

Tier 1 Top Priorities for Active Work and Promotion

CABTF members identified a short list of top priority recommendations that not only are expected to have a significant impact on inpatient psychiatric treatment access, but also are most likely to proceed toward implementation with the benefit of active work and promotion by task force members. These four priorities will serve as cornerstones of the CABTF's continued system design work subsequent to this report.

Other top priorities, determined to be equally important and effective in addressing the crisis, but where momentum toward implementation was already evident, are discussed separately in the next section.

Recommendation	Category
1a. Expand outreach and engagement services for those who are not enrolled with an outpatient community behavioral health agency, including access to comprehensive case management services for people who are ineligible for Medicaid.	Prevention and Early Intervention and Psychiatric Hospital Re-Entry

Outreach and engagement services should be expanded for individuals with serious behavioral health concerns who lack housing, to enhance an important part of the continuum between inpatient hospitalization and traditional outpatient behavioral health treatment in order to work towards prevention of hospitalization and reduce the frequency of hospitalization for more frequent users of inpatient hospital beds.

Homeless and select housed individuals, who are unwilling or unable to access behavioral health treatment, housing, and related supportive services, require proactive effort to enable them to benefit from the range of financial supports, treatment, and other services available to them. Absent this assertive outreach and engagement effort, a significant percentage of those who are reluctant to engage in services will be seen in emergency departments and admitted to inpatient psychiatric or medical beds. Others may attempt to avoid contact with service providers, police, and society in general.

Outreach, engagement, and intensive case management for high need and vulnerable individuals represent both a hospitalization prevention strategy and a post-hospital intervention strategy, as it reduces rates of future hospitalization and/or incarceration. Engagement and stabilization efforts interrupt and improve mental health status and also interrupt chaotic life circumstances associated with homelessness. A major outreach program provider agency working primarily in Seattle reported that given current capacity, 55 percent of referrals in recent months had not yet been contacted due to the limited capacity of the program. Based on the very limited outreach capacity in the rest of the County, it was estimated that only about 35 percent of the overall outreach need is met by current services.¹⁰¹ Therefore, doubling the current service capacity would allow many more individuals with service engagement challenges to receive the appropriately designed services at the right time. Additional investments in front-end outreach and engagement efforts would prevent or reduce deep-end system costs, such as emergency department (ED) and psychiatric hospital utilization.

Individuals who are not eligible for Medicaid or do not meet criteria for Medicaid outpatient benefits may still need access to comprehensive case management services to reduce their use of costly services

¹⁰¹ Downtown Emergency Service Center (DESC), March 2015.

such as EDs and psychiatric hospitalizations. Among these, individuals with Medicare or those referred to as “dually eligible” (having both Medicaid and Medicare) are often in need of comprehensive community mental health services at a level of intensity similar to that available to Medicaid recipients. Medicare provides much more limited mental health coverage than Medicaid, leaving those with more serious mental health and substance use disorders (SUDs) with very little support.

Using local Mental Illness and Drug Dependency (MIDD) funding, King County provides funding for some of this population and others without Medicaid – including new immigrants and undocumented individuals – to receive comparable comprehensive treatment and support through non-Medicaid outpatient benefits. It is an effective strategy for reducing the gross disparity between Medicaid recipients and individuals without Medicaid. However, resources fall significantly short of need, as all provider agencies report demand that exceeds their MIDD non-Medicaid funding allocation. Expansion of these core services is critical.

Additionally, individuals who are dually eligible for Medicare and Medicaid need case management services to help manage the eligibility and spend-down components of their benefits, and these services need to be reimbursable for providers, regardless of spend-down status.¹⁰²

Initial Steps Toward Implementation

- Conduct a needs assessment in order to determine the amount of additional funding necessary to offer comprehensive outpatient services to the non-Medicaid and Medicare population. Specifically, consult with local providers, consumers, and their families on implementation and funding needs to expand outreach and engagement efforts.
- Seek the expertise of designated mental health professionals (DMHPs), EDs, and hospital discharge staff to identify core principles for outreach services that are most likely to have the greatest impact, building toward an overarching goal of providing outreach on demand.
- Evaluate the best outreach and engagement efforts for the targeted population.
- Expand eligibility for outreach programs, ensuring clarity about which services will address certain subpopulations, including those who are not motivated to seek care on their own; are not able to get to services themselves; want services but cannot get access to a next-day appointment (NDA) or other urgent care entry points; or have not been successful in other programs in the past.
- **Policy Action:** Seek changes to the Medicaid state plan to allow outreach and engagement to be billed to Medicaid, or identified as billable, for individuals not yet enrolled in services. Even so, additional state funding will still be needed to support such services.

¹⁰² The IBIS (Intake and Brief Intervention Services) program at Harborview is one example of how these services might be provided. If someone is not referred or eligible for case management support through a community behavioral health agency, they can be seen in IBIS for three to six months or longer, depending on the individual’s needs. The patient is also assisted with outside referrals if that is appropriate. Services available through this model include an outpatient intake, crisis services, short-term case management and/or brief therapy, evidence-based brief therapy, and referral to outside resources or providers as appropriate including next day appointments (NDAs) when needed.

Recommendation	Category
1b. Expand crisis respite services, including new location(s) and the ability to accept referrals 24/7, and strengthen the staffing model to enable the program to serve more psychiatrically acute individuals and be used as a “step down” from psychiatric hospitalization or a “step up” diversion option for individuals with escalated symptoms.	Crisis Diversion and Psychiatric Hospital Discharge and Re-Entry

There is a need for expanded respite options for individuals who do not need hospitalization, or no longer need it, but need more than community-based support to manage a current crisis episode. Such programs provide crisis respite and transitional case management services for adults who are in need of shelter and mental health services; access to psychiatric consultation and medication services; linkages to permanent housing; and referral and support to access appropriate treatment services as needed.

In the short term, staffing at the existing Crisis Respite Program (CRP) in downtown Seattle could be increased to address more psychiatrically acute populations, which would also include increased access to medical professionals with prescriptive authority and other staffing support in the shelter where the CRP is co-located, and to enable the program to receive referrals 24 hours per day, 7 days per week.

A longer-term recommendation is to establish an additional CRP in south King County, which would require operating and capital investments.

With these enhancements to staffing and bed capacity, crisis respite services could serve even more effectively as a short-term “step up” resource to help people avoid a hospitalization or a “step down” to shorten lengths of stay and reconnect people to community care more quickly, thereby reducing demand by intervening at both ends of the care spectrum.

Initial Steps Toward Implementation

- Explore funding for a crisis respite model that does not depend on space and staffing from adjoining shelters.
- **Policy Action:** Increase local funding to support staffing and capacity enhancements for referrals at the current facility.
- **Policy Action:** Seek state operating and capital funding for crisis respite services.

Recommendation	Category
1c. Develop a coordinated inpatient care continuum, exploring the development of local alternatives for the delivery of long-term involuntary psychiatric treatment and easing access to higher-acuity inpatient beds by stepping patients down to less acute care models even before they are ready to discharge to the community.	Psychiatric Hospital Discharge and Re-Entry

Developing a continuum of levels of inpatient care, including various levels of acuity as well as alternatives to state hospital care for individuals committed via long-term 90- or 180-day court orders, would result in better care quality and less delay in delivering the level of care that best serves a patient’s unique and changing needs.

In the current system, by comparison, the state hospital is the sole long-term inpatient psychiatric care option, and many patients are left waiting in evaluation and treatment (E&T) facilities or single bed

certification (SBC) hospitals – occupying scarce acute care beds – until a state hospital bed becomes available.

As one aspect of launching a robust local inpatient continuum, the development of local alternatives to long-term psychiatric hospitalization at the state hospitals should be explored, given the severely reduced access to Western State Hospital (WSH) beds and the related local psychiatric hospital bed crisis described starting on page 23. The Revised Code of Washington (RCW) 71.24 allows for the development of local community inpatient psychiatric facilities for individuals ordered to 90- or 180-day inpatient psychiatric commitments. By bringing long-term care options to King County, improved coordination with community-based treatment, including faster transitions out of the inpatient setting, may be possible.

State legislation such as 2016's Engrossed Substitute Senate Bill (ESSB) 6656, described on page 47, has set in motion consultant studies that may lead to support for the launch of local long-term treatment alternatives such as the one included in this continuum.

Meanwhile, other patients who need specialized acute care beds cannot access them because they are already occupied by others who may be ready to step down in advance of discharge. With an inpatient stepdown system in place countywide, people would spend less time in the hospital and would return to community settings faster. Retooling the use of E&T beds to allow for patients to step down to less acute models of care will improve patient flow through the system and increase access to higher acuity beds – directly impacting treatment access for patients who are the most complex to place and serve effectively. This would involve moving patients to different units within the same facility, and/or between different facilities based on acuity and/or co-occurring medical needs, as their care needs changed, even before they were ready for discharge to the community. It would depend on effective continuity of care between different E&Ts.

