Long Term Care and Mental Health

Reducing the use of Antipsychotic Medications in Long Term Care

Comagine Health



- Comagine Health, formerly Qualis Health and HealthInsight, is a national, nonprofit, health care consulting firm. We work collaboratively with patients, providers, payers and other stakeholders to reimagine, redesign and implement sustainable improvements in the health care system.

- As a trusted neutral party, we work in our communities to address key complex health and health care delivery problems.

- We serve people in Alabama, Alaska, Idaho, Mississippi, Nevada, New Mexico, Oregon, Utah, Washington, D.C., Washington State and Wyoming.

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Agenda

Time	Facilitator	Topic
10:00 – 10:05	**Lenai Moore, MSHS, BS, RN,** Quality Improvement Consultant, Comagine Health	**Welcome/ Introductions**
10:05 – 10:55	**Dr. Thuan Ong**, Clinical Director, Systemwide Quality Improvement, Comagine Health **Nina Sanderson**, LSW, SMQT, Improvement Advisor, Comagine Health	**Decreasing Antipsychotic Medications and Behavior Management in Long Stay Residents**
10:55 – 11:00		**Question and Answer Period**
11:00 – 11:20	**Chaka A. Curtis, RN**, Psychiatric Nurse/PASSR Coordinator, Clinical Services Administration, DC Department of Behavioral Health **Alexis Mapes, LPC**, Director Community Response Team, DC Department of Behavioral Health	**Behavioral Health Resources for DC Long Term Care Residents**
11:20 – 11:30	**Lenai Moore, MSHS, BS, RN,** Quality Improvement Consultant, Comagine Health	**Questions/Closing**

Guest Presenter



Thuan Ong is a clinical director for systemwide quality improvement in patient health at Comagine Health, where he works with the long-term post-acute care team.

Dr. Ong has vast experience in geriatric medicine and serves as an attending physician at Harborview Medical Center in Seattle, as well as an associate professor at the University of Washington Division of Gerontology and Geriatrics. Since 2009, he has worked in various clinical teaching capacities, including with University of Washington-affiliated skilled nursing facilities and the inpatient geriatric service and in outpatient clinic. He was a site lead for a NIH/NIA study evaluating the impact of prazosin on patients with Alzheimer's dementia and agitation. He is a current co-PI on AHRQ study evaluating the effectiveness of a pharmacist led transitional care intervention for patients discharged to skilled nursing facilities.

Dr. Ong has been invited to give numerous talks on issues regarding geriatric health, including talks on delirium, post-acute care, polypharmacy and falls in elderly adults. Dr. Ong earned a bachelor's degree and a Master of Public Health from UCLA and holds a medical degree from Saint Louis University.

Guest Presenter



Nina Sanderson is a licensed Social Worker in Idaho for the past 24 years and has been certified by CMS to conduct both skilled nursing facility (SNF) and dialysis (ESRD) surveys. She worked in a nursing home for thirteen years, spent three years as a long-term care surveyor in Idaho, three years as co-supervisor of the Idaho State Long Term Care Survey and Certification program, and four years as a federal surveyor. She has been with Comagine Health as an Improvement Advisor since August 2022.

Enhancing Behavior Management While Reducing Antipsychotic Use in Long Stay Residents

Thuan Ong

Nina Sanderson

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Learning Objectives

At the end of this discussion, one should be able to:

- List factors commonly associated with agitation or aggression.
- Identify when a medical condition is possibly a source of agitation or aggression.
- Recall de-escalation methods.
- Develop an assessment to integrate into individualized care plans.

Definitions: Spectrum of Behaviors

- Agitation: constellation of symptoms and signs[1]
  - Pacing, wandering, repeated movements, general restlessness
- Aggression[1]: verbal and/or physical behavior
  - Hitting, kicking, pushing, throwing, spitting, biting, scratching, destroying property, hurting oneself or others, cursing, sexual advances
- Agitated behavior[2]: socially, inappropriate, verbal, vocal, or motor activity that is not a necessary by-product of a medical condition

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1 Cohen-Mansfield J. *Am J Geriatr Psychiatry* 2001. doi:10.1097/00019442-200111000-00005
2 Cohen-Mansfield J et al. *Int Psychogeriatr* 1989. doi:10.1017/S1041610289000165.

