

**CROSS-SYSTEM CRISIS RESPONSE PROJECT**



**Recommendations for Improvements to  
Crisis Response**

June 2004

*Prepared by:*

**Cross-System Crisis Response Task Force**

*At the request of:*

**Association of County Human Services  
Department of Social and Health Services**



To serve each person  
In the right way  
With the right service  
At the right time



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## ACKNOWLEDGEMENTS

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**The Cross-System Crisis Response Project would like to thank the following people for their hard work and contributions to this Project:**

- ❑ Representative Eileen Cody, Senator Jim Hargrove, and Former Senator Jeanine Long for their vision and inspiration
- ❑ The Plan-to-Plan Group: Marianne Backous, Chuck Benjamin, Rosemary Biggins, Fred Garcia, Dave Hopper, Chris Imhoff, Penni Newman, Elaine Odom, Cheryl Strange, Emilio Vela, and Jean Wessman
- ❑ The Task Force: Kim Ambrose, Barrie Antos, Chuck Benjamin, Cheryl Borden, Betsy Bosch, Flossie Bussmeir, Andy Byrne, Fred Garcia, Jackie Henderson, Dave Hopper, Pat Jennings, Mike Kerlin, Pat Knox, David Lord, Peter Lukevich, Theresa Mahar, Paul Mahlum, Jo Moore, Debra Murray, Elaine Odom, Milt Parham, Karyl Ramsey, Victoria Roberts, Carol Sloan, Pam Sloan, Dave Stewart, Cheryl Strange, Andy Toulon, Jon Tunheim, Emilio Vela, David Weston, and Jean Wessman
- ❑ Work Group Members who assisted the Task Force: Traci Adair, Rosemary Biggins, Rebecca Bird, Gary Carter, Karen Daniels, Jan Dobbs, Dick Gourd, Ian Harrel, Karen Hausrath, Preston Hess, Ed Holen, Bob Howenstine, Sherri Kashishian-Apilado, Susan Kinsinger, Dave Kludt, Harry Kramer, Rick Lichtenstadter, Diana Magan, Jim Miller, Bill Moss, Dan Peterson, Jerry Smith, and Jim Teverbaugh
- ❑ Forum Facilitators who assisted the T. F.: Cathy Andres-Ebbert, Sue Bush, Debra Eisen, Rosemary Gallagher, Travis Sugarman, and Tonia Sugarman
- ❑ Attorney General Staff: Pam Anderson and Sally Coats
- ❑ Legislative Staff: Jonnel Anderson, JoAnna Arlow, Jane Beyer, Fara Daun, Tanya Karwaki, and Bernie Ryan
- ❑ Governor's Office: Kari Burrell
- ❑ DSHS Leadership: Penny Black, Karl Brimmer, Tim Brown, Ed Hidano, Pat Lashway, Kathy Leitch, Linda Rolfe, and Ken Stark
- ❑ Association of County Human Services: Donna Bosworth, Cleve Thompson, and Jean Wessman
- ❑ DSHS staff support: Lin Dahmen, Lois Felber, Barbara Felver, Mark Glenn, Deana Kenelty, Gerry Larson, Neva Leons, Dario Longhi, and David Mancusco
- ❑ Project staff: Glenn Baldwin, Lesley Bombardier, Katie Cameron, Paul Dziedzic, Gaye Jensen, and Margaret Lopic

# EXECUTIVE SUMMARY

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## Purpose

The purpose of the Cross-System Crisis Response Project is to make recommendations for meaningful and significant improvements to crisis response for adults that would result in an integrated cross-system crisis response capability.

## Process

The Crisis Task Force met monthly between September 2003 and June 2004. A community stakeholder forum was held in November 2003 to seek community input. After the forum three work groups were formed to develop issue papers and draft recommendations. A second, follow-up forum was held in May 2004 to provide an opportunity for the same stakeholders to give reactions and feedback to the Task Force.

## Highlights

The Task Force adopted a project model that identified:

- ❖ The current experience: what does the customer need, what happens, what happens next;
- ❖ Evaluation of the current experience: what is working, what needs attention;
- ❖ Strategies that address the evaluation of the current experience: improvements to crisis response that would build on current strengths and respond to what needs attention; and
- ❖ The preferred experience: which provides a way to evaluate the outcomes of improvements that are recommended.

## Summary of Recommendations

- ❖ Combined 24-hour, 7-day crisis response, including a coordinated range of treatment resources and revisions of current Involuntary Treatment Acts to ensure access to resources and consistency of law.
- ❖ Increased availability of crisis triage and safe and secure detoxification.
- ❖ Intensive case management for individuals with chemical dependency and co-occurring disorders who over-utilize crisis services.
- ❖ Increased community diversion resources for populations that are most likely to benefit from hospital diversion.
- ❖ Cross-system, collaborative crisis intervention plans for dually court ordered individuals and others “at risk” as defined by each community. Consideration of the planning model developed by the workgroup for implementation of Senate Bill 6358.
- ❖ Cross-system training and consultation.

The Task Force cannot emphasize enough that the recommendations will require new resources, not a shifting of resources, to bring about the intended positive impact and avoid creating a new set of problems.

See Pages 16 and 17 of this report for the complete recommendations.



## **HISTORY OF THE PROJECT**

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The Cross-System Crisis Response Project is a collaboration and partnership between the Department of Social and Health Services (DSHS), Health and Rehabilitative Services Administration (HRSA), Aging and Disability Services Administration (ADSA) and the Association of County Human Services (ACHS). The idea for the current project began with a panel presentation to ACHS and DSHS staff December 1999 by three legislators: Senator Jim Hargrove, Senator Jeanine Long, and Representative Eileen Cody. Their comments focused on the challenges of serving clients whose needs cross multiple state and community systems. In the lengthy discussion that followed, participants identified four priorities: crisis management, maximum utilization of Medicaid benefits, improving communication, and reducing duplication.

The first effort to evolve from the above discussion was a project to analyze specific cases involving adults with complex and challenging needs. In June 2000, the Department initiated a Cross-Administration Review Team to examine 27 cases involving adults in frequent crisis who had received services from more than one program within DSHS. The purpose of this review was to better understand the needs of these clients, identify system barriers that might be contributing to their problems, and make practical recommendations for change. The final report noted a number of system barriers, including the lack of a comprehensive crisis response system. Recommendations clustered under the two primary system barriers found throughout the case reviews: (1) communication and coordination, and (2) residential and related services.

## **PROJECT OVERVIEW**

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ACHS and DSHS staff continued to discuss new ways of deploying resources to maximize the effectiveness of crisis response and decided on a project that would make recommendations for meaningful and significant improvements to crisis response for adults that would result in an integrated cross-system crisis response capability for the State of Washington and, if needed, develop a decision package for the 05-07 Biennium. It was decided not to study children's crisis response issues until the results of the Children's Mental Health Services Work Group became available in July 2004.

The Cross-System Crisis Response Task Force, composed of a broad cross section of stakeholders (See Appendix 9), was convened in September 2003. In addition to monthly meetings between September 2003 and June 2004, a stakeholder forum was held in November 2003 to seek community input and build a wider network of stakeholders who would be connected to the process but not be formal members of the Project.

Three work groups were formed after the November 2003 Forum to study stakeholder suggestions and draft recommendations under the direction of the Task Force. The three groups focused on Collaboration/Prevention, the Involuntary Treatment Act (ITA), and Service Gaps, prevalent themes from the Forum. The work groups developed issue papers and recommendations that were presented by the Task Force at a second stakeholder forum held in May 2004. Following the May forum, the Task Force met in June to finalize recommendations for this report.

# CRISIS RESPONSE OVERVIEW

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## Introduction

Users of crisis response services tell us that more often than not, they experience chaotic, fragmented and disorganized care during times of crisis. In addition, professionals, families, advocates, law-enforcement and others note that in fact, “the crisis response systems seem to be in crisis”. Access to appropriate resources at the needed time does not happen often enough. Crisis responders do not seem to have clear roles and responsibilities during the crisis. When the crisis is not resolved, the situation escalates and can result in harm to an individual or to the public at large. Inappropriate placements, lack of placement options, barriers resulting from geographical boundaries, and the lack of an integrated comprehensive commitment law are all major issues for citizens whose needs cross multiple systems.

The public mental health system serves as the default crisis response system for people with a wide range of emotional and behavioral issues. Services provided by local law enforcement, jails, and local hospital emergency rooms have become the de facto system for crisis response when an individual does not fit anywhere else.

The public mental health system has evolved over time in a somewhat inconsistent fashion and is often expected to be all things to all people. Available options are often not appropriate for people who are seeking help. Individuals who are combative and/or who have drug/alcohol issues add to the challenge of providing timely, effective crisis response. There are a variety of “first responders” but there is no connection or coordination between them. Consumers, professionals, and elected officials agree that hospitals and jails are not only over-utilized, they are costly and often inappropriate.

## Project Model

In its initial meetings, the Task Force developed a project model that would ultimately describe the current experience, assess it by identifying what seems to be working and what needs attention, recommend improvements, and define what a “preferred experience” would look like and accomplish.

## The Current Experience

In current experience, people from all walks of life and in diverse stages of crisis rely on help from public mental health, law enforcement, hospital emergency rooms and other first responders. They are young and old, rich and poor, people known as well as unknown to “the system,” some who are disabled or ill, others who are disturbed or violent or disenfranchised, and those in the midst of a psychotic episode or who have traumatic brain injury. Sometimes the issue is “situational” or a newly identified problem, and other times there are individuals with chronic and untreated challenges.

People who rely on mental health crisis response include families, individuals from the healthcare professions, social workers, case managers, churches, police, schools, hospitals, jails, community members, and elected officials.

Individuals seeking help may need de-escalating, calming, housing, detoxification, respectful treatment, medication, medical treatment, restriction or containment, understanding, support, comfort, counseling, case management, protection, or income/employment. Initial interventions may fall to any number of “first responders,” including police, emergency department, fire fighter, doctor or pastor. Although these individuals are professional and competent, they may lack expertise in dealing with the issue at hand and there is no established “system” for ensuring that the individual in crisis gets the right service in the right way at the right time.

What happens next depends on the expertise of the responders and available options and runs the gamut from psychiatric inpatient to detention, mental health or substance abuse treatment, counseling, detoxification, time out or respite, often nothing, and sometimes death.

### **Assessment of the Current Experience**

Programs and strategies identified by the Task Force as effective were overwhelmingly validated by November forum participants. They include collaboration between systems; specialty crisis teams and plans; mobile mental health services; extra funds for targeted groups; best practices and cross-training; non-hospital options when person is in crisis (including crisis triage centers); preventative services/resources; intensive case management; working cross-system agreements/protocols; individualized wrap-around services; 911 and toll-free lines; access to appropriate emergency services, for example, evaluation and treatment (E & T) beds, medical detoxification, and chemical dependency (CD) ITA; co-located service delivery for dually diagnosed at various stages; advocacy and education; jail mental health programs; and mental health court.

Although there was substantial discussion about areas needing attention, completion of this portion of the project model was deferred to the November forum in order to incorporate substantial stakeholder input.

### **Preferred Experience**

The Task Force has defined the preferred experience for collective crisis response. Descriptions about what it would look like and what it would accomplish provide opportunities for evaluating and measuring recommended improvements that are implemented. A complete list is attached in the appendix. As noted in the next section, stakeholders at the November forum rated our current experience as “poor” to “barely OK.”

### **Project Challenges**

Undoubtedly the biggest challenge to this project has been broad acknowledgement of the fact that there is not a crisis response *system*. People have all manner of behavioral and emotional crises. There are multiple responders. Resolution is varied depending on many and diverse factors. The lack of a “system” results in lack of meaningful data.

There are separate information systems for law enforcement, corrections, hospitals, mental health, chemical dependency, developmental disabilities, residential care, and aging. Each collects information that is pertinent to its own system. Each system is driven by what will be funded. No information is collected for services not delivered. Little data is available to demonstrate collaborative services. In fact, collaboration is often penalized by the funding source (e.g. Title XIX only pays for one “case manager” at any given time for a particular client.) Even when the law mandates collaboration (SB 6358), it will be a challenge to find a way for each community to identify its dually court-ordered individuals.

Nonetheless, advocates and professionals from every system that interacts with people in crisis are joining their voices and their efforts to find a way to move toward our preferred experience. Even without data, emergency room doctors and crisis workers across the state will identify substance use and abuse as an immense challenge. And the combined cost of over-utilization of our most expensive emergency services (local hospital, jail, state hospital) is most definitely escalating at a far greater rate than would be expected based on inflation and/or population growth.

## NOVEMBER 2003 FORUM

The purpose of the November 3, 2003 forum was to involve and inform a broad network of stakeholders and to brainstorm ideas and strategies for Task Force consideration. Approximately 160 representatives from DSHS, RSNs, providers, law enforcement, corrections, medical, and senior services attended.

Participants were divided into groups with an assigned facilitator at each table to guide and record the discussion. The discussion included a complete review of the Task Force Project Model. In small groups, they shared perceptions about the current experience (what's working and not working), rated how current reality measures up to what we want an effective crisis response to accomplish, and brainstormed specific ideas and suggestions for improvements.

The tables each reported their top five ideas to the larger audience with their ideas falling loosely into 6 categories.

- Crisis Response: strengthening collaboration/coordination
- Crisis Prevention: strategies and models that prevent a person from going into crisis
- Involuntary Treatment Act: exploring potential changes to current ITA statutes
- Service Gaps: identification of areas with critical service gaps and development of short and long-term plans/solutions
- Accountability: how to know where to invest resources; outcomes for various strategies
- Public Education/Advocacy: strategies to build awareness of the problem and support for solutions

Stakeholders were asked to rate how well current reality measures up to an ideal set of criteria for effective crisis response. Overall, it would be fair to say they rated current response to individuals in crisis from "poor" to "barely okay".

<b>On a scale of 1 to 6, from very poor to very well, to what degree does our collective crisis response currently result in:</b>	<b>Average Score</b>
Individual and community safety	3.0
Effective use of resources	2.7
Freeing up of critical resources	2.2
Low recidivism/revolving door	2.0
<b>On a scale of 1 to 6, from very poor to very well, how would you rate our current collective crisis response in terms of:</b>	
Being responsive	3.1
Being accessible	2.9
Employing effective interventions	2.8
Providing coordinated response and care	2.6
Having access to resources so that correct clinical decisions are made	2.4
Having a preventative focus	2.1

The Task Force determined from the November Forum input that further work should be focused on three areas: the Involuntary Treatment Act, Collaboration/Prevention and Service Gaps.

### **Involuntary Treatment Act (ITA) Work Group**

In the early 1990s, primary responsibility for mental health was turned over to counties, and Regional Support Networks were established to administer care. Today, there are 14 RSNs of varying geographic sizes and populations. Emergency services vary from one RSN to another. However, all RSNs are required to offer 24-hour, 7-day per week mental health crisis response and to evaluate people with mental disorders for possible involuntary detention in psychiatric inpatient facilities. Counties also have responsibility for implementing CD ITA. Strategies and capacities vary from county to county.

#### Two Involuntary Commitment Laws

There are two laws that govern involuntary detention: RCW 71.05 for adults with mental disorders and RCW 70.96A for treatment of alcoholism, intoxication, and drug addiction. The two laws that govern the detention of individuals against their will are not parallel in scope. The mental health law is mandatory, i.e., if the person as a result of a mental disorder is an imminent danger to themselves or others or is gravely disabled, the system must respond and take action. The chemical dependency (CD) law is based on availability of resources, which means that an intervention may not occur until there is actually an open bed. When resources are not available to the person in need of CD involuntary treatment and intervention, the mental health system (sometimes the emergency room or police) is often called on to be the responder.

#### Current Mental Health System

When a call is made to mental health crisis response, information is gathered to assess the situation. Response includes voluntary services, such as stabilization and diversion, referrals to other systems, detention investigations, and involuntary detention. Persons may initially be detained under the ITA statute for up to 72 hours by a County Designated Mental Health Professional (CDMHP) if they, as a result of a mental disorder, present an imminent danger to themselves or others or are gravely disabled and there is no less restrictive alternative to involuntary inpatient care.

Short term evaluation and treatment services are provided by state Mental Health Division certified stand-alone (non-hospital) residential facilities, free standing public & private psychiatric hospitals, acute care hospitals with psychiatric units and state psychiatric hospitals. In Fiscal-Year 2003, the Mental Health Division (MHD) reported that 28% of all Involuntary Treatment Act (ITA) investigations resulted in a 72-hour detention. All long-term involuntary commitment treatment services are provided at the state psychiatric hospitals, Eastern and Western State Hospitals.

#### Current Chemical Dependency System

Referrals for investigation come from a number of sources including family members, friends, co-workers, attorneys, Department of Corrections, chemical dependency practitioners, mental health involuntary commitment professionals, jails and shelters.

The County Designated Chemical Dependency Specialist (CDCDS) may make referrals to mental health providers, voluntary detoxification centers, sobering centers, shelter, crisis triage (hospitalization for medical issues), and chemical dependency treatment. To meet the criteria for ITA, typically at either Pioneer Center North or East, the CDCDS must allege in a petition to the court that a person is chemically dependent, and presents the likelihood of serious harm or is gravely disabled by alcohol or drug addiction; or that the person is chemically dependent and has threatened, attempted, or inflicted physical harm on another and is likely to inflict physical harm on another unless committed. Treatment is not court ordered unless placement is available.

### Critical Issues

Ideally, effective ITA laws would provide emergency safety, control and care; provide access to assessment and evaluation capabilities; refer clients to appropriate treatments; triage persons to the appropriate treatment resource; protect individual civil rights of clients; and be consistent (between the MH and CD laws).

The system we have now is not designed to always ensure access to a treatment program designed to best meet the needs of people diagnosed with mental disorders or chemical dependence. People with developmental disabilities, traumatic brain disorder, and dementia have traditionally been a particularly challenging population to serve appropriately within the mental health system. In addition, the discrepancies between the mental disorder and chemical dependency statutes result in unequal access to treatment.

There are key resources from the ITA Work Group perspective that need to be strengthened that could relieve the mental health crisis system:

- Increased funding for locked/secure and social detox, including co-locating CD social detox and MH crisis services in a triage setting,
- Added county designated CD specialists to CDMHP crisis response teams,
- Increased number of crisis/diversion beds for all populations,
- Enhancement of on-going specialty training to professionals regarding evaluation and treatment of individuals with developmental disabilities,
- Increased access to psychiatric supports for people with dementia and other organic mental disorders and behavior problems, and
- Access to psychiatrists and medications.

In addition to resources, a combined crisis response available 24 hours per day, 7 days per week would be an ideal improvement. A single, combined crisis response includes:

- The ability of CDMHPs and CDCDSs to manage resources and facilitate solutions (gatekeeper function),
- The ability of CDMHPs and CDCDSs to consult with appropriate, knowledgeable professionals,
- 24/7 crisis triage at a sufficient level to provide statewide coverage,
- Mobile crisis services, such as specialized teams and staff that could provide support in natural environments,
- Behavioral supports that can be brought in to facilities to assist staff with consumers in crisis, for example, one-on-one supports, and
- Training for crisis responders.

## Collaboration/Prevention (C/P) Work Group

There is consensus among stakeholders that the best crisis response posture is to prevent a crisis altogether. Coordination can minimize the intensity and frequency of crisis, and in many cases can prevent a situation from escalating into a crisis. Coordinated cross-system crisis plans clarify roles and responsibilities and increase the possibility of positive outcomes because the individual and the serving systems have prior agreements, in writing, regarding specific interventions at specific times for specific reasons.

### Confidentiality challenge

However, a consistent message at our November forum was that even though collaboration really works, it is not always possible to accomplish due to confusion and misunderstanding about sharing information. Cross-system training and related protocols that address all statutes and concerns pertinent to sharing of information must be thoughtfully and carefully developed.

### Mandate for dually court-ordered individuals

SB 6358 was recently signed into law and places some new requirements on information sharing for persons who are under both DOC supervision and court ordered mental health or chemical dependency treatment. It requires DOC and DSHS, in conjunction with a variety of interested groups, to develop a model for team staffing that complies with confidentiality laws. *The Collaboration/Prevention work group has worked closely with the agencies responsible for implementing this legislation to assure that the Task Force recommendation is aligned with SB 6358.*

### “At-risk”, non-mandated, population

Local communities should define other “at-risk” individuals who would be well-served by cross-system crisis plans, such as:

- frequent visitors to the Emergency Department, or
- chronic utilizers of high cost emergency response services, or
- individuals defined as a community safety risk, including those who are not current “clients” (e.g. receiving mental health or other treatment).

### Critical issues

Funds will be needed to address identified resource issues, including development, implementation, reimbursement for participants, and evaluation. Administrative and service level “buy-in” by all systems at all levels will be necessary. State policies, including memorandums of understanding, must be approved concurrently with training and protocol development. Ongoing training will be essential for successful cross-system collaboration and planning to be effective. Study sites to test the effectiveness of crisis plans for non-mandated populations will help to determine the best utilization and value of the process.

The recommendation to finalize and approve a statewide cross-system crisis planning process (for mandated and non-mandated populations) will assist our communities to serve each individual in the right way, with the right service, at the right time.



Development of a standardized cross-system crisis plan format, with accompanying protocols and training materials will increase individual and community safety, balance individual civil and treatment issues with community interests, and improve communication. People will be more likely to receive the help they need, including appropriate ongoing care.

The successfulness of this collaborative and preventative strategy will be measured by:

- reduction in premature death and/or disability
- low recidivism/revolving door
- effective use of resources and cost management over time
- accountability that leads to sustainability
- effective system(s) with support from elected officials

## Service Gaps Work Group

The Task Force work group chose to focus on three populations that pose challenges for cross-system crisis services:

- Adults of any age with medical and behavioral issues
- Adults of any age with chemical dependency issues
- Adults of any age with developmental disabilities and behavioral issues.

### Adults with medical and behavioral issues

Many communities struggle to meet the needs of individuals suffering from Alzheimer's disease or other types of dementia. In addition, adults with traumatic brain injuries or those with a mental illness combined with a complex medical condition pose special challenges for community providers. Crisis beds, transition beds, specialized behavioral support services, specialized training, and the availability of immediate behavioral consultation would minimize unnecessary hospitalization and incarceration.

### Adults with chemical dependency issues

Law enforcement officers, emergency departments, and behavioral health crisis workers are overwhelmed by the impact of adults with chemical dependency on every emergency response system. Of particular concern are violent acts, criminal behavior, and suicide. Lack of information and/or cross training between chemical dependency and mental health disciplines often exacerbate a crisis because interventions are not appropriate.

Education for crisis responders about evidence-based interventions can substantially reduce and/or prevent crisis escalation. Intensive case management for individuals with chronic chemical dependency and co-occurring mental illness is critically needed to reduce emergency service over-utilization (the "revolving door"). Case managers can help at critical stages of change and support individuals post-crisis and until appropriate services are in place. Individuals who are under the influence and present with combative, suicidal, and/or psychotic symptoms create chaos and crisis in every community across the state. Safe and secure detoxification beds, including post-detoxification transition beds, are seen as absolutely essential by a wide range of stakeholders and community members.

### Adults with developmental disabilities and co-occurring mental health/behavioral disorders

Community based care that is responsive to the needs of these individuals will lead to decreased lengths of stay at state and community psychiatric hospitals and will reduce inappropriate discharges from long-term care settings. Providers are currently reluctant to serve behaviorally challenged individuals. Potential injury to both staff and other residents are major problems, as is staff turnover. Yet continuing to serve them in a hospital results in potential loss of federal revenue. Less costly and more appropriate solutions include an increase in diversion opportunities, increased capacity for in-home stabilization, and cross-system crisis training (both for providers and allied partners).

The work group limited its identification of gaps to services that are used to avoid involuntary treatment and/or incarceration. The work group did not identify or develop recommendations related to the adequacy of resources and services utilized once an individual has been committed to involuntary treatment or incarceration.

Service gaps in the system of care that are not identified in this report include: psychiatric inpatient beds, free-standing psychiatric evaluation and treatment beds, chemical dependency residential treatment beds, long-term placements for individuals being placed from state hospitals or Department of Corrections settings, and residential licensing options for individuals with community protection issues. There is considerable additional work to do in order to identify long-term solutions for people in this state who are in crisis because they lack appropriate supportive resources.

There are several studies planned or already underway: the mandated residential capacity study for mental health and chemical dependency, the mandated study for psychiatric inpatient care capacity (state and local), and the Joint Legislative Task Force on Mental Health.

## MAY 2004 FORUM

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The purpose of the May 3, 2004 forum was to obtain stakeholder reaction to Task Force draft recommendations. In order to encourage open communication and foster audience participation and interaction, the Forum incorporated an electronic audience response system (ARS) into the meeting format to allow for anonymous voting, real time data, and instant results.

Approximately 100 people attended, with 46% representing mental health and chemical dependency. Developmental disabilities, senior services, law enforcement, corrections, advocates/consumers, medical and legislative staff were also represented. Participants were asked how long they have been involved in their primary field: 30% responded more than 26 years and another 30% responded 16 to 25 years.

The Forum agenda consisted of presentations from each of the three major work groups. Following a discussion at each table guided by facilitators, participants were asked on a scale of 1 (low) to 10 (high) to rate the effectiveness of the recommendation, how difficult to easy the recommendation would be to implement, and if the recommendation should go forward for implementation.

The table on the following page illustrates the ratings (mean average) for each recommendation and the percent voting that the recommendation should go forward. The recommendations that were rated the highest on a scale of 1 to 10, from not at all effective to very effective, were to provide intensive case management for individuals with chronic chemical dependency and co-occurring mental illness who over utilize the crisis system (8.5), to increase the availability of safe, secure detox beds (8.2), and to develop community resources to meet the needs of adults with medical and behavioral disorders (7.9).

None of the recommendations were rated as “very easy” to implement. The ratings varied from 2.4 to 6.4, from difficult to moderately easy, at best. In some cases, the higher the effectiveness, the harder it would be to implement. See the Scatter Chart in Appendix 8 for comparison of these two factors. The percent voting to recommend going forward varied from 45% to 91% with the 3 most effective recommendations noted above also the ones recommended to go forward with the highest audience response: 91%, 86%, and 88% respectively.

It should be noted that each recommendation was voted on separately and not in relationship to each other. In other words, we did not ask which recommendation would be most effective or easiest to implement. We only asked how effective or how easy to implement would that particular recommendation be. The Task Force did prioritize its final recommendations, contained in the next section, after reviewing the Forum participants’ assessment of the individual recommendations.

At the end of the day, using ARS, stakeholders were asked to rate on a scale of 1 to 4, from very poorly to very well, how well did the Forum accomplish its purpose. The mean average for audience response was 3.4.

## Stakeholder Forum Voting on Task Force Recommendations May 3, 2004 Forum Results Table

Recommendations	Effectiveness <small>(On a scale of 1 to 10, from not at all effective to very effective)</small>	Ease of Implementation <small>(On a scale of 1 to 10, from very difficult to very easy)</small>	% Recom. To Go Forward
<b>Cross system plans – Mandatory population required/non-mandatory recommended</b>	6.6		75
<b>Cross system plans – Mandatory population only</b>		5.1	
<b>Cross system plans – Non-mandatory only</b>		3.1	
<b>ITA 1 Combined Crisis Response</b>	6.2	3	65
<b>ITA 2 Overall Vision</b>	6.6	2.4	64
<b>Service Gaps: Adults w/Medical and Behavioral Issues</b>			
<b>A 1 Community Resources</b>	7.9	3.9	88
<b>A 2 Training</b>	6.6	6.1	85
<b>A 3 Immediate consultation</b>	6.4	6.4	82
<b>A 4 Medicare-eligible services</b>	6.8	4.4	74
<b>A 5 Access to Care Standards</b>	5.8	6.0	64
<b>A 6 TBI/other study</b>	5.9	6.3	45
<b>A 7 Prison population study</b>	5.6	6.0	54
<b>A 8 Crisis admits study</b>	6.5	5.6	73
<b>Service Gaps: Chemically Dependent Adults</b>			
<b>CD 1 Training/technical assistance</b>	6.9	6.3	84
<b>CD 2 Triage centers report</b>	5.0	6.0	45
<b>CD 3 Intensive case management</b>	8.5	4.3	91
<b>CD 4 1<sup>st</sup> Responders info</b>	6.0	4.9	65
<b>CD 5 Increase detox beds</b>	8.2	3.7	86
<b>Service Gaps: Adults with Developmental Disabilities and Mental Health/Behavioral Issues</b>			
<b>DD 1 Diversion beds/supports</b>	7.5	4.2	84
<b>DD 2 Community protection (beds)</b>	7.0	3.8	81
<b>DD 3 In home services</b>	7.4	4.8	85
<b>DD 4 Training DD system</b>	6.5	6.0	84
<b>DD 5 DD training for others</b>	6.6	6.0	77
<b>DD 6 Physician awareness</b>	6.3	4.2	60

# TASK FORCE RECOMMENDATIONS

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The purpose of the project was to recommend significant improvements in how communities respond to individuals in crisis. The Task Force is aware that asking for additional or new resources in a time of budget cuts, less federal revenue, and competing demands is not a popular thing to do. However, the following recommendations represent what the Task Force believes is truly needed “to serve each person in the right way, with the right service, at the right time”. These recommendations are prioritized in order of those having the most significant impact on creating an integrated cross-system crisis response capability.

