Creating a Stronger Safety Net for People Experiencing Homelessness with Severe Mental Illness

District of Columbia
Interagency Council on Homelessness

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The ICH is grateful to the following partners who shared their time and expertise for this project: DC Department of Behavioral Health, DC Department of Human Services, DC Fire and Emergency Management Services, DC Metropolitan Police Department, DC Office of the Attorney General, DC BID Council, Community Connections, Georgetown Ministries, Howard University Hospital, MBI Health Services, Miriam's Kitchen, N Street Village, Pathways to Housing, So Other Might Eat, Treatment Advocacy Center, Unity Health Care, and Washington Hospital Center.

I. Introduction

Since the launch of the Homeward DC plan in 2015, the DC interagency on Homelessness (ICH) has continuously worked with partners and stakeholders to identify and fix gaps in the continuum of care for people experiencing homelessness. One such gap is the safety net for people who are both unhoused and who suffer from serious mental illness. Street outreach workers, shelter providers, and physicians working with the population have repeatedly expressed concern over the welfare of individuals who struggle with ongoing and extreme levels of self-neglect and untreated complex conditions. These partners have long worked with ICH and with each other to identify solutions and overcome challenges when it comes to helping this group.

The District's Homeward DC strategy is rooted in a Housing First philosophy and recognizes that not all, or even a majority of, individuals experiencing homelessness suffer from such mental and physical health disorders. Ample evidence supports that subsidized housing and wrap around services work for most people in this group. That said, people with the most debilitating levels of illness, a small subset of the population, may need more intensive interventions to help them access care, treatment and housing that is better aligned with their complex needs.

One of those tools is Civil Commitment, which allows someone to be involuntarily hospitalized and treated for psychiatric illness. While involuntary hospitalization should never be thought of as a strategy to address homelessness in and of itself, the process can be utilized to help severely ill people get the treatment they need to eventually heal and thrive. However, taking someone's freedom, even if the intention is to help them, must never be taken lightly. The bar for involuntary commitment *should* be high. Additionally, involuntary hospitalization must be seen not as the endpoint, but a component of a larger system of care. For example, it's important to ensure the quality of the care received and to know that there is a plan for the person once they are psychiatrically and medically stabilized. When helping people in this category, stakeholders will need to continually ask: What kind of outpatient care will they receive? What kind of housing and other supports will be provided once hospitalization is no longer necessary? What are other, less restrictive settings where someone can receive residential treatment than a psychiatric hospital?

In 2018, the ICH conducted interviews and focus groups to better understand the challenges providers face in trying to help extremely vulnerable people obtain treatment for serious mental illness, including Civil Commitment. The research began with an examination of FD-12s, a process by which a person in crisis can be taken, involuntarily, to the hospital for emergency observation and diagnosis. FD-12s are often the step before Civil Commitment, an entry point into a system for someone in acute crisis.

The District's data seems to suggest that individuals who have experienced prolonged homelessness are subject to FD-12s[1] more often than their housed counterparts. This may be due to the inherent dangers associated with living on the street (weather, victimization, etc.), but it also may be that, without strong support networks in place, people experiencing homelessness deteriorate faster or without others noticing, leading to involuntary intervention when their condition reaches a crisis point. There is also evidence that shows that people whose mental illness has gone untreated for a sustained period of time or who lack insight into their conditions are at increased risk of becoming homeless in the first place. No matter what the root cause, a small but significant number of people experiencing homelessness find

[1] Form FD-12 is the official District Government form used to execute an emergency hospitalization.

themselves trapped in untreated psychosis that can lead to them being FD-12ed for their own, and for others' safety.

However, the FD-12 process only guarantees observation and sometimes diagnosis. It does not necessarily lead to treatment. In fact, more often than not, individuals with serious and acute illness quickly return to the street, with the only result of the FD-12 being broken trust between the client and service provider attempting to help. Providers reported anecdotally that it is not uncommon for a person to go through the FD-12 process five to seven times before getting admitted to a hospital for treatment. Data we were able to compile during this process – although imperfect – supports this claim: in 2018 MPD received 84,446 calls for welfare checks and disorderly individuals. Of these calls, just over 2,100 FD-12s and 522 certificates were filed.[2] Of these cases, 72 individuals were committed to inpatient treatment while another 110 were committed to outpatient treatment.

