

Governor's Task Force on Mental Health

CRISIS FORMULATION GROUP

Agenda and Formulation Document for 10/17

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Use of Telehealth

Crisis providers are already using telehealth services to expand their reach, and mitigate workforce shortages and long travel times. The following are potential strategies for building on this.

Support common standards and protocols

Minnesota could adopt a common standard for telehealth services relating to mental health crisis. This could include compatibility of hardware/software, identifying a model for other emergency responders to bring a connection out into the field through tablet or other device, as well as protocols for timelines and responsibilities each partner has in crisis telehealth. Would build on work already being done (see background document, Northwestern Mental Health Center).

Objectives: Identify a framework for how Minnesota intends to use telehealth for crisis care, and speed adoption in additional regions of the state.

Timeline: Would require further stakeholder work and research, but policy items could be adopted relatively quickly, with time needed for providers to implement. Infrastructure investment would require more time. Prior proposals for a statewide rural access fund ranged from \$35M to \$100M.

Resources: Variable. Identification of best practices for use and deployment would require relatively few resources. Building out broadband connectivity and the infrastructure could be far more ambitious.

Partners: Investments in telehealth infrastructure could be directed to MDH Office of Rural Health to promote faster adoption. Further stakeholder work would require broader representation: more hospital systems, crisis teams, other telehealth implementers.

Common pool for Telehealth Resources

Minnesota could establish a common pool of telehealth resources for urgent mental health needs. An RFP process would identify a provider to function as a reserve, available when local resources are not able to respond quickly.

If a person calls in to a crisis team during a busy time, a shortage of available responders might mean that they are told that the team cannot respond in a timely fashion. Instead, callers could be presented with options: a timeframe for mobile response, or directions to a site where they could access the telehealth team. Potential local sites could be clinics offering physical urgent care, a hospital without dedicated psychiatric resources, or fire station/paramedic base. The local site would need to be able to provide some level of support: paramedic or triage nurse, and the ability to call for further resources when required. A framework for responsibilities, reimbursement to the local site, and other funding considerations would need to be developed.

Drawing from a larger pool of potential callers, a more predictable staffing model could be developed for this reserve. Depending on the needs and staffing models of existing teams, they could potentially chose to cover calls from other areas during times when they have additional capacity.

Objectives: Decrease the number of instances where a potential recipient is told that crisis services are unavailable because all staff are already committed to calls. Existing mobile teams could refine focus on services in the community as a separate or collaborative response.

Timeline: Would require funding, the development of a new team, and the identification of appropriate sites to host the connections in the community. Due to the workforce issues around the state, the location would probably need to be in an area not currently identified as a shortage area: Metro and southeast MN. It would take approximately 3-6 months post signing of contract to get staff hired, get the equipment up and running and get staff trained in crisis response and in using the telehealth equipment. Host sites may take longer to develop, and host sites will need to train/collaborate with the telehealth crisis providers to work out logistics and team protocols.

Resources: An initial target would be 13 to 15 staff. This would allow 3 people to be available at a time for 3 shifts per day to provide assessments via telehealth and one additional person per shift to take calls routed from other teams.

Staff Costs (Professionals and practitioners available to provide telehealth services)	\$364,000
Administration staff costs	\$24,000
Other Administration/overhead	\$61,000
Total Team Cost:	\$550,000

To develop a new remote site in areas that do not already have the capability, costs for equipment and overhead might be around \$33,000/year based on prior expansions. The staffing needs at those locations could vary based on what services were already present.

Some of these timeframes could be accelerated if teams with existing telehealth capacity were able to contract for portions of this coverage. In some cases it might be more cost effective or expedient to pay for additional capacity in an already existing team.

Partners: 911 responding agencies, counties, existing mobile crisis teams, host site locations, DHS. Implementing hospitals would need buy in from internal stakeholders, especially at the remote sites: physicians, nurses.

Healthcare system based telehealth pools

Minnesota could support the development of telehealth resources for hospitals and urgent care settings that would be operated by the healthcare system for their affiliates. When a patient presented at a setting without dedicated resources for mental health, telehealth would be used to support the local ED in providing appropriate intervention and stabilization. For additional details, see the background document: CentraCare.

Some key advantages to this model would be greater familiarity between host/remote staff than might be expected in a statewide system. A provider with a set territory can better learn local referral resources and collaborate better with other providers in the same health system. May be more workable in some systems than others based on how many remote sites would need coverage vs. the number of sites that already had psychiatric staff present. Drawbacks include variations in how closely hospital based services connect with county based services in some areas. Might increase regional disparities in the availability of services.