## REVISED INVOLUNTARY TREATMENT ACT

1. Create a combined crisis response for all identified populations available 24 hours per day, 7 days per week. Create a coordinated range of voluntary and involuntary treatment resources to match the needs of a very diverse population. **This will require new resources**, not a shifting of resources. Amend existing involuntary treatment statutes to ensure access to appropriate resources and consistency throughout the law **to become effective when a defined level of resources is in place**.

## SECURE DETOXIFICATION AND CRISIS TRIAGE

2. Where service area size will support effective implementation:
  - a. Increase the availability of crisis triage, and
  - b. Increase the availability of safe and secure detox

This will require new resources, not a shifting of resources.  
(Refer to CD5, page 18, for additional details)

## INTENSIVE CASE MANAGEMENT

3. Implement intensive case management for individuals with chemical dependency who over-utilize crisis services, (including those with co-occurring disorders) with a focus on:
  - a. Intervention at critical stages of change (when police or hospital has to intervene, during detox), and
  - b. Follow-through and continuity of care while individual is waiting for inpatient treatment and post discharge to support reintegration in community

This will require new resources, not a shifting of resources.  
(Refer to CD3, page 18, for additional details)

## COMMUNITY DIVERSION RESOURCES

4. Increase community diversion resources for populations that are most likely to benefit from hospital diversion:
  - a. Develop community resources to meet the needs of adults with medical and behavioral issues

- b. Increase capacity for crisis diversion beds and services (with an opportunity for flexible length of stay based on need) for individuals with developmental disabilities and mental health/behavioral issues
- c. Increase capacity for appropriate in-home stabilization services for adults with developmental disabilities and mental health/behavioral issues
- d. Increase access to crisis diversion beds and services for adults with developmental disabilities and mental health/behavioral issues served through the Community Protection Program

This will require new resources, not a shifting of resources.  
(Refer to A1, DD1, DD2, and DD3, pages 18 and 19, for additional details)

## **CROSS-SYSTEM CRISIS PLANS**

- 5. To the extent permitted by federal law, continue the development of cross-system, collaborative crisis intervention plans for dually court ordered individuals and others “at risk” as defined by each community. This includes funding needed for the planning process, protocols, ongoing training, procedure development, and community start-up and ongoing implementation. This recommendation also requires development of supportive state policies and mandates.

The Task Force recommends that the planning model developed by the workgroup be considered in implementation of Senate Bill 6358.

This will require new resources, not a shifting of resources.  
(Refer to CP1, page 19, for additional details)

## **TRAINING AND CONSULTATION**

- 6. Provide training and consultation, including:
  - a. Training to address managing behavior, assessment and regulations for adults with medical and behavioral issues
  - b. Access to immediate consultation for long-term care providers by professionals at state hospitals
  - c. Training and technical assistance on crisis intervention for adults with chemical dependency
  - d. Opportunities for residential and other caregiver staff for individuals with developmental disabilities and mental health/behavioral issues to participate in crisis prevention and intervention training
  - e. Mental health/developmental disabilities training for hospital staff, DOC staff, law enforcement, and CDMHPs
  - f. Physician awareness of special needs and challenges of adults with developmental disabilities, especially individuals with undiagnosed medical or dental conditions

This will require new resources, not a shifting of resources.  
(Refer to A2, A3, CD1, DD4, DD5, and DD6, page 20, for additional details)

## REFERENCED RECOMMENDATIONS

The following language taken from the Work Group issue papers provides detail for the Task Force Recommendations on pages 16 and 17:

### SECURE DETOXIFICATION AND CRISIS TRIAGE

CD5 *As an alternative to the over-utilization of hospital emergency rooms and jails for crisis events, provide a substantial increase in the availability of safe, secure detoxification beds for adults under the influence who are combative, experiencing a psychotic episode and/or suicidal. This bed increase should include post-detox transitional beds to help maintain patient stability prior to entry to longer-term treatment.*

### INTENSIVE CASE MANAGEMENT

CD3 *Provide intensive case management for individuals with chronic chemical dependency and co-occurring mental illness who over utilize the crisis system. This case management is designed to follow-up after the crisis incident and to maintain frequent contact with the individual until appropriate services are available.*

### COMMUNITY DIVERSION RESOURCES

A1 *In order to avoid unnecessary hospitalization or incarceration of adults with medical and behavioral disorders, a variety of crisis related resources are needed including:*

- *Crisis beds which use County Designated Mental Health Professionals (CDMHP) or crisis teams as gatekeepers*
- *Transitional beds for individuals coming out of state or community hospitals or prisons which allow quicker reintegration and better assessment of community needs*
- *Specialized behavioral support services*
- *Specialized training for providers who serve this population*

*These resources, whether beds or other types of community services, need to be accessible for adults with complex medical and behavioral issues and able to address the needs of this population. Services provided through the Expanding Community Services (ECS) program for patients from the gero-medical units at the state hospitals have begun to address some of these needs and may be able to further meet some of the demand. In addition, program managers from HCS and MHD currently assist by providing technical assistance to regions on developing effective models and service approaches to meet the needs of this population.*

DD1 *Increase capacity for crisis diversion beds and services with an opportunity for increased length of stay.*



- DD2 *Increase access to crisis diversion beds and services for adults served through the Community Protection Program.*
- DD3 *Increase capacity for appropriate in-home stabilization services geared towards serving individuals with developmental disabilities in crisis. In-home stabilization services maintain individuals with developmental disabilities who are experiencing a mental illness and/or a mental health/behavioral disorder crisis in the residential and/or vocational setting by temporarily providing additional staff supports, evaluations, training to providers and families, and transitional case management.*

## **CROSS-SYSTEM CRISIS PLANS**

### **CP1 Recommendations:**

- *A cross-system crisis planning process (for mandated and non-mandated populations) be finalized and approved for the purpose of assisting our communities statewide to serve each individual in the right way, with the right service, at the right time.*
- *Priority attention be given to resolving confidentiality issues and concerns so that this planning process and related protocols can be effectively used. This may require involvement of the Attorney General, the Legislature, and/or others to resolve this critical issue.*
- *Confidentiality misunderstandings and inconsistencies be addressed and included in the training materials and protocols that support the planning process.*
- *State policies, including memorandums of understanding that support local communities to plan and implement cross-system crisis plans be proposed and approved concurrently with training and protocol development.*
- *Education and training regarding cross system planning be made available statewide at all levels of DSHS, DOC, treatment provider agencies, corrections, law enforcement, hospitals, residential programs, and the judicial system.*
- *Funds be allocated to ensure:*
  - *development of thorough and complete planning documents (formats, protocols, training manuals),*
  - *delivery of a statewide training program, including reimbursement for key people to attend the training,*
  - *implementation of the process at the county level (such as reimbursement funds for specifically identified county risk coordinators),*
  - *selection of specific study sites to determine the effectiveness of this strategy for the non-mandated population, and*
  - *Ongoing evaluation of the process, necessary updates and improvements, and ongoing training.*

## TRAINING AND CONSULTATION

- A2 *Regions report that providers do not always take advantage of the medical and behavioral interventions, which can help avoid crisis because of a lack of information, or misunderstandings regarding long term care regulations. In order to address this, training modules on topics specific to clients with both behavioral and medical challenges should be developed. These modules should be available on the Web and distributed to providers, Department of Social and Health Services staff, and other agencies. Topics could include:*
- *Ways to manage behavioral issues within current licensing regulations*
  - *Assessment and differential diagnoses*
  - *Specific interventions for dealing with difficult behaviors*
  - *Harm reduction techniques*
  - *Roles and regulations within the mental health system*
  - *Expectations for providers to meet a resident's special care needs*
  - *Strategies for providers to decrease liability*
- A3 *Immediate consultation for long-term care providers with residents experiencing behavioral issues can help prevent the need for hospitalization. Eastern State Hospital currently provides such consultation to nursing homes and other care settings. This model should be replicated at Western State Hospital.*
- CD1 *There is a lack of information and/or cross training between the chemical dependency and mental health disciplines. This lack of cross training can lead to crisis situations because an appropriate evidenced based intervention was not delivered. This is a training issue where modules on topics specific to crisis intervention for adults with chemical dependency and co-occurring mental illness can be developed. The goal of the technical assistance and training is to educate crisis responders about evidence based interventions that are designed to avoid an immediate crisis, to respond appropriately in an already escalating crisis situation and/or to keep a crisis situation from re-occurring. These training modules can be available on the Web and distributed to providers, DSHS staff, and other agencies.*
- DD4 *Develop opportunities for residential and other caregiver staff to participate in crisis prevention and intervention training, thus overcoming the barrier regarding training versus meeting clients' needs. It is often difficult for residential and other caregiver staff to obtain this training while continuing to provide direct care, as it often requires replacement staff coverage for continuity of care for the individuals with developmental disabilities.*
- DD5 *Provide training for hospital staff, Department of Corrections staff, law enforcement and County Designated Mental Health Professionals on resources available through the Division of Developmental Disabilities and the Mental Health Division.*
- DD6 *Increase physician awareness to special needs and challenges of adults with developmental disabilities. Individuals with developmental disabilities and undiagnosed medical or dental needs can exhibit mental health/behavioral disorders when these issues are not being met.*

**CROSS-SYSTEM CRISIS RESPONSE PROJECT**  
**June 2004**

**APPENDIX 1**  
**PROJECT MODEL**



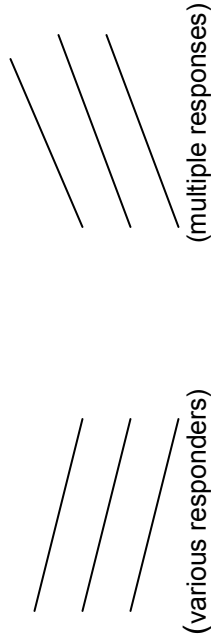
**CROSS-SYSTEM CRISIS RESPONSE PROJECT MODEL**

**CURRENT EXPERIENCE**

WHAT HAPPENS?

WHAT HAPPENS THEN?

De-escalating, calming, housing, detox, respectful treatment, medications, medical treatment in spite of behavior, restriction or containment, understanding, support, comfort, counseling, case management, protection from harm to self or others,



Time out, crisis resolved, psychiatric/medical inpatient, detention, shelter, mental health or substance abuse or medical treatment, respite, counseling, detox, "service plan" changes, death or disability. sometimes nothing

**ASSESSMENT OF THE CURRENT EXPERIENCE**

WHAT SEEMS TO BE WORKING?

Specific collaboration between systems (information sharing, team meetings, relationships, flex funds, coordinated plans), specialty crisis teams/plans, mobile mental health services, extra funds for targeted groups, best practices and cross-training, non hospital options including crisis triage, preventative services and resources (including respite, housing, work), intensive case management, working cross-system agreements and protocols, individualized wrap-around services, 911 and toll free lines, access to appropriate emergency services, co-located service delivery, advocacy/education, jail mental health programs, mental health court.

WHAT NEEDS ATTENTION?

- Rules, policies, mandates, strategies that promote cross-system collaboration, training, coordination, understanding, and communication.- especially HIPAA and silo funding issues.
- Expansion of known effective preventative strategies (case management, QA nurse, jail/mental health, CIT, crisis plans)
- Evaluation of current ITA statutes and practices.
- Development of protocols and policies that balance management of risk with rights of individuals to receive appropriate services.
- Identification of critical service gaps; long and short term plans
- Accountability: outcomes, investment justification

**Task Force Recommendations**

**THE PREFERRED EXPERIENCE**

WHAT WOULD AN EFFECTIVE CRISIS RESPONSE.....

BE LIKE/LOOK LIKE?

Preventative focus, average person could understand and access the help he or she needed, flexible and responsive, respectful, fair, consistent quality and interpretation of law across the state, coordinated response and care, effective interventions, satisfy consumer and family, appropriate resolution, considers individual diversity and choice, access to resources so that clinical decisions are based on best practice standards, able to document outcomes that determine what is working.

ACCOMPLISH?

Individual and community safety, balance of individual civil and treatment issues and community interests, people would get what they need, ongoing continuity of care, community, customer, and responder or provider satisfaction, reduction in premature death and/or disability, low recidivism/revolving door, effective use of resources resulting in cost management over time, accountability that leads to sustainability, effective systems with support from elected officials.

TO SERVE EACH PERSON IN THE RIGHT WAY, WITH THE RIGHT SERVICE, AT THE RIGHT TIME



**CROSS-SYSTEM CRISIS RESPONSE PROJECT**  
**June 2004**

**APPENDIX 2**

**SUMMARY OF NOVEMBER 2003  
STAKEHOLDER FORUM**







## CROSS-SYSTEM CRISIS RESPONSE PROJECT

### SUMMARY OF NOVEMBER 2003 STAKEHOLDER FORUM

**PURPOSE:** Involve and inform a broad network of stakeholders  
Brainstorm ideas and strategies for Task Force consideration

#### FORUM EVALUATION:

This was an invitation-only forum due to limited space. 230 invitations were issued; 157 people attended. Participants evaluated how well the forum accomplished its purpose on a scale from 1 (very poor) to 4 (very well); the mean average score was 3.6. More than half of the participants gave the forum a "4." Common positives were variety and mix of people at each table, organization of the day, food, and well-prepared table facilitators. The common concern is to see results, not just talk about the issues.

#### FORUM OUTCOMES:

Revisions were made to the project model based on recommendations and comments of forum participants.

A complete set of all recommendations of the participants at each of the 18 tables has been made a permanent part of the record of this project. Task force members have copies of the recommendations and are using them in the work groups that are currently underway.

A complete record was also kept of the top 5 ideas for change by table (a total of 90 ideas) and is also part of the background material available to the work groups.

**SUMMARY OF AREAS OF WORK:** the forum ideas fell loosely into 6 categories

- Crisis Response: strengthening collaboration/coordination
- Crisis Prevention: strategies and models that prevent a person from going into crisis
- Involuntary Treatment Act: exploring potential changes to current ITA statutes
- Service Gaps: identification of areas with critical service gaps and development of short and long-term plans/solutions
- Accountability: how to know where to invest resources; outcomes for various strategies
- Public Education/Advocacy: strategies to build awareness of the problem and support for solutions

(Specific recommendations from the top 90 have been organized according to the 6 categories. A full listing was printed and has been provided to the work groups.)

## CURRENT ACTIVITY:

Task force members have selected the work group area on which they will focus their attention for the next four months. There are three groups working in the following areas: collaboration/prevention, ITA, and service gaps. Each group will be identifying accountability measures for their recommendations. Education and advocacy will be addressed during the latter part of spring.

Groups are meeting at least monthly, conferring by conference call, and working independently on specific tasks. The Task Force meets as a whole group monthly for several hours.

## SPRING FORUM:

**May 3<sup>rd</sup> has been identified as the date for the spring forum.** Based on extremely positive comments by participants, it will be conducted in the same location as the November forum. Please mark your calendars and plan to attend. There will be specific recommendations made by the work groups designed to accomplish the results and characteristics that were identified as important to you.

## EFFECTIVENESS (of a crisis response system) CRITERIA:

Forum participants were asked to identify the four most important results of an effective crisis response system:

- |   |     |
|---|-----|
| 1. Individual and community safety:                                     | 83% |
| 2. Effective use of resources:  | 71% |
| 3. Low recidivism/revolving door:                                       | 67% |
| 4. Freeing up of critical resources:                                    | 52% |
| 5. Balance of community, customer, and responder/provider satisfaction: | 46% |
| 6. Balance of individual rights and community interests:                | 40% |
| 7. Effective cost management over time:                                 | 36% |
| 8. Satisfied public officials:  | 01% |

Forum participants identified the five most important characteristics of an effective crisis response system:

- |   |     |
|---|-----|
| 1. Is accessible:   | 68% |
| 2. Provides coordinated response and care                               | 65% |
| 3. Has access to resources so that correct clinical decisions are made: | 63% |
| 4. Has a preventative focus   | 62% |
| 5. Is responsive  | 62% |
| 6. Employs effective interventions                                      | 61% |
| 7. Provides appropriate resolution                                      | 46% |
| 8. Is respectful  | 32% |
| 9. Considers individual diversity and choice                            | 20% |
| 10. Is fair   | 14% |

**CROSS-SYSTEM CRISIS RESPONSE PROJECT**  
**June 2004**

**APPENDIX 3**

**PROPOSED PLAN OF WORK**  
**DECEMBER 2003**





# CROSS-SYSTEM CRISIS RESPONSE PROJECT

## PROPOSED PLAN OF WORK

December 4, 2003

The purpose of the November Crisis Forum was to generate as many ideas as possible for the Task Force to study and consider. There were 18 tables that generated over 90 individual ideas. Although there is some overlap, the ideas fell loosely into 6 categories.

### SUMMARY OF AREAS OF WORK

In order to accomplish as much work as possible, Task Force members would divide into smaller groups to address the following areas of work that emerged from Forum.

#### **1. CRISIS RESPONSE: STRENGTHENING COLLABORATION/COORDINATION**

Deliverables could include recommendations for local coordination strategies and models, and specific changes in state policies, WAC, eligibility, contracts, etc.

#### **2. CRISIS PREVENTION: STRATEGIES AND MODELS THAT PREVENT A PERSON FROM GOING INTO CRISIS.**

Deliverables could be recommend ways to expand known prevention models and strategies.

#### **3. INVOLUNTARY TREATMENT ACT: EXPLORING POTENTIAL CHANGES TO CURRENT ITA STATUTES**

This group could explore the possibility of a revised or integrated ITA. The deliverable would be to propose very specific changes to existing ITA statutes.

#### **4. SERVICE GAPS: IDENTIFICATION OF AREAS WITH CRITICAL SERVICE GAPS AND DEVELOPMENT OF SHORT AND LONG-TERM PLANS/SOLUTIONS**

This group's deliverable could be to identify the most significant service gaps and recommend ways to address them.

The Task Force as a group will discuss the following two areas of work at future meetings.

#### **5. ACCOUNTABILITY: HOW TO KNOW WHERE TO INVEST RESOURCES, OUTCOMES FOR VARIOUS STRATEGIES.**

#### **6. PUBLIC EDUCATION/ADVOCACY: STRATEGIES TO BUILD AWARENESS OF THE PROBLEM AND SUPPORT FOR SOLUTIONS.**

## **“TOP IDEAS” ORGANIZED BY AREAS OF WORK**

### **1. CRISIS RESPONSE: STRENGTHENING COLLABORATION/COORDINATION**

#### **Training**

(#1) Specific training curriculum for CDMHPs and a statewide standard to include timelines for new hires and ongoing staff. Also needs to include some sort of assessment of learning and practice. (Table 1)

(#35) Place emphasis on systems cross-training regarding limitations and restrictions. (Table 7)

(#41) Cross-system training: inter-disciplinary training that emphasizes best practices along with ongoing follow up meetings/training and public education. (Table 8)

(#66) “No Wrong Door” knowledge for line staff. (Table 13)

(#69) Revise mandatory training requirements for all registered, certified, and licensed professionals and programs to include cross-systems content. (Table 13)

#### **Organization/coordination and law & regulations**

(#4) Create task groups for defined geographical areas to include staff from DDD, ADSA, DOC, Public Defense, crisis response, mental health, RSN, etc. to discuss collaboration on crisis response and providing services. Might allow group to look at specific cases to come up with pro-active ideas for cases. (Table 1)

(#8) Coordinate disparate missions among agencies, divisions, and counties so that, to the degree possible, a benefit to one is not a loss to another. (Table 2)

(#16) All publicly funded human service contracts should require reciprocal collaboration and have plans for doing so. (Table 3)

(#21) Change liability laws so that providers will serve high-risk individuals. (Table 4)

(#26) Reduce duplication (e.g., administration, assessments, data, info) across and within systems to save money, improve continuity of care, and help front-line staff know who else is involved in a case. (Table 5)

(#27) Review and change residential facility WAC’s and licensing to make them more relevant to populations served. (Table 5)

(#29) Shared data agreements: Confidentiality and HIPPA (Table 6)

(#34) Blended funding for more holistic approach (Table 7)

(#39) Creation of statute/policy/system that emphasizes client-centered interdisciplinary services planning: delivery and inter-agency quick response crisis teams. (Table 8)

(#47) Consolidate all of DSHS adult services. (Table 9)

(#49) Early identification/community partnerships (“hand holding”, gatekeeper, peer support, public education) supported by integrated case management across systems. (Table 10)

(#59) Encourage and permit flexibility in funding so that there can be blended funding where each system shares in the risk and benefits. (Table 11)

(#62) Database for cross-agency sharing for collaborative care plans. (Table 12)

(#64) Better service coordination between agencies, e.g., single service coordination. (Table 12)

(#67) Statewide cross-system database or client information, e.g., “creative socio-medics” (Table 13)

(#68) Change privacy and confidentiality legal requirements or develop clear processes for the cross-system sharing of information. (Table 13)

(#73) Consider altering the existing administrative structure so that mental health, chemical dependency and all other behavioral health issues can be addressed cohesively. (Table 14)

(#75) Ensure follow from community-based services into crisis services and then back. (Table 14)

(#80) Review how state agencies are organized and how they work together. how they impact programs in the local community. What is the inter-rater reliability at the state level? (Table 15)

(#86) Put all agencies under the state umbrella to simplify confidentiality rules by redefining continuity of care and agency scope and rules. (Table 17)

## **Funding**

(#17) Task Force to examine all existing laws and work to change un-funded mandates and those that affect ability to provide treatment or restrict funding. (Table 3)

(#83) End “box thinking” and “funding silos”. Make resources more flexible and person-centered. (Table 16)

(#91) For un-funded people: expand definition of “Crisis Service” to include post-discharge services, access to meds, and help through the CSO process. (Table 18)

## **2. CRISIS PREVENTION: STRATEGIES AND MODELS THAT PREVENT A PERSON FROM GOING INTO CRISIS.**

### **Training**

(#2) For CIT – get agreements with law enforcement association to get as many officers trained as possible. Create specified goals to get them trained. Probably would need funding considerations because training is 40 hours. (Table 1)

(#79) Develop individual community-based best practices based on utilizing list from Table 15’s second bullet (#77)\* and based on individual needs. (Table 15)

*\*(#77) “One size does not fit all. Develop a list of what is working well, where and why. Then create a menu of options for local community design and implementation.*

### **Funding**

(#7) Somehow create a system where the fact that crisis response is involved creates eligibility for publicly funded services. (Table 1)

(#61) Flexible funding streams for persons at-risk (outside Medicaid). (Table 12)

(#70) “Second responder” cross-system resource/service-delivery system specifically tailored to community needs. (Table 13)

(#82) Medication and Medical Care—Regardless of financial eligibility at crisis, include medical assessments as part of crisis response. Must include incarcerated persons while incarcerated and at transition to community. (Table 16)

(#89) Expedite determination of eligibility for benefits/services to prevent crisis and ensure portability and predetermination. (Table 17)

### **Organization/coordination and law & regulations**

(#9) Uniformity in process to develop state plans—involve stakeholders and simplify drafting. (Table 2)

(#11) Identify regulations that impede best practice service delivery—including rates. \$\$ (Table 2)

(#18) Establish a legislative work group with community involvement to re-define/fund unified cross-system crisis teams. (Table 4)

(#25) Allow pre-app for services (e.g., welfare, Medicaid) for people in jails or hospitals so they are eligible immediately upon release. (Table 5)



(#51) Address Medicare and Medicaid changes that are impacting service delivery. (Table 10)

(#88) Collaborative case management that brings together all stakeholders utilizing technology, “tele-medicine”, “tele-conferencing”, etc. (Table 17)

### **Resources**

(#45) Peer support for crisis response interventions. (Table 9)

(#63) Expansion of models that decrease use of crisis resource; e.g., A-Teams, ECS, Colby House, MI. (Table 12)

### **3. INVOLUNTARY TREATMENT ACT: EXPLORING POTENTIAL CHANGES TO CURRENT ITA STATUTES**

(#3) Enact legislation to shorten time frames required for incompetency evaluations and to allow for on-site evaluations at the jails. (Table 1)

(#5) Enact some sort of general commitment law based on observable and reportable behaviors. (Table 1)

(#10) Develop community wide crisis response system. (Table 2)

(#13) Integrate/consolidate and co-locate disciplines for 24 hour service and create general commitment law. (Table 3)

(#22) Develop a short-term involuntary process for individuals with a documented history of risk behavior and failed treatment based on co-occurring disorders and/or disabilities. (Table 4)

(#24) Emergency capacity in all systems to ensure people are immediately or quickly served by the system responsible for their primary condition. 24/7 capacity from all systems. Fall back to RCW change so CDMHPs can detain to appropriate system. (Table 5)

(#32) Encourage disease model response to crisis (Medicaid Integration Project) (Table 6)

(#37) Legislation to add LRA capability to CD ITA. (Table 7)

(#38) Legislation to bring parity between the two involuntary commitment acts. (Table 7)

(#40) Develop comprehensive coordinated civil commitment/ITA statute. (Table 8)

(#46) Integrated ITA for DASA, MH, DDD, and Aging populations. (Table 9)

(#53) Develop one crisis response ITA system with supporting WAC's and RCWs: (Table 10)

- Continuum of resources providing prevention crisis systems responses and crisis follow-up (reducing use of hospital and jail beds)
- Complete cost analysis

(#54) Develop a common ITA law, with common terms, common standards and measured outcomes. Must include the examination of contradictory regulations (e.g., MH and CD issues require separate charting). (Table 11)

(#57) Research other states/countries where it is working better. (Table 11)

(#71) Allow CDMHP to use verifiable recent data for ITA criteria that was not directly observed by the CDMHP. (Table 14)

(#84) ITA Statutes and Rules—Review and update to meet current needs. (Table 16)

(#93) Develop an integrated crisis system and ITA law for all behaviors that require commitment. (Table 18)

#### **4. SERVICE GAPS: IDENTIFICATION OF AREAS WITH CRITICAL SERVICE GAPS AND DEVELOPMENT OF SHORT AND LONG-TERM PLANS/SOLUTIONS**

(#6) Create a point of contact for CCO's on-site, per location that acts as a qualified resource for CCO. (Table 1)

(#12) More beds for people who have medical and behavioral problems. (Table 2)

(#14) Triage centers in each county or region. (Table 3)

(#19) Develop a flexible array of housing, including respite capacity at ECS facilities for emergency placement until more permanent placement can be found. (Table 4)

(#28) Develop new types of licensed facilities, change regulations so residents of facilities placed out of the facility (e.g., hospital care—psych hospital) can return. Get DOH, ADSA and program regulations congruent. (Table 5)

(#30) Create One Stop Shopping, "24 Hour" Crisis Response Center: (Table 6)

- Fiscal incentives
- Administration over-site boards (multi-agency)

(#33) Encourage housing that supports crisis intervention, i.e., short and long-term (Table 6)

(#36) Creation of database of service recipients for first-responders. (Table 7)

- (#43) Co-located “one stop shopping” storefront service delivery center. (Table 8)
- (#42) Cross-discipline/coordinated access to service resources, such as, diversion beds, housing vouchers, etc. (Table 8)
- (#44) Centralized triage using professionals trained in dx, tx, assessment, and staff to respond. (For example, A-Team with quick response and centrally located/housed.) (Table 9)
- (#52) Protect and grow the infrastructure of community-based services, especially the severely under-funded alcohol and drug treatment services. (Table 10)
- (#72) Develop tenant support services as a less costly alternative to prevent crisis as well as to be used as a resource and stabilization for after a crisis has occurred. (Table 14)
- (#74) Build capacity so that services are readily available when needed. Determine this need with accurate forecasts. (Table 14)
- (#76) Entry at lowest possible level with a full continuum of care, like sobering houses and crisis beds. (Table 15)
- (#77) One size does not fit all. Develop a list of what is working well, where and why. Then create a menu of options for local community design and implementation. (Table 15)
- (#81) Housing—(Table 16)
- As prevention, access to appropriate type:
  - As diversion
  - As transition from in-patient
- (#85) Crisis Response—Customized diversion and treatment resources to meet wide range of needs. (Table 16)
- (#87) Housing: more crisis short-term, long-term etc.!!! (Table 17)
- (#90) Develop a continuum of timely and appropriate resources to address gaps in the system and misuse of current resources. (Table 17)
- (#92) Fund crisis triage model statewide, to be adopted in each community. (Table 18)
- (#94) Integrate CD services with Crisis Services to increase sobering centers and non-abstinence housing options. (Table 18)

- (#95) Expand cost-effective, lesser-restrictive alternatives to hospitalization: (Table 18)
- Psych step downs
  - Transitional housing
  - Day hospitals

## **5. ACCOUNTABILITY: HOW TO KNOW WHERE TO INVEST RESOURCES, OUTCOMES FOR VARIOUS STRATEGIES**

(#56) Demonstrate the cost effectiveness of appropriate intervention, including pre-crisis intervention and treatment/best practices. (Table 11)

## **6. PUBLIC EDUCATION/ADVOCACY: STRATEGIES TO BUILD AWARENESS OF THE PROBLEM AND SUPPORT FOR SOLUTIONS.**

(#15) Public education program that makes issue as familiar as CPR, seatbelts, etc. (Table 3)

(#20) Develop community-based coalitions of advocates to educate state legislators. (Table 4)

(#31) Education of CRS to stakeholder groups: (Table 6)

- Avert ER costs
- Crisis intervention—family involvement

(#55) Join together in a coalition for advocacy including MH, DD, CD, families and consumers. Increase public awareness. (Table 11)

(#65) Proactive education and training: community and service providers. (Table 12)

(#78) Educate and sensitize EVERYONE on the cost effectiveness of an adequately funded crisis service. More flexible use of funding to meet the needs of people in crisis that does not meet criteria of specific programs. (Table 15)

## **ODDS AND ENDS**

(#48) Secretary of DSHS should not be a political appointment. We need the position to be consistent and stable to effect real change. (Table 9)

(#50) Address service delivery system problems created by un-funded legislative mandates. (Table 10)

(#60) Comment: Overall, if the larger system had adequate resources, the cross-system would just fall into place. (Table 11)

And last, but not least: (#23) World Peace!! (Table 4)

**CROSS-SYSTEM CRISIS RESPONSE PROJECT**  
**June 2004**

**APPENDIX 4**

**COLLABORATION/PREVENTION**  
**WORK GROUP ISSUE PAPER**



CROSS-SYSTEM CRISIS RESPONSE PROJECT  
COLLABORATION/PREVENTION ISSUE PAPER  
MAY 2004

Issue:

Users of crisis response services tell us that more often than not, they experience chaotic, fragmented and disorganized care during times of crisis. In addition, professionals, families, advocates, law-enforcement and others note that in fact, “the crisis response systems seem to be in crisis”. Access to appropriate resources at the needed time does not happen often enough. Crisis responders do not seem to have clear roles and responsibilities during the crisis. When the crisis is not resolved, the situation escalates and can result in harm to an individual or to the public at large.

