MISSOULA
MOBILE SUPPORT TEAM
PILOT EVALUATION

September 2020 - June 2021

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Executive Summary

The Missoula Mobile Support Team (MST) provides mobile consultation, screening and brief intervention to individuals in crisis stemming from a behavioral health related issue. The goal of this program is to provide the right care in the right setting to people experiencing urgent behavioral health needs. The program also looks to reduce the time and resources Missoula first responders spend addressing situations where behavioral health is a chief concern and to decrease the number of arrests and emergency room visits.

The MST currently responds with law enforcement to behavioral health-related 911 calls. The response units consist of a licensed mental health clinician and an emergency medical technician (EMT). The MST also has a Case Facilitator who follows up with clients to provide resource navigation.

During the 7.5-month period that the MST was providing services (November 16, 2020 – June 30th 2021) they responded to 537 calls. The number of MST calls increased over time, with 50 calls for service in the first full month of availability (December) and 107 calls for service in in the last month of the pilot (June). Out of 890 hours the MST response units were available, they were responding to calls for 434 hours, or 49% of the time. This is comparable to other emergency first responders.

Calls for MST Unit 181 During Pilot
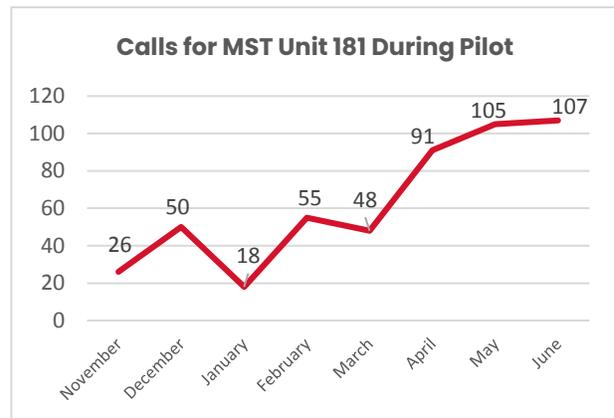
The majority of MST responses were to public locations (44%) or private residences (30%). During most encounters, the crisis was resolved and the client remained in the community (68% of calls). The MST estimates their responses resulted in 169 emergency department (ED) diversions, and 13 jail diversions.

Out of 537 calls, the MST met with 290 identifiable unique clients. Of those unique clients, 29 were frequent utilizers with 3 or more calls to MST, and 16 were super utilizers, with 3 or more calls and 4 or more hours devoted to them of MST time. Super utilizers represent 20% of MST response time. Ten of the super utilizers were unhoused (63.5%), and 6 were housed (37.5%).

The Case Facilitator made 895 follow-up phone calls, and was able to make contact with the client, or the client's care provider or family member during 712 of those phone calls. Follow-up and resource navigation was provided for 183 unique clients.

Please see the program evaluation for more detailed information on the data presented in this executive summary.

Acknowledgments

The MST pilot project would not have been possible without the financial support of Montana Department of Public Health and Human Services, the Addictive and Mental Disorders Division and the City and County of Missoula.

The MST is a collaboration between the Missoula Fire Department (MFD) and Partnership Health Center (PHC), and acknowledgment is due to both organizations for their tireless work to make this program a reality. Additionally, our community partners have been a vital part of this process. Without the cooperation and support of the Missoula Police Department, Missoula 911 Center, Providence St. Patrick Hospital, the Poverello Center's Homeless Outreach Team, and Erin Kautz, Grants Administrator for the County, the MST would not be successful.

Data for this report was gathered with support from John Petroff, MST Operations Manager, Cathy Janney, Administrative Support Specialist II with the MFD, Sherri Odlin, 911 Center Manager, and Alana McCreery, MST Case Facilitator, as well as the rest of the MST staff. Additional thanks are due to the community partners who offered their feedback on the program: Lance Somerfeld, Sherri Odlin, Theresa Williams, Riley Jacobsen, Sgt. Ben Slater, April Seat, Sgt. Bob Campbell, Officer J. Potter, Officer Kasey Williams, and Sgt. Patrick Erbacher.

Finally, the MST has been successful due to the hard work of the program management and staff. Randy Okon, followed by John Petroff as Operations Managers on the MFD side, and Terry Kendrick as the Program Manager with PHC have provided invaluable guidance and worked indefatigably to get the MST off the ground successfully. Brad Davis, Assistant Chief of the Missoula Fire Department, Dr. Sarah Potts, PHC Director of Behavioral Health, Rebecca Goe, PHC Director of Innovations, Gretchen Neal, Missoula County Mental Health Coordinator, Theresa Williams, CIT Program Manager, and Sergeant Ben Slater, Missoula Police Department, also provided direction and feedback on early operations issues for the MST. The clinicians, EMTs, and Case Facilitator have done an incredible job of serving the clients, building relationships with community partners and navigating the challenges of a new program.

Program Description

The MST provides mobile consultation, screening and brief intervention to individuals in crisis stemming from a behavioral health related issue. The purpose of the MST is to rapidly respond, effectively screen, and provide early intervention to help those individuals stabilize in the least restrictive setting and to ensure their entry into the continuum of mental health care at the appropriate level through follow-up by the Case Facilitator.

The primary goal of this program is to provide the right care in the right setting to people experiencing behavioral health emergencies, drawing on the expertise of PHC and MFD. A secondary goal is to reduce the time and resources Missoula first responders spend addressing situations where behavioral health is a chief concern and to decrease the number of arrests and emergency room visits.

In the grant proposal for this pilot program, the Missoula Fire Department (MFD) and Partnership Health Center (PHC) listed the following goals for the unit:

1. Create a Cohesive Approach to Mental/Behavioral Health in Missoula
2. Ensure all of the Available Resources Are Working Together to Meet the Needs of the Community
3. Provide a Mobile Response to Acute Mental Health Crisis and Behavioral Emergencies
4. Provide Resource Navigation and Follow Up for Persons in Need
5. Provide a Workload Reduction for Law Enforcement and Fire/Medical
6. Provide Jail Diversions
7. Provide Hospital Emergency Department Diversions
8. Offer a Cost Savings to Tax Payers
9. Collect and report process data, including measures for hiring, training, data collection, data reporting, meetings with stakeholders, and more

Funding for the MST began September 1, 2020, and the first MST unit responded to calls on November 16, 2021. The MST now operates 7 days per week, from 10:00 am to 8:00 pm.

MST Staff
The MST response unit is comprised of a licensed behavioral health clinician (LCPC, LCSW, Ph.D., Psy.D., etc.) or a Clinician-In-Training (pre-licensed clinician) employed by PHC and one Emergency Medical Technician (EMT) employed by MFD. The MST Case Facilitator is employed by PHC.

Clinician: The MST clinician provides behavioral health care in the field to stabilize patients in the least restrictive settings.

Emergency Medical Technician: The MST EMT responds to calls with the clinicians to provide an abbreviated medical evaluation, maintain scene safety and support the clinician in the field when requested.

Case Facilitator: The MST case facilitator follows up with individuals who had encounters with the MST to connect them with primary care, mental health care and social services. In addition, the case facilitator receives and triages non-emergency referrals from other first responders when the MST is not available.

Dispatch and Response

Calls to the MST are initiated via two pathways: A direct call from 911 dispatch, or a call from first responders currently on scene in which the first responders have determined the individual in question is experiencing a behavioral health related crisis. The MST also listens to dispatch via radio, and will attach themselves to a call if they hear certain key words or phrases like "mental health" or "suicide," etc. The MST does not respond to calls independent of law enforcement at this time.

