



COMMONWEALTH OF PENNSYLVANIA

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Dear Stakeholder:

The Office of Mental Health and Substance Abuse Services (OMHSAS) is pleased to present the Crisis Intervention recommendations developed by the Crisis Intervention workgroup members. This group represented a cross section of rural and urban counties, MH/MR administrators, crisis workers, BH-MCOs, peer specialists, state staff and other stakeholders. OMHSAS recognizes the critical role of a responsive crisis system in reducing the intensity and duration of an individual's distress. Effective crisis intervention services should ensure the individual gets the right service in the right way at the right time to avoid re-occurring crisis situations. To better understand the nature of crisis services being delivered across the state, OMHSAS, in collaboration with the Crisis Intervention Association of Pennsylvania, began the process of gathering statewide data on the status of the current crisis system. The initial data indicated a wide variation in the delivery of crisis services across the state.

To provide input and assist in the analysis of the data, a time-limited stakeholder workgroup was established. The goal of the workgroup was to identify best practice recommendations for refining crisis intervention services in the Commonwealth to reduce the potential for future crises and produce better outcomes for individuals seeking services.

Service coordination, peer services, staffing and training, and funding were key areas pertinent to the delivery of crisis services that were reviewed by the workgroup to develop specific recommendations. The workgroup further synthesized the individual recommendations into short-term and long-term recommendations for transforming the crisis system. It was recognized that many other partners are critical to creating lasting changes in any system and must continue as active, vibrant participants in the process.

I would like to express my appreciation to each workgroup member for their time and commitment to this important initiative. OMHSAS will continue to move forward with our partners to improve and support our crisis system.

Sincerely,

Sherry H. Snyder
Acting Deputy Secretary

Crisis Intervention Services

Transformation Recommendations

OMHSAS Crisis Intervention Workgroup

January 20, 2011

Acknowledgements

The Office of Mental Health and Substance Abuse Services would like to thank the workgroup members for their time, dedication, and recommendations that will assist in transforming our current crisis intervention services to support recovery in the community.

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Table of Contents

Acknowledgements

Table of Contents

Introduction

History

Background

Areas of Work

Best Practice Principles for Crisis Intervention

Recommendations

Conclusions

Appendices

Introduction

Children, youth, adults, older adults and family members utilize the public behavioral health system during a crisis situation, regardless of socio-economic status, health insurance coverage, or history of behavioral health problems. They can be individuals currently connected to “the system” as well as people who are unknown or who have never received behavioral health services. Crisis Intervention is obligated to serve all individuals who need the service despite funding resources or established connections to the behavioral health service delivery system. In 2008, approximately seventy-eight thousand individuals in the Commonwealth received at least one type of crisis intervention service from the public behavioral health system based upon data reported by the counties.

Any individual seeking help during a crisis needs understanding, support, and access to a variety of community resources to stabilize the situation. At times, the crisis system responds from a narrow perspective of “imminent danger” rather than a broad approach that addresses the actual issue underlying the crisis situation. For individuals diagnosed with serious mental illness that are reliant on the public behavioral health system, the delivery of crisis intervention services from such a narrow viewpoint focusing only on emergency services can have a profound impact. They can be at greater risk to experience recurrent utilization of crisis intervention services which can exacerbate a diminishing sense of control and increase feelings of disempowerment. The potential for re-traumatizing the individual can occur at multiple points during this type of crisis intervention process.

Effective crisis intervention services should ensure the individual gets the right service in the right way at the right time to avoid recurring crisis situations. Individuals should be assisted in accessing appropriate services and supports in the least restrictive setting to resolve the crisis in a timely manner. If a gap in community-based services and supports that impacts crisis situations is identified within the public behavioral health system, every effort should be made to address the lack of resources within the system.

To ensure that crisis intervention services are consistently provided in a manner that supports recovery across the state, the Office of Mental Health and Substance Abuse Services (OMHSAS) began to gather baseline information on the status of the existing crisis system in January of 2010. Based upon the statewide survey data and regional focus group discussion on the diverse status of crisis services in the Commonwealth, a time-limited statewide workgroup was convened on June 30, 2010 to offer recommendations on transforming the current crisis system from a reactive and cyclic approach to one that reduces the potential for future crisis and produces better outcomes. This paper provides an overview of this work and the workgroup’s final recommendations to begin the transformation of crisis intervention services in Pennsylvania.

History

The Mental Health and Mental Retardation Act of 1966 (50 P.S. §§ 4101-4704) established the present framework for the mental health delivery system in Pennsylvania. The Act distinguished basic responsibilities for the state and the counties. In Article III, Section 4301(d) (4) of the Act counties are required to provide emergency services twenty-four hours per day. This responsibility is assigned to the county mental health/mental retardation (MH/MR) administrator. Article IV, General Provisions Relating to Facilities; Admissions and Commitments, of the MH/MR Act governed the admission, transfer, discharge, and commitment process of patients from mental health facilities (50 P.S. §§4401-4413). The original language allowed patients to be “admitted to a facility through a voluntary admission, voluntary commitment, admission on application by a relative, guardian or friend, emergency detention, court commitment, or criminal court commitment” (50 P.S. §§4401-4408). Numerous sections of Article IV were declared unconstitutional on procedural due process grounds.

In order to address the legal issues of the MH/MR Act of 1966, the Mental Health Procedures Act was signed into law on July 9, 1976 as Act 143. The Mental Health Procedures Act (MHPA) addressed mental health procedures, provided for the treatment and rights of individuals diagnosed with mental illness, and adopted criteria for voluntary and involuntary examination and treatment. Approximately one year after Act 143 became law, a public hearing was held on the effectiveness of the Mental Health Procedures Act. Based upon stakeholder testimony, additional changes were recommended to the Act. Senate Bill 1105 amended the Act by including language clarifying Mental Health Review Officers duties, right to appeal commitments to the court of common pleas, extension of immunity to peace officers, and the right of person charged with a crime to seek voluntary mental health treatment. The bill was signed into law on November 26, 1978 as Act 324. The Mental Health Procedures Act established the standards for voluntary and involuntary commitment and the procedures for involuntary commitment.