What problem are we trying to solve?

Lack of coordination between multiple systems and services at the time of crisis prevents the delivery of services to at-risk individuals *in the right way, with the right service, at the right time*.

How would solving this problem help us move closer toward our “preferred experience”?

There is consensus among stakeholders that the best crisis response posture is to prevent a crisis altogether. Coordination can minimize the intensity and frequency of crisis, and in many cases can prevent a situation from escalating into a crisis. The use of a cross-system planning process for individuals who are at risk will increase the likelihood of positive outcomes because the individual and the serving systems will have prior agreements, in writing, regarding specific interventions at specific times for specific reasons.

Carefully crafted coordinated plans that are developed with and for individuals who are receiving services from more than one agency (and/or who are considered to be at risk of needing crisis services) would clarify roles and responsibilities. They would be:

- preventative
- understandable to the average person and increase the possibility that he or she could access needed help
- flexible and responsive
- respectful
- fair
- consistent in quality and interpretation of law across state
- coordinated for both response and care
- effective
- satisfying to the consumer and family
- appropriate and lead to resolution
- considerate of individual diversity and choice
- able to identify realistic resources to ensure that clinical decisions are based on best practice standards

Development of a cross-system plan format, with accompanying protocols and training materials would result in:

- serving each person in the right way with the right service at the right time
- individual and community safety
- balance of individual civil and treatment issues and community interests
- people getting what they need
- increased communication that could lead to ongoing continuity of care
- community, customer, and responder or provider satisfaction

The successfulness of coordinated cross-system crisis planning would document outcomes that are working. Success could be measured by:

- reduction in premature death and/or disability
- low recidivism/revolving door
- effective use of resources and cost management over time
- accountability that leads to sustainability
- effective system(s) with support from elected officials

#### What issues, concerns, or other factors are involved in addressing the problem?

A consistent message from stakeholders at our November forum was that collaboration really works, but is not always possible to accomplish due to confusion and misunderstanding about sharing information. Many individuals and systems have found coordinated planning strategies to be extremely helpful in both responding to, and preventing, a certain set of circumstances from becoming a full-blown crisis. It has also been documented that should the crisis escalate, particularly for an at-risk individual, advance planning results in more appropriate and coordinated responses.

Confidentiality can be a critical issue. When an individual authorizes the sharing of protected health information, there is no privacy issue. But, when there is no authorization, protected health information can only be shared when an exception to state or federal law is satisfied. Each legal exception has limitations. Therefore, collaboration teams for identified populations will need to have a working model to address communication in cases where a release of information cannot be obtained.

Generally releases are not required for those professionals within a system or entity treating the individual for information related to the treatment. Information may be shared with a somewhat larger group of persons in a bona fide emergency. Chemical dependency information may also be shared with a person providing professional services under a qualified service organizational agreement. This exception opens many possibilities. Mental health information may be shared under an appropriate court order or administrative request when it is required by law, and certain procedures are followed. There are currently questions about the extent to which information can be shared with law enforcement.



SB 6358 was recently signed into law and places some new requirements on information sharing for persons who are under both DOC supervision and court ordered mental health or chemical dependency treatment. It requires DOC and DSHS, in conjunction with a variety of interested groups, to develop a model for team staffing that complies with confidentiality laws.

*Our work group has been working closely with the agencies responsible for implementing this legislation to assure that our proposal is aligned with SB 6358.*

Cross-system training and related protocols that address all statutes and concerns pertinent to sharing of information must be thoughtfully and carefully developed. Funds will be needed to address identified resource issues. Administrative and service level “buy-in” by all systems will be necessary. Training will be essential for successful cross-system collaboration and planning to be effective. Study sites for non-mandated populations will help to determine the best utilization and effectiveness of the process.

What realistic public policy choices/options can we consider?

CHOICES/OPTIONS	PROS	CONS
1. Do nothing to change the current experience	<ul style="list-style-type: none"> <li>o No resistance</li> <li>o No changes</li> <li>o No new funding</li> </ul>	<ul style="list-style-type: none"> <li>o No improvement in crisis services</li> <li>o Continued disbanding of currently effective collaborative teams</li> <li>o Ongoing unnecessary excessive spending</li> </ul>
2. Require mandatory cross-system plans for individuals with DOC <u>and</u> Mental Health or Chemical Dependency court mandates for supervision	<ul style="list-style-type: none"> <li>o Supported by SB 6358</li> <li>o Concept supported by stakeholders</li> <li>o Ultimate cost savings</li> <li>o Minimal upfront investment</li> <li>o Already partially in place</li> <li>o May reduce recidivism</li> <li>o May reduce escalating crisis</li> <li>o May reduce death or disability in times of crisis</li> </ul>	<ul style="list-style-type: none"> <li>o Concern about caseload increases</li> <li>o Requires consistent AG support</li> <li>o Requires new resources (or re-allocated resources)</li> <li>o Requires contract changes</li> </ul>
3. Require mandatory cross-system plans for dually court-ordered individuals <u>and</u> recommend that such plans be developed for “at risk” individuals (as defined by each community based on individual needs and circumstances*.)	<ul style="list-style-type: none"> <li>o Supported by SB 6358</li> <li>o Concept supported by stakeholders</li> <li>o Ultimate cost savings</li> <li>o Minimal upfront investment</li> <li>o Already partially in place</li> <li>o Will reduce recidivism</li> <li>o Will reduce escalating crisis</li> <li>o Will reduce death/disability in times of crisis</li> </ul>	<ul style="list-style-type: none"> <li>o Concern about caseload increases</li> <li>o Requires consistent AG support</li> <li>o Requires new resources (or re-allocated resources)</li> <li>o Requires statute and contract changes</li> </ul>

\* Individuals to be defined by the local community could include those who are:

- frequent visitors to the Emergency Department, or
- chronically utilizing high cost emergency response services, or
- identified as a community safety risk, including those who are not current “clients” (e.g. not receiving mental health or other treatment).

### What is the recommended option and why?

Our recommendation is that:

- A cross-system crisis planning process (for mandated and non-mandated populations) be finalized and approved for the purpose of assisting our communities statewide to serve each individual in the right way, with the right service, at the right time. (Option #3)
- Priority attention be given to resolving confidentiality issues and concerns so that this planning process and related protocols can be effectively used. This may require involvement of the Attorney General, the Legislature, and/or others to resolve this critical issue.
- Confidentiality misunderstandings and inconsistencies be addressed and included in the training materials and protocols that support the planning process.
- State policies, including memorandums of understanding that support local communities to plan and implement cross-system crisis plans be proposed and approved concurrently with training and protocol development.
- Education and training regarding cross system planning be made available statewide at all levels of DSHS, DOC, treatment provider agencies, corrections, law enforcement, hospitals, residential programs, and the judicial system.
- Funds be allocated to ensure:
  - development of thorough and complete planning documents (formats, protocols, training manuals),
  - delivery of a statewide training program, including reimbursement for key people to attend the training,
  - implementation of the process at the county level (such as reimbursement funds for specifically identified county risk coordinators),
  - selection of specific study sites to determine the effectiveness of this strategy for the non-mandated population, and
  - ongoing evaluation of the process, necessary updates and improvements, and ongoing training.

## CROSS-SYSTEMS CRISIS PREVENTION AND INTERVENTION PLAN

Client Name	Client Phone #	Birth date	Soc. Sec. #	Residential Name/Setting		
Client Address		Ht.	Wt.	Eye Color	Hair Color	Phys. Characteristics
Alternate Location/Address		Guardian/Family/Friend Name			Contact Phone #	
Supervision/Court Order Status Corrections <input type="checkbox"/> LRA <input type="checkbox"/> DASA <input type="checkbox"/> Guardian <input type="checkbox"/> Other <input type="checkbox"/> Describe: _____					Court Mandated ROI <input type="checkbox"/>	
Insurance Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Comm. <input type="checkbox"/> None <input type="checkbox"/>		Current Meds Contact Name	Med Info Phone #	Med Issues/Allergies		
Diagnostic Information Axis I: Axis II: Axis III:		Date of Plan:      Revised:      Revised:				
		<b>TREATMENT TEAM MEMBERS</b>				
(Photo)		<b>Name/Agency</b>	<b>Phone #</b>	<b>Case #</b>		
History/Presenting Issues/Risk Indicators						



## Cross-Systems Crisis Prevention and Intervention Plan

<p>Presenting behaviors <b>1.</b> Possible causes</p>	<p>Who responds</p> <p>How to respond</p> <p>Who to notify</p>
<p>Presenting behaviors <b>2.</b> Possible causes</p>	<p>Who responds</p> <p>How to respond</p> <p>Who to notify</p>
<p>Presenting behaviors <b>3.</b> Possible causes</p>	<p>Who responds</p> <p>How to respond</p> <p>Who to notify</p>
<p>Presenting behaviors <b>4.</b> Possible causes</p>	<p>Who responds</p> <p>How to respond</p> <p>Who to notify</p>



**Cross-Systems Crisis  
Intervention and Prevention Plan**

This is the signature page for individuals responsible for monitoring court orders and implementing this plan. Please print your name and agency/affiliation, then sign and date this plan.

<b>Name/Agency or Affiliation</b>	<b>Signature</b>	<b>Date</b>





# Cross-Systems Crisis Plan Worksheet

## Overview of Cross-Systems Crisis Planning

Cross-systems crisis plans can be used for individuals who involve multiple service systems when having behavioral issues. This plan can also be a way to formally address the need to collaborate when individuals fall under multiple court orders from DOC, DASA, and the mental health system.

Cross-systems crisis plans provide a coherent and tailored response to individuals in crisis. Individuals responsible for implementing these plans will have a concrete plan of action, with a ready listing of other supports to call in when a behavioral crisis occurs. The existence of such a plan may allow for more confidence for family members, service providers, and first responders, because helpful information is readily available and ways to access increased supports are clearly described. The response described in these plans may assist the individual in crisis and reduce the rate and intensity of future crisis events.

The process of building cross-systems crisis plans builds collaboration between individuals and systems involved with the client. During the planning process one meets and gets to know the other people involved with the client. That leads to an increased understanding of the roles and responsibilities of fellow collaborators. We sometimes have an unreasonable expectation of what people in other fields are supposed to do and are able to do, and during a planning process we come to a better understanding of how systems work together and where the gaps are, which often can reduce frustration and finger-pointing, starting a more constructive conversation that is client focused. In addition, different service systems develop 'dialects', and one learns how to communicate better across systems.

As collaborators start discussing the history of the client, behavioral presentation, risk factors, and possible causes for the behaviors a shared view of how to understand the crisis behaviors evolves. There is a sense of support knowing that others are sharing the risks and challenges of supporting an individual in crisis. Collaborations often challenge everyone to a higher level of practice.

The following is a description of how to formulate a plan, with instructions of how to fill out the form and examples of how to fill out each section. There are also exercises so that one can practice formulating a plan.

## Gathering Demographic and Diagnostic Information

The first section is general demographic and contact information. The following provides some guidelines regarding this information:

- If an individual uses more than one name or uses aliases use what is considered the individual's legal name, particularly if the name appears on court orders. Aliases and other identifying information can be included in the "History/Presenting Issues/Risk Indicators" section if necessary. Provide the client phone number, birth date, and social security number. If any of this information is unknown, do not leave it blank but put in "Unknown".
- The "Residential Name/Setting" box can be used to indicate the name of a service agency providing residential supports (e.g. nursing home, AFH, residential drug and alcohol treatment, etc.). If the individual lives at home or with parents this can be indicated here, and if the person is homeless this can also be indicated.
- Provide the client address. If it is not known write in "unknown". If a person moves around but has a base (e.g. shelter) provide that address and phone number.
- When possible indicate collateral contacts by listing an alternate address, guardian/family/friends, and a phone number. If the person has a guardian use this section to provide the guardian's name and phone number, otherwise list a family member or friend as a contact person. This section altogether can be very helpful if a person is missing or if notification is needed during or after a crisis.
- Check the appropriate boxes indicating if the client has current court orders. Check the box if someone is guardian for the client. Use the "Other" box if there are additional court orders, e.g. no-contact orders, family support orders, etc. and briefly describe these additional orders in the box provided.
- Check the box for Court Mandated ROI if it is known that there is a court order requiring the client to sign a Release of Information permitting involved parties to communicate about the client.
- Check the appropriate box indicating medical insurance status. "Comm." means commercial insurance, either privately purchased or through employment.
- The "Current Meds Contact Name" and "Med Info Phone #" should provide contact information where someone could call regarding medications prescribed for an individual. If the individual is not on medications write in "Not on meds".
- If there are known contra-indications for medications or health issues there is room for a brief mention here. Further exposition if there are serious medication issues can occur in the "History/Presenting Issues/Risk Indicators" section.
- If an individual has a known psychiatric condition provide the diagnosis in the "Diagnostic Information" box..
- Provide the date when the plan was made, and dates if it is revised.

The following is a blank excerpt from the form. Think of a person who might benefit from a cross-systems plan. Change identifying information and name if doing this plan with others. This excerpt can be used to practice filling out demographic and diagnostic information on the client.

**CROSS-SYSTEMS CRISIS  
PREVENTION AND INTERVENTION PLAN**

Client Name	Client Phone #	Birth date	Soc. Sec. #	Residential Name/Setting		
Client Address		Ht.	Wt.	Eye Color	Hair Color	Phys. Characteristics
Alternate Location/Address		Guardian/Family/Friend Name			Contact Phone #	
Supervision/Court Order Status Corrections <input type="checkbox"/> LRA <input type="checkbox"/> DASA <input type="checkbox"/> Guardian <input type="checkbox"/> Other <input type="checkbox"/> Describe: _____					Court Mandated ROI <input type="checkbox"/>	
Insurance Medicaid <input type="checkbox"/> Medicare <input type="checkbox"/> Comm. <input type="checkbox"/> None <input type="checkbox"/>		Current Meds Contact Name	Med Info Phone #	Med Issues/Allergies		
Diagnostic Information Axis I: Axis II: Axis III:		Date of Plan:          Revised:          Revised:				

## Treatment Team members, Contacts, and Case Numbers

The next section to fill out is the “Treatment Team Members” section. It is essential that persons responsible for monitoring court orders be listed here. Treatment teams can also include the client, advocates, law enforcement, other involved support individuals, and family members. Some service systems use numbers to further identify the client, and this section provides a place for the agency staff person to list the client’s enrollment or case #. The “Case #” boxes can also be employed to provide case numbers for law enforcement contacts. This could assist law enforcement personnel to quickly call up a history of previous contacts during a response.

	Name/Agency	Phone #	Case #
(Photo)			

Attach (or scan in) a photo in the section labeled “Photo”.

## History/Presenting Issues/Risk Indicators

The following section, “History/Presenting Issues/Risk Indicators”, is where significant information is succinctly provided about the client. Fill in the blanks following each of the prompts that apply to the client, and leave non-applicable prompts blank. At the end there is a place to provide additional information.

### History:

- This client has used the following names/aliases in the past: .
- This client has been convicted for the following criminal offenses: .
- In the past ten years this client has been involuntarily detained in an E&T, locked psychiatric unit, or State Hospital on the following dates: .
- In the past ten years this client has received the following court mandated treatments for alcohol/substance abuse: .
- The client has a history of violence as evidenced by .
- The client has a history of gang affiliation as evidenced by .

### Presenting Issues:

- This client is currently under the supervision of DOC due to a conviction for .
- The client is currently subject to the following court orders (e.g. family support, no-contact orders, etc.): .
- This client has a civil court order due to alcohol/substance abuse, requiring the following: .
- This client is under a current civil order due to grave disability and/or harm to self and/or other, and the civil order requires: .
- This client has a history of using weapons in the commission of a crime, and/or may currently possess or have access to the following weapons: .
- This client in the past has demonstrated unusual strength during an outburst or when confronted, and law enforcement and crisis responders should know the following: .
- This client has the following serious medical conditions: , and the primary physician and physician phone number is .
- The client’s presenting issues may in part be due to the following medical/neurological/psychiatric conditions: .
- This client has a Mental Health Advanced Directive and more information about this specific Directive can be obtained by calling , at .
- The client’s presenting issues may be due to use of the following substances that impair behavioral self-control: .

### Risk Indicators:

- The following antecedents have been known in the past to increase the risk for crisis behaviors: .
- The following behaviors/symptoms may indicate that this client is headed into a crisis: .
- A significant change in eating habits and/or sleeping schedule indicates .
- *Enter additional information related to History/Presenting Issues/Risk Indicators here:* .

The following is an example of how the suggested prompts can result in a profile providing a sketch of the client’s history, presenting issues, and risk indicators:

History/Presenting Issues/Risk Indicators

This client has the following serious medical conditions: Hepatitis B, and the primary physician and physician phone number is Dr. Hager, 360-777-8888. This client has been convicted of the following criminal offenses: 2<sup>nd</sup> degree assault, poss. of controlled substance. This client is currently under the supervision of DOC due to a conviction for 2<sup>nd</sup> degree assault. This client has a history of using weapons in the commission of a crime, and/or may currently possess or have access to the following weapons: client menaced with knife and has access to kitchen knives at home. This client in the past has demonstrated unusual strength during an outburst or when confronted, and law enforcement and crisis responders should know the following: client impulsively grabs handy objects to wield as weapons, and may flee - is a very fast runner. This client has a civil court order due to alcohol/substance abuse, requiring the following: live at current address, attend outpatient d/a counseling, and refrain from substance use and alcohol. In the past ten years this client has been involuntarily detained in an E&T, locked psychiatric unit, or State Hospital on the following dates: 7/97 at WSH, 1/00 & 9/02 at St. Peters, and 2-04 at WSH. This client is under a current civil order due to harm to self and/or other, and the civil order requires: follow psychiatric med orders, refrain from alcohol/substance use, refrain from illegal acts. The following behaviors/symptoms may indicate that this client is headed into a crisis: missing 2 or more consecutive med passes, decrease in hygiene, staying up all night, any alcohol or use of drugs, especially methamphetamine.

If using this worksheet to practice the development of a plan, use the prompts provided above to fill in the blank “History/Presenting Issues/Risk Indicators” section of the plan.

History/Presenting Issues/Risk Indicators

## **Describing “Presenting Behaviors” and “Possible Causes”**

The next section is the heart of the cross-systems plan. Well-written plans are succinct, with concrete descriptions of behaviors and interventions. To come up with a succinct list of presenting behaviors it helps to informally keep notes while discussing what constitutes a crisis for the individual. The following questions can elicit this information:

- What does the individual say when angry (provide verbatim quotes)?
- How does the person communicate when angry (yelling, swearing, etc.)?
- How does the individual physically present when upset (pacing, fists clenched, intrusive, secludes self, etc.)
- What is the mental state of the individual when in crisis (tearful, paranoid, psychosis)?
- Does the individual threaten others or attempt to harm others?
- Does the individual threaten to harm herself and how do they present this threat?
- Does the individual have a history of serious self-harm behaviors?
- Does the individual use alcohol or other drugs during a crisis?
- Does the individual engage in property destruction?
- Does the individual leave so that others don't know where she is?
- Has the person failed to comply with treatment orders or court orders?
- Does the person have a Mental Health Advanced Directive?

From the notes taken of the discussion generated by these and other questions, one can identify the serious behaviors that would likely elicit a cross-systems response. It is important to delineate between a treatment plan and a crisis plan. Often good ideas for treatment collaborations come up in this discussion, which is a benefit of meeting together. However keep in mind that the final product from this meeting will be a clean and succinct crisis plan that will be of benefit to crisis responders. Resist including non-crisis behaviors and interventions in these plans.

Identify two to four specific behaviors from the discussion that would warrant a potential crisis response. The next job is to write out the problem behaviors and their possible causes. Objective descriptions of “Presenting Behaviors” are simple, descriptive, and concrete. The following statement – “Jim throws a fit” is not as descriptive and concrete as “Jim yells profanities, is physically intrusive, and is verbally threatening”.

It may be that a behavior occurs for more than one reason. For instance Jim may yell profanities when he is inebriated, and also when he is hearing voices due to a psychotic disorder. It is fine to list more than one potential cause for a presenting behavior.

The next task is to arrange these symptoms, going from the least concerning to the most overt behaviors. Number the ‘Presenting Behaviors’ from least concerning to most overt on the worksheet above list.

Sometimes the sequence listed describes a classic decompensation. This might be the case if the possible causes for the symptoms include depression, some forms of bi-polar disorder, increased involvement in alcohol and/or drug use, and schizophrenia. If an appropriate intervention occurs early on, perhaps a med review and increased contact from a MH case manager, then subsequent symptoms can possibly be averted.

Frequently behavioral challenges occur without an apparent pattern of decompensation. For instance, some individuals may suddenly appear violent and appear to be experiencing psychosis, without prior symptoms leading up to the more extreme presentation. In such cases this tool serves simply as a way to delineate responses across systems for an array of behavioral presentations.

Use the following worksheet to list potential symptoms on the left, and possible causes related to the specific symptoms on the right.

-	-
-	-
-	-
-	-



## Developing “Interventions”

There are three major considerations to include when developing each step of the intervention plan:

- Who is responsible for responding
- How to respond to each specific presenting behavior
- Who to notify about the behavior and response

The possible cause for each symptom will be very helpful in determining responses. For instance, one symptom might be:

- Stays out all night for several days without checking in, returning unkempt

If this were an indication of the onset of a manic episode then looking at a MH oriented response would make sense. If the person has dementia one might file a missing person’s report. If the behavior typically occurs near the first of the month after receiving a monthly check and drug use is suspected one might consider a CCO response or contact with a DASA counselor. One should remain aware of applicable court orders, which might prescribe a response irrespective of the possible causes of a presenting behavior.

In designing intervention strategies it is important to modulate the response protocols to suit the circumstances. For instance, a person having a visible episode indicating a possible decompensation but not actively engaging in behaviors that are risky may benefit from a case manager or crisis team outreach in the home setting rather than being transported to an ER for a psychiatric evaluation. A determination to involve police, CDMHPs, and/or emergency rooms should be based on concretely defined criteria indicating that the symptoms cannot be safely contained in a community setting. The plan should also indicate when a court order specifies a required response. For instance there may be a requirement for a CCO to take an individual into custody for particular violations.

The following is an example of how a plan might read. Following that is a blank plan. Transfer information from the worksheet describing “Presenting Behaviors” and “Possible Causes” into the left side of the blank plan. On the right side use the prompts to indicate who responds, what the response is, and who is notified of the behavior and response. It may be a family member, friend, or residential provider who first notices a crisis, and their role might be to either provide the response or to call in someone else to implement the intervention. Please note that there is limited space to describe this plan altogether. Please keep in mind that it is not a treatment plan, and that brevity is a virtue to individuals responsible for implanting these plans.

**CROSS-SYSTEMS CRISIS  
PREVENTION AND INTERVENTION PLAN**

<p><b>Presenting behaviors</b> 1. Jim stays out all night or for several days, returning unkempt.</p> <p><b>Possible causes</b> This may be due to deterioration due to bi-polar disorder.</p>	<p><b>Who responds</b> SoberHouse staff will initiate response if Jim stays out over one or more nights</p> <p><b>How to respond</b> Staff check to see if Jim missed meds while gone, and let Jim know they will be making notifications</p> <p><b>Who to notify</b> Notify Bill Eagle, MH case manager at 999-888-7777 for check in, possible med review. Leave message for CCO officer at 666-555-4444 to inform of possible violation.</p>
<p><b>Presenting behaviors</b> 2. Jim threatens to get into fights, is easily insulted, and yells and postures.</p> <p><b>Possible causes</b> Jim has a history of substance abuse, as well as bi-polar disorder.</p>	<p><b>Who responds</b> SoberHouse staff &amp; CCO will respond</p> <p><b>How to respond</b> SoberHouse staff will attempt de-escalation. CCO will confer &amp; decide whether to obtain drug screen. CCO will notify Jim if drug screen is required. If Jim tests positive the CCO will arrest Jim for violating his court order.</p> <p><b>Who to notify</b> Notify MH case manager of status. Results of drug screen test to be shared with all parties.</p>
<p><b>Presenting behaviors</b> 3. Jim presents with paranoid delusions, sometimes feels that he is being followed, and sometimes is in unreasonable fear for his life.</p> <p><b>Possible causes</b> Jim has a history of substance abuse, as well as bi-polar disorder with psychotic features.</p>	<p><b>Who responds</b> SoberHouse staff, MH case manager, CDMHPs</p> <p><b>How to respond</b> SoberHouse staff will contact MH case manager. MH case manager may request an evaluation from the CDMHPs, stating that Jim is on a least restrictive order and whether he has violated conditions of his order. If not detained MH case manager will follow-up w/ next day appt.</p> <p><b>Who to notify</b> MH case manager calls CCO, SoberHouse staff regarding result of CDMHP assessment &amp; status.</p>
<p><b>Presenting behaviors</b> 4. Jim may overtly threaten to kill specific individuals, engage in menacing behaviors, and breaks windows, doors, and punch holes in walls.</p> <p><b>Possible causes</b> Jim has a history of substance abuse, as well as bi-polar disorder with psychotic features.</p>	<p><b>Who responds</b> SoberHouse staff, law enforcement, CCO</p> <p><b>How to respond</b> SoberHouse staff will attempt de-escalation, work to keep others safe, and call 911. Police have discretion re: disposition, e.g. arrest or to ER for evaluation. If not ITA'd or taken into custody, CCO will consider arrest for violating court order, otherwise MH case manager will follow-up</p> <p><b>Who to notify</b> SoberHouse staff notify 911, MH case manager and CCO of disposition. CCO will notify all parties if arrest for violation occurs.</p>

**CROSS-SYSTEMS CRISIS  
PREVENTION AND INTERVENTION PLAN**

<p>Presenting behaviors <b>1.</b> Possible causes</p>	<p>Who responds</p> <p>How to respond</p> <p>Who to notify</p>
<p>Presenting behaviors <b>2.</b> Possible causes</p>	<p>Who responds</p> <p>How to respond</p> <p>Who to notify</p>
<p>Presenting behaviors <b>3.</b> Possible causes</p>	<p>Who responds</p> <p>How to respond</p> <p>Who to notify</p>
<p>Presenting behaviors <b>4.</b> Possible causes</p>	<p>Who responds</p> <p>How to respond</p> <p>Who to notify</p>

## **The Signature Sheet and Confidentiality**

The signature sheet is used to show that all parties, including the client when possible, have participated in the development of this plan and/or approve of how it is constructed. It is necessary that individuals responsible for implementing this plan indicate that they know of the plan and basically agree to its form, and then sign-off and date the plan.

