GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF MENTAL HEALTH

CRISIS EMERGENCY SERVICES PLANNING WORKGROUP

FINAL REPORT

DECEMBER 21, 2007

DEPARTMENT OF MENTAL HEALTH
CRISIS EMERGENCY SERVICES PLANNING WORKGROUP
FINAL REPORT

TABLE OF CONTENTS

I. PROBLEM STATEMENT

The District of Columbia needs a centralized, community-based system for providing coordinated crisis emergency services to people requiring emergency psychiatric care that is consumer centered, responsive to consumer needs and lived experiences and balances protecting public safety.

Many of the people who require emergency psychiatric care are known to the system and have disengaged from the public mental health system. In addition, there are significant numbers of persons with mental illness involved in the criminal justice system, in part because the first responders are the Metropolitan Police Department ("MPD") and also due to the lack of mental health crisis services.

The current crisis emergency services system does not include adequate emphasis on crisis prevention.

II. BACKGOUND INFORMATION ON THE CURRENT SYSTEM

A. Establishment of the Crisis Emergency Services Planning Workgroup.

On February 7, 2007, the Department of Mental Health ("DMH") convened the first meeting of the Crisis Emergency Services Planning Workgroup (the "Workgroup"). The initial workgroup included representatives from the MPD, Fire and Emergency Services ("FEMS"), the Office of Unified Communications, the D.C. Superior Court, both of the crisis bed providers, community providers, advocates and consumers. The Workgroup was charged with responsibility for reviewing the current system for delivering crisis emergency services and developing a comprehensive plan for delivery of such services. A copy of the Workgroup's charter is attached as ***Appendix A***. A list of the Workgroup members is attached as ***Appendix B***.

The Workgroup met eleven (11) times since its initial meeting. During those meetings, the Workgroup identified a number of gaps in the current service delivery system, identified the range of services needed in the District, examined another model for service delivery, and discussed and made recommendations about some of the identified services needed in the District.

The purpose of this Final Report is to summarize the work completed by the Workgroup.

B. Identified System Gaps.

The Workgroup identified a number of system gaps in the current service delivery system over the course of two (2) meetings held on February 28, 2007 and March 14, 2007. A list of all of the system gaps and concerns identified by the Workgroup is attached and marked as ***Appendix C***. The system gaps fell into eight (8) general areas of concern:

- The existing delivery system is fragmented and does not contain needed linkages to ongoing services.

- The Comprehensive Psychiatric Emergency Program ("CPEP") is the central receiving center. However, CPEP offers a limited range of services and is located in a building that is not conducive to extended observation.

- The Homeless Outreach Team and the Mobile Urgent Stabilization Team provide very limited mobile crisis services.

- Police are the primary responders for mental health issues.

- Emergency medical personnel are not authorized to involuntarily detain individuals for inpatient psychiatric care or transport patients to CPEP for evaluation.

- Crisis residential beds are under-utilized although utilization has improved over the past few months. These beds are not used for hospital step-down.

- No single point of entry, access or information exists. People enter the crisis system through MPD, CPEP, Access Helpline ("AHL") and community-based providers.

- Crisis services are not consumer-driven. Consumer perspective on informing and designing care is missing. Advance directives are underutilized.

- Training about stigma and recovery to ensure the provision of services that are responsive to consumer needs and lived experiences[1] has not been provided to service providers, first responders[2] and other crisis emergency personnel,

III. PROPOSED SYSTEM – GOALS AND RECOMMENDATIONS

In order to address the system gaps and concerns identified by the Workgroup, a number of recommendations were made with regard to the structure and operation of the crisis emergency services system. Those recommendations, which are discussed in more detail in sections IV and V below, are as follows:

- Consumer driven, consumer needs based system, that is culturally competent;

---

[1] The term "lived experience" in the context of mental health consumers commonly refers to someone who: (1) identifies as having a mental illness or has been diagnosed; or (2) has received mental health services. But it also means much more in that it identifies the person in the context of how "having a mental illness or diagnosis" and how "receiving mental health services" has affected them. Indeed, it can also refer to the lived experience of traumatic events or even the lived experience of recovery, by overcoming the negative effects of mental illness/extreme psychological distress, whether that means coming to a state of fulfillment, finding meaning, wellness, independence or, social integration. The term lived experience is powerful because it takes away the stigmatizing aspects associated with a simple understanding of diagnosis/behavior and contextualizes it. Further information about the lived experience can be found on the GAINS Center website (http://gainscenter.samhsa.gov/atc/text/papers/peer_support_paper.htm)

[2] MPD requires all officers to receive training in the Comprehensive Advanced Response Model, which includes thirty-two (32) hours of advanced training in Crisis Intervention. See discussion in Section IV.C.1 (a) about the ongoing collaboration between MPD and DMH with regard to training about mental health issues for members of the MPD.

- Focus on prevention, cooperation and collaboration between the various service providers;

- Ensure that persons with mental illness receive prompt and appropriate mental health services through the crisis emergency services system, rather than arresting an individual and processing the individual through the criminal justice system; and

- Mix of public and private service providers;

    - Retain and enhance existing services: CPEP, extended observation beds and crisis stabilization beds
    - Develop new services: separate crisis hotline, urgent care capacity and mobile crisis teams.

IV. PROPOSED SYSTEM - VALUES

Several themes emerged during the course of the meetings about the crisis emergency services system. The Workgroup agreed that the system design must reflect the following five (5) values. First, the system must be consumer-driven. Second, the system must focus on prevention. Third, the system must be collaborative and cooperative, involving other District agencies and private providers. Fourth, the system must be culturally competent. Finally, the system must focus on workforce development through training and education. Each of these values must be reflected in the overall system as well as in the individual components.

