initial assessment
		  ○ Nature of crisis
		  ○ Mental, emotional and behavioral status
		  ○ Overall functioning
		• Crisis plan
		  ○ Treatment goals derived from initial assessment
		  ○ Description of services required to resolve crisis
		• No more than 22 hours per SFY
		• Clinician plans and direct all ordered services other than pharmacological
		• Outpatient or community setting
		  ○ Can be provided in a hospital emergency room if the client has not been admitted
			• Uses the state form to document assessment, crisis plan and services
			• Initial assessment
			  ○ Overall functioning
			• Crisis plan
			  ○ Treatment goals derived from initial assessment
			  ○ Description of services required to resolve crisis
			• Clinician may assume responsibility and begin crisis intervention
			• Outpatient or community setting
			  ○ Can be provided in a hospital emergency room if the client has not been admitted
				• Summary of crisis intervention needs
				• Facilitation of transition to other community-based resources or natural supports
				• Advocacy for client needs with other service providers
				• For SUD, services are identified in a crisis plan by a mental health professional clinician
				• No service frequency/limits
				• Multiple service locations
				• Telehealth may be allowable with prior authorization
				• Must be provided by a peer working under the supervision of a mental health professional clinician or SUD counselor
				• The clinician or SUD counselor is available to the PSS onsite, telephonically or via telehealth to triage emergent crises

	Mobile Crisis Outreach and Response (1115 Waiver)	Crisis Intervention (State Plan)	Crisis Stabilization (State Plan)	Peer-Based Crisis Services (1115 Waiver)
Service Components	• Triage and screening • Crisis assessment • Peer support • Crisis planning • Coordination, referral and linkage • Medication linkage • Skills training to minimize future crisis situations	Crisis intervention services is a service code that covers: • Individual or family psychotherapy • Individual or family training and education • Safety monitoring • Medically necessary and clinically appropriate behavioral health clinic service, rehabilitation service, or intervention service included in a crisis plan	Crisis stabilization services is a service code that covers: • Individual or family counseling • Individual or family training and education • Safety monitoring • BH rehabilitation services	• Triage of crisis intervention needs • Crisis support services • Facilitation of the transition to the community by accessing community resources and initiating natural supports • Participation in planning for care needs if requested by the individual receiving the support • Activation of resiliency strength services • Advocacy services
Billing Models	CBHC with 1115	CBHC or MHPC Pharmacological and rehabilitation services provided as part of crisis plan are billed separately Only services ordered on the crisis plan are billable for the duration of the crisis plan	CBHC Only services ordered on the crisis plan are billable for the duration of the crisis plan	CBHC with 1115

Questions for Consideration

- Based on our team composition and availability, what are our potential funding sources?
- What is our sustainability plan to grow and then maintain mobile crisis services?
- How could we measure the financial impacts of MCT services may have on local health, emergency or criminal justice services?
    - Either direct costs, FTE or time saved, etc.?

Potential Partners

- Law Enforcement
- Fire/EMS
- MCT Operator(s)
- Public Safety Answering Point (PSAP)
- Peer advocacy and support programs
- Behavioral health providers
- Case management or care navigation programs
- Social service agencies
- Domestic violence and sexual assault programs
- Tribes and Tribal Organizations
- Local government

Section 6: Program Development

MCT Staff Training

Mobile crisis teams require initial and ongoing training to deliver high-quality crisis services, promote provider wellness and be an effective partner within a coordinated crisis system of care.

Agnew::Beck, in partnership with the Alaska Mental Health Trust Authority created a Provider Training Guide, Training Tables and a Self-Evaluation Framework to support organizational training needs and workforce development. You can contact Megan Carlson (megan@agnewbeck.com) to receive a copy of these documents.

The following lists SAMHSA's national guidelines and core principles for high quality crisis care. It is recommended that prospective, or current, MCT operators review the list below and *SAMHSA's 2025 National Guidelines for a Behavioral Health Coordinated System of Crisis Care* to identify which principles are already addressed within their organization's onboarding, and where training needs to be expanded or developed to encompass behavioral health and/or crisis care needs. SAMHSA's 2025 *Model Definitions for Behavioral Health Emergency, Crisis and Crisis-Related Services* provide additional recommendations for different types of mobile response teams.

Core Service Principles for Training Focus[15]

- Crisis Services Should Be Comprehensive, Integrated, Coordinated, and Developed Utilizing a Systems Based Approach
- Crisis Services Should Be Person-Centered, Family-Focused, and Provide the Right Level of Care at the Right Time
- Crisis Services Should Prioritize Safety
- Crisis Services Should Be Equitably Accessible and Responsive to the Diverse Needs of Populations
- Crisis Services Should Prioritize Quality and Effectiveness
- Crisis Services Should Be Developmentally Appropriate
- Crisis Services Should Be Resiliency- and Recovery-Oriented
- Crisis Services Should Be Trauma-Informed
- Crisis Services Should Provide Continuity of Care from Onset of Crisis Until Stability and Include Follow-Up Care and Linkage
- Crisis Services Should Be Evidence-Based, Evidence-Informed, and/or Reflect Best, Promising, and Emerging Practices
- Crisis Services Should Be Responsive to Individuals' Wholistic Needs

Potential Materials and Equipment

The full range of materials and equipment suggested for mobile crisis response teams may vary by team composition and professional scope of staff. Some important recommendations include:[16]

- **Vehicles.** Consider how vehicles are marked for team safety and to support comfort and de-stigmatization of community members receiving services. Consider whether mobile teams will provide transportation, and what comfort and safety considerations are necessary for transport. Also, consider whether alternate or non-traditional transportation is needed for your local geography.