These numbers, combined with the data we gathered through interviews and focus groups, indicate that too many extremely vulnerable people are falling through the cracks, unable to receive and benefit from sorely needed care. Recognizing the complexity of the system along with the complicated ethical issues at play when exploring involuntary treatment, the ICH hosted a series of meetings with partners to further define barriers and breakdowns. We then developed recommendations primarily focused on the Civil Commitment and FD-12 process that will fill some of the existing gaps in safety net for extremely vulnerable individuals whose needs are currently not being adequately met. What follows is a report that documents our findings such that each relevant agency may consider necessary changes to improve outcomes.

II. Project Overview

Civil commitment is a process that involves many different steps and many different partners. In addition to homeless services system providers, the Department of Behavioral Health (DBH), the Metropolitan Police Department (MPD), Fire and Emergency Management (FEMS), the Office of the Attorney General (OAG), and hospitals are among the entities involved in and affected by civil commitment process. The variety of steps and partners involved unfortunately means that there are numerous places where clients can slip through the cracks.

ICH staff began this project by conducting interviews with homeless service system partners to identify when and how the system most typically breaks down for vulnerable clients. The ICH used this information to structure the work group process into five parts: Intervention, Transportation, Assessment, Adjudication, and Treatment. While the civil commitment process could certainly be broken down in different ways, we noticed that these were the points at which different actors engaged in the process. From there, we identified specific partners that we anticipated would have insight about each particular stage. We then hosted work group meetings to 1) review challenges raised by homeless service system partners and identify any we may have missed; 2) explore root causes of the stated challenges, and 3) to identify potential solutions. At each meeting, the group also discussed potential data sources that may help further elucidate the challenges being experienced.

III. Key Findings: Obstacles and Process Breakdowns

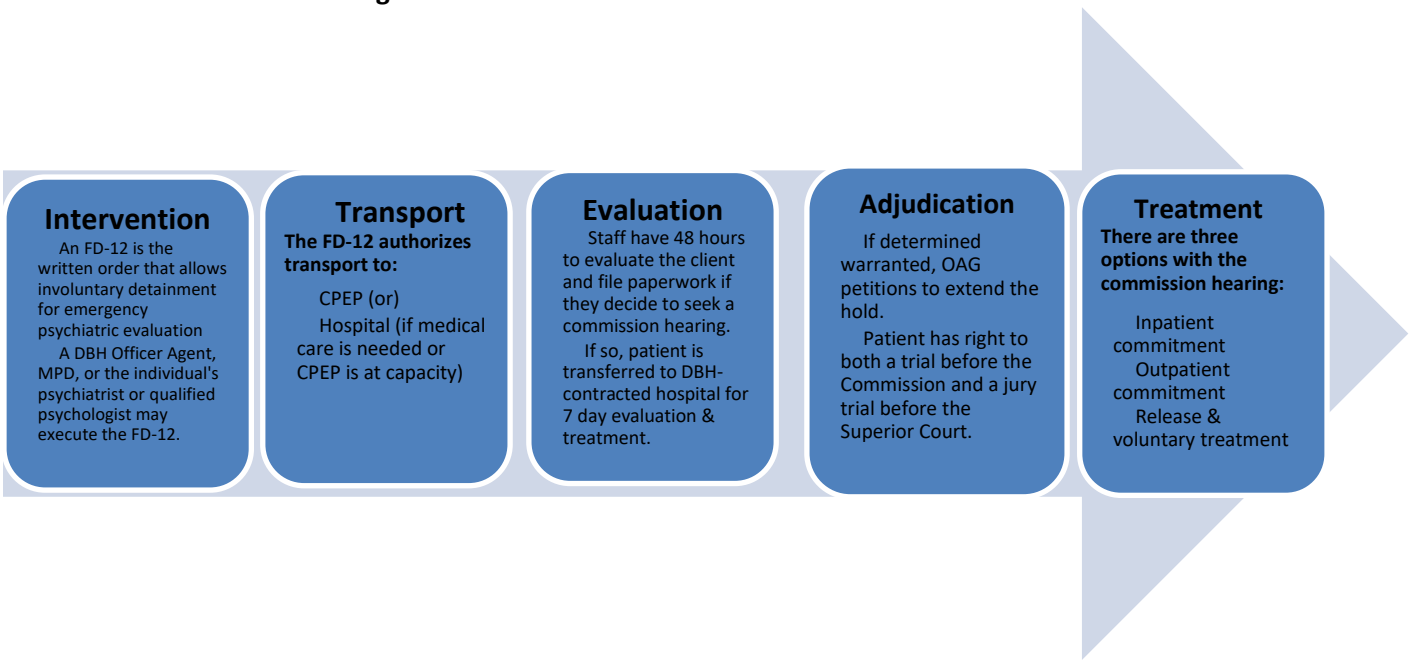
As illustrated in Figure 1 below, an involuntary hospitalization is triggered by completion of Form FD-12. An FD-12 may be completed by a DBH-certified Officer Agent, a law enforcement official authorized to

