North Sound Mental Health Administration
Regional Support Network for Island, San Juan, Skagit, Snohomish, and Whatcom Counties
Improving the mental health and well being of individuals and families in our communities
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NSMHA Contract Memorandum 2014-006

Date: April 25, 2014

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Mitch Lykins, Pioneer Human Services
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From: Joe Valentine, Executive Director

Subject: Revised ICRS Crisis Training Module and How to Document a Less Restrictive (LR) Violation

Attached please find the ICRS Crisis Training Module and document with the process for "How to Document a Less Restrictive (LR) Violation". The training module has been through all the approval processes and was passed by the Quality Management Oversight Committee 4/23/14.

Both documents will be available on the NSMHA website at:

Training Module - http://nsmha.org/Committee/RTC/ICRS/Crisis_Response_Module.pdf
LR Violation document - http://nsmha.org/Forms/index.asp. There will be a bullet established for the LR Violation document.

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NORTH SOUND MENTAL HEALTH ADMINISTRATION

INTEGRATED CRISIS RESPONSE SYSTEM TRAINING MODULE

TABLE OF CONTENTS

TRAINING OBJECTIVES:

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

INTRODUCTION

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

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

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

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

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

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

WHAT ARE THE PRINCIPLES OF THE ICRS?

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

WHAT TOOLS ARE AVAILABLE FOR MANAGING CRISES?

CRISIS PLANS

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

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

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

CRISIS ALERTS

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

MENTAL HEALTH ADVANCE DIRECTIVES

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

WELLNESS RECOVERY ACTION PLAN (WRAP)

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

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

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

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

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

CRISIS LINE

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

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

TRIAGE SERVICES

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

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

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

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

WHAT FACE-TO-FACE SERVICES ARE AVAILABLE?

CRISIS SERVICES APPOINTMENTS

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

EMERGENCY PSYCHIATRIC SERVICES

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

OUTREACH

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

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

MOBILE OUTREACH TEAM (MOT)

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

INVOLUNTARY INVESTIGATION SERVICES

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

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

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

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

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

WHAT RESIDENTIALLY BASED CRISIS SERVICES EXIST IN THE REGION?

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

WHATCOM COUNTY BEHAVIORAL HEALTH TRIAGE CENTER (WCBHTC)

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

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

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

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

SKAGIT COUNTY CRISIS CENTER (SCCC)

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

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

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

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

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

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

SNOHOMISH COUNTY TRIAGE CENTER (SCTC)

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

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

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

1. Referral Process:

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

2. Length of Stay/Discharge Planning:

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

WHAT IS THE PROCESS FOR PSYCHIATRIC HOSPITALIZATION?

VOLUNTARY HOSPITALIZATION

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

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

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

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

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

ASSESSMENTS FOR INVOLUNTARY TREATMENT

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

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

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

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

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

3. Does imminent danger exist?

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

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

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

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

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

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

WHAT HAPPENS AFTER AN INVOLUNTARY ADMISSION TAKES PLACE?

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

COURT ORDERS (LESS RESTRICTIVE ORDER AND CONDITIONAL RELEASE)

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

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

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

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

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

Clinicians are expected to document each violation in the individual's chart. Please see "How to Document CR/LR Violations" on the NSMHA website at http://nsmha.org/Forms/index.asp.

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

GLOSSARY OF TERMS

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

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

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

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

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

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

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

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

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

Integrated Crisis Response NSMHA Training Module

Post-Test

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

When and individual is released from the hospital on a Less Restrictive Order (LRO) the conditions of the order are documented (on the order), as well as on the individual's Recovery Plan LR/CR Addendum.

If an individual does not follow the conditions, they have violated the order.
Clinicians working with the individual will decide if the violation(s) results in a revocation, and determine if hospitalization is needed.

1. **When a clinician is considering a revocation of the CR/LR, the clinical decision rationale should include consideration of treatment interventions, listed below, and safety concerns, if any. There should be clear documentation of the clinical decision rationale.**

    A. Is there immediate medical intervention to address the individual's symptoms more effectively?
    B. What steps can the Outpatient Provider take to support the individual in engaging with Medical Providers and services?
    C. Identify the un-met needs of the individual. Use problem solving techniques to meet the needs.
    D. If the individual was not on an LR, what clinical steps could the Clinician take?
    E. Determine the individual's willingness to accept identified treatment and document the results.

2. **Documentation should also include specific conditions violated on the LR**

    A. Identify all missed appointment(s) the reason they occurred, and log all follow up attempts.
    B. What does the violation mean clinically? Document the response with consideration of the individual's potential need to return to the hospital.
    C. What is the current level of risk to self, others and/or property?
    D. What is the intensity and potential impact of the violation?

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