It may be necessary to obtain a release of information in order for all parties to actively participate in the development and implementation of this plan. This is especially true if law enforcement is present in formulating these plans. In such cases a signed release shall be signed and attached to this plan. If there is not a signed release of information but a requirement for this plan to be developed, individuals responsible to provide treatment to the individual may develop a plan, limiting the sharing of information to what is necessary for treatment planning. For further direction regarding the development of this plan without a signed release of information please refer to the Hargrove Legislation and the HIPAA regulations relevant to this process.

# FINAL DRAFT

## CROSS-SYSTEM CRISIS RESPONSE PLANNING PROTOCOLS For individuals with multiple court orders requiring supervision

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    - 1. Commissioners
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    - 3. Clerks
    - 4. Health Departments
    - 5. Human or Community Service Departments
      - a. Designated Chemical Dependency Specialists
      - b. Chemical Dependency Providers
  - E. Superior Court Judges
  - F. Community Hospitals
  - G. State Hospitals
  - H. Local law enforcement officials
- II. CROSS-SYSTEM PROCEDURES
  - A. Identification of individuals mandated to have CS Crisis Plans
  - B. Identification of team participants
  - C. Model process for meetings
    - 1. Facilitation
    - 2. Membership
    - 3. Meeting structure
  - D. Sharing of information
  - F. Plan Development
  - G. Location of and access to plan
  - H. Plan updates
- III. PROBLEM RESOLUTION PROCESS
- IV. EVALUATION
- V. ATTACHMENTS
  - 1. Format for Cross-System Crisis Prevention/Intervention Plan
  - 2. Plan worksheet
  - 3. Acronym Dictionary
  - 4. Pertinent statutes
  - 5. Pertinent RCWs and WACs



**CROSS-SYSTEM CRISIS RESPONSE PROJECT**  
**June 2004**

**APPENDIX 5**

**INVOLUNTARY TREATMENT ACT (ITA)  
WORK GROUP ISSUE PAPER**







# CROSS-SYSTEM CRISIS RESPONSE PROJECT

## INVOLUNTARY TREATMENT ACT (ITA) ISSUE PAPER

June 1, 2004

Issue: Are there changes in the involuntary treatment act laws for mental health (71.05 RCW) and chemical dependency (70.96A RCW) that would improve the crisis response system?

### What problem are we trying to solve?

The system we have now is not designed to always ensure access to a treatment program designed to best meet the needs of people diagnosed with mental disorders or chemical dependence. People with developmental disabilities, traumatic brain disorder, and dementia, in particular, have traditionally been a challenging population to serve appropriately within the mental health system. In addition, the discrepancies between the mental disorder and chemical dependency statutes result in unequal access to treatment.

The public mental health system serves as the default crisis response system for persons with a wide range of disabilities and services provided by local law enforcement, jails, and local hospital emergency rooms have become the de facto system for crisis response when an individual does not fit anywhere else. The current system has evolved over time in a somewhat inconsistent fashion and seeks to be all things to all people. Lack of appropriate inpatient resources, difficulty finding appropriate community placement or resources for clients, difficulty with combative individuals, and difficulty with individuals with drug/alcohol issues all add to the challenge of providing timely, effective crisis response.

The two laws that govern the detention of individuals against their will are not parallel in scope. The mental health law is mandatory, i.e., if the person as a result of a mental disorder is an imminent danger to themselves or others or is gravely disabled, the system must respond and take action. The chemical dependency law is based on availability of resources, which means that an intervention may not occur until there is actually an open bed. When resources are not available to the person in need of CD involuntary treatment and intervention, the mental health system (sometimes the emergency room or police) is often called on to be the responder.

### How would solving this problem help us move closer toward our “preferred experience”?

The goal of the Cross-System Crisis Response Project is to “serve each person in the right way, with the right service at the right time”. Effective ITA laws would:

- Provide emergency safety, control and care
- Provide access to assessment and evaluation capabilities
- Refer to clients to appropriate treatments
- Triage persons to the appropriate treatment resource
- Protect individual liberty rights of clients

- Be consistent (between the MH and CD laws)
- Clearly define who is covered by the law
- Be adequately funded

What realistic public policy choices/options did we consider?

The ITA Work Group considered the following broad options:

1. Separate the statutes for each affected population: persons with serious mental illness, chemical dependency, developmental disabilities, dementia, and TBI.
2. Create one single law for all populations: everyone goes into the same system and uses the same resources.
3. Create one single law for all disorders with a variety of different resources based on specific needs.
4. Keep the MH and CD laws separate, but change the CD law to be mandatory and fully funded.
5. Keep the MH and CD laws separate, and recommend small and/or technical changes to 71.05 RCW.
6. Keep the MH and CD laws separate and identify key resources that could be strengthened to relieve the MH crisis system
7. Develop coordinated initiatives to enhance communication and/or collaboration.

**Options 1 and 2:** Separate the statutes for each affected population: persons with serious mental illness, chemical dependency, developmental disabilities, dementia, and TBI.

Create one single law for all populations: everyone goes into the same system and uses the same resources.

The first option would require four separate laws, would not reflect clinical reality, and overall, was not seen as a coordinated or collaborative approach. The second option was also eliminated as impractical. Although a “one-stop shopping” approach might appeal to the general public, an incredible knowledge base of expertise would be required, there would be a huge problem with mixing populations, and it would not be a clinically appropriate system. This second option also would not be helpful for the CD population.

**Option 3:** Create one single law for all disorders with a variety of different resources based on specific needs.

The purpose of this option is to combine crisis response into a single approach and statute that would accommodate population-specific, including co-occurring, treatment approaches. The four broad categories of populations to be served include persons

with serious mental illness, developmental disabilities, serious chemical dependency (chronic drug use), and other organic mental disorders and behavior problems, including dementia, traumatic brain injury, delirium, and medically compromised.

A single, combined crisis response for all identified populations would be available 24 hours per day, 7 days per week and would require professional assessment competence with all populations and knowledge of, and access to, a full range of community diversion alternatives. Combined crisis response for this option means:

- One involuntary commitment statute and detention criteria
- The ability of CDMHPs and CDCDSs to manage resources and facilitate solutions (gatekeeper function)
- The ability of CDMHPs and CDCDSs to consult with appropriate, knowledgeable professionals
- 24/7 crisis triage at a sufficient level to provide statewide coverage
- Mobile crisis services, such as specialized teams and staff that could provide support in natural environments
- Behavioral supports in facilities that can be brought in to assist staff with consumers in crisis, for example, one-on-one supports
- Training for crisis responders

Pros for a combined law include:

- Would provide a unified approach to crisis response
- Could be simpler and cheaper to have an inter-disciplinary process with appropriate resources
- Could result in cost-efficiencies and less duplication of administration costs
- Would allow an individual designated as a CDMHP and CDCDS to handle all types of commitments
- Could sort people and direct them to appropriate resource
- Better funding for the CD population and greater access to treatment for people with chemical dependency needs.

Challenges include:

- Would be difficult to draft one single law. (For example, time frames in the two statutes for assessment are different and even the terminology for crisis responders would need to be changed.)
- Would need assurance that such population specific resources would be available before supporting an option like this. (DDD does not wish to operate involuntary facilities, and the numbers of DDD clients needing this are too low to justify separate facilities in the community.)
- Would be a large fiscal note.

Combined crisis response could be achieved with or without a vision for changing the overall system. See attachment describing both the conceptual overview of combining crisis response and adding population-specific diversion, and short-term and long-term detention options.

Facilitating an “easier” response to crisis will only make the situation worse if appropriate and available resources still do not exist. Changes must be contingent on adequate resources and adequate time to implement system change.

**Option 4:** Keep the MH and CD laws separate, but change the CD law to be mandatory and fully funded

This option became a sub-set of Option 3. A statutory change would be needed to change CD ITA from a “permissive” approach that manages the supply and demand to a 24/7 mandatory system.

**Option 5:** Keep the MH and CD laws separate, and recommend small and/or technical changes to 71.05 RCW.

The group considered two recommendations: (1) adding clarity to 71.05 RCW about discharging people early if they are voluntary, and (2) amending 70.96A.140 to specify that less restrictive alternative treatment was considered and why treatment less restrictive than detention is not appropriate. However, it was decided that opening the statutes for relatively small changes could be a risky strategy and that it would be better to explore other options for solving the problem. If the recommendation in Option 3 were adopted, these changes among others would likely be covered in a major “overhaul”.

**Option 6:** Keep the MH and CD laws separate and identify key resources that could be strengthened to relieve the MH crisis system.

Following the May 3, 2004 Stakeholder Forum, the ITA Group met again to consider the feedback and reaction to the recommendation to combine ITA detention. Although more than half (65%) of the stakeholders voted to move forward the recommendation to create a vision for an overall crisis response system, including combining the ITA laws, the stakeholders, on a 10 point scale of effectiveness (1 not effective/10 very effective), also rated this idea as 6.6, moderately effective at best. Both at the stakeholder level, as well as within the ITA Group, there is a view that the current laws would be “adequate if the resources were adequate”.

Resources that would clearly help when detention is the clinically recommended treatment path include:

- Increased funding for locked/secure and social detox, including co-locating CD social detox and MH crisis services in a triage setting
- Added county designated CD specialists to CDMHP crisis response teams
- Increased funding of DDD Crisis and Stabilization Teams
- Increased number of crisis/diversion beds for all populations
- Enhancement of on-going specialty training to professionals regarding evaluation and treatment of individuals with developmental disabilities
- Increased access to psychiatric supports for people with dementia and other organic mental disorders and behavior problems
- More CDMHPs
- Access to psychiatrists and medications

**Option 7:** Develop coordinated initiatives to enhance communication and/or collaboration.

There appear to be misconceptions and misunderstanding about the role of CDMHPs and investigations for populations with dementia, developmental disabilities, and traumatic brain injury. From Aging and Disability Services Administration perspective, the “problem” needs to be defined based on data (for example, HCS’ referrals to CDMHPs’ and outcomes of investigations in our six regions) rather than anecdotal information. Informally, it is recommended that ADSA data from referrals to CDMHPs and outcomes be collected to determine the scope of the problem and related issues.

Another issue included the CDMHP Protocols, which are voluntary guidelines. The group briefly considered recommending that the Protocols be mandatory, either in statute or in WAC, but felt that there would need to be a significant shift in the content to make such a substantial change. The Protocols are due to be revisited in the next year and that is a topic that they may want to consider. It is possible that an organized effort to provide training and more accurate information about the rules and alternatives would be a better course of action at this time.

Revised Recommendations:

**The following recommendations reflect consensus for a combined crisis response and adequate diversion options prior to detention. The question of whether or not combining the two laws would be helpful or harmful is less clear.**

1. **Revised:** Create a combined crisis response for all identified populations available 24 hours per day, 7 days per week. Create a coordinated range of treatment resources to match the needs of a very diverse population. Continue to have separate ITA laws and separate short-term evaluation and treatment.

**OR**

2. Create a vision for a combined crisis response for all identified populations available 24 hours per day, 7 days per week. Create a coordinated range of voluntary and involuntary treatment resources to match the needs of a very diverse population. Have a single combined involuntary treatment act, including combined short-term evaluation and treatment.

Attachments:

New Attachment 1: Combined Crisis Response (Rec. #1)

Renumbered Attachment 2: Combined Involuntary Treatment Act Proposal (Rec. #2)

Renumbered Attachment 3: Current Mental Health ITA

Renumbered Attachment 4: Current Chemical Dependency ITA



# New Attachment 1

## Proposal: Combined Crisis Response

June 1, 2004

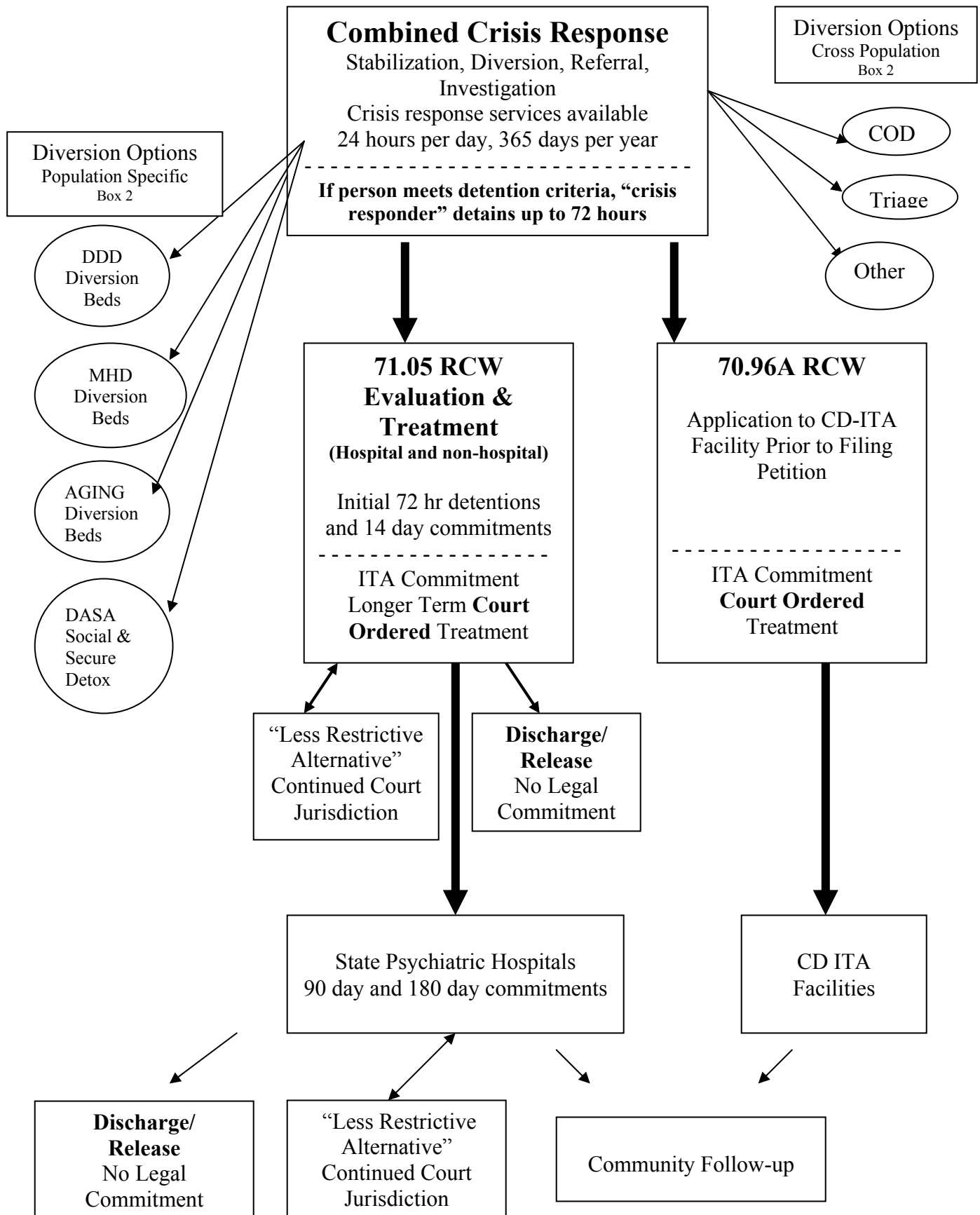
Populations to be served include persons with:

1. Serious mental illness
2. Developmental disabilities
3. Serious chemical dependency (Chronic drug abuse)
4. Other organic mental disorders and behavioral problems – Includes dementia, traumatic brain injury, delirium and medically compromised.

Crisis Response	<b><u>Single (combined) response system</u></b> for all identified populations available 24 hours per day, 7 days per week. The crisis responder would have professional assessment competence with all identified populations and knowledge of, and access to, full range of community stabilization and diversion alternatives across all systems. The crisis responder would have authority to detain persons for involuntary assessment and treatment for up to 72 hours <b>under mental health (71.05 RCW) <u>and/or</u> authority to detain under the rules governing chemical dependency (70.96A RCW).</b>
Diversion (voluntary)	<b><u>Multiple community diversion options</u></b> (alternatives to involuntary commitment) available for all populations. Diversion options (voluntary inpatient, crisis respite beds, sobering facilities, social and secure detox beds, intensive in-home stabilization services, crisis triage facilities, etc) to include both jointly funded, cross population programs (e.g., crisis triage facilities) and system specific funded programs for specific populations (e.g., detox, crisis respite beds for persons with developmental disabilities).
Mental Health Law 71.05 RCW	See Renumbered Attachment 3 for Current Mental Health ITA
Chemical Dependency Law 70.96A RCW	See Renumbered Attachment 4 for Current Chemical Dependency ITA

# Attachment 1: Combined Crisis Response and Involuntary Treatment (Separate Laws)

6/1/04





## Revised Attachment 2

### Recommendation 2: Combined Involuntary Treatment Act (Adults)

June 1, 2004

Combining the current adult mental health (RCW 71.05) & chemical dependency (RCW 70.96A) involuntary commitment laws and making additional changes.

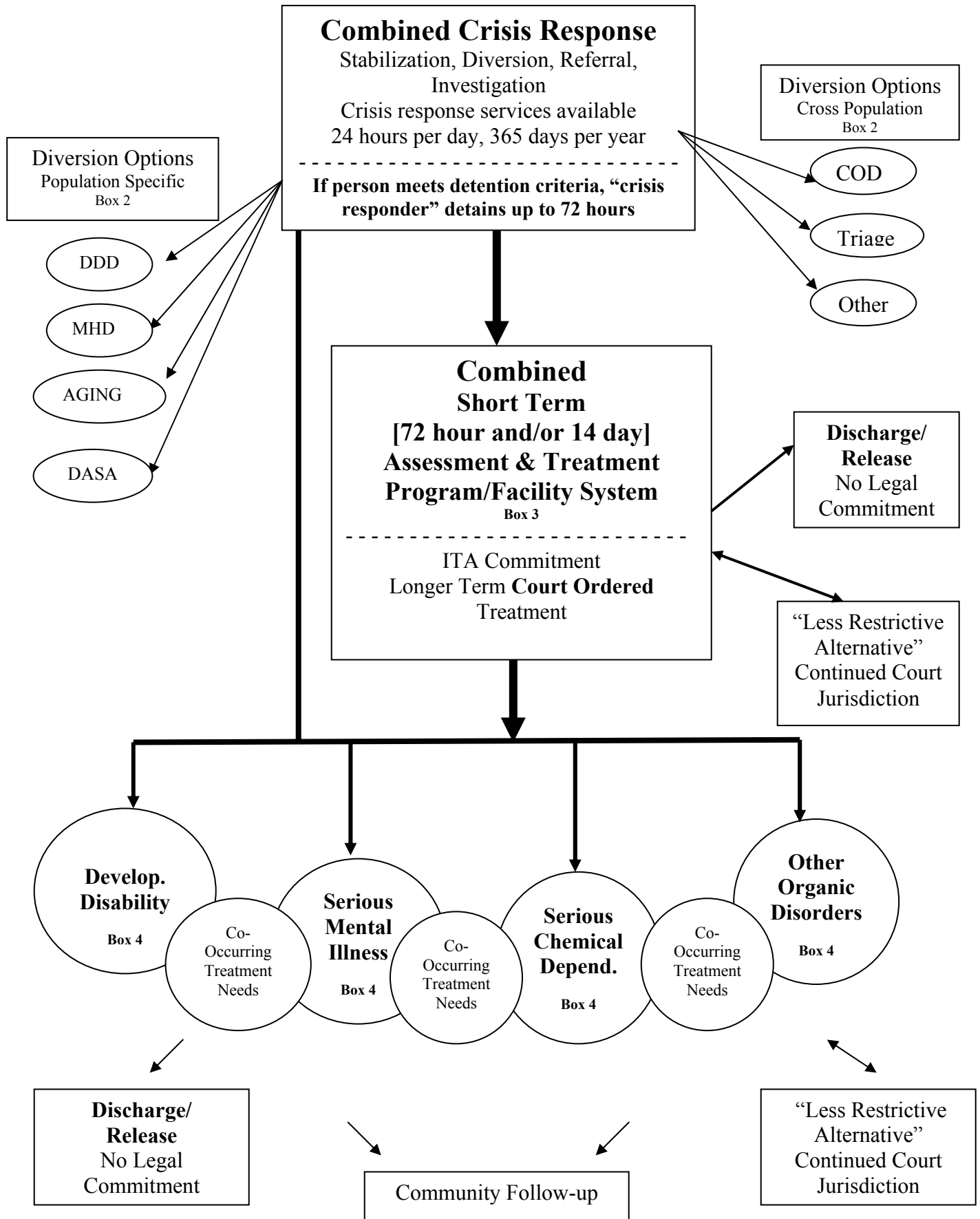
Populations to be served include persons with:

1. Serious mental illness
2. Developmental disabilities
3. Serious chemical dependency (Chronic drug abuse)
4. Other organic mental disorders and behavioral problems – Includes dementia, traumatic brain injury, delirium and medically compromised.

Crisis Response	<b><u>Single (combined) response system</u></b> for all identified populations available 24 hours per day, 7 days per week. The crisis responder would have professional assessment competence with all identified populations and knowledge of, and access to, full range of community stabilization and diversion alternatives across all systems. The crisis responder would have authority to detain persons for involuntary assessment and treatment for up to 72 hours. <i>(Note: This length of detention is taken from current mental health law and could be changed for this new proposal.)</i> The detention could be to any one of four different types of inpatient programs if the treatment modality needs were clear or to a “combined short term” facility if further, inpatient, assessment of needs was required.
Diversion (voluntary)	<b><u>Multiple community diversion options</u></b> (alternatives to involuntary commitment) available for all populations. Diversion options (voluntary inpatient, crisis respite beds, sobering facilities, detox beds, intensive in-home stabilization services, crisis triage facilities, etc) to include both jointly funded, cross population programs (e.g., crisis triage facilities) and system specific funded programs for specific populations (e.g., detox, crisis respite beds for persons with developmental disabilities).
Detention & Commitment (involuntary)  Short term & Longer term	<b><u>Multiple, combined and population specific, resources.</u></b> Five different types of detention and commitment programs/facilities are available (four population specific and one combined). Short term assessment and treatment could occur at any of the five types of programs/facilities. Longer term involuntary inpatient treatment would be provided at any of the four population specific programs/facilities. All four types of population specific programs/facilities would provide integrated treatment for persons with co-occurring treatment needs. <u>Professional staff at the inpatient programs/facilities would file population (system) specific petitions for persons with co-occurring treatment needs based on clinical judgment and “best fit”. Superior courts or juries would make final commitment determinations.</u> All commitment periods are “up to” and not absolute. The treating program/facility has the authority to release a person from the commitment and discharge them to the community if the person no longer needs inpatient care.
Commitment Less Restrictive	<b><u>Multiple, population specific, resources.</u></b> At any involuntary commitment hearing the superior court (or jury) may order <u>involuntary community treatment</u> – that is treatment in the community that is a “less restrictive alternative” (LRA) to inpatient care. Persons can be returned to inpatient care and their LRA revoked if they fail to abide by court ordered conditions or are found to have an increased risk.
Community Care (voluntary)	<b><u>Multiple, population specific, resources.</u></b> Four different community (voluntary) treatment systems, dependent upon the person’s primary treatment need.

# Revised Attachment 2: Involuntary Treatment Act Proposal

6/1/04



**Revised Attachment 3**  
**Current “Mental Illness Involuntary Treatment Act” (Adults) RCW 71.05**

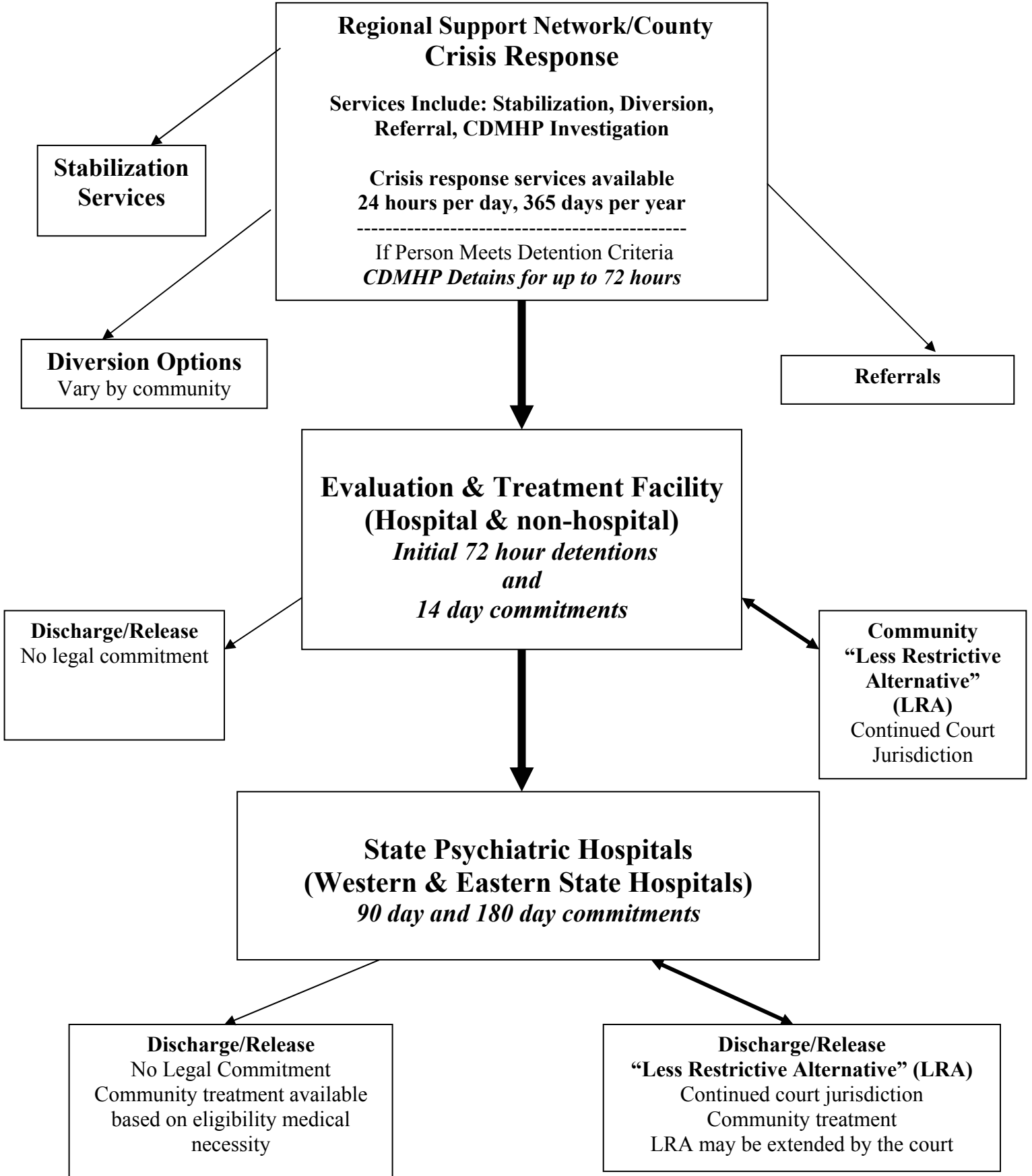
June 1, 2004

Populations served include the following persons with mental disorders:

1. Serious mental illness
2. Developmental disabilities
3. Other organic mental disorders – Includes dementia, traumatic brain injury, delirium and medically compromised.