The MST response units are dispatched and attached to calls via their assigned unit number. MST unit 181 is the primary response unit. On occasion, two units have been available to respond, and the secondary response unit is 182. The Operations Manager for the MST also has a unit number – 180 – and will sometimes respond with the MST, or will do street outreach.

Evaluation

Methods

This evaluation aimed to determine if the MST met their program goals during the pilot period (September 2020 – June 2021).

Using the language from the grant application, process and impact evaluation questions were written that asked if the MST achieved its goals in the pilot period. (Process evaluation determines whether program activities have been implemented as intended. Impact evaluation assesses short-term effectiveness in achieving program goals). Then, one or more measures were selected to answer the evaluation questions, and determine or estimate the success of the MST in meeting each goal.

Quantitative data were collected from the software platform New World, used by the Missoula Fire Department and other first responders, and IntakeQ, a secure data platform for logging clinician notes and follow-up information. Qualitative data were collected via interviews with MST staff, community partners, and via email request for comment.

Evaluation findings and data are organized below under the goals from the grant application.

Findings

Goals 1 and 2: Create a Cohesive Approach to Behavioral Health in Missoula and Ensure all of the Available Resources Are Working Together to Meet the Needs of the Community

These two goals are grouped together because the data and methods of evaluation for the two are similar. The team identified five measures to determine if the MST met these two goals:

1. The number of meetings that administrative staff and the case facilitator held with community partners (local hospitals, mental health centers, law enforcement and other first responders) to introduce and explain the MST, and to problem-solve and improve working relationships

2. The number of presentations that administrative staff made to other stakeholders (city and county agencies, social service agencies and elected officials) to introduce and explain the role of the MST
3. MST staff participation in local collaborative efforts to improve the behavioral health system and increase access to care
4. Documentation of gaps in the system through MST staff interviews
5. Interviews with community partners to identify strengths and challenges of the MST's interactions with partners' staff/agency

78 Meetings with Community Partners	**107** Presentations	**10** Community Collaborations

78 Meetings with Community Partners

For the MST to create a cohesive approach to behavioral health in Missoula and to ensure all resources are working together, the first step was to make sure that the community knew about the MST and to foster relationships with partners and other stakeholders. MST Managers Randy Okon, John Petroff, and Terry Kendrick held 72 meetings to introduce the MST, problem-solve, and improve working relationships. The MST Case Facilitator held 6 meetings bringing the total to 78 meetings with community partners.

107 Presentations

Randy Okon, John Petroff and Terry Kendrick gave 107 presentations to other stakeholders to introduce and explain the role of the MST.

10 Community Collaborations

Also important for developing a cohesive approach to behavioral health is participation in existing collaborative efforts to improve the system and increase access to care. The MST managers, Case Facilitator, EMTs and Clinicians participate in 10 different community collaborations that aim to improve the system and increase access, including:

- Crisis Intervention Team
- Strategic Alliance for Improved Behavioral Health
- High Utilizer/Complex Patients Meeting
- Frequent Users of Systems Engagement

- Missoula Hoarding Task Force
- Reserve St. Clean-up Task Force
- Justice Alliance for Behavioral Health
- Community Justice Coordinating Council
- Coordinated Outreach Team

Gaps in the Behavioral Health System

To ensure all available resources are working together to meet the needs of the community, it is important to identify what those needs are. The author of this report interviewed MST staff about the needs and gaps in the system they encountered in their work. Extensive research has been done on gaps/needs in the behavioral health system in Missoula County, and the observations of the MST staff mirror that research. Staff were asked "What are some of the gaps you have observed in the behavioral health system through your work with the MST?" Their answers were reviewed for themes and are listed below:

Poor communication between and within agencies	**Lack of available, affordable housing in Missoula**	**Few resources available after 5pm**
No place to take people besides the ED, especially if intoxicated	**"Difficult" clients aren't being served**	**Transition services are minimal or non-existent**
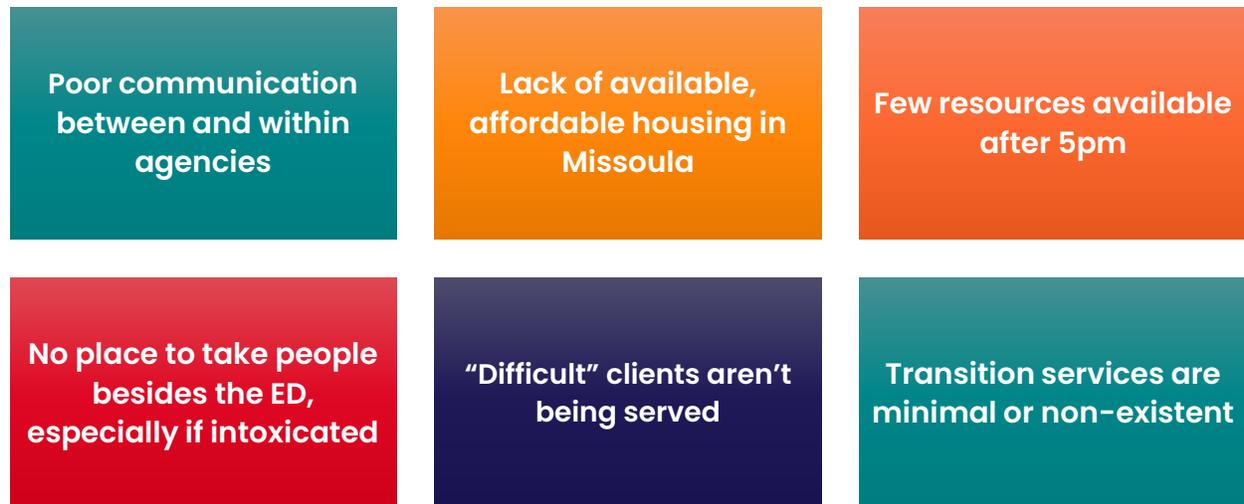
These gaps negatively impact the ability of service providers like the MST to provide the right care in the right setting, and to stabilize people experiencing a behavioral health crisis in the least restrictive setting. For example, it is difficult to divert people from the emergency room when there is nowhere else in the community that accepts people experiencing a crisis.

Community Partner Interviews

The MST is now a part of the behavioral health system in Missoula. To make sure the MST is working cohesively with the community, six partners who work closely with the MST were interviewed to identify strengths and challenges during MST interactions with community partner agencies. Interviewees included Lance Somerfeld with the Providence St. Patrick Hospital Emergency Department, Riley Jacobsen with the Poverello Center Homeless Outreach Team, Sergeant Ben Slater with the Missoula Police Department, April Seat with Hope Rescue Mission, Sherri Odlin with the Missoula 911 Center, and Theresa Williams with the Missoula CIT Program.

Due to the specificity of answers to each interviewee's particular program, themes among the answers were more difficult to identify. Their feedback was provided to MST managers, and the themes that were identified are listed below:

What has worked well during your agency/staffs' interactions with the Mobile Support Team?

- Open communication
- Ability to collaborate and work together
- Client hand-offs
- Availability of the MST
- General appreciation that this service exists, and recognition of how important it is

What have been some challenges?