CABTF members have begun meeting with some local E&T providers to explore piloting this arrangement, with a special focus on patients who are on long-term treatment orders, many of whom are on the wait list for WSH. Further research and close tracking of outcomes are planned as part of the development of this model.

With long-term alternatives in place locally, and a stepdown approach adopted within and between inpatient facilities, the inpatient care continuum within King County could create fluidity between co-located or closely coordinated long-term treatment settings, freestanding E&Ts, and hospital-based involuntary beds that can serve geropsychiatric patients or those with medical co-morbidity.

Initial Steps Toward Implementation

- Research local inpatient options in use in other states that have successfully reduced the number of their state hospital beds.
- Initiate a collaborative utilization review process to understand barriers to discharge at WSH, identify differences between specific client populations and their average lengths of stay, and assess unique clinical and service needs of these populations.
- Determine the number of needed long-term psychiatric beds for the next several years should be undertaken with assistance from the state Department of Social and Health Services (DSHS).

- **Policy Action:** Following these initial steps, King County should convene multiple stakeholders in a planning process in order to plan the appropriate continuum of care needed to serve individuals on long-term inpatient commitments within King County. This work should include recommendations regarding the specific client population(s) best served at the state hospital, as well as options to enable many patients to avoid state hospital placement altogether.
- Informed by the above assessment, create a plan for smaller-scale pilot program(s) to serve some patients locally, in accordance with funding opportunities that may be made possible via ESSB 6656 and/or successor legislation, and seek willing provider partners.
- Concurrently seek opportunities to inform and learn from the work of consultants tasked with recommending improvements to state hospital practices.
- **Policy Action:** Continue to seek funding flexibility to support potential movement of appropriate populations of current state hospital patients to local settings.
- Coordinate with current E&T and hospital providers to develop procedures for assessment of capacity to step patients down to less acute facilities, or to receive patients stepping down from more acute settings.
- Obtain buy-in for this model of care from E&T facilities and other hospital stakeholders represented by the existing patient placement task force.
- Set up agreements to establish continuity of care.
- Work through inpatient providers' concerns around payment.
- Make adjustments to the orders issued by the Involuntary Treatment Act (ITA) Court to allow greater placement flexibility.
- Rework the CABTF-initiated patient placement guidelines, not just to govern admission, but also for the use of different beds during a patient's involuntary treatment stay, including moving lower-acuity patients to freestanding (non-hospital) E&Ts.
- **Policy Action:** Focus inpatient capacity expansion efforts on geropsychiatric beds and other hospital-based beds that can effectively serve patients with co-morbid medical issues.

Recommendation	Category
1d. Increase the rates that fund behavioral health programs in the public sector, and expand existing health professional loan repayment programs to allow more types of workers to qualify, in order to promote a robust and sustainable community behavioral health workforce.	Policy Change

Programs designed to serve people in psychiatric crisis – whether in the community before involvement with the involuntary treatment system, in local inpatient settings, or at the state hospital – depend on a robust workforce supported by adequate rates and other incentives, such as loan repayment programs. As discussed beginning on page 32, the ability for any existing prevention, intervention, or crisis program to receive and serve clients in accordance with its stated capacity, or for any new program to ramp up successfully, depends on recruiting and retaining a full team of qualified staff. Programs that are otherwise fully operational are unable to meet demand adequately when they are short-staffed. Workforce shortages have also been a significant contributing factor to slowed state hospital admissions and rollback of a planned ward expansion, both of which have had systemwide collateral effects (see discussion starting on page 24). Other examples include slower progress in bringing new beds online at facilities, such as Cascade Behavioral Hospital, and occasional reductions in the number of people who can be served by King County's current crisis diversion facility (CDF).

The vast majority of funding for public behavioral health care comes in the form of rates paid by the state to behavioral health organizations (BHOs) based on the number of eligible individuals in that community. These rates in turn determine the amount of funding that can be passed along to community behavioral health agencies that provide services to clients. Therefore, rate increases or decreases directly correlate with compensation and workload for community-based providers and affect the quality and quantity of care clients receive. For example, lower rates hold down salaries and prevent agencies from hiring more staff, which in turn leads to higher caseloads. In fact, in considering this recommendation, some but not all CABTF members suggested ensuring that needed rate increases be directed specifically to worker compensation.

Rate increases will not only prevent costly and preventable hospitalizations, but will also promote a robust and sustainable workforce through more effective staff recruitment and retention. Very low core rates for funding public mental health and SUD treatment programs have contributed to the difficulties community agencies have had in recruiting and retaining staff. A limited amount of staff, whether due to turnover or otherwise, contributes to workforce challenges in outpatient settings. As a consequence, people may experience symptoms that may increase the likelihood of hospitalization.¹⁰³ As the state continues to set core rates for community behavioral health care at or near the low end of the actuarially allowed range, agencies must pay lower salaries and offer fewer benefits to employees in order to sustain business. Less financial resources also stymies innovations in care, as there are less funds to direct to strategies that can improve both the delivery and type of care to clients.

In King County, proposed rates were recently established for providers as part of the integration of mental health and substance abuse systems via the transition from separate regional support networks (RSNs) and county substance abuse coordinators to BHOs in April 2016. Significant changes to certain combined rates provided by the state under the BHO system – including all six core mental health rate categories¹⁰⁴ – do address somewhat the actual cost of maintaining an adequate workforce and providing sufficient care to people served by the behavioral health system, although rates still do not sufficiently acknowledge the rising cost of living or the compensation level needed to retain an experienced community behavioral health workforce. Further rate increases would only occur if commensurate funding is authorized by the state.

Loan repayment, another effective recruitment and retention tool for professionals working with underserved populations, is not currently available to most people who choose to work in the publicly funded behavioral health system. Specific recommended changes to address this include:

- Amending eligibility criteria to include individuals serving “medically underserved areas or populations,” rather than only those in “health professional shortage areas.”
- Expanding the list of eligible professions for the state’s program to match those eligible under the National Health Service Corps program, and
- Loosening the requirements for “community mental health center” that currently constrict agencies’ ability to participate in the program.

¹⁰³ Gill, J.M., Mainous, A.G., and Nsereko M. (2000). *The effect of continuity of care on emergency department use*. Archives of Family Medicine 9:333-338.

¹⁰⁴ DSHS Behavioral Health Administration (BHA), March 2016.

The Washington Student Achievement Council offers the Health Professional Loan Repayment Program.¹⁰⁵ At this time, this state program offers loan repayment to the following behavioral health professions only: psychiatrists, psychiatric physician assistants (PAs), advanced registered nurse practitioners (ARNPs), and psychiatric nurses (RNs). The only eligible sites, called Health Professional Shortage Areas, within King County are federally qualified community health clinics and tribal clinics. In 2015-16, individual providers are awarded up to \$70,000 for a minimum two-year full-time service obligation under the federal part of the program, with additional service year-for-year for contract extension renewals. The state-funded aspect of the program provides up to \$75,000 total for a three year-commitment of at least 24 hours per week.¹⁰⁶

A proviso in the state House budget proposal in 2016 would have added \$1 million in new funding to the Health Professional Loan Repayment Program, targeted specifically to behavioral health professionals including masters' level clinicians, chemical dependency professionals (CDPs), and unlicensed agency-affiliated counselors with bachelors' degrees, but neither the funding nor the eligibility expansion survived final budget negotiations.¹⁰⁷ The CABTF advocates for the reconsideration of such efforts in future sessions.

The Federal National Health Service Corps,¹⁰⁸ in contrast to the state program, offers loan repayment to the following behavioral health professions: psychiatrists, psychologists, licensed clinical social workers, licensed counselors, marriage and family therapists, psychiatric nurse specialists, psychiatric ARNPs, and psychiatric PAs. Eligible sites for this program mirror the requirements of the state program above. Clinicians can receive up to \$50,000 to repay health profession student loans in exchange for a two-year commitment in a high-need, underserved area.

Community mental health centers in King County, whether providing only mental health or also SUD services, do not technically qualify for these loan repayment programs primarily for two reasons:

- None of the locations where these agencies are physically located are considered Health Professional Shortage Areas, though a brief survey of larger agencies indicate that the areas are considered "medically underserved areas or populations." However, loan repayment only applies to Health Professional Shortage Area regions.
- Some of the agencies do not provide all of the "core services" required by the loan repayment programs, including not only outpatient services but also 24-hour emergency care services and day treatment, which go beyond what many agencies are able to provide, given their limited resources.¹⁰⁹

¹⁰⁵ Washington Student Achievement Council: Health Professionals. Retrieved from <http://www.wsac.wa.gov/health-professionals>.

