SUBJECT: *Community Engagement Teams*

DATE: *December 15, 2016*

TO: ABCGC: Subcommittee on *Subcommittee on Prevention, Intervention and Harm Reduction and Crisis*

FROM: *UNM-ISR Staff*

**Problem Statement:**

A method is needed to connect and serve people in need of sub-acute mental health services. People need mental health services because of an inability or reluctance to seek services themselves.

**Executive Summary:**

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| Proposed Intervention: | Community Engagement Team |
| Target Population: | Currently, the target population for the CET cannot be definitively established. The possible population of people who may benefit from CET services can be broadly estimated using data provided by the Substance Abuse and Mental Health Services Administration (SAMHSA). SAMHSA estimates the prevalence of people in Bernalillo county with mental health problems in one year is approximately 136 people per 1,000 aged over 18 per one year (SAMHSA, 2014). |
| Outcomes of Interest: | CET should address a series of questions:   * Does sub-acute care lessen contacts with public acute mental health services? * Does sub-acute care produce positive outcomes for people with a mental illness (Dench et al.,2008)? * Possible outcomes may include: reduced contacts with emergency hospital and psychiatric services, * Reduced contacts, use and length of stay at inpatient mental facilities and jail, * Reduced client rates of participation in outpatient pre and post CET, * Comparison of unexpected events after CET contact, e.g., self-harm, violence to others, homelessness, contact with the police, * Changes in the client’s quality of life (i.e., measures through an assessment of coping strategies; reduction in utilization of emergency departments and higher levels of care; keeping people safe from suicide or other violence, or contacts with law enforcement or the criminal justice system; sustained participation in treatment), * Measures of cost- effectiveness, * Satisfaction among clients, families, and program staff. |
| Evidence Base: | Studies of Crisis Response/Home Treatment Teams (CRHT) found a lower probability of being admitted to hospital and reductions in admission rates*.* An Australian report cited that there was an overall decrease in acute bed usage following the adoption of the CRHT model (Johnson, 2004). An English report found no evidence that the British CRHT policy per se had made any difference to admissions in mental health facilities (Jacobs and Barrenho, 2011). While the CRHT model made no impact on admissions it is may be a cost neutral method of delivering services.  According to the literature, peer support services have some benefits for consumer’s admission rates to psychiatric hospitals and community tenure, empowerment, social support and social functioning, empathy and acceptance, and reducing stigma. Some randomized controlled trials comparing the employment of peer support workers with care as usual or other case management conditions report either improved outcomes or no change. |
| Description of Intended Program: | CET is a team of professionals and quasi-professionals capable of assisting people who voluntarily want mental health assistance, are not in acute crisis, and do not require immediate hospitalization. CET targets people who are having a sub-acute mental health episode. Sub-acute mental health care refers to care for a person who is either becoming acutely psychiatrically unwell (whether or not they have previously been acutely mentally ill) or who is recovering from an episode of acute psychiatric illness (MHCH, 2011) The team offers clients practical support, and short term intervention at home. Clients have opportunities to talk through current problems with team staff, in addition to brief interventions aimed at increasing the persons’ problem-solving abilities and activities of daily living skills. The team refers clients and follows up to see if clients connect with referrals. Also CET provides clients and interested people with education about mental health problems for clients and their social network. |
| Preliminary Budget: | $1,000,000 |

**Recommendation to the ABCGC:**

The ABCGC Subcommittee on *Prevention, Intervention and Harm Reduction and Crisis* recommends that Bernalillo County and the City of Albuquerque take steps to expand *services to people that have sub-acute mental health needs* as described in the *Community Engagement Teams (CET)* Project Proposal.

**SECTION 1: Problem Identification**

Problem Statement:

A method is needed to connect and serve people in need of sub-acute mental health services. People need mental health services because of an inability or reluctance to seek services themselves.

Problem Description:

Bob, a 25-year-old man, lost his job, his friends feel he is depressed. Never having had a mental health episode, Bob is leery of contacting his doctor or the local mental health hospital for help. Last night, Bob’s well-meaning neighbor called 911 expecting to talk to a mental health professional. Instead, the police arrived at Bob’s house. After a very uncomfortable conversation with Bob, the police take him to the local mental health hospital.

The Lopez family had been concerned about their daughter’s behavior for almost a year. Alice was shy and quiet, she seldom left the house and seemed depressed. On several occasions her parents had thought of calling someone for help but they were afraid their daughter would have to go to a hospital and they already had hospital bills. No one seemed willing to come to their house to check on their daughter.

After several months in the hospital Alice was released. She felt a lot of stress – at home would she be able to use the coping skills she learned in the hospital?