A. Consumer-Driven System.

1. Consumer Input and Perception of Crisis is Valued.

Staff throughout the crisis emergency services system must remember that the crisis is defined by the consumer and must be trained to appropriately respond to crisis situations using a consumer-centric approach. However, each response to a crisis must balance the public safety, including the requirements of District law with regard to involuntary evaluation for those deemed to be likely to injure themselves or others.[3]

Consumers should be encouraged to create psychiatric advance directives[4] and crisis plans. Training and education for consumers and families about psychiatric advance directives, crisis

[3] See D.C. Official Code §21-521 regarding the detention and involuntary treatment of persons with mental illness (".An accredited officer or agent of the Department of Mental Health of the District of Columbia, or an officer authorized to make arrests in the District of Columbia, or a physician or qualified psychologist of the person in question, who has reason to believe that a person is mentally ill and, because of the illness, is likely to injure himself or others if he is not immediately detained may, without a warrant, take the person into custody, transport him to a public or private hospital, or to the Department, and make application for his admission thereto for purposes of emergency observation and diagnosis.") Also see, D.C. Official Code §7-1231.08 regarding the administration of medication.

[4] See DMH Policy 515.1 regarding advance directives.

plans, confidentiality of mental health information, and information sharing, needs to be developed and offered regularly throughout the District.[5]

Staff must to be trained regarding psychiatric advance directives and crisis plans. The consumer perspective must be incorporated into the training of staff throughout the crisis emergency services system about the lived experience[6] including crisis care and trauma informed care.[7]

Further work will be required to implement a training program for consumers, families and mental health providers regarding the development and use of advance directives and crisis plans. DMH will undertake to incorporate these topics within the DMH Training Institute agenda and make it a priority.

Consumers must participate in all aspects of system design, service delivery and service evaluation.

2. **Peer Specialists**.

Peer specialists are an integral part of service delivery. The system must be designed to include peer specialists in all aspects of service delivery and service evaluation, including, but not limited to the mobile crisis teams, CPEP and crisis stabilization beds.

DMH needs to take the lead in developing peer specialist training to ensure peer involvement in all aspects of the crisis emergency services system. The State of Georgia recently received approval from the Centers for Medicare and Medicaid Services (CMS) for a program for Medicaid-billable peer support services. There are peer-operated programs in both West Virginia and New York State, where peers are involved in running the crisis stabilization programs and providing mobile crisis services.

Further work will be required to develop and operationalize the peer specialist program.

B. **Prevention**.

Members of the Workgroup emphasized that there are a number of preventive activities that should be addressed by the public mental health system. The role of the Core Services Agency (CSA) in the provision of urgent care, as well as easy access to case managers, outreach and off hour services to consumers were identified as areas that needed to be addressed.

The Workgroup believed that an increased role for the CSAs in preventive care, including the provision of urgent care, would reduce the need for crisis interventions.[8]

---

[5] See discussion in Section III.B.2 below regarding prevention activities, specifically the discussion about the training and education that needs to be developed and made available to consumers and families about the crisis emergency services system. Training regarding advance directives should be incorporated into the overall training and education program for consumers and families about the crisis emergency services system.

[6] See footnote 1 regarding the lived experience.

[7] See Section III.E below for further discussion about workforce development and training of crisis emergency services staff.

[8] See discussion about the provision of urgent care in Section V.B.2 below.

Other prevention activities recommended by the Workgroup include:

- Offering regular trainings for consumers and family members about crisis emergency services. Training about crisis emergency services needs to be conducted by or coordinated by consumer and family organizations and include trainers from the various crisis emergency services providers. Training needs to be offered at various times throughout the day, including evenings and weekends at a variety of different locations throughout the District.

- Offering regular trainings for consumers and family members about recovery, advance directives and crisis plans. Training for consumers and family members also needs to include training about stigma and the lived experience.

- Increasing the involvement of peer specialists[9] in the provision of services. This would include the use of peer specialists by CSAs as outreach workers to contact consumers who have been inactive or missed appointments.

- Making flexible funds available to cover crisis-related services: rent, groceries, etc. This fund could be some kind of client support fund.[10]

- Offering more support for community support workers to prevent burnout.

- Establishing requirements for CSA staff competency regarding recovery and consumer centered treatment planning.[11] This will include training to enhance sensitivity and understanding of stigma, recovery and the lived experience. Workforce development training is also needed.

- Establishing incentives for CSAs to promote treatment outside of hospitalization based upon clinical needs.

- Establishing consumer operated drop-in centers.

The Workgroup agreed that the MHRS fee-for-service structure does not support the CSA's to provide outreach and crisis prevention services and that consideration should be given to contract funding for those services not covered through MHRS. DMH will take the lead in a review of the MHRS fee-for-service structure to address the various recommendations about improving preventive care.

C. **Cooperation and Collaboration**.

The Workgroup agreed that cooperation and collaboration between all components of the crisis emergency services system was critical to providing quality services. This requires effective,

[9] See discussion about the use of peer specialists in Section IV. A.2 above.
[10] Further work needs to be done with regard to establishing a flexible fund at DMH.
[11] See discussion regarding workforce development in section IV.E below.

ongoing communication and problem-solving mechanisms, as well as quality improvement activities that include other District agencies and private providers.

1. **Interagency Agreements**.

(a) **Metropolitan Police Department ("MPD")**. DMH and MPD have developed a strong working relationship, which will need to continue. Currently, the MPD responds to individuals with mental health needs in accordance with the Comprehensive Advanced Response Model, which requires that all officers receive thirty-two (32) hours of advanced training in Crisis Intervention. MPD's training has been coordinated through the DMH Training Institute and is provided for all members. MPD is in the process of working with DMH to create updates and auditing of its training module to ensure that the training is up to date with contemporary standards for first responders.

In the last quarter of FY 2007, DMH and MPD jointly implemented a pilot project in patrol service area 101 ("PSA 101"), to collaborate to provide mental health assessment, support and facilitate linkage for mental health services for persons with mental illness.

DMH and MPD will need to work together to update MPD's policies and procedures when applicable recommendations in this report are implemented. In addition, DMH and MPD will need to develop a Memorandum of Understanding ("MOU") that specifies how both agencies will work together and support one another, consistent with the recommendations contained in this Report.[12]

(b) **Fire and Emergency Medical Services ("FEMS")**. A small workgroup was formed to address the issues raised by FEMS regarding the detention and transport of consumers. The workgroup included representatives from DMH, FEMS, the Department of Health ("DOH"), the Office of the Attorney General and Superior Court. DMH has begun drafting rules regarding the certification of officer-agents (persons other than a physician or psychologist who are qualified by education and training, to assess and involuntarily detain someone for psychiatric evaluation under the Ervin Act)[13].