¹⁰⁶ Washington Student Achievement Council: Health Professionals. Retrieved from <http://www.wsac.wa.gov/health-professionals>.

¹⁰⁷ <http://leap.leg.wa.gov/leap/Budget/Detail/2016/HOBill0225.pdf>, section 610, page 250.

¹⁰⁸ National Health Service Corps Loan Repayment Program. Retrieved from <http://www.nhsc.hrsa.gov/loanrepayment/loanrepaymentprogram.html>.

¹⁰⁹ Washington Student Achievement Council: Federal-State Loan Repayment Program: FSLRP Site Reference Guide. Retrieved from <http://www.wsac.wa.gov/sites/default/files/2015.10.12.FSLRP.site.reference.guid.pdf> (page 21). Health Professional Loan Repayment Program: HPLR Site Reference Guide. Retrieved from <http://www.wsac.wa.gov/sites/default/files/2015.10.12.HPLR.site.reference.guid.pdf> (page 19).

Loosening the state and federal programs' restrictive definitions, along with expanding eligibility to more professions and providing commensurate funding, will help make the existing loan repayment programs more meaningful as recruitment tools for community behavioral health agencies and crisis providers in King County and statewide.

Initial Steps Toward Implementation

- **Policy Action:** Feature behavioral health rate increases and loan repayment program eligibility expansion in King County's state legislative agenda, and share with other partners for their consideration.
- Research community behavioral health payment rates, including especially how Washington's rates compare to those in to other states.
- Develop a clearinghouse of information that providers can use to advocate for these changes on their own.

Tier 1 Top Priorities with Strong Momentum Toward Implementation

The four top priorities described in this section are also very important to put in place, and are expected to yield significant benefits for the involuntary psychiatric treatment system. Members found these approaches to have strong momentum toward implementation, even beyond the work of the CABTF. Depending on the issue, this momentum took the form of supportive state legislative activity, promising options for local funding, emerging provider innovations, and/or King County planning efforts that are already under way. However, in each case, several steps remain before full implementation. CABTF members will monitor progress in these areas and intervene as needed to ensure that resources are made available and barriers to implementation are addressed effectively and appropriately.

Recommendation	Category
1e. Strengthen engagement efforts via open access intake appointments, ensuring engagement by beginning ongoing care promptly and/or providing interim support.	Prevention and Early Intervention

The CABTF recommends providing support to community behavioral health agencies to provide open access intake appointments, to ensure the availability of initial assessments on a daily basis from all outpatient providers for individuals requesting mental health services. Open access intake appointments are intended to expedite access to appropriate services at a community mental health agency.

At a minimum, each agency should be able to provide at least one open access appointment per day per site/clinic, with more such appointments available at larger agencies, in order to allow individuals to access intake appointments close to their home community, at an agency of their choice. Some agencies within the King County outpatient system are currently operating under this model or have done so in the recent past. The general consensus among providers is that services of this nature need to be staffed at an appropriate level – most often with dedicated intake personnel – in order to be responsive to client needs in the moment, without extended wait-times for services.

Having a mix of care coordinators and mental health professionals (MHPs) seems to help organizations more effectively utilize staff time based on job duties and the level of qualifications needed to complete different aspects of the intake process. This way, intakes can be a two-step process; a care coordination staff person assesses immediate needs, such as housing, food, and other entitlements, before the individual sees an MHP for the diagnostic portion of the appointment. Expedited initial access to psychiatry would further improve initial care, speed up stabilization, and prevent deterioration among new clients. Some, but not all, of the larger agencies in the current King County provider system are implementing some of these methods. With financial and technical support, the practice could be expanded to all providers.

It is not only critical to have access to services upon demand, but to ensure that interim care is provided between intake and assignment to an ongoing case manager. This engagement period is essential to maintain connection to services and move treatment forward, while awaiting a warm hand-off to a consistent case manager. When connection to services after intake takes up to a month, it does not capitalize on the individual's motivation for treatment, nor does it align with the intent of open access appointments, which is to help people get engaged with treatment as soon as possible.

Existing Momentum Toward Implementation

- A number of local community behavioral health providers already offer open access intake appointments.
- The open access model is viewed nationally as an emerging best practice.

Recommended Further Steps to Support Implementation

- Support expansion of this approach as a priority for all providers.
- Address the burden on providers to establish a scheduling system and provide the dedicated staffing needed to create open access capacity.
- Ensure that open access intake appointments are available in all regions of King County.
- Consult with providers to design a feasible approach to timely interim care that builds on clients’ motivation.
- **Policy Action:** Seek changes to the Medicaid state plan to allow engagement to be billed to Medicaid, or identified as billable, for individuals who may participate in an intake but not end up enrolling in ongoing services.

Recommendation	Category
1f. Increase the availability, flexibility, and outreach capacity of after-hours response for enrolled outpatient clients of the integrated behavioral health system.	Prevention and Early Intervention

The intent of crisis services for enrolled outpatient clients is to respond to people’s urgent behavioral health needs in the community, before they come into contact with emergency systems, with the goal of stabilizing them in the least restrictive setting appropriate to their needs, considering consumer strengths, resources, and choice.

The current crisis response system for individuals who are enrolled in mental health services in the behavioral health organization (BHO) does not require an outreach to the community to assess the individual’s needs or determine what services and supports could be provided to assist the individual with remaining in the community. Most after-hours support is provided telephonically, with limited outreach availability into the community to directly address a crisis need.

As continued efforts are made to try to tackle issues around psychiatric inpatient capacity and substance use disorder (SUD) residential inpatient capacity, the CABTF recommends development of a system that can provide a more consistent response to crisis calls for enrolled clients regardless of which provider agency serves them, including mobile crisis outreach and greater intensity of service that will lead to more diversion from inpatient care and provide some relief to the involuntary treatment system.

Existing Momentum Toward Implementation

- King County is already working on initial planning efforts to improve the crisis response services available for enrolled consumers to create an improved and consistent crisis response for the region.

Recommended Further Steps to Support Implementation

- Engage community providers in a study of what improvements are needed to achieve consistency and deliver best practices.
- Coordinate with community providers to assist in developing recommendations for implementation and associated costs.
- Determine whether the best delivery method for crisis outreach services is a centralized, uniform approach from one organization or continuation of the existing system where each individual community behavioral health agency decides whether to provide or contract for the service.

Recommendation	Category
1g. Establish a crisis diversion facility in south King County and include an enhanced drop-in center for individuals to use prior to, or instead of, an emergency department or psychiatric hospital stay. Co-locate mobile crisis teams at this facility and distribute such teams geographically throughout the County to ensure coverage.	Crisis Diversion

The creation of King County's second crisis diversion facility (CDF), located strategically in the south end of the County with an enhanced drop-in center co-located with the facility, along with additional mobile crisis teams (MCTs) both at the facility and distributed regionally, would allow for expanded access to pre-booking/pre-hospitalization diversion programs.¹¹⁰ A current program including many of these features is already in operation and could be replicated.

The existing Crisis Solutions Center (CSC) in Seattle provides King County first responders with alternative options to jail and hospital settings when engaging with adults in behavioral health crisis. The CSC, a pre-booking or pre-hospitalization diversion program, has three program components – a CDF, Crisis Diversion Interim Services (CDIS), and a co-located MCT – which together offer multiple levels of care in order to stabilize and support an individual in the least restrictive setting possible, while identifying and linking that individual directly to ongoing services in the community.

The goal of these programs is to reduce the cycling of individuals with mental health or SUDs through the criminal justice and crisis systems. Individuals in behavioral health crisis are not always best served in jail and hospital settings. This facility allows for individuals to receive services to both stabilize crises in the moment and to address the situations that cause or exacerbate crises. By focusing on an individual's immediate needs, and through facilitating engagement in services and supports in the community, the CDF may be able to reduce need for law enforcement involvement and/or psychiatric hospitalization.

A CDF is a 16-bed program for individuals in mental health and/or substance abuse crisis who can be diverted away from jails and hospitals. The facility accepts individuals 24 hours per day, 7 days per week, and has a 72-hour maximum length of stay. Individuals receive mental health and physical health screenings upon arrival. Services available include crisis and stabilization services; case management; evaluation and psychiatric services; mental health and SUD assessments; peer specialist services; and linkage to community-based services.

¹¹⁰ More detailed information about this recommendation, along with other related program components, is available in a briefing paper prepared for potential funding by MIDD II. See http://www.kingcounty.gov/~media/health/MHSA/MIDD_ActionPlan/RenewalPlanningDocuments/MIDDBriefingPapers/CrisisDiversion/BP37516466SouthCountyCrisisCenter.ashx?la=en.