Leaders in the development of early intervention services agree on several principles:

* Admission to mental health hospital has harmful as well as therapeutic effects, is unacceptable to many patients and carries a heavy stigma (Rose 2001). It should therefore be avoided whenever possible.
* Crises have important social and environmental triggers (Polak 1970). Addressing issues early in the home allows these to be better addressed.
* Coping skills are most effectively applied in the context in which they have been learnt (Stein 1980). Thus, after home treatment, patients are more likely to be able to apply skills learnt to pre-empt or reduce the severity of future crises.
* Relationships between patients and professionals are different and less dominated by inequalities of power when crises are managed in the patients’ own homes (Mezzina 1995).

According to the federal Substance Abuse and Mental Health Services Administration (SAMHSA) New Mexico has higher rates of mental illness, serious mental illness and suicide than national averages (NM LFC, 2014). SAMHSA estimates among adults in Bernalillo county an average of 20.2% experienced a diagnosable mental, behavioral, or emotional disorder in the past year. Additionally, SAMHSA estimates that 6.8% of adults in Bernalillo county had a major depressive episode in the past year (SAMHSA, 2014).

There may be many reasonable causes including, experiences of poor mental health services, lack of access, or concerns about stigma. Some mental illnesses can include a lack of insight or symptoms that are obstacles to seeking treatment. For people living with mental illness voluntary treatment is preferable (NM House Memorial 45 Task Force, 2012).

New Mexico Legislative Finance Committee. (2014). Results First: Adult Behavioral Health Programs. Found online at: https://www.nmlegis.gov/lcs/lfc/lfcdocs/resultsfirst/Evidence-Based%20Behavioral%20Health%20Programs%20to%20Improve%20Outcomes%20for%20Adults.pdf

Polak P. (1970). Patterns of discord: goals of patients, therapists, and community members. Archives of General Psychiatry 23: 277–83.

Rose D. (2001). Users’ Voices: The Perspectives of Mental Health Service Users on Community and Hospital Care. Sainsbury Centre for Mental Health.

SAMHSA. (2014). Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2012, 2013, and 2014.

Stein LI, Test MA. (1980). Alternative to mental hospital treatment. I. Conceptual model, treatment program, and clinical evaluation. Archives of General Psychiatry 37: 392–7.

Mezzina R, Vidoni D (1995) Beyond the mental hospital: crisis intervention and continuity of care in Trieste. International Journal of Social Psychiatry 41: 1–20.

**SECTION 2: System Linkage Identification**

Currently in Bernalillo County the majority of mental health services offer outpatient care, case management, and recovery oriented services. Fewer services are available for crisis care, residential services, intensive outpatient services, and housing. Currently mental health services outside of the inpatient setting connect with people at the point of a crisis or most often in an emergency situation. The majority of services offered to outpatients deal with substance abuse problems. Private services are available but are expensive while public service providers are less costly but generally have a waiting list (UNM Dept. of Psychiatry et al.,2014).

Public providers such as the UNM Psychiatric Center Psychiatric Emergency Services (PES) offer psychiatric services in a 24-hour facility. Other providers utilize a mobile team concept, traveling to the client. These providers such as Assertive Community Teams (ACT) offer intensive outpatient services for extended periods of time. Other team providers especially those associated with the Albuquerque Police Department (i.e., Crisis Intervention Team “CIT”, and Crisis Outreach and Support Team “COAST”) fill a need for early responses in emergency situations. Providers located in facilities and mobile police crisis teams reach specific segments of the population that is either willing to go to a mental health facility for services or are involved in an emergency mental health situation. Yet another portion of the population is unable or reluctant to seek mental health services. These people are not willing to go to a facility such as PES and they are subacute in terms of the urgency of their mental health crisis. Thus they do not take advantage of the PES services and they do not come to the attention of the CIT or COAST.

Funding for intensive outpatient programs is expensive and consistent funding is difficult to acquire and difficult to maintain. Consistent funding for innovative team concepts is difficult to obtain and keep. Most teams are financed with public funds. Some teams are piloted using limited funding from grants-in-aid and later may acquire recurring government funding if they are shown to be successful or politically popular. The recent election and ensuing changes to Medicaid are difficult to identify at the writing of this proposal.

Programs and services such as PES, ACT, CIT, and COAST have found a niche in the community. They have access to funding, an adequate number of clients, and have been functioning long enough to be established in the community. New providers attempting to reach a segment of the population that is not being served by PES or the police teams, may initially need to connect with those teams to become established.

