North Sound
Behavioral Health Organization, LLC

301 Valley Mall Way, Suite 110, Mount Vernon, WA 98273
http://northsoundbho.org 360.416.7013 800.684.3555 Fax 360.416.7017

INTEGRATED CRISIS RESPONSE SYSTEM (ICRS) *TRAINING MODULE*

Table of Contents

TRAINING OBJECTIVES:

1. Orient Providers to the Intergrated Crisis Response System (ICRS) process, resources and requirements.
2. Educate providers regarding behavioral health and Substance Use Disorder (SUD) crisis intergration.
3. Educate Providers regarding voluntary and involuntary hospitalization process.
4. Educate Providers regarding involuntary treatment laws.
5. 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 5 counties, regardless of enrollment status with service providers, ability to pay, or funding source. Crisis Services are available on a 24 hour basis for those who are in a self-defined state of crisis. A crisis is often some 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 that are intended to stabilize the individual in crisis in the least restrictive community setting possible. A network of North Sound BHO regional providers offer crisis services to include Voluntary and Involuntary mental health outreach teams and short-term behavioral health stabilization programs.

Crisis staff involved in crisis response intervention will be able to refer to a complete continuum of care including outpatient programs, to include intensive services,Triage facilities, substance abuse detoxification programs, and inpatient care. An individual in crisis is served from a non-stigmatizing, person-oriented approach, including responsive listening and respectful attention. Trained Crisis Services staff actively involve and collaborate with family members and other natural supports during a crisis as appropriate and within limits of confidentiality.

Below is a brief overview of our current providers and programs offering Crisis Response services in the North Sound BHO Region.

REGIONAL CRISIS SYSTEM PROVIDERS

County	Voluntary Crisis Services	Involuntary Investigations	Stabilization/Triage Centers*	CPIT
Island	Compass Health	Compass Health	Transportation Required	Not available in Island County
San Juan	Compass Health	Compass Health	Transportation Required	Not available in San Juan County
Skagit	Compass Health	Compass Health	Pioneer Human Services	Compass Health
Snohomish	Compass Health	Snohomish County Human Services	Compass Health	Compass Health
Whatcom	Compass Health	Compass Health	Whatcom Triage (Compass/Pioneer Human Services)	Compass Health

ICRS CORE PRINCIPLES

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.

The integrated crisis system will utilize a flexible array of services and supports, formal and informal, which fit the needs of the individual.

TOOLS TO MANAGE A CRISIS

Crisis Plans

The crisis plan is a document that the outpatient provider develops in collaboration with the North Sound BHO (enrolled individuals 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 provider and individual anticipate potential problems that might increase the chance of a crisis developing. The provider and individual identifies his/her specific triggers, "red flags", or early warning signs, to alert him/her that a crisis may be developing.

The purpose of the Crisis Plan is to outline coping strageties when the individual notices early warning signs. This 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. The original crisis plan should be provided to the individual and a copy provided to natural supports with the individual's permission. The Volunteers of America (VOA) Crisis Line also has the ability to view these to ensure that responding crisis staff can deliver interventions that are best suited for the individauls needs. Crisis Plans are now also being submitted for those enrolled in mental health services into the EDIE system, to give the ability for regional emergency departments to be able to see some details to improve collaboration when an individual is in crisis.

If the individual, a family member, or 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, VOA (Care Crisis Response Services [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 Alerts

Crisis alerts are created by behavioral health providers and contain information pertinent to the current crisis situation, in contrast to crisis plans, which contain long-term strategies. Crisis alerts contain important up-to-date information about individuals who are likely to require crisis services within the next 10 days. VOA CCRS receives, stores and utilizes this time-sensitive information and makes it available to Crisis Prevention and Intervention Teams (CPIT) 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 Revised Code of Washington (RCW) 71.32, in which a person makes a declaration of instructions or preferences and/or appoints an agent to make decisions on his/her 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, 7.70.40 and in North Sound BHO 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.

VOLUNTEERS OF AMERICA (VOA)

CARE CRISIS RESPONSE SERVICES (CCRS)

Crisis Line

CCRS provides 24-hours a day, 7 days a week, clinically staffed crisis line system. When someone in the community is in distress and is seeking assistance with a crisis situation, he/she should call the Crisis Line at 1-800-584-3578.

