Literature Review: Community Engagement Teams (CETs)

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Definition: Community Engagement Teams (CETs) engage and assist individuals who do not re require immediate inpatient or emergency care, but whose mental health illness interferes with their daily life.

Description: According to the Community Partners, Inc. (CPI) Behavioral Health Business Plan, community engagement teams are described as providing outreach to individuals with serious mental illnesses, and engage them voluntarily in treatment and/or other services. The overall goals of CET are to reduce the rate of law enforcement interventions and decrease the number of hospitalizations per individual (CPI, 2015). Contrasting the CPI, the CET proposal provided on the House Memorial 45 states "if a person believes that an individual living in the community may be unable to live safely in the community, and is in need of mental health services, and is also incapable of informed consent, that person may file an application with a CET, if one exists in the community where the individual resides or may be found". A team would then be dispatched to the home to make "reasonable efforts" to assess the person's capacity to make decisions and try to engage that individual in order to make appropriate referrals. Referrals would include assistance with housing, food, health care, and transportation. In the case where a CET is unable to assess the person, CET would then attempt to seek treatment for the person. Also, if necessary CET could help petition the court for a treatment guardian, and the possibility of an enforcement order to "compel outpatient treatment" as described in the consent to treatment statute, § 43---1---15 (HM 45, 2012). House Bill 222 states that community engagement teams are intended to "engage and assist" individuals who are consider unlikely to live safely in the community, but do not require inpatient or emergency care at the time of assessment (HB222, 2015). The bill also defines who should comprise the CETs; trained professionals with background in mental health, and certified peer support workers (HB222, 2015).

The description of CETs provided by the CPI, are non-specific, and are focused on measuring outcomes. For instance, the CPI indicates the purpose of CETs is intended to reduce law enforcement interventions, and decrease number of hospitalizations. These outcomes can be measured and used to evaluate the effectiveness of such programs. The House Memorial 45 provides a more specific proposal of what these teams should look like. The direction of the proposal is focused on the logistics of how the team should function, and how to intervene in crisis settings.

Research Summary: From our analysis of the literature, we were unable to find models of community engagement teams. In this report we describe two models: crisis resolution teams (CRTs), and peer support services. In combination these types of models have similar functions to how CETs are described above. Both models have similar objectives, but have different frequencies of care. CRTs are intended for short term care; patients are typically discharged from services within 2 weeks. According to the literature, length of care is determined by the patient, but in general the objective of CRT is to address immediate issues, and refer patients to long-term outpatient facilities (Carroll et al., 2001). Peer support services, such as ACT, are usually intended for long term continued care. However, most peer-run crisis respites are designed for a 1-3 week stay.

Model 1: Crisis Resolution Teams (CRT)

Crisis Resolution Teams (CRT) are separate multidisciplinary teams that work to deliver a full range of emergency psychiatric interventions. The primary objectives of CRTs are: 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, CRT's 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). The following figure shows the key characteristics of CRTs and the main interventions provided by CRTs (Johnson, 2004).

Figure 1: Key Characteristics of CRTs & Main Types of Interventions provided by CRTs (Johnson, 2004)

Key Characteristics of CRTs:

- A multidisciplinary team, which delivers a full range of emergency psychiatric interventions in the community
- Primarily targets severe emergencies in which admission would otherwise be required
- Staff visits typically consist of 2 or 3 times daily when needed
- 24-hour availability
- For patients already on the caseload of other community services (e.g. CMHTs), works in partnership
- All clients reviewed at least daily at handover meetings with other agencies
- Psychiatrists work within the team
- Rapid emergency assessments (response within 1 hour if required)
- Gatekeeping role – no admission to an acute bed allowed without prior assessment by the CRT
- Intensive home treatment offered rather than hospital admission if needed
- Attention paid to clinical and social triggers of the emergency and needs of patient
- Short term care only, most clients discharged within 6 weeks