Crisis Response	Regional Support Networks and Counties (or community mental health providers) provide response system for all identified populations available 24 hours per day, 7 days per week. Response includes voluntary services (stabilization, diversions, etc.), referrals to other systems, detention investigations and involuntary detentions. Initial detentions (up to 72 hours) are authorized by County Designated Mental Health Professionals (CDMHP). <i>Persons may be detained under the ITA statute if they, as a result of a mental disorder, present an imminent danger to themselves or others or are gravely disabled and there is no less restrictive alternative to involuntary inpatient care.</i>
Diversion (voluntary)	Voluntary and diversion options (crisis triage facilities, crisis respite beds, voluntary triage, sobering centers, detox beds, intensive in-home stabilization services, crisis triage facilities, etc) vary significantly from one community to another.
<b>Involuntary Commitment</b> Short term <i>72 hour and 14 day commitment periods</i>	Short term evaluation and treatment services are provided by state Mental Health Division certified stand-alone (non-hospital) residential facilities, free standing public & private psychiatric hospitals, acute care hospital with psychiatric units and state psychiatric hospitals. <u>All commitments beyond the initial 72 hour detention are ordered by a superior court after a petition is filed by the treating professionals.</u> At any time during a commitment the treating facility has the authority to release the person from the commitment and discharge them to the community if the person no longer needs inpatient care.
<b>Involuntary Commitment</b> Longer term <i>90 and 180 day periods</i>	All long term involuntary commitment treatment services are provided at the state psychiatric hospitals. (Eastern and Western State Hospitals) and <u>all commitments are ordered by a superior court after a petition is filed by the treating professionals.</u> As is true during the short term commitments, the treating facility has the authority to release the person from the commitment and discharge them to the community at any time during a commitment.
<b>Involuntary Commitment</b> Less Restrictive Alternatives <i>90 and 180 day periods</i>	At any involuntary commitment hearing the superior court (or jury) may order <u>involuntary community treatment</u> – that is treatment in the community that is a “less restrictive alternative” (LRA) to inpatient care. Persons can be returned to inpatient care and their LRA revoked if they fail to abide by court ordered conditions or are found to have an increased risk..
Community Care (voluntary)	Voluntary community mental health care is provided to Medicaid enrolled persons by RSNs and their community mental health providers.

Revised Attachment 3  
**Current “Mental Illness Involuntary Treatment Act” (Adults)**  
**RCW 71.05**

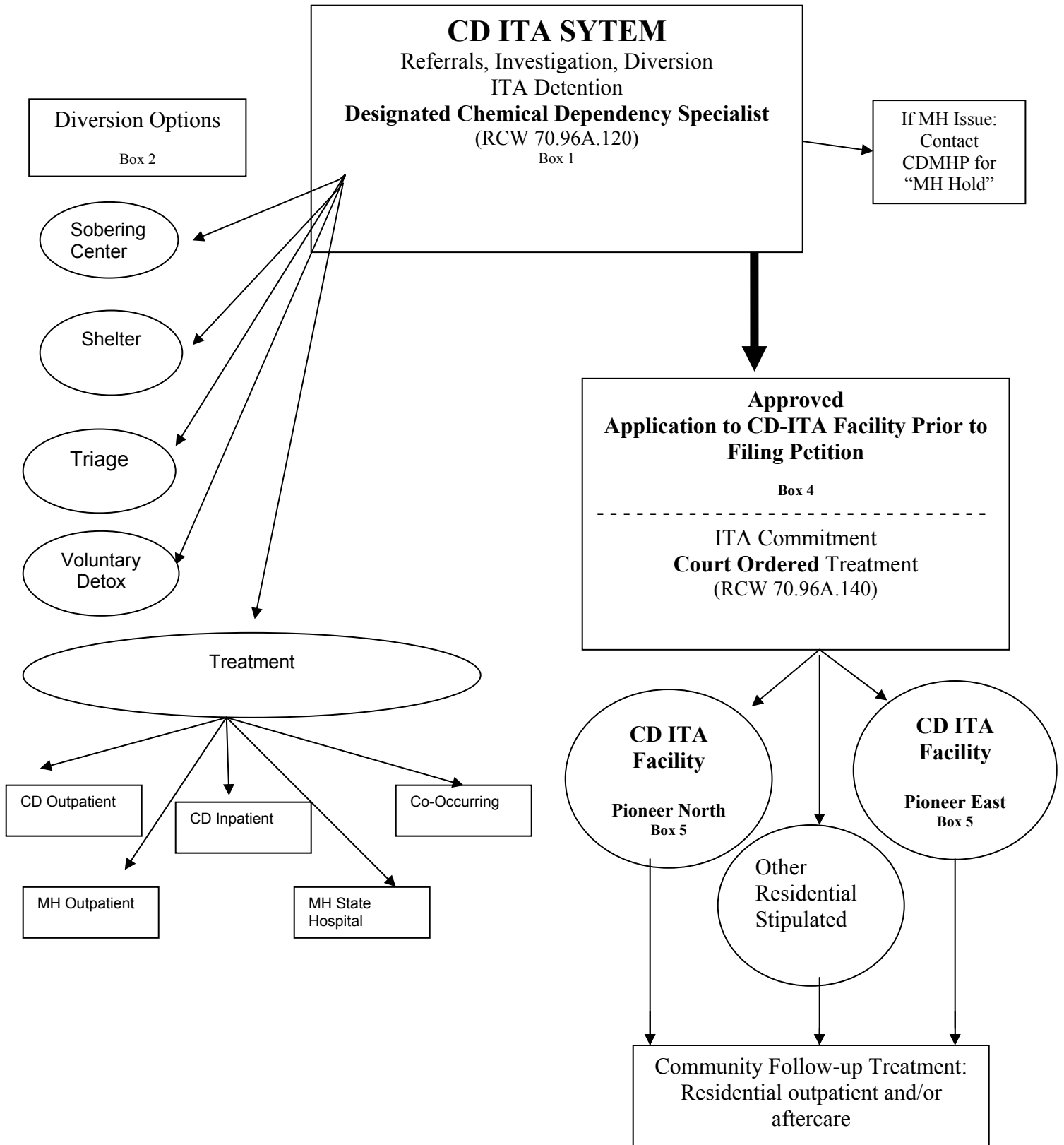


**Revised Attachment 4  
Involuntary Treatment Act for Chemical Dependency: RCW 70.96A**

June 1, 2004

<b>Chemical Dependency Involuntary Treatment Act System Components</b>	
<ul style="list-style-type: none"> <li>• Referrals For Investigation</li> <li>• Diversion</li> <li>• ITA Detention (70.97A, 120)</li> <li>• Designated Chemical Dependency Specialist</li> </ul>	
<b>Referrals For Investigation</b>	Referrals for investigation come from a number of sources to include: Family members, friends, co-workers, attorneys, Department of Corrections, chemical dependency practitioners, mental health involuntary commitment professionals, jails, shelters
<b>Diversion (Voluntary)</b>	Voluntary and referral options to mental health, voluntary detoxification, sobering centers, shelter, crisis triage (hospitalization for medical issues), chemical dependency treatment
<b>Involuntary Treatment 60 Days initially, plus, possibly 90 days more</b>	<p>The county designated Chemical Dependency Specialist must allege in a petition to the appropriate Court, that a person is chemically dependent, and:</p> <ul style="list-style-type: none"> <li>• Presents the likelihood of serious harm or is gravely disabled by alcohol or drug addiction, or</li> <li>• That the person is chemically dependent and has threatened, attempted, or inflicted physical harm on another and is likely to inflict physical harm on another unless committed under RCW 70.96A.140</li> </ul> <p>If placement in a chemical dependency program is available and deemed appropriate, the person can be detained at any appropriate treatment program. Usually, persons who are committed under RCW 70.96A.140 are treated at Pioneer Center North or Pioneer Center East.</p>
<b>Community Care Voluntary</b>	Voluntary community chemical dependency treatment or treatment that is provided through ADATSA (Alcohol Drug and Treatment Support Act) State and County contracted treatment agencies and programs accepting private insurance reimbursement.
<b>Treatment</b>	<p>Involuntary treatment act can involve:</p> <ul style="list-style-type: none"> <li>• Intensive outpatient</li> <li>• Chemical dependency inpatient</li> <li>• Co-Occurring disorder inpatient</li> <li>• Appropriate mental health care</li> </ul>

**Revised Attachment 4: Current CD ITA  
Treatment for Alcoholism, Intoxication, and Drug Addiction  
RCW 70.96A**



**CROSS-SYSTEM CRISIS RESPONSE PROJECT**  
**June 2004**

**APPENDIX 6**

**SERVICE GAPS**  
**WORK GROUP ISSUE PAPER**





**CROSS-SYSTEM CRISIS RESPONSE PROJECT**  
**Overview Of Service Gaps Issue Papers**  
**May 3, 2004**

**Overview**

The Service Gaps Work Group presents the following three papers for consideration by Forum attendees. The papers focus on the following three populations which workgroup members identified as posing challenges for cross system crisis services:

- Adults of any age with medical and behavioral issues. This includes adults suffering from Alzheimer's disease or other types of dementia who are often, but not always, older. It also includes adults with traumatic brain injuries or those with a mental illness such as schizophrenia combined with a complex medical condition.
- Adults of any age with chemical dependency issues. This includes adults with co-occurring chemical dependency and mental health issues. It also includes adults who may only be chemically dependent but are high utilizers of crisis services due to drug and alcohol induced behavioral issues.
- Adults of any age with developmental disabilities and behavioral issues. This includes adults with developmental disabilities and mental health/behavioral issues.

The work group limited its identification of gaps to services which are used to avoid involuntary treatment and/or incarceration such as crisis prevention, intervention, and diversion services. The workgroup did not identify or develop recommendations related to the adequacy of resources and services utilized once an individual has been committed to involuntary treatment or incarceration. Further study and planning efforts need to be done regarding these other service gaps in the system of care which are not addressed in the papers including:

- Psychiatric inpatient beds
- Free standing psychiatric evaluation and treatment beds
- Chemical dependency residential treatment beds
- Long term placements for individuals being placed from state hospitals or Department of Corrections settings
- Residential licensing issues for individuals with community protection concerns including consideration of expanding the use of the DD model of unlicensed supported housing programs formerly known as the Intensive Tenant Support program

For there to be relevant long term solutions, DSHS needs first to clarify which populations are in crisis because they lack supportive resources and therefore cause stress and/or undue expense for various actors in the response systems. Subsequent long term planning will then be able to focus on those areas of greatest need.

Each paper evolved from data and priorities generated from the November Cross-System Crisis Response Project Forum and other DSHS cross-system efforts, such as the Real Choices Grant stakeholder forums. The recommendations contained in the papers are not mutually exclusive or

dependent and are not ordered by priority. While each paper has a cross-systems target group as its focus, the recommendations can benefit as well other persons in crisis.

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**Service Gaps Workgroup  
Adults With Medical and Behavioral Issues Paper  
April 20, 2004**

**Specific Issue**

There are a variety of service gaps for adults of any age with medical and behavioral disorders. Many communities struggle to meet the needs of individuals suffering from Alzheimer's disease or other types of dementia. At the same time, adults with traumatic brain injuries or those with a mental illness such as schizophrenia combined with a complex medical condition pose special challenges for community providers. The service gaps described in this paper vary by community. The issues raised by this paper and future implementation of any recommendations need to take this into consideration.

**What problem/s are we trying to solve?**

- Inappropriate use of Emergency Rooms (ERs)
- Inability to timely place people into less restrictive settings
- Unnecessary discharges from long term care placements to more restrictive and expensive care
- Potential loss of federal revenue for continuing to serve people in hospitals once they are ready for discharge
- Cost shifting to other systems
- Challenges for adults coming out of Department of Corrections settings
- High rates of suicide

**How would solving this problem help us move us to our preferred experience?**

Improvements in the areas noted above will demonstrate success in commitment to providing community-based care responsive to the needs of individuals being served. Measurements could include:

- Decreased use of ERs in lieu of appropriate treatment
- Decreased lengths of stay at state and community psychiatric hospitals
- Decreased suicide rate
- Decreased inappropriate discharges from long term care settings

**What issues, concerns, or other factors are involved in addressing the problem?**

- Training
- Cross system coordination and planning
- Lack of resources, beds and services
- Licensing dynamics (e.g. regulations, resident rights, cultural issues)
- Funding dynamics

## **What are the options we should consider?**

The work group limited its identification of gaps to services which are used to avoid involuntary treatment and/or incarceration such as crisis prevention, intervention, and diversion services. The workgroup did not identify or develop recommendations related to the adequacy of resources and services utilized once an individual has been committed to involuntary treatment or incarceration. Further study and planning efforts need to be done regarding these other service gaps in the system of care which are not addressed in the papers including psychiatric inpatient beds; free standing psychiatric evaluation and treatment beds; chemical dependency residential treatment beds; long term placements for individuals being placed from state institutions; and residential licensing issues for individuals with community protection concerns.

1. In order to avoid unnecessary hospitalization or incarceration of adults with medical and behavioral disorders, a variety of crisis related resources are needed including:

- ) crisis beds which use County Designated Mental Health Professionals (CDMHP) or crisis teams as gatekeepers
- ) transitional beds for individuals coming out of state or community hospitals or prisons which allow quicker reintegration and better assessment of community needs
- ) specialized behavioral support services
- ) specialized training for providers who serve this population

These resources, whether beds or other types of community services, need to be accessible for adults with complex medical and behavioral issues and able to address the needs of this population. Services provided through the Expanding Community Services (ECS) program (see attached overview) for patients from the gero-medical units at the state hospitals have begun to address some of these needs and may be able to further meet some of the demand. In addition, program managers from HCS and MHD currently assist by providing technical assistance to regions on developing effective models and service approaches to meet the needs of this population.

2. Regions report that providers do not always take advantage of the medical and behavioral interventions which can help avoid crisis because of a lack of information or misunderstandings regarding long term care regulations. In order to address this, training modules on topics specific to clients with both behavioral and medical challenges should be developed. These modules should be available on the Web and distributed to providers, Department of Social and Health Services staff, and other agencies. Topics could include:

- ) ways to manage behavioral issues within current licensing regulations
- ) assessment and differential diagnoses
- ) specific interventions for dealing with difficult behaviors
- ) harm reduction techniques
- ) roles and regulations within the mental health system
- ) expectations for providers to meet a resident's special care needs
- ) strategies for providers to decrease liability

3. Immediate consultation for long term care providers with a resident experiencing behavioral issues can help prevent the need for hospitalization. Eastern State Hospital currently provides such consultation to nursing homes and other care settings. This model should be replicated at Western State Hospital.
4. Home health agencies are able to bill for outreach services under Medicare part A for hospital diversion services. Some home health agencies have developed specialized mental health services which are reported to be very effective in avoiding hospitalization for individuals in crisis. DSHS should expand services to individuals who are Medicare eligible by encouraging and developing resources for providers on how to effectively bill Medicare for specialized mental health services which help to avoid psychiatric hospitalizations.
5. Community mental health programs originally developed to serve individuals with conditions such as schizophrenia, depression, and bipolar disorders. Many of these programs have not developed specialty in serving conditions such as Dementia and other organic disorders. In the past, a number of RSNs excluded these conditions in their criteria used to determine access to mental health services. Current statewide Access to Care Standards clarify that diagnoses of dementia cannot be excluded in local mental health screening criteria when individuals have behavioral issues resulting from this diagnosis which are high risk or have recently resulted in psychiatric hospitalization. In order to provide access to crisis prevention and intervention services for individuals with dementia, statewide training and clarification on these standards should be provided to Regional Support Networks, Mental Health Providers, Home and Community Services, and Residential Care Services.
6. Complete a study of long term TBI and older adult patients at WSH to identify types of community resources and best practice models which help to prevent crisis for this population.
7. Complete a study of adults with medical and behavioral issues coming out of prison to identify resources and special services which help to prevent crisis for this population.
8. Develop a limited study of ER psychiatric admissions or gero-psychiatry unit admissions from long term care settings to identify crisis admissions due to inadequate care or coordination of services and develop strategies for addressing these issues.

### **What does the group recommend?**

All of these options are recommended for consideration and have not been laid out in any order of priority. The recommendations are not mutually exclusive or dependent and implementation of any or all of these recommendations could lead to some improvements to services for adults of any age with medical and behavioral issues.

Expanding Community Services  
Project Overview  
June 2, 2003

**Background**

At the national and state level, there is continued pressure to assure that individuals residing in institutions have the option for community living. These efforts have been highlighted through litigation such as the Olmstead lawsuit in Georgia where the Supreme Court found that the state was violating the rights of two plaintiffs by keeping them in a state psychiatric hospital despite their desire to live in the community.

As part of the 2001-2003 budget process, DSHS developed a proposal included in the Governor's budget for serving state hospital patients in community settings. The 2001-2003 Operating Budget supported this proposal by providing for the development and operation of community support services for long term Western State Hospital (WSH) patients who no longer required active inpatient psychiatric treatment. The 2002-2003 Supplemental Budget increased the scope of the project to include patients from Eastern State Hospital (ESH) and residents of the Program for Adaptive Living Skills (PALS) on the grounds of WSH. In accordance with the proviso, the Department of Social and Health Services ( DSHS) formally implemented the Expanding Community Services (ECS) initiative.

Planning to implement the transition of long term state hospital patients to community support services was conducted through the combined efforts of a number of DSHS entities and other partners. Individuals transitioned from WSH resided on wards of the Adult Psychiatric Unit (APU), Gero-Medical Unit (GMU), and PALS. Individuals transitioned from ESH resided on wards of the Gero-Psychiatric Unit (GPU). In accordance with the budget proviso, DSHS placed individuals as close to their home communities as possible.

The ECS initiative helped to strengthen DSHS efforts to assure services are provided in the community whenever appropriate. DSHS is closely monitoring and conducting a formal evaluation of these efforts to assess outcomes of the individuals served and assure that their needs are safely met in the community.

**Nisqually Earthquake**

An unforeseen event that affected the ECS initiative was the February 2001 earthquake in Western Washington. The earthquake damaged buildings and reduced capacity at WSH. To maintain the reduced capacity, efforts were undertaken to develop alternative placements and diversion for patients and individuals who would otherwise have been served at WSH. As a result of these efforts, there were no additional transitions required in order to accomplish the ward closures scheduled for December, 2001 and October 2002.

## **Implementation Efforts**

An implementation committee including representatives from various stakeholders developed and monitored progress of the ECS work-plan. Key accomplishments included:

- Identification and assessment of ECS patients
- Improvements in state hospital discharge processes
- Development of a consumer preference survey
- Development of a transition best practices guide
- Development of cross system teams to improve services to multiple needs clients
- Development of RSN plans for serving APU and PALS patients
- Development of contracts with long term care settings and mental health providers to serve GMU/GPU patients and others at risk of hospitalization
- Training for long term care facilities in accessing mental health and crisis services
- Training of County Designated Mental Health Professionals (CDMHPs) to increase consistency in implementation of involuntary treatment laws
- Research into other states efforts at serving state hospital patients in community settings
- Development of geriatric pharmacy residency programs
- Communication with the Center for Medicaid and Medicare Services (CMS) to assure optimum utilization of federal funding
- Collaboration on a successful \$1.4 million CMS grant toward systemic improvements towards community options for individuals in state hospitals and other facilities
- Evaluation of the ECS Initiative with a final report completed by April, 2004

## **Initiative Goals**

The transition of state hospital patients took place in phases with approximately 30 patients transitioned in each phase. The development of new and enhanced programs and services in the community allowed for the reduction of wards at the state hospitals concurrent with each of the phases. State hospital wards were closed according to the following schedule:

Phase 1: Dec. 2001, WSH APU Ward  
Phase 2: July 2002, WSH APU Ward  
Phase 3: Oct. 2002, WSH GMU Ward

Phase 4: Dec. 2002, ESH GPU Ward  
Phase 5: Jan. 2003, WSH PALS Ward  
Phase 6: April 2003, WSH GMU Ward

## **Program Contacts:**

For additional information regarding ECS, please contact:

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Phone: (206) 341-7653

**Service Gaps Workgroup  
Chemically Dependent Adult Issue Paper  
May 3, 2004**

**Specific Issue**

There are a variety of service gaps for adults with chemical dependency and/or adults with co-occurring chemical dependency and mental health issues. The service gaps described in this paper vary by community. The issues raised by this paper and future implementation of any recommendations need to take this into consideration.

**What problem/s are we trying to solve?**

- Inappropriate use of ERs and jails
- Inability to timely place people into less restrictive settings
- Unnecessary discharges from long term care placements to more restrictive and expensive care
- Potential loss of federal revenue for continuing to serve people in hospitals once they are ready for discharge
- Cost shifting to other systems
- Challenges for chemically dependent clients coming out of DOC settings
- High risk of violence, criminal acts, and suicidal behaviors

**How will this move us to our preferred experience?**

Improvements in the areas noted above will demonstrate success in commitment to providing community based care responsive to the needs of individuals being served. Measurements could include:

- Decreased use of ERs and jails in lieu of appropriate treatment
- Decreased lengths of stay at state and community psychiatric hospitals
- Decreased high risk behaviors (suicide, DUI, criminal offenses)
- Decreased inappropriate discharges from long term care settings
- Decrease of no-shows for entry into treatment

**What issues, concerns, or other factors are involved?**

- Training
- Cross system coordination and planning
- Lack of resources, beds and services
- Funding dynamics particularly related to the funding of detoxification, crisis services, and case management for these clients
- Shortage of involuntary treatment beds at Pioneer Center North and Pioneer Center East
- Lack of post crisis interim treatment services



## **What are the options we should consider?**

The work group limited its identification of gaps to services which are used to avoid involuntary treatment and/or incarceration such as crisis prevention, intervention, and diversion services. The workgroup did not identify or develop recommendations related to the adequacy of resources and services utilized once an individual has been committed to involuntary treatment or incarceration. Further study and planning efforts need to be done regarding these other service gaps in the system of care which are not addressed in the papers including psychiatric inpatient beds; free standing psychiatric evaluation and treatment beds; chemical dependency residential treatment beds; long term placements for individuals being placed from state institutions; and residential licensing issues for individuals with community protection concerns.

1. There is a lack of information and/or cross training between the chemical dependency and mental health disciplines. This lack of cross training can lead to crisis situations because an appropriate evidenced based intervention was not delivered. This is a training issue where modules on topics specific to crisis intervention for adults with chemical dependency and co-occurring mental illness can be developed. The goal of the technical assistance and training is to educate crisis responders about evidence based interventions that are designed to avoid an immediate crisis, to respond appropriately in an already escalating crisis situation and/or to keep a crisis situation from re-occurring. These training modules can be available on the Web and distributed to providers, DSHS staff, and other agencies.
2. Research and update the Report on Crisis Triage/Crisis Response Centers (originally produced by DASA in 1999 for Senator Long) and convey this information to all county departments and the Regional Support Networks responsible for the administration of mental health and chemical dependency treatment services. This information at a minimum includes: staffing, licensing, funding, clients served, and cost efficiencies so that this model can be replicated.
3. Provide intensive case management for individuals with chronic chemical dependency and co-occurring mental illness who over utilize the crisis system. This case management is designed to follow-up after the crisis incident and to maintain frequent contact with the individual until appropriate services are available.
4. In a crisis situation, there is often the need for the responders to quickly access consultation/information from experts in the treatment of co-occurring illnesses. It is recommended that a resource be developed for crisis responders to have immediate access to specialists in the chemical dependency and co-occurring fields, to be available to assist the front line CDMHPS and law enforcement personnel.
5. As an alternative to the over-utilization of hospital emergency rooms and jails for crisis events, provide a substantial increase in the availability of safe, secure detoxification beds for adults under the influence who are combative, experiencing a psychotic episode and/or suicidal. This bed increase should include post-detox transitional beds to help maintain patient stability prior to entry to longer term treatment.

**What does the group recommend?**

All of these options are recommended for consideration and have not been laid out in any order of priority. The recommendations are not mutually exclusive or dependent and implementation of any or all of these recommendations could lead to some improvements to services for adults with chemical dependency and/or adults with co-occurring chemical dependency and mental health issues.

Service Gaps Workgroup  
 Adults with Developmental Disabilities and  
 Co-Occurring Mental Health/Behavioral Disorders Paper  
 May 3, 2004

Specific Issue	There are a variety of service gaps for adults with developmental disabilities and co-occurring mental health/behavioral disorders. The service gaps described in this paper vary by community. The issues raised by this paper and future implementation of any recommendations need to take this into consideration.
What problem are we trying to solve?	<ul style="list-style-type: none"> <li>• Adequate crisis diversion services for immediate access at time of crisis</li> <li>• Adequate diversion bed capacity for adults served through the Community Protection Program</li> <li>• Reluctance of providers to accept the return to services of some behaviourally challenged individuals causing a crisis while temporary alternatives are being sought</li> <li>• Potential loss of future federal revenue for continuing to serve people in hospitals once they are psychiatrically stable and are awaiting the development of an individualized community placement</li> <li>• Lack of adequate primary medical and/or dental care</li> </ul>
How will this move us to our preferred experience?	<p>Improvements in resource access and training in the areas noted above will demonstrate success in commitment to providing community based care responsive to the needs of individuals being served. Measurements could include:</p> <ul style="list-style-type: none"> <li>• Decreased lengths of stay at state and community psychiatric hospitals</li> <li>• Decreased inappropriate discharges from long term care settings</li> </ul>
What issues, concerns, or other factors are involved?	<ul style="list-style-type: none"> <li>• Cross system coordination and planning</li> <li>• Diversion beds, services and in-home crisis stabilization services</li> <li>• Length of stay in diversion beds</li> <li>• Licensing dynamics (e.g. regulations, resident rights, cultural issues, language barriers – providers and cross-systems)</li> <li>• Funding dynamics</li> <li>• Staff turnover</li> </ul>

<p>What are the options we should consider?</p>	<p>The work group limited its identification of gaps to services which are used to avoid involuntary treatment and/or incarceration such as crisis prevention, intervention, and diversion services. The workgroup did not identify or develop recommendations related to the adequacy of resources and services utilized once an individual has been committed to involuntary treatment or incarceration. Further study and planning efforts need to be done regarding these other service gaps in the system of care which are not addressed in the papers including psychiatric inpatient beds; free standing psychiatric evaluation and treatment beds; chemical dependency residential treatment beds; long term placements for individuals being placed from state institutions; and residential licensing issues for individuals with community protection concerns.</p> <ol style="list-style-type: none"> <li>1. Increase capacity for crisis diversion beds and services with an opportunity for increased length of stay.</li> <li>2. Increase access to crisis diversion beds and services for adults served through the Community Protection Program.</li> <li>3. Increase capacity for appropriate in-home stabilization services geared towards serving individuals with developmental disabilities in crisis. In-home stabilization services maintain individuals with developmental disabilities who are experiencing a mental illness and/or a mental health/behavioral disorder crisis in the residential and/or vocational setting by temporarily providing additional staff supports, evaluations, training to providers and families, and transitional case management.</li> <li>4. Develop opportunities for residential and other caregiver staff to participate in crisis prevention and intervention training, thus overcoming the barrier regarding training versus meeting clients' needs. It is often difficult for residential and other caregiver staff to obtain this training while continuing to provide direct care, as it often requires replacement staff coverage for continuity of care for the individuals with developmental disabilities.</li> <li>5. Provide training for hospital staff, Department of Corrections staff, law enforcement and County Designated Mental Health Professionals on resources available through the Division of Developmental Disabilities and the Mental Health Division.</li> <li>6. Increase physician awareness to special needs and challenges of adults with developmental disabilities. Individuals with developmental disabilities and undiagnosed medical or dental needs can exhibit mental health/behavioral disorders when these issues are not being met.</li> </ol>
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<p>What does the group recommend?</p>	<p>All of these options are recommended for consideration and have not been laid out in any order of priority. The recommendations are not mutually exclusive or dependent and implementation of any or all of these recommendations could lead to some improvements to services for adults with developmental disabilities and co-occurring mental health/behavioral disorders.</p>
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**CROSS-SYSTEM CRISIS RESPONSE PROJECT**  
**June 2004**

**APPENDIX 7**

**MAY 2004 FORUM**  
**TABLE NOTES HIGHLIGHTS**





# TABLE NOTES HIGHLIGHTS



## **IMPROVING OUR RESPONSE TO CRISIS: A STAKEHOLDER FORUM**

Embassy Suites, Tukwila, Washington  
May 3, 2004

## **TABLE DISCUSSION HIGHLIGHTS: COLLABORATION/PREVENTION PRESENTATION**

Many comments focused on the proposal as a good idea, cost-effective, already being used effectively, the importance of uniformity across the state, the value of training, etc.

