NORTH SOUND
MENTAL HEALTH ADMINISTRATION

QUALITY MANAGEMENT OVERSIGHT COMMITTEE

MEETING PACKET

April 23, 2014
1:00 – 3:00 pm

1. Please join my meeting.
   https://global.gotomeeting.com/meeting/join/282127541

2. Use your microphone and speakers (VoIP) - a headset is recommended. Or, call in using your telephone.

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Access Code: 282-127-541

Audio PIN: Shown after joining the meeting
Meeting ID: 282-127-541

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QMOC GUIDING PRINCIPLES

The QMOC charge is to guide the quality assurance and quality improvement activities of mental health services within the NSMHA region. In assessing the necessary data and making appropriate recommendations, the QMOC members agree to the following:

- **Help create an atmosphere that is SAFE.**
- **Maintain an atmosphere that is OPEN.**
- **Manage your BEHAVIOR, be mindful of how you respond to others, understand intent vs. impact, and be responsible for your words and actions.**
- **Demonstrate RESPECT and speak with RESPECT toward each other at all times.**
- **LISTEN, people feel respected when they know you're listening to their point of view.**
- **Practice CANDOR and PATIENCE.**
- **Accept a minimum level of TRUST so we can build on that as we progress.**
- **Be SENSITIVE to each other's role and perspectives.**
- **Promote the TEAM approach toward quality assurance.**
- **Maintain an OPEN DECISION-MAKING PROCESS.**
- **Actively PARTICIPATE at meetings.**
- **Be ACCOUNTABLE for your words and actions.**
- **Keep all stakeholders INFORMED.**

Adopted: 10/27/99
Revised: 11/28/12

NORTH SOUND MENTAL HEALTH ADMINISTRATION
QUALITY MANAGEMENT OVERSIGHT COMMITTEE AGENDA

Date: April 23, 2014 **Time: 1:00-3:00 PM**

Location: NSMHA Conference Room **Chair: Rebecca Clark, Skagit County Human Services**

For information Contact Meeting Facilitator: Greg Long, NSMHA, 360-416-7013

Topic	Objective	ACTION NEEDED	Discussion Leader	Handout available pre-mtg	Handout available at mtg	Tab	Time
Introductions	Welcome guests; presenters and new members		Chair				*5 min*
Review and Approval of Agenda	Ensure agenda is complete and accurate; determine if any adjustments to time estimates are needed. Meeting will start and end on time.	Approve Agenda	Chair	Agenda		**1**	*5 min*
Review and Approval of Summary of Previous Meeting	Ensure meeting summary is complete and accurate.	Approve Meeting Summary	Chair	Summary		**2**	*5 min*
Announcements and Updates	• Status on Conversion to ICD 10 and DSM 5 • DSM 5 Training • DDA Training April 2 in Whatcom County-follow-up • Success of IMR Consultations • Other						*5 min*
Update on Regional Healthcare Alliance	Brief update.	Inform /discuss	Chair/ Greg				*5 min*
Quality Topics							
Adjustment of System to Expansion of Medicaid Eligibles	Brief discussion regarding adjustments providers and NSMHA are making to handle the increase of Medicaid eligible under the Affordable Care Act	Inform /discus	Rebecca Clark/ Greg Long	None	None		*10 min*
Ombuds Report	Ombuds Report on October –March 2014 Complaints and Grievances	Inform /discus	Chuck Davis/ Kim Olander	Yes		**3**	*15 min*
Crisis System Module	Presentation on the updating of the Integrate Crisis System Training Module	Inform/ Discuss/ Action	Sandy Whitcutt/ Greg Long	Yes		**4**	*10 min*
Policy 1561 Revocation of LRs and COs	This is final review of NSMHA's policy on revocation of Less Restrictive Orders and Conditional Releases	Inform/ Discuss/ Action	Sandy Whitcutt/ Greg Long	Yes		**5**	*10 min*
Policy 1562 Monitoring of LRS and COs	This is final review of NSMHA's policy on the monitoring of Less Restrictive Orders and Conditional Releases	Inform/ Discuss/ Action	Sandy Whitcutt/ Greg Long	Yes		**6**	*10 min*
Non-Clinical PIP	Update and discussion on the implementation of the Non-Clinical PIP.	Inform/ Discuss	Julie de Losada		Yes	**7**	*15 min*
WISe Implementation	Update on the implementation of this new Wraparound with Intensive Services (WISe) program for 0 thru 20 year olds	Inform/ Discuss	Julie de Losada		Yes	**8**	*15 min*
Other issues							
***Review of Meeting**	Were objectives accomplished? How could this meeting be improved? Eval forms						
Date and Agenda for Next Meeting	Ensure meeting date, time and agenda are planned						

Next meeting: May 28, 2014- 1:00-3:00 PM

Potential Future Agenda Items:

North Sound Mental Health Administration (NSMHA)
Quality Management Oversight Committee (QMOC)
NSMHA Conference Room
March 26, 2014
1:00 – 3:00 pm
MEETING SUMMARY

PRESENT: Mark McDonald, Marie Jubie and David Kincheloe, NSMHA Advisory Board; Rebecca Clark, Skagit County; Cindy Ferraro, Bridgeways; Dan Bilson, NAMI Whatcom; Mike Manley, Sunrise Services; Chuck Davis, Ombuds; Richard Sprague, Interfaith; Stacey Alles, Compass Health; Robert Sullivan, Skagit Triage and Kathy McNaughton, CCS.
BY PHONE: Kay Burbidge; LWC; Eric Chambers, NWESD; Jeff Reynolds, REACH; Kate Scott, Sea Mar; Pam Benjamin, WCPC; Anne Deacon, Whatcom County and Cammy Hart Anderson, Snohomish County.
STAFF: Greg Long, Julie de Losada, Joe Valentine and Barbara Jacobson.
OTHERS PRESENT: Carolyn Hetherwick Goza, NSMHA Advisory Board and Heather Fennell, Compass.

TOPIC	DISCUSSION	ACTION
1. **Introductions, Review of Agenda – Chair**	The meeting called to order and introductions made. Additions to the agenda called for; MikeM added the use of Urinalysis (UA) in clinical practice.	
2. Previous Meeting Summary – Chair	The minutes reviewed; a motion passed to accept as submitted.	Approved
3. Announcements and Updates – All	• GregL announced that Dan Bilson is retiring from QMOC and has been the longest-term volunteer with NSMHA. NSMHA appreciates his commitment to advocating for those with serious mental illness. NSMHA presented a plaque to Dan who thanked all and stated he will still serve on NAMI Whatcom Board. • DSM 5 training will be coming soon; a WSU professor with Cascade Training Institute will do the training. An email announcement will go out soon. • DVR will present training on collaboration between Developmental Disabilities and mental health presented by Dave Kludt on April 2nd. This training is open to all and will be at St Luke's at 10:00 am. DaveK is also doing a training series for DMHPs for the new law starting on July 1st. • MarieJ noted that Evergreen Manor will not detox those on Medicaid any longer; Cammy stated they are closing at the end of April and clients may need to go to King County. • MikeM announced that Sunrise Everett is moving into a second location at 5020 Broadway and the phone lines will be linked. Several clinicians, supervisory staff and administrative staff will move over; mental health clients will be seen in both locations. More space still being sought. • HeatherF announced youth mental health first aid training for $12. There is also a suicide assessment and treatment training coming up for $15.	Informational

	• CarolynH announced NAMI Snohomish is teaching a parents basics class on April 10th. NAMI will also teach the basics class for school faculty, tribes and others twice a year to maintain fidelity. • JoeV gave a brief update on the disaster response plan in talking with the state and Red Cross and VOA. Red Cross is deploying their professionals to assist and going to schools as well. Green Cross helps first responders. The VOA crisis line number has been given out and flooded with calls; the Red Cross has our contact information for dispatch if needed to connect people up with help. Our region does not have any crisis response team; we should take advantage of the crisis training offered by Red Cross for provider staff. Agencies noted they outreached to their clients in the area; and staff may need a check in too. MikeM noted the Arlington food bank is greatly impacted by the disaster; the Boy Scouts have rallied round them and donations are appreciated.	
4. Regional Health Alliance Update	The RHA focus on boarding is still ongoing. The Legislature passed health care reform funding so there may be some funding available. The next meeting is March 31st to look at next steps such as setting up a regional entity to pursue funding.	Informational
5. Wraparound with Intensive Services (WISe) Data Reporting	Julie deL noted that on July 1st 80 WISe slots will start in our region; there are multiple issues still to be worked out for the new coding that will be needed. This is for youth age 0-20; a special episode field may be able to be used. A -U8 modifier code will also start being used at that time. The workgroup is also looking at what a qualified WISe practitioner entails and the team makeup. Island and San Juan will be phased in later; currently there are 88 individuals that will roll into WISe in the region.	Informational
6. WRAP + MAP	WRAP + MAP (Managing and Adapting Practices). We will pilot this system which allows Evidence Based Practices (EBP) to be delivered without the whole EBP. NSMHA has training in April for this with 55 provider staff in our region and two NSMHA staff. There will also be two train-the-trainers to carry this forward. The UW will evaluate as we go along in this pilot.	Informational
7. Policy 1550 Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services	Policy revision brought back from February meeting due to concern the requirements were not in line with the actual contract. GregL noted that care coordination is expected everywhere now; Angela reviewed and this policy is in line with contractual requirements. Agencies must contact individual and contact referring doctor within 10 days; can be done by letter. GregL noted that the State maintains that you can contact Medicaid clients. MikeM presented a motion to approve as submitted; seconded and motion carried with reservations noted.	Motion carried
8. Care Coordination Database	CharissaW noted that NSMHA is developing a care coordination database to be more proactive in the care of high need individuals. We may contact you to let you know that an individual has come to our attention or we may ask for records or other things. This is being refined as we go along and we are looking for feedback. Providers can contact NSMHA for help with individuals as well. Agencies noted that they	Informational

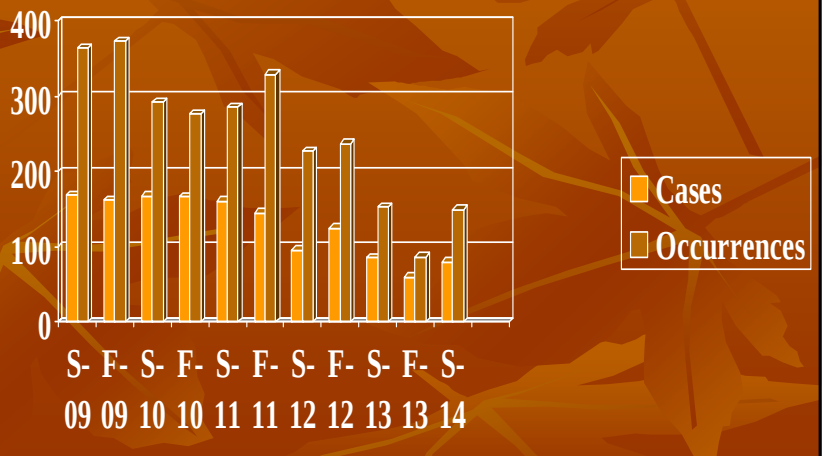
	would like an email sent to their designee with care coordination in the title.	
9. Policy 1720 Administration of Involuntary Treatment Program	This policy has been updated to line up with recent changes in the WACs; mostly small updates to definitions. A motion presented to accept this policy as submitted; seconded and motion carried.	Motion carried
10. Policy 1725 Mobile Outreach Team	Policy due for updating and a change that people can call the teams directly vs. going through VOA. Motion to accept as submitted; seconded and motion carried.	Motion carried
11. Regional Training Committee	NSMHA and Compass Health recommend reconvening the Regional Training Committee to coordinate the increasing number of trainings. NSMHA proposes meeting every other month to start at 3:15 pm after QMOC for an hour; with a representative from each agency. Motion to reconvene committee; seconded, motion carried.	Motion carried
12. Open Forum	MikeM noted that prescribers at Sunrise want to know all drugs that an individual takes; both recreational and those prescribed to them. Prescribers at Sunrise would like a UA given to those that come to them for medication management. He is seeking feedback over concerns of stigma, expense, too invasive and any legal issues. RichardS noted Interfaith does a lot of them for various reasons. StaceyA noted Compass requests if they are concerned and they have a pilot for one class of drugs. This to be added as a future agenda item.	Discussion. Add to future agenda.
13. Date and Agenda for Next Meeting	The meeting adjourned at 2:50 pm. The next meeting is April 23, 2014.	

NORTH SOUND REGIONAL OMBUDS & QUALITY REVIEW TEAM REPORT

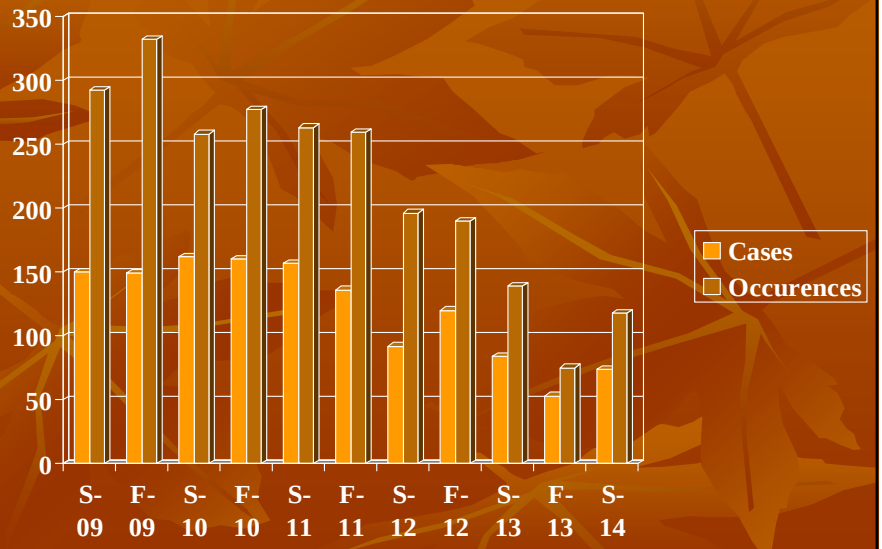
SPRING 2014

October 1, 2013 through March 31, 2014

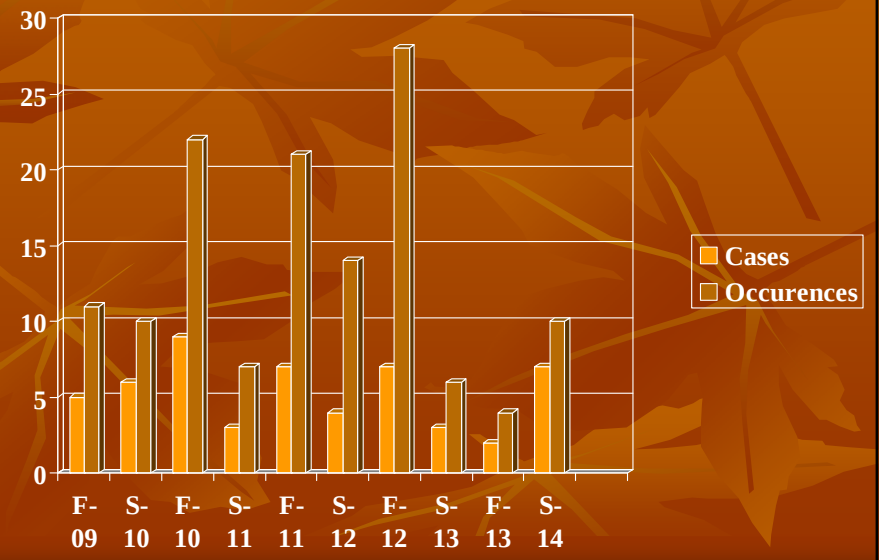
Semiannual Complaints & Grievances Overview

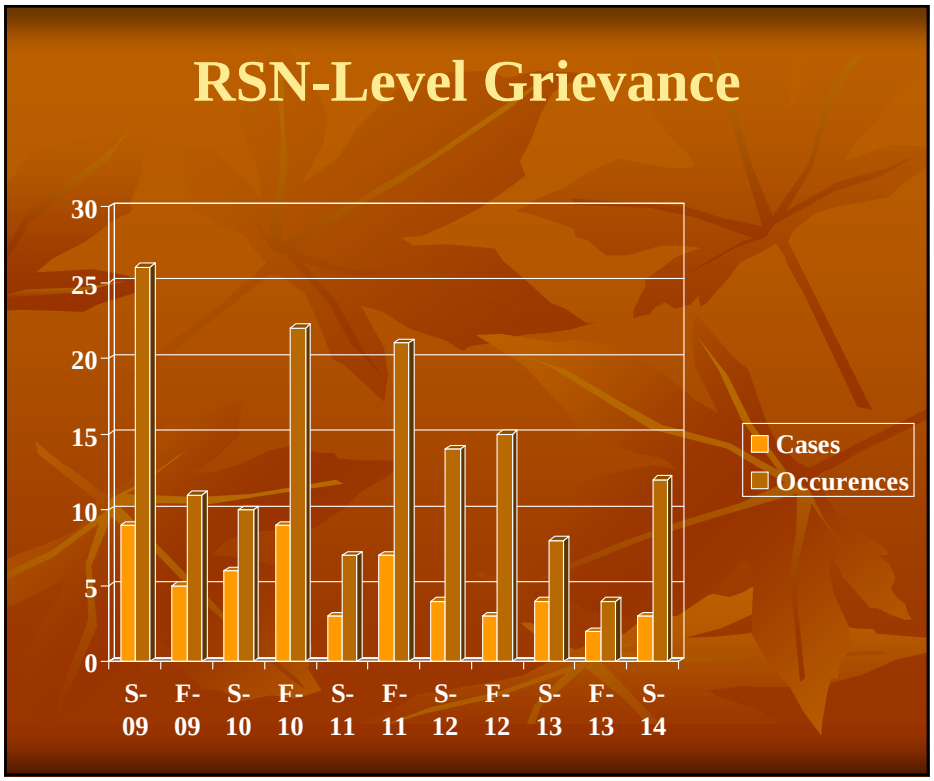


Complaint Issues



Provider-Level Grievance




RSN-Level Grievance
30
25
20
15
10
5
0
S-09
F-09
S-10
F-10
S-11
F-11
S-12
F-12
S-13
F-13
S-14
Cases
Occurences