UNM Department of Psychiatry and Behavioral Sciences, UNM Center for Education on Policy and Research, and RWJF Center for Health Policy at UNM. (2014) Landscape of Behavioral Health in Albuquerque. Online at https://www.cabq.gov/council/documents/task-force-on-mental-health-documents/BHTF\_20141028CityProjectReportFinal.pdf

**SECTION 3: Target Population**

Currently, the target population for the CET cannot be definitively established. The possible population of people who may benefit from CET services can be estimated in a variety of ways. The broadest population can be estimated using population estimates of all people in the community with mental health difficulties. SAMHSA estimates the prevalence of people in Bernalillo county with mental health problems in one year is approximately 136 people per 1,000 aged over 18 per one year (SAMHSA, 2014).

More specific estimates can be derived from individuals contacting the NM Crisis Access Line (NMCAL)individuals who come in contact with APD’s Crisis Intervention Unit (CIU) and Crisis Outreach and Support Team (COAST), 911 calls that are for mental health that are not related to a crime, hospital emergency room and psychiatric emergency service contacts that do not require emergency treatment, and families and individuals who are seeking help. Currently data from all these sources either is not available or does not exist to provide an estimate. NMCAL handles approximately 1,400 calls per month statewide and approximately 35% of these calls originate in Bernalillo County. CET could respond to “routine calls” and likely handle “urgent calls.”[[1]](#footnote-1) We estimate this to be an average of 500 calls per month for individuals 18 years of age and older. People from both call levels may possibly seek a rapid response to an event from the CET.

Preliminary data from the UNM Psychiatric Center Psychiatric Emergency Services (PES) suggests that a segment of individuals who present to the PES or Psychiatric Urgent Care Center (PUCC) may be eligible for CET services. This primarily includes individuals who have a lower acuity level assessed upon arrival. In discussions with PES staff, individuals who present with a Level I or Level II acuity level and who are not eligible for PES services may be eligible. Table 1 provides an estimate for Level I and Level II clients.

The estimate shown in Table 1 is the average number of individuals by each time period (calendar year 2015 and January 2016 – October 2016) and the average number of individuals for the entire time period who were assessed by PES as being Acuity Level I and Acuity Level II. Based on our review, for the time period of January 2015 through October 2016 there were an average of 18.1 individuals per month assessed as Acuity Level I and 30.1 individuals per month assessed as Acuity Level II.

Table 1 – PES Acuity Level

|  |  |  |  |
| --- | --- | --- | --- |
| **Acuity Level** | **2015** | **2016 (thru October)** | **Total** |
| Level I | 20.4 | 15.4 | 18.1 |
| Level II | 55.3 | 33.4 | 30.1 |
| Total | 75.7 | 48.8 |  |

Some preliminary data is also available using APD CIT related data and Bernalillo County Sheriff’s Department (BCSD) data. The data provided by APD showed that between January 2016 and October 2016 of 2,064 CIT related incidents reported by APD field officers 1,606 (51.6%) were transported to area hospitals that includes UNM’s PES. It is not known what portion of these calls would be eligible for CET services. APD also provided COAST data. Between January 2016 and October 2016 COAST assisted 300 unique mental health consumers and COAST staff contacted 1,049 individuals that were not the result of a call for service. COAST staff also contacted 348 individuals who were originally a call for service. According to APD, COAST’s primary objective is to safely resolve the behavioral health crisis causing police interaction by referring the individual with behavioral health disorder or in behavioral health crisis, to professional mental health services.

Using BCSD data from March 2015 through March 2016 there were 506 (average 38.9 a month) mental patient calls and 349 (average 26.8 a month) suicide threat calls. While we don’t know the final disposition of these calls there is no reason to believe, that similar to APD, a portion of these calls would be eligible for CET. Following this rationale, we believe that less than 50% of these calls might be eligible for CET.

SAMHSA. (2014). Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2012, 2013, and 2014.

Note: The formula for this calculation multiplies the 2014 US Census population for Bernalillo county (671,429) by SAMHSA’s estimate of the average yearly percentage of adults in Bernalillo county with a serious mental illness between 2012 and 2014 (20.24%). (671,429\*20.24% =135,897)

**SECTION 4: Outcome Identification**

A resource that meets the needs of people at the sub-acute mental health level must deliver measureable services and achieve specific performance measures and outcomes. In general, the resource should address a series of questions:

* Does sub-acute care lessen contacts with public acute mental health services?
* Does sub-acute care produce positive outcomes for people with a mental illness (Dench et al.,2008)?
* Possible outcomes may include: reduced contacts with emergency hospital and psychiatric services;
* Reduced contacts, use and length of stay at inpatient mental facilities and jail,
* Reduced client rates of participation in outpatient pre and post CET,
* Comparison of unexpected events after CET contact, e.g., self-harm, violence to others, homelessness, contact with the police, changes in the client’s quality of life (i.e., measures of through an assessment of coping strategies; reduction in utilization of emergency departments and higher levels of care; keeping people safe from suicide or other violence, or contacts with law enforcement or the criminal justice system; sustained participation in treatment),
* Measures of cost- effectiveness,
* Satisfaction among clients, families, and program staff.