Main Interventions provided by CRTs

- Comprehensive initial assessment (risks, symptoms, daily functioning, social circumstances and relationships, substance use and physical health status)
- Engagement attempts to establish a therapeutic relationship and formulate a treatment plan acceptable to patients and caregivers
- Symptom management (initiation or adjustment of medication, simple psychological interventions aimed at increasing ability to cope with symptoms) with patients or caregivers
- Administration of medication, twice daily if needed
- Practical help (resolving pressing financial, housing or childcare problems, getting home into a habitable state, obtaining food)
- Opportunities to talk through current problems, brief interventions aimed at improving problem-solving and daily living skills
- Education about mental health problems for patients and caregivers
- Social issues are identified and addressed
- Relapse prevention, planning for management of future crises
- Discharge planning begins early so patients can be transferred to continuing care services as soon as crisis has resolved

No major randomized controlled trials (RCTs) have so far been published on the current CRT model. One experiment conducted published a comparison report between CRTs and CMHT; outcomes from the experiment favored the CRT model, but as stated by Johnson the comparability of the two study groups is uncertain (Johnson, 2004). Aside from the lack of RCTs and comparable data, several investigations have report CRT outcomes. For instance, one report cited that there was an overall decrease in acute bed usage following the adoption of the CRT 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 CRT model produced good patient satisfaction (Johnson, 2004).

Since the early 1990s, multi-disciplinary teams have been providing community assessment, and treatment of psychiatric emergencies in Australia. The Northern Crisis Assessment and Treatment Team (NCATT) provides community-based assessment and treatment services 24-hours a day, 7 days a week. Dissimilar from the CET proposal, CRTs are consistently comprised of medical professionals such as nurses, psychologists, or social workers. The following figure displays the primary functions of the NCATT in Australia (Carroll et al., 2001).

Figure 3: Primary Functions of the NCATT

Primary Functions of NCATT

- Triage: Team members receive referrals from public, private mental health professionals, general practitioners, law enforcement, families, caretakers, or patients themselves. Patients who appear to be distraught and require admission or intensive home treatment are assessed by the team and an intake is conducted. Others are briefly counselled over the phone, and "re-referred" to more specialized agencies.
- Community-based assessment and treatment: All urgent referrals are addressed in a short response time, approximately 2 hours. During this intake process, emphasis is placed on examining the social support, risk factors, and suitability for home-based treatment. The standard number of visits is conducted in once daily, but can be conducted up to twice daily. **In addition to conducting assessments, team members are also trained to provide patients with advice, support, and psycho education for the patient or caregivers. This would include problem solving methods, dispensing medication if applicable, and addressing psychosocial/interpersonal difficulties.**
- Telephone Support: The CRT services are primarily conducted in person with patients, but patients are also encouraged to call the CRT at any time, day or night, if help is needed.
- Gatekeeping: There are 25 public sector acute adult beds. Only patients who complete the NCATT assessment and are determined to be unsuitable for community treatment can be admitted to ward. In general patients are determined as unsuitable, due to a history of non-compliance, being seriously suicidal, or displaying very disturbing behavior.
- Facilitation of admission & Early discharge management: In the case, where patients post severe signs of needing more intensive treatment care, NCATT coordinates with other agencies to provide transportation such as ambulance service or law enforcement escorts to inpatient facilities. The team functions as a liaison between agencies to coordinate proper care for patients who require more intensive care. This also includes ensuring hospitalization is as brief as possible.
- Referral of clients to ongoing care: The overall focus is on short-term intervention during the crisis. Teams members will provide referrals to outpatient treatment facilities that can provide long-term care. Referrals are given in "prompt" order.

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 workers can lead to a reduction in psychiatric hospital admissions among those with whom they work. 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. 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. 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 3-year period. In regards to social support and social functioning, a longitudinal study, Nelson, Ochocka, Janzen, and Trainor (2006) reported that at 3-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 built 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 of roles. Careful training, supervision and management of all involved are required (Repper, 2011). Important to note for the committee, 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.

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