The mental health system is organized in conformance with the existing state laws, the MH/MR Act of 1966, the Mental Health Procedures Act of 1976 as amended, and the Public Welfare Code which locates the Office of Mental Health and Substance Abuse Services (OMHSAS) under the purview of the Department of Public Welfare. The MH/MR Act requires county governments to provide community mental health services including inpatient, outpatient, partial hospitalization, information and referral, intake, specialized rehabilitation and training, vocational rehabilitation, consultation, aftercare, and 24-hour emergency service. Article III of the Act further mandated that these services be administered by county government either independently or in multi-county jointers and that local County Mental Health Boards be established for community input into the county mental health programs. Currently, there are 48 county mental health programs covering the 67 counties in the state. The Office

of Mental Health and Substance Abuse Services (OMHSAS) allocates funds to the county governments for the provision of the mandated community mental health services.

To meet the 24 hour emergency service requirement initially, many counties established a telephone hotline with hospital emergency room back-up. Some counties developed additional services such as mobile crisis services. The need to develop and implement consistent strategies to improve mental health crisis service capacity across the state was identified in the Pennsylvania State Mental Health Plan. To address this goal, in the fall of 1989, a workgroup which included representation from consumers, families, counties, providers and professional associations was convened to help define and guide implementation of a comprehensive array of mental health crisis intervention services. Five services were defined: telephone crisis service, walk-in crisis service, mobile crisis service, medical-mobile crisis service, and crisis residential service. The regulations for mental health crisis intervention services were drafted and published as proposed in Volume 23, Number 10 of the Pennsylvania Bulletin on March 6, 1993.

Initially, the services were supported by State/county program funding. To maximize funding needed for crisis service expansion, the Department applied for and received approval of a Medicaid State Plan Amendment to allow Medicaid reimbursement for all five crisis services. The plan identified the specific crisis intervention services that would permit Federal participation in payment for the delivery of these crisis services and continued the accountability for these services under county MH/MR administrators. In 1997, the Department of Public Welfare (DPW) was granted a 1915(b) waiver from the Centers for Medicare and Medicaid Services (CMS) to provide a new integrated and coordinated health care delivery system, known as the HealthChoices program to provide behavioral health care to Medical Assistance recipients residing in the Southeast zone of the state. The program was designed to improve access to and quality of care for recipients and to stabilize spending. Due to the success of the HealthChoices program, counties advocated for statewide implementation which occurred in 2007. The HealthChoices program funds mandatory telephone and mobile crisis services and provides opportunities for the expansion of cost-effective alternative crisis models.

The provisions of the Medicaid State Plan Amendment, the proposed Crisis Intervention regulations, the MH Procedures Act as amended and the HealthChoices program access standards furthered the goal of fostering a unified behavioral health system wherein there exists an array of community-based services that support the least restrictive service to meet behavioral health needs in each county. The intent of State legislation has been the creation and ongoing development of an integrated behavioral health system with the ability to deliver a comprehensive array of prevention and treatment services to those in need. Services are to be provided in an efficient and effective manner, in the least

restrictive setting, and with regard for the rights and dignity of individuals. An effective, responsive crisis intervention service is an essential element of any comprehensive behavioral health service system.

Background

Emergency services are required to be available 24 hours a day under Section 301(d) (4) of the Mental Health and Mental Retardation Act of 1966 of the Pennsylvania statute. Emergency services “consist of observation, treatment and close supervision which are available at any hour of the day or night to persons who are in need of immediate care, and must not be denied a person requiring such care” (55 Pa. Code 4210.41). Counties were to ensure that emergency mental health services were available twenty-four hours a day, seven days a week and be accessible to any individual in the community who needed such resources. Emergency services can include procedures for initiating involuntary examination and emergency treatment under the provisions of the Mental Health Procedures Act (MHPA) of 1976. The decision of whether or not to proceed with an involuntary examination for treatment is a serious responsibility that impacts an individual’s personal rights. All voluntary options should be explored before proceeding with any involuntary procedures based upon the criteria specified in Section 301 of the Mental Health Procedures Act of 1976.

55 PA Code Chapter 5240, Mental Health Crisis Intervention Services, as proposed, defines crisis intervention services as immediate, crisis-oriented services designed to ameliorate or resolve precipitating stress that are provided to adults or children and adolescents and their families who exhibit an acute problem of disturbed thought, behavior, mood or social relationships. These services provide rapid response to crisis situations which threaten the well-being of the individual or others. Mental Health Crisis Intervention (MHCI) services include intervention, assessment, counseling, screening, and disposition. Telephone crisis services must be available 24 hours a day, seven days a week to screen incoming calls and provide appropriate counseling, consultation and referral (§ 5240.71). HealthChoices, the mandatory Medicaid managed care behavioral health program, requires access to 24 hour telephone and mobile crisis intervention services as part of the program access standards for members.

The Office of Mental Health and Substance Abuse Services (OMHSAS) recognizes the critical role of a responsive crisis system in reducing the intensity and duration of the individual’s distress and utilizing least restrictive options while ensuring safety. To ensure that quality crisis services are being delivered consistently and in congruence with the existing regulations across the state, OMHSAS, in collaboration with the Crisis Intervention Association of Pennsylvania, began gathering statewide baseline data on the existing crisis system. A survey was disseminated to all county administrators in December of 2009. The survey data was analyzed in January of 2010 as the basis for reviewing statewide, regional and county crisis capability regarding telephone, walk-in, mobile, delegate function, contracted services, training, peer services, and MOU agreements. All counties completed the on-line survey. The results

were compiled into individual county profiles and statewide aggregate data. The following is a synthesis of the statewide survey information:

Telephone Crisis Services:

- Seven counties utilize 911 services to meet the 24 hour mandate.
- Two counties provide only telephone crisis service.
- Four counties do not have licensed telephone crisis services.