Performance measures should be evaluated as well as outcomes. Measures associated with the performance of the sub-acute service could be: is the service utilized at the anticipated rate of use, at what percentage do women use the service, are acute mental health hospital beds used inappropriately and does the new resource affect this situation?

In addition to outcomes and performance measures, client and staff satisfaction should be measured. Questions such as: what were clients particularly happy with and had found useful, the effectiveness of the help they had received, benefits of intervention at home, availability of staff at any time of the day or night, frequency of visits, plus the quick response from the CET, assistance with practical help such as help with benefits, and referral services. Staff satisfaction includes – job satisfaction, emotional exhaustion, personal accomplishment, team role clarity, and personal role clarity (MHCA, 2011).

Dench, McClean, Carlson (2008) *Evaluation of the Prevention and Recovery Care (PARC) Project*; Melbourne, Mental Health & Drugs Division, Victorian Department of Human Services.

Mental Health Council of Australia. (2011). National Health and Hospital Networks, COAG and Mental Health Reform: Sub-acute Care Initiative Positions Paper. Found online at: Australia MHCA\_Position\_Paper\_5\_-\_Sub-acute\_Care\_Initiative.pdf

**SECTION 5: Best Practice Identification**

People in jeopardy of reaching a point in their mental health requiring emergency services or at least acute crisis services need help before their health worsens. Currently, Bernalillo County and the City of Albuquerque provide mental health care in areas of prevention, maintenance services, outpatient support, sub-acute crisis intervention, and emergency services.

A recent summary literature review of best practice programs in the United States, United Kingdom, and Australia described two established best practice models. Both models have similar objectives, but have different frequencies of care. Crisis Resolution Home Treatment Teams (CRHTs) are intended for short term care; patients are typically discharged from services within two-weeks. According to the literature, length of care is determined by the patient, but in general the objective of CRHT is to address immediate issues, and refer patients to long-term outpatient facilities (Carroll et al., 2001). Peer support services, are usually intended for long term continued care. Most peer-run crisis respites are designed for a 1-3 week stay.

**Model 1:** Crisis Resolution Teams and Crisis Resolution Home Treatment Teams

The terms crisis resolution team, crisis resolution and home treatment team, crisis assessment and treatment team, and intensive home treatment team are currently used roughly synonymously (Johnson, 2013). Crisis resolution and home treatment teams (CRHTs) are separate multidisciplinary teams that work to deliver a full range of emergency psychiatric interventions. The primary objectives of CRHTs are to: assess patients being considered for emergency admission, provide intensive home treatment for eligible patients, continue home treatment until the crisis has been resolved, refer patients to other agencies for further care that may be needed, and reduce length of stay by early discharge from hospital to intensive home treatment when feasible. According to Minghella, CRHTs have reduced admissions to hospitals by between 20% and 40 %, and have also reduced the length of stay for patients who are admitted (Minghella et al., 1998). Johnson and colleagues reported results of a before and after study and a randomized controlled trial of a CRHT team based in an inner-London setting. These studies found a lower probability of being admitted to hospital within 8 weeks after the crisis and reductions in admission rates from 71 to 49% in the 6 weeks after the crisis. However, this study may suffer from a lack of generalizability to the rest of the UK (Jacobs and Barrenho, 2011). Using secondary data in a policy evaluation and using control groups and estimations to control for confounding factors, Jacobs and Barrenho found, contrary to previous studies, no evidence that the British CRHT policy per se has made any difference to admissions in mental health facilities.

Additional investigations have reported CRHT outcomes. For instance, one report cited that there was an overall decrease in acute bed usage following the adoption of the CRHT model in Australia. Surveys to report patient satisfaction have also been conducted, but experienced overall poor response rates. From the survey responses reported, researchers concluded that the CRHT model produced good patient satisfaction (Johnson, 2004).

CRHT continues to evolve, in a 2013 article, Sonia Johnson describes innovations in the CRHT model. Linking CRHT to residential facilities, integrating CRHT with outpatient day services as well as linking CRHT with inpatient facilities and rotating staff between facilities and CRHT is another innovation. The CRHT model can be adapted to address jurisdictional needs. The future of CRHT may require the development of a fidelity scale to measure adherence to best practices in delivering the CRHT model.