Objectives: Achieve a higher standard of care for patients who present in Emergency Departments where mental health providers are not available on-site.

Timeline: Primarily dependent on workforce considerations. Discussions between ED staff and mental health providers do take time to build trust, rapport, and clear delineation of responsibilities. ~6-12 month timeframe after funding is allocated.

Resources: Available workforce has been identified as a significant concern. Additional funding to target student loan forgiveness could be offered. Grant support for physical and IT infrastructure might be required.

Partners: Hospital/Healthcare systems, MDH, DHS. Implementing hospitals would need buy in from internal stakeholders, especially at the remote sites: physicians, nurses.

Pre-service CIT as required training for law enforcement

Minnesota could implement 40 hours of pre-service CIT training for all officers through the Law Enforcement Academy. In service officers would get 4-8 hours of refresher training every 3 years. Because of the high cost of taking in service officers off patrol for 40 hours, pre-service training is the best approach as Minnesota seeks 100% CIT training for law enforcement. In addition, courses would be made available for Fire/EMS responders. Formulation group members expressed interest in integrating training on trauma, including sexual assault.¹

New officers may be more receptive to training, but each agency will need veteran officers or leadership who are trained and invested in the CIT model. Changes in policy may be needed to realize best outcomes, including clarifying who is the lead officer at a scene involving a mental health crisis.²

Objectives: Increase community and officer safety when responding to mental health related calls by providing CIT training to law enforcement pre-service, and to Fire/EMS responders.

Timeline: Training could be started relatively quickly. However, a focus on pre-service training would mean a lag time before a critical mass of officers would have the training. Current practice has been to

¹ Sara Suerth recommended "Understanding Trauma" as presented by Central Minnesota Sexual Assault Center.

² Dupont, R., Cochran, M. S., & Pillsbury, S. (2007, September). Crisis Intervention Team Core Elements. Retrieved October 2016, from University of Memphis CIT Center, http://www.cit.memphis.edu/information_files/CoreElements.pdf

restrict the 40 hour course to currently in-service officers since they have additional context for the training. The Task Force will need to consider this tension.

Resources: Contracts for CIT training have typically been \$650 for a 40 hour training with actors, which is recognized as the highest quality training. 30 people can be trained in a cohort. Minnesota has approximately 650 officers entering service each year, and about 11,000 in service. The table below illustrates how that would translate to different training models.

Training Type	Persons being trained	Cost per seat	Total per year
Pre-service 40 hour course	800-1300 peace officer candidates, Fire/EMS personnel in training	\$650 (training cost only, no salary or travel)	\$500,000-\$850,000
Pre-service 40 hour course	~650 Fire/EMS personnel in training	\$650 (training cost only, no salary or travel)	\$425,000
Early in service 40 hour course	650 officers per year, targeted for 2 nd year of services	\$3600 (includes salary and travel)	\$2,350,000
4 or 8 Hour refresher, 3 year cycle	3666 currently serving peace officers	\$415 -\$760 (includes salary and travel)	\$1,200,000 to \$2,800,000

Partners: Law enforcement agencies, cities, counties, Fire/EMS services, MnSCU, CIT training organizations, individuals with lived experience, DHS, DPS

Additional resources where people already seek help

Co-location of Community Mental Health Center staff in Critical Access Hospitals

Minnesota could prioritize the co-location of outpatient mental health services delivered by Community Mental Health Centers into Critical Access Hospitals (CAH). CAH's are 25 bed or smaller hospitals and are eligible for cost-based payment for Medicare/Medicaid. They must be a certain distance from the next available hospital, and most provide primary care and outpatient services in attached or satellite clinics. The underlying value is the recognized need to maintain some level of access to treatment, even in less densely populated areas. Residents of these areas are used to going to the hospital for regular outpatient services, as providers see a mix of clinic and hospital patients throughout the day. Sometimes, it may be the only primary care provider located nearby. Both providers and clients benefit from ease of accessing multiple kinds of care from a single site. Better care of mutual clients, and opportunities for joint system engagement. In crisis situations, mental health staff are on site and can offer consultation. In some CAHs, hospital staff also comprise the local Crisis Intervention Team.

Objectives: Significantly increase access in rural communities to mental health care located in Critical Access Hospitals. As a secondary benefit, those providers would be better able to offer consultation or services on an as needed basis to patients presenting through the emergency department.

Timeline: Prior projects have taken about one year to implement.