Table notes indicated that the primary concern focused on adequate funding (“otherwise it won’t happen!”) for leadership of the process at the county or community level, payment as needed for participation, and development of non-crisis resources.

Reservations about implementing the process included the need to resolve confidentiality issues (between systems and from qualified professionals), client participation and ROI is essential, the need for funding – especially for non-Medicaid, and several comments indicating that it “won’t work for all populations.”

Implementation issues discussed included:

- Electronic information sharing
- Limited number of professional staff available 24/7
- How information would be shared “after hours”
- Who would be first responders? What information will they have – and how will they get it?
- Who owns the plan?
- Who leads the process?
- What will happen if client does not sign ROI?
- Absolutely essential for state policy to be in place.

Concerns included how the “at risk” population would be identified, what would be the risk to participants, should the proposal be limited to a fairly select target group, duplication, and what the jail “buy-in” would be. Most felt this would be easier to implement with the 6358 population.

Challenges identified repeatedly were: FUNDING (because this would be a “huge” workload increase and because additional resources are needed for clients), the need to CHANGE MINDSETS (“culture change takes a long time”), JARGON (e.g. overcoming when collaborating), SHARING INFORMATION, and UPDATING the plans so they are useful.

## **TABLE DISCUSSION HIGHLIGHTS: ITA PRESENTATION**

### **1. Reaction to the recommendations:**

Reaction to Recommendation 1, to create a combined crisis response for all identified populations, ranged from a “great concept”; “doesn’t go far enough”; and “we already have it”; to “can’t see it happening” and “creating an unfunded mandate is dangerous”. A number of comments focused on the CD ITA. For example, this recommendation would be a major benefit to the CD system and chemical dependency could become mandatory vs. voluntary. Also, the need for safe, secure detox options was noted frequently. Another theme had to do with resources, that most crisis responders already know what they need, but they don’t have the resources to be effective.

Reactions to Recommendation 2, to create a vision for an overall crisis response system, ranged from “liked the concept” to “sadly unrealistic”. The theme of more resources carried over into the second recommendation, including detox, and especially the need for diversion beds. Again the feeling that if you “create adequate resources to implement current system, no new vision would be required”. There was some question about cost effectiveness for population specific facilities (longer term commitment); however, there was positive support for developing resources for individuals with organic disorders. There was also a positive reaction to the possibility of more long-term resources for co-occurring treatment.

### **2. What critical resources would need to be developed?**

Critical resources included developing a pool of specialists, cross training for staff, and resources to pay trained professionals. Other resources include strong community processes, diversion and other specialized resources, including increased rates, funding for CD, and court costs for county prosecutors and other personnel. There was also a strong sentiment expressed not to reallocate resources, only to add to what we have now.

### **3. What implementation issues would need to be taken into account?**

Implementation issues include the difficulty of securing new funds; the challenges that come with any new transition; the need to involve the community in implementation at the earliest possible time; education/training across systems; concern that law changes not stray from the overall context of the proposal; understanding who is in charge; facility/program/professional certification and accreditation; and not enough diversion options in communities. Some felt that legislation could be fully effective out in the future with other structural things being effective sooner.

### **4. Other comments:**

Other comments were reflected above, and/or reiterated similar themes such as, not seeing the recommendations as separate issues; needing one law for MH/CD/DD vs. keeping changes in the law minimal and not expanding the reasons for commitment; adequately funding the full continuum of CD needs; providing supportive services, such as housing, transportation, day care, etc.; and time needed to bring all the partners together. For some lack of funding makes the vision impractical.

## **TABLE DISCUSSION HIGHLIGHTS: SERVICE GAPS FOR ADULTS WITH MEDICAL AND BEHAVIORAL ISSUES**

--Data is needed to clarify the amounts and types of community resources needed by the target group (crisis and transitional beds and behavioral supports); numbers and characteristics of those in the target group need to be estimated.

--With the right beds and supports in the right amounts, crisis situations could decrease, and for those who experience crisis, they would subsequently be able to have a stable living situation.

--Training in managing behavior, assessment, harm reduction and regulations is valuable to the range of long term care providers, including Adult Family Home providers, advocates, in home care providers, and family members.

--There was mixed review about Western State Hospital being able and willing to provide helpful consultation to long term care providers. Suggestions were to look into other entities, from the private non-profit and profit-making sectors.

--Given federal oversight and changes to Medicaid and Medicare, proceed with caution and knowledge based on research before encouraging billing Medicare.

--Training in the Mental Health Access to Care Standards would probably have value, but it would need to take into account that each Regional Support Network may have added to the minimum set.

--Regarding the three recommendations for studies, much data currently exists and should be reviewed before additional data is gathered. The subjects of the three recommended studies seemed important. Coordinate any effort on them with various other studies underway or planned.

## **TABLE DISCUSSION HIGHLIGHTS: SERVICE GAPS FOR CHEMICALLY DEPENDENT ADULTS**

The recommendations suggesting an expansion of intensive case management and secure detoxification received very positive comments in the table discussion notes. These resources could result in better management of difficult behaviors and a decrease in the demand for emergency rooms and jails. The table groups identified a number of implementation concerns that include seeking clarity on the models of case management and secure detoxification to be used and an understanding of what personnel and funding would be available (among other comments). There were concerns that high utilizing population served with intensive case management should also include high utilizing individuals with chemical dependency only and the broader set of individuals with mental disorders rather than just those with mental illnesses.

Generally, participants saw developing training and technical assistance on crisis intervention as desirable. Participant said that although some training is already available, it should be go beyond the mental health system to a broader group including law enforcement, medical 911, ER staff, and chemical dependency providers.

Fewer participants saw a need for a system of providing access to specialty consultation in CD and COD fields for CDMHPs. While some saw this as useful, especially if using video and teleconferencing technologies, others doubted whether it could be provided in a timely enough fashion to assist the CDMHP in their decisions.

Updating the report on Crisis Triage/ Crisis Response Centers garnered largely positive comments due to the inherent collaboration and creative problem solving that can occur there, but the discussion also generated a number of concerns about the licensing of such facilities and the potential constraints and over-regulation that new licensing requirements might place on both new and old centers.

### Discussion About Ease or Difficulty of Implementation

Finding funding and a lack of collaboration between state agencies were seen as the primary obstacles in implementing recommendations for case management and detoxification. Other comments acknowledged the difficulty in finding resources for criminal offenders with behavioral problems due to stigma and fears of public safety.

## **TABLE DISCUSSION HIGHLIGHTS: SERVICE GAPS FOR ADULTS WITH DEVELOPMENTAL DISABILITIES AND MENTAL HEALTH/BEHAVIORAL ISSUES**

--A first step should be to clarify the definition of the target group (how many people are in it, their costs to systems when in crisis, best practices pertaining to their unique characteristics) before refining the recommendations and implementation strategies.

--Some stakeholders responded as if the target group were all persons with developmental disabilities, instead of persons with developmental disabilities AND mental health/behavioral issues.

--DDD case managers should interact more frequently with at risk clients, in order to recognize de-compensation and to minimize crises.

--Crisis prevention and intervention training is more valuable if it is client-specific and is conducted at a client's residence.

--In home stabilization, wherever the home is, is more cost effective and makes for a better outcome for the client.

--The system needs more long-term placement opportunities; otherwise, beds used for crisis become the placement and are not available when needed by others.

--Comments focus on needs of facilities; attention should also be given to needs of in home care takers.

--Advocates/families/consumers also should be the recipients of the recommended training.

--Consumer/family/advocate voices are not prevalent in the comments.

**CROSS-SYSTEM CRISIS RESPONSE PROJECT**  
**June 2004**

**APPENDIX 8**

**MAY 2004 FORUM**  
**DEMOGRAPHICS & FORUM RESULTS**





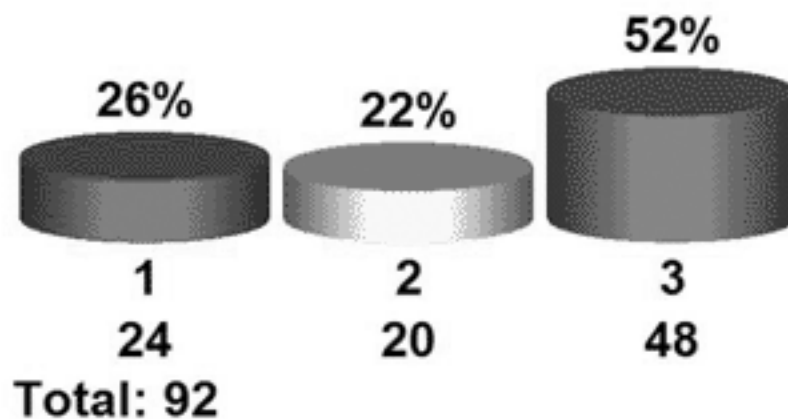
# Improving Our Response to Crisis: A Stakeholder Forum

Embassy Suites, Tukwila Washington

May 3, 2004

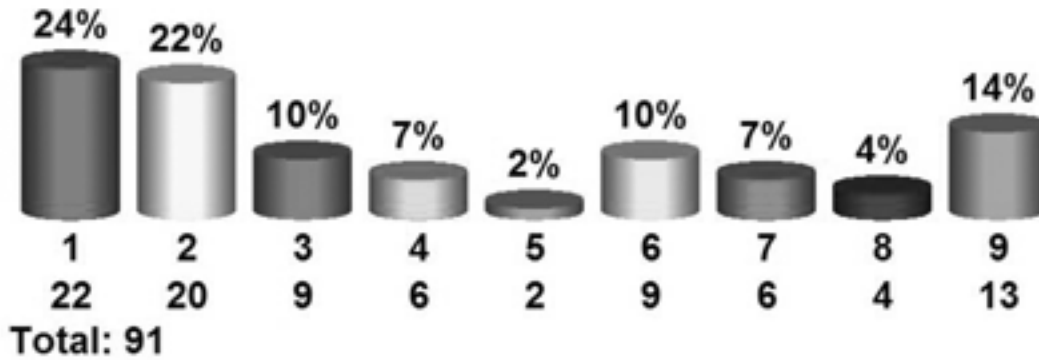
How would you describe the  
community that you represent?

1. Large metropolitan
2. Rural
3. Something in between



What is your primary field? (As a provider, advocate or a consumer?)

1. Mental Health
2. Chemical Dependency
3. Developmental Disabilities
4. Senior Services
5. Law Enforcement / Judicial (Fire Dept./ Police / 911 Dispatch)
6. Corrections (jails, prison, parole and probation)
7. Medical (Hospital / hospital psych unit / emergency dept. / Medic / Ambulance Medical Transport)
8. Legislative Staff
9. Other

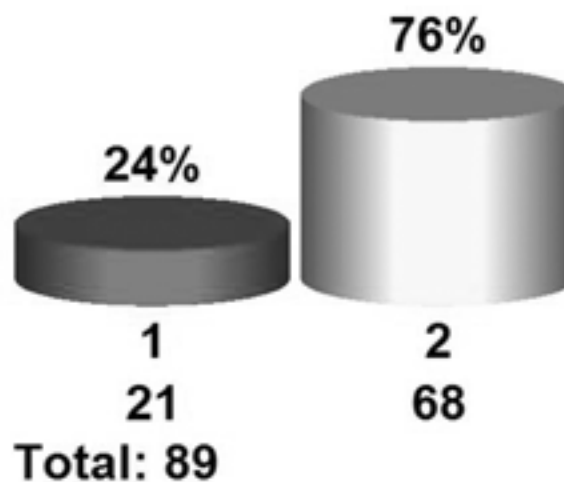


Have you yourself ever been a consumer of crisis services?

1. Yes

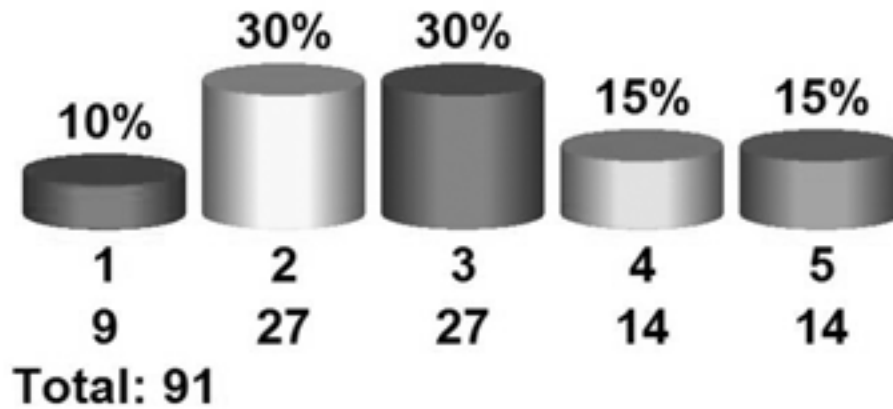
2. No

(Scope of this Project as guide to answer this questions - All presenting problems except strictly medical or acts of God)



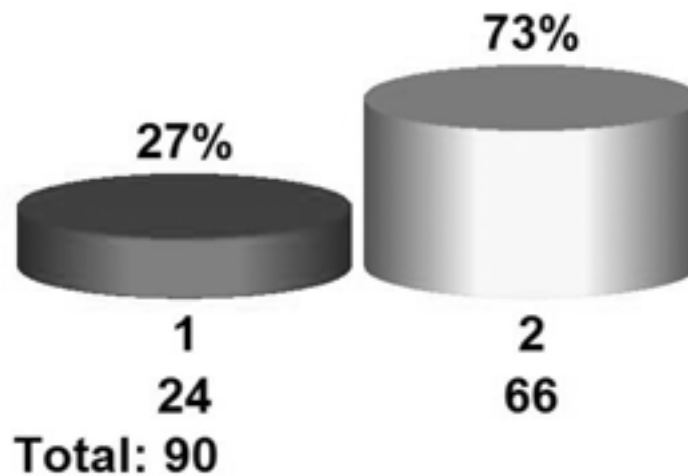
How long have you been involved in your field as indicated above?

1. 0 - 5 years
2. 6- 15 years
3. 16 - 25
4. 26 - 30 years
5. 30+ years



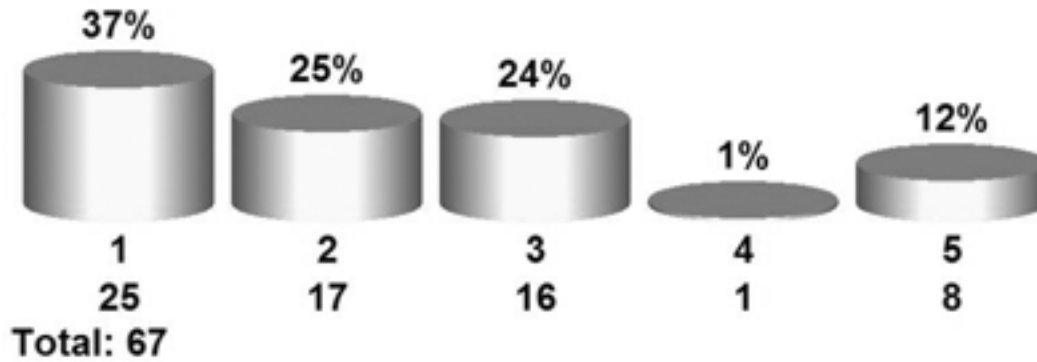
In your role are you a front line responder to crisis?  
(One on one involvement or face to face)

1. Yes
2. No



Are you interested in staying involved in the implementation of these recommendations at the state and/or local level?

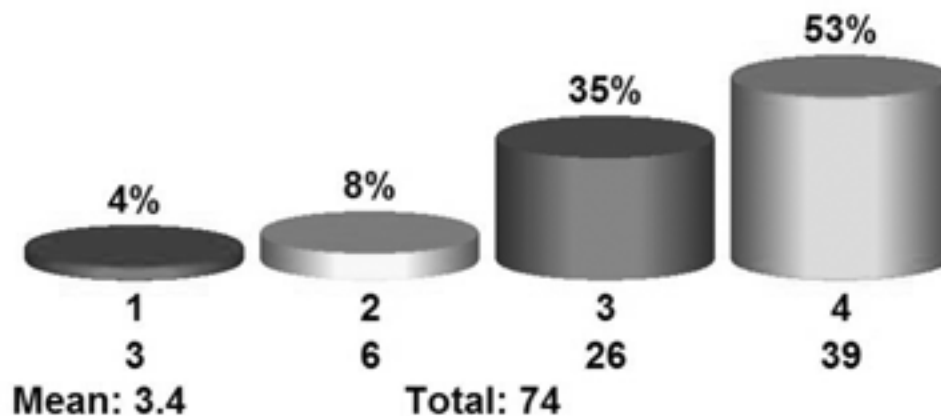
1. I plan to be involved in the adoption and implementation of these recommendations
2. I will closely follow the progress of these recommendations and be helpful where I can
3. I support action on the recommendations and will help if asked
4. I don't plan to be involved in the implementation of the recommendations
5. I will oppose some of the recommendations



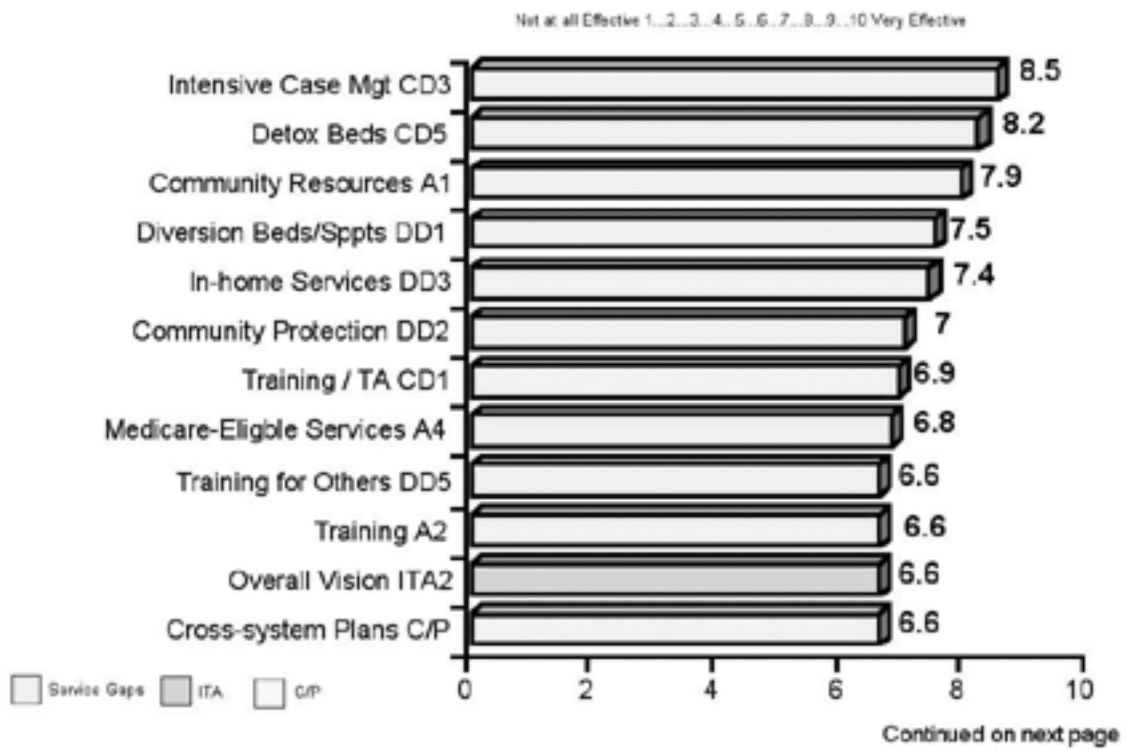
Our purpose today was to give you the opportunity to review the work of the Task Force and give reactions and feedback.

How well did we do in accomplishing our purpose?

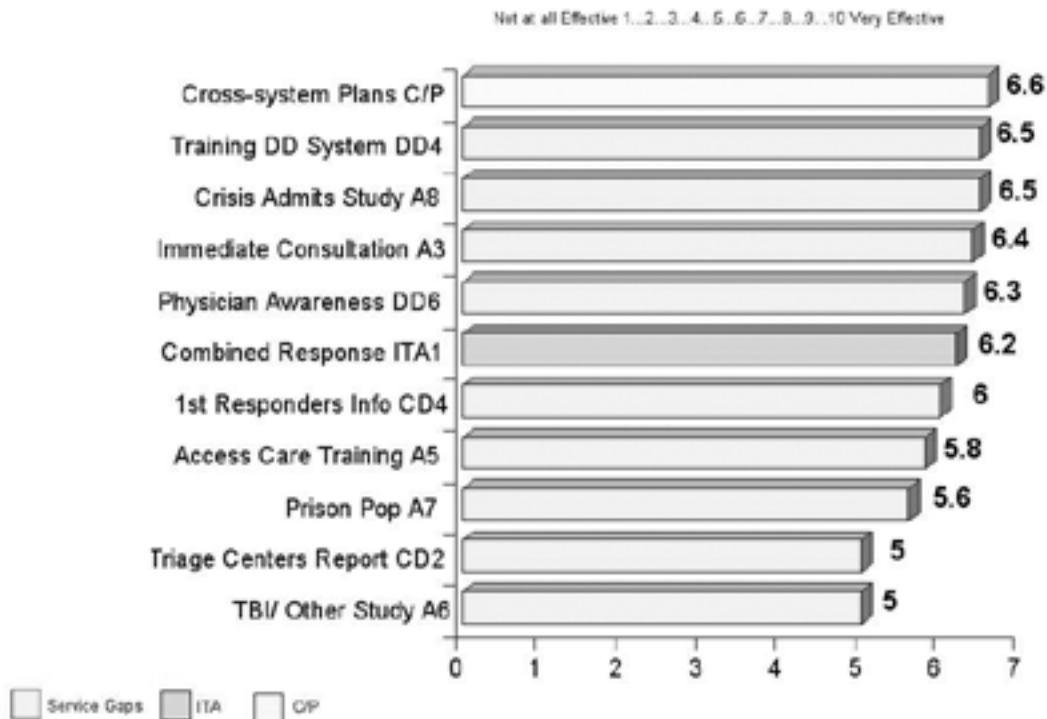
1. Very poorly
- 2.
- 3.
4. Very well



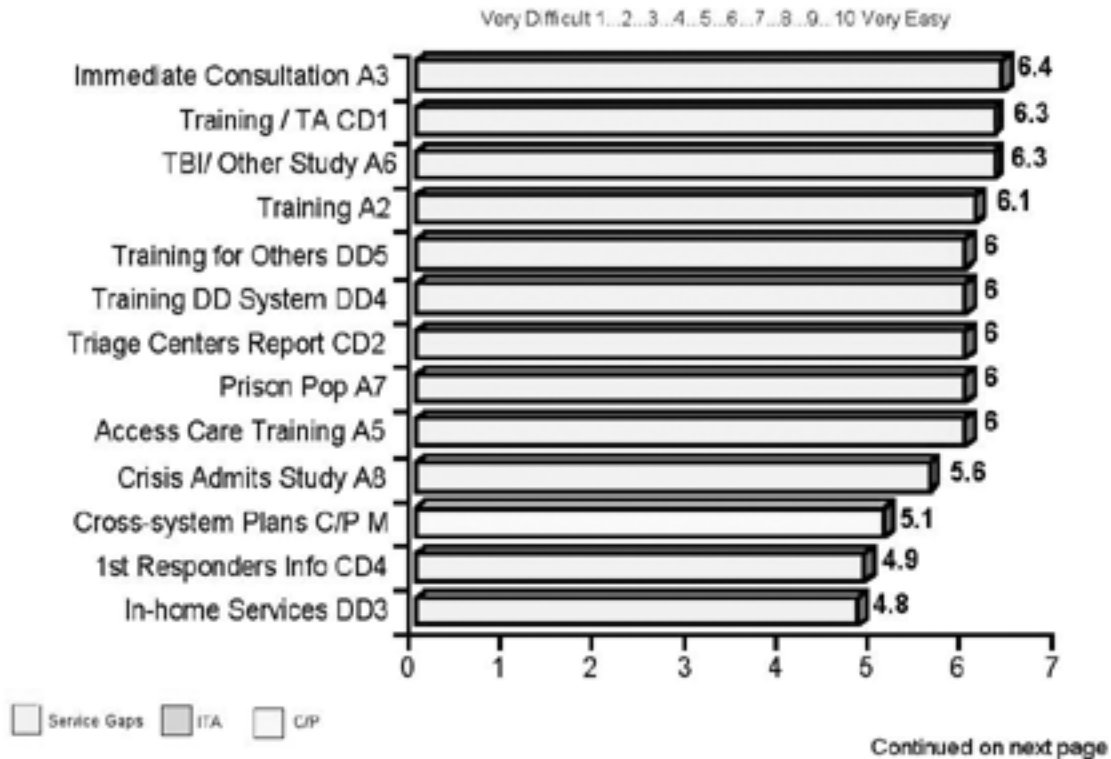
Effectiveness – 22 Recommendations in Descending Order by Mean