[15] 2025 National Guidelines for a Behavioral Health Coordinated System of Crisis Care. SAMHSA shared these documents were temporarily offline for editing during the 09/10/25 Crisis Jam; revised documents not available as of 10/14/2025. Copies of the National Guidelines original publication are available at this site.

[16] Recommendations come from the SAMHSA Mobile Crisis Team Toolkit Draft and the City of Durham Community Safety Department materials

- **Medical equipment.** The supplies needed for first aid and non-emergency medical care. This may include medications for opioid overdose reversals, or more advanced medical equipment, pending the professional scope of practice for team members.
- **Snacks and water**
- **Radio or cellphones** for updates from dispatching entity and general communication needs.
- **Tablets, computers** or other technologies necessary for documentation, referrals or other practice needs.
- **Identification badges or uniforms.** Consider how to make staff easily identifiable to any public safety first responders without conveying stigmatizing information or unnecessarily disclosing that a person may have a behavioral health issue.

This list is non-exhaustive. Mobile team operators and community partners should collaborate on the equipment and materials necessary to meet SAMHSA's core service principles within the unique cultural and geographic needs of their region. SAMHSA's anticipated MCT Implementation Toolkit[17] may have additional recommendations.

Triage and Dispatch [Someone to Contact]

Mobile crisis response teams (MCT) are complimentary to existing emergency services provided by law enforcement, EMS and fire departments. MCTs may be dispatched by their local public safety answering point (PSAP) or by 988. Either method requires close partnership and communication with partners to understand current dispatch protocols and the role of mobile crisis response teams with other public safety agencies. MCTs can play a vital community role in triage/screening, assessment and on-scene care to reduce unnecessary Emergency Department care, inpatient psychiatric hospitalizations and law enforcement involvement.[18]

Questions for Consideration

Behavioral health crises include situations where an individual is in crisis related to mental health and/or substance use conditions.

- How are fire, law enforcement and EMS services currently dispatched?
    - What decision trees or policies guide Dispatch to make these decisions?
    - What calls to the PSAP could be transferred to 988 for care instead of in-person response? See the NENA Standards for 9-1-1/988 Interactions for additional information.
- How will the MCT be dispatched to people in crisis?
    - 988? Local PSAPs?
    - What communication tools or platforms will be needed to share dispatch directions and communications with the MCT?
    - What training and policies are necessary to support dispatchers offering alternative response options- including the option to decline law enforcement or have an extended wait if MCT services aren't immediately available?
    - How will the MCT operator communicate to the dispatching entity about team availability, if teams aren't available 24/7?
- What factors will be used to decide when to dispatch mobile crisis response instead of traditional law enforcement or fire/EMS response?
    - How will the PSAP support 'warm hand offs' to MCTs?
    - What policies and procedures are needed if MCTs need to request law enforcement or EMS services?
- If community need does **not** support a behavioral health provider-only MCT, what training or resources for law enforcement and EMS can enhance their ability to respond to behavioral health?

[17] SAMHSA released a draft in January of 2025 and announced ongoing work to finalize the guide during the 09/10/25 Crisis Jam. Finalized documents not available as of 10/14/2025.

[18] SAMHSA 2025 National Guidelines. p37.

Potential Conversation Partners

- Public Safety Answering Point (PSAP)
- Law Enforcement
- Fire/EMS
- Careline (988)
- MCT Operator(s)
- Tribes and Tribal Organizations
- Peer advocacy and support programs
- Behavioral health providers
- Case management or care navigation programs
- Social service agencies
- Domestic violence and sexual assault programs
- Tribes and Tribal Organizations
- Local government

Note: there are several communities in Alaska providing MCT services who are excellent contacts and partners to share policies, lessons learned, etc. The City of Durham, NC also has robust resources on its website about its MCT and community outreach team service development and operations, including policies and procedures.

Section 7: Monitoring and Evaluation

The premise of MCT services as part of a behavioral health coordinated system of crisis care is that a robust behavioral health service continuum can 'support wellness, promote safety and avoid unnecessary care in both healthcare and law enforcement institutional settings'.[19] Ongoing monitoring and evaluation is essential to measuring if MCT services are high quality, what services are provided, and if these services have the desired positive impacts. MCTs are only one component within a coordinated system of care- it is not (or should not be) expected for MCTs to single-handedly improve system outcomes.

The Trust, in partnership with Agnew::Beck, DBH and community partners created a Mobile Crisis Response logic model and minimum key performance indicators (KPIs) for mobile crisis teams to support monitoring and evaluation efforts. The logic models and key performance indicators were designed with crisis response teams in mind and the minimum KPIs may not be relevant for non-crisis response teams.

Logic models provide an overview of how we think an initiative should work, the resources needed to support the initiative, and the kinds of impacts we expect the initiative will have. Logic models try to provide a comprehensive illustration of how the resources (inputs), activities and outputs contribute to the desired goals or outcomes of a project or program. A logic model is a roadmap that identifies the relationships between these categories and a visual explanation of strategy.[20]

The Mobile Crisis Team (MCT) Logic Model intends to guide Alaska's MCT operators toward achieving system-wide outcomes and support alignment on data collection. This logic model was developed using Alaska Crisis Now long-term outcomes,[21] national publications on best practices, and technical assistance provided by RI International. The language used in the logic model should provide both guidance and flexibility to adapt to MCT operations across diverse service delivery settings with the goal of collecting individual and aggregate data to measure the impact of Crisis Now services over time.

