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# North Sound Mental Health Administration

Section 1700 – Crisis Services – Crisis Prevention and Intervention Teams (CPIT)

Authorizing Source: NSMHA contract, WACs 388-877A-0200, 0240
Cancels:
See Also:
Providers must comply with this policy and may develop individualized implementation guidelines as needed
Responsible Staff: Deputy Director

Approved by: Executive Director
Signature:

Date: 8/28/2015

**POLICY #1727.00**

**SUBJECT: CRISIS PREVENTION AND INTERVENTION TEAMS (CPIT)**

## PURPOSE

The purpose of the CPITs is to provide community outreach and engagement to individuals who are experiencing a behavioral health crisis or who are believed to be suffering from significant behavioral health symptoms which are interfering with activities of daily living. These individuals may be referred to the CPIT via themselves, family, friends, law enforcement, emergency medical services, or others and prompt attempts will be made to engage them in order to reduce the likelihood of the need for more intense interventions.

## POLICY

CPIT is designed to provide proactive and/or early intervention to those experiencing a behavioral health crisis or who are believed to be suffering from significant behavioral health symptoms. In Whatcom and Snohomish Counties, individuals must present with a mental health concern but in Skagit County the program also provides services to those with a Substance Use Disorder (SUD) or who are presenting primarily with concerns related to substance use. This program is intended to provide early intervention and to assess, engage, stabilize, and make appropriate linkage to community treatment and support resources.

Program outcomes should include diversion from jail, emergency departments and inpatient psychiatric facilities and active engagement with available community resources. Additionally, CPIT will address community concerns about those who have apparent unmet needs and actively partner with community members (e.g. law enforcement, emergency departments, homeless outreach programs, shelters, and general community members) to address potentially problematic situations and facilitate continuity of care.

CPIT will respond to emergent needs within 2 hours of request and to urgent requests within 24 hours. Requests for intervention may come from the Crisis Line or via direct referral to the team. Any concerned person may request CPIT response, to include the individual themselves, family, friends, or other concerned community members. The individual does not have to be well known, can be in crisis or just of significant concern, but must be identifiable. Every effort will be made to coordinate with collateral formal and informal supports, to include current treatment providers and other supports.

When CPIT responds to a crisis situation, the team is expected to stay involved until the situation is stabilized or resolved. Episodes of care are expected to be no more than 14 days, although in rare circumstances an extension to this time period may be requested.

Program staffing must include professionals who are able to rapidly respond and address a broad range of behavioral health concerns in a varied population. To this end, Certified Peer Counselors, Mental Health Professionals (MHP) and Chemical Dependency Professionals (CDP) will be critical members of the CPIT and management staff will be available for consultation at all times.

## PROCEDURES

### I. CPIT Composition and Coverage

A. Snohomish County CPIT will be staffed 24/7/365. Core staffing will include an MHP and Certified Peer Counselor available at all times to provide paired outreach. Management will be available for consultation at all times.
B. Skagit County CPIT will be staffed 7 days per week at peak day and evening hours (e.g. 0900 through 2400 hours). Core staffing will include an MHP, CDP, and Certified Peer Counselor available at all times to provide (at least) paired outreach. Management will be available for consultation at all times. During "uncovered hours", the DMHP staff may be dispatched by the Crisis Line to respond to Emergent (2 hour response) outreach needs.
C. In Whatcom County, CPIT will be staffed 7 days per week at peak day and evening hours (e.g. 0900 through 2400 hours). Core staffing will include an MHP and Certified Peer Counselor available at all times to provide paired outreach. Management will be available for consultation at all times. During "uncovered hours", the DMHP staff may be dispatched by the Crisis Line to respond to Emergent (2 hour response) outreach needs.

### II. CPIT Workflow and Response Expectations

A. CPIT must follow all applicable WAC, most specifically WAC 388-877A-0200 through 0270.
B. Referrals may come from the Crisis Line or directly. Crisis Line pages require a response within 10 minutes.
C. Initial screening will result in a determination of whether an Emergent (2 hours or less) or Urgent (within 24 hours) response is warranted.
D. If the individual is enrolled with a Community Mental Health provider, that provider is responsible for crisis response that may be needed during typical business hours. If the individual is in an "intensive program" (to include Program for Assertive Community Treatment (PACT), Wraparound with Intensive Services (WISe), etc. there is an expectation that the intensive program will provide 24/7/365 response.
E. Prior to any community-based (unstaffed) location a safety screening must be completed and documented using standard criteria. When the request is received directly by CPIT, they will contact the Crisis Line in order to inquire about any available information, to include history of contacts with the community mental health system and performance of a WATCH screening. CPIT will dispatch to locations per Policy 1702.00 – Outreach Safety Screening.
F. Each situation will be assessed in the context of the role of CPIT and a response plan developed between the members of the team. Management should be consulted when appropriate and all service requests, services, and service attempts thoroughly documented and transmitted to NSMHA per established protocol.
G. Initial contacts by CPIT should focus on engagement and stabilization of the presenting concern(s). CPIT should build a short-term focused Care Plan grounded in Recovery and evidence-based clinical models (e.g. Trauma Informed Care, Motivational Interviewing, Cognitive Behavioral Therapy, etc.).
H. Initial outreach contacts should be coordinated with other involved parties (e.g. law enforcement, homeless outreach team, outpatient provider, etc.) and done with these entities when that might facilitate engagement.

I. The need for ongoing contact by CPIT, to include coordination with formal and informal supports, should be evaluated and included in the Care Plan. The over-arching goal should be engagement with ongoing supports within the span of CPIT episode (within 2 weeks). Appropriate Releases of Information should be obtained to facilitate communication.
J. CPIT should call in a disposition on all cases referred to them upon completion of first contact with the individual of concern. If the individual is unable to be located, the disposition should be called in within two days of the referral.
K. CPIT should coordinate as needed with all parts of the regional crisis system, to include Triage/Crisis Stabilization Facilities, DMHP teams, Crisis Line, etc.
L. Services after the initial contact and stabilization should be consistent with the established Care Plan and may include phone contacts, outreach, or facility-based appointments. Further, services may be provided to the individual directly or in support of their family, friends, or other service providers. These services may last for up to 14 days. If appropriate, CPIT should assist the individual in applying for Medicaid and/or other state and local programs.
M. CPIT is expected to actively work to divert individuals from costly and restrictive interventions, to include jail, emergency departments, and inpatient psychiatric care. Triage and Crisis Stabilization Facilities and other community-based interventions must be thoroughly explored before referral to more acute or restrictive resources including voluntary hospitalization and referring the individual to the DMHP for evaluation.
N. There are individuals who are frequent utilizers of the crisis system for various reasons. CPIT will work actively with NSMHA Care Managers to address the needs of these individuals when either party is made aware of a particularly troublesome situation.
O. Psychiatric medication evaluation is available on a limited basis for individuals who have needs that can be addressed in this short-term program.
P. Flex Funds are also available and typically can be used to address targeted transportation needs, assist with medication purchase, or address other basic need issues for which there are no other community or personal resources available.

## III. Program Leadership Expectations

A. Leadership should be available for consultation during all covered hours of CPIT operation
B. Leadership should actively market the program to the communities within which the team(s) will be active, to include local Emergency Departments and Emergency Medical Services (EMS).
C. Leadership should make particular efforts to engage law enforcement regarding CPIT and the interface between CPIT and the law enforcement.
D. Leadership should attend local community meetings as appropriate (e.g. local Crisis Oversight meetings).
E. Leadership should actively engage in a process of continuous quality improvement with CPIT and should promote a program culture that can adapt to changing needs within the local communities.

## ATTACHMENTS

None