DMH and FEMS have discussed training supervising paramedics (approximately 30 people) as officer-agents, so that FEMS has the ability to detain consumers. Representatives from the Office of the General Counsel at both DMH and DOH are reviewing applicable laws, regulations and policies to determine whether FEMS is able to transport involuntarily detained consumers to CPEP for evaluation.[14] DMH and FEMS are also developing an MOU to address the scope of training for supervising paramedics and other issues involving services to consumers.

---

[12] See discussion regarding the relationship between the MPD and the crisis hotline in Section V.B.1 below, as well as the relationship between the MPD and the mobile crisis teams in Section V.B.4 below.

[13] The rules regarding the certification of accredited officer-agents will address certification of DMH employees and FEMS employees, as well as establish a process for determining the eligibility of the employees of other District agencies and mental health providers to serve as an officer-agent.

[14] DMH has requested that the OAG, through the DMH and DOH Offices of General Counsel issue a legal opinion regarding the FEMS transport question.

DMH and FEMS will also need to work together to revise the FEMS Protocol for Handling Behavioral Emergencies to reflect current practice and the recommendations contained in this Report.

(c) **Office of Unified Communications ("OUC")**. DMH needs to develop an MOU with the OUC regarding the coordination of calls both from the crisis hotline and from OUC to the crisis hotline. The MOU will need to address ongoing training of staff from both entities and the necessary ongoing communications.[15]

(d) **Addiction, Prevention, Recovery Administration ("APRA")**. DMH needs to develop an MOU with APRA regarding the transfer of consumers to detoxification or other substance abuse treatment programs. DMH will also partner with APRA to develop additional substance abuse treatment services for consumers, that may include some or all of the services identified by the Workgroup that are discussed in Section III.E.2 below.

2. **Development of Needed Services**.

The Workgroup recommended the development of the following services to fill identified gaps in the mental health service delivery system.

(1) Single Room Occupancy respite beds;
(2) Family respite—in home support to relieve the family;
(3) Community-based and other services to support the work of the crisis team;
(4) Various levels of residential settings;
(5) Substance abuse services such as:
    (i) Sobering stations;
    (ii) Detox programs; and
    (iii) Long-term treatment programs.

The mobile crisis team will provide family respite and take the lead in developing relationships with existing community-based services needed to support its work.[16]

DMH will take the lead in developing the residential alternatives that may include some or all of the levels of services identified by the Workgroup.

3. **Quality Improvement.**

Ongoing quality improvement is required, including case conferences between the various components of the crisis emergency services system about crisis cases. Quality improvement activities (system evaluation, data collection, quality improvement plans and customer satisfaction surveys) need to be built into the system and properly resourced. Consumers need to be involved in quality improvement activities.

[15] See discussion about the operation of the crisis hotline in Section V.B.1 below.
[16] See discussion in Section V.B.4 below regarding the services that will be provided by the mobile crisis team.

Some of the outcomes measurements that will be built into the quality improvement system are expected to include:

(a) Disposition of interventions (to be determined);

(b) Percentage of cases that are stabilized in the community;

(c) Decrease in involuntary hospitalizations;

(d) Satisfaction with the service by primary users, such as MPD, FEMS, family members and consumers;

(e) Reduction in the number of calls that MPD and FEMS receive for assistance for individuals with mental illness;

(f) Increase in connection of consumers with long-term providers; and

(g) Reduction in inpatient hospitalization.

Additional work is required to develop the quality improvement system. Statutory changes may be required to ensure that peer review activities conducted as part of the quality improvement system remain confidential and protected from discovery in litigation under District law.[17]

4. **Confidentiality and Information Sharing**.

Special attention must be paid to issues of confidentiality as well as access to information that can be shared between the various components of the crisis emergency services system.

Statutory changes may be required to accomplish the necessary information sharing. The Workgroup agreed that a comprehensive review of confidentiality laws and regulations, as well as recommendations about needed statutory and regulatory changes must be completed. DMH will take responsibility for convening such a group.

Education for all components of the system (providers, consumers, family members) about confidentiality, including what kinds of information is confidential and what kind of information can be shared, is needed.

5. **Integrated Case Management System**.

Data integration is needed to develop an integrated case management system that would be accessible to the mobile crisis teams and other first responders to a crisis (FEMS, Homeless Outreach). The Workgroup identified the need for an integrated case management data system that should include the following information:

[17] See D.C. Official Code §44-805 for definition of "peer review" activities and the protection afforded to such activities.

- Mental health history;
- Primary care history;
- Diagnosis;
- Medications;
- Individual recovery plan;
- Legal status (regarding civil commitment);
- Name of service provider(s);
- Address and telephone number (email if available);
- Contact information for family or significant others;
- Advance directives (medical and psychiatric care);
- Safety plans; and
- Crisis plans.

Further work is needed to develop an integrated case management system and DMH needs to raise the issue with the Attorney General's office and staff of the City Administrator as it involves a number of District agencies.

D. Cultural Competency.

The crisis emergency services system must be culturally and linguistically competent.[18] Planned services should be responsive to the unique health-related beliefs, attitudes, communication style and values of the consumers it serves.

DMH and its private providers and contractors must comply with Title VI of the Civil Rights Act of 1964, DMH Policy 500.1, Language Interpretive Services and DMH's Biennial Language Access Plan.