- Understanding and defining the lane/role of MST in terms of calls they would go on, service provided, and how to reach them
- Referral and hand-off process

What suggestions do you have to improve the MST's interactions with your agency/team?

- Continue to improve communication through warm hand-off's, Slack, and stopping by/checking in with agencies.
- Clarify role of MST
- Keep participating in CIT and high utilizer meetings
- Continue to build relationships

What are 1-2 suggestions you have for increasing or improving MST's role/visibility in the community?

- Would like a direct way to contact the team, not through dispatch
- Increase community outreach
- Public relations to educate public about MST
- Expanded hours
- More communication between MST and other groups like coordinated entry system

Goal 3: Provide a Mobile Response to Acute Mental Health Crisis and Behavioral Emergencies

The team identified four measures to determine if the MST provided a mobile response to acute mental health crisis and behavioral emergencies. Those measures are:

1. The number of hours the MST was active and available to respond to calls
2. The number calls that the MST responded to
3. Client, disposition, and response information for each call for service
4. The number of unique clients, as compared to total client encounters

890 Available Hours

890 Available Hours

During the pilot period, the MST was active and available to respond to calls for 89 days, or 890 hours. The MST was actively responding to calls for 434 hours, 23 minutes, and 13 seconds, or 49% of the time. This is a high percentage of active response time, considering time is needed for shift preparation, training, problem-solving tough situations, participating in collaborative community efforts, and reporting/documentation. For comparison, the Missoula Fire Department has a response unit out on calls 30-40% of time, and they are staffed 24 hours a day.

537 Responses

537 Responses

The MST went on 537 calls during the pilot, including responses by units 181, 182, and 180. Those responses included calls that MST units were dispatched to via 911, calls that the units attached themselves to, and a small number of calls and outreach efforts that did not dispatch through 911. Average call time was 48:36.

Of those 537 calls, 496 resulted in an encounter with a client(s), and 41 resulted in no encounter with a client (includes calls where the team was staged in the area and then cancelled, or arrived on scene and the client was gone, etc.).

The MST has seen an increase in calls over time. The increase in calls is demonstrated below:

Number of Calls for MST* During Pilot

Month	Calls
November	26
December	50
January	18
February	55
March	48
April	91
May	105
June	107
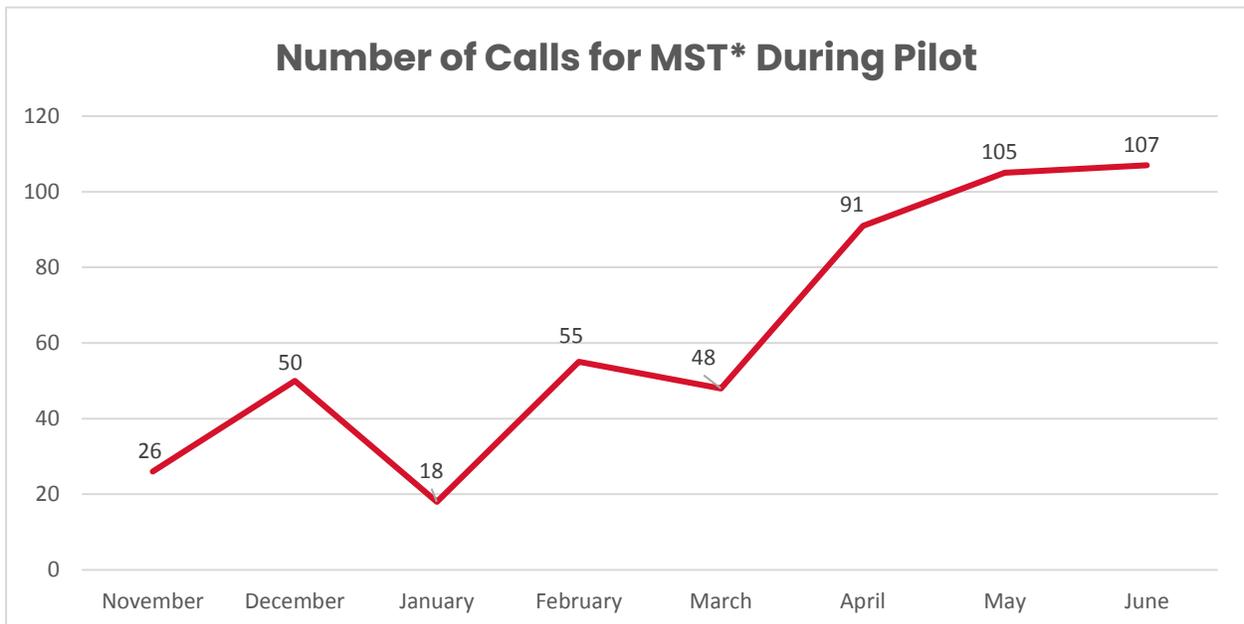
*Number of calls for unit 181

Response Data

Call Types

Calls to 911 are classified as a "call type." The 911 Center provided a summary of the types of calls to which the MST was dispatched. During the pilot, the 911 center dispatched the MST to 594 calls. However, that number includes calls that were canceled enroute, and do not include call types for calls to which the MST self-attached, or outreach efforts. Thus, the call type data from 911 provides a good representation of the types of calls MST responds to, but not an exact account.

Call types, counts, and percentage of all calls are listed below:

Call Type	Call Count	Percentage of all calls
Assist Fire	15	2.53%
Assist Law Enforcement	105	17.68%
Disturbance	10	1.68%
Emergency Evaluation	61	10.27%
Follow-up Investigation	12	2.02%
Medical Call ALS*	13	2.19%
Medical Call BLS*	46	7.74%
Medical Standby BLS*	35	5.89%
Medical Transfer	31	5.22%
Person Needs Assistance	82	13.80%
Person to be Removed	12	2.02%
Public Assistance (Fire)	13	2.19%
Suicidal Person	46	7.74%
Welfare Check	41	6.90%
Other	72	12.12%
Total	594	100%

*ALS: Advanced Life Support; BLS: Basic Life Support

Location of Response

Location of response data presented here is for MST unit 181. Location categories are named as identified in New World.

Location of Response	Call Count
Crisis Stabilization Facility*	16
Emergency Room	7
Other	49
Phone Call**	24
Private Residence	148
Public Location	222
No contact with client	35

Location of Response

- Crisis Stabilization Facility
- Emergency Room
- Other
- 1021 Phone Call
- Private Residence
- Public Location
- No Contact with Client
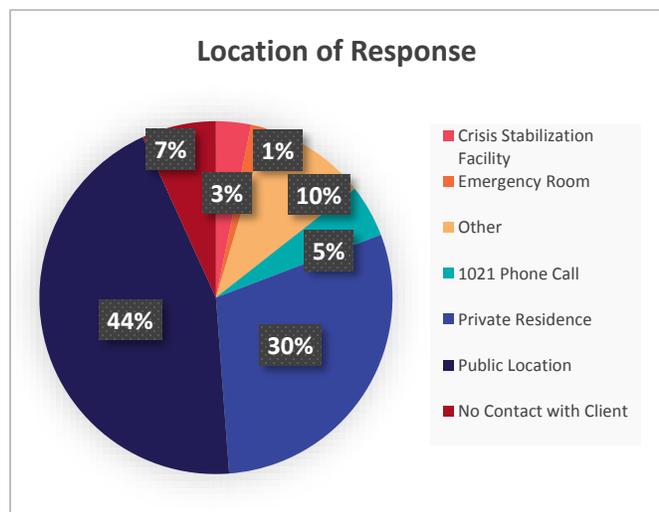
*Dakota Place
**The MST sometimes responds via phone call at the request of 911 dispatch.