Mobile crisis teams provide a range of services; KPIs help create a shared language, based on national guidelines and Alaska priorities, of key areas to measure how mobile crisis response was implemented, how well services were provided, and whether your community is better off because of these services. The MCT Logic Model and KPI are available in the Appendices.

Quality Improvement

Monitoring and evaluation are vital to create a cycle of feedback, action and change for MCT operating agencies and their partners. No service model is perfect on the first attempt- ongoing communication and evaluation will help to refine the MCT and its operations into a high-quality, meaningful services to partners and the broader community.

Questions for Consideration

- How will the MCT receive and use feedback from staff?
- How will the MCT and crisis system receive feedback from each other, or the community?
    - What MOAs/MOUs are needed to have informed and direct conversations?
- How will the MCT receive client feedback?
- If our MCT is composed of partners from separate organizations or divisions, how will we address problems or concerns as they arise?
- What is important for our team, and community, to measure as a sign that our services are working well?
    - What's required by funders, professional requirements or our organization?

[19] SAMHSA 2025 National Guidelines, p3.

[20] District of Columbia Department of Health. Smith, J.A. (2020, August 26). Logic Models as Tools for Developing Performance Measures. [PowerPoint Slides].

[21] Alaska Mental Health Authority. (2020). Crisis Now Logic Model.

Reporting and Sharing

Monitoring the impacts of MCT services and partnerships is an important element of program sustainability. People are more likely to invest time, attention and financial resources to programs they understand and feel are effective.

Questions to Consider

- How will we track, and share, the work of the MCT within the larger crisis system?
    - What tools can be used for public reporting to improve transparency and support service advocacy?
    - Newsletters, websites, or maybe even a dashboard?
- What precautions do we need to take to maintain the privacy and confidentiality of people who received MCT services?
- How do we clearly interpret and communicate what our data means?

Section 8: Community Partnerships

While this toolkit is focused on mobile crisis team (MCT) implementation planning, MCTs are intended to provide service within a behavioral health coordinated system of crisis care.[22] This section of the toolkit will explore the additional components identified as best practice, or essential, to high-quality MCT services. MCTs cannot, and should not, operate in a behavioral health service vacuum- partnerships are essential for a healthy service continuum to can 'support wellness, promote safety and avoid unnecessary care in both healthcare and law enforcement institutional settings'[23]

Center-Based Stabilization Supports [A Safe Place for Help]

Many people who use MCT services will be able to resolve, or at least stabilize, their crisis to connect with their provider(s) or other resources later. Others require immediate, continued response beyond what the MCT can continue to provide. Without a facility-based space for continued stabilization supports, MCTs may respond to the same people multiple times per shift- or bring them to more expensive, higher levels of care such as the emergency department. MCTs will need connections with safe places for help for people whose crisis cannot resolve with MCT support alone. See *SAMHSA's 2025 National Guidelines for a Behavioral Health Coordinated System of Crisis Care* for ideas of the potential continuum of facility-based care options.

Questions for Consideration

- Where do current mobile crisis response and first responder teams bring people who need immediate care and additional support?
- Are there other places where someone could be brought for ongoing care, even if they are not open 24/7?
- If the clinic/emergency department remains our best option for additional stabilization, what training or resources could enhance care provided in this setting?
- What resources, policies and procedures are needed for MCTs to transport individuals to other locations to receive other stabilization supports?

Potential Conversation Partners

- Public Safety Answering Point (PSAP)
- Law Enforcement
- Fire/EMS
- Careline (988)
- MCT Operator(s)
- Tribes and Tribal Organizations
- Peer advocacy and support programs
- Behavioral health providers
- Case management or care navigation programs
- Social service agencies
- Domestic violence and sexual assault programs
- Tribes and Tribal Organizations
- Local government

[22] SAMHSA 2025 National Guidelines p3.

[23] Ibid.

Prevention and Follow Up

There are many reasons people enter into crisis. We've grown to understand that many crises are rooted in struggles with relationships or meeting basic needs (food, shelter, housing). Crisis response requires connections and planning to connect with resources that could divert a crisis and support mobile crisis response teams develop care plans and provide resources to people.

988 and 211 can be essential partners to help support individuals after a crisis, or to provide services that may prevent or reduce crisis events. Your local community will have additional resources and care connection opportunities.

Table 5. 988 and 211 comparison

988	211
• Statewide resource. • People can call when in crisis- call takers are trained crisis counselors. • Offers follow up calls. • Can help navigate and find resources and supports locally. • 911 Dispatch able to transfer appropriate calls to 988. • Pilot project with MCTs: Release of Information and care coordination as part of follow-up care plan for people frequently in crisis.	• Statewide resource. • People can call when in crisis- call takers help navigate healthcare, housing and other resource or referral needs. ○ Navigators will transfer the call if there are active safety concerns or needs outside of their scope. • Online resource directory to help people or organizations identify resources statewide.

Questions for Consideration

- What resources and partnerships are needed to support ongoing follow up needs and care after the preliminary MCT crisis response?
- Does the mobile crisis response team have staffing support and capacity to provide follow up contact and support within 72 hours of the crisis event?
  - Who are partners in our community to support these efforts? What policies and procedures are needed for effective, client-driven care?
- Some people regularly in crisis may already be connected to resources and supports. What is in place for care management coordination for people may need ongoing coordinated care in response to high utilization of services?