Walk-In Crisis Services:

- Six counties do not provide walk-in crisis services.
- The majority of walk-in services are available only during business hours.

Mobile Crisis Services:

- Three counties do not provide mobile crisis services.
- Eleven counties provide mobile crisis services only during business hours.
- One county joinder provides mobile crisis by appointment only.

Peer Supports:

- One county utilizes peer services as part of crisis intervention services.
- Warmlines are available in nineteen counties but not utilized as a crisis resource.

Delegate Service:

- Delegate services are provided as a separate and distinct function from crisis intervention in twenty-one counties.

Training:

- Training for crisis staff varied by county with ranges from two hours to forty hour standard curriculums.

To expand upon the baseline survey data, a series of regional focus groups were scheduled beginning in March of 2010 to continue the information gathering process and enhance the dialogue to include key stakeholders in each county. Five regional focus groups were convened to solicit input on crisis intervention services across the state. Prior to the focus group, each county received their individual county profile information to compare with the aggregate statewide survey data. Each focus group discussed a standard set of questions addressing coordination of care, follow-up protocols, delegate function, supervision, training, documentation, and other issues.

Each focus group provided input on key challenges that impact the ability to effectively and efficiently provide crisis intervention services within their geographic region. Based upon the input received four areas were consistently identified in each of the focus groups. The feedback has been condensed into the following topics:

Service Coordination

- Timely access to community resources – Inpatient, Outpatient, and Psychiatrists
- Minimal diversion resource options
- Waiting lists for psychiatric time, outpatient services

- Limited cooperation with ER doctors (hospitalization vs. interventions)
- Large geographic distances which impacts crisis response time
- Lack of transportation resources
- Limited coordination with law enforcement
- Absence of resources to manage multiple diagnosis (co-occurring mental health and substance use, mental health and developmental disorders)
- Minimal coordination across county lines
- Inadequate resources for special populations

Staffing/Training

- Recruiting and retaining staff challenges
- Training – access, cost, core topics
- Insufficient staff to cover 24/7 adequately (Crisis/Delegate)
- Increased volume of calls – burnout issues
- Access to training specific to crisis intervention skills – basic and advanced
- No core curriculum for crisis training
- Inconsistent interpretation of Mental Health Procedures Act across state

Funding

- Funds to support 24/7 service not adequate
- Increased utilization of crisis services impacting base funds
- More uninsured – new to system
- Training costs
- Increased call volume

Peer Support

- Peer Services minimal in all regions
- Lack of support for children/adolescents/families
- Minimal utilization of Wellness Recovery Action Plan (WRAP) and Mental Health Advanced Directives (MHAD) during crisis
- Limited use of peer resources during and after crisis

The information gathered through this process expanded on the identified challenges to providing quality crisis intervention services across the state that includes:

- The utilization of 911, answering services, or national hotlines to meet the 24/7 telephonic access requirement;
- The lack of coordination of care/follow-up services between contracted crisis providers and county services;
- The use of crisis workers to fulfill the delegate function;
- The limited access to community diversion resources resulting in the use of more restrictive services to resolve the crisis;
- The underutilization of peer services as a resource for crisis intervention opportunities;

- The lack of uniform training requirements for crisis intervention staff, and;
- The inadequate funding to support quality crisis intervention services.

These challenges represent additional factors that can impact individuals relying on the public behavioral health system for resources and supports. In rural areas, the lack of service and support resources impacted the ability to provide adequate intervention and follow-up to the immediate crisis situation. In urban areas, the increased utilization of crisis services has challenged the capacity of the system to provide comprehensive timely service. Whether in an urban or rural setting, ready access to services and supports is critical in reducing the intensity and duration of the individual's distress. The crisis situation should not be attributable, in part or whole, to the inability to access community services in a timely manner. Crisis intervention must be meaningfully provided to reduce the risk of future episodes and improve the individual's opportunity for recovery despite the challenges in the current system design.

Service Coordination Recommendations

Service coordination is an essential part of crisis intervention services. Ready access to interventions and resources in a crisis situation is essential to reduce the intensity and duration of the individual's distress. As the crisis escalates, community diversion options often decrease. Timely access to community services requires coordination and collaboration between crisis intervention services and the larger behavioral health system.

For certain populations, crisis intervention may be the only service available due to the insufficient availability of appropriate community resources to address needs. At times, community providers utilize crisis services as an after hour resource to support their programs. Adequate community supports are essential to ensure opportunity for recovery in the least restrictive settings. Crisis intervention should not become the disposition from higher levels of care if services are not available in a timely manner.

Coordination and collaboration with key providers and supports before, during and after the crisis intervention is essential to ensure access to needed resources during the crisis and beyond. Coordination and collaboration expands to other organizations that respond to mental health crisis situations such as police, first responders, clergy, or hospital personnel. Transforming crisis services from a reactive repetitive process for many individuals to a recovery – oriented service, requires coordination across the behavioral health care system and beyond.

Crisis intervention services must be viewed in the context of the larger behavioral health care system to ensure appropriate services and supports are provided after the crisis situation has been stabilized. An integrated crisis intervention system can access the appropriate available resources (assessment, referral, appointments) in a timely manner to resolve the immediate crisis situation effectively and promote recovery.

To begin the transformation, the Service Coordination sub-committee identified the following infrastructure changes:

1. Crisis intervention should be integrated with all needed services, providers, and systems involved in the process.

- Memorandums of Understanding (MOU) with other agencies/services should be developed utilizing the current MOU writing guide as a template to ensure coordination for all crisis intervention from the inception of the process through follow-up protocols.
- The MOUs should include access standards for community treatment services such as detoxification, psychiatric appointments, medication checks, and outpatient services to ensure access to needed services before, during and after crisis intervention.