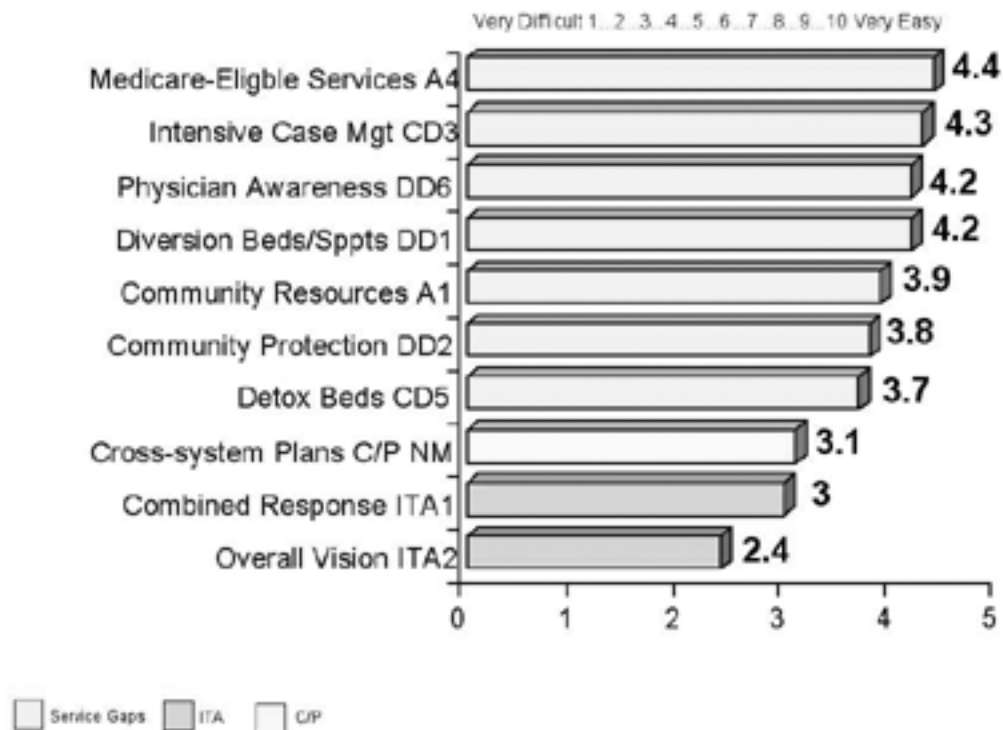
Effectiveness - continued



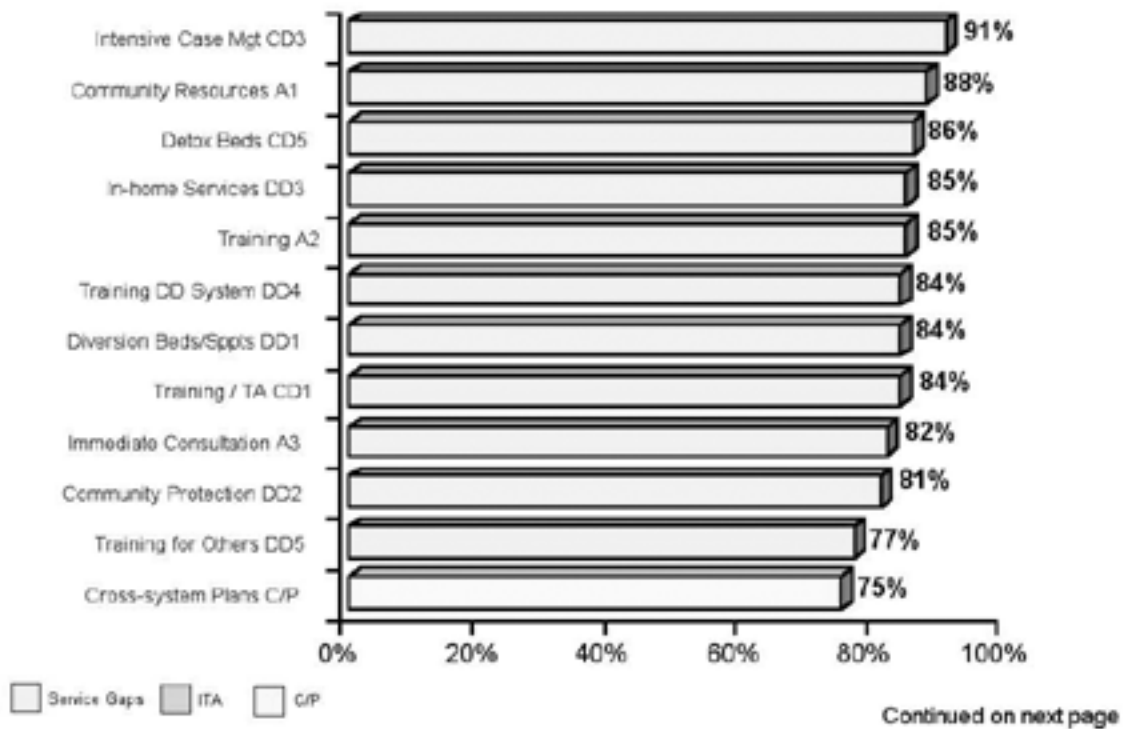
Ease of Implementation – 22 Recommendations in Descending Order by Mean



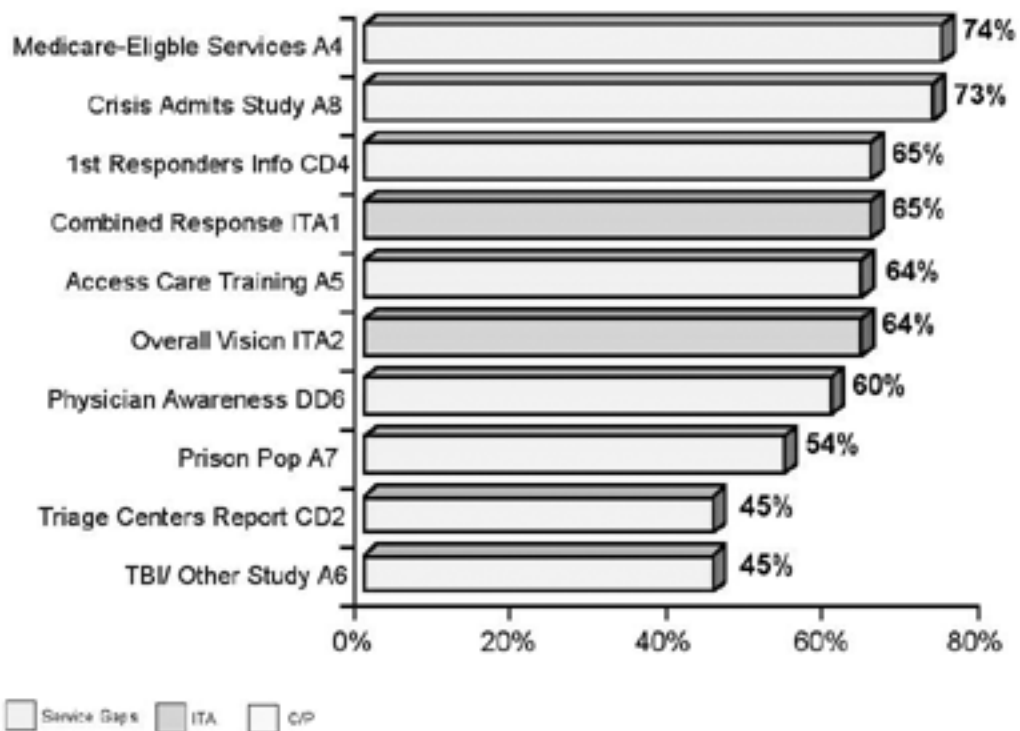
Ease of Implementation – Continued

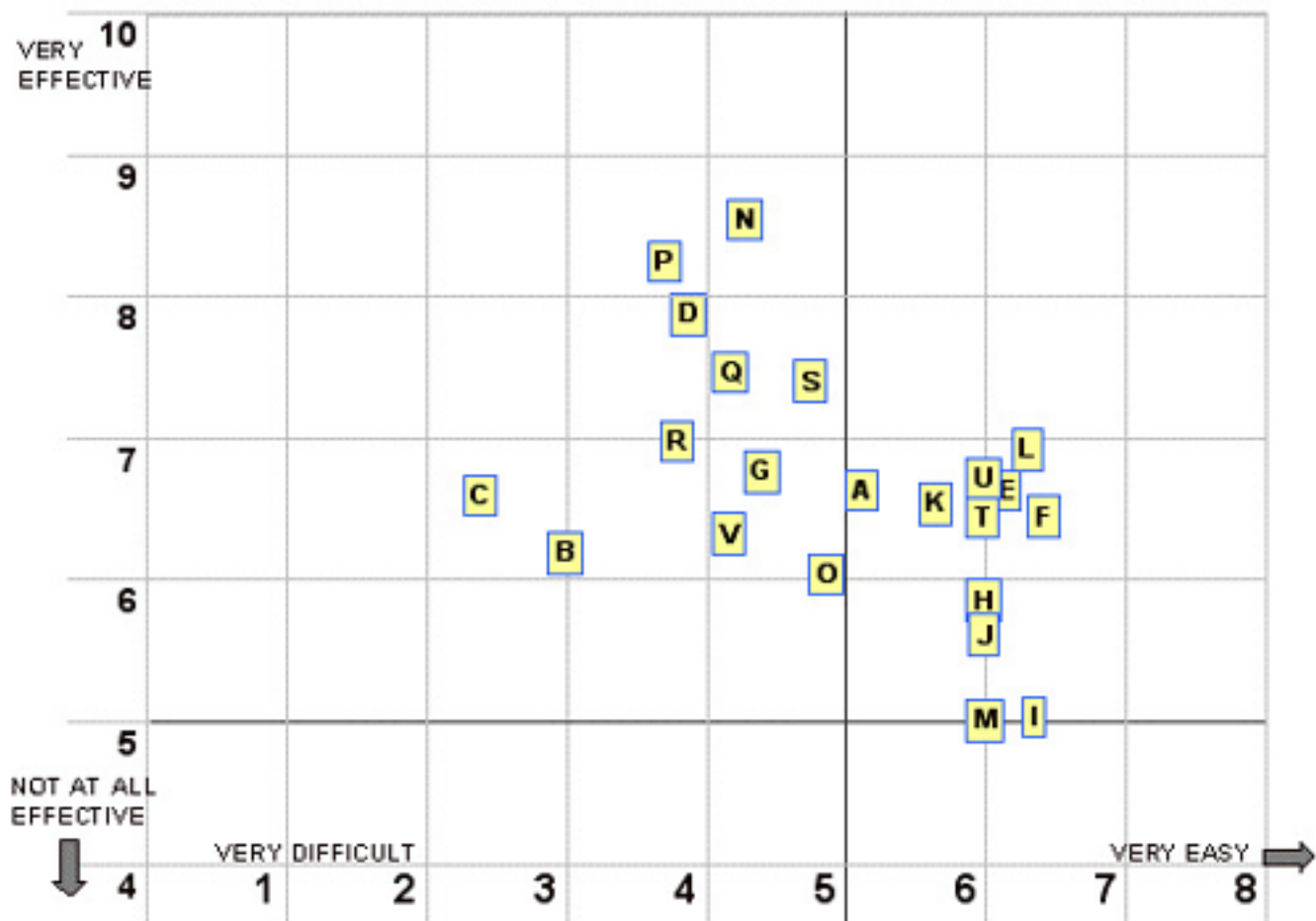


**% Recommending Yes – 22 Recommendations in descending order**



**% Recommending Yes - continued**





Recommendations	Effectiveness	Difficulty
<b>A</b> Cross System Plans	6.6	5.1
<b>B</b> Combined Response	6.2	3.0
<b>C</b> Overall Vision	6.6	2.4
<b>D</b> Community Resources	7.9	3.9
<b>E</b> Training	6.6	6.1
<b>F</b> Immediate Consultation	6.4	6.4
<b>G</b> Medicare Eligible Services	6.8	4.4
<b>H</b> Access Care Training	5.8	6.0
<b>I</b> TBI/ Other Study	5.9	6.3
<b>J</b> Prison Population	5.6	6.0
<b>K</b> Crisis Admits Study	6.5	5.6
<b>L</b> Training / TA	6.9	6.3
<b>M</b> Triage Centers Report	5.0	6.0
<b>N</b> Intensive Case Mgt	8.5	4.3
<b>O</b> 1 <sup>st</sup> Responders Info	6.0	4.9
<b>P</b> Detox Beds	8.2	3.7
<b>Q</b> Diversion Beds / Spts	7.5	4.2
<b>R</b> Community Protection	7.0	3.8
<b>S</b> In-Home Services	7.4	4.8
<b>T</b> Training DD System	6.5	6.0
<b>U</b> Training for Others	6.6	6.0
<b>V</b> Physician Awareness	6.3	4.2



**CROSS-SYSTEM CRISIS RESPONSE PROJECT**  
**June 2004**

**APPENDIX 9**

**TASK FORCE ROSTER  
& AFFILIATIONS**



# CROSS-SYSTEM CRISIS RESPONSE PROJECT

Task Force Roster—June 2004

Name County/State	Representing	E-mail	Telephone
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# CROSS-SYSTEM CRISIS RESPONSE PROJECT

Task Force Roster—June 2004

Page 2

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**CROSS-SYSTEM CRISIS RESPONSE PROJECT**  
**June 2004**

**APPENDIX 10**

**CRISIS DATA\***

DSHS Mental Health Division Data: ITA Investigations and Outcomes

DSHS Research and Data Analysis:  
“Outpatient Mental Health Treatment Reduces Medical Costs and Mortality”  
“Frequent Emergency Room Visits Signal Substance Abuse and Mental Illness”

\* The recommendations of the Task Force were developed independently of this data.



## Mental Health Division Data

### Involuntary Treatment Act Investigations and Outcomes

In Fiscal Year 2003, 28% of all ITA investigations resulted in a 72 hour detention. This paper describes the individuals who were detained, and highlights the locations of those detentions.

<b>Table 1</b>			
<b>FY03: Frequency of Investigation Outcomes</b>			
Outcome Code	Definition	Frequency	Percent
1	72 hour Detention	6,851	28.0%
2	Referred to Voluntary Outpatient Mental Health Services	6,069	24.8%
3	Referred to Voluntary Inpatient Mental Health Services	1,117	4.6%
4	Returned to Inpatient Facility/Filed Revocation Petition	966	3.9%
5	Filed Petition Recommending LRA	266	1.1%
6	Referred to non-Mental Health Community Resources	797	3.3%
9	Other	8,443	34.5%
	<b>Total</b>	<b>24,509</b>	<b>100.0%</b>
<small>Data Note: See January 1, 2002 MHD Data Dictionary for Definitions Investigation Outcome Data Element Definition/Reporting Guidelines.</small>			

#### Client Characteristics

The majority of detainees (77%) were between the ages of 18-59. A large proportion of detainees (17.2%) were over 60.

The most frequent diagnosis reported was schizophrenia, followed by Bipolar Disorder and Major Depression.

Few detainees were employed (6.3%). Fourteen percent had been homeless at some point during the year. Fifty-five percent had been Medicaid eligible at some point during the year.

The majority of detainees had functioning scores in the impaired range (below 50). Although a few (more than expected) had reported functioning levels that were in the normal and superior range.

<b>FY03: Client Characteristics for 72 hour detainees</b>			
<b>Age</b>		<b>Frequency</b>	<b>Percent</b>
	0-17	400	5.80%
	18-59	5269	77.0%
	60+	1178	17.2%
<b>Diagnosis</b>			
	Schizophrenia	1,195	17.4%
	Bipolar	768	11.2%
	Major Depression	484	7.1%
	Other Psychotic Disorder	413	6.0%
	Substance Abuse ( primary or secondary diagnosis)	326	4.8%
	Other Mood Disorder	287	4.2%
	Other Mental Health Diagnosis	215	3.1%
	Anxiety	98	1.4%
<b>Employment Status</b>			
	Employed at some time in FY03	431	6.3%
<b>Homeless Status</b>			
	Homeless at some time in FY03	996	14.5%
<b>Title XIX Status</b>			
	Received Title XIX Service at Some Point in FY03	3,778	55.1%
<b>Global Assessment of Functioning Score</b>			
	Score 0 – 10 Persistent danger of severely hurting self or others	31	0.5%
	Score 10 - 20 Some danger of hurting self or others	425	6.2%
	Score 20 - 30 Serious impairment in communication or judgment	574	8.4%
	Score 30 - 40 Major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood.	943	13.8%
	Score 40 – 50 Any serious impairment in social occupational or school functioning.	1,322	19.3%
	Score 50 - 60 Moderate symptoms	829	12.1%
	Score 60 - 70 Some mild symptoms	258	3.8%
	Score 70 – 80 If symptoms are present , they are transient and expectable reactions to stressors.	37	0.5%
	Score 80 - 90 Absent of minimal symptoms	5	0.1%
	Score 90 – 100 Superior functioning in a wide range of activities	35	0.5%

### Location of Detentions

As expected, urban counties account for most of the 72 hour detentions. King County shows the most detentions followed by Spokane, Pierce, Snohomish and Clark.



**Table 3****FY03: Location of Clients Detained for 72 hrs**

County Code	County	Frequency	Percent
01	Adams	12	0.2%
01	Asotin	9	0.1%
03	Benton	120	1.8%
04	Chelan	81	1.2%
05	Clallam	73	1.1%
06	Clark	503	7.7%
07	Columbia	7	0.1%
08	Cowlitz	183	2.8%
09	Douglas	16	0.2%
10	Ferry	9	0.1%
11	Franklin	36	0.6%
12	Garfield	1	0.0%
13	Grant	35	0.5%
14	Grays Harbor	9	0.1%
15	Island	75	1.1%
16	Jefferson	43	0.7%
17	King	1507	23.0%
18	Kitsap	232	3.5%
19	Kittitas	56	0.9%
20	Klickitat	36	0.6%
21	Lewis	41	0.6%
22	Lincoln	12	0.2%
23	Mason	35	0.5%
24	Okanogan	42	0.6%
25	Pacific	13	0.2%
26	Pend Oreille	11	0.2%
27	Pierce	654	10.0%
28	San Juan	16	0.2%
29	Skagit	230	3.5%
30	Skamania	3	0.1%
31	Snohomish	636	9.7%
32	Spokane	858	13.1%
33	Stevens	1	0.0%
34	Thurston	146	2.2%
35	Wahkiakum	3	0.1%
36	Walla Walla	26	0.4%
37	Whatcom	321	4.9%
38	Whitman	20	0.3%
39	Yakima	311	4.8%
40	Unknown	132	2.0%

Source: MHD-CIS - KWR

Date: May 12, 2004 JH

<b>Table 4</b>				
<b>Investigation Outcomes for Fiscal Year 2000 - 2003</b>				
<b>Investigation Outcomes</b>	<b>Fiscal Year</b>			
	<b>2000</b>	<b>2001</b>	<b>2002</b>	<b>2003</b>
Detention (72 hours as identified under ITA - RCW 71.05)	3393	7131	6943	6851
Referred to Voluntary Outpatient Mental Health Services	4034	8423	7656	6069
Referred to Voluntary Inpatient Mental Health Services	954	814	1229	1117
Returned to Inpatient Facility/Filed Revocation Petition	371	977	966	966
Filed Petition Recommending LRA	539	426	398	266
Referred to Non-Mental health Community Resources	334	770	777	797
Other	5693	9088	8835	8443
<b>Total</b>	<b>15318</b>	<b>27629</b>	<b>26804</b>	<b>24509</b>

### State Hospital Data

<b>Table 5</b>								
<b>Number of Discharges and Average Length of Stay (ALOS) by Hospital</b>								
<b>Hospital</b>	<b>ALOS for Patients Discharged in FY 2003 (July 1 – June 30, 2003)</b>				<b>ALOS for Patients Still in the Hospital on July 1, 2003</b>			
	<i>Adults</i>		<i>Older Adults</i>		<i>Adults</i>		<i>Older Adults</i>	
	Number of Discharges	ALOS	Number of Discharges	ALOS	Number of Patients	ALOS	Number of Patients	ALOS
<b>ESH</b>	683	74.9	151	303.9	149	347.7	51	496.1
<b>PALS</b>	131	731.1	7	1264.6	119	862.1	6	1239.7
<b>WSH</b>	745	174.0	138	654.2	367	963.3	149	1076.6
<b>Total</b>	<b>1559</b>	<b>254.4</b>	<b>296</b>	<b>569.2.0</b>	<b>635</b>	<b>892.4</b>	<b>206</b>	<b>1159.3</b>



Washington State  
Department of Social  
& Health Services

DSHS Research and Data Analysis Division, 3.29fs

## Outpatient Mental Health Treatment Reduces Medical Costs And Mortality

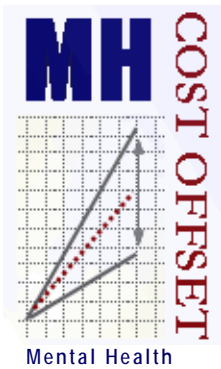
WASHINGTON STATE ADULT AGED AND DISABLED CLIENTS

### Outpatient Mental Health Treatment Reduces Medical Costs

The Washington State Mental Health Services Cost Offset and Client Outcome Study<sup>1</sup> examined the effects of publicly funded mental health care on medical costs and mortality for adult aged, blind, or disabled medical assistance clients.<sup>2</sup> The study found:

- Medical costs for Medicaid-only aged and disabled clients receiving outpatient mental health treatment in Fiscal Year (FY) 2000 were lowered by \$109 per member per month (pmpm) in FY 2001 and by \$126 pmpm in FY 2002, compared to clients with mental illness who did not receive mental health treatment. Reduced medical costs offset 44 to 50 percent of the \$250 pmpm average cost for providing the outpatient mental health care to Medicaid-only aged and disabled clients.
- Medical costs for General Assistance Unemployable (GA-U) clients receiving outpatient mental health treatment in FY 2000 were lowered by \$255 pmpm in FY 2001, compared to GA-U clients with mental illness who did not receive mental health treatment. Reduced medical costs in FY 2001 more than offset the \$180 pmpm average cost for providing outpatient mental health treatment to GA-U clients. However, significant medical savings did not persist into the second follow-up year (FY 2002).

Research & Data Analysis  
Division



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Sharon Estee, Ph.D.  
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In conjunction with  
Mental Health Division

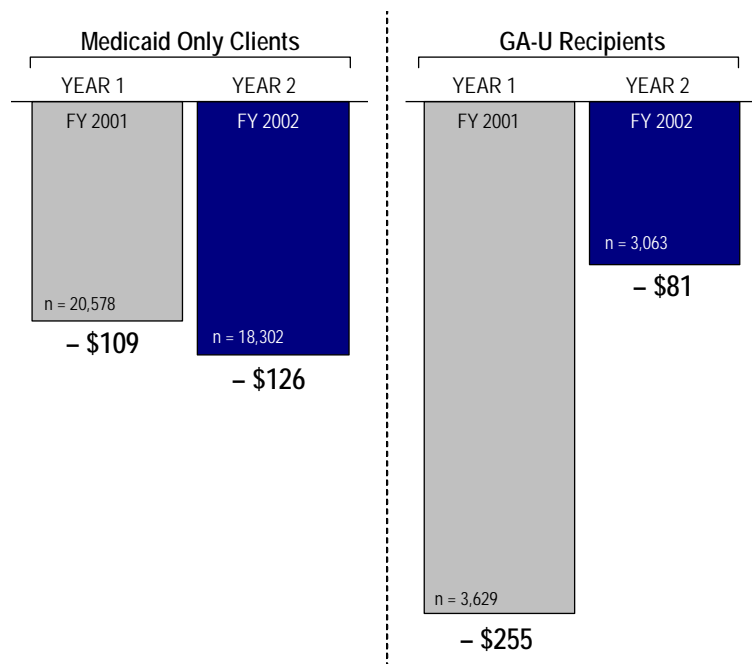
Karl Brimmer, Director  
Judy Hall, Ph.D.

UPDATED JUNE 2004

**DRAFT**  
6/24/04

#### Medical Cost Offset Associated With Outpatient Mental Health Treatment

GROSS medical cost  
offset per client per  
month in first and  
second years of  
follow-up



<sup>1</sup> The technical report is available electronically at <http://www1.dshs.wa.gov/rda/research/3/29.shtm>.

<sup>2</sup> See the Technical Notes on page 6 for more information about the study population and analysis methods.

## Outpatient Treatment With Psychotropic Medication Is More Effective Than Psychotropic Medication Alone

Many clients with mental illness are prescribed anti-depressant, anti-anxiety, anti-psychotic or anti-mania medications. To distinguish the effect of outpatient mental health treatment in reducing medical costs from the effect of psychotropic medications, we estimated three separate “treatment” effects (compared to clients who received neither outpatient treatment nor psychotropic medication):

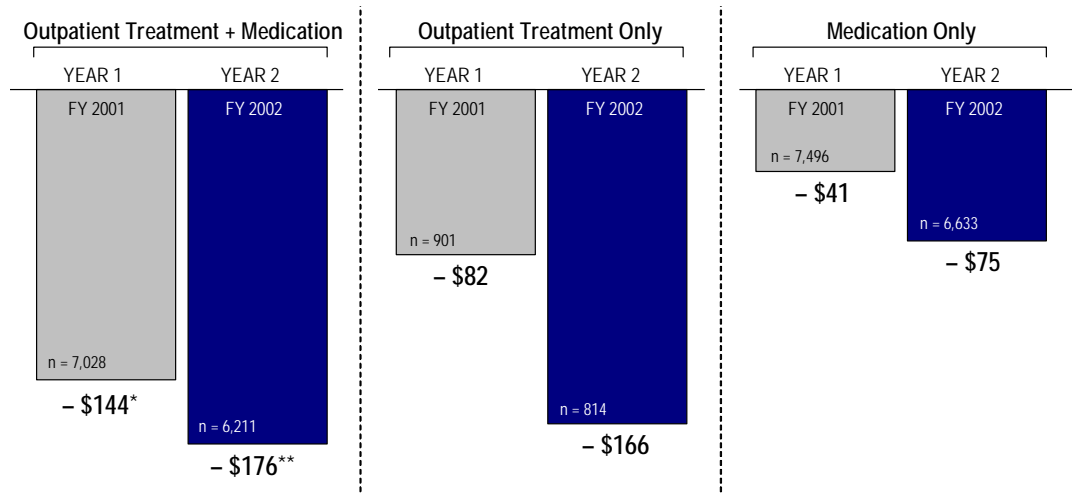
- The effect of outpatient treatment with psychotropic medication,
- The effect of outpatient treatment without psychotropic medication, and
- The effect of psychotropic medication alone (without outpatient treatment).

We focused on Medicaid-only aged and disabled clients because the relatively small number of GA-U clients in the study population does not permit detailed subgroup analysis. **We found that outpatient therapy with psychotropic medication was more effective in reducing medical care costs than psychotropic medication alone:**

- Medicaid-only aged and disabled clients receiving both therapy and medication experienced significant cost savings of \$144 and \$176 pmpm in FY 2001 and FY 2002, respectively, compared to clients who received neither outpatient therapy nor psychotropic medication.
- These savings offset 52 to 64 percent of the cost for providing outpatient mental health care.
- In contrast, savings were lower and not statistically significant – \$41 and \$75 pmpm in FY 2001 and FY 2002, respectively – for Medicaid-only aged and disabled clients receiving psychotropic medication alone.

### Medical Cost Offsets: Outpatient Treatment Vs Psychotropic Medication

GROSS medical cost offset per client per month in first and second years of follow-up  
Medicaid-only aged and disabled clients



\* Significant at the 5% level.  
\*\* Significant at the 1% level.

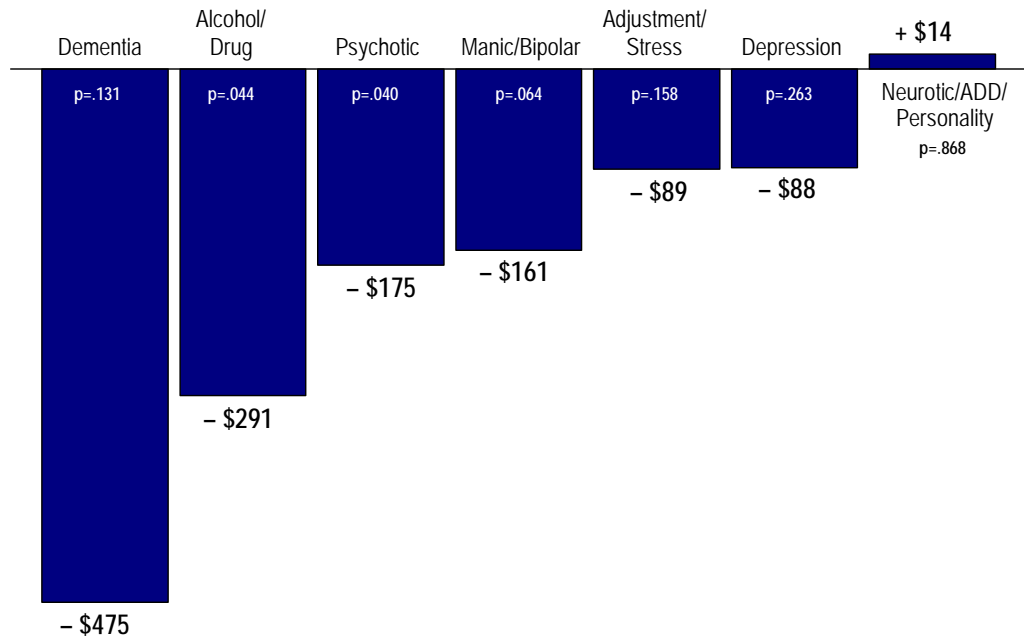
### The Effect Of Outpatient Mental Health Treatment On Medical Costs Varies With Clients' Mental Illness Conditions

We estimated the medical cost offsets from outpatient mental health treatment provided to clients with different types of mental illness diagnoses. The ICD-9-CM diagnosis codes used to group mental illness conditions are described on page 5.<sup>3</sup>

- Large medical cost offsets are associated with mental health treatment provided to clients with psychotic disorders, mania/bipolar disorders, and co-occurring alcohol/drug disorders. Medical cost reductions from mental health treatment provided to aged and disabled clients with these conditions were \$175, \$161, and \$291 pmpm, respectively.
- Outpatient mental health treatment costs averaged \$415 pmpm for Medicaid-only aged and disabled clients with psychotic disorders, \$271 pmpm for clients with mania/bipolar disorders, and \$252 pmpm for clients with co-occurring alcohol/drug disorders. The net cost offsets from outpatient mental health treatment for these conditions were 42 percent, 59 percent, and 115 percent, respectively.
- A large medical cost offset was also estimated for outpatient mental health treatment provided to clients with dementia (\$475 pmpm). Although this estimate does not achieve statistical significance at the standard 5 percent level, it is substantially greater than the \$241 pmpm cost of outpatient mental health therapy for these clients.
- We did not find significant medical cost offsets associated with outpatient mental health treatment provided to clients with adjustment/stress disorders, depression, neurotic disorders, attention deficit disorder, or personality disorders.