Individuals in behavioral health crisis often come to the attention of law enforcement due to minor criminal infractions. In many cases, these infractions may be more a symptom of a behavioral health issue than criminal intent. In cases where officers are engaged with individuals that are thought to be experiencing behavioral health problems and an eligible offense has been committed, officers have the discretion to refer that individual to a CDF on a jail diversion. All attempts are made by facility staff to engage with and encourage these individuals to stay and accept services, but a person diverted to a CDF may be charged with the original offense if they choose not to engage in services and leave the facility without clinical agreement from the staff.

The CABTF also recommends that a south King County crisis facility also feature an enhanced drop-in center, available 24 hours per day, 7 days per week, with shelter capacity. Designed to divert people from emergency department (ED) use and inpatient psychiatric hospitalization, this aspect of the program would focus on addressing specific behavioral health needs and assisting with basic needs and linkage to resources including benefits, and would be staffed largely by peers with lived experience in behavioral health recovery. The service would be targeted to pre-screened referrals from certain referral sources, including the Crisis Clinic and community behavioral health clinics, police, emergency medical technicians (EMTs), and local EDs. In addition, this enhanced drop-in center would include access to on-call medical staff as needed.

An MCT consists of two mental health clinicians with training in the field of SUDs. The team operates 24 hours per day, 7 days per week. They work with first responders in the field to assist with people in mental health and/or substance abuse crisis. The team intervenes with individuals in their own communities, identifies immediate needs and resources, and in most cases, relieves first responders of the need for any further intervention. They can also provide transportation. The MCT is available for consultation or direct outreach to any location in King County, although they are not intended to provide services that social workers or other professionals already perform in EDs.

Geographically based programs are often preferred, as individuals can be served in or near their own community. Currently, the CSC programs are located just south of downtown Seattle. Although the program is available to all first responders countywide, there have been significantly fewer direct first responder referrals to the facility from first responder agencies south of the Seattle area. In fact, 76 percent of direct referrals from law enforcement are from Seattle or jurisdictions in north and east King County, while only about 8 percent of referrals are known to come from south King County agencies. There has also been a steady increase in the estimated response times for the MCT. Being able to develop a program that is more accessible to first responder partners in the south end of the County will likely reduce wait and transport times for first responders and allow for diversion options closer to an individual's home.

An interim approach would be to expand staffing to include full-scale MCTs specifically placed in the south end of King County to ensure adequate coverage countywide. The CABTF further recommends adding developmental disability expertise to MCTs. The CABTF is collaborating with the King County Developmental Disabilities Division to identify appropriate resources and specialists that may be accessible to the MCT, and to consider piloting the inclusion of developmental disabilities specialists with the current MCT.

Existing Momentum Toward Implementation

- Responding to significant community interest in this idea, preliminary funding recommendations for a potential renewed MIDD include funding for crisis services in south King County, which may include MCTs and/or a potential crisis center.
- During its 2016 session, the state legislature provided \$2.9 million statewide in operating funds for MCT expansion and enhancement, as well as capital funding for diversion projects including potential crisis stabilization facilities. At the time of this writing, it was not known whether any of this funding will come to King County.
- Regionally based MCTs are already being piloted on a limited basis in east and south King County by redistributing existing resources to those regions in order to improve response times.

Recommended Further Steps to Support Implementation

- **Policy Action:** Support prioritization of south King County crisis diversion programming for funding under MIDD II.
- **Policy Action:** Seek state and/or local funding to support enhanced 24/7 staffing of regionally based MCTs while exploring and then developing an additional CDF site.
- Consult with EDs about ways to improve access to CDF beds for their patients.
- Coordinate with community providers, including EDs, evaluation and treatment (E&T) facilities, and inpatient psychiatric units, to assist in shaping recommendations and determining costs of the enhanced drop-in center component.
- Identify the services provided at the CDF and/or drop-in center that could be billable under the Medicaid state plan.

Recommendation	Category
1h. Create a secure detoxification facility and continue to evolve involuntary treatment statutes to support integrated primary and behavioral health care.	Crisis Diversion and Policy Change

A secure detoxification facility in King County, paired with the new integrated commitment framework addressing risk stemming from either or both substance abuse and mental illness under 2016’s Engrossed Third Substitute House Bill (E3SHB) 1713 (described on page 47), is expected to have significant benefits for people in behavioral health crisis upon its full implementation. It would allow for a more comprehensive response to clients’ overall risk and vulnerability, when paired with new resources such as secure detoxification facilities. (Currently, individuals in substance abuse crisis most often receive any withdrawal management support in overstretched EDs, and only rarely can any subsequent involuntary substance abuse treatment be accessed.)

This new integrated approach to involuntary commitment could divert up to 1,200 people per year in our community – or 30 percent of current initial mental health detentions¹¹¹ – out of inpatient psychiatric units and into less expensive and more appropriate acute SUD treatment. In addition, an estimated 450 more people per year who are currently not detained and go without treatment, because their risk is solely substance-related, would benefit from such a facility.¹¹² (Currently, such individuals

¹¹¹ Survey of King County designated mental health professionals (DMHPs), spring 2015.

¹¹² Survey of King County DMHPs, spring 2015.

may only be reached when they have subsequent contact with more expensive emergency medical or criminal justice systems.)

Based on these estimates, preliminary analysis of the net effect on acute care expenditures from full implementation of E3SHB 1713 suggested that up to \$5.9 million per year could be saved on an ongoing basis in King County alone.¹¹³

In 2006, the Washington Department of Social and Health Services (DSHS) established a two-county Integrated Crisis Response pilot program using Designated Crisis Responders with authority to detain people up to 72 hours if there was a likelihood of serious harm or grave disability as a result of a mental disorder, SUD, or both. Secure detoxification facilities were also created to serve people detained under this law.

A Washington State Institute for Public Policy (WSIPP) evaluation of the Integrated Crisis Response detoxification facilities found that their use was correlated with fewer psychiatric and medical hospitalizations, more rapid entry into SUD treatment, and higher rates of employment. WSIPP found that the secure detoxification program saved \$1,286 per admission, by avoiding higher-cost care at E&T facilities while also reducing hospitalizations.¹¹⁴

Further refinements to the new law may be advisable as implementation proceeds, to ensure that it recognizes the complexities of co-occurring behavioral health conditions and does not unnecessarily segregate substance abuse from mental illness at the point of detention.

Following up on the integrated commitment statute established through E3SHB 1713, the CABTF also recommends future exploration of ways to clarify and ensure access to care for individuals who are unsafe or unable to care for their essential life safety needs due to mental disorders related to dementia, brain injuries, and other cognitive disorders, as a next step toward an integrated health commitment system.

Existing Momentum Toward Implementation

- E3SHB 1713 has passed, and there is evidence that the state may intend to help launch as many as nine secure detoxification facilities statewide between now and the full implementation date of 2026.
- In King County, a site and a provider for an initial 16-bed secure detoxification facility has been identified, and \$2 million in state capital funds from the Department of Commerce have been committed to support the project.

Recommended Further Steps to Support Implementation

- Participate in assessment and planning efforts around implementation of E3SHB 1713's integrated commitment framework.
- Seek to expedite implementation of the policy in King County by bringing secure detoxification resources online as soon as possible.
- Continue to explore additional locations and provider partners who could help launch potential additional facilities in King County in future years.

¹¹³ King County Department of Community and Human Services (DCHS) fiscal analysis, December 2015.

¹¹⁴ Mayfield, J. (2011). *Integrated crisis response pilots: Long-term outcomes of clients admitted to secure detox*. Olympia: Washington State Institute for Public Policy, Document No. 11-05-3902. Retrieved from <http://www.wsipp.wa.gov/ReportFile/1087>.

- As implementation proceeds, continually assess whether expected acute care improvements and savings are being realized and make adjustments accordingly.
- **Policy Action:** Advocate for capital and operating funding specific to secure detoxification facilities to ensure that capacity is sufficient to meet community needs.
- Looking toward a possible future of integrated health commitment, articulate the overlap of symptoms resulting from diseases of the brain that result in people presenting danger to themselves, danger to others, danger to property, or are gravely disabled.

Tier 2 Priorities: For Concurrent Action as Opportunities Arise

In addition to the eight interventions above that were identified as the highest priority, CABTF members highlighted five additional system changes that would also have significant impact on the inpatient psychiatric care access crisis, and should be pursued as opportunities arise. Some of these recommendations require further research, partnership building, program development work or funding that may extend the time to implementation.

All were determined by the CABTF to be likely to significantly affect access to appropriate community based care once implemented, so these approaches should be pursued when possible.