- OMHSAS should develop standard language for the MOU process and require all counties to implement.
- At a minimum, MOUs should be signed with key community providers such as emergency departments, forensic system partners, behavioral health network providers, school systems, and peer support providers.
- OMHSAS should provide web-based training on MOU development.
- The language in Section 5240.23(10) of the current proposed regulations should be amended to include Memorandums of Understanding to ensure coordination of care before, during and after the crisis intervention service.
- All MOUs should be reviewed as part of the OMHSAS licensing process.
- BH-MCOs should monitor coordination of care for Crisis Intervention services as part of the provider credentialing process.
- OMHSAS, in partnership with the Department of Health and other applicable departments, should develop training on confidentiality issues (D&A, HIV) specific to crisis intervention.

2. Timely access to supports and services reduces the likelihood of reliance on crisis intervention services.

- The behavioral health system, in conjunction with their community partners, should identify service gaps that impact crisis services as part of the county planning process and develop a plan to address resource needs from a regional and local perspective.
- The local CFST teams should survey individuals who have utilized crisis intervention services to gather information on service gaps and needed resources from a consumer perspective.
- Behavioral Health providers should develop policy and procedures for crisis management on site during business hours.
- Crisis programs should review and revise their current program policy and procedures to align with the SAMHSA Practice Guidelines for Responding to Mental Health Crises as part of their quality improvement measures.
- The HealthChoices contract language addressing crisis intervention services should be reviewed and revised to address coordination of care and access issues post crisis.
- A Webinar on creating agency crisis management plans should be developed.
- The Network of Care should be utilized as a resource guide to services and supports for each county.

3. Diversion resources should be available through the entire crisis intervention process.

- Counties should review existing services to determine resources needs to divert individuals from the forensic system.
- Each county should develop and provide a resource manual to the behavioral health network.

- Peer run and/or peer supported services should be explored, developed and piloted as diversion resources.
- Drop In Centers, Recovery Centers, Clubhouses, Warmlines, the Living Room model, telepsychiatry, telephonic outreach, respite services, and other community resources should be available for ongoing support and stability post crisis intervention.
- The use of mobile crisis aides that can provide extended services to assist in accessing necessary resources and supports to stabilize the situation should be infused into the system.
- Mobile assessment and referral capability should be available during a crisis situation as part of the community resource network.
- Community alliances/partnerships should be developed to ensure access to ancillary resources that may be needed to stabilize a crisis such as shelter, food, clothing, and emergency funds.

4. Crisis Intervention services should engage any appropriate support system (family, significant other, providers, community partners, etc).

- OMHSAS should develop standard educational information on Crisis Intervention services to be distributed to community partners, family members, support systems, and other interested parties.
- Education and outreach to community partners should be developed to ensure all existing supports/resources are available and utilized during and after the crisis intervention process.
- The crisis intervention professional should be able to effectively communicate with the individual to ensure meaningful engagement in the crisis resolution process (interpreter services, sign language, cultural sensitivity).
- Input from support persons, family, friends should be gathered with the consent of the individual receiving crisis services.
- Crisis intervention professionals should include questions regarding any WRAP or MHAD documents that include a crisis plan and utilize any appropriate supports with the consent of the individuals receiving services.
- Support services and resources should be made available to friends, family, significant others as part of a comprehensive crisis response.
- Counties should educate their communities about the Network of Care as a resource and ensure behavioral health resource information is accurate and updated on their site.

5. Crisis intervention services require timely access to aftercare services.

- Outpatient and psychiatric appointments should be available when needed as part of the crisis intervention aftercare protocol.
- Crisis intervention services such as telephone outreach and mobile should continue as part of follow-up until the individual is engaged in community services and supports.

- Crisis Intervention programs should include a dedicated follow-up coordinator position to ensure the individual is supported until engaged in community services and supports.
- A review and analysis of transportation issues should be completed statewide as this presents a barrier to timely access to aftercare services in rural and urban areas.

Peer Support

Peer services should be infused in the crisis response process to allow an individual access to a supportive person with lived experience. Key values that are critical in the delivery of crisis services include, but are not limited to, hope, choice, and self advocacy. Holistic, flexible, person- centered services based on an individual's strengths necessitate the availability of peer support in a time of crisis. Peers can convey a sense of lived experience and empathy that impacts the feelings of isolation and fear that can be part of the crisis experience for many individuals. In the Substance Abuse and Mental Health Services Administration's (SAMHSA) Core Elements for Responding to Mental Health Crisis, it is recommended that "Services should afford opportunities for contact with others whose personal experiences with mental illness and past mental health crisis allow them to convey a sense of hopefulness first-hand".

SAMHSA's Practice Guidelines state that "crisis services must have as its goal a reduction in the number of crisis episodes among individuals with mental illness." The cyclic approach to behavioral health crisis must be replaced with one that reduces the likelihood of future emergencies and produces a better outcome. Peer run and peer support services are a vital component in promoting empowerment and assisting an individual to build on strengths that lead to personal wellness. Crisis intervention services should incorporate opportunities for contact with peer services.

The following recommendations recognize the importance of peer support as an integral part of crisis services in supporting an individual to regain a sense of control and connect with a circle of supportive peers.

1. Support from Peers should be available to all persons in crisis.

- OMHSAS should develop a bulletin to clarify that a Certified Peer Specialist meets the current staffing requirements to provide crisis intervention services.
- The language in 55 PA Code Chapter 5240, Section 5240.31(b)(5) should be amended to include a Certified Peer Specialist as meeting the qualifications to be employed as a Mental Health Crisis Intervention Worker.
- OMHSAS, in conjunction with the MCOs should review the current staff qualifications for crisis intervention workers to ensure all requirements are congruent and recognize peer specialists.
- Crisis intervention programs should utilize peer support as a resource for crisis prevention, intervention, and stabilization.

2. Require Linkages to Peer Run and Peer Support Services.

- Peer Support should be a vital component of crisis services to support the empowerment of an individual to build on strengths that lead to

personal wellness and develop a plan to help avert or lessen the crisis situation.