E. Workforce Development – Training and Education.

1. Training Recommendations for all Crisis Emergency Services System Staff.

The nature of the required training was addressed by a subcommittee that met in August 2007. Recommendations are as follows:

- Visit and observe all components of the crisis emergency services system, including the crisis hotline, the mobile crisis team, CPEP, St. Elizabeths Hospital, a private hospital inpatient unit, a crisis bed program, APRA Intake, Detox Unit at DC General, and at least three emergency shelters;

- Training about the consumer perspective on what it is like to experience crisis and understand the importance of listening to consumer preferences for treatment, including

[18] Cross, T. L., Bazron, B. J., & Issacs, M. R. (1989). Towards a culturally competent system of care: A monograph on effective services for minority children who are severely emotionally disturbed (Vol. 1). Washington, DC: CASSP Technical Assistance Center, Georgetown University, Child Development Center.

advance directives and crisis plans balanced with the requirements of ensuring individual and public safety during a crisis;

- Training about de-escalation and verbal re-direction interventions and strategies, including certification for identified staff;[19]

- Shadow other jurisdictions, such as Baltimore's BCRI and Montgomery County Crisis Center;

- Officer-Agent training for qualified staff[20];

- Substance abuse assessment and treatment training, including training from APRA on GAIN assessment or Addiction Severity Index (ASI); and

- Cultural and linguistic competency, including but not limited to but not limited to the provision of services that are responsive to racial, ethnic, cultural groups and access to interpreter services for persons with limited English proficiency or those who are hearing impaired.

2. **Training Recommendations for Providers**.

Training for mental health providers (other than those providing crisis emergency services) and other healthcare providers who interface with the mental health system should include the following:

- Training about the structure of the crisis emergency services system and how to access the system;

- Training about the consumer perspective on what it is like to experience crisis and understand the importance of listening to consumer preferences for treatment, including advance directives and crisis plans, balanced with the requirements of ensuring individual and public safety during a crisis;

- Training about de-escalation and verbal re-direction interventions and strategies;[21]

- Officer-Agent training for qualified staff;

- Substance Abuse assessment and treatment training, including training in use of screening tools;

---

[19] A subcommittee of the Workgroup recommended contracting with the Crisis Prevention Institute ("CPI") to develop training for all mental health staff that would include a "Train the Trainer" workshop. This training would be available on a regular basis (at least annually) for all crisis emergency services staff.

[20] See discussion in Section IV.C.1 (b) regarding officer agent training.

[21] See footnote 12 regarding the CPI training on de-escalation and verbal re-direction interventions and strategies.

- Cultural and linguistic competency, including but not limited to the provision of services that are responsive to racial, ethnic, cultural groups, access to interpreter services for persons with limited English proficiency or those who are hearing impaired.

V. SYSTEM ORGANIZATION AND STRUCTURE.

A. General Organizational Issues.

The Workgroup agreed that the structure to provide crisis emergency services will be a combination of public and private providers. The crisis hotline will be operated by DMH. Urgent care services will be provided by a combination of public and private providers. CPEP will continue to be operated by DMH. Mobile crisis services will be deployed and supervised by CPEP. Crisis residential stabilization services will continue to be operated by private providers.

The organizational structure must include a clear and smooth process for transitioning consumers between the various organizational components regardless of how the components are organized or governed.

B. Individual System Components.

The Workgroup identified five (5) components of an effective crisis emergency services delivery system. Those components are (1) access – single telephone line; (2) availability of urgent care; (3) CPEP; (4) mobile crisis outreach teams; and (5) crisis respite/residential services. All components should have effective linkages to the community.

1. Access – Single Telephone Line.

A specific crisis line that is answered 24/7 needs to be established. The crisis hotline must have the capacity to handle calls from callers with limited English proficiency, including those with hearing impairments. The crisis hotline staff must be welcoming. Staff must remember, if the consumer is the caller, that the crisis is identified by the consumer and must be trained to handle calls accordingly. The system must also provide support to family members and others (including neighbors and friends) seeking crisis assistance for an individual. The crisis hotline staff must include peer support.[22]

The crisis hotline should be a separate number from the AHL. The crisis hotline will triage calls for the mobile crisis team. The crisis hotline must also have the ability to interface with the entire network of crisis emergency service providers and refer directly to needed services, including the mobile crisis team, the crisis respite/residential providers, urgent care, CPEP or a CSA. The crisis hotline must have the ability to connect with all aspects of District government including but not limited to the Unified Communication Center (UCC), FEMS and MPD, for purposes of both receiving and making referrals as appropriate.

[22] See discussion about the role of peer specialists in the provision of preventive care through outreach work in Section IV.A and Section IV.B above.

The existence of this crisis hotline must be well communicated to the public. A social marketing strategy will need to be developed as part of the implementation plan for the new crisis emergency services system.

Special attention must be paid to issues of confidentiality as well as access to information that can be shared (what information can be shared; must meet confidentiality requirements). A mechanism should be in place to access the legal status of the caller; there may or may not be hesitancy on the part of a patient in giving this information if they feel it makes them vulnerable. The Workgroup recommended the development of an integrated case management data system to facilitate information sharing.[23]

Crisis hotline staff must be well trained and receive ongoing training. See the discussion about workforce development in Section IV.E for further details about the nature of the required training.

The Workgroup recommended that DMH review the multi-lingual telephone access system used at Multi-Cultural Services in Falls Church, VA. The development of the crisis hotline will be a priority for DMH during the implementation of the recommendations contained in this Report.

2. **Walk-In or Urgent Care.**

The Workgroup recommended that the system include sufficient capacity for urgent or same-day ambulatory mental health services. For purposes of this report, the term "urgent care" is defined as "the provision of a clinical psychiatric service on an unscheduled basis, including having the resources to provide medication." The range of urgent care services should include the ability to see an individual in a timely manner on an unscheduled basis, provide assessments and begin treatment immediately, including medication. Urgent care services would also offer short-term services with the intent of linking the individual for ongoing care.[24]

The Workgroup believes that if consumers had easy access to psychiatric services when needed, they would not require the intensity of mobile crisis and/or crisis stabilization residential services.[25] Effective urgent care programs must have the capacity to see individuals in a timely manner on an unscheduled basis, provide an assessment and begin treatment, including medication and offer short-term services with the intent of linking the individual for ongoing care.

DMH is in the process of expanding urgent care services through the District of Columbia Community Services Agency ("DCCSA") and developing a new Urgent Care Clinic at Superior Court.