**Model 2:** Peer Support Services

Peer Support Service is an individualized, recovery focused approach that promotes the development of wellness self-management, personal recovery, natural supports, coping skills, and self-advocacy skills and development of independent living skills for housing, employment and full community inclusion (Alliance Behavioral Healthcare). Peer supporters are people who use their experience of recovery from mental health disorders to support others in recovery. Combined with skills often learned in formal training, their experience and institutional knowledge put them in a unique position to offer support (Mental Health America). In both mutual support groups and consumer-run programs, the relationships that peers have with each other are valued for their reciprocity; they give an opportunity for sharing experiences, both giving and receiving support and for building up a mutual and synergistic understanding that benefits both parties (Mead, Hilton, & Curtis, 2001). In contrast, where peers are employed to provide support in services, the peer employed in the support role is generally considered to be further along their road to recovery (Davidson, Chinman, Sells, & Rowe, 2006). Peers use their own experience of overcoming mental distress to support others who are currently in crisis or struggling. This shift in emphasis from reciprocal relationship to a less symmetrical relationship of ‘giver’ and ‘receiver’ of care appears to support the differing role of peer support in naturally occurring and mutual support groups and peer support workers employed in mental health systems.

The literature demonstrates that peer support services can lead to a reduction in psychiatric hospital admissions. Additionally, associated improvements have been reported on numerous issues that can impact the lives of people with mental health problems (Repper, 2011). According to the literature, some benefits for consumers from peer support services are admission rates to psychiatric hospitals and community tenure, empowerment, social support and social functioning, empathy and acceptance, and reducing stigma (Gillard et al., 2013). Some randomized controlled trials comparing the employment of peer support workers with care as usual or other case management conditions report either improved outcomes or no change (Simpson et al., 2014). Solomon and Draine (1995) in a 2-year outcome study reported no differences in the impact of care provided by peers and care as usual on hospital admission rates or length of stay. Similarly, O’Donnell et al. (1999) reported no significant difference in admission rates when comparing three case management conditions; standard case management, client-focused case management, and client-focused case management with the addition of peer support. It is important to note that a result of no difference demonstrates that people in recovery are able to offer support that maintains admission rates (relapse rates) at a comparable level to professionally trained staff. However, Clarke et al. (2000) found that when assigned to either all peer support worker or all non-consumer community teams that those under the care of peer support workers tended to have longer community tenure before their first psychiatric hospitalization. This study was based on following two Assertive Community Treatment (ACT) teams in Oregon, one comprised of peers (case workers with a mental health diagnosis) and one with no peers. Furthermore, in a longitudinal comparison group study, Min, Whitecraft, Rothband, and Salzer (2007) found that consumers involved in a peer support program demonstrated longer community tenure and had significantly less re-hospitalizations over a three-year period. In regards to social support and social functioning, a longitudinal study, Nelson, Ochocka, Janzen, and Trainor (2006) reported that at three-year follow-up, consumers continuously involved in peer support programs scored significantly higher than comparison groups on a measure of ‘community integration’, which was assessed using the meaningful activity scale.

According to SAMHSA (2009), effective roles of peer supported services are providing mentoring and coaching, connecting people to needed services and community supports, and helping in the process of establishing new social networks supportive of recovery. Currently there are many forms of peer support services offered. As mentioned before, the ACT team is a SAMHSA evidence-based model that provides comprehensive treatment and support services to individuals who are diagnosed with serious mental illness. This is achieved through continued care provided at the consumers’ home or in the community. Most of the time, ACT teams are multidisciplinary teams made up of clinicians, nurses, case managers, substance abuse specialists and peer support specialists. Target populations are identified by referrals, post-psychiatric hospitalizations, and post-incarcerations.

Also, many current peer supported services are respite based. Peer-run crisis respites are usually located in a house in a residential neighborhood. They provide a safe, homelike environment for people to overcome crisis. The intended outcomes are diverting hospitalization by building mutual, trusting relationships between staff members and users of services, which facilitate resilience and personal growth (Ostrow, 2011). The National Coalition for Mental Health Recovery (NCMHR), a driving force behind the establishment of peer-run crisis respite services nationwide, has described PRCRs as a place for people in crisis to process stress, explore new options for short-term solutions, increase living and coping skills, and reduce susceptibilities to crisis in an environment that provides support and social connectedness. Evidence is still being compiled for peer-run crisis respites, but one randomized controlled trial of a PRCR has been conducted (Greenfield, Stoneking, Humphreys, Sundby, & Bond, 2008). This study found that the average rate of improvement in symptom ratings was greater in the alternative than in the hospital comparison group, and that the peer-run alternative group had much greater service satisfaction. The cost was significantly less: $211 per day versus $665 per day for hospitalization. The study authors concluded that this alternative was “at least as effective as standard care” and a “promising and viable alternative” (Greenfield, Stoneking, Humphreys, et al., 2008).