- In order to promote coordination of care and increase awareness of peer run services that are available, Letters of Agreement (LOA) or Memorandums of Understanding (MOUs) should be in place between all Crisis Intervention Providers and all Peer Run and Peer Support Providers, including Warmlines.
- The MOU should include standard language addressing the protocols for collaboration and coordination between Crisis Intervention Providers and Peer Run and Peer Support Services.
- The MOU language will be reviewed as part of the annual licensing process.

3. Promote and utilize Mental Health Advanced Directives.

- During a crisis situation, crisis intervention professionals should support the decision making abilities and preferences of individuals by including crisis plans that were developed as part of a Wellness Recovery Action Plan (WRAP) or Mental Health Advanced Directive (MHAD) to assist the individual in regaining a sense of control.
- All crisis staff should ask any individual receiving crisis intervention services if they have a MHAD and if so, permission for the directive to be accessed.
- Crisis documentation requirements should include discussion of the individual's existing MHAD information or offering information on resources to develop a MHAD.
- OMHSAS should develop a bulletin addressing crisis intervention service providers responsibility to honor an individual's existing MHAD.

Staffing/Training

The effective delivery of crisis intervention services requires a high degree of skill by the professional. It can be a high-risk, demanding service and must be delivered effectively to ensure a positive outcome. Providing crisis intervention services can be stressful and at times, traumatic for staff. Professionals providing crisis intervention services must be appropriately trained and be able to demonstrate competence in understanding not only clinical interventions but the actual lived experience of the population seeking services. Research supports that staff development opportunities results in positive program outcomes. Additionally, supervisory training is directly related to staff retention.

The current regulations require crisis intervention programs to develop a written training plan that specifies training for each staff person prior to providing services and establishes the documentation of an ongoing training plan. The requirements do not include specific training topics, content or hours. There is no uniform crisis intervention training curriculum standard across the state. Survey data indicated a wide variation in training topics and hours across the state with some crisis agencies providing forty hours of training while others provided a minimum of two hours. To ensure quality crisis services are delivered consistently across the state, a standard list of crisis intervention training topics should be developed. The topics should include suicide risk assessment, active listening skills, assessment techniques, safety, mental status assessment, substance use/co-occurring, trauma-informed, recovery orientation (Mental Health Advanced Directives/Wellness Recovery Action Plans), local resources, cultural competency, and Mental Health Procedures Act. Crisis intervention services are required to be available 24 hours/7days a week creating a challenge for providing training opportunities to staff.

At times, the crisis intervention proceeds to emergency service provision. Emergency services consist of observation, treatment, and close supervision which are available at any hour of the day or night to persons with a mental health disability who are in need of immediate care, and must not be denied to a person requiring such care per the regulations. Under the Mental Health Procedures Act (MHPA), involuntary examination and treatment may be provided to individuals who “are severely mentally disabled and as a result of mental illness their capacity to exercise self-control, judgment, and discretion in the conduct of their affairs and social relations or in the care of their personal needs is so lessened that they pose a clear and present danger of harm to self or others”. It is the responsibility of the Mental Health County Administrator or designee to issue a warrant requiring the emergency examination based upon the relationship of the person’s behavior and the statutory grounds of danger to self or others pursuant to the Mental Health Procedures Act.

The function of the mental health delegate is to serve as the initial gatekeeper in Pennsylvania’s emergency involuntary commitment process which is distinct

from that of a crisis intervention professional. The survey data, as well as, the focus group discussion points indicated that the delegate function is performed as part of the crisis intervention process in some counties. In the various regional dialogues, the interpretation of the current regulations regarding the delegate function as separate and distinct from crisis intervention services was not consistent. This inconsistency in interpretation of the regulations should be clarified by OMHSAS.

The ability to perform the delegate functions requires training in specific areas. There is no standard training across the state that addresses the delegate function. At a minimum, crisis intervention programs should provide basic orientation training on the mental health delegate function which would include a review of the legal basis for involuntary commitment process, least restrictive option, petition process, warrant process, emergency detention, notification of rights, securing property and personal effects, involuntary admission process, Pennsylvania Instant Check System (PICS) process, and serving the 302 warrant issues. A standard list of training topics for the delegate function should be developed.

The following recommendations address the need for adequate training, retention, and resources to ensure qualified professionals provide crisis intervention and delegate services across the state.

1. Crisis Intervention programs should provide a standard training program based on best practice to all staff (crisis intervention and delegate) as part of the initial orientation and continue to provide ongoing training opportunities.

- Core training modules should be developed to include initial (orientation) topics and advanced skill building topics.
- Crisis intervention programs should provide a minimum of 12 hours annually of ongoing training opportunities based upon individual training plans and job duties.
- Documentation of all training should be reviewed as part of the licensing review annually.
- OMHSAS should review and approve training content during licensing visits.
- OMHSAS should issue a bulletin addressing training requirements for all crisis intervention staff.

2. Crisis Intervention program staffing patterns should be designed to ensure access to training opportunities, increase retention, decrease stress, and encourage recruitment opportunities.

- Regional collaboration for training opportunities should be explored to address staff coverage (telephone response/mobile dispatch) and cost effectiveness.

- Available resources such as the Network of Care and web-based technology should be utilized to provide crisis intervention training 24/7.
- Crisis intervention programs should develop opportunities for staff recognition.
- Crisis intervention programs in partnership with MCOs should provide professional development opportunities for supervisory staff to increase retention and skills.
- Crisis intervention staff should be encouraged to develop a Wellness Recovery Action Plan to address stress and have access to a debriefing process after traumatic situations.
- Crisis intervention programs should work with local colleges to recruit staff by offering internship or practicum opportunities.
- Crisis intervention programs should participate in local job fairs, partner with the Office of Vocational Rehabilitation, and Career Link centers.
- OMHSAS should collaborate with the Office of Vocational Rehabilitation and Department of Education to develop opportunities for the recruitment of qualified crisis intervention professionals.
- All crisis intervention programs should be required to develop retention and recruitment plans.