Call Disposition

Call disposition is the outcome of a MST response. Disposition data is presented here for all 537 MST responses. Sixty-eight percent of encounters resulted in the crisis being resolved and the client remaining in the community.
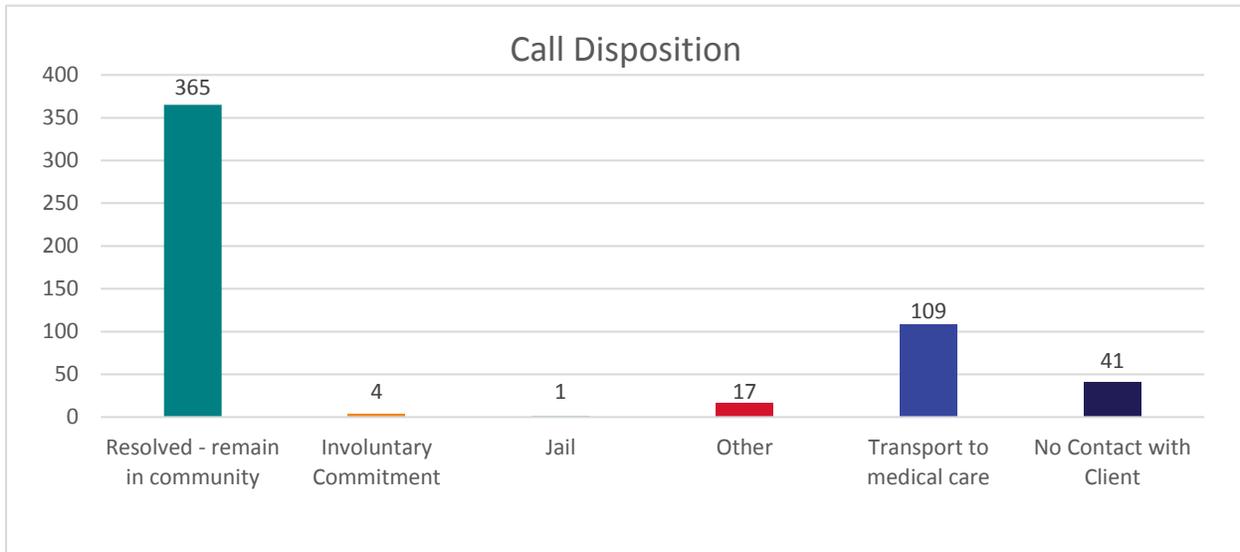

Client Demographics

Client demographics are presented here for each unit 181 call/encounter (500 total calls), and compared to demographics for unique clients where possible.

Out of the 537 responses, the MST units met with 290 identifiable unique clients. "Unique clients" are unduplicated clients, and do not include client encounters with unknown identities, nor responses where the client was named in New World (the software platform used by first responders) but the MST did not interact with the client. The number of unique clients reflects a clean-up of the data to exclude clients listed more than once with a slight misspelling of their name, or clients listed separately with and without a middle name, etc. Not all data points were available for every call, or for each unique client.

Gender

Gender by Encounter	Call Count
Unknown	7
No contact w/client	35
Man	229
Non-binary	7
Transgender Woman	5
Woman	217
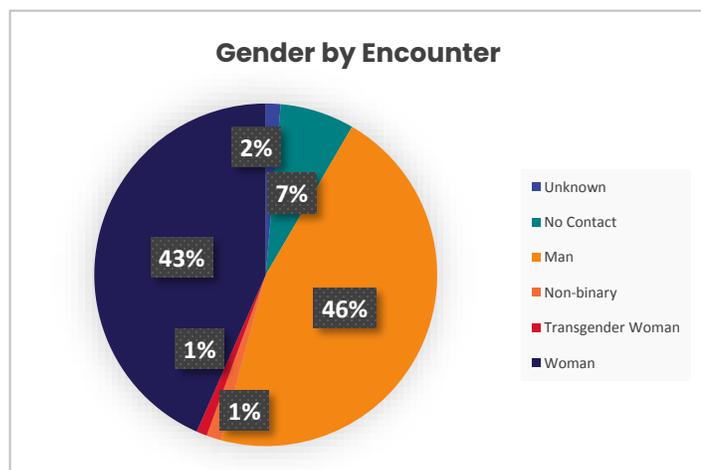
Gender by Unique Client	Call Count
Unknown	6
Man	139
Non-binary	3
Transgender Woman	3
Woman	139
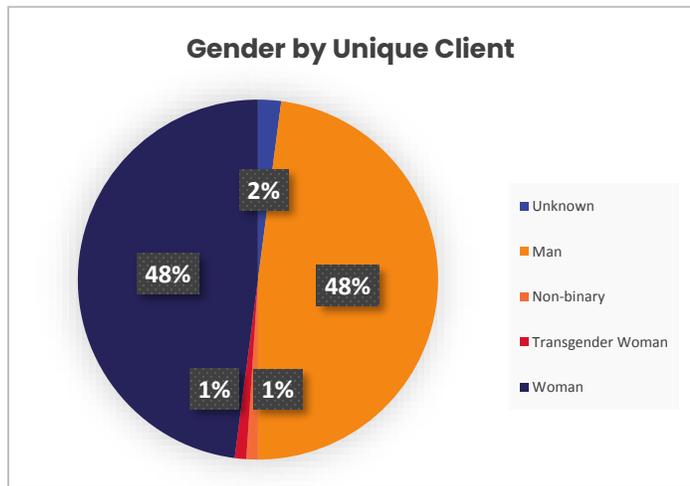
Race

Categories for race are included as recorded in New World.

Race by Encounter	Call Count
Other/Unknown	114
African American	8
Caucasian	283
More than one race	35
Native American	25
No Contact w/Client	35
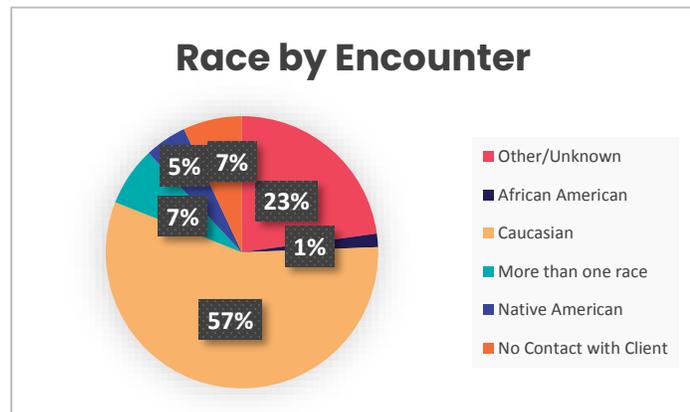
Race by Unique Client	Call Count
Other/Unknown	91
African American	8
Caucasian	163
More than one race	9
Native American	18
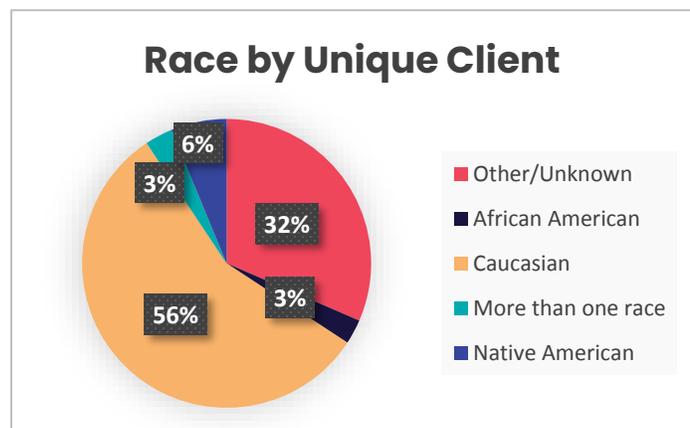
Age