Akathisia:

- Spectrum of disease severity
- Difficult to distinguish from agitation often present in patients with dementia
- Most common form of extrapyramidal side effect
  - Motor restlessness
    - Inability to stay still, shifting positions, pacing, writhing
    - Milder forms may not have motor signs
  - Patients describe
    - Anxiousness
    - Restlessness
  - Linked to:
    - Dopamine antagonist (aka antipsychotics)
    - SSRIs
  - Generally, develops within days
- https://www.youtube.com/watch?v=ER4JGnRssSk

Agitation/Aggression/Agitated Behaviors

- Responsive behaviors[1]
  - Agitated and/or aggressive behaviors manifest in response to internal or external stimulus
- 32y W, TBI from MVA
- 59y M, chronic schizophrenia
- 73y W, with CVA and residual L hemiparesis, dysarthria, and dysphagia
- 84y W with Alzheimer's dementia
- How about us?
  - Moments of agitation/irritability occur regularly among "normal" persons too.
    - But less likely to escalate

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1 Gitlin LN et al. *JAMA* 2012.doi:10.1001/jama.2012.36918

Decreasing Antipsychotic Medications

- “a patient isn't a disease with a body attached, but a life into which a disease has intruded”

  - Atul Gawande in “Complications”

- Don’t start it in the first place.
- Hospital Elder Life Program (H.E.L.P.)
- Many other non-pharmacologic interventions

B.E.H.A.V.I.O.R. : A Framework

- B – bored
- E – environment, elimination
- H – hungry, H_2O
- A – ache
- V – violence (history of violence, fear)
- I – inability to communicate
- O – organic causes
- R – routine change

Schizophrenia: New Diagnosis?

- Affects <1% of people in the general population.
- Rarely a new diagnosis given in later life.
  - Typically diagnosed in the teenage to early 30s
- 3x increase in diagnosis in Medicare claims history in SNFs (2015-2019)[1]
  - In 2015, antipsychotic use incorporated into quality rating.
  - Schizophrenia, Tourette's syndrome, and Huntington's disease excluded from impacting quality rating.

1 US DHHS OIG. Long-term trends of psychotropic drug use in nursing homes. November 2022. OEI-07-20-00500

F699* - Trauma Informed Care

- **The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident.**
- 70% of adults have experienced some kind of trauma at least once in their lives (SAMHSA).
- Does not require a diagnosis.
- Individualized care plans developed based on an assessment which includes a thorough social history.
- Uses culturally competent approaches to address needs and preferences.
- Focused on minimizing triggers and/or re-traumatization.
- Important aspect of improving care quality and removing health disparity.
- Trauma linked to chronic physical health conditions, such as diabetes and heart disease.
- Included in "Quality of Care" regulatory grouping

Medical Trauma[1]

- Trauma from direct contact with the medical setting, developing through complex interactions between the patient, medical staff, medical environment, and procedural experiences
- Powerful psychological impacts due to the patient's unique interpretation of the event.
- Subjective
  - Can be innocuous to us indoctrinated into healthcare
- Continuum
- Biopsychosocialspiritual
- Contextual
- Relational
- Goes unacknowledged
- Not a diagnosis

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Hall, Michelle F. Hall, Scott E. 2016. *Managing the Psychological Impact of Medical Trauma. A Guide for Mental Health and Health Care Professionals*. Spinger Publishing.

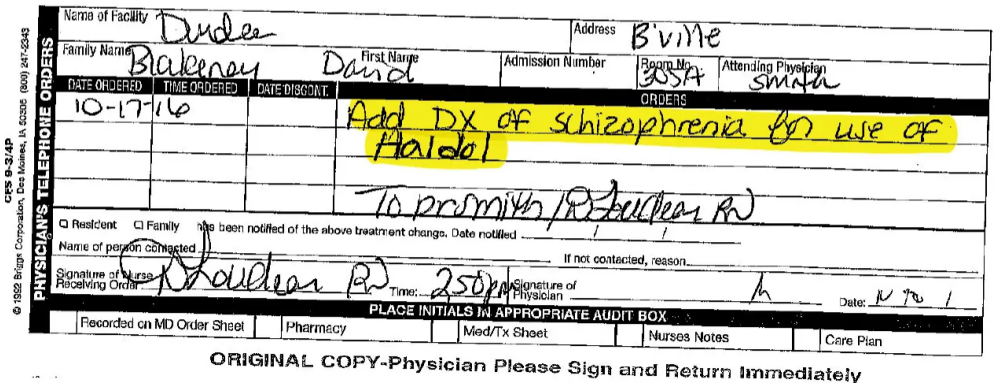
The New York Times

Phony Diagnoses Hide High Rates of Drugging at Nursing Homes

At least 21 percent of nursing home residents are on antipsychotic drugs, a Times investigation found.