CCRS's range of support and referral services include:

1. Making mental health referrals to the community;
2. Having access to language bank interpreters and TDD equipment;
3. Ensuring referral to age and culturally appropriate services and specialists;
4. Scheduling crisis appointments;
5. Providing telephone stabilization and intervention services for individuals with non-acute issues;
6. Ensuring timely and consistent crisis response;
7. Providing telephone consultation, intervention and stabilization for individuals and/or family members/natural supports as appropriate and within limits of confidentiality;
8. Determining when face-to-face services are needed, both voluntary and involuntary and dispatching a DMHP or CPIT;
9. Tracking the outcome of face-to-face services and seeing if further services are warranted;
10. Deciding when cross-system services are needed;
11. Working closely with law enforcement when appropriate;
12. Consulting with detoxification providers, licensed care facilities, hospitals and other community providers;
13. Troubleshooting cross-system referrals in which there is a difference of opinion of appropriate services or system response; and
14. Providing telephone follow-up with individuals after hours as part of an individual crisis.

CCRS also offers a Triage line. When a professional wishes to speak with someone at the Crisis Line, they can contact the CCRS Triage Clinician (masters level clinicians) directly at 1-800-747-8654. The CCRS Triage Clinician has the responsibility of deciding when face-to-face evaluation and/or stabilization services are needed and dispatch the CPIT and/or DMHP staff to a community location outside of the provider's office.

CCRS also offers a regional Care Crisis chat program (www.ImHurting.org) which offers support resources for crisis intervention.

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 CPIT or DMHP and deemed at risk of hospitalization. Access to these psychiatric appointments is through the CPIT 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.

CPIT/DMHPs must respond to pages from the VOA within 10 minutes. Once dispatched, CPIT/DMHP will contact the requestor within 10 minutes with Estimated Time of Arrival (ETA). In general, their outreaches will occur within 2 hours or less in the community. Following the completion of any outreach, CPIT/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 CPIT 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.

Crisis Prevention And Intervention Teams (CPIT)

CPIT is a community service available in Snohomish, Skagit and Whatcom counties for individuals and families not currently enrolled in Medicaid outpatient services. These teams, comprised of Mental Health Professionals (MHP), Chemical Dependency Professionals (CDP) and peers, are intended to respond to a behavioral health crisis, defined as a situation 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 (for up to 14 days) 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 (5) 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 a mental disorder. They work closely with the voluntary crisis teams, as well as, outpatient providers or programs (i.e., Intensive Outpatient Program [IOP] & Program for Assertive Community Treatment [PACT]), hospitals, triage facilities and other allied systems.

Their specific role and investigation procedures are further detailed later in this module.

Regional Residential Crisis Services

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 behavioral health crisis. Additionally, the programs in Skagit and Whatcom Counties provide non-hospital based withdrawal management services 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.

Residential crisis/triage services are based on a strength-based Recovery model and utilize Substance Abuse and Mental Health Services Administration (SAMHSA) Principles of Recovery. Staffing can include CDPs, MHPs, Registered Nurses, 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.

The services offered at these facilities are voluntary. These programs provide a less restrictive option to hospitalization. These programs have few exclusionary critiera, but for the safety of others, are unable to accept individuals who are level three sex offenders, violent, assaultive, or have a history of fire setting.

Emergency Management Services (ambulances) have the ability to directly drop off individuals to these facilities, increasing diversion from the Emergency Departments when clinically appropriate.

The Referral Process for all of the Whatcom, Skagit and Snohomish Stabilization/Triage (to include Withdrawal management) programs are:

1. For Behavioral 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.
2. Once accepted, it is the responsibility of the referring Behavioral Health Clinician, Case Manager, or 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.

   Length-of-Stay/Discharge Planning:

   a. The length-of-stay is limited; up to five (5) days but extensions are available if clinically warranted.
   b. Staff plan for discharge at the point of admission and all attempts are made to coordinate care with outpatient providers and natural supports.

PSYCHIATRIC HOSPITALIZATION

Voluntary Hospitalization

Prior to voluntary hospitialization, the provider working with the individuals needs to evaluate whether a less restrictive option, such as, increased outpatient services, staying with family or natural supports, or 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 BHO Region. The program is available 24 hours per day, 7 days per week.

When a provider 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 provider will have to provide clinical and demographic information;
   b. Discuss and justify the reasons, including the acuity of 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, initial hospitalization will be authorized for up to five (5) days.
6. For those requests that are denied, the individual has the right to appeal or grieve and the admitting psychiatric facility has the right to appeal (see North Sound BHO policies 1001-1004 and 1020).
7. 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.