Birthdate data are not available for all encounters or for all unique clients. For those clients we have birthdates for, the average client age is 47. Median client age is 45.

| Age	Number of Clients
10-19	18
20-29	34
30-39	30
40-49	40
50-59	40
60-69	28
70-79	18
80-89	12
90-99	4
Unknown	66
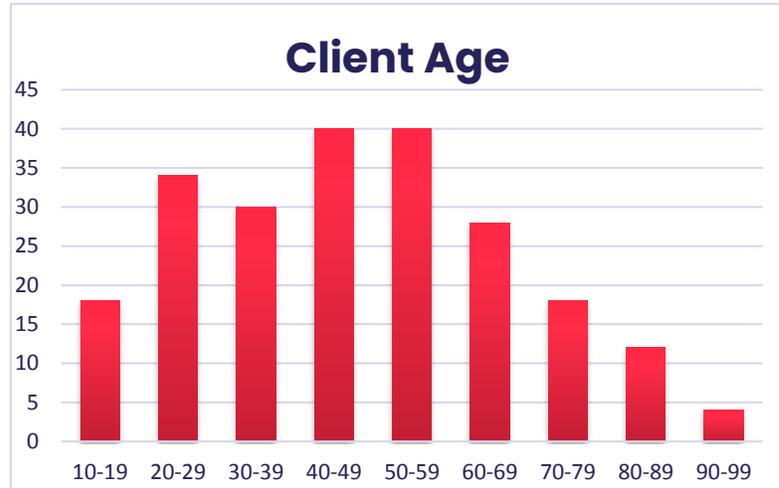
Housing Status

Housing status is recorded by category in New World. Categorized data for MST responses is below, as well as simplified housing status data that combines the New World categories. Many of the MST's unique clients have different housing statuses reported during separate encounters therefore unique clients' housing status is not presented. Current housing status for the MST's frequent utilizers can be found in the next section.

Categorized Data

Housing Status by Encounter	Call Count
Crisis Stabilization Facility	11
Foster Home	3
Group Home	9
Homeless - couch surfing	16
Homeless - shelter	35
Homeless - street	107
Living in house/apt	158
Living independently	21
Other/Unknown	105
No Contact with Client	35
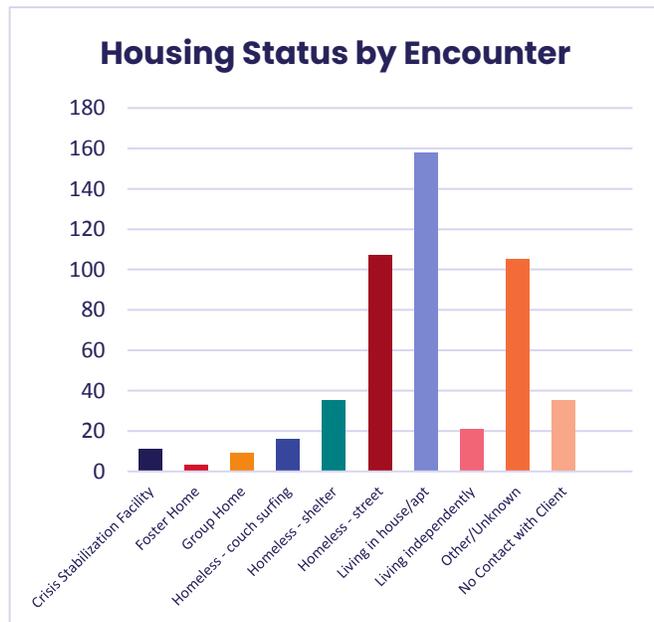
Simplified Data

Housing Status by Encounter	Call Count
Housed	202
Unhoused	158
Other/Unknown	105
No Contact with Client	35

Housing Status by Encounter

- Housed — 40%
- Unhoused — 32%
- Other/Unknown — 21%
- No Contact with Client — 7%
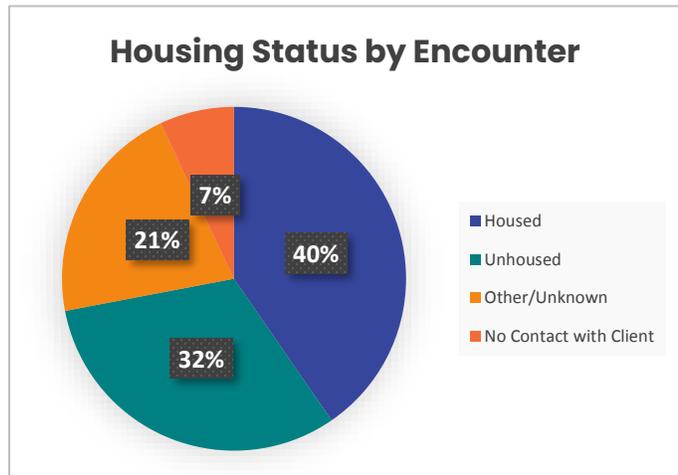
Frequent and Super Utilizers

In the evaluation plan, "frequent utilizers" were defined as those clients with 3 or more calls during the pilot period. However, not all frequent utilizers actually required much of the MST's time, despite frequency of calls. During this evaluation, it was recognized that the MST also has "super utilizers" of services – those clients who have 3 or more calls and 4+ hours dedicated to their case by MST staff. Given this, more detailed information is presented here for the super utilizers.

29 Frequent Utilizers
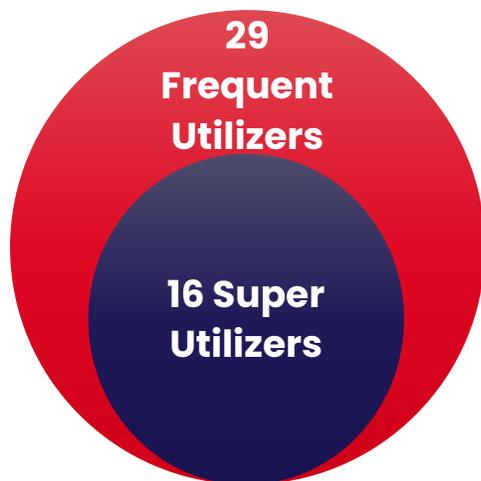
16 Super Utilizers

**Frequent Utilizer = 3+ calls to the client during the pilot period**

Super Utilizer = 3+ calls to the client AND 4+ hours dedicated to their case

The MST had 29 frequent utilizers (includes super utilizers) during the pilot period. One hundred and forty-eight of the calls unit 181 responded to were for frequent utilizers.