By Katie Thomas, Robert Gebeloff and Jessica Silver-Greenberg

Published Sept. 11, 2021 Updated Oct. 15, 2021



PHYSICIAN'S TELEPHONE ORDERS

Name of Facility: Dudley Address: Bivine

Family Name: Blakeney First Name: David Admission Number: Room No.: 305A Attending Physician: Smith

DATE ORDERED	TIME ORDERED	DATE DISCONT.	ORDERS
10-17-16			Add DX of schizophrenia for use of Haldol
			To primary RN Faulkner RN

☐ Resident ☐ Family has been notified of the above treatment change. Date notified: ____ If not contacted, reason: ____

Name of person contacted: ____

Signature of Nurse Receiving Order: Faulkner RN Time: 2:50pm Signature of Physician: ____ Date: 10/17/16

PLACE INITIALS IN APPROPRIATE AUDIT BOX

Recorded on MD Order Sheet | Pharmacy | Med/Tx Sheet | Nurses Notes | Care Plan

ORIGINAL COPY-Physician Please Sign and Return Immediately

CPS 9-3/4P © 1992 Bridge Corporation, Des Moines, IA 50265 (800) 247-2343

https://www.nytimes.com/2021/09/11/health/nursing-homes-schizophrenia-antipsychotics.html Last accessed 4/12/23.

F744* - Dementia Care

A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being.

- Dementia is defined as a general set of symptoms related to cognitive loss, which may or may not have been specifically diagnosed.
- Requires a comprehensive assessment including physical, mental, and psychosocial needs.
- Individualized care plan derived from the assessment.
- Can be complicated by a history of trauma, adjustment disorder, or mental illness.
- One of the areas of required training for all staff, volunteers, contractors, and agency.
- On survey, this requirement is often investigated in conjunction with F758, Unnecessary Psychotropic Medications.

F758* Unnecessary Psychotropic Medications

- §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior.
- Includes antidepressants, anti-anxiety, hypnotic, and antipsychotics.
- A resident who has used psychotropic medications before is not started on them without a specific diagnosis
- Residents on psychotropic medications receive gradual dosage reductions unless contraindicated.
- PRNs are not used unless medically necessary and reviewed every 14 days.

COVID-19 Impact on Resident Mental Health

- Visitor bans
- Population based cohort studies
- Increase in use of antipsychotics
  - All psychotropics: benzodiazepine, antidepressants, anticonvulsants, opioids

Campitelli MA et al. *JAMA Netw Open* 2021. doi:10.1001/jamanetworkopen.2021.18441
McDermid J et al. *Int J Geriatr Psychiatry* 2023. doi: 10.1002/gps.5878
Ferro Uriguen A et al. *Drugs Aging* 2022. doi: 10.1007/s40266-022-00948-9

COVID-19 Impact on Healthcare Worker

- Pressures from work
  - High exposure to suffering, staffing, PPE, organizational support
- Pressures from home
- High levels of
  - Post traumatic stress disorder
  - Mood signs and symptoms
  - Moral injury
- What now?

Brady C et al. *Int J Geriatr Psychiatry* 2021. doi: 10.1002/gps.5648
Dyer AH et al. *J Am Med Dir Assoc* 2022. doi: 10.1016/j.jamda.2022.06.028

B.E.H.A.V.I.O.R. : A Framework

- B – bored
- E – environment, elimination
- H – hungry, H_2O
- A – ache
- V – violence (history of violence, fear)
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- O – organic causes
- R – routine change

Decreasing Antipsychotic Medications

- B.E.H.A.V.I.O.R.
  - Empathy
- Don’t start it in the first place.
- Hospital Elder Life Program (H.E.L.P.)
  - Delirium
  - Designed to prevent delirium in hospitalized older adults

Delirium: The “O” in B.E.H.A.V.I.O.R.