[2] Together, the FD-12 and 522 certificate form the government's initial Emergency Petition. OAG indicated that it was likely many more FD-12s were written where the client was briefly hospitalized and released.

make arrests in the District, or the individual's physician or qualified psychologist.[3] The FD-12 authorizes police to transport a person to DBH's Comprehensive Psychiatric Emergency Program (CPEP) for further evaluation. If the individual requires medical care in addition to psychiatric evaluation, or if CPEP beds are fully occupied, the client will be diverted to a hospital. Staff have 48 hours to complete an evaluation, determine if they will seek a commission hearing, and subsequently file the petition needed to extend the hold.

If medical staff determine continuation of a hold is warranted, a patient will then be transferred to one of three DBH-contracted hospitals to allow psychiatric evaluation, observation, and treatment for a seven-day period. If the involved parties determine civil commitment should be pursued, OAG will petition to extend the hold and proceed to a hearing. Under District law, patients have the right to both a trial before the Commission and then a jury trial before the Superior Court. There are three options with the commission hearing: inpatient commitment, outpatient commitment, and release with voluntary treatment. In the sections that follow, we look at key obstacles within each stage of the process.

Figure 1: Civil Commitment Transition Points



A. Intervention

1. Role Confusion in an FD-12 Event. The process for the civil commitment is broadly discussed in the FEMS general orders and more specifically in MPD orders, but those orders do not discuss how different parties interact in the case of a disagreement. Further complicating the matter is that in some instances, MPD is called to the scene only to assist with transport (in cases where an Officer Agent is on the scene and has written the FD-12), while in other cases, they are called to write the FD-12 (because the caregiver is not an Officer Agent).

   Partners noted that it was not uncommon for MPD to arrive and decline to write the FD-12 because they had not witnessed the behavior themselves. This was particularly frustrating for

[3] For more information, see *Policy 220.1: DBH Officer-Agent Certification,* available online at https://dbh.dc.gov/sites/default/files/dc/sites/dmh/publication/attachments/220.1%20TL-226.PDF

homeless services system providers, who are often in the position of knowing the client most intimately and seeing the individual's pattern of behavior over time. During work group discussions, MPD officers noted that they take very seriously the notion of taking someone's liberties away from them, and that when it is the officer's name on the paperwork, they have difficulty signing off if they haven't witnessed the behavior or if the caregiver otherwise hasn't provided sufficient information/documentation.