Resources: Workforce is and will continue to be a significant barrier. Recommendations in the Workforce Report may assist in this process, including development of more rural-focused programs and clinical training through the University and MnSCU systems. Additional funds for targeted student loan forgiveness could also be used. Co-location can reduce capital/overhead expense for the Community Mental Health Center, and can help drive additional patient volume to the local hospital and clinic.

Partners: This proposal would require significant partnership and buy in between hospitals/health systems, and Rule 29 Community Mental Health Centers. DHS and MDH would have roles in supporting and monitoring this work.

Urgent Care for Mental Health

Minnesota could develop more Urgent Care for Mental Health settings, combining detox (and/or withdrawal management), crisis response team, and urgent access to psychiatry (medication). This model does not have a locked or secure unit, and operates below the inpatient level of care. Data from the East Metro Crisis Alliance shows promising outcomes for individuals who access crisis stabilization. Individuals who infrequently access care saw gains in their connection to ongoing outpatient services. Both low and high frequency service recipients had fewer visits to the Emergency Department as well as inpatient hospitalizations. For patients receiving urgent or gap psychiatry, 2/3rds would have otherwise presented in an emergency department.

This model is focused on Medicaid and other publically funded care. Clinic networks and healthcare systems are more likely to offer reserve appointments in general purpose clinic during daytime hours than a more narrowly focused standalone. The governance group may wish to consider what barriers may exist for such models to adapt for greater integration with health plans and clinic networks.

Objectives: Provide rapid access to psychiatry, crisis stabilization, and urgent chemical healthcare, in a less intensive setting than an inpatient unit.

Timeline: *Needs further development, will update for 10/17.*

Resources: This model may be better suited to a broader range of communities than dedicated psychiatric emergency rooms. Some population center is needed to sustain the volume, but it is not as resource intensive as an in-patient unit.

Partners: Counties, Health Plans, DHS, Hospitals, Community Mental Health Centers.

Psychiatric Emergency Rooms

Minnesota could support the development of more capacity in psychiatric emergency rooms. This model would support for higher levels of acuity than other centralized models. One key value would be preserving the focus on a mental health response to crisis (services are provided in a dedicated

healthcare setting) but still support collaboration with law enforcement (shortened timeframe for transferring a patient to care, able to support individuals with recent assaultive behavior.) See background document for more details: HCMC APS.

This model requires a significant patient volume and on-going operational funding, which likely restricts the model to urban areas. HCMC sees about 2/3rds of the cost recouped by billing, a shortfall of approximately \$1M per year. The value the psychiatric ER provides in assisting the ED and other areas of the hospital are significant, but not directly captured. Standalone “receiving centers” present much higher hurdles, including increased reliance on law enforcement if staff from other units are not available during code calls. The IMD exclusion is also a strong concern for a patient population with high rates of Medicaid eligibility. The experience of current providers also indicates that a key value of a psychiatric ER is being able to accept transfers from other units of the hospital, including the standard Emergency Department.

Objectives: Replicate and refine a model for people in crisis of moderate to high acuity, including aggressive behaviors, as an expansion of services in high-volume emergency rooms.

Timeline: Physical spaces which are conducive to recovery would need remodeling or building. Funding would need to be secured, and staff hired and trained. *Needs more development, will update for 10/17.*

Resources: Funding streams, particularly for costs that cannot be billed for, need to be identified. Eg: security personnel needed to ensure staff and patient safety. Depending on the persons served, some portion of the billed services would be to public health programs.

Partners: Hospital/Healthcare systems would be needed as key partners, along with counties. MDH, DHS. Partnerships with law enforcement could be used to address security needs.

Mental Health/Law Enforcement Co-responder Models

Minnesota could pilot models for embedded mental health providers within law enforcement.

While national models are available, some questions will need to be answered as we map those ideas to Minnesota’s service spectrum. One major concern will be the availability of a qualified workforce. Nationally, models for co-responders have emphasized having a master’s level provider as the embedded person. They have a more significant clinical background, are better equipped to accurately assess risk, and have a licensing board to whom they are also accountable. This may help provide a counter balance to any pressure they experience to deliver services in a manner that is expedient to law enforcement.³

One of the key needs that a collaborative or co-responder model can meet is in informing police about the decision making process for assessment and intervention. Law enforcement officers frequently reference the experience of bringing an individual to the hospital, only to encounter them again in a