- Sudden change mentation (hours to days) and fluctuating in course
- Signs include changes in:
  - Behavior
  - Mood
  - Confusion and disorientation
  - Attention and concentration
  - Delusions
  - Hallucinations
  - Sleep patterns
- Duration is variable: days, weeks, months
- Can recur
- Commonly caused by multiple factors

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Oldham MA et al. Responding to Ten Common Delirium Misconceptions With Best Evidence: An Educational Review for Clinicians. J Neuropsychiatry Clin Neurosci. 2018. doi:10.1176/appi.neuropsych.17030065

Hospital Elder Life Program (H.E.L.P.)[1]

- Orientation and activities
- Hearing
- Vision
- Eating/Hydration
- Mobility or range of motion
- Sleep protocol



- 5% reduction in incident delirium.
- NNT=20
- Reduced total # days with delirium.
- Reduced functional decline[2]

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1 Inouye SK et al. *N Engl J Med* 1999. DOI: 10.1056/NEJM199903043400901
2 Inouye SK et al. J Am Geriatr Soc 2000. DOI: 10.1111/j.1532-5415.2000.tb03885.x

Multifactorial: Keep Looking

- Delirium
  - 44% w/ >1 cause (62 possible étiologies, 2.8/patient)[1]

- D – drugs (also withdrawal of drugs)
- E – ears/eyes (visual/hearing impairment); EtOH
- L – low O2 states (ACS, PE, CVA, etc...)
- I – infection
- R – retention (urine/stool); restraints
- I – (post) ictal states
- U – under hydration/nutrition; undertreated pain
- M – metabolic (Ca^{2+}, glucose, Na, etc...)
- S – subdural; substances

- B.E.H.A.V.I.O.R.S.
- B – bored
- E – environment, elimination
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- O – organic causes
- R – routine change

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1 Francis J et al. *JAMA* 1990. PMID: 2299782

Data Points: Observations and Analysis Before the Prescription/Order

Hypertension - the process

- Risk factors
- Severity
- Associated symptoms
- Measurements at home
- How was it measured
- Missed medications, Diet

Behaviors - the process

- Family, friend, caregiver observations and history
- Invite an independent observer
- “Fly on the wall”
- Keep a journal/log of behavioral observations
- Do a “look back” of the incident
- Identify need for education, training, support

Know the History: Understanding the Person

- Recent losses
- Relationship stress
- Psychiatric history
- Personality
- Prior aggression/violence
- Service, employment history
- Substance use
- Trauma

F745 * Medically Related Social Services

The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident.

- **Defined as assisting residents in attaining and maintaining their mental and psychosocial health.•**
- **Does not require a trained or licensed social worker.**
  - **Advocating for resident rights.**
  - Voicing grievances.
  - Arranging for personal items.
  - Informing and educating on risks and benefits of care options.
  - Referrals to outside entities, such as absentee ballots or talking books.
  - Assistance with financial and legal matters.
  - Transitions of care services.
  - **Arranging for counseling services.**
  - **Identifying ways to obtain resident input on their care plan.**
  - **Encouraging staff to maintain or enhance resident dignity.**
  - Assisting residents with Advanced Care Planning or Advanced Directives.
  - **Identifying and promoting non-pharmacological approaches to care.**
  - **Supporting residents who are grieving or coping with stressful events**

Learn the Situation: Understanding the Behavior

- What preceded the incident?
- What kind of day was it?
- Who, what, when, where, and how?
- Changes in routine, environment, routine, caregiver, visitors, roommate?
- Who were staff that interacted with the resident?
- Non-verbal cues
  - Grimacing
  - Movement
  - Tense
  - Stressed/Anxious

DOs of De-escalation

- Stop activity if leading to aggression
- Provide personal space
- Slow down
- Make eye contact
- Listen
- Express understanding, pay attention to body language
- Calm, quiet tone and volume
- Be concise
- Reassurance
- Use re-direction
- Consider moving resident to area with lower stimulation
- Approach with one staff member if safe
- Be mindful of your egress
- Have a way to call for help
- Take time to debrief

DON'Ts of De-escalation

- Argue or criticize
- Challenge delusions or hallucinations
- Use complex questions or statements
- Continue to try to force care
- Match their volume
- Take it personally