Overall, peer support workers have the potential to drive through recovery-focused changes in services. However, many challenges are involved in the development of peer support such as boundaries, stress on peer support workers, and maintaining roles. Careful training, supervision, and management of all involved are required (Repper, 2011). Important to note, interventions for peer support services are evidence-based per the Consumer Operated Services Evidence Based Practices Toolkit (SAMHSA, 2011). Also important to note, peer support services are Medicaid reimbursable when using certified peer support workers.

Both CRHT and peer support services contain characteristics that address the elements of the Problem Statement of this proposal. CRHT has existed in Australia and Europe since the 1990s. Extensive literature has been published regarding the advantages and weaknesses of CHRT. As a model, CHRT has evolved and can be changed to fit the need of the user. An advantage of peer support services is it’s ability to provide mentoring and coaching, connecting people to community services, and assisting in establishing recovery support to the client. An innovative model like CHRT can be matched with a supportive program such as peer support services an address the problem statement described in this proposal.

Carroll, A., Pickworth, J., & Protheroe, D. (2001). Service Innovations: An Australian approach to community care - the Northern Crisis Assessment and treatment team. Psychiatric Bulletin, 25(11), 439-441.

Clarke, Gregory N., Heidi A. Herinckx, Ronald F. Kinney, Robert I. Paulson, David L. Cutler, Karen Lewis, and Evie Oxman. (2000). Psychiatric Hospitalizations, Arrests, Emergency Room Visits, and Homelessness of Clients with Serious and Persistent Mental Illness: Findings from a Randomized Trial of Two ACT Programs vs. Usual Care. *Mental Health Services Research*, Vol. 2, No. 3.

Community Partners, INC. (2015). Behavioral Health Business Plan (pp. 1-99) (Bernalillo County Behavioral Health Initiative, Bernalillo County Board of County Commissioners). Community Partners, INC.

Davidson, L., Chinman, M., Sells, D., & Rowe, M. (2006). Peer support among adults with serious mental illness: A report from the field. *Schizophrenia Bulletin*, 32(3), 443–445.

Gillard, S. G., Edwards, C., Gibson, S. L., Owen, K., & Wright, C. (2013). Introducing peer worker roles into UK mental health service teams: A qualitative analysis of the organisational benefits and challenges. *BMC Health Services Research, 13*(188). doi: http://www.biomedcentral.com/1472-6963/13/188

Greenfield, T. K., Stoneking, B. C., Humphreys, K., Sundby, E., & Bond, J. (2008). A randomized trial of a mental health consumer-managed alternative to civil commitment for acute psychiatric crisis. *American Journal of Community Psychology, 42*(1), 135-144.

Jacobs, R. and E. Barrenho. (2011). Impact of crisis resolution and home treatment teams on psychiatric admissions in England. The British Journal of Psychiatry,  199, 71–76. doi: 10.1192/bjp.bp.110.079830

Johnson, S. (2004). Crisis resolution and intensive home treatment teams. Psychiatry, Medical Publishing Company, 3(9), 22-25.

Johnson, S., Fiona Nolan, Stephen Pilling, Andrew Sandor, John Hoult, Nigel McKenzie, Ian R White, Marie Thompson, Paul Bebbington. (2005). Randomised controlled trial of acute mental health care by a crisis resolution team: the north Islington crisis study. BMJ, doi:10.1136/bmj.38519.678148.8F (published 15 August 2005)**.**

Johnson, S. (2013). Crisis resolution and home treatment teams: an evolving model. Advances in psychiatric treatment (2013), vol. 19, 115–123 doi: 10.1192/apt.bp.107.004192.

Mead, S., Hilton, D., & Curtis, L. (2001). Peer support: A theoretical perspective. *Psychiatric Rehabilitation Journal*, 25(2), 134–141.

Min, S., Whitecraft, J., Rothband, A.B., & Salzer, M.S. (2007). Peer support for persons with co-occurring disorders and community tenure: A survival analysis. *Psychiatric Rehabilitation Journal*, 30(3), 207–213.

Minghella, E., et al.. (1998). Open all hours, 24-hour response for people with mental health emergencies. The Sainsbury Centre for Mental Health.

Nelson, G., Ochocka, J., Janzen, R., & Trainor, J. (2006). A longitudinal study of mental health consumer/survivor initiatives: Part 1 – Literature review and overview of the study. *Journal of Community Psychology*, 34(3), 247–260.

New Mexico Legislative Finance Committee. (2014). Results First: Adult Behavioral Health Programs. Found online at: https://www.nmlegis.gov/lcs/lfc/lfcdocs/resultsfirst/Evidence-Based%20Behavioral%20Health%20Programs%20to%20Improve%20Outcomes%20for%20Adults.pdf

O’Donnell, M., Parker, G., & Proberts, M. (1999). A study of client-focused case management and consumer advocacy: The community and consumer service project. *Australian and New Zealand Journal of Psychiatry*, 33(5), 684–693.