#### Medical Cost Offsets Associated With Outpatient Mental Health Treatment, By Diagnosis

GROSS medical cost offset per client per month in first year of follow-up (FY 2001)  
 Medicaid-only aged and disabled clients



<sup>3</sup> Clients with multiple mental illness disorders are represented in the analysis for each condition present in their mental illness profile.

## Outpatient Mental Health Treatment Reduces Mortality Among Medicaid-only And GA-U Clients

We examined the relationship between receipt of outpatient mental health treatment and the risk of death. We focused on outpatient mental health treatment provided in FY 2000, to allow for two follow-up years to track mortality outcomes.

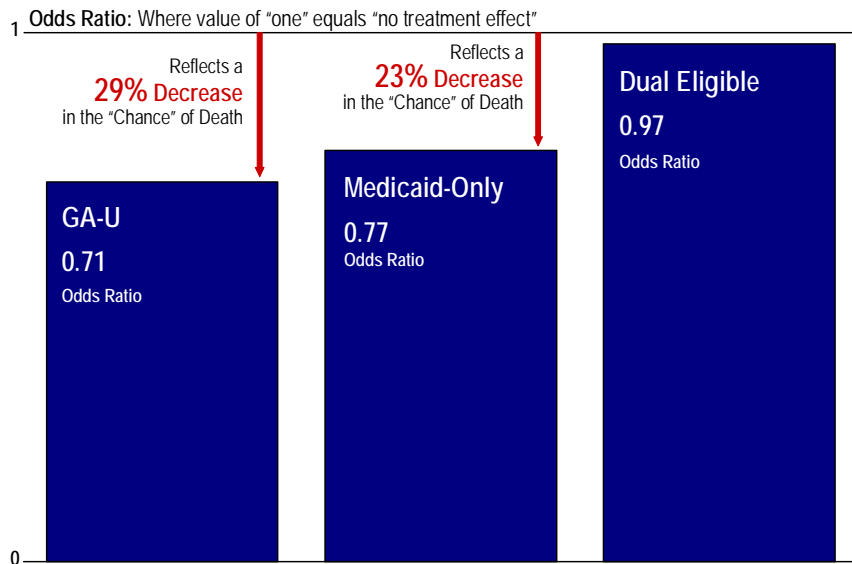
The figure below reports the relationship between outpatient mental health treatment and the chance of death in the follow-up period, as measured by odds ratios derived from logistic regression models. An odds ratio of less than 1 means that clients receiving mental health treatment are less likely to die in the follow-up period, compared to clients with mental illness who do not receive mental health treatment.

For Medicaid-only and GA-U clients, outpatient treatment is associated with a reduced risk of death, even after controlling for age, gender, baseline health status, and baseline mental illness conditions:

- Among Medicaid-only aged and disabled clients the odds of death are 23 percent lower for clients receiving mental health treatment, compared to untreated Medicaid-only aged and disabled clients with mental illness.
- Among GA-U clients the odds of death are 29 percent lower for clients receiving treatment, compared to untreated GA-U clients with mental illness.
- We did not find a statistically significant relationship between outpatient treatment and the risk of death among aged and disabled Medicaid clients who were dually eligible for Medicare (“dual eligibles”).

### Outpatient Mental Health Treatment Reduces Mortality

FY 2000 treatment year, two year follow-up period (FY 2001-2002)



**Mental Illness Diagnosis Groups**

	ICD-9-CM Codes	ICD-9-CM Category Name
Psychotic Disorders	295 297 298.2 to 298.9 299	Schizophrenic disorders Paranoid states Other non-organic Psychoses, childhood origin
Mania and Bipolar Disorders	296.0-296.1 296.4-296.9 298.1	Manic Bipolar Excitative-type psychosis
Depression	296.2 296.3 298.0 300.4 311	Major depression, single Major depression, recurrent Depressive type psychosis Neurotic depression Depression, not otherwise classified
Dementia and Organic Disorders	290 293 294 310	Dementia Transient organic psychosis Chronic organic psychosis Organic, non-psychotic
Neurotic, Personality, and Attention Deficit Disorder (ADD)	300 (except 300.0, 300.1, 300.4) 301 302 307 312 313 314.0 314.2-314.9	Neurotic (e.g., phobia, obsessive-compulsive, etc.) Personality (e.g., anti-social, histrionic, paranoid, etc.) Sexual deviation/disorder Symptoms or syndrome not otherwise classified Conduct disturbance Childhood/adolescent emotion disturbances Attention Deficit Disorder Other Attention Deficit Disorder, ADHD
Adjustment and Stress Disorders	300.0 300.1 308 309	Anxiety Hysteria Acute stress reaction Adjustment reaction (e.g., post-traumatic stress disorder)
Alcohol or Other Illegal Drug Disorders	303 305.0 291 304 305.2 to 305.9 292	Alcohol dependence Alcohol abuse Alcoholic psychosis Drug dependence Drug abuse Drug psychosis

**TECHNICAL NOTES**

This report used data from the Washington Medicaid Integration Partnership (WMIP) database. The WMIP database is a longitudinal client-level database spanning FY 1999 to FY 2002 (July 1998 to June 2002). The database links fee-for-service medical claims from the Medicaid Management Information System Extended Database (MMIS-EDB); Client Services Database (CSDB) information on client-level service encounters and expenditures for most services provided by DSHS, including mental health treatment services; medical assistance eligibility; client demographics; mortality; and criminal justice data.

The study population included clients eligible for Medicaid through the aged, blind, disabled, and presumptively disabled (GA-X) programs, as well as those receiving state-funded medical assistance through the General Assistance Unemployable (GA-U) program. Clients dually eligible for Medicare were excluded from the “cost offset” components of the study because information on most of the medical care they receive is not available in the Medicaid claims data. The average age of the study population was 45 years for Medicaid-only aged and disabled clients, 41 years for GA-U clients, and 53 years for dual eligible aged and disabled clients. Fifty-seven percent of Medicaid-only and dual eligible aged and disabled clients were female, while a slight majority (52 percent) of GA-U clients were male.

In this report, outpatient mental health treatment refers to outpatient mental health services administered and funded through the Mental Health Division. The relatively small volume of Medicaid-paid outpatient mental health services not funded through the Mental Health Division is excluded from our definition of mental health treatment. Outpatient mental health services and costs were identified using CSDB data tables that were derived from Mental Health Division Client Information System (MHDCIS) data.

Treatment and comparison clients were restricted to those with mental illness conditions identified in their medical claims. The specific mental illness conditions are identified on page 5. Because mental illness disorders are frequently underreported in diagnoses recorded in medical claims, we identified the presence of mental illness disorders for each client in the study population using all medical claims available for the client in the FY 1999 to FY 2002 period.

To estimate cost differences, we used the conditional difference-in-differences model.<sup>4</sup> This approach analyzes the change in per member per month medical expenditures from the baseline year to the follow-up year. This model removes selection bias if the amount of bias does not change from the baseline to follow-up period. The effect of outpatient mental health treatment on mortality outcomes was estimated using logistic regression models.

Regression models controlled for age, gender, and baseline mental illness conditions. In addition, because chronic health conditions are strongly correlated with ongoing medical expenditures we controlled for baseline differences in chronic disease conditions using both the Chronic Illness and Disability Payment System (CDPS) and Medicaid Rx System.<sup>5</sup>

Additional copies of this fact sheet may be obtained from:

<http://www1.dshs.wa.gov/RDA/>



<sup>4</sup> The conditional difference-in-differences model is described in Heckman J, Smith J, Ichimura H, Todd P. 1997. Characterizing Selection Bias Using Experimental Data. National Bureau of Economic Research Working Paper No. 6699.

<sup>5</sup> The CDPS model is described in Kronick, Richard, Ph.D., Gilmer, Todd, Ph.D., Tony Dreyfus, M.C.P., and Lora Lee, M.S. 2000. *Improving Health-Based Payment for Medicaid Beneficiaries: CDPS*. Health Care Financing Review, Volume 21, Number 3, Spring. The Medicaid Rx model is described in Gilmer T, Kronick R, Fishman P, and Ganiats TG. 2001. "The Medicaid Rx Model, Pharmacy-Based Risk Adjustment for Public Programs." *Medical Care*, Volume 39, Number 11, pp 1188-1202.





Washington State  
Department of Social  
& Health Services

Research & Data Analysis  
Division

DSHS Research and Data Analysis Division, 11.119fs

## Frequent Emergency Room Visits Signal Substance Abuse And Mental Illness

WASHINGTON STATE'S AGED, BLIND, AND DISABLED CLIENTS

### Frequent Emergency Room Visitors Have High Rates Of Alcohol Or Drug Disorders And Mental Illness

A cause for concern is the high rate of alcohol or drug (AOD) disorders and mental illness among aged, blind, and disabled fee-for-service clients who make frequent visits to the emergency room (ER):<sup>1</sup>

- **56 percent** who visited the emergency room 31 times or more in fiscal year (FY) 2002 had diagnoses of **both an AOD disorder and mental illness**.<sup>2</sup>
- An additional 10 percent of the most frequent ER visitors had an AOD disorder only, while 23 percent had a mental illness disorder only. Only 11 percent had no indication of an AOD disorder or mental illness.
- Although they are less than one percent of the aged and disabled population, the 198 most frequent ER users had over 9,000 ER visits in FY 2002.



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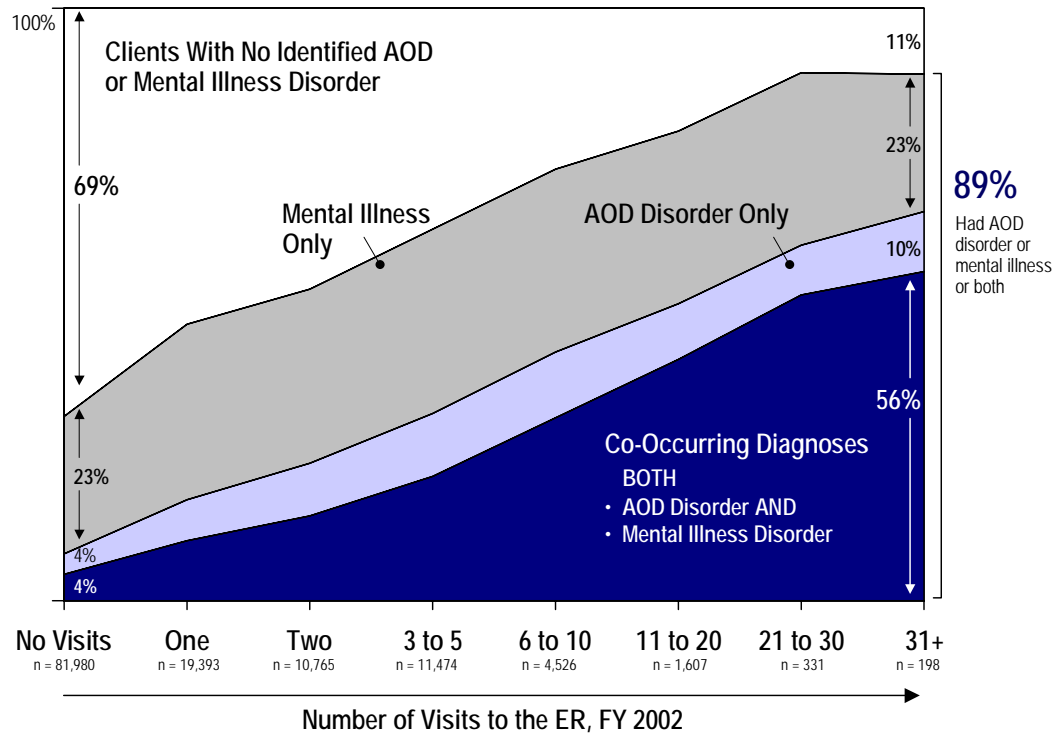
### Frequent ER Visitors Have High Rates Of AOD Disorders And Mental Illness

In conjunction with

*Division of Alcohol and  
Substance Abuse*

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UPDATED JUNE 2004



<sup>1</sup> This study used data from the Washington Medicaid Integration Partnership database. The study population included 130,274 clients eligible for medical assistance in the aged, blind, disabled, presumptively disabled, or General Assistance-Unemployable categories in FY 2002. Clients dually eligible for Medicare were excluded.

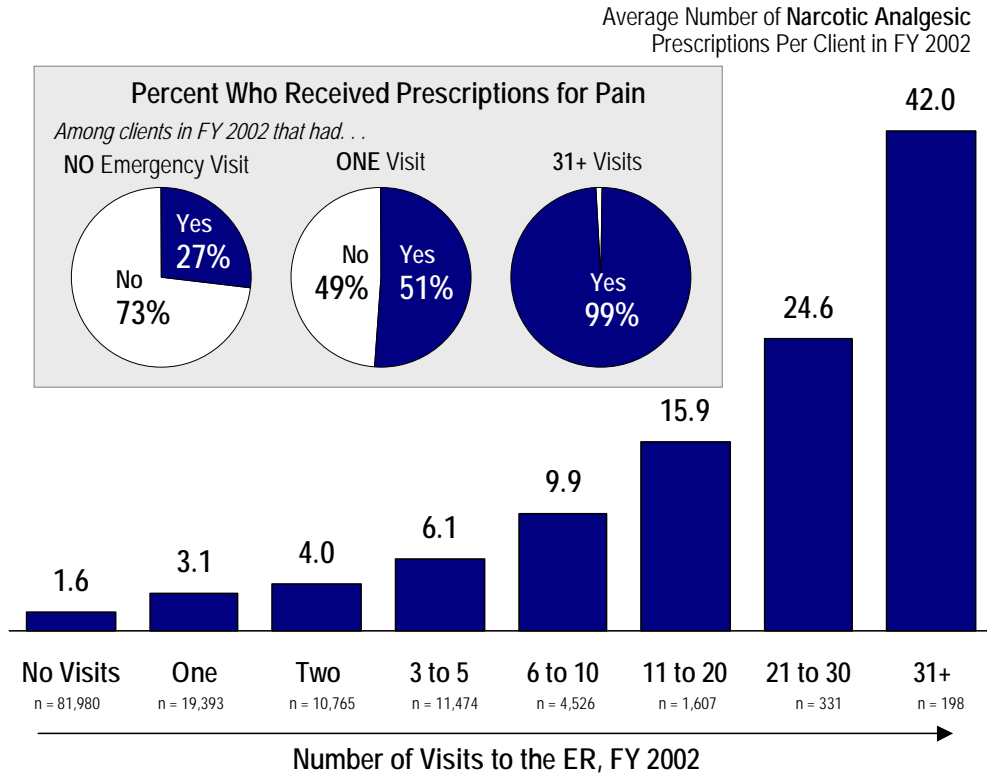
<sup>2</sup> AOD disorders and mental illness were identified in client medical claims using diagnosis categories from the Chronic Illness and Disability Payment System. AOD disorders were identified by diagnoses of substance abuse, dependence, or psychosis. Diagnoses indicating mental illness were primarily schizophrenia, mania and bipolar disorders, and depression.

## Frequent Emergency Room Visitors Receive Many Prescriptions For Pain And Have High Medical Costs

**Also of concern** is the high volume of pain medication prescribed to the most frequent users of the ER:

- The average number of narcotic analgesic prescriptions issued to those who visited the ER 31 times or more in FY 2002 is alarming: **42 prescriptions** per person with an **average of 296 days of narcotics supplied in FY 2002**.
- Most narcotic analgesic prescriptions were for **hydrocodone** (such as Vicodin, 40 percent) or **oxycodone** (such as Oxycontin, 27 percent).
- In FY 2002, total ER costs for these aged and disabled clients were \$168 million. Narcotic analgesic costs were an additional \$19 million.<sup>3</sup>
- Increased access to AOD treatment may significantly reduce ER use and narcotic analgesic costs for aged and disabled clients.

### Frequent Emergency Room Visitors Use High Volumes Of Pain Medication



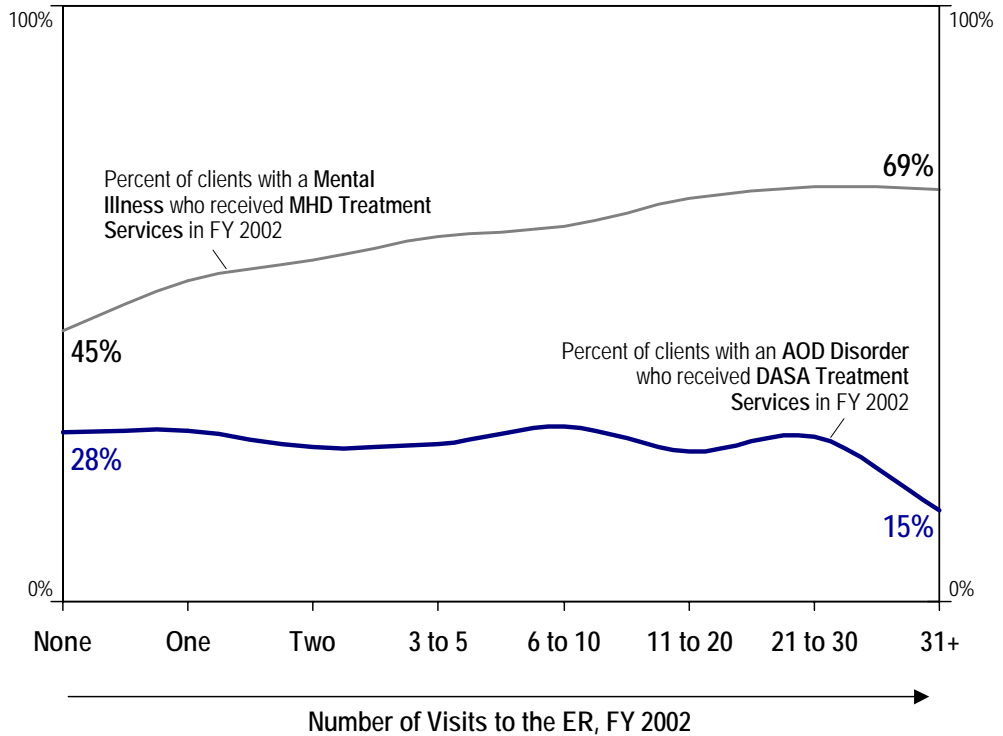
### Annual Costs, FY 2002 (In Thousands)

	No Visits n = 81,980	One n = 19,393	Two n = 10,765	3 to 5 n = 11,474	6 to 10 n = 4,526	11 to 20 n = 1,607	21 to 30 n = 331	31+ n = 198	TOTAL n = 130,274
ER Costs	\$0	\$15,333	\$33,797	\$54,831	\$36,455	\$19,348	\$5,048	\$3,068	\$167,881
Narcotics	\$7,020	\$2,995	\$2,128	\$3,347	\$2,209	\$920	\$262	\$225	\$19,107
ALL MAA	\$282,022	\$130,027	\$117,551	\$170,973	\$99,031	\$45,721	\$10,985	\$6,989	\$863,299

<sup>3</sup> Narcotic analgesic costs are not adjusted for rebates.

## Few Frequent Emergency Room Visitors With AOD Disorders Receive AOD Treatment

Treatment Penetration Rates For Clients With AOD Disorders And Mental Illness



We linked AOD and mental health treatment records with clients’ medical claims to identify how treatment “penetration rates” vary among clients visiting the ER at different frequencies. A penetration rate is the proportion of clients identified as needing treatment who actually receive treatment for their condition. We found that:

- **Two out of three clients with mental illness** who were the most frequent visitors to the ER (31 or more visits) received mental health services from the DSHS Mental Health Division in FY 2002. For mental illness, the penetration rate was higher among clients frequently visiting the ER. Why clients receiving MHD services continue to use the ER frequently may warrant further study.
- In contrast, **fewer than one in six clients with an AOD disorder** who made 31 or more visits to the ER received treatment services from the DSHS Division of Alcohol and Substance Abuse in FY 2002. For AOD disorders, the penetration rate held steady at 25 to 30 percent among clients visiting the ER up to 30 times in FY 2002, but was only 15 percent among the most frequent ER visitors.

### Policy Implications: Improve Screening, System Linkages

Our findings indicate the need to:

- **Improve screening** in the ER to identify AOD disorders and mental illness.
- **Strengthen linkages between the ER and AOD and mental health treatment systems** to increase penetration rates – especially for AOD treatment.
- **Ensure that treatment systems have sufficient capacity** for increased demand that would likely arise from improved screening and referral from ER settings.

### TECHNICAL NOTES

This report used data from the Washington Medicaid Integration Partnership (WMIP) database. The WMIP database is a longitudinal client-level database spanning FY 1999 to FY 2002 (July 1998 to June 2002). The database links:

- Fee-for-service medical claims from the Medicaid Management Information System Extended Database (MMIS-EDB).
- Client Services Database (CSDB) information on client-level service encounters and expenditures for most services provided by DSHS, including AOD and mental health treatment services.
- Medical assistance eligibility, client demographics, mortality, and criminal justice data.

The database was created to support the planning and development of the WMIP project – a DSHS initiative to better serve aged and disabled clients with complex health needs through the integration of medical care, long-term care, mental health, and AOD treatment services.

The study population included 130,274 FY 2002 clients eligible for Medicaid through the aged, blind, disabled, and presumptively disabled (GA-X) programs, as well as those receiving state-funded medical assistance through the General Assistance-Unemployable (GA-U) program. Clients dually eligible for Medicare were excluded from the study because information on most of the medical care they receive is not available in the MMIS system.

The WMIP database incorporates risk-adjustment software to create client-level summaries of the detailed diagnosis information available in the MMIS-EDB claims. AOD disorders were identified using the “Substance Abuse” diagnosis categories of the Chronic Illness and Disability Payment System (CDPS).<sup>4</sup> These categories include alcohol or drug abuse, alcohol or drug dependence, and alcohol or drug psychosis. Mental illness disorders were identified using the CDPS “Psychiatric” diagnosis categories. These categories include schizophrenia, mania and bipolar disorders, and depression. Narcotic analgesic prescriptions were identified using drug therapy class information in the MMIS-EDB.

Because they are frequently underreported in diagnoses recorded in medical claims, we identified the presence of AOD and mental illness disorders for each client in the FY 2002 study population using all medical claims available for the client in the FY 1999 to FY 2002 period.

ER events were identified using the methodology recently established by the Medical Assistance Administration (MAA). This methodology is used in MAA’s bi-annual report on emergency room visits by FFS clients. The report provides statewide and county-level emergency room utilization rates, use rates by ethnicity, and expenditure trends for the FFS population.<sup>5</sup>

<sup>4</sup> Kronick, Richard, Ph.D., Gilmer, Todd, Ph.D., Tony Dreyfus, M.C.P., and Lora Lee, M.S. 2000. *Improving Health-Based Payment for Medicaid Beneficiaries: CDPS*. Health Care Financing Review, Volume 21, Number 3, Spring.

<sup>5</sup> Washington State Department of Social and Health Services, Medical Assistance Administration. 2004. *Emergency Room Visits by Washington State Medicaid Fee-for-Service Clients: Fiscal Years 1999-2003*. January 2004.

Additional copies of this fact sheet may be obtained from the following websites:

<http://www1.dshs.wa.gov/RDA/> or <http://www1.dshs.wa.gov/dasa/>

or through the Washington State Alcohol/Drug Clearinghouse by calling 1-800-662-9111 or 206-725-9696 (within Seattle or outside Washington State), by e-mailing [clearinghouse@adhl.org](mailto:clearinghouse@adhl.org), or by writing to 6535 Fifth Place South, Seattle, Washington 98108-0243.



Research and Data Analysis Division  
Report Number 11.119fs



Department of Social and Health Services  
Division of Research and Data Analysis  
JUNE 16, 2004

## Frequent Emergency Room Visits Signal Substance Abuse and Mental Illness

Washington State Aged, Blind, Disabled, Presumptively Disabled, and General Assistance-Unemployable Clients  
Excludes clients dually eligible for Medicare

### SUPPORTING DETAIL 11.119fs

#### Mental Illness and AOD Disorder Prevalence

TOTAL Medicaid-only Aged and Disabled Clients  
Co-occurring Mental Illness and AOD Disorder  
Mental Illness Only  
AOD Disorder Only

0 Visits	ER Visits, FY 2002						Total
	1	2	3-5	6-10	11-20	21-30	
81,980	19,393	10,765	11,474	4,526	1,607	331	130,274
3,653	1,951	1,530	2,416	1,398	655	171	11,884
18,894	5,736	3,157	3,578	1,396	470	96	33,373
2,880	1,361	982	1,213	498	149	28	7,131
							31+
							198
							110
							46
							20
							7,131

#### Selected Medical Expenditures, FY 2002

TOTAL ER costs  
Has Mental Illness or AOD Disorder  
No Mental Illness or AOD Disorder  
TOTAL Narcotic Analgesic Costs  
Has Mental Illness or AOD Disorder  
No Mental Illness or AOD Disorder  
TOTAL Medical (MAA)  
Has Mental Illness or AOD Disorder  
No Mental Illness or AOD Disorder

0 Visits	ER Visits, FY 2002						Total
	1	2	3-5	6-10	11-20	21-30	
\$0	\$15,333,453	\$33,797,294	\$54,831,187	\$36,455,223	\$19,348,299	\$5,048,004	\$167,881,303
\$0	\$7,934,417	\$17,405,771	\$33,280,020	\$24,759,317	\$14,532,677	\$4,599,722	\$105,428,643
\$0	\$7,399,036	\$16,391,523	\$21,551,167	\$11,695,906	\$4,815,622	\$448,282	\$62,452,660
\$7,020,137	\$2,995,241	\$2,128,440	\$3,346,539	\$2,209,058	\$920,243	\$262,217	\$19,107,093
\$3,147,375	\$1,789,189	\$1,224,895	\$2,312,830	\$1,686,855	\$783,487	\$228,871	\$11,378,414
\$3,872,762	\$1,206,053	\$903,545	\$1,033,709	\$522,203	\$136,757	\$33,346	\$7,728,679
\$282,021,836	\$130,027,279	\$117,551,345	\$170,973,245	\$99,030,575	\$45,720,599	\$10,984,903	\$863,299,109
\$110,420,057	\$61,739,098	\$58,296,473	\$98,701,715	\$64,302,034	\$32,766,522	\$10,092,000	\$442,819,364
\$171,601,779	\$88,288,181	\$59,254,872	\$72,271,530	\$34,728,541	\$12,954,077	\$892,903	\$420,479,745

#### Mental Health Treatment Penetration Rate

Clients with Mental Illness  
Clients with Mental Illness Served by MHD/RSN, FY 2002  
MHD/RSN Penetration Rate, FY 2002

0 Visits	ER Visits, FY 2002						Total
	1	2	3-5	6-10	11-20	21-30	
22,547	7,687	4,687	5,994	2,794	1,125	267	45,257
10,238	4,131	2,688	3,665	1,758	761	186	23,535
45%	54%	57%	61%	63%	68%	70%	69%
							108
							69%
							52%

#### AOD Treatment Penetration Rate

Clients with AOD Disorder  
Clients with AOD Disorder Served by DASA, FY 2002  
DASA Penetration Rate, FY 2002

0 Visits	ER Visits, FY 2002						Total
	1	2	3-5	6-10	11-20	21-30	
6,533	3,312	2,512	3,629	1,896	804	199	19,015
1,859	949	652	956	558	203	55	5,252
28%	29%	26%	26%	29%	25%	28%	28%
							130
							20
							15%
							28%

#### Arrest Rate

TOTAL Medicaid-only Aged and Disabled Clients  
Number Arrested at least once in FY 2002  
Total Arrests, FY 2002  
Total Charges, FY 2002  
Percent Arrested at least once, FY 2002

0 Visits	ER Visits, FY 2002						Total
	1	2	3-5	6-10	11-20	21-30	
81,980	19,393	10,765	11,474	4,526	1,607	331	130,274
3,933	1,697	1,058	1,455	654	256	64	9,158
5,944	2,658	1,673	2,341	1,092	445	116	14,330
8,750	4,030	2,523	3,473	1,564	654	169	21,244
5%	9%	10%	13%	14%	16%	19%	21%
							198
							41
							61
							81
							7%