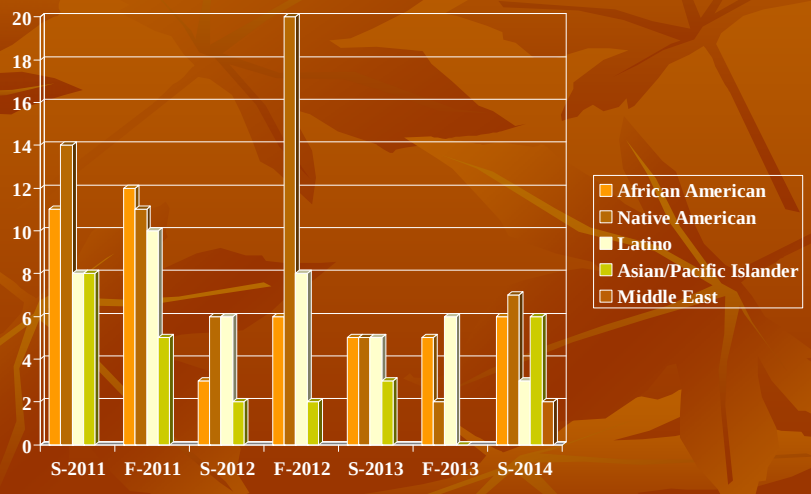

Complaint Breakdown
35
30
25
20
15
10
5
0
Consumer Rights
Physicians & Meds
Dignity & Respect
Other
Access
Emergency Services
Financial
Service Intensity
Housing
Unreturned Calls
Quality Approp.
Participation in Tx
Residential
Transportation
Confidentially
Access to Inpatient

Appeals & Administrative Hearings

- One Appeal Case: “Access to Inpatient Svs”
- Two Administrative Hearings:

  Access; Consumer Rights; dignity & Respect; Emergency Svs; Housing; Physicians & Meds; Quality Appropriateness; Services Coordination, Intensity.

Ethnicity of Non-Caucasian Client



Breakouts

- Physicians & Meds Complaints

Notes and Recommendations

- Case Resolution Outcomes
- Mental Health Block Grant Contracts & Grievances
- Developmentally Disabled Clients & Grievances
- Non-literate Clients
- 13 Year Old Clients and Authority
- Healthplanfinder
- No-shows

Notes & Recommendations (cont)

- Landlord-tenant Issues
- Successfully Resolving Grievances
- Washington Medicaid Integration Partnership
- Senate Bill 6312
- Supported Employment
- International Classification of Diseases-10
- Success Story

Ombuds and Quality Review Team Report

QUESTIONS or COMMENTS?

SPRING 2014 OMBUDS AND QUALITY REVIEW TEAM REPORT

SLIDE 1: We are Chuck Davis & Kim Olander-Mayer from Ombuds and Quality Review Team (QRT). This report covers October 1st 2013 through March 31st, 2014. Two items in your packet accompany it: a report breaking out complaints & grievances by agency and the complaint & grievance definitions we used. We estimate the region's complaint rate at 4% or less..

SLIDE 2: This slide shows our work historically. "S-14," bottom right, stands for spring 2014. F's stand for fall reports. A "Case" is a person. An "Occurrence" is a type of complaint or grievance. We assisted **79** people this period with **118** complaint occurrences, **10** provider-level grievance occurrences, **12** RSN-level grievance occurrences, **1** appeal occurrence, and **8** administrative hearing occurrences. Four **4** of these 79 people had complaints specifically against the hospitals or Medicaid transportation. We also provided information and referral services to an estimated **300** people--not included here. Our clients numbered **45** women and **34** men. We assisted **8** children. Our numbers are still quite low historically but our 3½ year downward trend in clients and issues ceased this period. We opened cases on 20 more people than last period and had 73 more issues. We saw no underlying trends except that clients frequently express concern about where healthcare and their services are heading in Washington. We also actively sought out non-Caucasian clients. We continue to attribute the historically low numbers of clients and problems primarily to effective treatment programs in the North Sound region--especially evidenced-based programs.

SLIDE 3: This complaint slide clarifies our primary numbers since grievances just repeat complaint issues at higher levels. We had **118** complaint occurrences from **74** people. The downward trend in complaints had a small reversal this period.

SLIDE 4: Provider-level grievances: **7** people had **10** occurrences: **2** in Consumer Rights, **3** in Housing, **3** in Physicians & Meds, **1** in Quality Appropriate services, and **1** in Financial services. The client decides whether to initiate a provider-level grievance.

SLIDE 5: RSN-level grievances: **3** people had **12** RSN-level grievance occurrences: **3** in Consumer Rights; **3** in Physicians & Meds, **2** in Quality Appropriateness, **1** in Financial Services, **1** in Emergency Services, **1** in Service Intensity and **1** in Dignity & Respect.

SLIDE 6: We opened **118** complaint occurrences on **74** people: **31** in Consumer Rights; **21** in Physicians & Meds; **14** in Services Coordination/Intensity; **14** in Dignity & Respect; **11** in Housing; **6** in Financial Services; **5** in Emergency Services; **4** in Access; **4** in Quality Appropriateness; **2** in Other Type; **2** in Violation of confidentiality; **2** in Transportation; **1** in Phone calls not returned and **1** in Participation-in-Treatment.

SLIDES 7: We had **1** Appeal case of Access to Inpatient Service. There were **2** new administrative hearings with issues of Access, Consumer Rights, Dignity & Respect, Emergency Services, Housing, Physicians & Meds, Quality Appropriateness and Services Coordination/Intensity.

SLIDE 8: There were: **55** Caucasians; **3** Latinos; **6** African Americans; **7** American Indian/Alaskan Natives, **6** Asian/Pacific Islanders; and **2** people of Middle Eastern ethnicity. We provided information & referral to two local tribes but opened no cases on local tribal members. 30.3% of Ombuds clients were non-Caucasian—excellent progress toward our goal of 34% non-Caucasian clients.

SLIDE 9: We broke out this period's Physicians & Meds complaints. They are as follows:

1. Client complained of too many meds prescribed by provider and E&T. Titrated own meds down. Meds now too tightly controlled.
2. Client quit taking a medication. Prescriber stopped client's benzodiazepine without advising why.
3. Client needed meds but has no DSHS insurance. Wanted a prescription so he could buy them.
4. Client wanted to know how his meds would affect him in the long run. Wasn't given a proper answer.
5. Client wanted to titrate off a medication. Prescriber left client on medication due to historical reasons.
6. Client's family member alleged "chemical restraint" & wanted meds stopped. Family member couldn't produce guardianship document.
7. Client wanted different meds while in E&T and also wanted more descriptive facts sheet about meds.
8. Client complained of insufficient meds delivery by provider--meds days change & are inconsistent.
9. Client is concerned about side effects; isn't getting fact sheets with meds.
10. Client claimed a hospital was "injecting him with drugs and sabotaging him."
11. Client wants benzodiazepine meds back that were taken away following relapse.
12. E & T client complained meds weren't right and client isn't seeing the doctor enough.
13. Client claims to have a current prescription for 2 meds but the Triage Center won't give them to her.
14. Client complained his meds are not working effectively.
15. Client's pharmacist said he needs more meds that is being prescribed. Provider resolved the issue.
16. Client claims to have ADHD and wants her prescriber to prescribe a psycho-stimulant.
17. Client claims insufficient time for meds appointments…is refractive on meds but some will work with sufficient trial. Prescriber cut benzodiazepines too low. Client fears other meds will be reduced.
18. Client is at E&T and wants to take some meds but not others.
19. Client is just now seeking access; will run out of meds soon.
20. Client feels his meds regimen is entirely inappropriate and contends he was denied meds management by a provider.
21. Client's long history of meds problems helped elevate the case to a high-level issue.

SLIDES 10 & 11: Here are our Quality Review Team notes and recommendations.

1. Outcomes: We closely monitored the outcomes of our cases.
- **20** or our 79 clients have **open** cases.
- **52** were favorably closed through **conciliation and mediation**.
- Nearly all of the estimated 300 callers we didn't open cases on received information & referral.
- **7** clients didn't pursue their issues. Here is a breakout of these **non-pursued** cases:

-- Reason for "Non-Pursued":	Our follow up:
Family member wanted grievance--had no guardianship	Dropped the issue; Client is OK with treatment.
Client is incarcerated; doesn't wish to pursue.	Contact client upon release from incarceration.
Client didn't return release form; doesn't wish to pursue.	Called several times but no contact.
Client dropped out of telephone contact.	Sent letter; no response.
Client didn't return release form; doesn't wish to pursue.	Called several times but no contact.
Client dropped out of contact	Unable to reach client.
Client dropped out of telephone contact.	Sent letter; no response; no phone.

2. We recommend NSMHA include its grievance process in future Mental Health Block Grant (MHBG) contracts. We received a complaint about a MHBG-contracted organization but found no reference to a complaint system in its contract. We believe community mental health program members should have the right to use the NSMHA grievance system in their complaints against NSMHA-contracted agencies.

3. We have had grievances involving developmentally disabled clients who experience mental disorders. These cases are few in number and don't seem to be on the increase across the state according to DBHR. Nevertheless they are exceedingly intense. We commend NSMHA for reviewing each grievance of this

type carefully and taking action. We recommend: (1) NSMHA consider having periodic meetings with the Developmental Disabilities Administration to at least discuss joint approaches to treatment for specific clients. (2) NSMHA is proposing a 3-month initial authorization period to clarify the diagnostic picture to determine needs. When a developmentally disabled client is granted that 3-month access to treatment, providers should make it *crystal clear* to guardians/caregivers that access is granted primarily for the purpose of determining if the client is eligible for services. (3) Right after intake the provider should start the process for children to receive an Applied Behavioral Analysis (ABA) evaluation. Although we suggest providers refer developmentally disabled adults to their managed care plans for Autism treatment, we find no ABA-trained psychologists in our region. The Health Care Authority person we spoke to mentioned a psychologist down in Centralia but he was the only one she knew of in the state. (4) NSMHA should find a professional who they can trust to make thorough and competent assessments as to whether clients are legitimately eligible for community mental health program services. And (5) NSMHA should develop a clinical guideline or policy on treatment for clients with Autism Spectrum Disorder.

4. We dealt with a question about whether there is a process for protecting the rights of clients who are not literate when it becomes necessary to sign paperwork. WAC 388-877-0600 requires that clients be "reasonably accommodated in case of sensory or physical disability, limited ability to communicate, limited English proficiency, and cultural differences." There is no formal NSMHA policy on this; nevertheless we recommend NSMHA place this issue in its audit process. It seems to us an illiterate person is in much the same position as a person needing an interpreter/translator. We suggest a process something like this: providers who run into this situation could have the clinician read the document to the client, then sign and date it just as an interpreter would, and note on the document that the client is illiterate so it was read to them.

5. There arose an appeal regarding in-patient hospital services in which we assisted a 13-year old. It became necessary for us to procure an appeal letter with both the client's and the parents' signature. We did not realize parents had such authority in this situation. We recommend NSMHA obtain a legal reading on young children and in-patient hospitalization (i.e. who has what authority) and publicize it to Ombuds and the providers.

6. Ombuds has received a number of calls from people seeking to understand healthcare changes involving *healthplanfinder*, Medicaid expansion, the HMOs, and Apple Health. We have witnessed considerable frustration among those callers but have tried our best to listen to them and point them in the right direction.

7. Clients frequently mention no-shows. We suspect the community mental health program's client no-show rate is somewhere around 20% and we wonder how a program can run effectively with this level of untidiness. We wish the providers would get together, conduct a study and develop measures to resolve this problem. Perhaps analysis would clarify the root causes and point out solutions. It may be necessary to break out children verses adults, and the type of appointment. We wonder whether DSHS insurance is charged for no-shows.

8. This period we continued to receive a number of calls about landlord-tenant issues involving provider agencies' housing programs. The callers invariably claim the landlord-tenant issues are causing trauma and hindering recovery. We have taken to advising the providers of the problems (because we think they need to know about them) but not counting them among the issues we recorded in this report. We will continue to discuss this issue at meetings with NSMHA.

9. In the interest of discovering what best resolves grievance resolutions and keeps them resolved, we went back through our records to find the elements that proved most valuable. Here's what we found:

1. Things Ombuds can do with clients and advocates:
(a) Prior to, and at grievance meetings work closely to ensure all the client's issues are presented clearly. It takes a good deal of discussion to uncover and present the client's most important issues.
(b) Present pertinent laws, contracts & guidance and make the client and advocates familiar with them.
(c) Justify medical necessity!
(d) Focus on the heart of the problem to ensure the grievance resolution meets the client's needs.
(e) Encourage the client and advocates to be open to collaborating with providers at meetings.
(f) Upon receipt of the resolution, discuss the resolution at length with the client and advocates to target showstopper problems and to develop a plan on the client's part to make the resolution work.
(g) Keep family member and advocates involved in making the resolution work.
(h) Follow up until the issue is resolved.
2. Things NSMHA can do:
(a) Focus on what the client really wants as well as what is most clinically appropriate.
(b) Encourage brainstorming and collaboration at grievance meetings.
(c) Use clinical specialists when necessary to conduct assessment and evaluations.
(d) Carefully consider all feasible possibilities, including those that are costly.
(e) If the answer to the client's request is "No," offer as many possibilities and alternatives as possible.
3. Things the providers can do:
(a) Be open to collaborating with the client at meetings.
(b) Submit thoughtful 90-day follow-up reports.

10. Ombuds has assisted clients in the Washington Medicaid Integration Partnership (WMIP) with their complaints for the past two years under a separate contract with Molina Healthcare of Washington. The WMIP program is now in the process of closing and many of the clients will come back to NSMHA in the next two months.

11. With the legislature passing Senate Bill 6312 about Behavioral Health Purchasing we see the chemical dependency treatment program moving away from fee for services and into managed care with RSNs. We suggest NSMHA remain in close contact with the legislative task force that will be instigating changes. There are many questions that will have to be answered. How will this affect mental health funding? How will chemical dependency treatment fit into Medicaid treatment? How will the integration process proceed? Will there be a peer support component? And, of course, what will this look like for Ombuds?

12. In the new DBHR-RSN contracts there will be added emphasis on outcomes and housing. We support these as does NSMHA. There will also be added emphasis on supported employment. It is our contention, after talking to many clients over many years that clients are not involved in supported employment because (1) they fear losing their benefits and (2) they have the mindset that they cannot possibly ever work. Both of those are invalid assumptions and NSMHA needs to figure out a way to overcome them. The Dignity & Respect Committee is also working on them. We suggest publicizing *success stories* as often as possible.

13. The ICD-10 is an updated International Classification of Diseases (ICD) diagnosis coding and inpatient procedure coding system. We have been using the ICD-9 for a long time. The federal Centers for Medicare & Medicaid issued the requirement to change to the ICD-10 on October 1, 2014. This is going to require the utmost effort of NSMHA and providers. With the ICD change and beginning to use the DSM V we expect Access to Care standards to change to eliminate A and B diagnoses, and access will generally depend upon level of need. With the Global Assessment of Functioning no longer in the DSM V there will need to be a psychiatric level of functioning system that shows good inter-rater reliability. We suggest NSMHA convince the state that LOCUS/CALOCUS would work best for that purpose.

14. Success story: A client blamed their provider agency for a clinician's alleged mismanagement that resulted in damage to their personal automobile. At a grievance meeting the provider showed that they weren't responsible for the damage but nevertheless assisted the client with automobile repairs through the use of flexible funds. The client found this resolution very favorable and is now able to use the car to attend appointments.

SLIDE 12: Are there questions or comments?

AGENCY COMPLAINT/GRIEVANCE OCCURRENCE COUNTS

Out-patient clients served by provider agencies (based on 2013 statistics), and occurrence numbers:

Catholic Community Services: 1961 clients in 2013; 2 occurrences this period.
Compass Health South: 8771 clients in 2013: 43 occurrences this period.
Compass Health North: 2369 clients in 2013; 28 occurrences this period.
Interfaith Family Health Center: 375 clients in 2013; 4 occurrences this period.
Lake Whatcom Center & PACT: 377 clients in 2013; 10 occurrences this period.
SeaMar: 2732 clients in 2013; 4 occurrences this period.
Sunrise Services: 1598 clients in 2013; 29 occurrences this period.
Whatcom Counseling/Psychiatric Clinic: 1980 clients in 2013; 3 occurrences this period.
LKI Family Services: 5 clients in 2013; no occurrences this period.
20,308 outpatient clients in North Sound in 2013: 118 occurrences this period.