Recommendation	Category
2a. Create a local center of excellence with specialized units to deliver best practice services to individuals with brain injuries, dementias, and developmental disabilities.	Prevention and Early Intervention and Policy Change

There is a significant need to create more local options to treat complex patients, particularly for individuals with dementias, traumatic brain injuries, and developmental disabilities who may not benefit from environments designed to treat psychiatric conditions.

The CABTF recommends a long-term strategy of developing a local center of excellence, potentially in partnership with the state Department of Social and Health Services (DSHS), the Traumatic Brain Injury Association, Developmental Disabilities Administration (DDA), University of Washington Medical Center, and/or other affiliated stakeholders. Such an institute could incorporate specialize units to identify and implement best practice medical, psychosocial, and care delivery models, with a particular emphasis on care models for this very challenging population. With such a resource in place, many individuals who currently occupy psychiatric beds could avoid involuntary commitment completely.

The center of excellence could help inform the development of additional resources in the community and create opportunities to forge partnerships with the state agencies responsible for community care of these individuals as well as potential provider agencies, all of whom could benefit from the center's innovations.

Initial Steps Toward Implementation

- Collaboratively research and design care models to be implemented and/or explored via the center of excellence, including best available science about the treatment environments and services that promote stabilization for this population.
- Establish partnerships with the stakeholders above to work together toward the development of a center of excellence, including options for funding.
- Monitor the current study that Behavioral Health Administration (BHA) has authorized regarding the potential advantages of establishing a statewide Habilitative Mental Health center of excellence to serve individuals with intellectual disabilities who have been in residence at the state hospital longer than 180 days.
- **Policy Action:** Continue to seek legislative support to serve these populations locally, moving them out of the state hospital environment that does not serve their needs effectively, thereby

making state hospital beds and/or resources available for individuals who can benefit from long-term psychiatric care.

- **Policy Action:** Provide a specialized supported living stepdown option for individuals with co-occurring behavioral health and developmental disabilities, with an emphasis on behavioral supports.
- **Policy Action:** Rework detention laws to support the needs of this population.

Recommendation	Category
2b. Assess the service-linked housing continuum to determine where capacity is inadequate (including, but not limited to, permanent supported housing, transitional housing, skilled nursing facilities, and adult family homes) and increase capacity where shortages are most acute.	Prevention and Early Intervention and Psychiatric Hospital Discharge and Re-Entry

The scarcity of supportive housing environments for people with serious behavioral health conditions is commonly identified by evaluation and treatment (E&T) providers, community hospital emergency departments (EDs), and the state hospital, as a significant contributor to involuntary treatment and hospital length of stay. Furthermore, the lack of these resources may also contribute to individuals deteriorating in outpatient care due to lack of needed housing and supports to the point that involuntary commitment is necessary.

Expanded cross-system work between the behavioral health system, housing system, and aging and disability systems will be a key to bringing the full range of resources from all systems to address this significant challenge. For example, current efforts to establish coordinated entry for permanent supportive housing may not specifically address the needs of the involuntary treatment population.¹¹⁵ Scoring systems for priority access to such housing should specifically incorporate this as a factor.

To begin exploring the community capacity needs of the service system in King County, the CABTF has initiated a snapshot survey of E&T providers to determine what resources, if available, would meet the discharge needs of a given day's patient population. The CABTF expects this survey to begin to identify certain levels of care where targeted capacity increases in existing care models could make a significant difference in addressing involuntary treatment demand by preventing admissions, decreasing lengths of hospital stays, preventing re-hospitalization, and supporting increased independence in the community.

Initial Steps Toward Implementation

- Develop an assessment methodology to determine the extent of the need, and the types of housing services needed to address the continuum of care. Toward this end, continue the CABTF's current snapshot survey, gathering complete data from all E&T facilities, and extend the survey to include the perspectives of community hospitals serving individuals on single bed certifications (SBCs).
- Examine coordinated entry criteria to make sure the involuntary treatment population's level of vulnerability would be captured and prioritized.

¹¹⁵ Committee to End Homelessness (now All Home) Coordinated Entry/Engagement (CE): System Vision, All Populations, March 2015. Retrieved from http://www.kingcounty.gov/~media/socialServices/housing/documents/FHIDocs/CEH_-_Coordinated_Entry_for_All_Vision_3-30-15.ashx?la=en.

- Actively invite All Home and the coordinated entry system to participate in the CABTF’s work in order to help the housing system prioritize the unique needs and vulnerabilities of the involuntary treatment population.
- **Policy Action:** Secure funding and support successful siting of additional supportive housing resources once specific needs are identified.

Recommendation	Category
2c. Create residential stepdown programs specifically designed to shorten hospital length of stay and help people maintain stability in the community.	Psychiatric Hospital Discharge and Re-Entry

The CABTF strongly supports development of a hospital stepdown program that would provide a temporary placement and a safe therapeutic environment to which individuals in inpatient psychiatric hospital beds could be discharged while other identified local community resources are being secured, featuring reduced barriers to access and flexible housing that can be adjusted to fit emerging needs.¹¹⁶ Demand for such programming would likely warrant multiple facilities within King County.

A stepdown program would provide a healthy and safe treatment environment within a harm reduction framework, and services would include group treatment, medication management and monitoring, transportation assistance, advocacy and assistance with linkages for ongoing behavioral health care services, housing, and essential needs. The program would be connected to a care management team for out of facility services including linkages to needed behavioral health services, residential/supported housing resources, and benefits access assistance, with flexible funds to provide for needs not met by other systems. Once such a program were operationalized, the care management team associated with a stepdown system of care may have capacity to serve individuals needing transition and linkage assistance from the state hospital but for whom a facility-based stepdown program is not the best option. Expected lengths of stay would be approximately six weeks per client.

This program would benefit many of the individuals from King County who are in local inpatient settings but who are ready for discharge to the community with sufficient supports. By providing a short-term discharge option for those individuals, more local psychiatric hospital beds would become available for those individuals who are in acute need of involuntary psychiatric hospitalization.

Such a hospital stepdown program could allow for an increased flow of individuals through the hospital system, and ensuring that inpatient psychiatric beds are being utilized primarily for those individuals in acute need of intensive psychiatric inpatient beds. This structured flow, providing just the amount of care patients need to increase their stability and independence while continuing the care initiated in the community hospital or E&T facility, would be a key to the program’s success.

This stepdown model may take the form of a residential treatment facility, which is qualified to care for persons detained under the Involuntary Treatment Act (ITA), or could be attached to freestanding E&Ts. By providing connection with community supports and teaching resiliency skills supporting independence, it will contribute to shorter lengths of inpatient stay and prevent future crisis and re-hospitalization.

¹¹⁶ More detailed information about this recommendation is available in a briefing paper prepared for potential funding by MIDD II. See http://www.kingcounty.gov/~media/health/MHSA/MIDD_ActionPlan/RenewalPlanningDocuments/MIDDBriefingPapers/RecoveryReentry/BP_12_105_Hospital_Step-Down_Step-Up_Program.ashx?la=en.

In addition, many but not all CABTF members support making similar programming available for state hospital patients, as offering a stepdown environment for that population is expected to have a comparable effect, freeing up bed capacity at multiple levels of care. This approach is already commonly used at Eastern State Hospital, where there are several options for stepdown programs to which patients are discharged when they no longer need inpatient psychiatric hospitalization.

Initial Steps Toward Implementation

- Work in partnership with community providers to fine-tune program design to fit strategic needs and tailor it to have the greatest impact on hospital utilization, community linkage, and overall client wellness.
- Ensure flow by ensuring that utilization is appropriate to the need, with robust mechanisms in place to transition individuals to less-intensive supports when indicated without delay. Develop program expectations in this regard to be implemented consistently across all providers.
- Determine whether services will be attached to an existing service such as a residential treatment facility or freestanding E&T, or built as a standalone location. Pair these services with existing resources whenever possible for transition support.
- Design the program in light of established housing policy so that it does not interrupt a person's transition to permanent supportive housing.
- **Policy Action:** Seek funding for this programming model, potentially from the state behavioral health innovation fund newly authorized under Engrossed Substitute Senate Bill (ESSB) 6656, and/or local sources.

Recommendation	Category
2d. Establish a regional peer bridger program serving patients at all community hospitals and evaluation and treatment (E&T) facilities, including individuals on the state hospital wait list, and identify indicators to ensure such services discontinue at an appropriate time.	Psychiatric Hospital Discharge and Re-Entry

The CABTF recommends a significant expansion of the successful peer bridger program to all hospitals in King County by establishing a regional program, extending these services to all residents regardless of benefit coverage or public funding, and provide such extended engagement efforts for both individuals currently enrolled in behavioral health organization (BHO)-funded mental health services but disengaged from these services, as well as for non-BHO service enrolled individuals, with the intention of connecting/reconnecting them to services in their community. Patients in E&Ts and community hospitals on the wait list for Western State Hospital (WSH) should also have access to peer bridger services, to help explore options for diverting them from the state hospital completely.