Side Effects of Antipsychotics

- Tardive dyskinesia
  - Extrapyramidal symptom
  - Rhythmic, involuntary movements
    - Facial: Tongue, lips, jaw, eyes
  - May persists even after antipsychotic is stopped
- Sedation
- Orthostatic hypotension
- Anticholinergic effects

Non-Pharmacologic Interventions

Intervention	Resources
Education of staff	Parks SM. Evaluation of an educational program for long-term care nursing assistants. *J Am Med Dir Assoc* 2005. doi: 10.1016/j.jamda.2004.12.001 Arcand M et al. Educating nursing home staff about the progression of dementia and the comfort care option: impact on family satisfaction with end-of-life care. *J Am Med Dir Assoc* 2009. doi: 10.1016/j.jamda.2008.07.008
Exercise therapy	Volicer L et al. Effects of continuous activity programming on behavioral symptoms of dementia. . *J Am Med Dir Assoc* 2006. doi: 10.1016/j.jamda.2006.02.003 Aman E et al. Supervised exercise to reduce agitation in severely cognitively impaired persons. *J Am Med Dir Assoc* 2009. doi: 10.1016/j.jamda.2008.12.053
Music therapy	Zare M et al. The effects of music therapy on reducing agitation in patients with Alzheimer's disease, a pre-post study. *Int J Geriatr Psychiatry* 2010. doi: 10.1002/gps.2450
Enhancing dining environment	Nihs K et al. Malnutrition and mealtime ambiance in nursing homes. J Am Med Dir Assoc 2009. doi: 10.1016/j.jamda.2009.01.006
Therapeutic touch	Woods DL et al. The effect of therapeutic touch on behavioral symptoms and cortisol in persons with dementia. *Forsch Komplementmed* 2009. doi: 10.1159/000220479
Dance therapy	Guzmán-García A et al. Dancing as a psychosocial intervention in care homes: a systematic review of the literature. *Int J Geriatr Psychiatry* 2013. doi:10.1002/gps.3913
Pet therapy	Banks MR et al. Animal-assisted therapy and loneliness in nursing homes: use of robotic versus living dogs. *J Am Med Dir Assoc* 2008. doi: 10.1016/j.jamda.2007.11.007
Social stimuli	Cohen-Mansfield J et al. Can agitated behavior of nursing home residents with dementia be prevented with the use of standardized stimuli? J Am Geriatr Soc 2010. doi: 10.1111/j.1532-5415.2010.02951.x
Psychosocial therapy	Ballard C et al. Brief psychosocial therapy for the treatment of agitation in Alzheimer disease (the CALM-AD trial). *Am J Geriatr Psychiatry* 2009. doi: 10.1097/JGP.0b013e3181b0f8c0

Pharmacologic Substitutions: Not Recommended

- Antipsychotic use in SNFs decreased (31% in 2011➔ 22% in 2019).
- Anticonvulsant use increased
  - 28% in 2011 ➔ 40% in 2019
- Overall psychotropic use unchanged (~80% of SNF residents)



Epilepsy drugs as 'chemical restraint' on rise in nursing homes

Inspector general's report says increased use of anticonvulsant medications coincided with a reduction in antipsychotic drugs

By Christopher Rowland

November 17, 2022 at 4:43 p.m. EST

The Washington Post

Democracy Dies in Darkness

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US DHHS OIG. Long-term trends of psychotropic drug use in nursing homes. November 2022. OEI-07-20-00500
https://www.washingtonpost.com/business/2022/11/17/nursing-home-drugs-dementia/ Last accessed 4/12/23.