The MST had 16 super utilizers during the pilot period. These clients accounted for 103 of 500 calls to unit 181. The MST response units spent 87.76 hours (20% of response time) with them, and the Case Facilitator spent 139 hours on follow-up, for a total of 226.76 hours spent, and an average of 14.17 hours per client (compared to an average of 1.9 hours for all clients). The chart below compares the hours spent per client between the MST response units, Case Facilitator, and in total.

16 Super Utilizers → 103 Calls → 20% of Response Time → 139 Hours of Follow-Up → 227 Total Hours Spent

Hours Committed to Super Utilizers
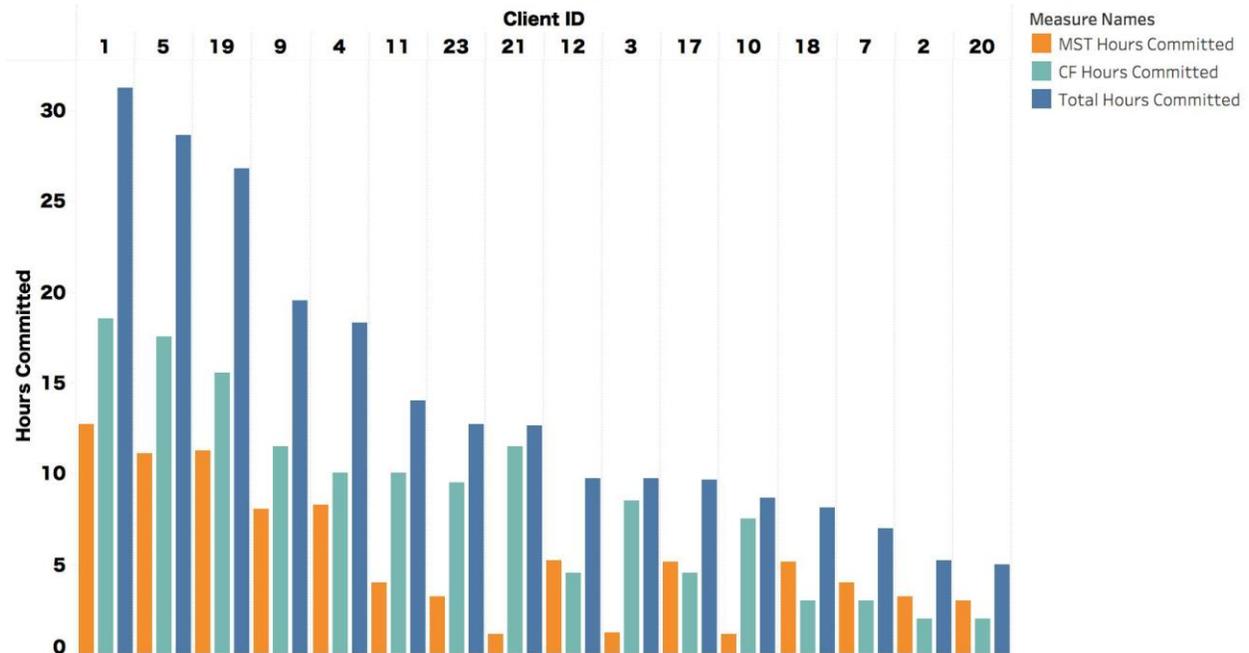
Graph Credit: Alana McCreery

Ten of the super utilizers were unhoused (63.5%), and 6 were housed (37.5%). The chart below displays the housing status of super utilizers compared with the number of encounters with MST response units.

Housing Status of Super Utilizers Compared to Number of Encounters

Graph Credit: Alana McCreery

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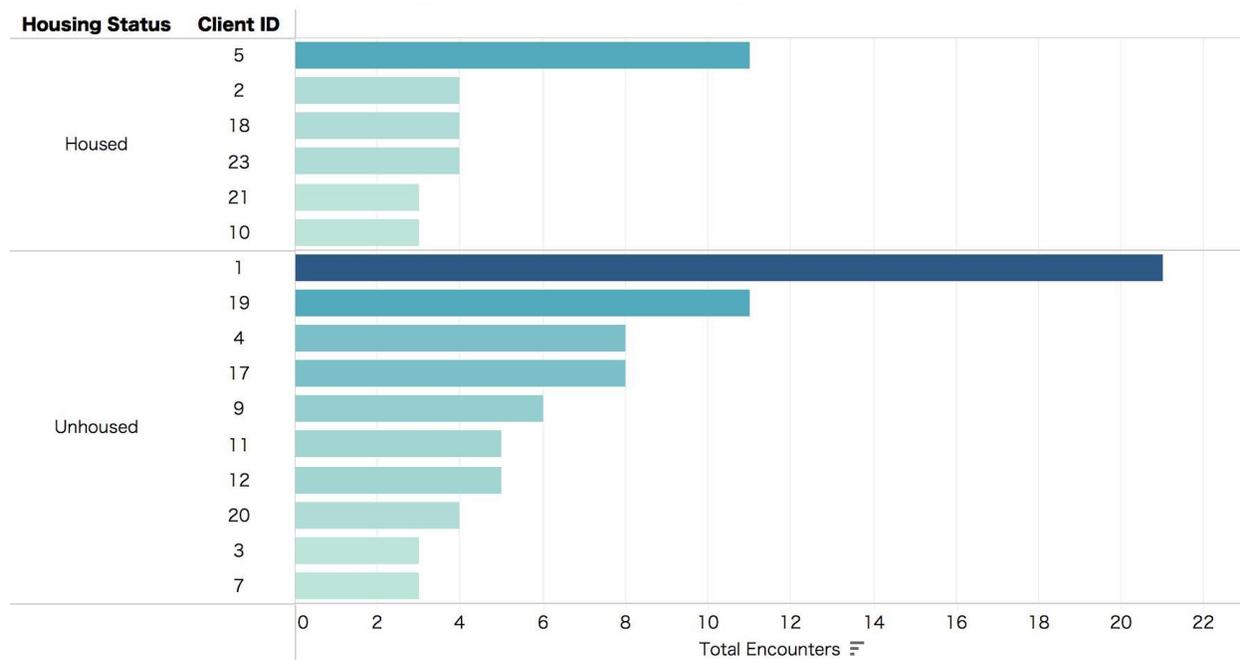
<u>Goal 4:</u> Provide Resource Navigation and Follow Up for Persons in Need

The team identified three measures to determine if the MST provided resource navigation and follow up for persons in need:

1. The total number of follow-up calls made by the Case Facilitator, including to a client's primary care, behavioral health, or case management provider
2. The number of contacts made during those calls, including direct client contacts, and collateral contacts
3. The number of MST clients who established care at PHC after interacting with the MST

895 Follow-up Calls	712 Contacts Made	21 Clients Established with PHC

895 Follow-up Calls

The MST Case Facilitator's role includes resource navigation and follow-up. To meet that need, the Case Facilitator made 895 total calls to 183 unique MST clients, and to clients' primary care/behavioral health providers, family members, case managers, and other relevant contacts.

712 Contacts Made

During those 895 calls, the Case Facilitator was able to speak with either the client or collateral contact 712 times. Eighty-nine of those calls were with clients, and 623 of those calls were with clients' primary care and behavioral health providers, family members, case managers, and other relevant contacts.

21 Clients Who Established Care at PHC

After interacting with the MST Case Facilitator, 21 of 183 unique clients chose to establish care at PHC. Some of those clients interacted with the MST multiple times before establishing care. Sixty-eight clients were already patients at PHC before interacting with the MST. The Case Facilitator offers clients in need of primary or behavioral health care a variety of provider options within the community.

