Governor's Task Force on Mental Health

CRISIS FORMULATION GROUP

Background and Agenda for 9/15/16

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Time	Topic
4:00	Introductions
4:05	Review of summation document (below) and outline of areas for further research. Does this accurately capture our conversations and the Task Force's input?
No later than 4:40	Presentation and use of time for 9/26. What format should we present our work? • Option 1: Items are outlined in terms of values (rationale and basis for the group's choices) and functions (key capabilities a solution should be able to deliver). At next meeting, we ask the Task Force to ratify or amend that list, and we return in the final working meeting with an updated version of the functions/values list with some further detail, including assignment (who needs to take this work and move it forward with granular detail and implementation?). • Option 2: Chart with functions on one axis, and potential models on the other. Where a model can address a function, key points (aptitude of the model, key tradeoffs or barriers, changes or resources required) fill in the matrix. We present this chart to the Task Force to facilitate their discussion of recommendations.

For information on upcoming meetings, see Task Force website: https://mn.gov/dhs/mental-health-tf/

Values For Crisis Response Services

Compiled based on conversations of the full Task Force and the Formulation Group.

1. Service standards that build Crisis as a credible "4th response" along with police, fire, and EMS.
    a. Cross training all emergency responders to promote collaboration
    b. Credibility of response: timeliness, consistency, ability to stay on the line when appropriate, alignment with service expectations for other responders.
    c. Diversion from intensive resources is not an end unto itself. Many 911 calls for physical concerns still lead to hospital visits. Promote means reduction, family psychoeducation, or referral to an appropriate setting.
    d. Build relationships that allow for trust between responders and flexible response. Referral to another service isn't a one way door: all parts of the system function as a team to meet the changing needs of an individual's situation.
2. Identifying and building funding streams that address infrastructure needs along with per call costs.
    a. Comparison and modeling to other rapid response infrastructure.
    b. Exploring models for building capacity to respond quickly, and bridge the gap between scarcity of a specialized work force and the timeline needed by communities.
    c. Understanding costs and connections to other levels of service: what unmet needs do individuals experience prior to crisis?
3. Services that promote recovery in connection with natural supports
    a. Options for children to receive residential crisis services without a county placement
    b. Placing connections and resources for crisis assistance where people in the community will seek them (urgent care, community hospital, 911)
4. Providing effective follow up to avert repeated crisis calls
    a. Standards for discharge/crisis planning from all high intensity services
    b. Promoting standardized use and distribution for crisis plan documents through electronic medical records
    c. Promote a process for individuals to consider sharing information on crisis planning to local law enforcement. Paired with standardized means for law enforcement to retain the data they do collect (officer observations, disclosures from the individual, key contacts and trusted individuals).
    d. Process and accountability for ensuring individuals get to the next level of care that they need.

Potential Models for Examination

These models would be further researched for fit against the values and functions listed above.

1. Use of telehealth to support community hospitals without dedicated psychiatric resources.
2. Co-responder or embedded mental health professional with law enforcement.
3. Preservice police training on CIT, during coursework. Paired with refresher courses at a regular interval.
4. Adaptation of CIT for other responders. Paired with a forum or process for building shared understanding and trust between crisis teams and other responders.

5. Centralizing resources in a trusted location. Psychiatric ERs, Urgent Care (Ramsey model), colocation with existing urgent care for physical conditions.
6. Research and root cause analysis. What data or study would be necessary to better understand the preconditions of crisis, and outcomes evaluation for interventions?
7. Shared data on crisis planning. Follow up with Fairview Health on pilot project for incorporation of crisis plan in to Electronic Medical Records.
8. What functions/values are not well addressed?

Next Steps and Assignments:

1. Telehealth: Ben will compile information on resources needed for implementation, barriers to be addressed. Fairly well developed based on prior work.
2. Co-responder. Need a volunteer from formulation group to participate in a call to Duluth PD.
3. Preservice training: Could Rodney or Sara (or designated colleague) outline the required elements, resources needed, and what entities need to buy in or support this plan?
4. Adaptation of CIT/improve collaboration between responders: Group discussion on how to tackle this.
5. Centralized resources. Ben will get a call w HCMC or other psychiatric ER provider, as well as a provider that has both Urgent Care and mental health care, but does not currently combine them.
6. Research/root cause. Group discussion on how to tackle this.
7. Shared data on crisis planning. Need a volunteer from formulation group to participate in a call to Fairview/MN Medical Association for information on their efforts. Connections to MDH SIM Grant team?