Potential Partners

- Public Safety Answering Point (PSAP)
- Law Enforcement
- Fire/EMS
- Careline (988)
- MCT Operator(s)
- Tribes and Tribal Organizations
- Peer advocacy and support programs
- Behavioral health providers
- Case management or care navigation programs
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- Local government

Community Outreach and Education

Mobile crisis response is a complimentary alternative to traditional emergency response in communities. It is important for partners and the public to be aware of why changes are implemented and what to expect. While some details may need to remain opaque, such as specific dispatch protocols, it is vital that community members feel changes to crisis response are transparent. Community members and people with lived experience should feel they can provide input to or co-develop the new service model.

Setting expectations about pilot periods can also help people understand when a newer service model and approach to crisis care may experience some 'bumps in the road,' or when they could expect to receive a response from the MCT rather than law enforcement or EMS.

Questions for Consideration

- How will the community be informed about changes to or an additional mobile crisis response?
    - What are some concerns or questions that can be addressed preemptively?
    - How can partners in local media support community education and outreach?
- What needs to be in place for community members and partner organizations to provide feedback about when MCT operations (from dispatch to service ending) went well or if improvements are needed?
- How will positive or 'successful' stories about mobile response services be shared?
- Which partner(s) will be the primary points of contact to communicate to the public, and with one another about MCT service development, operations and impacts?

Potential Conversation Partners

- Public Safety Answering Point (PSAP)
- Law Enforcement
- Fire/EMS
- Careline (988)
- MCT Operator(s)
- Tribes and Tribal Organizations
- Peer advocacy and support programs
- Behavioral health providers
- Case management or care navigation programs
- Social service agencies
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Appendices

Appendix: Logic Model

Logic models provide an overview of how we think an initiative should work, the resources needed to support the initiative, and the kinds of impacts we expect the initiative will have. Logic models try to provide a comprehensive illustration of how the resources (inputs), activities and outputs contribute to the desired goals or outcomes of a project or program. A logic model is a roadmap that identifies the relationships between these categories and a visual explanation of strategy.[24]

The Mobile Crisis Team (MCT) Logic Model intends to guide Alaska's MCT operators toward achieving system-wide outcomes and support alignment on data collection. This logic model was developed using Alaska Crisis Now long-term outcomes[25], national publications on best practices, and technical assistance provided by RI International. The language used in the logic model should provide both guidance and flexibility to adapt to MCT operations across diverse service delivery settings with the goal of collecting individual and aggregate data to measure the impact of Crisis Now services over time.

Key Points

Logic models help programs and systems plan strategically on how to achieve long-term outcomes (performance monitoring). There are usually three primary questions asked to measure the impact of new services and programs during quality improvement processes or evaluations after services start. Ideally, these questions are intended to help tell the stories of what happened to improve crisis systems in Alaska. This data can then be used to support quality improvement, expansion, adaptation or maintenance of crisis care components and systems.

Question 1: What was done?

The Logic Model provides an outline of the basic expectations of MCT operations. Inputs and Activities highlight nationally and Alaska-based recommendations on the resources and actions viewed as best-practice to create and sustain MCT operations. Outputs identify where MCT programs may quantify activities or services provided.

- Where is the work happening?
- Who are MCT service users?
- Were MCT operations integrated with dispatch, first responders and/or 988/Careline?

Question 2: How was it done?

MCTs operate in unique settings and community contexts throughout Alaska. This Logic Model can help teams learn from one another while establishing some common operations or data collection expectations. Identifying some of these unique community contexts can also help identify trends about what enables MCT operations. Clear measurement of community context and team composition can also minimize inaccurate, or unjust, comparisons between MCTs.

- Where are MCTs operating?
- What is the community context of the MCTs?
- What is the composition of the MCTs/Who is doing the work?
- How were MCT operations integrated into existing first responder and healthcare systems?

Question 3: Are people or systems better off?

This question is the most challenging to define and measure. Defining 'success' or 'better' is not a neutral or objective process; these definitions are unique to the context of service user, context and time. Improvement cannot be measured solely by the impact of MCT operations and rather requires the collaboration of all key components to crisis systems and post-crisis care. Further collaboration and coordination of multiple local and state organizations, agencies and divisions to identify, aggregate and analyze data across various systems is necessary. Potential impact questions identified during discussions for the MCT Logic Model include:

- Has the service user's quality of life improved as a result of MCT operations?
  - Do they have improved quality of engagement with behavioral health, health, or other systems of care?
- How were connections to services increased through MCT operations?
- How has pressure on criminal justice and healthcare systems been reduces through MCT operations?
  - Are we preventing people from experiencing a crisis and/or entering the criminal justice cycle?
- Is this service cost efficient?
  - What revenue was generated?
  - Where did community and state systems see cost shifts and/or savings?
- How has our understanding of what led someone to crisis in the first place expanded?
- Who and what circumstances are MCTs best positioned to support?
  - Who are the types of people MCTs respond to?
  - Who are the unique and repeat clients MCTs see?

[24] District of Columbia Department of Health. Smith, J.A. (2020, August 26). Logic Models as Tools for Developing Performance Measures. [PowerPoint Slides].

[25] Alaska Mental Health Authority. (2020). Crisis Now Logic Model.