2. Inconsistent Interpretation/Application of the Law (Risk of Harm vs Self-Neglect). In addition to confusion around the process of an FD-12, substantial confusion and disagreement exists around what behavior constitutes "danger to self or others." The Ervin Act does not expressly define this threshold, which means that it's open to interpretation by each professional interfacing with the client at every stage in the process. The District is one of only five states that does not codify persistent self-neglect ("grave disability") in its law, which means that individuals unable to care for themselves and without insight into their illness often receive no care.[4] Confusion also exists because many actors assume the danger to self or others must be "imminent" (which is not accurate), and stakeholders also noted the difficulty of assigning behavior to mental health issues when substance use is also involved.

   During the work group meetings, OAG cited case law that can be applied in civil commitment cases that would allow someone that is gravely disabled to be detained under the District's law, though other work group members noted that it was unrealistic to expect front line workers to know case law, and that reliance on case law certainly contributed to inconsistent opinions about whether a given individual met the law's threshold.

3. Different Perspectives on the Purpose of an FD-12. In addition to inconsistent interpretation of the law as it is written, the purpose of an FD-12 also seemed to be a point of confusion. Some work group participants stated the importance of knowing an individual's "baseline" and determining whether the client had deteriorated from that baseline before moving forward with the civil commitment process. Others disagreed, pointing out that individuals struggling with persistent self-neglect may then never get the help they need if that state *is* their baseline. In other words, work group members did not have a common understanding of whether the purpose of the law was only to intervene in a short-term crisis, or whether the law was intended to protect individuals so vulnerable that they have no insight into their conditions or ability to care for themselves.

4. Bed Shortages & Perception of FD-12s Perceived as Futile. Many work group participants, and especially MPD, believed FD-12s to be futile since the most common outcome is that the individual returns to the street within 48 hours or less. Bed shortages were a recurring theme during the work groups meetings – at CPEP, at DBH-contracted hospitals, and at Saint Elizabeths.[5] Ultimately, many stakeholders felt that the lack of psychiatric treatment beds would

[4] For more information, see "Grading the States: An Analysis of State Psychiatric Treatment Laws" (Sept 2020) from the Treatment Advocacy Center. https://www.treatmentadvocacycenter.org/grading-the-states

[5] The ICH launched this project in 2019. Due to changes in DBH leadership, followed by the emergence of the COVID-19 public health emergency, this project was temporarily placed on pause. However, many of the themes identified during the original work group meeting – such as psychiatric treatment bed shortages – have only grown worse during the public health emergency.

invariably result in the client's discharge. Given the trauma to the individual and the broken relationships that result, past experience presents a very significant obstacle for moving forward with FD-12s.

B. Transport

1. Ambulance Transports. Once an FD-12 has been determined necessary, getting the individual to CPEP or the hospital is the next critical step in the process. As mentioned in the introduction to this section, individuals will be diverted to the hospital when medical care is needed and/or when CPEP beds are full. However, ambulances typically bring clients to the nearest Emergency Room (ER) with availability, and not all ERs are equipped for persons with severe mental illness. Work group members noted that they have had clients simply walk out of the ER.[6] Work group members also noted instances where contracted ambulances let an individual out (of the ambulance) because the individual indicated that they did not want to go to the hospital.

2. Transport of Individuals who Present "No Danger." As discussed under item III.A.1 above, role confusion exists not only with the writing of the FD-12, but also with transport. The MPD General Orders state that if the individual being FD-12ed presents no danger, he/she should be transported to CPEP by the DBH Officer Agent. However, in the Work Group, DBH indicated that Officer Agents are not allowed to transport individuals in their personal vehicles.

C. Evaluation

1. Window to File Emergency Petition is Very Short. OAG stated that it was, at times, very difficult to pull together the information needed to file the Emergency Petition within the Ervin Act's 48-hour window. Further, time limits are not extended when courts are closed (e.g., weekends or holidays). Across the country, state laws more typically allow 72 hours for the initial hold, and nearly all exclude weekends and holidays from the hold duration.