3. The parameters of the delegate function in crisis intervention programs should be clearly defined and applied across the state based upon current state law.

- The interpretation of current regulations regarding the delegate function is not consistent across the state and requires clear interpretation by OMHSAS to ensure compliance with existing statutes.
- The current law governing the delegate function should be reviewed by OMHSAS legal counsel to address at a minimum, who can perform the delegate function, delegate process for warrant approval and signature requirements, and clarification of what are crisis services versus emergency services.
- The legal interpretation of the delegate function should be provided to all stakeholders by OMHSAS.
- The delegate function should be uniformly applied across the state based upon OMHSAS interpretation.
- Based upon the legal interpretation, OMHSAS should issue a bulletin clearly defining the delegate role within crisis intervention services.

Funding

Crisis intervention services were initially supported by State/county funds only. To maximize funding for crisis service expansion, the Department applied for and received approval of a Medicaid State Plan Amendment to allow Medicaid reimbursement for five identified crisis services. Currently, the statewide HealthChoices mandatory medical assistance managed care program funds, Medical Assistance Fee for Services funds, State base allocations, county funds and the HealthChoices reinvestment funds can be utilized as payment mechanisms for crisis intervention services.

It is critical that crisis intervention services receive adequate funding to ensure that counties are capable of providing meaningful and effective responses to individuals in crisis when needed. In some rural counties, the units of service generated by telephone and mobile crisis intervention are very low, making it difficult to support the service on a 24/7 basis under the standard funding mechanisms. As a result to contain costs, some counties utilize 911 or answering services to meet the telephone requirement which has not created an optimal crisis response system to adequately meet the needs of individuals in the community. Adequate funding supports county collaboration, effective linkage to appropriate services, increased safety for the individual and community, and improved service coordination.

Counties are facing increased financial challenges to crisis service provision due to:

- The depletion of base funds by increased utilization of crisis services for larger numbers of uninsured individuals;
- The rates for the provision of 24/7 crisis coverage has not increased to cover the actual cost of the service;
- The inability to recover the cost of providing crisis intervention to individuals with private insurance and Medicare coverage;
- The increase in call volume;
- The increased cost of fuel for mobile service deployment in rural counties that cover large geographic areas, and,
- The cost associated with training is not covered.

After reviewing how crisis services have been historically funded and examining the current challenges to providing quality services 24/7, the sub-committee recommends the following considerations.

1. Crisis intervention programs should consider utilizing Alternative Payment Arrangements (APA) within the HealthChoices program to support cost effective strategies in service delivery.

- OMHSAS, in partnership with MCOs must review cost effectiveness of alternative payment arrangements for crisis intervention services.

- OMHSAS, in partnership with the county and MCO, should explore the option of alternative payment arrangements to support crisis intervention services.
- OMHSAS should review utilization rates for telephone and mobile services across the state to determine any limitation of service delivery.
- OMHSAS should review current regulations and bulletins requiring crisis intervention services to determine if the current base allocations can support the service.

2. A statewide assessment should be conducted to determine what crisis intervention services are funded by each county.

- OMHSAS should conduct a statewide review to determine how funds are utilized to deliver 24/7 crisis services.
- OMHSAS, in partnership with identified counties and MCOs should collaborate to create options for providing 24/7 telephonic crisis services that do not include the utilization of 911 services.
- A similar process should occur to address the co-mingling of crisis intervention services with the delegate function.
- OMHSAS should revise the current regulations to clarify the delivery of 24/7 telephonic crisis intervention services and the role of the delegate in relationship to crisis intervention services.

3. The “coffee table model” of service delivery should be explored to support cost-saving strategies in rural counties.

- OMHSAS, in partnership with counties and MCOs should explore the “coffee table model” to support an on-call system that has the potential to be a cost-effective option for rural counties.
- OMHSAS, in partnership with counties and MCOs should explore options such as the regionalization of telephone crisis services or the combining of mandatory on-call services at one location as a cost effective alternative.
- OMHSAS should support the development of various payment arrangements such as weekly on-call stipend that covers the actual cost of the service based upon county resources.
- OMHSAS should explore a variety of options for the delivery of crisis intervention services in rural areas of the state to develop a cost effective model.
- Reinvestment funds may be used as start up to create crisis services to fill identified gaps and meet required access standards.

Best Practice Guidelines for Crisis Intervention Services

As the workgroup began developing recommendations that would improve the delivery of crisis services, key themes began to surface as essential components of any crisis system regardless of the nature of the crisis, the location where assistance is offered or the individual providing the intervention. Understanding that there is no “non-effect” in crisis intervention – either the effect has a positive outcome or the potential for negative outcome for the individual seeking services, the workgroup identified the following concepts as best practice guidelines for agencies to consider in the provision of any crisis intervention service.

1. Crisis intervention services should encompass a strength-based, person-centered approach identifying and reinforcing individual resources that support recovery and protect against future crisis events.
2. Crisis intervention services should be provided in a culturally competent manner to ensure a clear understanding of the crisis from the unique perspective of the individual.
3. Crisis intervention services should be delivered from a trauma-informed perspective to ensure that prior to any intervention the potential risks and benefits are considered.
4. Peer support services should be utilized as part of the entire crisis intervention process to afford opportunities for individuals to connect with supportive people with lived experience who convey a sense of hope.
5. Crisis intervention services should be provided by individuals with appropriate training and skills to effectively intervene and support the individual in gaining a sense of control over thoughts, feelings and events.
6. The individual should be treated with dignity and respect throughout the crisis intervention process.
7. Crisis intervention should utilize the least restrictive services that are appropriate to preserve the individual’s formal and natural support networks.
8. Crisis intervention services should ensure the individual is informed of their rights and supported in exercising their rights throughout the crisis process.
9. Crisis intervention services should have timely access to needed community supports and services to stabilize the situation and reduce the intensity and duration of the crisis.
10. Crisis intervention services should focus on reducing the likelihood of future crisis events by working in partnership with individuals served and the larger behavioral health community.