Table 6. Mobile crisis response logic model (2023)

Inputs	Activities	Outputs	Outcomes Short-Term	Outcomes Medium-Term	Outcomes Long-Term
1. Community context a) Size b) Geography 2. 24/7 Availability[1] 3. Staff a) Appropriate staffing for 2-person team such as:[2] Peer Specialist, Behavioral Health Aide, Police, EMS, Counselor, access to Psychiatry b) Administrative support (leadership, data management, paperwork/billing) 4. Partnerships, collaborations, and interagency committees 5. Team Equipment[3] a) Vehicle capable of transporting guests b) Vehicle with subtle/small branding c) Standardized uniform d) Vans are set up with supplies for staff and guests including first aid/infection control, water/snacks; blankets, and vehicle safety equipment. 6. Technology[3] a) GPS tracking on team member phone or key fob. b) Real-time access to EHRs 7. Crisis Continuum of Care a) Available appointments for post-crisis resources	1. Training/Capacity Building a) Develop appropriately trained crisis response services, to include increased cultural responsiveness, diversity of workforce, use of peers, and evidence-based practice for service delivery. b) Minimum training standards should include motivational interviewing (or similar) and naloxone provision, and population-specific trainings, depending on service area:[3] i. Alaska Native community ii. Veterans iii. Child Development iv. Individuals with Developmental Disabilities v. Co-Occurring disorders c) Develop staff training on customer service and racial equity. Incorporate concepts, assessment tools and strategies into ongoing staff performance reviews and patient feedback opportunities.[4] d) Develop workforce to ensure available staff to provide services. e) Integrate suicide care best practices training such as Zero Suicide and Suicide Safer Care into training schedule.[1] f) Incorporate trauma-informed care training into new employee orientation with regular refreshers.[4] g) Maintain current policies and procedures to support all aspects of MCT operations. 2. Recovery Oriented Teams a) Supervisors available for regular staff support and debriefing.[4] b) Staff have a designated place to take breaks.[3] c) Team members engage individuals in the care process during a crisis.[5] d) Communicate clearly regarding all care options and offer materials regarding the process in writing in the individual's preferred language whenever possible. e) Ask the service user about their preferences and do what can be done to align actions to those preferences.	1. Availability a) # of teams b) Days/week c) Hours/day(week) 2. Staffing Arrangement 3. Care Coordination and Partnerships a) Protocols, policies and guidelines are shared between crisis services providers b) Decision trees or triage developed for MCT dispatch c) Number of MOU/MOAs developed with other crisis providers d) Number of MOU/MOA with care continuum providers e) Community care/case conferencing process developed f) Formal data sharing agreements in place between mobile teams and all crisis providers, local PSAP and Careline 4. Call Response a) Time of first contact between 988 and/or PSAP and MCT. b) Time of MCT arrival on location[3] c) Number of MCT responses[3] d) Number of duplicated and unduplicated clients served e) Number of calls transferred from local PSAP	1. Service user knows who to call/where to go for help.[7] 2. Service user satisfaction a) Felt valued.[8] b) Felt experience was helpful. c) Felt safe.[9] 3. Service provider satisfaction 4. Increased diversion from emergency departments or acute inpatient care 5. Service user stays in community 6. Improved coordination and collaboration between police, mental health services, and emergency departments	1. Crisis care workers are appropriately trained and reflective of the community. 2. Increased appropriate service referrals and pathways to treatment 3. Increased rate of service users comfortable participating in follow-up care 4. Increased rate of service users comfortable enrolling in case management, when appropriate 5. Increase rate of people served closer to home. 6. Reduce time law enforcement and EMS spend triaging and responding to people in behavioral health crisis. 7. Increased clinical and peer support response to behavioral health crisis. 8. Increased diversion from arrest or detainment by law enforcement.[9, 8]	Improved Safety and Wellbeing for All[10] 1. Increased stabilization in least restrictive care setting. 2. Connection to health care, housing and supports. 3. Increased access to follow-up care post-crisis. 4. Reduced rate of Trust beneficiaries held in jail awaiting trial for a misdemeanor offense and the number of beneficiaries serving sentences related to misdemeanors. 5. Reduced race-based disparities among Trust beneficiaries held in DOC. 6. Reduced readmission rates for inpatient psychiatric care.[8] 7. Increased voluntary admissions for inpatient psychiatric care. 8. Reduced rate of people with behavioral health conditions presenting to hospital emergency.[8] departments. 9. Reduced rate of people with behavioral health conditions presenting to hospital emergency departments and being held for more than 8 hours.[8] 10. Decreased suicide deaths following crisis care.Decreased substance-related mortality.[11] 11. Improved sustainability and parity for behavioral health services continuum. 12. Improved sustainability and parity for behavioral health services continuum.

b) Available higher-level of care services	3. Partnerships and Collaborations a) Build and participate in partnerships, collaborations, and interagency committees. b) Dispatch/LE connects with MCT. c) Documentation of crisis shared with providers. 4. Service Implementation a) Dispatches occur at request/referral of Call Center, PSAP, and community member request. b) Team meets caller at their current location.[1] c) Team responds within 1-2 hours.[1, 3] d) Care includes: i. Triage and screening, including explicit screening for suicidality.[6] ii. Assessment (includes all Essential Crisis Now Defined Elements[2]) iii. De-escalation and crisis resolution[6] iv. Peer support utilized, when available[6] v. Coordination with behavioral health and medical services.[6] vi. Appropriate crisis planning and follow-up referrals based on assessment of service user needs.[6] e) Patients and their designees directly participate in determining and preparing for ongoing care during and after transitions.[5] 5. Marketing/Outreach/Public Relations a) Develop continuous communication plan to educate and re-educate community members, first responders, dispatch and providers about available services and program impacts. 6. Monitoring/Evaluation a) Identify key metrics to report on a regular basis (such as monthly). b) Established, publicized method to receive feedback from callers and community members. 7. Funding	*f)* Number of calls transferred from 988/Careline g) Number of calls from first responders h) Nature/Reason for call i) Time of scene: law enforcement j) Time of scene: EMS k) Number of MCT telehealth responses l) Duration of MCT response[3] m) Location of MCT response 5. Caller/User Demographic data a) Name b) DOB c) Gender d) Race/Ethnicity e) Housing Status 6. Call Outcome / Disposition a) Number of responses resolved in the community[Error! Bookmark not defined.] b) Number of transports by location and agency providing transport c) Referrals to resources needed by service user d) Number of ROIs signed by service users 7. Call Follow-Up a. Referral by service or agency type b. Number of follow-up calls by MCT			

Key:

- References and citations to logic model components are identified using a blue superscript number (xyz[00])
- Highlighted components represent data already collected by operational MCTs in Alaska.