2. Inconsistent Interpretation/Application of the Law. The challenges related to an inconsistent interpretation and application of the law that occur at the point of intervention are repeated throughout every stage in the process as new players enter the picture. While in the hospital, a psychiatrist will consult with the individual's other caregivers (e.g., Core Service Agency, street outreach, or shelter staff) only if they are known to the psychiatrist. Accordingly, the psychiatrist may not have the benefit of understanding the patient's fuller history and patterns of behavior. If they are overly focused on the question of "imminent risk of harm" – patients struggling with persistent self-neglect will often be discharged.

   Further, the statute provides authority to detain an individual for "diagnosis and observation" but does not explicitly reference treatment. This is another area where lack of clarity in the law

[6] During the work group meetings, stakeholders indicated that, depending on where the client was transported, there may not be a psychiatrist on staff or available during the short period of the hold, and/or that the hospital may have inadequately secure facilities. Stakeholders indicated that it wasn't uncommon to have the assessment made by an ER physician who has little background or experience with psychiatric conditions, and that they tended to focus on physical conditions and then discharge accordingly.

may unintentionally lead to poorer outcomes if physicians interpret the law to mean that treatment may not begin prior to the formal civil commitment process.

3. Bed Shortages and Medicaid Reimbursement. Bed shortages were a recurring theme during the work groups meetings – at CPEP, at hospitals throughout the District, and at Saint Elizabeths. Caregivers for patients who have not been stabilized during their seven-day hospital stay face a difficult choice. If they decide to pursue involuntary treatment, the patient needs a bed while they wait for the hearing. The hospital can keep the patient without getting reimbursed, or they can send the patient to St. Elizabeths – if a bed is available (which is often not the case) and if transport can be arranged.

4. Prohibition on "Self-Referrals." Work group members noted that the Ervin Act prevents doctors from involuntarily admitting consumers to the hospital where the doctor works. As a result, when a consumer is already present at the hospital and exhibiting symptoms that would warrant emergency detention, the hospital is required to call DBH or another provider to travel to the hospital and assess the individual rather than simply allowing the hospital doctor to admit the consumer. This becomes particularly problematic when CPEP beds are full and clients are routinely diverted to hospitals for care, which has increasingly been the case during the public health emergency.

D. Adjudication

1. Financial Barriers to Hospital Participation. There are a number of issues that make it difficult for hospitals to participate in the commission hearing. During the work group meetings, psychiatrists and other physicians stated that the time required by doctors and other staff to prepare for, travel to, wait for, and participate in a commission hearing is significant, and Medicaid does not reimburse for this time. Further, because psychiatrists must leave the floor to attend hearings, hospitals must coordinate replacement staff.[7] For these reasons, hospitals may be less receptive to receiving and holding involuntary patients in the first place.

5. Law Allows for Two Separate Trials. Work group members pointed out that under the Ervin Act, a person being held for involuntary hospitalization has a right to a trial before the Commission *and* then a jury trial before the Superior Court. Having the right to two trials presents an unreasonable burden upon the District and is highly unusual (no other states were known to have this requirement).

E. Treatment

1. Shortage of Non-Forensic Psychiatric Beds. As mentioned above under item III.A.4, bed shortages were a recurring theme during the work group meetings. Many work group members indicated that generally there were no beds available at St. Elizabeths for non-forensic patients. Further, the knowledge of this bed shortage by frontline staff seems to impact decision about how best to proceed with a patient's case, such that fewer patients are FD-12ed or held relative

[7] As mentioned in footnote number 6, this work group process originally took place in 2019. While the courts historically have not allowed remote hearings, a number of emergency measures were temporarily enacted in 2020 in response to the public health emergency – including video conferencing. As discussed in item IV.A.4, we would recommend amending the law to ensure remote hearings permanently remain an option.

to the number that might need more intensive support to stabilize. In other words, the bed shortage may actually be more severe than it even seems.