PROVIDER AGENCY: **OCCURRENCES:**

Catholic Community Services Everett: 2 Occurrences **Last period 0 Occurrences**
Quality Appropriateness: 1
Services Coordination/Intensity: 1

Compass Health Residences (Greenhouse): 1 Occurrence **Last period 0 Occurrences**
Provider level grievances: 1
Housing: 1

Compass Health, Everett: 14 Occurrences **Last period 14 Occurrences**
Access: 2
Consumer Rights: 1
Dignity & Respect: 2
Financial & Admin Services: 1
Housing: 1
Physicians & Meds: 2
Services Coordination/Intensity: 1

RSN-level grievances: 4
Consumer Rights: 1
Emergency Services: 1
Financial & Admin Services: 1
Physicians & Meds: 1

Compass Health Snohomish Triage Facility: 2 Occurrences **Last period 0 Occurrences**
Emergency Services: 1
Physicians & Meds: 1

Compass Health, Lynnwood (children's & adults): 8 Occurrences **Last period 7 Occurrences**
Consumer Rights: 1
Financial & Admin Services: 2
Physicians & Meds: 1
Unreturned Phone Calls: 1

Provider-level grievances: 3
Consumer Rights: 1

Financial & Admin Services: 1
Physicians & Meds: 1

Compass Health, Marysville: 2 Occurrences **Last period 3 Occurrences**
Consumer Rights: 1
Participation in Treatment 1

Compass Health, Mount Vernon: 14 Occurrences **Last period 6 Occurrences**
Access: 1
Consumer Rights: 4
Dignity & Respect: 3
Housing: 1
Physicians & Meds: 2
Quality Appropriateness: 1
Services Coordination/Intensity: 1
Violation of Confidentiality: 1

Compass Health, San Juan: 1 Occurrences **Last period 0 Occurrence**
Emergency Services: 1

Compass Health, Snohomish: 2 Occurrences **Last period 0 Occurrences**
Consumer Rights: 1
Dignity & Respect: 1

Compass Health, Whidbey: 5 Occurrences **Last period 0 Occurrences**
Consumer Rights: 1
Dignity & Respect: 1
Housing: 1
Services Coordination/Intensity: 2

Interfaith: 4 Occurrences **Last period 3 Occurrences**
Consumer Rights: 1
Physicians & Meds: 2
Services Coordination/Intensity: 1

Lake Whatcom Center: 10 Occurrences **Last period 10 Occurrences**
Consumer Rights: 1
Dignity & Respect: 2
Housing: 2
Physicians & Meds: 1
Services Coordination/Intensity: 2

Provider-level grievances: 2
Housing: 1
Physicians & Meds: 1

Whatcom PACT: 3 Occurrences **Last period 0 Occurrences**
Consumer Rights: 1
Financial Svs: 2

Skagit PACT: 8 Occurrences **Last period 0 Occurrences**
Dignity & Respect: 2

Housing: 2
Physicians & Meds: 1
Services Coordination/Intensity: 2
Transportation: 1

Snohomish PACT: 5 Occurrences **Last period 0 Occurrences**
Dignity & Respect: 1
Consumer Rights: 2
Physicians & Meds: 2

Mukilteo Evaluation & Treatment Center: 9 Occurrences **Last period 15 Occurrences**
Consumer Rights: 2
Emergency Services: 3
Physicians & Meds: 4

PeaceHealth Medical Center: 2 Occurrence **Last period 1 Occurrences**
Consumer Rights: 1
Physicians & Meds: 1

Skagit Valley Hospital: 1 Occurrences **Last period 0 Occurrences**
Financial Services: 1

Swedish Edmonds Hospital: 0 Occurrences **Last period 2 Occurrences**

United General Hospital (Sedro-Woolley): 1 Occurrence **Last period 0 Occurrences**
Consumer Rights: 1

Northwest Medicaid Transportation: 1 Occurrence **Last period 0 Occurrences**
Transportation: 1

Sea Mar, Everett: 1 Occurrence **Last period 0 Occurrence**
Dignity & Respect: 1

SeaMar Lynnwood: 3 Occurrences **Last period 0 Occurrences**
Access: 1
Quality Appropriateness: 1
Services Coordination/Intensity: 1

Skagit County Involuntary Treatment Services: 0 Occurrences **Last period 1 Occurrences**

Sunrise Services, Everett: 22 Occurrences **Last period 8 Occurrences**
Consumer Rights: 5
Housing: 3
Physicians & Meds: 1
Violation of Confidentiality: 1

Provider-level grievances: 4
Consumer Rights: 1
Housing: 1
Physicians & Meds: 1
Quality Appropriateness: 1

RSN-Level Grievances: 8
Consumer Rights: 2
Dignity & Respect: 1
Physicians & Meds: 2
Quality Appropriateness: 2
Services Coordination/Intensity: 1

Sunrise Services, Mount Vernon: 4 Occurrences **Last period 4 Occurrence**
Consumer Rights: 1
Dignity & Respect: 1
Physicians & Meds: 1
Services Coordination/Intensity: 1

Sunrise Services, Concrete: 3 Occurrences
Housing: 1
Quality Appropriateness: 1
Services Coordination/Intensity: 1

Whatcom Counseling & Psychiatric Clinic: 3 Occurrences **Last period 5 Occurrences**
Consumer Rights: 2
Physicians & Meds: 1

VoA (Access Line & Care Crisis Line): **0 Occurrences** **Last period 1 Occurrences**

NSMHA: 18 Occurrences **Last period 2 Occurrences**
Consumer Rights (Second Opinion): 5
Other Type: 2
Physicians & Meds: 1
Services Coordination/Intensity: 1

Appeals: 1
Access to Inpatient Svs: 1

Administrative Hearings: 8
Access: 1
Consumer Rights: 1
Dignity & Respect: 1
Emergency Svs: 1
Housing: 1
Physicians & Meds: 1
Quality Appropriateness: 1
Services Coordination/Intensity: 1

COMPLAINT & RESOLUTION DEFINITIONS

COMPLAINTS:

Access: Concerns (1) access to initial inpatient or outpatient services and (2) terminations from services primarily. Deals with having trouble getting into services or having on-going services cut back or terminated. May deal with eligibility for services or taking too long to receive services. A complaint about access is not only about access into services, but perhaps how long it took, or sometimes about a type of service not available to the consumer.

Dignity & Respect: Actual or perceived such treatment. How the consumer felt treated by the staff.

Quality Appropriateness: Appropriate type of service needed either isn't available or isn't being provided. Example: Client has PSTD and is put in an anxiety group. Client questions quality of the therapist, isn't satisfied with anxiety group counseling, and wants individual therapy for PTSD.

Phone Calls Not Returned: Just what it says--usually client to case manager/therapist. This would normally be when the consumer is already in services.

Service Intensity or Coordination of Services: Has to do with insufficient amount of services being provided. It may involve level of care or a type of therapy not available in that agency (for instance, treatment for eating disorders). Also deals with coordination between provider and another agency or possibly between service providers in the same agency. Example is an alcoholic client where there must be coordination between the person's medical doctor, substance abuse treatment provider and mental health clinician. This could have to do with something like personal care in the home while also in therapy. Could have to do with case manager not coordinating appointments with the right providers.

Consumer Rights: These are listed in the WAC and in our NSMHA brochure. It has a number of sub-categories. Mental health consumers have specific rights as listed in the WACs; this would involve a complaint that one or more had been violated. (Remember that "dignity and respect" is its own category).

Physicians and Medications: When someone wants another type of medication or different dosage. Perhaps they think their psychiatrist isn't listening to what they say about their medications. It may involve interaction with the PCP. Usually it involves medication and refers to psychiatrists and psychiatric meds. Complaints in this area might be around side effects and the doctor not paying attention to the consumer's concerns about them.

Financial and Administrative Services: Having to do with client funds. Generally deals with payees and pay problems. We would generally seek assistance from the case manager and payee. These complaints might be about SSI eligibility, or the consumer having a payee that controls his or her benefits.

Residential: This deals with any agency-provided housing. It may be an issue concerning supported living, boarding alone, agency-owned housing. Aurora House is an example of agency-owned housing. These complaints would involve supported living situations managed by the agency.

Housing: This deals with regular, independent housing out in the community, or perhaps integrating mental health clients back into the community. It also involves Section 8 applications or Shelter Plus Care. A complaint here might be that the agency hasn't done enough to find a consumer independent living.

Transportation: May deal with transportation coupons, bus passes, taxis, obtaining an access bus, or possibly transportation to and from services or places they need to go for normal living. May deal with clients who have agoraphobia and have trouble with public transportation. A complaint here would involve transportation to and from mental health services.

Emergency Services: Has to do with crisis services such as Crisis Clinics, or may involve E & T centers. May involve interaction with CDMHP. This complaint would involve crisis services, either the crisis line, or a CDMHP evaluation, or difficulty in the hospital emergency room during a mental health crisis.

Participation in Treatment: Client's voice and viewpoint aren't being heard by the treatment provider or reflected in their treatment.

Violation of Confidentiality: An aspect of a client's diagnosis, treatment history, or current treatment has been inappropriately revealed.

Access to Inpatient Treatment: A client is denied access to needed hospitalization.

Other: Any other type of complaint.

RESOLUTIONS:

Information or Referral: Giving information/names/numbers, or referring to another source. May involve significant follow up by Ombuds.

Conciliation/Mediation: Working out the issue between Ombuds, the provider and the client. Usually involves meetings, letters, phone calls, etc.

Arbitration: Grievance or Fair Hearing ruling by a higher authority.

Fair Hearing: Normally filed with an administrative law judge when an RSN's grievance ruling is unsatisfactory to a client.

Other: Another type of resolution. Perhaps the client moved away or died, is hospitalized, etc.

Not pursued: Client dropped the complaint. Perhaps the client didn't understand the system and were satisfied once they understood the whole situation, or they became satisfied during the working of the complaint or grievance.

NSMHA COMMITTEE DISCUSSION FORM

AGENDA ITEM: Crisis Response Module

PRESENTER: Sandy Whitcutt or Greg Long

COMMITTEE ACTION: Action Item (x) FYI & Discussion (x) FYI only ()

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:
The Crisis Response Module was developed to provide an overview for new clinicians to introduce the principles of the Integrated Crisis Response System (ICRS) and make them aware of tools available for managing mental health crises.

There are specific training objectives that will orient clinicians to the mental health crisis system's processes, resources and requirements, educate clinicians regarding voluntary and involuntary hospitalization, educate clinicians regarding involuntary treatment laws and processes and provide guidance regarding the completion of an affidavit for initial detention or petition to revoke.

This module was due for minor revisions to include more detail on how to document violations of less restrictive orders. ICRS has reviewed and approved the revisions made.

CONCLUSIONS/RECOMMENDATIONS:
TIMELINES:
This revised module, if approved, will go into effect 60 days after it is posted on the NSMHA website.

ATTACHMENTS:
Crisis Response Module, clean version and Module with revision,
How To Document a less restrictive violation document

North Sound Mental Health Administration
Regional Support Network for Island, San Juan, Skagit, Snohomish, and Whatcom Counties
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NORTH SOUND MENTAL HEALTH ADMINISTRATION

INTEGRATED CRISIS RESPONSE SYSTEM TRAINING MODULE

TABLE OF CONTENTS

TRAINING OBJECTIVES:

1. Orient clinicians to the mental health crisis system's processes, resources and requirements.
2. Educate clinicians regarding voluntary and involuntary hospitalization.
3. Educate clinicians regarding involuntary treatment laws and processes.
4. Provide guidance regarding the completion of an affidavit for initial detention or petition to revoke.

INTRODUCTION

Crisis Services are one of the major components of public mental health services. Crisis services are available to all individuals and families physically located in the North Sound region's five counties, regardless of enrollment status with service providers, ability to pay, or funding source. Services are available on a 24 hour basis for those who are in a self-defined state of crisis (a turning point in the course of anything decisive or critical; a time, a stage or an event of great danger or trouble, whose outcome decides whether possible bad consequences will follow).

Crisis Services include a broad array of services: telephone-based crisis assessment and support, outreach, crisis triage centers and involuntary treatment assessments. Crisis services are intended to stabilize the individual in crisis in the least restrictive community setting possible. Services are matched to the individual's need and severity of the crisis. An individual in crisis is served from a non-stigmatizing, person-oriented approach, including responsive listening and respectful attention.[1] Crisis Services staff actively involve and collaborate with family members and other natural supports during a crisis as appropriate and within limits of confidentiality.

Crisis Services are provided by the following agencies in the following counties:

County	Voluntary Crisis Services	Involuntary Investigations	Triage Centers*	Mobile Outreach Team
Island	Compass Health	Compass Health	Island County residents may access triage if transportation can be arranged	Not available in Island County
San Juan	Compass Health	Compass Health	San Juan County residents may access triage if transportation can be arranged	Not available in San Juan County
Skagit	Compass Health	Compass Health	Pioneer Human Services	Pioneer Human Services
Snohomish	Compass Health	Snohomish County Human Services	Compass Health	Not available in Snohomish County
Whatcom	Whatcom Counseling and Psychiatric Clinic (WCPC)	WCPC	WCPC	WCPC

***Note:** Triage Centers in the North Sound Region may have some restrictions on admission for Chemical Dependency services based upon county of residence of the referred individual.

[1] See Journal of Psychiatric Practice, Vol. 9, No. 1: *Individuals' Wants and Needs During a Psychiatric Emergency*

WHAT ARE THE PRINCIPLES OF THE ICRS?

1. Crisis services include voluntary and involuntary service options.
2. Crisis services are delivered across social service systems in a fully integrated, seamless and consistent manner.
3. An individual in crisis is treated as a whole person, rather than focusing on categorical problems.
4. A crisis is self-defined, rather than needing to meet categorical criteria.
5. An individual in crisis will have easy and timely access to appropriate intervention and care.
6. Clinicians involved in crisis response intervention will be able to refer to a complete continuum of care in order to respond to a variety of needs.
7. Individuals experiencing a behavioral health crisis will be stabilized in the least restrictive setting, in the individual's home or in any in vivo setting, and will be referred to the least restrictive resource available to manage the crisis.
8. Crisis response services are community-based.
9. Crisis response services are available to both adults and children.
10. Crisis services and information will be available 24 hours a day, 365 days a year throughout the Region.
11. Crisis services will be fully integrated and coordinated at both the local and regional level.
12. All crisis services will be culturally competent and responsive.
13. Standards of care will be adhered to throughout the region.
14. Crisis services will be provided in a manner recognizing the uniqueness of each individual.
15. The integrated crisis system will utilize a flexible array of services and supports, formal and informal, which fit the needs of the individual.

WHAT TOOLS ARE AVAILABLE FOR MANAGING CRISES?

CRISIS PLANS

The crisis plan is a document that the outpatient clinician develops in collaboration with the North Sound Mental Health Administration (NSMHA) enrolled individual and his/her family and/or other natural supports. The plan is intended to help both the clinician and individual in the event that he/she experiences a crisis during treatment. Working together, the outpatient clinician and individual anticipate potential problems that might create a crisis. The outpatient clinician helps the individual identify his/her specific triggers, "red flags", or early warning signs, to alert him/her that trouble may be developing. The outpatient clinician and individual make a plan for what to do when the individual sees these early warning signs. The plan starts with low intensity interventions that the individual can probably accomplish on his/her own, then progresses to interventions of increasing intensity that include family, natural supports and professional staff as needed. A copy of the crisis plan is kept in the individual's chart, given to the individual, given to the identified family or natural supports with the individual's approval, and given to the Crisis Line.

If the individual or a family member/natural support calls the Crisis Line during a crisis, the Crisis Line staff can provide assistance based on the information in the crisis plan. When responding to a crisis, clinicians, CCRS, and crisis services workers will continue to work with family members and other natural supports to best support the individual within limits of confidentiality. Crisis plans shall be reviewed at least every 180 days, updated to reflect any changes in the individual's needs,

or as requested by the individual, their parent, or other legal representative. This shall include any known safety concerns. See NSMHA Policy 1551 Individual Service Plans/Resiliency and Recovery Plans for additional requirements related to crisis plans.

CRISIS ALERTS

Crisis alerts contain important up-to-date information about individuals who are likely to require crisis services within the next 10 days. Crisis alerts are created by clinicians and contain information pertinent to the current crisis situation, in contrast to crisis plans, which contain long-term strategies. CCRS receives, stores, and utilizes this time-sensitive information, and makes it available to Mobile Outreach Teams (MOT), Emergency Mental Health Clinicians (EMHC) and Designated Mental Health Professional (DMHP) staff to assess risk and effectively intervene in a crisis. Crisis alerts are kept on file for 10 days and can be renewed if clinically warranted.