---

[23] Specific procedures for sharing information with AHL regarding individuals receiving services/enrolled in services through the Crisis Hotline need to be developed as part of the information sharing process. Also see discussion about the integrated case management system in Section IV.C.5 above.

[24] See discussion in Section V.B.5 regarding the provision of interim case management services by the mobile crisis teams.

[25] See discussion in Section IV.B about preventive care and the role of the CSA's in preventive care.

The Workgroup recommended that DMH explore the availability of other funding mechanisms to provide urgent care services, such as the clinic option, a brief intervention code or some other mechanism using primary care as a model. DMH needs to explore these options.

The system needs to make arrangements for consumers to have access to alternate means of transportation to urgent care or walk-in services. MPD or EMS are not and should not be seen as transportation resources for consumers seeking ambulatory urgent care services. Transportation could be provided by the mobile crisis team or by peer support teams. DMH will explore this with the provider community.

3. **Comprehensive Psychiatric Emergency Program**.

The Workgroup agreed with the recommendation from DMH that the mobile crisis teams should be operated by and deployed from CPEP.

Currently, CPEP provides triage and assessment of psychiatric patients. Medication is also provided as needed. CPEP currently admits approximately 35% of individuals seen to psychiatric hospitals and refers approximately 10% of its consumers for medical clearance for conditions such as chest pains.

CPEP needs to have the capacity to conduct initial medical evaluations, which could be done by a physician or a physician extender (nurse practitioner, physician assistant, etc.) plus baseline laboratory work including the capacity to handle high blood pressure and high glucose levels. CPEP will be hiring addiction counselors in early FY 2008 to provide addiction counseling services to people with co-occurring substance abuse disorders. In addition, APRA has hired mental health social workers to provide services at its intake program.[26]

DMH has funding in the FY 2008 budget to establish 6 – 10 new extended 72 hour observation beds at CPEP. The funding includes additional staff and will increase CPEP's capacity to provide crisis stabilization.

The Workgroup recommended that CPEP develop capacity to provide outreach and assistance to consumers during the period between discharge from crisis services and an appointment with a mental health provider. It is highly recommended that peer specialists participate in these services.[27]

4. **Mobile Crisis Teams.**

It is recommended that the new mobile crisis teams be established by CPEP.

Mobile crisis teams need to be able to respond to individuals throughout the District who are experiencing a psychiatric crisis who are unable or unwilling to travel to receive mental health

[26] See discussion about cooperation and collaboration with other service providers, including interagency agreements with District agencies and relationships with other service providers in Section IV.C.
[27] See discussion in Section IV.A.2 regarding the use of peer specialists throughout the crisis emergency services system.

services. The mobile crisis service should respond to the situation and spend as much time as needed to ensure crisis stabilization and to make an appropriate disposition. The mobile crisis teams need to be able to be available to respond to the requests of MPD, FEMS, family members, concerned citizens and/or the individual. The mobile crisis teams must be able to offer a range of services including but not limited to onsite crisis stabilization including dispensing of medications, in home services and linkage to other services such as crisis beds, assessment for voluntary and involuntary hospitalizations, FEMS and MPD when needed.

Ideally, mobile crisis services would be available 24/7, if funding permits. However, if the necessary funding is not immediately available to fund services 24/7, then, it should be determined through discussions with MPD, FEMS, CPEP and other stakeholders, the hours the teams would be most needed including week-ends and holidays. The crisis hotline will be used to triage calls for mobile crisis services.

The Workgroup recommended that the District set a goal to have a minimum of three (3) mobile crisis teams operating at any given time. The composition of the mobile team is crucial. The Workgroup recommended the following regarding the composition of the mobile team:

- Mobile crisis team service be a distinct component within CPEP;
- Each mobile team will be staffed by 2 people;
- One staff person will be a mental health professional;
- Each mobile crisis team will have adequate psychiatric coverage;
- Teams must be co-occurring competent (mental illness and substance abuse);
- Teams must be sensitive to diversity issues, including ender, race, ethnicity, linguistic competence;
- Debriefing of mobile team members must be built into scheduling;
- Teams need to overlap coverage during peak times 11 am – 10 pm;
- Each qualified[28] mobile team member will be certified by DMH as an "officer/agent;"
- Mobile crisis team members and rest of the CPEP staff will be cross-trained;
- Mobile crisis team members will participate in CPEP rounds;

[28] DMH is currently developing rules for the certification of an accredited officer-agent, which limit certification only to those designated as "qualified practitioners" in the rules. In general, a qualified practitioner is a licensed healthcare professional. Although the rules are in draft form, DMH expects that the final version of the rules will include this kind of limitation on eligibility for certification as an officer-agent.

- Mobile crisis teams will have the ability to assess and admit consumers directly to crisis residential stabilization beds; and

- Peer specialists will work with the mobile crisis teams.

The Workgroup identified a broad range of services that will be offered by the mobile crisis teams. Mobile crisis teams will offer in-home supports. The length of involvement will be tied to the needs of the consumers. Mobile crisis teams must have the ability to admit directly to crisis residential stabilization beds and have immediate access to other aspects of the crisis system[29] Mobile crisis services are seen as short term (from two (2) to six (6) weeks depending on consumer need) and not ongoing. There will be a need to link up with current providers where possible.

Mobile crisis teams may provide interim case management services to consumers until the consumer sees a psychiatrist. These interim case management services may extend beyond the short term intervention typically handled by a mobile crisis team. The Workgroup recommended peer involvement in case management services. Further work is needed to establish the eligibility criteria for the cohort of patients qualified to receive interim case management services.

Data integration is needed to develop an integrated case management data system that would be accessible to the mobile crisis teams and other first responders to a crisis (FEMS, Homeless Outreach).[30] Further work is needed to develop an integrated case management system.

The mobile crisis teams need to develop strong linkages with MPD, FEMS and all potential users of the service. Developing these relationships and resources will be the responsibility of the program leadership of the mobile crisis team.[31]

Ongoing quality improvement is required, including case conferences between the parties about crisis cases. Quality improvement activities (system evaluation, data collection, quality improvement plans and customer satisfaction surveys) need to be built into the crisis system and properly resourced.