2. Lack of Knowledge Regarding Enforcement of Outpatient Commitment. When an individual's case progresses to a commission hearing, outpatient commitment is the result more often than inpatient commitment. However, there was a general consensus by mental health organizations participating in the work group that outpatient commitments have "no teeth," and therefore are largely inadequate for assisting individuals who need intensive care. They indicated that outpatient commitment does not mandate the specific treatment needed, and as result, many patients disregard or do not comply with the doctor's recommendations, thereby undermining the purpose of commitment. During work group meetings, OAG representatives were able to explain tools for making outpatient commitments more enforceable, though the information shared was widely unknown by stakeholders in the discussion, suggesting a significant training/information gap.

3. Lack of Connection to Available Supportive Housing Assistance. Work group members also pointed out that outpatient commitment was typically ineffective for people experiencing homelessness because people need to have their basic needs met before they can focus on recovery and healing. While it's true that the District (like every other city in America) has a major affordable housing crisis, and that we cannot today immediately offer every individual that experiences homelessness a permanent housing subsidy, it's also the case that Mayor Bowser has been investing significantly in Permanent Supportive Housing (PSH) and that the resources we do have within the homeless services system are allocated via our Coordinated Assessment and Housing Placement (CAHP) protocols based on vulnerability. Given that we are talking about a relatively small number of people that may need involuntary treatment, there should not be a problem earmarking a housing resource for these individuals. The challenge is that the housing process is not immediate – individuals must complete their voucher application, compile necessary documentation, identify a unit, pass landlord screening, and then schedule the lease-signing and move-in. These steps typically take a minimum of three months, during which time the client needs stability or the entire process falls apart.

IV. Recommendations

As the work group progressed through discussions on each stage of the civil commitment process, recommendations emerged in three key categories: 1) legislation, 2) resource needs, and 3) process improvements. Process improvements covers a wide range of items, including revisiting forms, guidance, training, communication, and interagency coordination.

A. Legislation: Update & Enhance the Ervin Act

While the work group did not do a comprehensive review of the Ervin Act to outline every update that might be desired, following are some of the biggest issues that were raised.

1. Define Risk of Harm to Include Grave Disability. As explained in Section III, the District is one of five states that does include the concept of "grave disability" in their civil commitment law. While OAG indicated that case law has allowed them to successfully argue cases on the grounds of persistent self-neglect, not having this language explicitly in the law creates significant room for inconsistency by the many actors involved in this process. Stakeholders also suggested

amending the definition of mental illness to expressly include co-occurring alcohol and substance use disorders.[8] Lastly, they suggested incorporating language to address the needs of individuals whose behavior may be more likely tied to an intellectual disability or a condition like dementia. Currently, individuals with these conditions can exhibit similar behaviors as an individual with SMI, but there is no law to protect such individuals or provide for involuntary placement into a hospital or nursing facility.[9] Stakeholders noted that a patient may make it all the way to a hearing and then have the case dismissed because it is an intellectual or developmental disability giving rise to the crisis (versus mental illness), and that in those instances, there is no follow up or assistance provided to the individual.

2. Extend the Window to File the Emergency Petition. Work group members stated that 48 hours in not enough time to file the Emergency Petition. The work group suggested extending this time to 72 hours, and ensuring the time frame accounts for weekends and holidays.

3. Extend the 7-day Hold Period to Allow Treatment. Work group members felt that a longer initial hold period (e.g., going from 7 to 10 or 14 days) could allow more time for evaluation, treatment, and stabilization – with the goal of reducing the total number of civil commitment petitions filed but also increasing the effectiveness of the process when it's needed.

4. Allow Remote Hearings. Hospital representatives indicated that amending the law to allow for video conferencing would allow the psychiatrist to testify without leaving the hospital, and it would allow the hearing to proceed without having to transport the client to and from court – both of which are cost saving measures for the hospital but also ease the burden on both patient and doctor.

5. Expand Definition of Expert. The work group suggested that the District consider expanding the definition of "expert" (with regard to who may testify in a hearing). As work group members pointed out, LICSW/Psychiatric Nurses are able to diagnose individuals and are often the clinician most involved with the patient. Work group members felt that they should be able to testify as an expert in commission hearings.