MENTAL HEALTH ADVANCE DIRECTIVES

A Mental Health Advance Directive is a written document, consistent with the provisions of RCW (Revised Code of Washington) 71.32, in which a person makes a declaration of instructions or preferences and/or appoints an agent to make decisions on her/his behalf regarding that individual's mental health treatment during times when he/she is incapacitated by a mental disorder and cannot give informed consent. If the clinician has received an individual's advance directive, it will become part of the individual's medical record and the clinician will be considered to have actual knowledge of its contents. More information regarding compliance and conditions for noncompliance can be found in RCW 71.32.150, RCW 7.70.40 and in NSMHA Policy 1518 Mental Health Advance Directives.

WELLNESS RECOVERY ACTION PLAN (WRAP)

WRAP® is an evidence based self-management and recovery system designed by Mary Ellen Copeland and developed by a group of people who had mental health difficulties and were struggling to incorporate wellness tools and strategies into their lives. WRAP is designed to:

1. Decrease and prevent intrusive or troubling feelings and behaviors;
2. Increase personal empowerment;
3. Improve quality of life; and
4. Assist people in achieving their own life goals and dreams.

WRAP is a structured system to monitor uncomfortable and distressing feelings and behaviors and, through planned responses, reduce, modify or eliminate them. It also includes plans for responses from others when individuals cannot make decisions, take care of themselves or keep safe.

The clinician may ask if an individual has a crisis plan, mental health advance directive or WRAP, but he/she may have chosen not to create these plans. The mental health advance directive and WRAP are not available through VOA.

WHAT IS THE ROLE OF VOA CARE CRISIS RESPONSE SERVICES (CCRS)?

CRISIS LINE

CCRS provides 24-hour a day, 7 day a week, professionally staffed crisis line system. When someone is in distress and is seeking assistance with a crisis situation, he/she should call the Crisis Line at 1-800-584-3578. They provide a range of support and referral services including:

A. Making mental health referrals to the community;
B. Having access to language bank interpreters and TDD equipment;
C. Assuring referral to age and culturally appropriate services and specialists;
D. Scheduling crisis appointments;
E. Providing telephone stabilization and intervention services for individuals with non-acute issues;
F. Assuring timely and consistent crisis response;
G. Providing telephone consultation, intervention and stabilization for individuals and/or family members/natural supports as appropriate and within limits of confidentiality;
H. Determining when face-to-face services are needed, both voluntary and involuntary, and dispatching a DMHP, MOT, or EMHC;
I. Tracking the outcome of face-to-face services and seeing if further services are warranted;
J. Deciding when cross-system services are needed;
K. Working closely with law enforcement when appropriate;
L. Consulting with detoxification providers, licensed care facilities, hospitals and other community providers;
M. Troubleshooting cross-system referrals in which there is a difference of opinion of appropriate services or system response; and
N. Providing telephone follow-up with individuals after-hours as part of an individual crisis plan.

TRIAGE SERVICES

VOA CCRS Triage Clinicians are Masters-level mental health professionals. When a professional wishes to speak with someone at the Crisis Line, they can contact the CCRS Triage Clinician directly at 1-800-747-8654.

The CCRS Triage Clinician will have the responsibility of deciding when face-to-face evaluation and/or stabilization services are needed and dispatch the MOT, EMHC, and/or DMHP staff to a community location outside of the provider's office. The MOT, EMHC, or DMHP may not decline a referral for face-to-face services, but decides if backup or other provisions are needed to mitigate risk.

Outreach services shall be provided within two (2) hours of dispatch by the CCRS Triage Clinician.

MOT, EMHC, and DMHP will report the disposition of the case back to the CCRS Triage Clinician by phone or fax within one (1) hour of the completion of the case and to law enforcement when requested.

WHAT FACE-TO-FACE SERVICES ARE AVAILABLE?

CRISIS SERVICES APPOINTMENTS

Urgent and follow-up appointments are available for adults and children who are not currently enrolled in the public mental health system, are determined to be in need of face-to-face evaluation or intervention, and who meet certain criteria. Appointments are available at provider agencies in each county, and are scheduled by VOA CCRS staff. Crisis Services appointments provide brief treatment on a voluntary basis, generally for persons at risk of harm to self or others, at risk of hospitalization, and/or who may be in need of a referral for an emergency medication evaluation. Enrolled individuals' urgent needs will be addressed by their outpatient clinician, treatment team or backup as appropriate.

EMERGENCY PSYCHIATRIC SERVICES

Emergency psychiatric medication evaluations are available for those individuals who have been assessed by an EMHC or DMHP and deemed at risk of hospitalization. Access to these psychiatric appointments is through the EMHC or DMHP. This process varies from county to county. Follow up psychiatric consultations are available when clinically indicated by the prescriber. Generally this service is used for non-enrolled individuals.

OUTREACH

Outreach is the provision of face-to-face evaluation and/or intervention services (voluntary or involuntary) in community locations. The expectation is that emergency outreach clinicians providing crisis response services will provide services to the individual in the community. Outreach services are an important and available service, both when necessary to support the person in crisis and to provide services in the least restrictive, appropriate manner, with the use of family and natural supports within limits of confidentiality. The intent, however, is never to promote outreach at the expense of anyone's safety – including individual, staff, family/natural support, and the public.

EMHCs/DMHPs must respond to pages from the VOA within 10 minutes. Once dispatched, the EMHC and DMHP must be on-site with the person in crisis within 2 hours. Within 1 hour following the completion of any outreach, the EMHC and DMHP calls the CCRS Triage Clinician to relay the disposition of the case back to the CCRS Triage Clinician and, when appropriate, the referral source, to include the individual's clinician. If EMHC or DMHP is unable to arrive to the dispatch location within two hours due high volume, inclement weather, etc., they will document the reason for the delay.

MOBILE OUTREACH TEAM (MOT)

Mobile Outreach is a community service available in Skagit and Whatcom, counties for individuals and families not currently enrolled in Medicaid outpatient services. These teams are intended to respond to non-emergent mental health situations, defined as situations where the level of stress has overwhelmed the individual's ability to cope. The teams are available to provide early intervention to assess, engage, and provide temporary support and make referrals to community resources. These teams can be accessed by calling the VOA Care Crisis Line or directly contacting the provider. The teams are designed to integrate with the existing Emergency Services and Involuntary Treatment Investigation Services.

INVOLUNTARY INVESTIGATION SERVICES

Involuntary investigations are another crisis service available in all five counties and performed by the DMHPs. These individuals have specialized training in performing mental health investigations, and are designated by their counties. Their role is to assess for danger to self, others, property and/or grave disability as a result of an acute mental disorder. They work closely with the voluntary teams, hospitals, triage facilities, and other allied systems. Their specific role and investigation procedures are further detailed later in this module.

WHAT SERVICES ARE AVAILABLE FOR ADULTS ENROLLED WITH THE DEVELOPMENTAL DISABILITIES ADMINISTRATION (DDA)?

For adults (18 or older) who are enrolled with the DDA, there are additional services that are available during times of crisis. These services are based on an urgent, not emergent, model and rely upon referral from the DDA Case Manager during business hours.

The EMHC/DMHP can check on an individual's enrollment status by calling the Care Crisis Line. An assessment for stabilization services can be arranged through the DDA Mental Health/ Developmental Disability Resource Manager, if criteria are met (enrolled with DDA, not currently enrolled with the RSN, and at risk of hospitalization or loss of placement).

Region 2-North DDA also has access to one Hospital Diversion bed located in North Seattle. Referrals for hospital diversion bed services should be made to the DDA Mental Health/ Developmental Disability Resource Manager.

WHAT RESIDENTIALLY BASED CRISIS SERVICES EXIST IN THE REGION?

Crisis stabilization/triage facilities for adults are located in Whatcom, Skagit, and Snohomish counties. These programs typically provide short-term support (up to 5 days) in a staffed facility for adults who are in or at high risk of experiencing a mental health crisis. The programs in Skagit and Whatcom Counties provide sub-acute detoxification and the program in Snohomish County provides (non-medical) sobering services for chemically abusing or dependent individuals. When an outpatient clinician believes that an individual would benefit from crisis stabilization/triage, they may call the facility directly to make the referral or call the Care Crisis Line and speak to a CCRS Triage Clinician to make the referral. Staff at each facility is trained to review the presenting information and establish whether placement is appropriate.

WHATCOM COUNTY BEHAVIORAL HEALTH TRIAGE CENTER (WCBHTC)

Pioneer Human Services and Whatcom Counseling and Psychiatric Clinic have a cooperative agreement to provide crisis services and sub-acute detoxification services at the WCBHTC. Pioneer Human Services has started a suboxone program on site and has a physician who runs a suboxone clinic several times a week.

WCBHTC is licensed for 13 beds, 8 beds are designated for detoxification and 5 beds are designated for crisis stabilization. The residential services are 24/7 and the usual length of stay in both programs is between 3 to 5 days. This is a less restrictive option to hospitalization. The services offered at WCBHTC are voluntary. Referral sources include, but are not limited to, hospital staff and social workers, case managers, law enforcement, correctional officers and jail staff.

There are DMHPs housed at the site who can assist with crises that may need their expertise. A Physician Assistant is available to assist residents in stabilization beds with their basic medical needs, as well as, being available to staff for medical consultations. A strong and developing part of

WCBHTC is the utilization of Certified Peer Counselors who provide supportive services to those in residence. WCBHTC also provides access to the Behavioral Health Access Program (BHAP) that provides mental health and chemical dependency treatment for residents who have no source of funding. BHAP workers regularly interview their individuals on site.

SKAGIT COUNTY CRISIS CENTER (SCCC)

Pioneer Human Services operates the Skagit County Crisis Center (SCCC) in Burlington, WA. The SCCC provides short-term stabilization services for individuals who are experiencing a mental health crisis or are experiencing the effects of intoxicants and require sub-acute detoxification services. SCCC will provide supportive care 24 hours a day, 7 days a week, for individuals while they stabilize from a mental health crisis or withdraw from the transitory effects of intoxication. SCCC is a non-medical, community based program that offers a less-restrictive placement option to inpatient hospitalization, or acute detoxification. This facility is a voluntary unit and does not use restraints or seclusion.

SCCC services are based on a strength-based Recovery model and utilize SAMHSA (Substance Abuse and Mental Health Services Administration) Principles of Recovery. Staffing includes Chemical Dependency Professionals, Mental Health Professionals (MHP), Certified Peer Counselors, as well as, other professional staff. Referrals can be made by community professional staff, to include case managers, chemical dependency providers, mental health clinicians, hospital social workers and discharge planning staff and law enforcement.

SCCC is a combined facility providing integrated care for individuals who are experiencing mental health and/or chemical dependency issues. It is unable to accept individuals who are leveled sex offenders, violent, assaultive or have a history of fire setting.

1. <u>Sub-acute detoxification referrals</u>:

    a. Sub-acute detoxification placement is offered at SCCC. As with other non-medical, detoxification service facilities, SCCC is unable to accept individuals who are detoxing from benzodiazepines or barbiturates.
    b. Face-to-face assessment may be necessary and completed by medical personnel to determine the appropriateness of placement in a non-medical setting for unknown persons or those with known history of severe withdrawal symptoms. Referrals will also be accepted from community providers using the Community Professional/Case Manager Screening Form.
    c. The referral source will contact the SCCC regarding the availability and the appropriateness (review inclusion/exclusion criteria) of the placement.

If the placement is appropriate and the SCCC agrees to accept the individual, the referral source or SCCC staff will arrange for appropriate transportation.

SNOHOMISH COUNTY TRIAGE CENTER (SCTC)

Compass Health operates the SCTC in Everett. This facility provides short-term stabilization services for individuals experiencing a behavioral health crisis, which might include mental health or chemical abuse/dependency symptoms. The program does not provide detoxification services, but does provide support to those who are sobering.

SCTC services are based on a Recovery Model, and staffing includes Certified Peer Counselors, as well as, other professional staff. Referrals can be made by a wide range of professional staff to include case managers, chemical dependency providers, mental health clinicians, hospital social work and discharge planning staff, and others. Additionally, this facility is "locked", and accepts direct referrals from any Snohomish County Law Enforcement officer as a diversion from jail or hospital emergency departments.

Duration of stay averages three to four days, but may be as short as one day or as long as five with the need for continued stay based on clinical criteria to include presentation and strength of discharge planning.

1. Referral Process:

    a. For Mental Health Clinicians or Case Managers and Community Professionals, referral to any of these programs can be accomplished by calling the program directly. Program staff will complete a screening questionnaire during the call, and will evaluate the referral to determine whether any exclusionary criteria are present. Generally an answer to the referral can be made during this initial call but sometimes some internal consultation is necessary. Program staff is committed to providing an answer to the referral as quickly as possible.
    b. For Mental Health Clinicians or Case Managers, it is generally expected that the individual being referred has been seen recently and evaluated as being in need of this level of care.
    c. Once accepted, it is the responsibility of the referring Mental Health Clinician or Case Manageror Community Professional to ensure safe transportation to the facility and to assist with all details related to admission. These details may include obtaining medications, communicating with other supports/systems, assisting with obtaining releases to facilitate discharge planning, etc.

2. Length of Stay/Discharge Planning:

    a. The length of stay is limited; up to 5 days but extensions are available if clinically warranted.
    b. The discharge planning will begin at the time of initial placement at the facility.

WHAT IS THE PROCESS FOR PSYCHIATRIC HOSPITALIZATION?

VOLUNTARY HOSPITALIZATION

The clinician evaluates whether a less restrictive option such as increased outpatient services, staying with family or natural supports, a crisis triage center stay, might be sufficient to stabilize the individual. If all less restrictive options are ruled out (i.e., have been tried unsuccessfully, are inappropriate for some clear and documentable reason), the clinician may proceed with the voluntary hospitalization process.

The VOA Inpatient Utilization Management Team conducts the authorization process for voluntary psychiatric hospitalization for all Medicaid and Medicaid-eligible residents of the North Sound region. The program is available 24 hours per day, 7 days per week. When a clinician feels that the individual they are working with requires psychiatric hospitalization they must do the following:

1. Conduct a face-to-face evaluation with the individual within 24 hours of the request for inpatient care.
2. Contact a psychiatric hospital and secure a bed.
3. After a bed has been identified, but before admission, the clinician must call VOA at 1-800-707-4656 and request the authorization.

    a. The clinician will have to provide clinical and demographic information;
    b. Discuss and justify the reasons, including specific symptoms and behaviors, requiring inpatient hospital care;
    c. Describe what less restrictive options have been attempted.

4. VOA consults with a psychiatrist on all requests for hospitalization of children/youth and on any requests for which medical necessity is in question.
5. If the individual meets medical necessity criteria the hospitalization episode will be authorized. For those requests that are denied, the consumer has the right to appeal or grieve and the admitting psychiatric facility has the right to appeal (see NSMHA policies 1001-1004 and 1020).
6. The outpatient clinician may then make the final arrangements for admission (e.g., contacting the hospital to notify of authorization or denial, transportation, etc). In those instances where a denial has been issued and an admission will not occur, the outpatient clinician is responsible for developing an alternative plan with the individual to address the individual's needs.

ASSESSMENTS FOR INVOLUNTARY TREATMENT

Persons who are alleged to be a danger to themselves, others or property or are gravely disabled (unable to meet their basic needs of health and safety) as the result of an acute mental disorder may be assessed for involuntary treatment.

Note: Individuals, who are developmentally disabled, impaired by chronic alcoholism or drug abuse, or suffering from dementia shall not be detained solely by reason of that condition. The detention may be appropriate if said condition meets the definition of an acute mental disorder as defined in RCW 71.05 and detention grounds are met.

In Washington State, DMHPs conduct all assessments for involuntary treatment. In assessing whether or not a person should be detained against their will to an inpatient psychiatric unit DMHPs focus their evaluations on the following questions:

1. Is the person suffering from an acute mental disorder? RCW 71.05 defines mental disorder as "any organic, mental or emotional disorder which has substantial adverse effects on an individual's cognitive and volitional functions."
2. Is there evidence that the person, as the result of mental disorder:

    a. Presents a likelihood of serious harm to him or herself, other persons, or the property of others; or
    b. May be gravely disabled?

3. Does imminent danger exist?

a. A DMHP should take a person into emergency custody only when the person presents an **imminent** likelihood of serious harm or is in imminent danger because they are gravely disabled.
b. Before filing the petition, the DMHP must personally interview the person, unless the person refuses an interview, and determine whether the person will voluntarily receive appropriate evaluation and treatment at an evaluation and treatment facility.

4. Does the person present, as a result of a mental disorder, likelihood of serious harm, or grave disability, but without imminent danger?

    a. If the person does meet criteria for detention, but no imminent danger exists, then the DMHP may initiate a non-emergent detention by petitioning the superior court for an order to detain. There are variances between counties on this. **Note:** Imminent danger is not required for the emergency detention of minors.

5. What appropriate alternatives to involuntary hospitalization exist? Will the person voluntarily accept appropriate, available, less restrictive treatment options?

In evaluating a person for involuntary treatment, DMHPs investigate not only the immediate circumstances around the request for the evaluation, but also must consider reasonably available history. This includes reviewing reasonably available records and/or databases in order to obtain the person's background and history prior to interviewing the person to be investigated. If family members are available and deemed credible, the DMHP will interview them to obtain further information and may request a written statement. The DMHP reviews, if available, at a minimum, a person's history of violent acts, suicide attempts and prior detentions/commitments.