The structure of the mobile crisis teams should ensure that staff are valued and supported in their work. It is critical that the mobile crisis teams receive necessary support related to the intensity of the work and resulting emotional drain. This would include providing opportunities for debriefing and other interventions that are standard for emergency responders.

5. **Crisis Respite/Residential Services.**

DMH currently funds and supports the operations of fifteen (15) crisis residential stabilization beds ("crisis beds") through contracts with two (2) community-based providers. Eight (8) crisis

[29] See discussion about the linkages between the various components of the crisis emergency services system in Section IV.C above.
[30] See discussion regarding integrated case management system in Section IV.C.5 above.
[31] See discussion regarding collaboration and cooperation with other agencies in Section IV.C above.

beds are operated by Woodley House and seven (7) crisis beds are operated by So Others Might Eat ("SOME").

Crisis beds are an alternative to psychiatric hospitalization, are voluntary, community-based and offer 24 hour/7 days per week home-like support for individuals, who, due to a psychiatric crisis would otherwise be hospitalized, can not remain in their current residence or do not have a stable living environment to remain in. Services include immediate access to psychiatric, medical, and if needed assistance with obtaining benefits, housing and resolving impediments to community stability.

To be eligible for a crisis bed, there must be acute psychiatric symptoms that put the individual at risk for a more restrictive setting such as inpatient care or homelessness.

There was a consensus that there must be low barriers to admission into crisis beds. The crisis bed providers must maintain the capability to admit directly following DMH's medical necessity criteria. Ideally, the crisis bed providers will have the ability to conduct mobile assessments of candidates for crisis stabilization services, which might include riding along with the mobile crisis team, as appropriate.

Although the assessment process has been streamlined, efforts need to be made to further refine the assessment process and to figure out ways to expedite the sharing historical information about care, treatment and services provided to the person in crisis.

In FY 2008, DMH has begun authorizing and reimbursing for the use of crisis beds as step-down from inpatient care.

DMH has developed guidelines and expectations for the operation of crisis beds. Some of these guidelines and expectations are memorialized in the contracts for the services. Others are not. Therefore, DMH must develop rules for the operation of crisis beds that, at a minimum address staffing and psychiatric and medical oversight.

VI. IMPLEMENTATION PLAN

It is the goal of DMH to begin implementation of some of the recommendations in FY 2008. The initial items to be implemented are the following:

- Establishment of the specific crisis hotline;
- Development and establishment of the mobile crisis teams;
- Establishment of a new Urgent Care Services Clinic at Superior Court;
- Establishment of a multi-agency information technology ("IT") taskforce, including representatives from the Office of the Chief Technology Officer ("OCTO"), FEMS, MPD, DMH and APRA to develop electronic exchange of assessment and treatment information about persons requiring crisis services;

- Implementation of increased urgent care services by the DCCSA at its various sites (effective November 1, 2007);

- Development of the rules and training to enable EMS personnel to become accredited officer-agents;

- Development of MOUs with MPD, EMS and OUC to address the recommendations of the Workgroup;

- Revision of MPD General Order regarding transportation of persons suspected of having mental illness and FEMS protocol regarding behavioral health emergencies; and

- Implementation of the process developed by DMH to further review the MHRS fee for service system during the first quarter of FY 2008, which hopefully will include a review of the urgent care payment issues raised by the Workgroup.

VII. CONCLUSION AND FOLLOWUP ACTIVITIES

The Workgroup reached consensus on the following:

- Service components;

- Peer involvement in all aspects of services;

- Integrated case management system;

- Quality improvement activities (including regular case conferences); and

- Deployment and supervision of mobile crisis teams from CPEP.

The following areas will require additional work:

- Review of MHRS system to address concerns about availability of preventive care, including urgent care capacity and transportation for urgent care;

- Developing and operationalizing a peer specialist program;

- Development of new services to fill identified system gaps set forth in Section III.E.2.;

- Development of eligibility criteria for the cohort of patients who will qualify for interim case management services provided by the mobile crisis teams; and

- Review of District laws governing privacy and confidentiality of healthcare information to develop recommendations about changes needed to facilitate information sharing, including the integrated case management system. This should be done in conjunction

with the work of the multi-agency IT taskforce that will include representatives from OCTO, FEMS, MPD, DMH and APRA.

Finally, DMH is committed to having the Workgroup continue to meet on at least a quarterly schedule to review the implementation of its recommendations.

APPENDIX A

GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF MENTAL HEALTH

CHARTER FOR MENTAL HEALTH CRISIS EMERGENCY SERVICES PLANNING WORKGROUP

Name Of This Group.

Crisis Emergency Services Planning Workgroup

Background Information/Context To The Formation Of This Group.

The Department of Mental Health has a need to evaluate its current model for delivering crisis/emergency services and develop a comprehensive plan for the delivery of such services.

The Mission (Purpose) Of This Group.

The Director has charged this workgroup with reviewing the current system for delivering crisis/emergency services and developing a comprehensive plan for delivery of such services .

This Group's Core Functions.

1. *To review the current system for delivering crisis/emergency services, including the statutes, regulations, policies and procedures governing the process.*

2. *To review other models for the delivery of crisis/emergency services in urban areas.*

3. *To review models for financing the delivery of crisis/emergency services in urban areas.*

4. *To develop a comprehensive plan for the delivery of crisis/emergency services in the District of Columbia.*

The Vision of This Group's Mission Accomplished.

A comprehensive plan for the delivery of crisis/emergency services in the District of Columbia is completed.

APPENDIX A

Stakeholder Assessment.

1. *Mental health consumers and families*
2. *District agencies -- MPD, EMS, DOH/APRA, DHS/APS, CFSA, DYRS, DCPS*
3. *Community hospitals and emergency rooms*
4. *Community-based providers*
5. *Superior Court*

For each key stakeholder/stakeholder group, what is the 'win' from the work of this group?

- *Timely and quality services for consumers and families*
- *Improved efficiencies for District agencies*

Macro Work Process Plan.