The discharge planning will begin at the time of initial placement at the facility.

Parent Initiated Treatment (PIT)

PIT is a type of hospitalization that is available to support parents when considering hosptization for their minor child (ages 13-18).

A parent may bring, or authorize the bringing of, his or her minor child to an evaluation and treatment facility or an inpatient facility and request the professional person examine the minor to determine whether the minor has a mental disorder and is in need of inpatient treatment. The consent of the minor is not required for admission, evaluation and treatment if the parent brings the minor to the facility.

A professional person then may evaluate whether the minor has a mental disorder.

1. The evaluation shall be completed within 24 hours of the time the minor was brought to the facility, unless the professional person determines the condition of the minor necessitates additional time for evaluation.
2. In no event shall a minor be held longer than 72 hours for evaluation. If, in the judgment of the professional person, it is determined it is a medical necessity for the minor to receive inpatient treatment, the minor may be held for treatment.
3. The facility shall limit treatment to that which the professional person determines is medically necessary to stabilize the minor's condition until the evaluation has been completed.
4. Within 24 hours of completion of the evaluation, the professional person shall notify the department if the child is held for treatment and of the date of admission.

The provider is not obligated to provide treatment to a minor under PIT. No provider may admit a minor to treatment under this section unless it is medically necessary.

No minor receiving inpatient treatment under this section may be discharged from the facility based solely on his or her request.

Involuntary Treatment Assessment (ITA)

Individuals 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 a 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 a 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 an individual should be detained involuntarily to an inpatient psychiatric unit, DMHPs focus their investigation on the following questions:

1. Is the individual suffering from a mental disorder? RCW 71.05 defines mental disorder as "any organic, mental, or emotional impairment which has substantial adverse effects on an individual's cognitive and volitional functions."
2. When a DMHP receives information alleging that an individual, as a result of a mental disorder:

    (i) Presents a likelihood of serious harm;
    (ii) Is gravely disabled; or
    (iii) Is in need of assisted outpatient mental health treatment;

3. The DMHP may, after investigation and evaluation of the specific facts alleged and of the reliability and credibility of any person providing information to initiate detention or involuntary outpatient evaluation, if satisfied that the allegations are true and that the person will not voluntarily seek appropriate treatment, file a petition for initial detention or involuntary outpatient evaluation.

Before filing the petition, the DMHP must personally interview the individual, unless the individual refuses an interview, and determine whether the individual will voluntarily receive appropriate evaluation and treatment at an evaluation and treatment facility, crisis stabilization unit, or triage facility.

In evaluating an individual 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 individual's background and history prior to interviewing the individual 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, an individual'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 an individual 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 individual continues to require involuntary treatment. In the hearing, it will be determined whether the initial commitment was appropriate and, if so, does the individual still present a danger to themselves, others or property, or is gravely disabled as the result of a mental disorder. Family member/natural support input is generally encouraged in preparation for these hearings.

The Court has the option of continuing the involuntary detention, discharging the individual back home on a voluntary basis (dismissal of petition), or releasing the individual on a Less Restrictive Order (LRO). An LRO contains a number of requirements. These are called the "conditions" of the LRO. 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, Conditional Release and Assisted Outpatient Treatment (LRO/CR/AOT)

For individuals involuntarily committed under RCW 71.05 or 71.34, Inpatient psychiatric facilities are required to provide notice of discharge and copies of the conditions of their release to the DMHP office responsible for the initial detention and the office where the individual resides.

When an individual is released on an LRO, they receive a written notice containing the conditions of their release from 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 individual 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.

A CR is 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 individual 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 individual 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.

Similar to a LRO/CR is AOT. Courts usually order a AOT for 90 days and have very similar processes for monitoring and ensuring continued treatment after discharge from inpatient psychiatric care. At this time, AOT is not currently used within the state.

When an individual is released from an inpatient unit on an LRO, there will need to be an assignment of a care coordinator; this individual will have the responsibility of monitoring the LRO/CR/AOT (see Policy 1562.00 – Monitoring of the LRO/CR/AOT).

Monitoring of Court Orders

Sometimes, however, individuals either do not follow through on the conditions of their LRO/CR/AOT or experience substantial deterioration in their functioning even when following the conditions. Under these circumstances, for LROs or CRs, a DMHP may file a petition for revocation which places the individual back in the hospital for up to five (5) days pending a revocation hearing. There are no revocation proceedures for AOT.