This information should always be considered in light of the intent to provide prompt evaluation, as well as, timely and appropriate treatment.

WHAT HAPPENS AFTER AN INVOLUNTARY ADMISSION TAKES PLACE?

When a person is detained, he or she is entitled to a court hearing within 72 hours of the initial detention. This is called a probable cause hearing. Weekends and holidays are excluded in the calculation of the initial 72 hours. The treating psychiatrist/physician or psychiatric Advanced Registered Nurse Practitioner (ARNP) may discharge any patient at any time during a commitment if, in their opinion, the criteria for involuntary treatment are no longer being met. The focus of the probable cause hearing is to determine if the person continues to require involuntary treatment. In the hearing, it will be determined whether the initial commitment was appropriate and, if so, does the person still present a danger to themselves, others or property or is gravely disabled as the result of an acute mental disorder. Family member/natural support input is generally encouraged in preparation for these hearings. The judge has the option of continuing the detention, discharging the individual back home on a voluntary basis (dismissal of petition), or releasing the person on a Less Restrictive Order (LRO or LR). An LR contains a number of requirements. These are called the "conditions" of the LR. Examples include taking medications as prescribed, attending scheduled appointments, not using non-prescribed drugs or alcohol, refraining from threats or acts of harm toward themselves or others, and not having access to weapons.

COURT ORDERS (LESS RESTRICTIVE ORDER AND CONDITIONAL RELEASE)

When a person is released on an LR, they receive a written notice containing the conditions of their release. Caregivers, including those providing residential supports and the mental health system, are expected to support the individual in meeting these conditions. This includes getting the person to appointments, and working closely together as service providers to address problems in a proactive manner. Family members/natural supports can also help the individual adhere to the conditions especially if the individual resides with them.

There is another type of court order called a Conditional Release (CR). When an individual is committed to the hospital for 14 days or 90 days (this is called the More Restrictive Order (MRO)) the treating physician can decide to discharge the person on a CR. He/she must have an accepting outpatient provider to follow up on the CR. The physician writes a document outlining the conditions the person agrees to follow. This document is given to the receiving outpatient provider, the individual on the CR and is filed with the court without a hearing taking place.

Sometimes, however, people either do not follow through on the conditions of their LR/CR or experience substantial deterioration in their functioning even when following the conditions. Under these circumstances, a DMHP may file a petition for revocation which places the individual back in the hospital for up to five days (including holidays & weekends) pending a revocation hearing. This hearing is held in order to determine whether the individual needs to be returned to inpatient status ("revoked") for up to the number of days left on the order. Whenever possible, the person will be stabilized and discharged back to where they were living, often on the same LR/CR. The facility may choose to discharge the person on the existing LR/CR without requesting a court hearing.

When a DMHP receives notice that an individual has violated the conditions of their LR/CR and/or is experiencing substantial deterioration that requires inpatient treatment it is at their discretion to file a petition for revocation. However, if a DMHP is notified by the treatment provider that an individual has violated the conditions and, as a result, poses an increased likelihood of serious harm, the DMHP is **required** to file a petition for revocation. The treatment provider is then **required** to submit an affidavit detailing the reason(s) for the revocation and be prepared to provide the main court testimony (see "How to Write an Affidavit" on the NSMHA website at http://nsmha.org/Committee/RTC/ICRS/Writing_an_Affidavit.pdf). **Note:** this does **not** guarantee a revocation hearing **and** the person could still be discharged by the treating psychiatrist/physician/ psychiatric ARNP.

When serving a person on a LR/CR, it is required that the agency keep a copy of the court document listing the conditions in the clinical record. It is important to provide this document to the DMHP if requested. It is also necessary that the person communicating with the DMHP has specific knowledge about how the person on the LR/CR has violated the order (See Policy 1562.00), problems they have experienced that are causing the concerns, and what steps have been taken or considered to help support the person in a less restrictive way/setting.

Clinicians are expected to document each violation in the individual's chart. Please see "How to Document CR/LR Violations" on the NSMHA website at http://nsmha.org/Committee/RTC/ICRS/Crisis_Response_Module.pdf

Information from family members/natural supports is crucial in determining whether the filing of a petition for revocation is appropriate and necessary. Family members/natural supports are often the first persons to identify the individual's non-adherence or deterioration and can share this information with the clinician without compromising confidentiality requirements. If the individual has not authorized the release of information, the clinician may simply listen to the family's concerns without revealing protected information. **Note:** A LR/CR is not intended to be used in a punitive manner, but to help the in individual maintain their health and safety in the community.

GLOSSARY OF TERMS

Crisis – crisis (a turning point in the course of anything decisive or critical; a time, a stage or an event of great danger or trouble, whose outcome decides whether possible bad consequences will follow).

Conditional Release (CR) is a court order that is filed by the treating physician during the involuntary inpatient commitment. This order specifies what the person needs to do to remain in the community. It differs from an LR in length and because there is no court hearing.

Designated Mental Health Professional (DMHP) is a mental health clinician appointed by the County to perform the duties specified in chapters RCW 71.05 and 71.34. This includes having the legal authority to detain a person against their will for up to 72 hours.

Evaluation and Treatment Center (**E&T)** – The North Sound Region operates one (1) facility via contract with Compass Health, in Mukilteo (Mukilteo E&T). This program provides involuntary evaluation and treatment to those detained by the DMHP staff. Other inpatient psychiatric facilities are licensed as Evaluation and Treatment Centers, but most often the term "E&T" refers to the regional facility.

Integrated Crisis Response System (ICRS) – This is the service system that provides crisis response interventions throughout Island, San Juan, Skagit, Snohomish and Whatcom Counties. Service providers include VOA, Compass Health, Snohomish County Human Services and Whatcom Counseling and Psychiatric Clinic and Pioneer Human Services.

Mental Illness Involuntary Treatment Act (ITA) – RCW 71.05 and Mental Health Services for Minors – RCW 71.34. These are the laws that allow persons who are a danger to themselves, others, property or who are gravely disabled as the result of a mental disorder to be detained against their will for inpatient psychiatric treatment.

Less Restrictive Order/Less Restrictive Alternative (LRO/LRA) – A court order that is put in place, by court hearing or stipulation, for some individuals after they have been involuntarily detained. This order specifies what the person needs to do to remain in the community after discharge from an inpatient unit.

CCRS Triage Clinician: The mental health professional at the Crisis Line, who coordinates services, dispatches the DMHP, Mobile Outreach Team (MOT), Emergency Mental Health Clinicians (EMHCs) and provides telephone-based support 24 hours a day.

Volunteers of America (VOA) Care Crisis Response Services (CCRS) – Provides telephone-based support and triage through the Crisis Line. The CCRS Triage Clinician can also schedule Urgent Appointments and dispatch local crisis response teams when face-to-face interventions are required.

Integrated Crisis Response NSMHA Training Module

Post-Test

Please circle the appropriate response to indicate whether the following statements are true or false:

1. T/F Individuals and the general public should be instructed to call the VOA CCRS Triage Clinician if they feel that they are in crisis.

2. T/F Crisis alerts expire after 10 days if they are not renewed.

3. T/F Crisis services appointments are only for individuals who are currently enrolled in services.

4. T/F When requesting admission for voluntary hospitalization, one should be prepared to discuss what less restrictive options have been considered.

5. T/F When DMHPs are doing an assessment for initial detention they are required to consider reasonably available history.

6. T/F When someone is on a LR or CR, it is not important to keep a copy of the order.

7. T/F Any person who is in crisis and who is physically located within the North Sound region is eligible for crisis response services.

8. T/F Once a person is detained, a court hearing must be held within 48 hours to determine if he/she continues to meet commitment criteria.

Please fill in the appropriate response for each of the following statements:

1. Once dispatched, crisis response staff must make face-to-face contact within _____ hours.

2. What type of service should be considered when an individual is unwilling to accept voluntary services and presents a likelihood of serious harm to him/herself as the result of a mental disorder but is not in imminent danger?
   _____

3. When a person is discharged from an evaluation and treatment center on a LR, the requirements/constraints on their behavior are referred to as the _____ of their release.

4. When someone is returned to an inpatient unit for not complying with an LR, the process is called a _____.

Discussion questions *(will be reviewed by your supervisor, but not scored)***:**

1. How can crisis plans assist enrolled individuals who are in crisis?

2. Provide 3 situations in which using a crisis alert would be appropriate.

3. What is the clinician's role when voluntary hospitalization may be needed to support a person on his/her caseload?

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NORTH SOUND MENTAL HEALTH ADMINISTRATION

INTEGRATED CRISIS RESPONSE SYSTEM TRAINING MODULE

TABLE OF CONTENTS

TRAINING OBJECTIVES:

1. Orient clinicians to the mental health crisis system's processes, resources and requirements.
2. Educate clinicians regarding voluntary and involuntary hospitalization.
3. Educate clinicians regarding involuntary treatment laws and processes.
4. Provide guidance regarding the completion of an affidavit for initial detention or petition to revoke.

INTRODUCTION

Crisis Services are one of the major components of public mental health services. Crisis services are available to all individuals and families physically located in the North Sound region's five counties, regardless of enrollment status with service providers, ability to pay, or funding source. Services are available on a 24 hour basis for those who are in a self-defined state of crisis (a turning point in the course of anything decisive or critical; a time, a stage or an event of great danger or trouble, whose outcome decides whether possible bad consequences will follow).

Crisis Services include a broad array of services: telephone-based crisis assessment and support, outreach, crisis triage centers and involuntary treatment assessments. Crisis services are intended to stabilize the individual in crisis in the least restrictive community setting possible. Services are matched to the individual's need and severity of the crisis. An individual in crisis is served from a non-stigmatizing, person-oriented approach, including responsive listening and respectful attention.[1] Crisis Services staff actively involve and collaborate with family members and other natural supports during a crisis as appropriate and within limits of confidentiality.

Crisis Services are provided by the following agencies in the following counties:

County	Voluntary Crisis Services	Involuntary Investigations	Triage Centers*	Mobile Outreach Team
Island	Compass Health	Compass Health	Island County residents may access triage if transportation can be arranged	Not available in Island County
San Juan	Compass Health	Compass Health	San Juan County residents may access triage if transportation can be arranged	Not available in San Juan County
Skagit	Compass Health	Compass Health	Pioneer Human Services	Pioneer Human Services
Snohomish	Compass Health	Snohomish County Human Services	Compass Health	Not available in Snohomish County
Whatcom	Whatcom Counseling and Psychiatric Clinic (WCPC)	WCPC	WCPC	WCPC

***Note:** Triage Centers in the North Sound Region may have some restrictions on admission for Chemical Dependency services based upon county of residence of the referred individual.

[1] See Journal of Psychiatric Practice, Vol. 9, No. 1: *Individuals' Wants and Needs During a Psychiatric Emergency*

WHAT ARE THE PRINCIPLES OF THE ICRS?

1. Crisis services include voluntary and involuntary service options.
2. Crisis services are delivered across social service systems in a fully integrated, seamless and consistent manner.
3. An individual in crisis is treated as a whole person, rather than focusing on categorical problems.
4. A crisis is self-defined, rather than needing to meet categorical criteria.
5. An individual in crisis will have easy and timely access to appropriate intervention and care.
6. Clinicians involved in crisis response intervention will be able to refer to a complete continuum of care in order to respond to a variety of needs.
7. Individuals experiencing a behavioral health crisis will be stabilized in the least restrictive setting, in the individual's home or in any in vivo setting, and will be referred to the least restrictive resource available to manage the crisis.
8. Crisis response services are community-based.
9. Crisis response services are available to both adults and children.
10. Crisis services and information will be available 24 hours a day, 365 days a year throughout the Region.
11. Crisis services will be fully integrated and coordinated at both the local and regional level.
12. All crisis services will be culturally competent and responsive.
13. Standards of care will be adhered to throughout the region.
14. Crisis services will be provided in a manner recognizing the uniqueness of each individual.
15. The integrated crisis system will utilize a flexible array of services and supports, formal and informal, which fit the needs of the individual.

WHAT TOOLS ARE AVAILABLE FOR MANAGING CRISES?

CRISIS PLANS

The crisis plan is a document that the outpatient clinician develops in collaboration with the North Sound Mental Health Administration (NSMHA) enrolled individual and his/her family and/or other natural supports. The plan is intended to help both the clinician and individual in the event that he/she experiences a crisis during treatment. Working together, the outpatient clinician and individual anticipate potential problems that might create a crisis. The outpatient clinician helps the individual identify his/her specific triggers, "red flags", or early warning signs, to alert him/her that trouble may be developing. The outpatient clinician and individual make a plan for what to do when the individual sees these early warning signs. The plan starts with low intensity interventions that the individual can probably accomplish on his/her own, then progresses to interventions of increasing intensity that include family, natural supports and professional staff as needed. A copy of the crisis plan is kept in the individual's chart, given to the individual, given to the identified family or natural supports with the individual's approval, and given to the Crisis Line.

If the individual or a family member/natural support calls the Crisis Line during a crisis, the Crisis Line staff can provide assistance based on the information in the crisis plan. When responding to a crisis, clinicians, CCRS, and crisis services workers will continue to work with family members and other natural supports to best support the individual within limits of confidentiality. Crisis plans shall be reviewed at least every 180 days, updated to reflect any changes in the individual's needs,

or as requested by the individual, their parent, or other legal representative. This shall include any known safety concerns. See NSMHA Policy 1551 Individual Service Plans/Resiliency and Recovery Plans for additional requirements related to crisis plans.

CRISIS ALERTS

Crisis alerts contain important up-to-date information about individuals who are likely to require crisis services within the next 10 days. Crisis alerts are created by clinicians and contain information pertinent to the current crisis situation, in contrast to crisis plans, which contain long-term strategies. CCRS receives, stores, and utilizes this time-sensitive information, and makes it available to Mobile Outreach Teams (MOT), Emergency Mental Health Clinicians (EMHC) and Designated Mental Health Professional (DMHP) staff to assess risk and effectively intervene in a crisis. Crisis alerts are kept on file for 10 days and can be renewed if clinically warranted.

MENTAL HEALTH ADVANCE DIRECTIVES

A Mental Health Advance Directive is a written document, consistent with the provisions of RCW (Revised Code of Washington) 71.32, in which a person makes a declaration of instructions or preferences and/or appoints an agent to make decisions on her/his behalf regarding that individual's mental health treatment during times when he/she is incapacitated by a mental disorder and cannot give informed consent. If the clinician has received an individual's advance directive, it will become part of the individual's medical record and the clinician will be considered to have actual knowledge of its contents. More information regarding compliance and conditions for noncompliance can be found in RCW 71.32.150, RCW 7.70.40 and in NSMHA Policy 1518 Mental Health Advance Directives.

WELLNESS RECOVERY ACTION PLAN (WRAP)

WRAP® is an evidence based self-management and recovery system designed by Mary Ellen Copeland and developed by a group of people who had mental health difficulties and were struggling to incorporate wellness tools and strategies into their lives. WRAP is designed to:

1. Decrease and prevent intrusive or troubling feelings and behaviors;
2. Increase personal empowerment;
3. Improve quality of life; and
4. Assist people in achieving their own life goals and dreams.

WRAP is a structured system to monitor uncomfortable and distressing feelings and behaviors and, through planned responses, reduce, modify or eliminate them. It also includes plans for responses from others when individuals cannot make decisions, take care of themselves or keep safe.

The clinician may ask if an individual has a crisis plan, mental health advance directive or WRAP, but he/she may have chosen not to create these plans. The mental health advance directive and WRAP are not available through VOA.

WHAT IS THE ROLE OF VOA CARE CRISIS RESPONSE SERVICES (CCRS)?

CRISIS LINE

CCRS provides 24-hour a day, 7 day a week, professionally staffed crisis line system. When someone is in distress and is seeking assistance with a crisis situation, he/she should call the Crisis Line at 1-800-584-3578. They provide a range of support and referral services including:

A. Making ~~requested~~ mental health referrals to the community;
B. Having access to language bank interpreters and TDD equipment;
C. Assuring referral to age and culturally appropriate services and specialists;
D. Scheduling crisis appointments;
E. Providing telephone stabilization and intervention services for individuals with non-acute issues;
F. Assuring timely and consistent crisis response;
G. Providing telephone consultation, intervention and stabilization for individuals and/or family members/natural supports as appropriate and within limits of confidentiality;
H. Determining when face-to-face services are needed, both voluntary and involuntary, and dispatching a DMHP, MOT, or EMHC;
I. Tracking the outcome of face-to-face services and seeing if further services are warranted;
J. Deciding when cross-system services are needed;
K. Working closely with law enforcement when appropriate;
L. Consulting with detoxification providers, licensed care facilities, hospitals and other community providers;
M. Troubleshooting cross-system referrals in which there is a difference of opinion of appropriate services or system response; and
N. Providing telephone follow-up with individuals after-hours as part of an individual crisis plan.

TRIAGE SERVICES

VOA CCRS Triage Clinicians are Masters-level mental health professionals. When a professional wishes to speak with someone at the Crisis Line, they can contact the CCRS Triage Clinician directly at 1-800-747-8654.