Ostrow, L., Fisher, D. (2011). Peer-Run Crisis Respites: A Review of the Model and Opportunities for Future Developments in Research and Innovation.

Repper, J., Carter, T. (2011). A Review of the Literature on Peer Support in Mental Health Services. *Journal of Mental Health*, 20(4), 392-411.

Shapiro GK, Cusi A, Kirst M, O’Campo P, Nakhost A, Stergiopoulos V. (2014). Co-responding police-mental health programs: a review. Adm. Policy Mental Health Mental Health Service Res. 2014;42:606–20. Available from: http://dx.doi.org/10.1007/s10488-014-0594-9.

Simpson, A., et al. (2014). Results of a pilot randomised controlled trial to measure the clinical and cost effectiveness of peer support in increasing hope and quality of life in mental health patients discharged from hospital in the UK. *BMC Psychiatry, 14*(30). doi:10.1186/1471-244X-14-303

Solomon, P., & Draine, J. (1995). The efficacy of a consumer case management team: Two-year outcomes of a randomized trial. *Journal of Mental Health Administration*, 22, 135–146.

Substance Abuse and Mental Health Services Administration/Recovery Community Services Program. (2009). What Are Peer Recovery Support Services? Rockville, MD: HHS Publication No. (SMA) 09-4454.

Substance Abuse and Mental Health Services Administration//Center for Mental Health Services. (2011). Consumer-Operated Services: The Evidence. Rockville, MD: HHS Pub. No. SMA-11-4633.

**SECTION 6: Description of Intended Intervention**

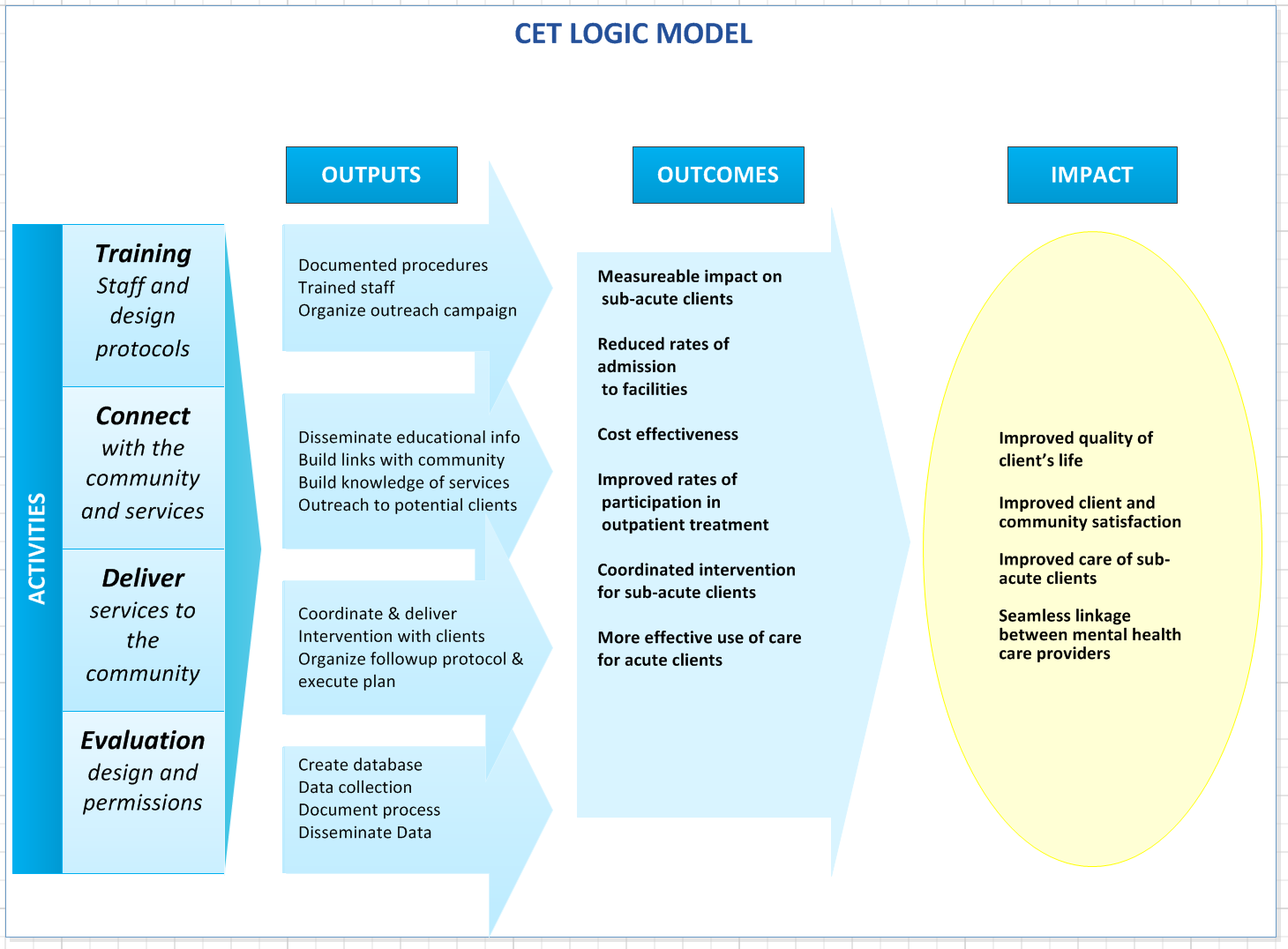
In addressing the stated problem, officials in Bernalillo determined to support a CET program, partly modeled after the crisis resolution/home treatment teams in the UK. Locally the CRHT concept has been conceived as an intervention for sub-acute clients. Sub-acute in this context is a person who is either becoming acutely psychiatrically unwell (whether or not they have previously been acutely mentally ill) or who is recovering from an episode of acute psychiatric illness (MHCH, 2011). Titled “Community Engagement Team” (CET) the local program focuses on intervening with sub-acute clients.