6. Allow Commission Hearing *or* Jury Trial. Work group members felt that the District should bring its law into alignment with other states and allow a jury trial with the Superior Court (if the patient requests it) *or* a commission hearing, but not both.

7. Allow Treating Doctor to Admit Patients. Work group participants felt that the Ervin Act was overly rigid with regard to its prohibition on doctors admitting clients to the hospital where the doctor works. While they understood why the law was originally crafted in this manner, they felt that it far exceeded the intent of the Stark Law and provided a barrier to clients obtaining the support needed.

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[8] The work group expressed significant concern about individuals who are putting their lives in danger because of substance use. While in some cases, substance use may be co-occurring but masking the mental illness (making it more difficult to diagnose a client), while in other cases, extreme substance use may be the issue causing imminent risk of harm (e.g., in the case of repeated overdoses). The group acknowledged that this second issue may not be able to be addressed via the Ervin Act, but felt that it was important to raise, nonetheless. We learned that some states do include SUD with their mental health laws and others keep them separate, and that there is not necessarily consensus nationally on which approach is better.

[9] In the District and nationally, the single adult homeless population is an aging one. This trend has been well documented in national research. See, for example, The *Emerging Criss of Aged Homelessness* at https://www.aisp.upenn.edu/wp-content/uploads/2019/01/Emerging-Crisis-of-Aged-Homelessness-1.pdf Physicians in the work group raised concerns that dementia (often layered on top of mental health and substantial use issues) will become a growing issue in the years ahead.

B. Address Resource Gaps

The work group made the following recommendations with regard to resource gaps:

1. Reimburse Hospitals for Participation in Adjudication Process. Hospital representatives participating in the work group indicated that one of the biggest challenges (for them) is that Medicaid does not reimburse for time psychiatrists and other staff spend preparing for and participating in commission hearings. One idea suggested by work group participants was that DBH consider a contract model, so that hospitals can be reimbursed for all parts of the process including the chart review, 545 documentation preparation, waiting in court, and the hearing itself – as well as transportation to and from court (for both hospital staff and the patient).[10] Work group participants felt a contract model would help prevent vulnerable individuals from losing opportunities to receive care simply due to hospital staff bandwidth. They also thought more hospitals might be willing to contract with DBH to take involuntary patients, as they would not be losing money every time they follow through with civil commitment proceedings.
2. Address Bed Shortage. While the work group acknowledged this was not an easy fix (due to facility constraints), participants felt that this particular action item was the lynchpin to making every other recommendation work. It's worth re-stating that long-term institutionalization is not the goal, but rather having adequate supply of beds to facilitate treatment, stabilization, and connection back to housing and available community support. It's not clear how many beds would be needed to meet this objective, or whether the District needs some surge capacity in the short term that could then be right-sized. DBH would need to do some internal data analysis and modeling to develop projections.

C. Improved Coordination & Process Improvements

The work group discussed a number of items that fall under the category of process improvements. These items include everything from clarifying roles and protocol to re-writing forms and guidance.

1. Consider Expansion of Officer Agents. Given MPD's understandable hesitancy to participate in the execution (writing) of an FD-12, particularly for individuals they do not know and for behavior they personally haven't witnessed, DBH may want to consider whether there is an opportunity to expand the pool of Officer Agents such that other professionals who work more directly with clients have the ability to write the FD-12. This may help eliminate role confusion, and it may also help improve documentation of the person's condition and behavior for individuals who will be responsible for evaluating the patient at subsequent steps.
2. Modify Form FD-12. Work group members noted that despite needing and qualifying for an FD-12, consumers often do not receive the help they need because of a rushed writing of an FD-12. Often, the situation is urgent and the Officer Agent/Police Officer is writing the FD-12 on the street and/or in the midst of a crisis. To address this issue, the work group thought that a redesign of the form could be very helpful. For example, participants thought that the form could make greater use of standardized response options (check boxes) to make completion easier. MPD also suggested that there could perhaps be an additional page for witness testimony to alleviate their concern about writing an FD-12 for someone they didn't know and behavior they didn't witness. This latter recommendation would be particularly important if the pool of Officer Agents is not expanded, such that MPD will be expected to continue being a

[10] As noted under IV.A.4. above, allowing remote hearings could eliminate some of these expenses, though not all of them.

major player in writing FD-12s. These are just initial ideas; perhaps the Lab@DC could be engaged in form redesign if their bandwidth allows.