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 individual will be stabilized and discharged back to the community, often on the same LRO/CR. The facility may choose to discharge the individual on the existing LRO/CR without requesting a court hearing.

When a DMHP receives notice that an individual has violated the conditions of their LRO/CR and/or is experiencing substantial deterioration that requires inpatient treatment, it is at their discretion to file a petition for revocation. The treatment provider needs 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 North Sound BHO website at http://northsoundbho.org/Forms. **Note:** this does **not** guarantee a revocation hearing **and** the individual could still be discharged by the treating psychiatrist/physician/psychiatric ARNP.

When serving an individual on a LRO/CR/AOT, it is required that the agency that has assigned a care coordinator closely monitor the LRO/CR/AOT and 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 care coordinator communicating with the DMHP has specific knowledge about how the individual on the LRO/CR/AOT 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 individual in a less restrictive way/setting.

Care coordinatorss are expected to document each violation in the individual's chart. Please see "How to Document LRO/CR/AOT Violations" on the North Sound BHO website at http://northsoundbho.org/Forms.

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:** An LRO/CR/AOT is not intended to be used in a punitive manner but to help the individual maintain their health and safety in the community.

GLOSSARY OF TERMS

Assisted Outpatient Treatment (AOT) is an order for Less Restrictive Alternative (LRA) Treatment for up to 90 days from the date of judgement. An AOT shall not order inpatient treatment.

Behavioral health refers to mental/emotional well-being and/or actions that affect wellness. **Behavioral health** problems include Substance Use Disorders (SUD); alcohol and drug addiction; and serious psychological distress, suicide and mental disorders

Care Coordinator is a clinical practitioner who coordinates the activities of LRA treatment. The Care Coordinator coordinates activities with the DMHP necessary for enforcement and continuation of LRA orders and is responsible for coordinating service activities with other agencies and establishing and maintaining a therapeutic relationship with the individual on a continuing basis.

Crisis Prevention Intervention Team (CPIT) provides community outreach and engagement to individuals who are experiencing a behavioral health crisis or who are believed to be suffering from significant behavioral health symptoms which are interfering with activities of daily living

Crisis: A mental health crisis is defined as a turning point in the course of anything decisive or critical, a time, stage, or an event or time of great danger or trouble, whose outcome decides whether possible bad consequences will follow. Crisis services are intended to stabilize the individual in crisis, prevent further deterioration and provide immediate treatment and intervention in a location best suited to meet the needs of the individual and in the least restrictive environment available.

Conditional Release (CR) is a court order that is filed by the treating physician during the involuntary inpatient commitment. This order specifies what the individual needs to do to remain in the community. It differs from an LRO 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 RCW chapters 71.05 and 71.34. This includes having the legal authority to detain an individual against their will for up to 72 hours.

Evaluation and Treatment Center (**E&T)** – The North Sound BHO Region operates two (2) facilities via contract with Compass Health, in Mukilteo (Mukilteo E&T) and TELECARE (North Sound E &T) in Sedro Wooley. These programs provide 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) 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 Compass Whatcom and Pioneer Human Services.

Mental Illness Involuntary Treatment Act (ITA) is RCW 71.05 and **Mental Health Services for Minors** is RCW 71.34. These are the laws that allow individuals 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) is 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 individual needs to do to remain in the community after discharge from an inpatient unit.

Care Crisis Response Services (CCRS) Triage Clinician – The MHP at the Crisis Line, who coordinates services, dispatches the DMHP, CPIT, Emergency Mental Health Clinicians (EMHCs) and provides telephone-based support 24 hours a day.

Volunteers of America (VOA) 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.

Post-Test

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

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

2. T/F Crisis plans are intended to help both the clinician and individual in the event that he/she experiences a crisis during treatment.

3. T/F Crisis alerts expire after 30 days if they are not renewed.

4. 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.

5. T/F Once dispatched, crisis response staff should make face-to-face contact in the community within 2 hours.

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

7. T/F An Involuntary investigation 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.

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

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

10. T/F When an individual is discharged from an evaluation and treatment center on a LRO, the requirements/constraints on their behavior are referred to as the conditions of their release

11. T/F When someone is placed on a LRO, a care coordinator is designated by the agency to monitor the order and coordinate with the DMHP office.

12. T/F When someone is returned to an inpatient psychiatric unit for not complying with an LRO, the process is called a revocation.