In Bernalillo County a Community Engagement Team is envisioned as having the following characteristics and providing the following services.

* A team of individuals capable of assisting people who voluntarily want assistance, are not in acute crisis, and do not require immediate hospitalization.
* The target population is people who are having a sub-acute mental health episode. Sub-acute mental health care refers to care for a person who is either becoming acutely psychiatrically unwell (whether or not they have previously been acutely mentally ill) or who is recovering from an episode of acute psychiatric illness.
* The team offers clients practical support, such as help with resolving pressing financial, housing, or childcare problems, getting home into a habitable state, and obtaining food or medications.
* Clients have opportunities to talk through current problems with team staff, in addition to brief interventions aimed at increasing the persons’ problem-solving abilities and activities of daily living skills.
* The team refers clients and follows up to see if clients connect with referrals. Also teams provide clients and interested people with education about mental health problems for clients and their social network. Education curriculum includes identification and discussion of potential triggers to mental health episodes, including difficulties in family and other important relationships.
* Relapse prevention work and planning for management of future crises is also offered.
* Rapid response by the team is offered in the community within 24 hours when needed.
* Brief home intervention is offered rather than hospital admission. No treatment is offered.
* Low client team ratio allows the team the time for multiple visits daily to see the client when necessary.
* When the team is full composed 24-hour availability could be offered.
* The team works in partnership with agencies already providing services to clients in need or asking for CET services.
* Team approach, with workloads shared between teams and daily handover meetings for review of clients.
* Engagement with the team is short term, with most clients discharged to continuing care services (if needed) within 6 weeks.

The precise composition of the team is not clear but most likely would employ a psychiatrist or psychologist, peer workers, a case management professional and licensed social workers.

Mental Health Council of Australia. (2011). National Health and Hospital Networks, COAG and Mental Health Reform: Sub-acute Care Initiative Positions Paper. Found online at: Australia MHCA\_Position\_Paper\_5\_-\_Sub-acute\_Care\_Initiative.pdf



**SECTION 7: Cost & Budget Considerations**

**Preliminary Budget**

There are no budget documents available regarding the funding of the proposed CET. Preliminarily, the approximate cost of the CET program is $1,000,000 depending on the quality of the responses.

**SECTION 8: ANTICIPATED TIMELINE**

Milestone and timeline information necessary to complete this portion of the proposal was not available.

Step #1: Draft Project Proposal Complete

Step #2: Project proposal reviewed & approved by appropriate ABCGC subcommittee

Step #3: Project proposal reviewed & approved by ABCGC steering committee

Step #4: Project proposal reviewed & approved by full ABCGC

Step #5: Project proposal reviewed & approved by the BCC

Step #6: Project proposal turned into RFP or other contracting scope of services

Step #7: Service provider(s) signs contract

Step #8: Services delivery begins

1. Routine Calls: Call is resolved with de-escalation of the caller. Caller is offered a referral to local resources. Caller initiates next steps. Urgent Calls:Call requires de-escalation. A determination is made, with consultation from clinical supervisor, that an outbound call will be scheduled to follow up with the caller. Emergent calls: require immediate emergency attention. [↑](#footnote-ref-1)