Table 6 Footnotes

[1] Neylon, K. & Shaw, R. (2022). "Telling the story: data, dashboards, and the mental health crisis continuum." Prepared for National Association of State Mental Health Program Directors. Retrieved 30 March 2023 from: https://www.nasmhpd.org/sites/default/files/2023-01/Data-Dashboards-and-the-Mental-Health-Crisis-Continuum_NASMHPD-3.pdf

[2] Assessments should cover 1) Causes leading to the crisis event; including psychiatric, substance abuse, social, familial, legal factors and substance use; 2) Safety and risk for the individual and others involved; including an explicit assessment of suicide risk; 3) Strengths and resources of the person experiencing the crisis, as well as those of family members and other natural supports; 4) Recent inpatient hospitalizations and/or any current relationship with a mental health provider; 5) Medications prescribed as well as information on the individuals compliance with the medication regimen; and 6) Medical history as it may relate to the crisis. SAMHSA. (2020). "National guidelines for behavioral health crisis care: best practice toolkit executive summary."

[3] RI International. Technical assistance recommendations for best practice from 2020-2023.

[4] RI International. Browning, C. (2023, April 21). Fusion Model for Alaska [Webinar].

[5] National Quality Forum. (2010). "Preferred practices and performance measures for measuring and reporting care coordination: a consensus report. Retrieved 3 April 2023 from: https://www.qualityforum.org/publications/2010/10/preferred_practices_and_performance_measures_for_measuring_and_reporting_care_coordination.aspx

[6] SAMHSA. (2020). "National guidelines for behavioral health crisis care: best practice toolkit executive summary." Retrieved 30 March 2023 from: https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-services-executive-summary-02242020.pdf

[7] National Council for Mental Wellbeing. (17 Jan 2023). "Quality measurement in crisis services." Retrieved 30 March 2023 from: https://www.thenationalcouncil.org/resources/quality-measurement-in-crisis-services/

[8] Balfour, M. E., Stephenson, A. H., Delany-Brumsey, A., Winsky, J., & Goldman, M. L. (2022). Cops, clinicians, or both? Collaborative approaches to responding to behavioral health emergencies. Psychiatric Services. https://doi.org/10.1176/appi.ps.202000721

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[10] Alaska Mental Health Authority. (2020). Crisis Now Logic Model.

[11] Chung, D. T., Ryan, C. J., Hadzi-Pavlovic, D., Singh, S. P., Stanton, C., & Large, M. M. (2017). Suicide rates after discharge from psychiatric facilities: a systematic review and meta-analysis. JAMA psychiatry, 74(7), 694-702.

Appendix: Minimum KPIs

Below are suggested key performance indicators (KPI) for mobile crisis response teams in Alaska. These KPIs are based on published literature, national subject matter experts, extensive dialogue with MCT providers statewide and a performance monitoring pilot in Anchorage. This document identifies and defines the KPIs, suggested reporting frequency and the domains for results-based accountability informed by that KPI. Results based accountability asks three key questions *(How much/What did we do? How well did we do it? Is anyone better off?)* to help identify if provided services are working as intended to improve community health. *To learn more: https://www.dhs.state.il.us/onenetlibrary/27896/documents/by_division/dchp/rfp/rbaguide.pdf*

We suggest the following KPIs as the minimum standards for documenting mobile crisis response efforts to enhance alignment in measuring interventions and outcomes. Performance monitoring has been an essential feature of multi-year efforts to transform our behavioral health systems of care. Aligning data definitions and reporting helps elevate the statewide impacts of mobile crisis response rather than relying on individual community data and experiences. Individual communities and providers may choose to track additional indicators they find useful and meaningful to their context.

'Mobile Crisis Team' (MCT) is the term used to reference 'mobile outreach and crisis response services' as defined in 7 AAC 139.350. According to that statute, MCT crisis response services can only be provided by "(i) a mental health professional clinician; and (ii) a qualified behavioral health professional, as defined in Alaska Behavioral Health Providers Services Standards & Administrative Procedures for Behavioral Health Provider Services, adopted by reference in 7 AAC 160.900." Mobile outreach and crisis response services are provided to "(i) prevent a substance use disorder or mental health crisis from escalating; (ii) stabilize an individual during or after a mental health crisis or crisis involving a substance use disorder; or (iii) refer and connect to other appropriate services that may be needed to resolve the crisis."

This team composition remains in greatest fidelity to SAMHSA's recommended mobile crisis response teams for Behavioral Health Practitioner-Only MCT Services. In addition to at least one licensed or credentialed behavioral health practitioner, the team may include unlicensed or uncredentialed behavioral health practitioners and/or peer support workers. (1)

This document is intended to reflect only data collection of MCTs consistent with the definition from the regulation in 7 AAC 139.350 and the 1115 Waiver Services. Additional clarification and updates to terminology will be necessary if KPI collection includes mobile crisis response teams with Emergency Medical Service (EMS) or Law Enforcement team members.