What are the major phases of the work to be accomplished?

1. *Kickoff Meeting -- Review where we are*
2. *Meeting 2 -- Review other system models*
3. *Meeting 3 -- Discuss and agree upon range of desired services*
4. *Meeting 4 -- Discuss and agree upon structure of providers*
5. *Meeting 5 -- Discuss and agree upon funding options*
6. *Meeting 6 -- Identify structural barriers to implementing desired system changes (legislative, regulatory, policy, etc.)*
7. *Meeting 7 -- Finalize draft report*

When will this group's work begin?

February 7, 2007 from 10 A.M. to 11:30 A.M. at DMH - Kickoff Meeting.

When will the work of this group be completed?

Phase 1 -- Draft Comprehensive Plan for Adults -- May 31, 2007
Phase 2- Draft Comprehensive Plan for Children-To be determined

APPENDIX A

Desired Outcomes Expected From This Group.

Completion of comprehensive plan for delivery of crisis/emergency services, inclusive of budget, funding strategy and implementation plan.

When will each desired outcome be accomplished?

First report due by May 31, 2006

Sponsoring Authority For This Group.

What person, persons, or body is commissioning this group?

The Director, DMH

To whom is this group accountable for its results?

The Director, DMH

Scope of and Constraints To This Group's Authority.

What is the scope of this group's authority?

Applicable DC Statutes, Rules and Regulations

What decisions are within the purview of this group?

Design recommendations.

Group Membership.

Who are the core group members?

See attached list of invited group members.

What criteria govern ongoing and additional membership?

If a core member position turns over or becomes vacant, the appropriate sponsoring authority will replace the member in a timely manner.

APPENDIX A

Group Member Roles And Responsibilities.

What are the general group member responsibilities?

Attend meetings and complete assignments that we enable group to evaluate the process and determine what systemic changes are required.

Decision-Making Method.

How will this group make decisions?

By consensus.

If the decision-making method is consensus or consensus decision making delegated with constraints, what is the fallback decision-making method in the absence of a consensus agreement?

Resolution by the Director.

Adopted from DMH Priority Populations Workgroup, which used this form that was developed by Richard Mettler ,October 1999

APPENDIX B
WORKGROUP MEMBERS

1.	Dorothy Adams, Consumer Leadership Forum (CLF)
2.	Stephen T. Baron, Director, Department of Mental Health (DMH)
3.	Barbara J. Bazron, Ph.D., Deputy Director, Office of Programs and Policy, DMH
4.	Jana Berhow, Chief of Access, Care Coordination, DMH
5.	Mary Blake, Director of Training, Consumer Action Network
6.	Tori Brown, SOME
7.	Dr. Ray Brown, Homeless Outreach Program, DMH
8.	Lois Calhoun, Forensic Coordinator, DMH
9.	Tyrone Cartwright, Woodley House
10.	Ann Chauvin, Administrator, So Others Might Eat
11.	Michael Clancy, Deputy Administrator, Green Door
12.	Travis Dupree, Office of Unified Communication
13.	Christine Elwell, Outreach Worker, D.C. Central Kitchen
14.	Suzanne Fenzel, Chief, Mental Health Section, Office of the Attorney General for the District of Columbia
15.	Tedla Giorgios, District of Columbia Community Services Agency (DCCSA)
16.	Magistrate Judge Joan Goldfrank, D.C. Superior Court
17.	Frederica Gonzales, Consumer Leadership Forum
18.	Molly Graham, Woodley House, Inc.
19.	Chet Grey, Downtown DC Business Improvement District, Homeless Services
20.	Lt. Silvia Hamelin, Metropolitan Police Department
21.	Alexis Haynes, Director, Care Coordination, DMH
22.	Cynthia Holloway, Director, Comprehensive Psychiatric Emergency Program (CPEP), DMH
23.	Regina Hughes, Woodley House, Inc.
24.	Claire Johnson, CSOSA
25.	Phyllis Jones, Public Information Officer, DMH
26.	Assistant Chief, Brian Jordan, Metropolitan Police Department
27.	Linda Kaufman, Pathways to Housing
28.	Claire Kelleher-Smith, Case Manager, Bread for the City
29.	Yvonne Keyes, Office of Consumer and Family Affairs, DMH
30.	Dr. Robert Keisling, Director of Psychiatry, Unity Healthcare
31.	Tracy Knight, Bread for the City
32.	Mary Ann Luby, Washington Legal Clinic for the Homeless
33.	John Lynch, CLF
34.	Kemba Maish, Ph.D., Forensic Services, DMH
35.	Andres Marquez-Lara, Clinical Director, Green Door
36.	Michele May, Homeless Services Coordinator, Homeless Outreach Program, DMH
37.	Barbara McKenna, Washington Nursing Facility
38.	Denise McNeal, CLF
39.	Steve Newman, Executive Director, NAIMI-DC
40.	Dr. Ikechi Nnawuchi, Medical Director, CPEP, DMH

APPENDIX B
WORKGROUP MEMBERS

41.	Christine O'Connor, So Others Might Eat
42.	Valentine Onowuche, Department of Health, Addiction, Prevention & Recovery Administration
43.	Juanita Price, CEO, DCCSA
44.	Audrey Read-Brown, So Others Might Eat
45.	Juanita Reaves, Ph.D., Director of Adult Services, DMH
46.	Galina Sergen, Legal Aid Society
47.	Susan Shaffer, Director, Pretrial Services Agency
48.	Effie Smith, Director of Advocacy, Consumer Action Network
49.	Dr. Steven Steury, Chief Clinical Officer, DMH
50.	Anne M. Sturtz, Deputy Director, Office of Strategic Planning, Policy & Evaluation, DMH
51.	Gerard Thomas, Consumer Leadership Forum
52.	Anne Weiss, Deputy Director, DMH, Office of Accountability
53.	LaToya Wesley, Research Analyst, CJCC
54.	Gwendolyn Williams DMH
55.	Dr. Michael Williams, Medical Director, D.C. Department of Fire and Emergency Services
56.	Debra Young, Executive Director, Woodley House