3. Clarify Roles & Responsibilities and Update Guidance . Regardless of whether the pool of Officer Agents gets expanded, MPD will still be called upon at times to write an FD-12. It will be important that officers understand the distinction of when they are being asked to write the FD-12 vs when they are simply being called to the scene for transport, and what happens when there is disagreement among actors about the need for an FD-12. To address this challenge, guidelines need to be created to clarify roles, and then FEMS' and MPD's orders should be reviewed and revised. The group also felt that the FEMS orders needed more clarification on transport issues – including where to transport and how to ensure connection at the receiving hospital.

4. Provide Regular Training. Throughout the work group process, it became clear that Officer Agents, MPD officers, mental health providers, private physicians and psychiatrists, DBH physicians and psychiatrists, and OAG attorneys may all have different understandings of the law. While a legislative update could help eliminate some of these challenges, regular training will still be needed simply because of the sheer volume of actors involved in this process and the turnover of staff. Because consistency is important, training ideally would be provided by the same organization for all partners. Suggested training should include guidance on how to interpret the law's language; procedure at an FD-12 event; the role of each partner agency (including who holds final decision-making authority); information that should be included in the written FD-12; continued responsibility after writing an FD-12 (e.g., accompanying an individual to CPEP or hospital); care coordination (e.g., between hospital and patient's treatment team, between the patient's treatment team and the District's CAHP system); and procedures to follow for an individual violating their outpatient commitment.

   In addition to training for those involved in the civil commitment process, training for individuals who are caregivers – including shelter staff, homeless outreach workers, and other homeless service system partners – would also be very helpful. The training should provide information on the purpose of the law, when and who to call (and how to escalate concerns), information they should be prepared to provide, follow-up responsibilities, and HIPPA guidance with regard to emergency situations.

5. Improve Coordination between Hospitals and Treatment Team. Protocol should be established such that hospital staff are in touch with a patient's treatment team any time a client appears at the hospital because of an FD-12. This would allow more consistent identification of patients struggling to maintain their treatment plan under an outpatient commitment order.

6. Establish Process to Ensure Connection to PSH via District's CAHP System. As discussed under item III.E.3, the District's CAHP protocols help the homeless services system prioritize access to available supportive housing resources. Based on the experience of working group members, the vast majority of individuals that end up moving through the civil commitment process are extremely vulnerable and have been offered housing many times. Accordingly, the issue is not availability of a resource for them, but one of timing and connection. That is, if physicians are able to work with the client to regain stability and help them to get to "yes" on housing, then housers need time to identify appropriate options and help the client navigate the housing process. Specific protocols must be established so individuals on a patient's treatment team know who is responsible for following up on housing and how to do it. Further, because the housing process can take a few months, DBH may want to consider how to strategically use

Community Residential Facilities (CRFs) and/or other programs within its portfolio as an interim arrangement for clients that no longer need hospitalization but need time to access housing.

V. Summary

Civil commitment is a complex process. As we learned through this project, even when every partner is acting in good faith, attempting to make responsible decisions, and working to effectively carry out their responsibilities, the process can still go terribly wrong for vulnerable individuals.

It is important to note that the recommendations in this report should be considered as a package. That is, legislative reform will not ultimately be very helpful if the District does not invest in a deeper and more comprehensive level of residential treatment, and likewise, expansion of residential treatment options alone will not help us reach our most vulnerable neighbors if the District does not update its law to consider cases of persistent self-neglect. While not all actions need to be pursued on the same timetable, ultimately each of these pieces will need to be addressed to ensure we have a stronger safety net for individuals experiencing homelessness and living with severe and persistent mental illness.