'Beneficiary' is the term used by the Alaska Mental Health Trust Authority (the Trust) to collectively refer to broad groups of Alaskans who experience:

- mental illness
- intellectual and developmental disabilities
- substance use disorders
- Alzheimer's disease and related dementia
- traumatic brain injuries

The Trust also works in prevention and early intervention services, such as MCTs, for individuals at risk of becoming beneficiaries as part of its mandate.

'Beneficiary' in this document is used in recognition of the Trust's role and priority in helping communities develop mobile response services and refers to the individual(s) in crisis receiving MCT services.

Please note this document is intended only as a reference or type of glossary; separate tools are needed for data collection and analysis.

(1) Substance Abuse and Mental Health Services Administration: Model Definitions for Behavioral Health Emergency, Crisis, and Crisis-Related Services. HHS Publication No. SMA XX-xxxx [or PEPXX-XX-XX-XXX]: Substance Abuse and Mental Health Services Administration, 2025. https://www.samhsa.gov/mental-health/national-behavioral-health-crisis-care

Mobile Crisis Team Minimum Key Performance Indicators (KPI)

KPI	Results Based Accountability	Reporting Frequency	Measurement Unit	Definition
MCT Volume of Services				
Total Requests for MCT services	*How Much*	Monthly	##	The total count of requests for MCT services from the mobile crisis operator agency or dispatch entity, including 911 or 988. Total requests should include those requests that are outside of operator hours, service area, scope of service, etc.
Total In-Person MCT Crisis Responses	*How Much*	Monthly	##	Count of each event when the mobile crisis team made contact with the reported persons(s) in crisis. At least one crisis staff met face-to-face with the individual; crisis interaction cannot be 100% virtual or telephonic. [SAMHSA Model Definitions, 2025, p 33]
Total number MCT follow up services	*How Much*	Monthly	##	Follow up occurs within 72 hours from MCT services provided during an initial crisis event. Follow up services include in-person, telephonic, video call or text engagement with the same person(s) to whom services were provided during the crisis event. Follow up occurs with the individual's consent and may include check ins, referral support, etc. This data does NOT include additional crisis intervention services to the same person(s) within the 72-hour period and differs from follow up disposition as noted in regulation and 1115 manuals. There is immense value and need for that provide follow up services beyond the 72-hour window identified here. Ongoing navigation, coordination and encouragement are essential crisis-related services to prevent future acute behavioral health crises or emergencies. It is encouraged to share the impact of these related services in other contexts.
Total Incomplete MCT Crisis Responses to Initial Request	*How Much, How Well*	Monthly	##	This category counts each time the MCT was unable to respond in person to a request for service.
# Unable to find person(s)			##	MCT receives and takes the request for service in their queue. MCT makes effort to locate and engage and is unable to identify or find beneficiary at last reported location and unable to engage in services.
# MCT unable to respond/declined responding			##	This category documents when the mobile crisis team receives a request for service and is unable to engage the beneficiary. Reasons to not respond or decline request include: outside of MCT service area; request for service is outside of MCT scope of practice; MCT call queue exceeds capacity to accept additional requests for service; MCT declines because request/beneficiary needs are otherwise deemed inappropriate for MCT before engagement with beneficiary in crisis.

Mobile Crisis Team Minimum Key Performance Indicators (KPI)

KPI		Results Based Accountability	Reporting Frequency	Measurement Unit	Definition
Outcomes of MCT Call-Out for Crisis Response					
MCT Call Outcome		*How Much, How Well, Better Off*	Monthly	*(blank)*	Describes the outcomes of requests for service where the MCT engages beneficiary(s) in some level of care and service support.
# responses when crisis resolves on location, without transportation to any other location				##	The number of responses in a given period when the MCT is able to provide interventions to the person(s) to resolve the crisis and stabilize the person(s) at the location of the call response. No transportation by the MCT or additional agencies are needed physically on scene for care or safety needs.
# responses transitioned emergency medical services (EMS)				##	The number of responses where the MCT concludes services with beneficiary to transition care to the scope of services provided by local EMS/paramedics. This category does not include events where EMS was initially on scene and transition care to the MCT.
# responses transitioned to Law Enforcement				##	The number of responses where the MCT concludes services with care transition to the scope of services provided by law enforcement. This category does not include events where law enforcement arrived first or helped assess the crisis event and transition services to the MCT. Law enforcement includes any individual or agency tasked with maintaining order and enforcing laws within their jurisdiction, including Alaska State Troopers, VPSOs, Police officers and Tribal Police Officers.
# responses transitioned to other agency				##	The number of responses where the MCT engages and need to transition services and care of the person(s) in crisis to another agency that is not EMS or law enforcement.
Number of call outs with MCT transportation to another location		*How Much, How Well, Better Off*	Monthly	##	Counts the number of times MCT responds to an individual 'on scene', and intervention services includes or ends with transportation to alternate location(s).
# Crisis Stabilization Facility	# Voluntary		Monthly	##	The number of responses where MCT brings the beneficiary to a Crisis Stabilization facility for further services and care. In this definition, Crisis Stabilization Facility refers to programs which provide prompt care and services to the person(s) in an acute behavioral health crisis that are not a standard Emergency Department unit, correctional facility or outpatient provider with openings held in their schedule for crisis slots. Crisis Stabilization services are provided for up to 23 hours and 59 minutes in facilities or programs including peer crisis respite, sub-acute mental health facilities and hospital-based behavioral health emergency unites (EmPATH Unit).
	# Involuntary		Monthly	##	The number of crisis call out events where the MCT transports an individual to the Crisis Stabilization facility under the processes described in AS 47.30.705. Not all communities will have Crisis Stabilization facilities that accept involuntary admissions.
# Emergency Department	# Voluntary		Monthly	##	The number of responses where MCT brings the beneficiary to an Emergency Department for further services and care.