Pharmacologic Alternatives

Class	Condition	Concomitant Condition	Example of Medication	Resource
Acetylcholinesterase inhibitors	DAT; PD	-	Donepezil Rivastagmine	Birks JS. *Cochrane Database Syst Rev* 2006. doi: 10.1002/14651858.CD005593 Maidment I et al. *Cochrane Database Syst Rev* 2006. doi: 10.1002/14651858.CD004747.pub2
NMDA antagonist	DAT; VAD	-	Memantine	Tariot PN et al. *JAMA*. doi: 10.1001/jama.291.3.317 McShane R et al. *Cochrane Database Syst Rev* 2019. doi: 10.1002/14651858.CD003154.pub6
SSRIs/SNRIs	Dementia	Mood disorders	Citalopram	Seitz DP et al. *Cochrane Database Syst Rev* 2011. doi: 10.1002/14651858.CD008191.pub2
Alpha blocker	DAT	HTN, PTSD,	Prazosin	Wang LY et al. Am J Geriatr Pyschitary 2009. doi: 10.1097/JGP.0b013e3181ab8c61
Melatonin	-	Insomnia		Jansen SL et al. *Cochrane Database Syst Rev* 2006. doi: 10.1002/14651858.CD003802.pub3
Trazodone	Dementia	Insomnia		Martinon-Torres G et al. *Cochrane Database Syst Rev* 2004. doi: 10.1002/14651858.CD004990
$GABA_A$/$GABA_B$ agonist	-	EtOH use disorder; pain	Gabapentin	Anton RF et al. JAMA Intern Med 2020. doi: 10.1001/jamainternmed.2020.0249
Propranolol	-	TBI		Fleminger S et al. *Cochrane Database Syst Rev* 2006. doi: 10.1002/14651858.CD003299.pub2
Amantadine	-	TBI		Hammond F et al. *J Head Trauma Rehabil* 2014. doi: 10.1097/01.HTR.0000438116.56228.de

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DAT: Dementia Alzheimer's Type; PD: Parkinson's Disease; VAD: Vascular dementia;
PTSD: Post-traumatic stress disorder; HTN: hypertension; TBI: Traumatic brain injury

Problem behavior

↓

Identify environmental, psychosocial, or medical factors

-B.E.H.A.V.I.O.R.

-D.E.L.I.R.I.U.M.S.

↓

Implement interventions

↓

Acceptable conditions

DO NOT prescribe antipsychotics in only for: fidgeting, nervousness, unsociability, depression without psychosis, agitated behaviors not dangerous to self or others, poor self-care, restlessness, wandering, insomnia, anxiety.

Psychosis
Mood disorder with psychosis
Refractory hiccups, nausea/vomiting, pruritus
Tourette's syndrome
Huntington's chorea

Dementia with agitated behaviors

↓

Document target behavior: persistent, causing psychotic symptoms and danger to resident or others

↓

Monitor for side effects: akathisia, tardive dyskinesia, parkinsonism, orthostatic hypotension, sedation, cognitive impairment.

↓

Set a timeline for gradual dose reduction.

Gurvich T, Cunningham, JA. Appropriate use of psychotropic drugs in nursing homes. *Am Fam Physician* 2000.

Summary

- Lead with empathy.
- Agitation and untoward behaviors are most often multifactorial.
- Consistently use a framework to methodically review possible causes.
- Look for organic causes.
- De-escalation techniques are paramount.
- Non-pharmacologic interventions cornerstone of care plans.

Acknowledgments

- Whitney Carlson, MD
- Sarah McCutcheon, MD

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Department of Health Care Finance

Questions?

H.E.L.P. in SNFs

Gradual Dose Reductions
Psychotropic Time Outs

D.E.L.I.R.I.U.M.S.

- D – drugs (also withdrawal of drugs)
- E – ears/eyes (visual/hearing impairment); EtOH
- L – low O2 states (ACS, PE, CVA, etc...)
- I – infection
- R – retention (urine/stool); restraints
- I – (post) ictal states
- U – under hydration/nutrition; undertreated pain
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Gurvich T, Cunningham, JA. Appropriate use of psychotropic drugs in nursing homes. *Am Fam Physician* 2000.

Questions?

DC Department of Behavioral Health Presentation

Chaka Curtis, RN, Psychiatric Nurse/PASSR Coordinator, Clinical Services Administration, DC Department of Behavioral Health

Alexis Mapes, LPC, Director Community Response Team, DC Department of Behavioral Health