Issues Discussed with Clients

During follow-up calls, the Case Facilitator discussed a number of issues with clients. The four main issues were mental health service needs, medical health service needs, housing, and physical safety. The chart below displays the number of times each issue was discussed.

Issues Discussed with Case Facilitation Clients
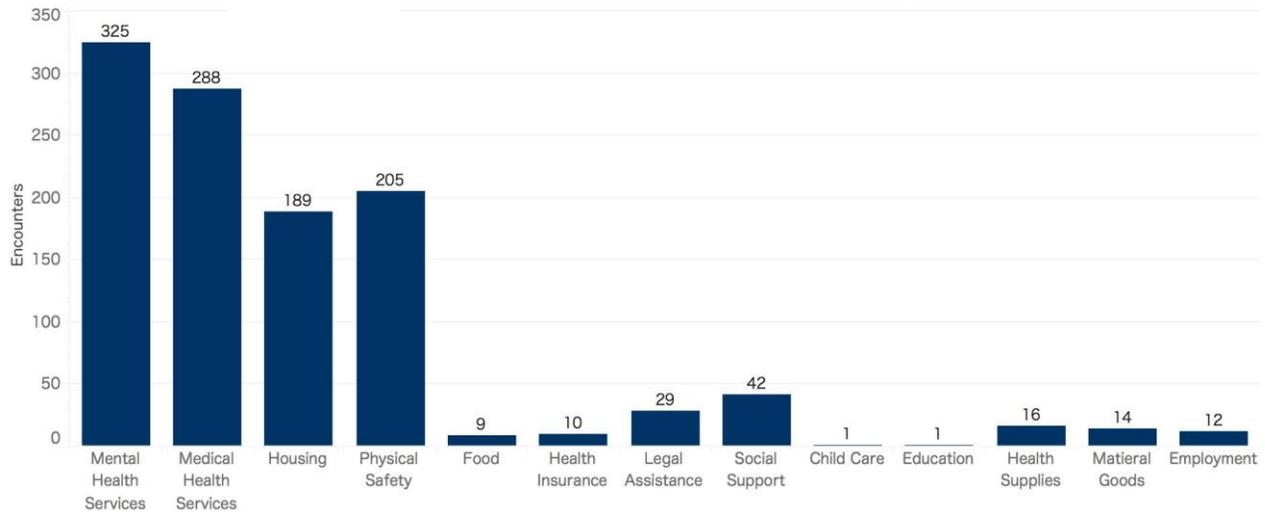
Graph Credit: Alana McCreery

<u>Goal 5</u>: Provide a Workload Reduction for Law Enforcement and Fire/Medical

The team sought feedback from responders to determine if the MST provided a workload reduction for Law Enforcement and Fire/Medical. A more exact measurement of workload reduction would require data that was unavailable for this evaluation.

Officers had mixed opinions about workload reduction. One Missoula Police Department sergeant observed:

"I would say early-on I was concerned about utilization, their role in our crisis situations, and follow-up afterwards. The last couple of months, however, things seem to be "gelling" much better…I believe we're turning the corner on these teams, making a positive difference on how involved we remain on crisis-type calls, freeing us up for more appropriate law enforcement type activities."

From another MPD officer:

"The MST has been great to work with. They are very helpful as another resource to mental health calls once it has been determined there are not current safety issues. It's great to get their professional insight on how to proceed and what is best for the person. They also frequently take over the call for service and take the person and transport them to a higher level of care. For phone calls, they often take them if they are mental health related."

However, another officer noted:

"They are invaluable for what they do, but that does not mean that they have lightened our workload at all. The amount of time officers have to spend on these calls now has at least tripled. They have to respond, then call for and wait for 181 [MST], then stay there while 181 does their thing. They are a valuable resource, but the only way they will ever "lighten" our work load instead of doing just the opposite is to respond to mental health calls without law enforcement."

16

Given that the MST was a pilot project, it is likely that workload reduction will become more clear over time, as first responders and the MST build trust and become more accustomed to working together, and MST staff gain experience.

Despite the differing opinions about workload reduction, first responders clearly feel that the MST is invaluable. They were very happy to have the MST, expressed gratitude, and reiterated how valuable the MST is as a resource:

"I've seen this crew work their hinies off while I'm left to feel guilty. They integrate incredibly well with us and I really hope that this cooperation continues. I've had a few [calls] lately that the result was far better than the old days…I appreciated the peace of mind is what I guess I'm trying to say."

"My opinion is they have been invaluable. I'd like to explore ideas on how to grow their role even more."

"I just wanted to pass along my gratitude for the teams. My shift usually always overlaps a team and as patrol sergeant they have greatly increased the effectiveness of mental health responses. I know both my officers and myself greatly appreciate the work the teams are doing and from my perspective, there have been many times where the MST team has allowed for a much better resolution than my officers would have been able to reach themselves."

"I think the "trial" period or whatever to test the Team's effectiveness has been a complete success. I have experienced complete cooperation and team work working with the MST, plus they are pleasant, professional and fun to work with. I think the combo response to address Missoula's incidents of crisis, mental health related calls, homelessness and other support needed has greatly benefited our community."

Goal 6: Provide Jail Diversions

13
Jail Diversions

To measure jail diversions, the MST clinicians and EMTs were asked to use their best judgment to identify encounters that were jail diversions, i.e. situations where the client would or could have been taken to jail if the MST had not responded. They identified 13 total jail diversions. They did take into account COVID-19 restrictions on jail admissions for misdemeanor offenses. This number would likely be higher in a non-pandemic period.

Goal 7: Provide Hospital Emergency Department Diversions

169
ED Diversions

To measure emergency department (ED) diversions, the MST clinicians and EMTs were asked to use their best judgement to identify encounters that were ED diversions, i.e. situations where the client would or could have gone to the ED if the MST had not responded. They identified 169 total ED diversions.

Goal 8: Offer a Cost Savings to Tax Payers

Calculating cost savings presents a challenge in such a short pilot period. However, two measures were identified to *estimate* how much the MST may have saved tax payers:

1. The average cost of a behavioral health visit to the ED multiplied by the number of estimated ED diversions
2. The estimated cost savings from jail diversions

$251,400 Estimated ED Diversion Savings	The average behavioral health visit to the St. Patrick Hospital ED in 2019 cost $2,049. 72.6% of those behavioral health ED visits were paid by Medicaid or another gov't source. The MST recorded 169 ED diversions. Multiplying MST ED diversions by the average cost of a behavioral health ED visit, and then by the percent of those visits that would likely by paid by a gov't source allows an *estimate* of $251,400 in ED diversion savings for tax payers.
$1,534 Estimated Jail Diversion Savings	The cost of a one day stay at the Missoula County Detention Facility is $118. The MST recorded 13 jail diversions. Multiplying MST jail diversions by the cost of one day in jail allows an *estimate* of $1534 in jail diversion savings for tax payers.
$252,934 Estimated Total Cost Savings to Tax Payers	Combining the estimated ED diversion savings and jail diversion savings resulted in $252,934 in estimated total savings for taxpayers.

Cost Savings Data Limitations

All cost savings estimates are necessarily limited by the amount of available data. For example, behavioral health ED visits may cost more or less than average depending on time spent in the ED and services received. Jail diversion cost saving estimation is likely low, as jail stays are often longer than one day. Data does not exist for average cost for jail stays for people with a behavioral health diagnosis, and that data would be necessary for a more accurate estimate of cost savings for tax payers. This also does not include the cost of discharge, court fees, etc.