The CCRS Triage Clinician will have the responsibility of deciding when face-to-face evaluation and/or stabilization services are needed and dispatch the MOT, EMHC, and/or DMHP staff to a community location outside of the provider's office. The MOT, EMHC, or DMHP may not decline a referral for face-to-face services, but decides if backup or other provisions are needed to mitigate risk.

Outreach services shall be provided within two (2) hours of dispatch by the CCRS Triage Clinician.

MOT, EMHC, and DMHP will report the disposition of the case back to the CCRS Triage Clinician by phone or fax within one (1) hour of the completion of the case and to law enforcement when requested.

WHAT FACE-TO-FACE SERVICES ARE AVAILABLE?

CRISIS SERVICES APPOINTMENTS

Urgent and follow-up appointments are available for adults and children who are not currently enrolled in the public mental health system, are determined to be in need of face-to-face evaluation or intervention, and who meet certain criteria. Appointments are available at provider agencies in each county, and are scheduled by VOA CCRS staff. Crisis Services appointments provide brief treatment on a voluntary basis, generally for persons at risk of harm to self or others, at risk of hospitalization, and/or who may be in need of a referral for an emergency medication evaluation. Enrolled individuals' urgent needs will be addressed by their outpatient clinician, treatment team or backup as appropriate.

EMERGENCY PSYCHIATRIC SERVICES

Emergency psychiatric medication evaluations are available for those individuals who have been assessed by an EMHC or DMHP and deemed at risk of hospitalization. Access to these psychiatric appointments is through the EMHC or DMHP. This process varies from county to county. Follow up psychiatric consultations are available when clinically indicated by the prescriber. Generally this service is used for non-enrolled individuals.

OUTREACH

Outreach is the provision of face-to-face evaluation and/or intervention services (voluntary or involuntary) in community locations. The expectation is that emergency outreach clinicians providing crisis response services will provide services to the individual in the community. Outreach services are an important and available service, both when necessary to support the person in crisis and to provide services in the least restrictive, appropriate manner, with the use of family and natural supports within limits of confidentiality. The intent, however, is never to promote outreach at the expense of anyone's safety – including individual, staff, family/natural support, and the public.

EMHCs/DMHPs must respond to pages from the VOA within 10 minutes. Once dispatched, the EMHC and DMHP must be on-site with the person in crisis within 2 hours. Within 1 hour following the completion of any outreach, the EMHC and DMHP calls the CCRS Triage Clinician to relay the disposition of the case back to the CCRS Triage Clinician and, when appropriate, the referral source, to include the individual's clinician. If EMHC or DMHP is unable to arrive to the dispatch location within two hours due high volume, inclement weather, etc., they will document the reason for the delay.

MOBILE OUTREACH TEAM (MOT)

Mobile Outreach is a community service available in Skagit and Whatcom, counties for individuals and families not currently enrolled in Medicaid outpatient services. These teams are intended to respond to non-emergent mental health situations, defined as situations where the level of stress has overwhelmed the individual's ability to cope. The teams are available to provide early intervention to assess, engage, and provide temporary support and make referrals to community resources. These teams can be accessed by calling the VOA Care Crisis Line or directly contacting the provider. The teams are designed to integrate with the existing Emergency Services and Involuntary Treatment Investigation Services.

INVOLUNTARY INVESTIGATION SERVICES

Involuntary investigations are another crisis service available in all five counties and performed by the DMHPs. These individuals have specialized training in performing mental health investigations, and are designated by their counties. Their role is to assess for danger to self, others, property and/or grave disability as a result of an acute mental disorder. They work closely with the voluntary teams, hospitals, triage facilities, and other allied systems. Their specific role and investigation procedures are further detailed later in this module.

WHAT SERVICES ARE AVAILABLE FOR ADULTS ENROLLED WITH THE ~~DIVISION OF~~ DEVELOPMENTAL DISABILITIES ADMINISTRATION (DDA~~D~~)?

For adults (18 or older) who are enrolled with the DDA~~D~~, there are additional services that are available during times of crisis. These services are based on an urgent, not emergent, model and rely upon referral from the DDA~~D~~ Case Manager during business hours.

The EMHC/DMHP can check on an individual's enrollment status by calling the Care Crisis Line. An assessment for stabilization services can be arranged through the DDA~~D~~ Mental Health/ Developmental Disability Resource Manager, if criteria are met (enrolled with DDA~~D~~, not currently enrolled with the RSN, and at risk of hospitalization or loss of placement).

Region 2-North DDA~~D~~ also has access to one Hospital Diversion bed located in North Seattle. Referrals for hospital diversion bed services should be made to the DDA~~D~~ Mental Health/ Developmental Disability Resource Manager.

WHAT RESIDENTIALLY BASED CRISIS SERVICES EXIST IN THE REGION?

Crisis stabilization/triage facilities for adults are located in Whatcom, Skagit, and Snohomish counties. These programs typically provide short-term support (up to 5 days) in a staffed facility for adults who are in or at high risk of experiencing a mental health crisis. The programs in Skagit and Whatcom Counties provide sub-acute detoxification and the program in Snohomish County provides (non-medical) sobering services for chemically abusing or dependent individuals. When an outpatient clinician believes that an individual would benefit from crisis stabilization/triage, they may call the facility directly to make the referral or call the Care Crisis Line and speak to a CCRS Triage Clinician to make the referral. Staff at each facility is trained to review the presenting information and establish whether placement is appropriate.

WHATCOM COUNTY BEHAVIORAL HEALTH TRIAGE CENTER (WCBHTC)

Pioneer Human Services and Whatcom Counseling and Psychiatric Clinic have a cooperative agreement to provide crisis services and sub-acute detoxification services at the WCBHTC. Pioneer Human Services has started a suboxone program on site and has a physician who runs a suboxone clinic several times a week.

WCBHTC is licensed for 13 beds, 8 beds are designated for detoxification and 5 beds are designated for crisis stabilization. The residential services are 24/7 and the usual length of stay in both programs is between 3 to 5 days. This is a less restrictive option to hospitalization. The services offered at WCBHTC are voluntary. Referral sources include, but are not limited to, hospital staff and social workers, case managers, law enforcement, correctional officers and jail staff.

There are DMHPs housed at the site who can assist with crises that may need their expertise. A Physician Assistant is available to assist residents in stabilization beds with their basic medical needs, as well as, being available to staff for medical consultations. A strong and developing part of

WCBHTC is the utilization of Certified Peer Counselors who provide supportive services to those in residence. WCBHTC also provides access to the Behavioral Health Access Program (BHAP) that provides mental health and chemical dependency treatment for residents who have no source of funding. BHAP workers regularly interview their individuals on site.

SKAGIT COUNTY CRISIS CENTER (SCCC)

Pioneer Human Services operates the Skagit County Crisis Center (SCCC) in Burlington, WA. The SCCC provides short-term stabilization services for individuals who are experiencing a mental health crisis or are experiencing the effects of intoxicants and require sub-acute detoxification services. SCCC will provide supportive care 24 hours a day, 7 days a week, for individuals while they stabilize from a mental health crisis or withdraw from the transitory effects of intoxication. SCCC is a non-medical, community based program that offers a less-restrictive placement option to inpatient hospitalization, or acute detoxification. This facility is a voluntary unit and does not use restraints or seclusion.

SCCC services are based on a strength-based Recovery model and utilize SAMHSA (Substance Abuse and Mental Health Services Administration) Principles of Recovery. Staffing includes Chemical Dependency Professionals, Mental Health Professionals (MHP), Certified Peer Counselors, as well as, other professional staff. Referrals can be made by community professional staff, to include case managers, chemical dependency providers, mental health clinicians, hospital social workers and discharge planning staff and law enforcement.

SCCC is a combined facility providing integrated care for individuals who are experiencing mental health and/or chemical dependency issues. It is unable to accept individuals who are leveled sex offenders, violent, assaultive or have a history of fire setting.

1. Sub-acute detoxification referrals:

    a. Sub-acute detoxification placement is offered at SCCC. As with other non-medical, detoxification service facilities, SCCC is unable to accept individuals who are detoxing from benzodiazepines or barbiturates.
    b. Face-to-face assessment may be necessary and completed by medical personnel to determine the appropriateness of placement in a non-medical setting for unknown persons or those with known history of severe withdrawal symptoms. Referrals will also be accepted from community providers using the Community Professional/Case Manager Screening Form.
    c. The referral source will contact the SCCC regarding the availability and the appropriateness (review inclusion/exclusion criteria) of the placement.

If the placement is appropriate and the SCCC agrees to accept the individual, the referral source or SCCC staff will arrange for appropriate transportation.

SNOHOMISH COUNTY TRIAGE CENTER (SCTC)

Compass Health operates the SCTC in Everett. This facility provides short-term stabilization services for individuals experiencing a behavioral health crisis, which might include mental health or chemical abuse/dependency symptoms. The program does not provide detoxification services, but does provide support to those who are sobering.

SCTC services are based on a Recovery Model, and staffing includes Certified Peer Counselors, as well as, other professional staff. Referrals can be made by a wide range of professional staff to include case managers, chemical dependency providers, mental health clinicians, hospital social work and discharge planning staff, and others. Additionally, this facility is "locked", and accepts direct referrals from any Snohomish County Law Enforcement officer as a diversion from jail or hospital emergency departments.

Duration of stay averages three to four days, but may be as short as one day or as long as five with the need for continued stay based on clinical criteria to include presentation and strength of discharge planning.

1. Referral Process:

    a. For Mental Health Clinicians or Case Managers and Community Professionals, referral to any of theseis programs can be accomplished by calling the program directly. Program staff will complete a screening questionnaire during the call, and will evaluate the referral to determine whether any exclusionary criteria are present. Generally an answer to the referral can be made during this initial call but sometimes some internal consultation is necessary. Program staff is committed to providing an answer to the referral as quickly as possible.
    b. For Mental Health Clinicians or Case Managers, it is generally expected that the individual being referred has been seen recently and evaluated as being in need of this level of care.
    c. Once accepted, it is the responsibility of the referring Mental Health Clinician or Case Manageror Community Professional to ensure safe transportation to the facility and to assist with all details related to admission. These details may include obtaining medications, communicating with other supports/systems, assisting with obtaining releases to facilitate discharge planning, etc.

2. Length of Stay/Discharge Planning:

    a. The length of stay is limited; up to 5 days but extensions are available if clinically warranted.
    b. The discharge planning will begin at the time of initial placement at the facility.

WHAT IS THE PROCESS FOR PSYCHIATRIC HOSPITALIZATION?

VOLUNTARY HOSPITALIZATION

The clinician evaluates whether a less restrictive option such as increased outpatient services, staying with family or natural supports, a crisis triage center stay, might be sufficient to stabilize the individual. If all less restrictive options are ruled out (i.e., have been tried unsuccessfully, are inappropriate for some clear and documentable reason), the clinician may proceed with the voluntary hospitalization process.

The VOA Inpatient Utilization Management Team conducts the authorization process for voluntary psychiatric hospitalization for all Medicaid and Medicaid-eligible residents of the North Sound region. The program is available 24 hours per day, 7 days per week. When a clinician feels that the individual they are working withhave assessed requires psychiatric hospitalization they must do the following:

1. Conduct a face-to-face evaluation with the individual within 24 hours of the request for inpatient care.
~~1.~~2. Contact a psychiatric hospital and secure a bed.
~~2.~~3. After a bed has been identified, but before admission, the clinician must call VOA at 1-800-707-4656 and request the authorization.

    a. The clinician will have to provide clinical and demographic information;
    b. Discuss and justify the reasons, including specific symptoms and behaviors, requiring inpatient hospital care;
    c. Describe what less restrictive options have been attempted.

~~3.~~4. VOA consults with a psychiatrist on all requests for hospitalization of children/youth and on any requests for which medical necessity is in question.
~~4.~~5. If the individual meets medical necessity criteria the hospitalization episode will be authorized. For those requests that are denied, the consumer has the right to appeal or grieve and the admitting psychiatric facility has the right to appeal (see NSMHA policies 1001-1004 and 1020).
~~5.~~6. The outpatient clinician may then make the final arrangements for admission (e.g., contacting the hospital to notify of authorization or denial, transportation, etc). In those instances where a denial has been issued and an admission will not occur, the outpatient clinician is responsible for developing an alternative plan with the individual to address the individual's needs.

ASSESSMENTS FOR INVOLUNTARY TREATMENT

Persons who are alleged to be a danger to themselves, others or property or are gravely disabled (unable to meet their basic needs of health and safety) as the result of an acute mental disorder may be assessed for involuntary treatment.

Note: Individuals, who are developmentally disabled, impaired by chronic alcoholism or drug abuse, or suffering from dementia shall not be detained solely by reason of that condition. The detention may be appropriate if said condition meets the definition of an acute mental disorder as defined in RCW 71.05 and detention grounds are met.

In Washington State, DMHPs conduct all assessments for involuntary treatment. In assessing whether or not a person should be detained against their will to an inpatient psychiatric unit DMHPs focus their evaluations on the following questions:

1. Is the person suffering from an acute mental disorder? RCW 71.05 defines mental disorder as "any organic, mental or emotional disorder which has substantial adverse effects on an individual's cognitive and volitional functions."
2. Is there evidence that the person, as the result of mental disorder:

    a. Presents a likelihood of serious harm to him or herself, other persons, or the property of others; or
    b. May be gravely disabled?

3. Does imminent danger exist?

a. A DMHP should take a person into emergency custody only when the person presents an **imminent** likelihood of serious harm or is in imminent danger because they are gravely disabled.
b. Before filing the petition, the DMHP must personally interview the person, unless the person refuses an interview, and determine whether the person will voluntarily receive appropriate evaluation and treatment at an evaluation and treatment facility.

4. Does the person present, as a result of a mental disorder, likelihood of serious harm, or grave disability, but without imminent danger?

    a. If the person does meet criteria for detention, but no imminent danger exists, then the DMHP may initiate a non-emergent detention by petitioning the superior court for an order to detain. There are variances between counties on this. **Note:** Imminent danger is not required for the emergency detention of minors.

5. What appropriate alternatives to involuntary hospitalization exist? Will the person voluntarily accept appropriate, available, less restrictive treatment options?

In evaluating a person for involuntary treatment, DMHPs investigate not only the immediate circumstances around the request for the evaluation, but also must consider reasonably available history. This includes reviewing reasonably available records and/or databases in order to obtain the person's background and history prior to interviewing the person to be investigated. If family members are available and deemed credible, the DMHP will interview them to obtain further information and may request a written statement. The DMHP reviews, if available, at a minimum, a person's history of violent acts, suicide attempts and prior detentions/commitments.

This information should always be considered in light of the intent to provide prompt evaluation, as well as, timely and appropriate treatment.

WHAT HAPPENS AFTER AN INVOLUNTARY ADMISSION TAKES PLACE?

When a person is detained, he or she is entitled to a court hearing within 72 hours of the initial detention. This is called a probable cause hearing. Weekends and holidays are excluded in the calculation of the initial 72 hours. The treating psychiatrist/physician or psychiatric Advanced Registered Nurse Practitioner (ARNP) may discharge any patient at any time during a commitment if, in their opinion, the criteria for involuntary treatment are no longer being met. The focus of the probable cause hearing is to determine if the person continues to require involuntary treatment. In the hearing, it will be determined whether the initial commitment was appropriate and, if so, does the person still present a danger to themselves, others or property or is gravely disabled as the result of an acute mental disorder. Family member/natural support input is generally encouraged in preparation for these hearings. The judge has the option of continuing the detention, discharging the individual back home on a voluntary basis (dismissal of petition), or releasing the person on a Less Restrictive Order (LRO or LR). An LR contains a number of requirements. These are called the "conditions" of the LR. Examples include taking medications as prescribed, attending scheduled appointments, not using non-prescribed drugs or alcohol, refraining from threats or acts of harm toward themselves or others, and not having access to weapons.

COURT ORDERS (LESS RESTRICTIVE ORDER AND CONDITIONAL RELEASE)

When a person is released on an LR, they receive a written notice containing the conditions of their release. Caregivers, including those providing residential supports and the mental health system, are expected to support the individual in meeting these conditions. This includes getting the person to appointments, and working closely together as service providers to address problems in a proactive manner. Family members/natural supports can also help the individual adhere to the conditions especially if the individual resides with them.

There is another type of court order called a Conditional Release (CR). When an individual is committed to the hospital for 14 days or 90 days (this is called the More Restrictive Order (MRO)) the treating physician can decide to discharge the person on a CR. He/she must have an accepting outpatient provider to follow up on the CR. The physician writes a document outlining the conditions the person agrees to follow. This document is given to the receiving outpatient provider, the individual on the CR and is filed with the court without a hearing taking place.

Sometimes, however, people either do not follow through on the conditions of their LR/CR or experience substantial deterioration in their functioning even when following the conditions. Under these circumstances, a DMHP may file a petition for revocation which places the individual back in the hospital for up to five days (including holidays & weekends) pending a revocation hearing. This hearing is held in order to determine whether the individual needs to be returned to inpatient status ("revoked") for up to the number of days left on the order. Whenever possible, the person will be stabilized and discharged back to where they were living, often on the same LR/CR. The facility may choose to discharge the person on the existing LR/CR without requesting a court hearing.