The peer bridger program works to provide effective transition support, utilizing peer counselors, to people who are being discharged from inpatient services using the nationally recognized peer bridger model to promote hope, wellness, self-determination, and recovery for participants. Peer bridger programs are intended to connect program participants to mental health and/or substance use disorder (SUD) treatment, primary care, and other services, based on the strengths, needs, and priorities of the individual. The current program is available at only two E&T facilities. Funding for the program to date has been dependent on a two-year grant and other one-time resources.

The peer bridger program model has been shown to be effective. In a 2015 outcomes report for the program, it was determined that participants in King County's peer bridger program are achieving

significant reductions in hospitalizations and hospital days. The rate of re-hospitalization for individuals in peer bridgers was 10 percent within 30 days of discharge, compared to 14 percent for a comparison group, and the rate of re-hospitalization within 90 days of discharge was 15 percent for peer bridger program participants, compared to 22 percent for the control group. Participants also become enrolled in outpatient mental health services and in Medicaid at a higher rate than the comparison group.¹¹⁷ The analysis suggests that the peer bridger program is meeting its goals of reducing hospital use and increasing engagement in community-based mental health services.

Because of the high demand for this program, indicators should be established to ensure such services discontinue at an appropriate time, with participants handed off promptly and effectively to appropriate follow-up services. By ensuring flow, the program can maintain capacity to serve other patients as they are leaving community hospitals and E&Ts.

Initial Steps Toward Implementation

- Develop service benchmark expectations regarding discharge.
- **Policy Action:** Identify sustainable funding beyond Medicaid for program expansion, including potential partnerships with managed care organizations.

Recommendation	Category
<p>2e. Create a legal procedure for consent to certain health treatments, Medicaid applications, or facility transfers, for individuals who appear to lack capacity and lack a surrogate decision maker, while ensuring that individuals still have the right and opportunity to refuse any such treatment.</p>	<p>Policy Change</p>

Clarity of the limits of consent for guardians and other surrogate decision makers regarding signing voluntary psychiatric admission consents and other consents for psychiatric treatment is necessary and recommended by the CABTF. Recommended revisions to Washington’s informed consent statute are being finalized by the King County Bar Association’s Guardianship Committee.¹¹⁸ The specific areas of revision are:

- Expansion of the court’s ability to authorize a guardian ad litem to be able to provide consent for health care as a surrogate decision maker;
- Presumed consent of an adult patient who appears to lack capacity and lacks a surrogate decision maker will include transfer between healthcare facilities or for post-acute care; and
- Assistance with applications for public benefits, including healthcare benefits.

As is the case now with guardians and other surrogate decision makers, the expanded authority and presumed consent would not be valid if the person by clear voice or action objects to the course of action. The additional protection of the ITA statute is the expected course of action in those situations.

Revisions to informed consent procedures could have a significant impact in how quickly and effectively hospitals can respond to individuals who are detained under the ITA as gravely disabled. For many such patients, medical conditions are a driving factor in their behavioral presentation and in their inability to

¹¹⁷ King County Mental Health, Chemical Abuse and Dependency Services Division (MHCADSD) (now Behavioral Health and Recovery Division, or BHRD) Peer Bridger Program Participant and Comparison Group Outcome Analysis, August 2015.

¹¹⁸ Revised Code or Washington (RCW) 7.70.065.

consent to care, benefit from initiation, or transfer to appropriate non-psychiatric facilities. With the added flexibility that would be afforded by the proposed changes, many patients could be stabilized with less complex, intensive, and expensive interventions than psychiatric hospitalization.

An informal survey of King County inpatient psychiatric programs revealed significant variation in practice, including misunderstandings of guardianship and designated surrogate decision maker authority regarding their consent limits for voluntary psychiatric admission. The CABTF recommends further study of current screening admission practices related to assessing the ability of patients to understand rights, to better inform capacity needs for the population and to determine what gaps exist in assuring rights of the population are being upheld. The study should explore current assessment practices regarding patients' ability to provide consent for admission and their right to leave or refuse treatment, and mechanisms for assuring a level of informed consent for administration of psychiatric medications depending on whether their admission status is voluntary or involuntary admission status.

Initial Steps Toward Implementation

- Refine current draft changes to the informed consent statute.
- Reach out to the Joint Legislative Executive Committee on Aging and Disability Issues.
- **Policy Action:** Partner with the Washington State Hospital Association (WSHA) to advocate for legislative changes regarding guardianship and surrogate decision makers.

Tier 3 Recommendations: On the Horizon for Future Action

Six interventions are highlighted by the CABTF as recommendations that are on the horizon for future action. These programs and policies are essential to implement in order to establish a functional continuum of care for individuals with intensive behavioral health needs, but they are expected to have a more moderate impact on involuntary treatment capacity specifically.

Recommendation	Category
3a. Develop appropriate community alternatives to reduce admissions of young adults ages 18-26 to the state hospital.	Crisis Diversion

The CABTF recommends studying the population of young adults at the state hospital, researching best practices, and then working to develop, pilot, and evaluate local alternatives to the state hospital for youth, possibly in collaboration with Best Starts for Kids (BSK). Providing alternatives at this age could prevent long-term or recurring hospitalization and system use over the lifespan, thereby significantly affecting bed access at all levels of the involuntary system.

One potential model that could be explored is the Open Dialogue approach being used in Finland, as well as elsewhere in Europe. The principles of this model include the provision of immediate help to the family system and the individual experiencing a first break or escalation in symptoms of psychosis, featuring 24-hour crisis support. The model uses a social network perspective, meeting with the entire family system daily, attempting to keep the individual at home with intensive services rather than hospitalization, and delaying or avoiding the use of psychotropic medications. The program was evaluated at years two and five with positive outcomes, including fewer relapses, fewer residual symptoms of psychosis, fewer hospital days, and less reliance on neuroleptic medications and disability payments.¹¹⁹

Recommendation	Category
3b. Deliver intensive supports to help meet the needs of high-risk individuals, including specialized stepdown programs to promote hospital discharge and successful community placement.	Psychiatric Hospital Discharge and Re-Entry

The elimination of state proviso funds in 2015 left many people with a history of significant violence against persons without customized Medicaid-ineligible care and housing. Without these unique supports, the risk to the community may lead to more hospitalization, jail, and prison costs. Specialized stepdown programs for individuals identified as high-risk and violent would allow these people to be discharged from state hospital beds when they no longer need such intensive psychiatric treatment but cannot yet be successfully or safely placed in traditional community settings.

¹¹⁹ Seikkula, J., Aaltonen, J., Alakare, B., Haarakangas, K., Keränen, J. and Lehtinen, K. Five-year experience of first-episode nonaffective psychosis in open-dialogue approach: Treatment principles, follow-up outcomes, and two case studies. *Psychotherapy Research*, 16(2): 214-228.

A new focus on state hospital reform and diversion funding may present opportunities to recreate appropriate discharge supports for these individuals. Implementation planning in coordination with potential providers would be necessary.

Recommendation	Category
3c. Provide specialized integrated care to support placement for people with behavioral and medical conditions.	Psychiatric Hospital Discharge and Re-Entry

New programs are needed for people whose co-occurring behavioral issues and medical needs exclude them from traditional care environments. Specifically, this would include developing intensive integrated supportive services to be delivered to clients where they live and that include medical care, personal care, and behavioral health care. This would allow for care to be provided in less restrictive settings; free up hospital capacity; strengthen medical care, personal care, and behavioral health partnerships; and save money.

Partnering with Home and Community Services providers, this approach would leverage Medicaid funding, including Medicaid personal care, along with flexible state funding targeted to unique Medicaid-ineligible behavioral health care and other services needed to enable these people to achieve and maintain stability and recovery. This proposal could build upon and expand the new Specialized Behavioral Support model administered by Home and Community Services that provides additional dedicated staffing within adult family homes for very challenging clients, along with behavior management supports for the client and provider. Combined with customized physical and behavioral health care services and made available also to nursing homes, this would enable quicker and more successful hospital discharges. Furthermore, this approach would support integrated physical and behavioral health care delivery.

Recommendation	Category
3d. Implement robust utilization management and redesigned discharge planning for King County's state hospital patients to reduce lengths of stay, expedite community placement, and divert patients pending conversion from criminal to civil commitments.	Psychiatric Hospital Discharge and Re-Entry

King County has conducted occasional utilization management activities of its residential and supported housing programs and makes recommendations to its providers to discharge residents who no longer meet medical necessity for those levels of care, but it has not yet begun taking the step of reducing or stopping payment to those providers who consistently failed to move individuals into less restrictive settings when clinically warranted.