Mobile Crisis Team Minimum Key Performance Indicators (KPI)

# Involuntary		Monthly	##	The number of crisis call out events where the MCT transports an individual under the processes described in AS 47.30.705 *or from* apparent incapacitation from substance misuse in a public place.
# Outpatient medical		Monthly	##	The number of responses where the MCT transports the person(s) in crisis to outpatient medical appointments immediately following stabilization of the crisis. This could include pharmacy, primary care, dentist or other outpatient specialty care focused on physical health needs.
# Outpatient behavioral health / SUD		Monthly	##	The number of times the MCT provides transportation to outpatient treatment services for behavioral health and/or substance use treatment. This could include outpatient therapy, psychiatry, support groups or medication-assisted treatment appointments.
# Correctional Facility		Monthly	##	The number of times the MCT brings the person in crisis to the local correctional facility, including detention centers or jail.
# Shelter / Warming Center		Monthly	##	The number of MCT transportations to a local shelter, warming center or sleep off center.
# Home / Private Residence		Monthly	##	The number of times the MCT transports the beneficiary to their home, current residence or private residence of people within their social support system.
# Unsheltered location		Monthly	##	The count of MCT transports a beneficiary to public setting with absent or limited shelter. This includes camps.
# Unknown / Other		Monthly	##	The number of transports with location unknown / not documented or that fits a category not included in the current categories and definitions.
MCT Service Information				
MCT time to arrival to person(s) in crisis.	*How Much, How Well*	Monthly	hh:mm	Average time in minutes (hh:mm) it took the MCT to find and engage individuals in crisis after initial request from the dispatching entity.
Service Satisfaction Survey	*How Well, Better Off*	Quarterly	TBD	The opportunity for feedback following crisis and follow up services provided by the MCT through surveys conducted during follow-up contacts. Surveys are not recommended during or immediately upon conclusion of the crisis event. It is recommended surveys focus on feelings of value, helpfulness, and safety (see MCT logic model for details). To encourage survey language that is relevant to the context and populations served by each MCT provider, specific questions are not required at this time. A sample MCT survey methodology and questions are available here.
Stories of Impact	*How Well, Better Off*	Quarterly	Stories	MCT operator provides quotations or short stories about the impact of MCT services from beneficiaries, staff or partners. Stories of impact are anonymized, unless permission is granted, and will include the calendar year and month the story of impact was shared with the MCT.

Mobile Crisis Team Minimum Key Performance Indicators (KPI)

KPI	Results Based Accountability	Reporting Frequency	Measurement Unit	Definition
MCT Service Demographics				
Number of unique individuals receiving services. (Monthly)	*How Much*	Monthly	##	The total count of known unique individuals receiving mobile crisis services from the first to the last day of the reporting month.
Number of unique individuals receiving services. (Annual)		Annual	##	The total count of known, or estimated, unique individuals receiving mobile crisis services for the reporting calendar year.
Reported Age		Monthly	##	The age of unique individuals receiving MCT services for crisis events. Age may be self-reported or taken from the electronic health record for known individuals. MCTs will not make 'best guess' or age estimates; age will be counted as Unknown / Not reported in those instances.
# <18 years			##	
# 18-64			##	
# 65+			##	
# Unknown / Not reported			##	
Housing Status	*How Much*	Monthly	##	Counts of self-reported housing status from unique individuals receiving mobile crisis services. Housing status can be unstable, and reporting counts are anticipated to change within communities.
# Unhoused			##	Count of unique individuals reporting homelessness or unsheltered status at the time of service, including those residing in vehicles or camps but not self-identifying as homeless.
# Housed			##	Count of unique individuals reporting stable housing at the time of service provision for the reporting period.
# Unknown / Not reported			##	Total count of unique individuals where documentation error, beneficiary self report and MCT transportation/other service supports make it unclear whether the beneficiary has sustained housing.
Primary Conditions	*How Much*	Monthly	##	Primary conditions or diagnoses for unique individuals receiving crisis services from the MCT. Conditions or diagnoses can be self-identified by the person in crisis or their support network present during the crisis. Conditions or diagnoses may also be determined during MCT assessment. Sum of primary conditions or diagnoses will be greater than the number of unique individuals served, as people may experience concurrent conditions or disabilities.
# Mental Illness			##	
# Developmental Disability			##	
# Chronic alcoholism or SUD			##	
# Traumatic Brain Injury			##	
# Dementia			##	
# Unknown			##	

Mobile Crisis Team Minimum Key Performance Indicators (KPI)

Number of secondary individuals supported during MCT response	*How Much; How Well*	Monthly	*##*	The total count of people present during a crisis response, but who were not the person in acute crisis. These secondary individuals may receive direct support, encouragement or coaching during MCT interventions or indirect support with the care provided to the person in crisis. Secondary beneficiaries may include the family, friends, partners, co-workers or care staff of the person in crisis.
MCT Training and Staffing				
See Self-Evaluation Framework; following pages	*How Much; How Well*	Annual	*Text*	See Appendix: Self-Evaluation Framework
Staff roles / professional scope	*How Much; How Well*	Annual	*Text*	Identify staff profession(s) within the MCT.