³ Smith-Kea, N., Yarbrough, M., & Myers, S. (2016, September 28). Police-Mental Health Collaboration Programs: A Different Way of Policing. Retrieved October 04, 2016, from <https://csgjusticecenter.org/law-enforcement/webinars/police-mental-health-collaboration-programs-a-different-way-of-policing/>

short time period. Without a solid assessment of what (if anything) a hospital might reasonably provide to an individual, the officer's decisions tend to be made on the side of caution, bringing that person to the ER. This gap in expectations results in lost time, inferior outcomes, and significant costs. Minnesota should make a careful assessment of how to best provide for collaboration and communication that addresses that gap. The required workforce is in short supply across the state, with most areas being designated as Mental Health Professional Shortage Areas (MHPSA). While the time that the embedded mental health professional spends in ride-alongs and other non-clinical work can help bridge healthcare and law enforcement cultures, many communities already struggle to hire and retain the workforce needed for clinical services.

The other major need addressed by different co-responder models is proactive outreach to individuals who come in frequent contact with crisis providers and law enforcement. Models in Texas and California emphasize this function. In most cases the mental health provider is leading the conversation, and the officer is there to build trust in the even law enforcement does have to respond to that person in the future. Health providers, such as case managers, seek a release of information that covers the mental health team on the law enforcement agency. Minnesota should carefully consider how closely this role should be tied to law enforcement. Case management and ACT teams should be accepting referrals for service from police. But it is not always clear where that service benefits from long-term police involvement.

Some co-responder models are a standalone unit within a police department. The mental health provider is directly hired and is accountable to that agency. Others are a collaboration between mental health crisis services and law enforcement. These providers already have expertise in crisis assessment, intervention and stabilization. They cover distinct geographic regions, and have 24/7 access to a mental health professional, even if the assigned "embedded" clinician is not on duty.⁴ Because Minnesota already has a county based mental health crisis response infrastructure, this may be a better match. This may reduce the likelihood of co-responders becoming another service silo that is not connected with other resources. With any of these models, racial disparities are a possible collateral consequence. Communities that have significant levels of mistrust towards police may be less likely to call for crisis services if they believe that they are connected to law enforcement.

A significant factor in long-term outcomes is the strength of the community services to which individuals are being redirected. Despite differences in various co-responder models, a common point is that a mental health provider assists law enforcement in making choices about disposition related to mental health. If the choices available are insufficient, the co-responder model will struggle.⁵

Objectives: Provide timely, on-scene assessment of an individual's needs and possibilities for diversion to community resources. Proactive outreach to individuals who come into frequent contact with hospitals, crisis services, and law enforcement.

⁴ Advocates. Replication Guide. (*FULL CITATION NEEDED*) Page 4.

⁵ Helfgott, J.B., et al., A descriptive evaluation of the Seattle Police Department's crisis response team officer/mental health professional partnership pilot program, *International Journal of Law and Psychiatry* (2015), <http://dx.doi.org/10.1016/j.ijlp.2015.08.038>

Timeline: From planning to operation, co-responder programs have taken 1-2 years to develop.

Resources: [How do we estimate?](#)

Partners: Law enforcement, crisis teams, community mental health providers.

Improved Data Sharing and Collaboration

Uniform Crisis/Discharge Planning for Intensive Services

Conversation with Jill Kemper, ICSI. Scheduled for Wednesday @ 9. Discussion of RARE report.

Improvements to interoperability of electronic medical records

Some states have created a centralized registry of advance directives. Individuals complete their plans and store them through a secure online portal.⁶ They may print a wallet card or store information on their phone that links their name and registry ID. In case of an emergency, a healthcare provider can access their documents with the individual's name and registry ID. Minnesota could implement an option for individuals to choose if they wish to have information disclosed to law enforcement in a crisis situation. While this does not necessarily mean the advance directive is integrated directly into the patient record, it does allow for the person to present at any healthcare provider and still have that information be accessible.

Standard form for voluntary disclosure to law enforcement

[Combine with above?](#)

Further Improvements to Community Services ~~Crisis Standards~~

Inclusion of Psychiatry and Medication Access in Crisis Services

In 2011-2012, the East Metro Crisis Alliance commissioned a study by Wilder Research to understand the costs and results for the Urgent Care for Adult Mental Health program.⁷

- Emergency department utilization decreased significantly post-crisis stabilization for all patients, including “high-frequency” patients.
- Use of outpatient mental health services increased significantly for low-frequency patients following stabilization; no statistically significant change in utilization was observed for high-frequency patients.

⁶ Models reviewed: Virginia, California, Idaho.