Final Recommendations

The purpose of the workgroup was to make recommendations to transform the current crisis system from a reactive approach to a responsive system that reduces the potential for future crisis situations and produces better outcomes for any individual using the service. The following recommendations represent the initial process to begin the transformation of the existing crisis system to a recovery-oriented system. These recommendations should be considered as the beginning point in the process.

Short Term Recommendations:

1. OMHSAS, in partnership with key stakeholders should review the current Memorandum of Understanding (MOU) Writing Guide and utilize the MOU process to address key issues impacting the delivery of integrated crisis intervention services across the state.
 - At a minimum, OMHSAS should require counties to implement MOUs with key community partners such as emergency departments, forensic partners, behavioral health network providers, school systems, and peer service providers, including local warmlines.
 - The MOU should include access standards for community treatment services such as psychiatric appointments, medication checks, outpatient services to ensure access to needed services before, during and after the crisis event.
 - OMHSAS should develop and provide web-based training on MOU development.
 - All MOUs should be reviewed by OMHSAS.
2. To support the decision making abilities and preferences of individuals utilizing the crisis system, existing Mental Health Advanced Directives (MHAD) should be utilized during the crisis intervention process by all providers.
 - All crisis staff should support the decision making abilities and preferences of individuals by including crisis plans that were developed as part of the Wellness Recovery Action Plan (WRAP) or Mental Health Advanced Directive (MHAD) and if so, permission for the plan to be accessed and utilized.
 - If an individual in crisis does not have a MHAD, resource information on developing one should be provided.
 - Crisis documentation should include verification of the MHAD discussion or the provision of resource information on MHAD development.
3. Crisis intervention programs should provide standard training based upon core topics to all staff (crisis worker, delegate, supervisor) as part of the initial orientation process and the ongoing skill-building process.

- OMHSAS, in partnership with key stakeholders, should develop initial orientation and advanced skill building topics.
 - Crisis intervention programs should provide a minimum of 12 hours annually of ongoing training opportunities based upon individual training plans and job duties (crisis worker, supervisor, delegate).
 - OMHSAS, in partnership with the Department of Health and other applicable departments, should develop a training module on confidentiality (D&A and HIV) related to crisis intervention procedures.
 - Available resources such as the Network of Care and web-based technology should be utilized to provide access to crisis intervention training on a 24/7 basis.
 - Crisis intervention programs in partnership with MCOs should provide opportunities for professional development and recognition.
 - Documentation of all training should be reviewed as part of the annual licensing review.
 - OMHSAS should review and approve all training curriculum as part of the annual licensing visit.
4. OMHSAS should request that the Department of Public Welfare's legal counsel review state law and regulation governing the delegate function to ensure consistent interpretation and application of this function across the state.
- The interpretation of current regulations regarding the delegate function is not consistent across the state and requires clear interpretation by OMHSAS to ensure compliance with existing statutes.
 - At a minimum, OMHSAS should clarify who can perform the delegate function, delegate process for warrant approval and signature requirements, and clarification of what constitutes crisis intervention versus emergency services.
 - OMHSAS should provide written clarification on the delegate function to all stakeholders.
 - The delegate function should be uniformly applied across the state based upon DPW legal interpretation.
5. OMHSAS, in partnership with key stakeholders, should conduct a statewide assessment of funding resources utilized for crisis intervention services.
- OMHSAS should conduct a statewide review to determine how funds are utilized to deliver mandated 24 hour/7 days a week crisis services.
 - OMHSAS, in partnership with the MCOs must review the cost effectiveness of alternative payment arrangements for crisis intervention services.
 - OMHSAS, in partnership with identified counties and MCOs should collaborate to create options for providing 24/7 telephonic crisis services that do not include the utilization of 911 services.

- OMHSAS should require the counties, in partnership with their community partners, to conduct an analysis of service gaps which includes the lack of diversion resources that increase the utilization of crisis services and develop a plan to address the resource need from a regional and local perspective.
 - OMHSAS should support the development of various payment arrangements within the managed care system that cover the actual cost of crisis intervention service delivery.
6. The HealthChoices contract language should be reviewed and revised to support crisis intervention services.
- The HealthChoices contract language related to crisis intervention services should be reviewed and revised to address coordination of care and access issues related to post crisis community aftercare services.
 - OMHSAS, in partnership with the MCOs should review the current staff qualifications for crisis intervention workers in the HealthChoices program to ensure all requirements are congruent with civil service and regulatory requirements.
 - The utilization of HealthChoices reinvestment funds to create crisis services to fill identified gaps should be encouraged.
7. OMHSAS should issue a Crisis Intervention Bulletin to clarify the existing regulations and provide policy guidelines for the delivery of crisis intervention services that incorporates the recommendations of the Crisis Intervention Workgroup.
- OMHSAS should issue a bulletin to clarify that Certified Peer Specialist meets the current staffing requirements to provide crisis services.
 - OMHSAS should issue a bulletin addressing the utilization of Mental Health Advanced Directives during the crisis intervention process.
 - OMHSAS should issue a bulletin addressing training requirements for all crisis intervention staff including delegates.
 - OMHSAS should issue a bulletin clearly defining the delegate role within the crisis intervention process.
 - OMHSAS should issue a bulletin defining the parameters of MOUs for crisis intervention services with key community partners.
 - OMHSAS should issue a bulletin to clarify documentation expectations for crisis intervention service providers.
8. OMHSAS, in partnership with key stakeholders, should develop a time-limited crisis service pilot opportunity to test the utilization of peer support models, crisis diversion models, and rural service delivery models.
- Peer run and peer supported services should be explored, developed and piloted as crisis diversion resources.
 - OMHSAS, in partnership with counties and MCOs should explore the “coffee table model” to support an on-call system that has the potential to be a cost-effective option for rural counties.