APPENDIX C
SYSTEM GAPS

DEPARTMENT OF MENTAL HEALTH
CRISIS EMERGENCY SERVICES PLANNING WORKGROUP

SYSTEM GAPS

February 28, 2007 & March 14, 2007

Superior Court

- Lack of crisis services at consumer/family home (lack of mobility) causes delays in service because of time required to commit or get service (either in the hospital or in the community)
    - Need linkage to police
    - Team composition should include someone with medical training, law enforcement and special transport
- Use of criminal charges to get family members treatment
- Insufficient crisis bed capacity
- Limitations on length of stay in crisis beds to 14 days

Police

- Domestic violence law in the District mandates arrest, police officers have no discretion with regard to mental health issues
    - If crisis team responded the police intervention would not be necessary

Consumer & Family

- Why is EMS response different for a mental health issue than for a physical issue
    - Example: If consumer in crisis engages in destructive behavior and breaks leg during the incident, EMS would transport to hospital for treatment. If no medical issue, consumer would be arrested.
    - EMS wants to change this approach – offers San Francisco model as a way of handling these kinds of issues.
- The consent policy needs to be enhanced and consumers and providers need to be educated about what constitutes consent, advance directives and advance crisis planning. Consumer crisis plans need to be accessible to mobile teams, CPEP and other service providers.
- Families find it hard to get guardianship.
- Lack of services available to treat the entire family. Need better communication to families, education for families about consumer rights and options, linkages to other services.
- Lack of coordination between agencies.
- More concerns about HIPAA issues than treatment.
- Focus seems to be only on hard to manage children
- Not enough day services for people with SSDI.

APPENDIX C
SYSTEM GAPS

- Families want more school screening (objections by some consumer advocates to more screening because of the stigma)
- Failure to learn from crisis. No after crisis analysis, no work to identify warning signs, so that the consumer can learn from the crisis.
- Lack of representative payee services/financial services. Disconnects between the team and the consumer with regard to money causes consumer crisis.
- Lack of capacity to transport consumers to crisis beds or to other needed mental health services. Need minimal or low barrier to access to transport.
- More flexibility in the system
- Lack of mental health services in jail.
- Missing linkages to other systems – such as aging, private insurance.
- Limited amount of time to meet with psychiatrists. Lack of cultural competency on the part of psychiatrists.
- Consumers need to know who to call -- need better access to community-based providers to avert crises. Better prevention strategies.
- Insufficient day treatment.
- Peaceful drop-in places for homeless consumers.
- Language access – both for people who do not speak English and those with a hearing impairment
    - Make training available for staff to deal with consumers with limited language proficiency
- Lack of training for law enforcement and medical personnel on how to handle a mental health crisis
- Need better protocols to address services for consumers in crisis who are between providers
- More capacity to provide urgent care – ability to get immediate, unscheduled access to a psychiatrist or mental health professional to avert crisis, especially for consumers who can't handle the structure of the existing process
    - Currently, Unity Healthcare fulfills this need
- Lack of services for the uninsured or those whose insurance does not cover mental health or substance abuse treatment services (is there a patter of waiting to get help until there is a crisis in the uninsured and underinsured?
- People discharged from community hospitals or federal prison without medications
- Need to better define the population and the needs
- How do those with private insurance access the crisis system – what are private insurance options – currently, MPD is called.

Providers

- Need better education about options available for getting assistance for consumers, like 911 for other emergencies
- Need to develop viable options for addressing crisis
    - Such as a single number with authority that includes a feedback loop

- Sharing the contact number with neighboring jurisdictions

EMS

- Rules require EMS to transport to hospital
- EMS paramedics need the ability to write FD-12's
- Need integrated aftercare
- No data system to share information about crisis plans, advance directives for outreach workers, CPEP and throughout the healthcare service network
- Poor communication between various providers about the consumer's history, needs, etc.
- Use of ER's not effective because of elopments and delays in seeing a mental health professional

Front End Issues

- Expectations of the provider community are unclear
- Crisis planning ought to be addressed at the front end
- Providers need to ensure back-end continuity as well.
- Sometimes there are behavioral crises that are not caused by mental illness.
- System does not address trauma.
- Providers fail to ask consumers about natural supports.
- Need consistent training and criteria for Officer –Agents regarding issuance of FD 12's and 522s – need policy on these issues

Crisis Beds

- Need more education for crisis bed providers about substance abuse treatment options services for the homeless
  - The Montgomery County Model was recommended as an integrated service model that works
- Need more low barrier beds (look at old Statement of Work for crisis bed contract)
- Need mobile crisis with a single access number
- Need continuous training, education and outreach
  - Include training in the DMH Training Institute schedule
- Inadequate case manager response to crisis
- Lack of adequate housing – requires discharge from crisis beds to street or shelter
- Trauma patients in need of mental health services languish in inpatient wards, because there is no place for them to go in the community, so the hospital beds are serving as crisis services
- Need better linkage to other services
- Need a flow chart of current system to help identify gaps

APPENDIX C
SYSTEM GAPS

CPEP

- Linkage of CPEP to a medical facility to immediately rule out any medical conditions
- Clinical staff to assist consumers who are newly linked to CSA services and awaiting services
- CPEP is not able to consistently implement the full treatment model of emergency psychiatry due to staffing & space
- Evening and week-end services (on-call services do no appear to be sufficient)
- Supportive housing or supervised residences
- Insufficient number of day treatment programs for consumers and their families to learn about & understand mental illness
- Urgent Care facilities to treat non-emergency psychiatric problems
- Immediate access to consumer's treatment information to better treat consumers presenting in a crisis
- Crisis Intervention at the community level
- MPD training, initial and on-going to familiarize and keep officers abreast of mental health treatment alternatives
- Mandatory clinical training for all employees involved in direct treatment of mentally ill consumers
- Treatment of the dually diagnosed consumer and adequate identification of and education to treatment resources
- Facilities to delouse consumers who have that need
- Respite facilities for consumers who are in the care of agencies or family members
- Crisis or behavioral plans for consumers in care facilities (CPEP rarely sees crisis plans or has them made available)