The CABTF recommends the development of an aggressive utilization management approach for intensive, costly supported housing and residential programs to ensure that only those individuals requiring that level of care remain in those programs, and to make it possible for the community treatment system to accept patients from local and state hospitals in a timely manner.

Data referenced by the state Department of Social and Health Services (DSHS) Division of Behavioral Health and Recovery (DBHR) indicates that King County patients at Western State Hospital (WSH) have the longest lengths of stay of any of region in Western Washington. Furthermore, an average of 60 to 70 King County individuals are placed on the "ready to discharge list" at WSH each month. High quality discharge planning services are critical to the timely discharge of individuals who no longer require

hospitalization and ensure the flow of individuals into and out of the state hospital without significant delays.

King County has contracted with a local agency to provide discharge planning at WSH for many years, and targeted discharge outcomes have rarely been met. King County's practice of contracting out discharge planning at the state hospital is rare among behavioral health organizations (BHOs). Because County staff handling discharge planning functions would have the authority to ensure that there is cooperation from WSH treatment teams or from community providers to accept referrals, they are likely to be more effective than the contractor in promptly moving patients to the community. The work could likely be accomplished more effectively with a Lean team of full-time County staff, including a peer staff position. Funding from the 2016 state legislative session for peer bridgers at the state hospital may help to fund such a peer position.

Furthermore, King County should explore all opportunities to divert individuals with behavioral health disorders from arrest, booking, and competency restoration at WSH. Every person in the State of Washington found incompetent to stand trial and ordered to competency restoration is transferred to the state hospitals for treatment. Once an individual is at the state hospital and found unable to be restored, an individual is often evaluated for civil commitment and prioritized for a bed on a civil ward of WSH. On average, 40 percent of all admissions to WSH's civil units come directly from the forensic unit at WSH via a conversion or "flip," a phenomenon that directly interferes with the state hospital's ability to accept admissions from local hospitals. To date these conversions have not been monitored actively on a case-by-case basis.

As part of this redesigned approach, the County-level discharge planning team at WSH should include a liaison to provide resources to the forensic unit at WSH for all individuals pending conversion to a civil commitment from a criminal commitment. This work would include ensuring that individuals who do not meet medical necessity criteria for long-term psychiatric inpatient services are discharged from this level of care. The development of local resources for competency restoration, pre-booking diversion efforts, and prosecutorial diversion using Second Engrossed Second Substitute Senate Bill (2E2SSB) 5177 funding as discussed on page 46 will also contribute to reducing the number of patients who enter the civil wards via conversion.

Recommendation	Category
3e. Make regulatory changes to ease access to enhanced services facilities for community hospital patients.	Policy Change

Many individuals on long-term commitments with medical care needs are not accepted by the state hospital. Additionally, some individuals who are waiting for placement at WSH achieve sufficient stabilization while waiting and could potentially avoid the state hospital entirely and be treated with appropriate supports in enhanced services facilities. However, current legislation restricts use of enhanced services facilities to discharges from the state hospital. The CABTF recommends regulatory changes to allow patients who meet enhanced services facility criteria and are on long-term court orders to be placed in such facilities even if they will not be or have not yet been accepted for admission by a state hospital, thereby delivering needed care and reducing the numbers of patients on long-term orders in local hospitals.

Recommendation	Category
3f. Make certain exceptions to the Department of Social and Health Services (DSHS) Secretary’s Disqualifying List of Crimes and Negative Actions for certified peer specialists.	Policy Change

If someone has been convicted of a crime on the state DSHS Secretary’s Disqualifying List of Crimes and Negative Actions, then the individual is “denied unsupervised access to vulnerable adults, juveniles, and children.”¹²⁰ Thus, this individual is essentially prohibited from working in the publicly funded behavioral health system.

Some crimes have an expiration date of five years associated with them. For example, if someone has been convicted of simple assault (Assault 4), which could be as low-risk as throwing a sandwich while intoxicated, “that person is automatically denied unsupervised access unless five or more years has [sic] passed since the date of conviction,”¹²¹ regardless of the circumstances or the degree to which they may have achieved recovery. There is broad agreement that people convicted of certain crimes such as rape of a child should not work with a vulnerable population. However, some of the crimes on the list may unjustly block people who are qualified and have the will and skills to work in the field.

Only DSHS maintains this list. The Department of Health, which is responsible for licensing and certifying individuals, does not. In practice, this means that currently, individuals who have been convicted of a listed crime may achieve significant recovery and successfully go through the entire process to obtain a certificate or license, only to learn that they are prohibited from working in a DSHS-licensed facility.

The CABTF recommends creating certain exceptions to the disqualifying list, specifically for individuals seeking to work as certified peer specialists. This way, a person with a significant experience of recovery, effective interpersonal skills, and system knowledge whose period of active illness included a lower-level criminal charge on the disqualifying list, could bring their unique skills and experiences to benefit individuals in inpatient settings or in the community, rather than being excluded from the field entirely.

¹²⁰ DSHS Secretary’s List of Crimes and Negative Actions, for use by all programs administered by DSHS, including DSHS state employees in covered positions with access to vulnerable people. Retrieved from <https://www.dshs.wa.gov/sites/default/files/FSA/bccu/documents/Secretary%27sCrimesListforALLPrograms.pdf>.

¹²¹ DSHS Secretary’s List of Crimes and Negative Actions.

Tier 4 Endorsements: Interventions Addressed Primarily by Others or Less Focused on Inpatient Psychiatric Crisis

A final group of ten interventions, initially considered as draft recommendations by the CABTF, were ultimately identified as endorsements, for either or both of two reasons:

- To a significant degree, the intervention was already being implemented but the task force felt it was important to provide its public support; and/or
- Although expected to make a positive difference in publicly funded behavioral health care in some important way, a clear and direct link to involuntary inpatient psychiatric treatment access was not evident.

As a result, these interventions were placed in a lower category, but are still described here as important aspects of a comprehensive care continuum.

Endorsement	Category
4a. Support Familiar Faces' flexible care management model.	Prevention and Early Intervention

The CABTF endorses and supports the Familiar Faces team's proposal to further develop and test the concept of multiple agencies working across organizational boundaries (with signed releases of information) to provide a care management team in community settings. While Familiar Faces serves a subset of the entire behavioral health population, the CABTF believes that the model can help assess the efficacy and utility of a single care plan model across multiple systems, assist with information coordination and sharing, and demonstrate how a cross-agency/system model functions as a care management team offering holistic person-centered care coordination and treatment services. The CABTF recognizes that additional work on the Familiar Faces model is necessary in order to be a functional pilot.

Endorsement	Category
4b. Support Wraparound with Intensive Services (WISe) implementation for youth.	Prevention and Early Intervention

The CABTF supports ongoing efforts to invest in coordinated intensive children's mental health services in the context of the 2013 *T.R. vs. Quigley and Teeter* lawsuit settlement agreement. The funding provided to implement WISe for eligible children and youth will be available statewide by the end of 2017. Focusing on Medicaid-eligible youth up to age 21 with complex behavioral health needs, WISe supports providing needed services and supports in home and community settings including crisis planning, and face-to-face crisis intervention, using a strength-based wraparound approach including a single care plan.¹²² It is intended to help divert children and youth from juvenile detention, emergency

¹²² Department of Social and Health Services (DSHS) Behavioral Health Administration (BHA) 2016 Fact Sheet: WISe and the *T.R. et al vs. Kevin Quigley and Dorothy Teeter* Settlement. Retrieved from <https://www.dshs.wa.gov/sites/default/files/BHSIA/dbh/Fact%20Sheets/Children's%20MH%20-%20WISe%20-%20TR%20Settlement.pdf>.

departments (EDs), community hospitals, and the Children’s Long-Term Inpatient Program (CLIP). They prevent family disruptions and help some families avoid foster care or group care placements.

Endorsement	Category
4c. Improve coordination among prevention and early intervention programs by supporting system navigation assistance, increasing school- and community-based education and orientation, and exploring opportunities to improve data sharing.	Prevention and Early Intervention

Without system navigation assistance and effective data sharing, both clients and providers struggle to learn about service options and as a result do not access them. This lack of coordination results in lost opportunities to intervene effectively to prevent psychiatric hospitalization, whether voluntary or involuntary. Prevention activities, such as school-based trainings and community-based courses like Mental Health First Aid, can give people skills to recognize symptoms of behavioral health conditions and ways to intervene. If people are more aware of early intervention programs and how to engage in those services, they may be more likely to pursue treatment sooner, thus preventing the need for psychiatric hospitalization.