- OMHSAS, in partnership with counties and MCOs should explore options such as the regionalization of telephone crisis services or the combining of mandatory on-call services at one location as a cost-effective alternative.
- OMHSAS should explore a variety of options for crisis intervention services in rural areas of the state to develop a cost-effective model that ensures the delivery of quality services.

Long Term Recommendation:

1. OMHSAS should collaborate with key state agencies, including but not limited to, Corrections, Pennsylvania Commission on Crime and Delinquency, Probation and Parole, Education, State, Insurance, Health and Labor and Industry to enhance the ability of the crisis system to effectively and efficiently intervene and promote positive outcomes across all systems.
 - OMHSAS should collaborate with the Office of Vocational Rehabilitation and the Department of Education to develop opportunities for the recruitment of qualified crisis intervention professionals.
 - OMHSAS should partner with other key agencies to develop standard Public Service Announcements and community educational material on Crisis Intervention services that can be distributed statewide.
 - OMHSAS should partner with key state agencies to ensure all existing supports/resources are available and utilized during the crisis process.
 - OMHSAS, in partnership with key state agencies, should encourage ongoing collaboration at the county level to ensure any ancillary supports that may be needed to stabilize a crisis situation are accessible.
2. Peer services should be a vital component of all aspects of crisis intervention services.
 - All crisis intervention programs should utilize peer services as a resource for crisis prevention, intervention, and follow-up.
 - Peer services should be available for ongoing support and stability post crisis intervention.
 - Peer services should be utilized to provide follow-up services to ensure the individual is supported while engaging in community services.
3. OMHSAS should convene a stakeholder workgroup to amend and promulgate the crisis intervention regulations.
 - The language in Section 5240.23(10) of the current proposed regulations should be amended to include Memorandums of

Understanding to ensure coordination of care before, during and after the crisis intervention.

- The language in Section 5240.31(b)(5) of the current proposed regulations should be amended to include a Certified Peer Specialist as meeting the qualifications to be employed as a Mental Health Crisis Intervention Worker.
- The amended crisis intervention regulations should include a section addressing the delegate function.
- OMHSAS should review the amended regulations to determine if the current base allocations can support the service requirements as written.
- OMHSAS should promulgate the amended crisis intervention regulations.

Conclusion:

Improving the current crisis intervention system is essential. Although no one is immune to experiencing a crisis event in their life, research indicates that individuals diagnosed with a mental health challenge often experience recurrent crisis episodes. Any crisis situation has the potential to traumatize the individual who may be subjected to forcible removal from their home, being taken into police custody, transported to a hospital in a police car or ambulance, involuntarily evaluated in an emergency department of a local hospital, and civilly committed to a psychiatric facility against their will. Such a scenario would become the norm without appropriate crisis intervention services being readily available to individuals who need them. Effective crisis intervention can have a significant, positive impact on the lives of individuals receiving community services and supports.

The crisis intervention workgroup has formulated initial recommendations to transform crisis intervention responses to ensure that the interventions are guided by standards consistent with recovery and resiliency. The crisis response should be consistent, fair, and flexible while considering the individual's personal preferences to meet the identified needs. The interventions should stabilize the situation by accessing appropriate resources in the least restrictive manner that ensures safety. This approach would improve the satisfaction of the individual receiving services, reduce recidivism and promote cost containment over time.

Crisis intervention services do not exist in isolation but are part of the broader set of behavioral health services and community supports that individuals may utilize. The crisis intervention process can extend beyond the purview of the crisis agency, as well as the existing behavioral health system, to include the local police, court system, and general hospital services in an effort to effectively resolve the crisis event. The criminal justice system and the hospital emergency departments are key partners in the crisis intervention process. The workgroup recognizes the need for coordination and collaboration with other entities that are often involved in crisis events by recommending that OMHSAS begin engaging key state agencies in discussing crisis intervention services from a systemic perspective as the next step in the process.

Statistics provided by the Substance Abuse and Mental Health Services Administration indicate that approximately 7 percent of all police contacts in urban settings involve a person believed to have a mental illness, individuals incarcerated in state prisons are three to four times more likely to have a mental health diagnosis, and 6 percent of all hospital emergency department visits are mental health emergencies. Based upon this data, the engagement of these systems is essential to move crisis intervention transformation forward to ensure that quality services are provided consistently and collaboratively with all system partners engaged in the process to ensure a positive outcome for individuals experiencing a crisis.

Appendices

Appendix 1. Crisis Workgroup Recommendations

Appendix 2. Statewide Survey Results

Appendix 1

Crisis Intervention Workgroup Recommendations

Crisis Intervention Workgroup Recommendations:

Crisis intervention should be integrated with all needed services, providers, and systems involved in the process.

Timely access to supports and services reduced the likelihood of reliance on crisis intervention services.

Diversion resources should be available throughout the entire crisis intervention process.

Crisis intervention services should engage any appropriate support system (family, significant other, providers, community partners, etc).

Crisis intervention services require timely access to aftercare services.

Support from peers should be available to all persons in crisis.

Require linkages to Peer Run and Peer Support services.

Promote and utilize Mental Health Advanced Directives.

Crisis intervention programs should provide a standard training program based on best practice to all staff (crisis intervention and delegate) as part of the initial orientation and continue to provide ongoing training opportunities.

Crisis intervention program staffing patterns should be designed to ensure access to training opportunities, increase retention, decrease stress, and encourage recruitment opportunities.

The parameters of the delegate function in crisis intervention programs should be clearly defined and applied across the state based upon current state law.

Crisis intervention programs should consider utilizing Alternative Payment Arrangements (APA) within the HealthChoices program to support cost-effective strategies in service delivery.

A statewide assessment should be conducted to determine what crisis intervention services are funded by each county.

The “coffee table model” of service delivery should be explored to support cost savings strategies in rural counties.

Appendix 2

Statewide Crisis Survey Results