Additionally, the preventative work the MST, and particularly the Case Facilitator, will likely result in significant long-term cost savings. However, the cost savings of preventative work is particularly hard to measure. Public health and medicine recognize the value of prevention: catching a disease early or preventing its onset results in more successful treatment and fewer long-term costs. Connecting clients to resources, like mental health care and housing, will likely reduce costs to tax payers in the long term, but tracking those savings was beyond the scope of this evaluation.

Finally, cost savings is only one way to measure the value of a program. The need for an alternative way to respond to behavioral health crises is evident, both in our community and across the nation. The MST's community partners recognize that this program is important and takes a vital step in re-structuring our behavioral health system. If the MST is meeting a need and providing a necessary service, cost savings is important to consider, but should not be the end-all, be-all consideration for continuing the program

Goal 9: Collect Process Evaluation Data

In the grant proposal, PHC and MFD also proposed to conduct process evaluation during the pilot period. The results of that process evaluation are below:

First Month

- MOU between MFD and PHC completed
- MFD provided 2 vehicles (including Insurance, Maintenance, and Fuel) for the program
- Met with County Criminal Justice Services Division to establish collection and reporting of data through New World

Months 2–10

- Enhanced existing policies and procedures to establish guidelines/protocols for the Mobile SupportTeam
- Facilitated meetings with key stakeholders identified in the RFP. This continued for first 4 months
- Began invoicing Missoula County for services rendered. This has occured monthly throughout the pilot
- Worked with funding agency to establish metrics and data collection reporting requirements
- Hired personnel
- Provided training for personnel
- Purchased team uniforms – team elected to wear jackets not uniforms
- Started providing services Nov. 16
- Conducted strategic goal session with MST related PHC and Missoula Fire leaderrship
- Expanded to 7-day coverage

Month 10

- Created a final report including number and types of calls, estimated cost savings, workload reductions, diversions, demographic infomation about clients, frequent utilizers, and follow-up
- Pursued funding for continuation of program

Mobile Support Team Staff Interviews

As a part of the process evaluation, the team interviewed MST managers and staff to get feedback on successes and challenges during the pilot period. Themes from those interviews are presented below.

What has worked well for the MST?
- Using IntakeQ has improved communication
- Team cohesiveness
- Quality staff
- Clearly defined roles for different staff
- Having one person to go to, one manager
- Partnership between PHC and MFD
- Active involvement and commitment from community partners, particularly MPD and 911
- Our ability to be flexibile

What has gone well for you personally?
- Relationships within the team, and with community partners
- Having clear role expectations for staff and management
- The flexibility
- Proud of the program and the ability to help people in new ways

What have been the challenges for the MST?
- Data collection and reporting – double documentation, not having IntakeQ initially, no shared software access for EMTs and clinicians, continued changes in data procedures
- Staffing – particularly early on, getting the right people
- Managing community expectations
- Knowing where our lane is – what is the MST's job, and what other agencies should be doing
- Being accepted and utilized by community partners
- Meshing culture of PHC and MFD
- Early inconsistency in leadership – too many cooks in the kitchen, unclear roles
- Structural challenges around case facilitation role – difficult to reach many clients, need clear and realistic expectations for that role
- Van isn't accessible

What have been the challenges for you personally?
- Communication, both within the team, and with supervisors
- Unclear expectations for positions
- Staffing – both having appropriate staff, and having enough staff that people can take time off
- Professional challenges of learning new roles/expanding skill sets

What are 1-2 changes you would make to the program?
- Get an accessible van
- An administrative system that allows both clinicians and EMT's to enter/see data in the same place, get rid of double documenting to increase efficiency
- 24-hour coverage
- Increased staff – more EMT's, another case facilitator, a data person
- Be able to be directly dispatched, not through co-response model

Any additional comments?
- Proud of the work we do!
- The data issue is a big deal and needs to be addressed

Conclusion

The Mobile Support Team succeeded in meeting the goal of providing the right care in the least restrictive setting to community members with behavioral health needs during the pilot period, and this evaluation demonstrates that they successfully met the goals outlined in the grant application, where sufficient data was available.

It's important to remember that the statistics in this evaluation represent the lives of people who were in distress. For the MST, "meeting its goals" means Missoula community members were able to stay in their home or in the community instead of going to the Emergency Department or to jail. It means unhoused community members were connected to housing resources and medical care, elderly people were connected to social supports, and students were connected to needed mental health services. The value of these preventive services, while difficult to measure, represent a forward step for Missoula toward an accessible, equitable behavioral health crisis care system.

Limitations

This evaluation has some limitations.

1. Data collection was a challenge during the pilot period. The determination of what data to collect about each client is still evolving, and as a result, some data that would have been useful in evaluation was not collected. Of the data points chosen, not all points were collected for every client. In some cases, this was due to human error, and in other cases due to the nature of the MST's work. Not every client will provide all of the personal information requested, and not every client encounter is long enough to collect all the data desired.
Double-documentation is also a limitation. Due to program restrictions within the MFD/PHC partnership, MST call data is collected on two separate platforms. Double-documenting led to some discrepancies.
Additionally, duplicate data had to be identified and eliminated, and it is possible that some duplicates were missed. The data was carefully examined, but it is possible that one or two duplicates were missed.
Finally, the evaluator did not have access to either software platform used by the MST, and had to rely on data as it was provided. Thus, it is possible that there are errors in the data the evaluator was unable to identify.
2. The goals of the MST, as written in the grant application, were difficult to measure precisely, and thus required estimations in many cases.
3. The pilot period for the MST was short, and took place during a global pandemic. Given this, a longer time frame for evaluation should be considered to better evaluate the program.
4. The outcomes of preventative programs like the MST are challenging to measure, and were not within the scope of this evaluation. Tracing long-term client outcomes back to a successful prevention effort is tenuous at best and causation often cannot be definitively established.

Recommendations

The following recommendations are provided as a result of the evaluation process:

Data collection issues should be resolved. If possible, data should be collected on a single platform. Data points collected for each client should be reexamined for relevancy and completeness, and a more concerted effort made to collect all data points. Duplicate data should be eliminated from New World prior to populating the custom field report used for data analysis.

Communication and close coordination with community partners should continue, and improvement in relationships continuously pursued. The MST is already seen as a vital component of the crisis continuum in Missoula. Every stakeholder and community partner who provided feedback during this evaluation process expressed gratitude that the MST exists, and their hopes for continued collaboration.

Consider methods to decrease first responder work load, and methods to effectively measure that decrease. This includes ways to more quickly release officers from the scene, and identifying types of calls or ways to for the MST to respond independently, without law enforcement or other first responders.

Staffing for the program should be increased to ensure adequate coverage, and to allow for program expansion. The MST should have enough staff to provide coverage for current operating hours, while also allowing staff to take time off. Additional staff would also allow for program expansion, including expanded hours of service, and expanded follow-up services.

If you have questions about the Mobile Support Team, please contact John Petroff, Operations Manager, at 406-830-4302, or Terry Kendrick, Program Manager, at 406-459-9440.

If you have questions about this report, please contact Gretchen Neal, Missoula County Mental Health Coordinator, at 406-258-4390.