When a DMHP receives notice that an individual has violated the conditions of their LR/CR and/or is experiencing substantial deterioration that requires inpatient treatment it is at their discretion to file a petition for revocation. However, if a DMHP is notified by the treatment provider that an individual has violated the conditions and, as a result, poses an increased likelihood of serious harm, the DMHP is **required** to file a petition for revocation. The treatment provider is then **required** to submit an affidavit detailing the reason(s) for the revocation and be prepared to provide the main court testimony (Ssee "How to Write an Affidavit" on the NSMHA website at http://nsmha.org/Committee/RTC/ICRS/Writing_an_Affidavit.pdf). **Note:** this does **not** guarantee a revocation hearing **and** the person could still be discharged by the treating psychiatrist/physician/ psychiatric ARNP.

When serving a person on a LR/CR, it is required that the agency keep a copy of the court document listing the conditions in the clinical record. It is important to provide this document to the DMHP if requested. It is also necessary that the person communicating with the DMHP has specific knowledge about how the person on the LR/CR has violated the order (See Policy 1562.00), problems they have experienced that are causing the concerns, and what steps have been taken or considered to help support the person in a less restrictive way/setting.

Clinicians are expected to document each violation in the individual's chart. Please see "How to Document CR/LR Violations" on the NSMHA website at (http://nsmha.org/Committee/RTC/ICRS/Crisis_Response_Module.pdf

~~and documented.be smedical that can better address the symptomology?~~
~~What can the outpatient provide do to the individual to better engage with medical provider and servicesIdentify and problem solveswith the individual regarding their s.yconditions violated on.current to self, others and/or propertyand potential impact~~
~~This l~~information from family members/natural supports is crucial in determining whether the filing of a petition for revocation is appropriate and necessary. Family members/natural supports are often the first persons to identify the individual's non-adherence or deterioration and can share this information with the clinician without compromising confidentiality requirements. If the individual has not authorized the release of information, the clinician may simply listen to the family's concerns without revealing protected information. **Note:** A LR/CR is not intended to be used in a punitive manner, but to help the in individual maintain their health and safety in the community.

GLOSSARY OF TERMS

Crisis – crisis (a turning point in the course of anything decisive or critical; a time, a stage or an event of great danger or trouble, whose outcome decides whether possible bad consequences will follow).
~~A situation where an individual is acutely mentally ill or experiencing a serious disruption in cognitive, volitional, psychosocial, or neuro-physiological functioning.~~

Conditional Release (CR) is a court order that is filed by the treating physician during the involuntary inpatient commitment. This order specifies what the person needs to do to remain in the community. It differs from an LR in length and because there is no court hearing.

Designated Mental Health Professional (DMHP) is a mental health clinician appointed by the County to perform the duties specified in chapters RCW 71.05 and 71.34. This includes having the legal authority to detain a person against their will for up to 72 hours.

Evaluation and Treatment Center (**E&T)** – The North Sound Region operates one (1) facility via contract with Compass Health, in Mukilteo (Mukilteo E&T). This program provides involuntary evaluation and treatment to those detained by the DMHP staff. Other inpatient psychiatric facilities are licensed as Evaluation and Treatment Centers, but most often the term "E&T" refers to the regional facility.

Integrated Crisis Response System (ICRS) – This is the service system that provides crisis response interventions throughout Island, San Juan, Skagit, Snohomish and Whatcom Counties. Service providers include VOA, Compass Health, Snohomish County Human Services and Whatcom Counseling and Psychiatric Clinic and Pioneer Human Services.

Mental Illness Involuntary Treatment Act (ITA) – RCW 71.05 and Mental Health Services for Minors – RCW 71.34. These are the laws that allow persons who are a danger to themselves, others, property or who are gravely disabled as the result of a mental disorder to be detained against their will for inpatient psychiatric treatment.

Less Restrictive Order/Less Restrictive Alternative (LRO/LRA) – A court order that is put in place, by court hearing or stipulation, for some individuals after they have been involuntarily detained. This order specifies what the person needs to do to remain in the community after discharge from an inpatient unit.

CCRS Triage Clinician: The mental health professional at the Crisis Line, who coordinates services, dispatches the DMHP, Mobile Outreach Team (MOT), Emergency Mental Health Clinicians (EMHCs) and provides telephone-based support 24 hours a day.

Volunteers of America (VOA) Care Crisis Response Services (CCRS) – Provides telephone-based support and triage through the Crisis Line. The CCRS Triage Clinician can also schedule Urgent Appointments and dispatch local crisis response teams when face-to-face interventions are required.

Integrated Crisis Response NSMHA Training Module

Post-Test

Please circle the appropriate response to indicate whether the following statements are true or false:

1. T/F Individuals and the general public should be instructed to call the VOA CCRS Triage Clinician if they feel that they are in crisis.

2. T/F Crisis alerts expire after 10 days if they are not renewed.

3. T/F Crisis services appointments are only for individuals who are currently enrolled in services.

4. T/F When requesting admission for voluntary hospitalization, one should be prepared to discuss what less restrictive options have been considered.

5. T/F When DMHPs are doing an assessment for initial detention they are required to consider reasonably available history.

6. T/F When someone is on a LR or CR, it is not important to keep a copy of the order.

7. T/F Any person who is in crisis and who is physically located within the North Sound region is eligible for crisis response services.

8. T/F Once a person is detained, a court hearing must be held within 48 hours to determine if he/she continues to meet commitment criteria.

Please fill in the appropriate response for each of the following statements:

1. Once dispatched, crisis response staff must make face-to-face contact within _____ hours.

2. What type of service should be considered when an individual is unwilling to accept voluntary services and presents a likelihood of serious harm to him/herself as the result of a mental disorder but is not in imminent danger?
   _____

3. When a person is discharged from an evaluation and treatment center on a LR, the requirements/constraints on their behavior are referred to as the _____ of their release.

4. When someone is returned to an inpatient unit for not complying with an LR, the process is called a _____.

Discussion questions *(will be reviewed by your supervisor, but not scored)*:

1. How can crisis plans assist enrolled individuals who are in crisis?

2. Provide 3 situations in which using a crisis alert would be appropriate.

3. What is the clinician's role when voluntary hospitalization may be needed to support a person on his/her caseload?

~~**WRITING AN AFFIDAVIT**~~

~~See "How to Write an Affidavit" on the NSMHA website at: http://nsmha.org/Committee/RTC/ICRS/Writing_an_Affidavit.pdf~~

~~DOCUMENTING CR/LR VIOLATIONS~~
~~See "How to Document CR/LR Violations" on the NSMHA website at:~~

How to Document CR/LR Violations in the Individual's Chart

When and individual is released from the hospital on a Less Restrictive Order (LRO) the conditions of the order are documented (on the order), as well as on the individual's Recovery Plan LR/CR Addendum.
If an individual does not follow the conditions, they have violated the order.
Clinicians working with the individual will decide if the violation(s) results in a revocation, and determine if hospitalization is needed.

1. **When a clinician is considering a revocation of the CR/LR, the clinical decision rationale should include consideration of treatment interventions, listed below, and safety concerns, if any. There should be clear documentation of the clinical decision rationale.**
    A. Is there immediate medical intervention to address the individual's symptoms more effectively?
    B. What steps can the Outpatient Provider take to support the individual in engaging with Medical Providers and services?
    C. Identify the un-met needs of the individual. Use problem solving techniques to meet the needs.
    D. If the individual was not on an LR, what clinical steps could the Clinician take?
    E. Determine the individual's willingness to accept identified treatment and document the results.
2. **Documentation should also include specific conditions violated on the LR**
    A. Identify all missed appointment(s) the reason they occurred, and log all follow up attempts.
    B. What does the violation mean clinically? Document the response with consideration of the individual's potential need to return to the hospital.
    C. What is the current level of risk to self, others and/or property?
    D. What is the intensity and potential impact of the violation?

3. **The documentation of the clinical rationale should be reflected either in the progress note section or section of the chart that is designated for legal paperwork. This can be done with your agencies forms per your agencies policy. It should be readily available for review.**

NSMHA COMMITTEE DISCUSSION FORM

AGENDA ITEM: Policy 1561 Revocation of Less Restrictive Order/Conditional Release Orders

PRESENTER: Sandy Whitcutt or Greg Long

COMMITTEE ACTION: Action Item (x) FYI & Discussion (x) FYI only ()

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:

This policy standardizes the coordination process between Outpatient Service Providers and Designated Mental Health Professionals (DMHPs) initiating a petition for revocation of a Less Restrictive Court Order (LRO)or Conditional Release Order (CR). It explains the criteria of adults and children, and describes the procedures required when a request for revocation is made.
This policy was due for revision to update the new WAC source. The crisis response module was also revised and is contained in this packet. There are very slight changes to the policy. ICRS has reviewed and approved the revisions made.

CONCLUSIONS/RECOMMENDATIONS:
Approve policy with the revisions

TIMELINES:
This policy, if approved, will go into effect 60 days after it is posted on the NSMHA website.

ATTACHMENTS:
Policy 1561, clean version and Policy 1561 with revisions

Effective Date: 7/7/2008; 8/30/2007
Revised Date: 11/26/13
Review Date: 11/26/13

North Sound Mental Health Administration

Section 1500– Clinical: Revocation of Less Restrictive Order (LRO)/ Conditional Release (CR) Orders

Authorizing Source: RCW 71.05.340, RCW 71.34.780 WAC 388-877-0195
Cancels:
See Also: Approved by: Executive Director Date:
Providers are required to have a "policy consistent with" this policy
Responsible Staff: Quality Manager Signature:

POLICY #1561.00

SUBJECT: REVOCATION OF LESS RESTRICTIVE ORDER (LRO)/CONDITIONAL RELEASE (CR) ORDERS

PURPOSE

To standardize the coordination process between Outpatient Service Providers and Designated Mental Health Professionals (DMHPs) initiating a petition for revocation of a Less Restrictive Court Order (LRO)or Conditional Release Order (CR).

POLICY

Revised Code of Washington (RCW) 71.05.340 establishes criteria for possible revocation of an LRO/CR for an adult. RCW 71.34.780 provides guidance on revocation of an LRO/CR for a minor. Outpatient Providers shall notify the DMHP upon identification of any of the criteria indicated below:

1. **Criteria for adults:**
   a. **DMHP Determination ("may revoke") - RCW 71.05.340 (3)(a):** The DMHP *may* order the person be temporarily detained in an Inpatient Evaluation and Treatment Facility in or near the county in which he or she is receiving outpatient treatment if the Outpatient Provider or DMHP determines:

      i. The person fails to comply with the terms and conditions of his or her LRO/CR;
      ii. The person experiences substantial deterioration in his or her condition;
      iii. There is evidence of substantial decompensation with a reasonable probability the decompensation can be reversed by further inpatient treatment; ***or***
      iv. The person poses a likelihood of serious harm.

   b. **Outpatient Provider Determination ("shall revoke") - RCW 71.05.340(3)(b):** The Outpatient Provider shall notify the DMHP and the DMHP *shall* order the person be temporarily detained in an Inpatient Evaluation and Treatment Facility in or near the county in which he or she is receiving outpatient treatment when:

      i. The person fails to comply with the terms and conditions of his or her LRO/CR; ***and/or***
      ii. The person experiences substantial deterioration in his or her condition; ***and***
      iii. The person presents an increased likelihood of serious harm.
      In "shall revoke" cases the obligation to testify solely falls on the Outpatient Provider.

2. **Criteria for minors:**
   If the Professional Person in charge of an Outpatient Treatment Program or a DMHP determines a minor is failing to adhere to the conditions of the LRO/CR, or substantial deterioration in the minor's functioning has occurred, the Professional Person shall notify the DMHP. The DMHP may order the minor be taken into custody and transported to an Inpatient Evaluation and Treatment Facility.

PROCEDURE

1. In all cases, when the Outpatient Provider makes a specific request for Petition for Revocation of an LRO/CR, the request must include a written affidavit detailing specific facts in support of the revocation which should include:

   a. The date and time the Outpatient Provider last personally evaluated the person; ***and***
   b. The specific conditions of the LRO/CR which have been violated; ***and***
   c. Specific behaviors demonstrating substantial deterioration; ***and***
   d. Specific behaviors indicating an increased likelihood of serious harm; ***and***
   e. Interventions attempted by the Outpatient Provider to maintain the individual in the community; ***and***
   f. By what means the individual would benefit from inpatient treatment.

   See the North Sound Mental Health Administration's Integrated Crisis Response System Training Module (http://nsmha.org/Committee/RTC/ICRS/Crisis_Response_Module.pdf) for additional information on writing an affidavit.

2. Should a Revocation Hearing be scheduled, the Outpatient Provider is expected to testify.
3. If the individual's LRO/CR is revoked and the individual returns to an inpatient unit, a Treating Psychiatrist or Psychiatric ARNP can discharge the individual from the inpatient facility at any time without a hearing.

ATTACHMENTS

None

Effective Date: 7/7/2008; 8/30/2007
Revised Date: 11/26/13
Review Date: 11/26/13

North Sound Mental Health Administration

Section 1500– Clinical: Revocation of Less Restrictive Order (LRO)/ Conditional Release (CR) Orders

Authorizing Source: RCW 71.05.340, RCW 71.34.780 WAC 388-877-0195
Cancels:
See Also: Approved by: Executive Director Date:
Providers are required to have a "policy consistent with" this policy
Responsible Staff: Quality Manager Signature:

POLICY #1561.00

SUBJECT: REVOCATION OF LESS RESTRICTIVE ORDER (LRO)/CONDITIONAL RELEASE (CR) ORDERS

PURPOSE

To standardize the coordination process ~~by outpatient service providers, who coordinate with~~between Outpatient Service Providers and Designated Mental Health Professionals (DMHPs~~), to initiate~~) initiating a petition for revocation of a ~~less restrictive court order~~Less Restrictive Court Order (LRO)or ~~conditional release~~Conditional Release Order (CR).~~order~~

POLICY

Revised Code of Washington (RCW) 71.05.340 establishes criteria for possible revocation of an LRO/CR for an adult ~~and.~~ RCW 71.34.780 provides guidance on revocation of an LRO/CR for a minor. Outpatient ~~providers~~Providers shall notify the DMHP ~~when~~ upon identification of any of the criteria indicated below ~~are identified.~~:

1. **Criteria for adults:**
   a. **DMHP Determination ("may revoke") - RCW 71.05.340 (3)(a):** The DMHP *may* order ~~that~~ the person be temporarily detained in an ~~inpatient evaluation~~Inpatient Evaluation and ~~treatment facility~~Treatment Facility in or near the county in which he or she is receiving outpatient treatment if the ~~outpatient provider~~Outpatient Provider or DMHP determines:

      i. The person fails to comply with the terms and conditions of his or her LRO/CR;
      ii. The person experiences substantial deterioration in his or her condition;
      iii. There is evidence of substantial decompensation with a reasonable probability ~~that~~ the decompensation can be reversed by further inpatient treatment; ***or***
      iv. The person poses a likelihood of serious harm.

   b. **Outpatient Provider Determination ("shall revoke") - RCW 71.05.340(3)(b):** The ~~outpatient provider~~Outpatient Provider shall notify the DMHP and the DMHP *shall* order the person be temporarily detained in an ~~inpatient evaluation~~Inpatient Evaluation and ~~treatment facility~~Treatment Facility in or near the county in which he or she is receiving outpatient treatment when:

      i. The person fails to comply with the terms and conditions of his or her LRO/CR; ***and/or***
      ii. The person experiences substantial deterioration in his or her condition; ***and~~,~~***
      iii. The person presents an increased likelihood of serious harm.

In "shall revoke" cases~~,~~ the obligation to testify solely falls on the ~~outpatient provider~~Outpatient Provider.

2. **Criteria for minors:**
   If the ~~professional person~~Professional Person in charge of an ~~outpatient treatment program~~Outpatient Treatment Program or a DMHP determines ~~that~~ a minor is failing to adhere to the conditions of the LRO/CR, or ~~that~~ substantial deterioration in the minor's functioning has occurred, the ~~professional person~~Professional Person shall notify the DMHP. The ~~DMHP may~~DMHP may order ~~that~~ the minor be taken into custody and transported to an ~~inpatient evaluation~~Inpatient Evaluation and ~~treatment facility~~Treatment Facility.

PROCEDURE

1. In all cases, when the ~~outpatient provider~~Outpatient Provider makes a specific request for ~~petition~~Petition for ~~revocation~~Revocation of an LRO/CR, the request must include a written affidavit~~, which details~~ detailing specific facts in support of the revocation ~~and~~which should include:

   a. The date and time the ~~outpatient provider~~Outpatient Provider last personally evaluated the person; ***and***
   b. The specific conditions of the LRO/CR ~~that~~which have been violated; ***and***
   c. Specific behaviors ~~that demonstrate~~demonstrating substantial deterioration; ***and***
   d. Specific behaviors ~~that indicate~~indicating an increased likelihood of serious harm; ***and***
   e. Interventions attempted by the ~~outpatient provider~~Outpatient Provider to maintain the individual in the community; ***and***
   f. ~~How~~By what means the individual would benefit from inpatient treatment.

   See the North Sound Mental Health Administration's Integrated Crisis Response System Training Module (http://nsmha.org/Committee/RTC/ICRS/Crisis_Response_Module.pdf) for additional information on writing an affidavit.