Endorsement	Category
4d. Increase early identification and referrals for young people experiencing a first episode of psychosis via implementation of the state’s Early Psychosis Initiative.	Prevention and Early Intervention

Current research provides strong evidence that treating individuals experiencing a first episode of psychosis with a team-based, coordinated specialty care approach produces better clinical and functional outcomes than typical community care, and that treatment is most effective for people who receive care soon after psychotic symptoms begin.¹²³ Hospitals associated with the University of Washington have already taken strides to provide services for this population.

Washington State’s Early Psychosis Initiative aims to increase early identification and referrals for young people experiencing a first episode of psychosis, in alignment with emerging science showing key benefits including treatment engagement, quality of life, work/school involvement,¹²⁴ and reductions in hospitalization¹²⁵ from comprehensive, proactive approaches for this population. The first site for this statewide initiative was in Yakima, where it achieved positive outcomes including reduction in re-hospitalization, so the state is preparing to fund two additional programs. The CABTF supports King County’s interest in pursuing implementation of the program in this community, in anticipation that it will help reduce the number of young people with psychosis who are referred for involuntary detention.

¹²³ Kane, J.M., Robinson, D.G., Schooler, N.R., et al. (2015, October). *Comprehensive versus usual community care for first episode psychosis: two-year outcomes from the National Institute of Mental Health early treatment program*. *American Journal of Psychiatry*. Retrieved from <http://ajp.psychiatryonline.org/doi/abs/10.1176/appi.ajp.2015.15050632>.

¹²⁴ Kane, J.M., Robinson, D.G., Schooler, N.R., et al. (2015, October).

¹²⁵ McFarlane, W.R., Susser, E., McCleary, R., Verdi, M., Lynch, S., Williams, D., McKeague, I.W. (2014, October). Reduction in incidence of hospitalizations for psychotic episodes through early identification and intervention. *Psychiatric Services* 65(10), 1194-1200. Retrieved from <http://dx.doi.org/10.1176/appi.ps.201300336>.

Endorsement	Category
4e. Maintain 2-1-1 services and make them more robust.	Prevention and Early Intervention

The Crisis Clinic's 2-1-1 community information program¹²⁶ already serves as a repository of available resources and plays an important role in supporting King County's service system. Though its data is available to crisis line volunteers 24 hours per day, 7 days per week, the program is unable to provide personalized services with options tailored for the specific individual who calls for help. The CABTF endorses increased funding support for 2-1-1 to both help maintain its current status and make it more robust so it can help connect the right people to the right services at the right time. This extra funding support could also help the Crisis Clinic become a more effective centralized access point for services and provide more education and information to the community.

Endorsement	Category
4f. Support the existing crisis intervention training program for first responders, and enhancements that will better serve fire department personnel and paramedics.	Crisis Diversion

The CABTF strongly supports the crisis intervention training (CIT) that is improving outcomes and service linkages for people in behavioral health crisis who encounter law enforcement, including attempts to address the needs of individual in crisis outside of the criminal justice system, and as able, outside of hospital systems. The CIT program has a clear positive effect on law enforcement officers' identification of people in behavioral health crisis, as well as their subsequent interactions and the ultimate case disposition, based on an independent evaluation¹²⁷ and Seattle Police Department data.¹²⁸ The CABTF also supports efforts to ensure that fire department personnel and corrections staff have access to appropriate training to assist them in engaging with individuals with behavioral health disorders.

Endorsement	Category
4g. Support Familiar Faces diversion innovations that would also benefit the civil commitment population.	Crisis Diversion

The CABTF supports current efforts already underway that are likely to affect both the involuntary treatment population and individuals involved with the criminal justice system. The Familiar Faces project, which aims to serve a specific subset of the larger behavioral health population, includes some concepts are most relevant to the population being addressed by the CABTF, including neighborhoods of health/diversion campuses that link to first responders, cross-system staffing meetings to assist individual clients, and prosecutorial diversion strategies.

¹²⁶ King County 2-1-1. <http://crisisclinic.org/find-help/2-1-1-resources-and-information/>.

¹²⁷ Helfgott, J.B., Atherley, L., Pollock, J., Vinson, J., Strah, B., Neidhart, E., Conn-Johnson, C., Hickman, M., and Wood, N. (June 30, 2015). *Evaluation of the Washington State Criminal Justice Training Commission's "Warriors to Guardians" cultural shift and Crisis Intervention Training final report*, Seattle University Department of Criminal Justice.

¹²⁸ Seattle Police Department Data Driven Policing Unit Compliance Section. Crisis Intervention Program Quarterly Update May 15, 2015 – August 15, 2015.

Endorsement	Category
4h. Support and expand the Children’s Crisis Outreach Response System (CCORS), which is effective in assisting children and families in crisis and diverting young people from inpatient care.	Crisis Diversion

The CABTF supports the existing CCORS program and promotes its expansion as a hospital diversion strategy. CCORS offers flexible, short-term, community-based, and family-centered services with the goal of immediate crisis prevention and intervention as well as placement stabilization. One key role of CCORS is to assist families who have presented at EDs seeking inpatient hospitalization, helping them find community-based solutions other than the hospital whenever possible, including short-term intensive in-home supports and assistance with linkage to ongoing care.¹²⁹

Endorsement	Category
4i. Support alternative approaches to training so mental health professionals can earn dual credentials with greater ease, permitting them to serve people with the full spectrum of behavioral health needs.	Policy Change

There are few incentives in place at this time to encourage professionals to obtain both mental health and substance use disorder (SUD) credentials, though this is a significant workforce need in the context of a system wide move toward integrated whole-person care. Competing and overlapping requirements serve as a disincentive for providers with a single behavioral health credential to work toward a second one that would enable them to practice in a truly integrated fashion. To begin to address this, the Washington State Department of Health has drafted language that creates an alternative training plan for certain professions,¹³⁰ including mental health professionals (MHPs),¹³¹ to obtain a chemical dependency professional (CDP) license. The proposed rule change does not change the number of supervision hours these professions must complete, but required coursework for current license holders is proposed to be reduced to 15 quarter or 10 semester college credits. These professions must still take the national exam. The CABTF supports these proposed changes among other potential interventions that may further reduce barriers to dual credentialing.

¹²⁹ According to a five-year outcome study, 88 percent of children and youth who were referred to CCORS out of the concern that they would not be able to remain in their home and stay safe, were able to stay safely in their home. Approximately 75 percent of those referred for hospital diversion were kept out of the hospital in less restrictive settings that addressed their needs. The King County Mental Health, Chemical Abuse and Dependency Services Division (MHCADSD) (now Behavioral Health and Recovery Division, or BHRD) CCORS Five-Year Data and Outcomes Summary, 2007-2011, May 2012.

¹³⁰ Washington State Department of Health Proposed Rule Making, filed March 22, 2016. <https://fortress.wa.gov/doh/policyreview/Documents/1607123chemicaldependencyprofessionaltrainee102final.pdf>.

¹³¹ According to section 388-865-0150 of the Washington Administrative Code (WAC), the designation “mental health professional” encompasses the following professions: psychiatrists; psychologists; psychiatric nurses; social workers; and people with a Master’s degree or further advanced degree in counseling or one of the social sciences from an accredited colleges or university, plus at least two years of experience in direct treatment of people with psychiatric conditions under the supervision of another mental health professional. Retrieved from <http://apps.leg.wa.gov/wac/default.aspx?cite=388-865-0150>.

Endorsement	Category
4j. Create joint outcomes and innovative partnerships with the Aging and Long-Term Support Administration (AL TSA) and Developmental Disabilities Administration (DDA) to promote effective state hospital discharge planning and development of needed community resources.	Policy Change

Bifurcated financing of community and state hospital care for people with primarily developmental disabilities or long-term care needs, along with a severe shortage of appropriate community resources for this population, creates significant discharge barriers when these individuals' level of risk has risen to involuntary commitment standards under the Involuntary Treatment Act (ITA), especially when they are placed in the state hospital. Such individuals often languish at the hospital for long periods of time even though they are not benefiting from the expensive psychiatric care being funded solely by the behavioral health system. DDA policies prohibiting payment for involuntary services present a further barrier to the systems sharing this responsibility.

Some provisions of 2016's Engrossed Substitute Senate Bill (ESSB) 6656, addressing state hospital reform, may prompt further work on this issue, and this could be addressed as part of Healthier Washington system changes. To address this significant barrier, the CABTF supports the development of shared outcomes, protocols, and agreements to create joint efforts and accountability between behavioral health organizations (BHOs) and the developmental disability and long-term care systems in arranging prompt discharge to community alternatives for this population.