⁷ Bennett, A. L., & Diaz, J. (2013, May). The Impact of Community-Based Mental Health Crisis Stabilization. Retrieved October 3, 2016, from Wilder Research, <http://www.wilder.org/Wilder-Research/Publications/Studies/Mental%20Health%20Crisis%20Alliance/The%20Impact%20of%20Community-Based%20Mental%20Health%20Crisis%20Stabilization,%20Brief.pdf>

- All-cause inpatient hospitalization decreased significantly for all patients, including high-frequency patients. In addition, significant decreases in mental health-related admissions were observed for patients as well.
- A cost-benefit analysis found that for every one dollar spent on Crisis Stabilization services, there is a savings of \$2.00 - 3.00 in hospitalization costs.

Additional data suggests a higher diversion rate (did not need to use Emergency Room or in-patient) among clients who saw a psychiatric provider (able to prescribe medication when appropriate.) In addition, the Urgent Care gave individuals a short-term supply of their medication or connected them with other medication assistance programs.⁸ As teams reach 24/7 mobile coverage, Minnesota could commit to integrated psychiatry within crisis response as the next benchmark for service.

Objectives: Achieve best practices in Minnesota's crisis teams by increasing capacity to respond to individuals with high acuity symptoms that require immediate access to psychiatry.

Timeline: *From RAMSEY.*

Resources: *From RAMSEY.*

Partners: Counties, mobile crisis teams, health systems with psychiatry. Workforce would remain a key issue, additional funds could expand the psychiatry residencies offered at the University of Minnesota.

Development of Children's Crisis Residential

The 2015 Legislature gave instructions for the Department of Human Services (DHS) in consultation with stakeholders to develop recommendations on funding for children's mental health crisis residential services that will allow for timely access without requiring county authorization or child welfare placement. In June 2016, the Department of Human Services, Mental health division published an RFP to contract with a qualifying vendor to conduct a study on funding around this benefit. A vendor has been selected and the project is currently in the contracting phase.

The duties for the contract are to research and interpret best practices including researching other state's coverage for children's crisis residential services. Research will include state laws, literature search and other related research to inform policy and standards around treatment coverage such as funding, staffing, eligibility criteria and overall oversight. Research on funding models would include state Medicaid plan and private insurance, particularly on room and board to inform any research around this level of care, cost effectiveness, quality and outcomes. Conduct surveys and interview key stakeholders and providers to define problem, identify barriers and level of care needed. Facilitate and coordinate stakeholder meetings under the guidance of the children's mental health division. Identify topics for each meeting such as crisis models, target population, licensing and certification, authorization authority, review interviews and research. Submit final report of recommendation to the Department of Human Services by June, 30 2017 with a summary of research findings, meetings, interviews and other sources included.

⁸ M. Trangle. Interview.

Recommendations submitted to the department's mental health division will be used to inform establish children's mental health crisis residential services without requiring county authorization or child welfare as a new benefit with Center for Medicaid Services (CMS) approval.

The formulation group recommends that the Task Force adopt a rubric of values and functions to be used in this process, to judge how well potential solutions meet the needs expressed in TF meetings.

Expand Forensic ACT Capacity

Minnesota could invest in specialized Forensic Assertive Community Treatment teams to meet the needs of individuals at risk of future/continued involvement in the justice system due to their mental health needs.

Assertive Community Treatment (ACT) is an evidence based service for people with severe mental illness (specifically schizophrenia and bipolar disorders) and is a multidisciplinary, team-based approach with a small staff to client ratio and 24/7 hour staff availability. ACT is a non-residential service, working with clients in the community, and provides all treatment, rehabilitation, and support needs from within the team (e.g., services not brokered out to other providers). ACT is sometimes described as a "hospital without walls".

Forensic assertive community treatment (FACT) is an adaptation of the traditional model that is designed to help clients that have higher risk of repeated involvement with the criminal justice system or incarceration, than traditional ACT clients. This is a highly underserved population with complex challenges that require a high level of treatment, rehabilitation and services in order to more successfully re-integrate back into their communities. One FACT team is already operating, as a collaboration between the Department of Corrections, Department of Human Services, Ramsey County, and South Metro Human Services. Hennepin County is also starting a Forensic ACT team to work with clients who enter the county jail or are involved in the Mental Health Court. The OLA report recommended further expansion of the Forensic ACT team model to bring this needed service to additional communities.

Objectives: Provide high quality community based mental health services to individuals at high risk of future involvement in the criminal justice system. Reduce jail and hospital bed days among individuals served.