2. Should a ~~revocation hearing~~Revocation Hearing be scheduled, the ~~outpatient provider~~Outpatient Provider is expected to testify.
3. If the individual's LRO/CR is revoked and the individual returns to an inpatient unit, a ~~treating psychiatrist or psychiatric~~Treating Psychiatrist or Psychiatric ARNP can discharge the individual from the inpatient facility at any time without a hearing.

ATTACHMENTS

None

NSMHA COMMITTEE DISCUSSION FORM

AGENDA ITEM: Policy 1562: Monitoring of Conditional Release (CR)/Less Restrictive Order (LRO)

PRESENTER: Sandy Whitcutt or Greg Long

COMMITTEE ACTION: Action Item (x) FYI & Discussion (x) FYI only ()

SIGNIFICANT POINTS OR EXECUTIVE SUMMARY:
The purpose of this policy is to ensure a consistent and meaningful process for individuals on CR or LRO court orders.
When an individual is placed on a less restrictive order, inpatient psychiatric facilities are required to provide notice of discharge and copies of CRs/LROs to the Designated Mental Health Professional (DMHP) office responsible for the detention and the DMHP office in the county where the individual is expected to reside
Inpatient psychiatric facilities are also expected to contact CMHAs to request the CMHA assume responsibility of the CR/LRO, at a minimum, prior to the individual's discharge
In order to ensure integrated, well-coordinated and medically necessary services are delivered to individuals on a CR/LRO, CMHAs will need to work closely with DMHPs and other allied professionals in the community.
This policy details procedures needed to ensure the consistent coordination between inpatient programs, DMHP offices, and outpatient programs.

This policy was due for revision to update to the new WAC source. The crisis response module was also revised and is contained in this packet. There are very slight changes to the policy. ICRS has reviewed and approved the revisions made.

CONCLUSIONS/RECOMMENDATIONS:
TIMELINES:
This policy, if approved, will go into effect 60 days after it is posted on the NSMHA website.

ATTACHMENTS:
Policy 1562, clean version and Policy 1562 with revisions

Effective Date: 9/30/2011; 11/16/2009; 3/5/2009; 8/30/2007
Revised Date: 6/27/2013
Review Date: 6/27/2013

North Sound Mental Health Administration

Section 1500– Clinical: Monitoring of Conditional Release (CR)/Less Restrictive (LR) Orders

Authorizing Source: WAC 388-865-0245 2(a)(b); WAC 388-877A-0195; RCW 71.05.340; RCW 71.05.320; RCW 71.05.700-715; Crisis Training Module
Cancels:
See Also:
Providers must "comply with" this policy | Approved by: Executive Director | Date:
Responsible Staff: Deputy Director | Signature:

POLICY#1562.00

SUBJECT: MONITORING OF CONDITIONAL RELEASE (CR)/LESS RESTRICTIVE ORDER (LRO)

PURPOSE

The purpose of this policy is to ensure a consistent and meaningful process for individuals on CR or LRO court orders.

POLICY

For individuals involuntarily committed under Revised Code of Washington (RCW) 71.05 or RCW 71.34, inpatient psychiatric facilities are required to provide notice of discharge and copies of CRs/LROs to the Designated Mental Health Professional (DMHP) office responsible for the detention and the DMHP office in the county where the individual is expected to reside. This notification is required to occur as soon as possible and no later than one business day after the individual's discharge from the inpatient psychiatric facility. The DMHP office located in the county where the individual is expected to reside will contact the responsible Community Mental Health Agency (CMHA) as soon as they are made aware of the CR/LRO on the individual.

Inpatient psychiatric facilities are also expected to contact CMHAs to request the CMHA assume responsibility of the CR/LRO, at a minimum, prior to the individual's discharge. However, once a CMHA becomes aware of an individual's CR/LRO, lack of notification by the inpatient facility to the CMHA prior to the individual's discharge does not eliminate responsibility to follow up with the individual on the CR/LRO (see Procedure section).

In order to ensure the provision of services to individuals on a CR/LRO, CMHAs must be certified by DBHR for outpatient psychiatric and medical components of community support services and involuntary treatment services consistent with Washington Administrative Codes (WAC) 388-877A-0195.4.

In order to ensure integrated, well-coordinated and medically necessary services are delivered to individuals on a CR/LRO, CMHAs will need to work closely with DMHPs and other allied professionals in the community.

Legal status does not preclude the individual's financial responsibility for outpatient services. State funds payment by NSMHA for individuals receiving State plan services shall be considered payment in full as long as they meet State funding qualifications and do not have third party resources.

PROCEDURE

1. The inpatient psychiatric facility is expected to contact the CMHA to request the CMHA assume responsibility of the CR/LRO. This contact may be an oral or written request and is expected to occur prior to the individual's discharge from the inpatient facility.
2. Although a CMHA may decline to assume responsibility of the CR/LRO if there is clinical rationale to do so, this should be a rare occurrence. Any CMHA declining the request from an inpatient facility will need to notify NSMHA prior to notifying the inpatient facility of the decision. The CMHA declining the request will need to offer alternative service options to the inpatient psychiatric facility.
3. If the CMHA has agreed to serve the individual, the inpatient facility must contact Volunteers of America (VOA) Access Line to complete a request for service. Availability of Open Access/same day appointment does not eliminate the need for the discharging hospital to call the VOA Access Line.
4. CMHAs shall ensure periodic evaluation of each committed individual for release from or continuation of an involuntary treatment order by documenting the individual's adherence to the conditions of the CR/LRO in accordance with current WACs.
5. CMHAs shall document each violation of the conditions of the CR/LRO in the chart. This shall include an evaluation of the need to pursue revocation. See the North Sound Mental Health Administration's Integrated Crisis Response System Training Module (http://nsmha.org/Committee/RTC/ICRS/Crisis_Response_Module.pdf) for additional information on revocation.
6. For an individual placed on a CR/LRO who is not currently in an open outpatient treatment episode with a North Sound Mental Health Administration (NSMHA) CMHA:

    a. The CMHA is responsible for providing follow up services with the individual when a request for service at that CMHA has been made (refer to NSMHA Policy #1502.00 – Accessibility, Engagement and Utilization of Services for High Need Individuals Not Engaging in Treatment).

        i. The CMHA clinician will coordinate appropriate follow up needs with his/her supervisor.
        ii. The CMHA clinician will report to the DMHP office if the individual does not attend the assessment appointment.
        iii. The CMHA and DMHP offices may need to coordinate on further follow up needs as appropriate. This could include outreach, crisis alerts, affidavits, etc.
        iv. All CMHA clinicians will document their attempts to contact and engage the individual.
        v. Any and all DMHP involvement will be documented.

    b. The DMHP office is responsible for notifying the CMHA when the office is made aware of an individual being placed on a court order for a specific CMHA.
    c. When no assignment to a CMHA has been made on the court order, the DMHP office will retain the order pending further action.

        i. The DMHP office will notify a NSMHA Care Coordinator when an unassigned or inappropriately assigned order is received and/or the DMHP office is contacted by an individual on an unassigned or inappropriately assigned order. The NSMHA Care Coordinator will contact a regional CMHA to seek an assignment of the court

order, and then coordinate with the designated DMHP office to facilitate appropriate assignment by the court and referral of the individual to that CMHA. The CMHA is then responsible for follow up with the individual and monitoring of the order.

1. If the DMHP office is contacted by the individual on an unassigned or inappropriately assigned court order, the DMHP office will advise the individual of his or her rights and responsibilities while on a CR/LRO. The DMHP shall ask the individual which CMHA he/she prefers in order to facilitate appropriate assignment and also provide the individual with the VOA Access Line number to be referred to a regional CMHA.

ii. If the individual refuses to comply with the conditions of the CR/LRO, the DMHP may revoke the court order and send the individual back to the hospital (based on clinical and safety needs).

7. For an individual on a CR/LRO who is currently in an open outpatient treatment episode with a NSMHA CMHA:

    a. The CMHA/shall monitor the CR/LRO as ordered by the court.

8. In order to monitor individuals on CRs/LROs, CMHA clinicians shall prioritize the following:

    a. The CR/LRO is a tool to assist the individual in their recovery and to maintain stability and safety in the community.
    b. An individual's participation in treatment, per the CR/LRO.
    c. Providing DMHPs with information needed to support petitions for further court-ordered less restrictive treatment.

9. CMHAs shall notify the DMHP if non-adherence with the CR/LRO impairs the individual sufficiently to warrant evaluation for revocation of the CR/LRO.
10. DMHPs shall maintain a system which tracks CRs/LROs as well as ensuring CMHAs are informed of the process for extending a CR/LRO.
11. Petitioning to extend the CR/LRO shall occur whenever the individual continues to meet the criteria for further commitment and when further less restrictive treatment will support the individual's recovery. Clinicians are encouraged to consider information from all natural supports and other treatment providers. In this circumstance, the CMHA clinician shall request an extension from their local DMHP office three to four weeks prior to the expiration of the CR/LRO.
    a. CMHA clinicians shall be fully educated and aware of the ability to continue or extend a CR/LRO, even when the individual's circumstances do not warrant hospitalization or meet acute care criteria. The individual's past history of decompensation without continued involuntary outpatient treatment is important to consider when determining if the criteria for grave disability can be met.
12. A CMHA assigned to monitor an enrolled individual on a CR/LRO may not discharge the individual from mental health services while they are on the CR/LRO. CMHAs involved in the care of an individual on a CR/LRO, but who are not the CMHA assigned to monitor the order, will need to coordinate care with the assigned CMHA (see NSMHA Policy #1540.00 - Discharge from Treatment for information related to discharge).

ATTACHMENTS: none

Effective Date: 9/30/2011; 11/16/2009; 3/5/2009; 8/30/2007
Revised Date: 6/27/2013
Review Date: 6/27/2013

North Sound Mental Health Administration

Section 1500– Clinical: Monitoring of Conditional Release (CR)/Less Restrictive (LR) Orders

Authorizing Source: WAC 388-865-0245 2(a)(b); WAC 388-877A-0195; RCW 71.05.340; RCW 71.05.320; RCW 71.05.700-715; Crisis Training Module
Cancels:
See Also:
Providers must "comply with" this policy
Responsible Staff: Deputy Director
Approved by: Executive Director
Signature:
Date:

POLICY#1562.00

SUBJECT: MONITORING OF CONDITIONAL RELEASE (CR)/LESS RESTRICTIVE ORDER (LRO)

PURPOSE

The purpose of this policy is to ensure a consistent and meaningful process for individuals on CR or LRO court orders.

POLICY

For individuals involuntarily committed under Revised Code of Washington (RCW) ~~)~~ 71.05 or RCW 71.34, inpatient psychiatric facilities are required to provide notice of discharge and copies of CRs/LROs to the Designated Mental Health Professional (DMHP) ~~)~~ office responsible for the detention and the DMHP office in the county where the individual is expected to reside. This notification is required to occur as soon as possible and no later than one business day after the individual's discharge from the inpatient psychiatric facility. The DMHP office located in the county where the individual is expected to reside will contact the responsible Community Mental Health Agency (CMHA) as soon as they are made aware of the CR/LRO on the individual.

Inpatient psychiatric facilities are also expected to contact CMHAs to request the CMHA assume responsibility of the CR/LRO, at a minimum, prior to the individual's discharge. However, once a CMHA becomes aware of an individual's ~~/~~CR/LRO, lack of notification by the inpatient facility to the CMHA prior to the individual's discharge does not eliminate responsibility to follow up with the individual on the CR/LRO (see Procedure section).

In order to ensure the provision of services to individuals on a CR/LRO, CMHAs must be ~~-~~certified by DBHR for outpatient psychiatric and medical components of community support services ~~and involuntary~~and involuntary treatment services consistent with Washington Administrative Codes (WAC) ~~)~~ 388-877A-0195.4.

In order to ensure integrated, well-coordinated and medically necessary services are delivered to individuals on a CR/LRO, CMHA will need to work closely with DMHPs and other allied professionals in the community.

Legal status does not preclude the individual's financial responsibility for outpatient services. State funds payment by NSMHA for individuals receiving State plan services shall be considered payment in full as long as they meet State funding qualifications and do not have third party resources.

PROCEDURE

1. The inpatient psychiatric facility is expected to contact the CMHA to request the CMHA assume responsibility of the CR/LRO. This contact may be an oral or written request and is expected to occur prior to the individual's discharge from the inpatient facility.
2. Although a CMHA may decline to assume responsibility of the CR/LRO if there is clinical rationale to do so, this should be a rare occurrence. Any CMHA declining the request from an inpatient facility will need to notify NSMHA prior to notifying the inpatient facility of the decision. The CMHA declining the request will need to offer alternative service options to the inpatient psychiatric facility.
3. If the CMHA has agreed to serve the individual, the inpatient facility must contact Volunteers of America (VOA) Access Line to complete a request for service. Availability of Open Access/same day appointment does not eliminate the need for the discharging hospital to call the VOA Access Line.
4. CMHAs shall ensure periodic evaluation of each committed individual for release from or continuation of an involuntary treatment order by documenting the individual's adherence to the conditions of the CR/LRO in accordance with current WACs.
5. CMHAs shall document each violation of the conditions of the CR/LRO in the chart. This shall include an evaluation of the need to pursue revocation. See the North Sound Mental Health Administration's Integrated Crisis Response System Training Module (http://nsmha.org/Committee/RTC/ICRS/Crisis_Response_Module.pdf) for additional information on revocation.
6. For an individual placed on a CR/LRO who is not currently in an open outpatient treatment episode with a North Sound Mental Health Administration (NSMHA) CMHA:

    a. The CMHA is responsible for providing follow up services with the individual when a request for service at that CMHA has been made (refer to NSMHA Policy #1502.00 – Accessibility, Engagement and Utilization of Services for High Need Individuals Not Engaging in Treatment).

        i. The CMHA clinician will coordinate appropriate follow up needs with his/her supervisor.
        ii. The CMHA clinician will report to the DMHP office if the individual does not attend the assessment appointment.
        iii. The CMHA and DMHP offices may need to coordinate on further follow up needs as appropriate. This could include outreach, crisis alerts, affidavits, etc.
        iv. All CMHA clinicians will document their attempts to contact and engage the individual.
        v. Any and all DMHP involvement will be documented.

    b. The DMHP office is responsible for notifying the CMHA when the office is made aware of an individual being placed on a court order for a specific CMHA.
    c. When no assignment to a CMHA has been made on the court order, the DMHP office will retain the order pending further action.

        i. The DMHP office will notify a NSMHA Care Coordinator when an unassigned or inappropriately assigned order is received and/or the DMHP office is contacted by an individual on an unassigned or inappropriately assigned order. The NSMHA Care Coordinator will contact a regional CMHA to seek an assignment of the ~~court order~~court order, ~~then~~and then coordinate with the designated DMHP office to

facilitate appropriate assignment by the court and referral of the individual to that CMHA. The CMHA is then responsible for follow up with the individual and monitoring of the order.

1. If the DMHP office is contacted by the individual on an unassigned or inappropriately assigned court order, the DMHP office will advise the individual of his or her rights and responsibilities while on a CR/LRO. The DMHP shall ask the individual which CMHA he/she prefers in order to facilitate appropriate assignment and also provide the individual with the VOA Access Line number to be referred to a regional CMHA.

ii. If the individual refuses to comply with the conditions of the CR/LRO, the DMHP may revoke the court order and send the individual back to the hospital (based on clinical and safety needs).

7. For an individual on a CR/LRO who is currently in an open outpatient treatment episode with a NSMHA CMHA:

   a. The CMHA/shall monitor the CR/LRO as ordered by the court.

8. In order to monitor individuals on CRs/LROs, CMHA clinicians shall prioritize the following:

   a. The CR/LRO is a tool to assist the individual in their recovery and to maintain stability and safety in the community.
   b. An individual's participation in treatment, per the CR/LRO.
   c. Providing DMHPs with information needed to support petitions for further court-ordered less restrictive treatment.

9. CMHAs shall notify the DMHP if non-adherence with the CR/LRO impairs the individual sufficiently to warrant evaluation for revocation of the CR/LRO.
10. DMHPs shall maintain a system which tracks CRs/LROs as well as ensuring CMHAs are informed of the process for extending a CR/LRO.
11. Petitioning to extend the CR/LRO shall occur whenever the individual continues to meet the criteria for further commitment and when further less restrictive treatment will support the individual's recovery. Clinicians are encouraged to consider information from all natural supports and other treatment providers. In this circumstance, the CMHA clinician shall request an extension from their local DMHP office three to four weeks prior to the expiration of the CR/LRO.
    a. CMHA clinicians shall be fully educated and aware of the ability to continue or extend a CR/LRO, even when the individual's circumstances do not warrant hospitalization or meet acute care criteria. The individual's past history of decompensation without continued involuntary outpatient treatment is important to consider when determining if the criteria for grave disability can be met.
12. A CMHA assigned to monitor an enrolled individual on a CR/LRO may not discharge the individual from mental health services while they are on the CR/LRO. CMHAs involved in the care of an individual on a CR/LRO, but who are not the CMHA assigned to monitor the order, will need to coordinate care with the assigned CMHA (see NSMHA Policy #1540.00 - Discharge from Treatment for information related to discharge).

ATTACHMENTS

~~None~~