DC Department of Behavioral Health

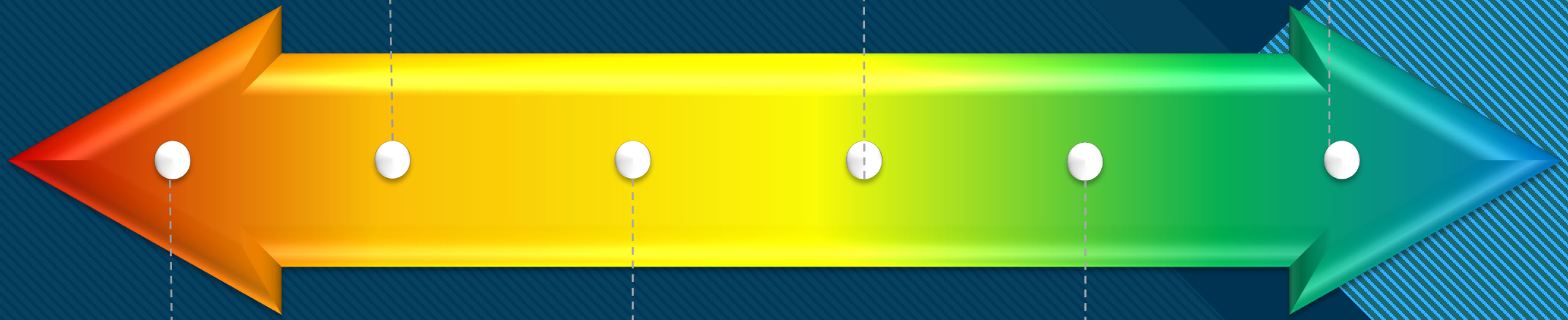
Crisis Continuum of Care

Psychiatric Care Continuum

Voluntary Hospitalization: CPEP or any hospital ED

Community Based Crisis Stabilization: Community Response Team, Access Helpline

Community Based Treatment: Core Service Agencies



Involuntary Hospitalization via FD12 CPEP, UMC, PIW, WHC

Residential Crisis Bed: Short term psychiatric treatment

Intensive Community Support: Intensive Care Coordination, Assertive Community Treatment

DBH Crisis Services

CPEP

Comprehensive Psychiatric Emergency Program

- Most intensive level of care, offering 24/7 support to adults experiencing a psychiatric emergency.
  - Voluntary
  - Involuntary
    - FD12
      - CRT, MPD, DBH Officer Agent
- Staffing: Psychiatrists, Psychiatric Nurses, Clinicians, Security, Administrative
- Location: 1905 E St SE, Washington, DC 20003
- Phone: 202-673-9319
- Website: https://dbh.dc.gov/service/emergency-psychiatric-services

DBH Crisis Services

Residential Crisis Beds

Residential Crisis Program

- Community Based Short Term Residential Care
  - Woodley House- Crossing Place (202) 830-3517
  - Jordan House (202) 292-4491
    - Voluntary
      - Hospital diversion and step-down from inpatient care
      - 2-14 days intensive support, adults only
- Staffing: Psychiatrists, Psychiatric Nurses, Clinicians, Security, Administrative
- Eligibility:
  - Age 18 or older
  - Experiencing a psychiatric crisis
  - Must be able to maintain safety of self or others
  - Must not be in need of medical detoxification or other inpatient care

DBH Crisis Services

CRT

Community Response Team

- Community Based Care, offering 24/7 support to adults experiencing a psychiatric emergency; outreach to vulnerable individuals and communities; critical incident response; community engagement and education.
  - Facilities voluntary and involuntary hospitalization
  - Care coordination and connection with service providers
- Staffing: Clinician Supervisors, Community Behavioral Health Specialists, Peer Support Specialists
- Location: 1905 E St SE, Washington, DC 20003 & 35 K St NE, Washington, DC 20002
- Phone: 202-673-9300 (CPEP) 202-673-6495 (35K)
- Website: https://dbh.dc.gov/service/community-response-team

DBH Crisis Services

AHL

Access Helpline

- 24/7 Call Support
  - Facilities service connection
  - Deescalates crises and/or dispatches CRT as appropriate
  - Supports service authorization
  - Consultation and problem solving
  - Supports any age range
- Staffing: Clinician Supervisors, Care Coordinators
- Location: 64 New York Ave, NE, Washington, DC 20002
- Phone: 988, 1(888)7WE-HELP, 1-888-793-4357
- Website: https://dbh.dc.gov/service/access-helpline

Questions:

How should DCPL best utilize DBH services?

How does CRT differ from AHL, ACT/CSA, and other DBH services?

Examples of when to call CRT…

Round Robin



People start to heal the moment they feel heard.

-Cheryl Richardson

Thank You!

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Questions?