Timeline: Prior expansion has been done at about 1-2 teams per year. The staffing requirements to meet fidelity standards are rigorous, and it may be difficult to find qualified individuals any faster.

Resources: Prior ACT team expansion has required technical assistance and grant funding from DHS. The rate a team has is based on prior costs, and so the year in which they build up to a full case load can require additional funding. Adding 4 teams, each with the capacity to serve about 70 individuals in a year would cost approximately \$5M.

Partners: Counties, jails, Department of Corrections, DHS, community mental health providers.

Expand Pre-Crisis Services

MN Warmline. Program description is incoming.

Objectives: Provide one number access to moderate intensity peer services for all Minnesota residents.

Timeline: Hiring and training additional peers might take 2-3 months after funding is allocated.

Resources: Mental Health Minnesota currently handles X calls/month, with a monthly budget of Y.

Partners: Counties, mobile crisis teams, health systems.

Revised Service Standards for Residential Crisis/Intensive Residential Treatment Centers

Minnesota could consider greater integration of peer run services into crisis response. This would align with recommendation from “Inpatient” group to consider further variants on the IRTS model to expand the populations that could be served. A potential model was studied in California in 2008.

“This experiment compared the effectiveness of an unlocked, mental health consumer-managed, crisis residential program (CRP) to a locked, inpatient psychiatric facility (LIPF) for adults civilly committed for severe psychiatric problems. Following screening and informed consent, participants (n=393) were randomized to the CRP or the LIPF and interviewed at baseline and at 30-day, 6-month, and 1-year post admission.”⁹

Study model: Crisis residential program	Control setting: Inpatient psychiatric facility
Consumer (peer) managed.	County operated.
Small, 6 bed, home-like environment.	80 beds, locked units. Modern, one story design.
Core program staff had lived experience with mental illness, and prior training through community college on peer services, including a certified addiction counselor.	Professionally staffed to provide a medical model of care. Staff noted to have high morale.
Intended length of stay of 8 days, maximum 30.	Average length of stay ~6 days.
Medication management was available onsite via visits from a psychiatrist.	Onsite psychiatry, staffing typical for medical model of care.
Staff provided assertive community outreach after discharge.	Program did not provide outreach after discharge.

⁹ Abstract. 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(1-2), 135–144. doi:10.1007/s10464-008-9180-1

Participants entered the study after being assessed at a crisis clinic. Some came voluntarily, others had been brought by county services. Individuals were eligible if they:

- Had a major mental illness.
- Showed significant needs in a functional assessment.
- Met criteria for an involuntary 72 hour hold due to being gravely disabled by their condition or by being a danger to themselves.

The study excluded individuals who:

- Met criteria for involuntary hold due to being a danger to others.
- Had private insurance to pay for psychiatric care.
- Were not medically stable enough.
- Were younger than 18, and older than 59.

Those who were eligible and agreed (n=393) were assigned to the Crisis Residential or secure in-patient unit by randomized selection. Some participants could not be located at later follow up in each group. However, because the assertive community outreach of the Crisis Residential Program kept more participants in touch with the study, the end results likely understate the effectiveness of the model. Costs between groups were relatively even. The in-patient unit was more expensive upfront, but the group with crisis residential and community outreach ended up using more services on an on-going basis. That outcome may be preferable if it reflects individuals with periodic emergency care transitioning towards more consistent access to recovery/maintenance level care.

The study was much larger, and more objective study than was previously available. Individuals were included in the study with a broader range of needs, and the placement decision was fully randomized for any participant. "Outcomes were costs, level of functioning, psychiatric symptoms, self-esteem, enrichment, and service satisfaction. [...] Participants in the CRP experienced significantly greater improvement on interviewer-rated and self-reported psychopathology than did participants in the LIPF condition; service satisfaction was dramatically higher in the CRP condition."

In Minnesota, some existing crisis residential options come close on some aspects, but further variation may be needed. One key attribute was the smaller size. The other is the integration of the crisis residential staff into ongoing outreach efforts.

Objectives: Provide high quality residential crisis response that is connected to ongoing support in the community. Pilot a model for higher acuity with fewer beds (~6 vs 12-16).

Timeline: Including planning time to match the model to regional needs, additional crisis residential facilities might take 1-2 years to open.

Resources: Prior expansion grants have been about \$X, with ongoing annual costs of \$Y, per program.

Partners: Counties, mobile crisis teams, community mental health providers, hospitals.