



King County

Community Alternatives to Boarding Task Force Final Report

Response to Motion 14225

June 2016

Contents

Part One: Introduction	3
Executive Summary.....	4
The Community Alternatives to Boarding Task Force	8
Part Two: Background and Context.....	10
Essential Laws and Definitions.....	11
The Recent History of Psychiatric Boarding: A Treatment Access Crisis.....	15
Speedy Response Yields Significant Gains	22
A Significant Setback: State Hospital Access Challenges and Their Effects on King County Patients.....	23
The Public Behavioral Health Workforce Shortage	32
Engagement with Broad System Change Processes	35
Key Results from the 2015 and 2016 Legislative Sessions.....	42
Part Three: Short- and Long-Term Sustainable Solutions	49
King County’s Immediate Response to the Crisis.....	50
CABTF Short-Term Solutions Already Showing Results	52
Bringing More Local Acute Care Beds Online	58
The CABTF’s Process for Developing Sustainable Long-Term Improvement Recommendations	60
An Overview: Recommendations Across the Continuum.....	65
Table of Recommendations by Priority Level	66
Table of Recommendations by Category.....	71
Tier 1 Top Priorities for Active Work and Promotion	75
Tier 1 Top Priorities with Strong Momentum Toward Implementation.....	83
Tier 2 Priorities: For Concurrent Action as Opportunities Arise	90
Tier 3 Recommendations: On the Horizon for Future Action.....	96
Tier 4 Endorsements: Interventions Addressed Primarily by Others or Less Focused on Inpatient Psychiatric Crisis.....	100
Part Four: Next Steps and Conclusion	105
The CABTF’s Next Steps	106
Conclusion.....	107
Appendices	109
Appendix A: Index of Motion 14225 Requirements	110
Appendix B: Motion 14225	111
Appendix C: Task Force Charter	115
Appendix D: Task Force Membership	120
Appendix E: Washington Supreme Court Ruling <i>In re the Detention of D.W. et al</i>	122
Appendix F: Inventory of Existing Service Continuum	134
Appendix G: Patient Placement Guidelines	144
Appendix H: Public Comment	145

Part One: Introduction

Executive Summary

The Community Alternatives to Boarding Task Force

Governor Jay Inslee and King County Executive Dow Constantine jointly convened the Community Alternatives to Boarding Task Force (CABTF) in August 2014 as part of a broad effort to address a treatment access crisis that was affecting thousands of King County residents in need of acute psychiatric care. The growing number of individuals involuntarily detained for inpatient psychiatric care who were held in temporary settings that were not serving their mental health needs precipitated this coordinated action.

This phenomenon, known as “psychiatric boarding,” was also the subject of a Washington Supreme Court ruling in August 2014. The Supreme Court’s ruling in *In re the Detention of D.W. et al.*,¹ in combination with subsequent rulemaking by the state Department of Social and Health Services (DSHS) to operationalize the Court’s finding,² made it illegal to detain a person involuntarily without adequate care while awaiting a certified evaluation and treatment (E&T) bed, and required the provision of timely and appropriate mental health care to all individuals held involuntarily for psychiatric treatment.

King County and its community partners strongly supported this ruling because it directly addressed an enduring problem and made appropriate treatment access a primary priority throughout the state, creating an environment in which necessary and creative changes could occur.

After the ruling was fully implemented in December 2014, a new standard was established: no longer could people simply be held until a certified bed was available. Instead, for a designated mental health professional (DMHP) to seek temporary single bed certification (SBC) authority from the state, any non-certified facility holding a patient had to demonstrate that it would bring psychiatric services to the person to meet his or her needs. Even this approach was a stopgap solution. Washington State, King County, providers, legislators, and others broadly acknowledged the need for increased inpatient psychiatric capacity to meet the service need.

However, the Governor and the Executive also looked to key stakeholders to seek innovative, coordinated solutions that went beyond merely increasing inpatient capacity and instead sought to decrease demand via community-based prevention, early intervention, diversion, and re-entry strategies. Thus, the CABTF was convened, bringing together representatives from the executive, legal, judicial, and treatment systems that serve individuals involved in the involuntary commitment process.

Motion 14225: Short- and Long-Term Sustainable Solutions

Passed by the Metropolitan King County Council on September 15, 2014, Motion 14225 requested that the task force develop sustainable solutions to the psychiatric boarding crisis. The legislation further asked the task force, with assistance from the King County Executive, to review and recommend short-

¹ *In re the Detention of D.W., et al.* Case 90110-4. Washington Supreme Court. The full text of this ruling is included with this report as Appendix E.

² Washington Administrative Code (WAC) 388-865-0526. <http://app.leg.wa.gov/wac/default.aspx?cite=388-865-0526>.

and long-term sustainable solutions for prevention, early intervention, and least restrictive alternatives for individuals in mental health and substance abuse crisis.³

Specifically, the Motion asked the task force to develop recommendations that: (a) increase the use of least restrictive alternatives for individuals in behavioral health crisis, thereby reducing demand for involuntary treatment, including the demand for involuntary treatment court services; (b) provide for successful re-entry into the community for individuals who have received services from psychiatric hospitals; and (c) focus especially on prevention and intervention services.

The Motion, attached to this report as Appendix B, called for the CABTF to deliver two progress reports and a final report on their work. This report is the third and final report called for by Motion 14225. An index of motion requirements can be found in Appendix A.

Scope and Purpose of This Report

As the final report from the CABTF to the King County Council, this report's main purpose is to present the task force's short- and long-term solutions to address involuntary treatment system demand.

Background

To place its primary content in context, this report begins with significant background on psychiatric boarding and the inpatient psychiatric treatment access crisis, including data and analysis from its first two progress reports:

- Key laws and definitions, especially those associated with the Involuntary Treatment Act (ITA) in Washington State;
- The phenomenon of psychiatric boarding in Washington and King County, including history, major drivers, and the *D.W.* court ruling that helped create momentum for change;
- Early major improvements in direct access to preferred E&T services that were achieved locally as King County and the CABTF responded to the crisis in late 2014 and the first half of 2015;
- Access challenges at Western State Hospital (WSH) beginning in mid-2015 and their effects locally, including the erosion of earlier gains even as legal compliance continued;
- Larger contextual factors and system change processes that present challenges and opportunities in the effort to improve treatment access; and
- Legislative action from 2015 and 2016 that relates directly to involuntary treatment access and community-based alternatives.

Behavioral Health Strategic Plan

The CABTF's strategic plan to improve access to the right care at the right time for people in behavioral health crisis includes:

- Ongoing immediate improvements including **system efficiencies and new partnerships** to improve access to the right care at the right time given existing resources;

³ The terms "mental health" and "substance abuse" are used in the Task Force charter and in Motion 14225. In this report and in the emerging parlance of integration at the local, state, and national levels, the term "behavioral health" is used to encompass both mental health and substance abuse needs and/or services. In Washington, these two previously separate service systems are currently being integrated into one system of care in response to state legislation, 2014's Second Substitute Senate Bill 6312.

- Active support for multiple projects working to bring online a **significant expansion of inpatient psychiatric bed capacity** in King County to address an enduring shortage of such beds; and
- Most significantly, a **broad-ranging, prioritized set of proposed system resources and improvements** that, when resourced and implemented, would significantly reduce involuntary treatment demand.

These system design recommendations are sorted into four tiers. They center around four top priorities for active work and promotion and four top priorities with strong momentum toward implementation, as well as five additional priorities for concurrent action as opportunities arise. The plan also describes six other recommended interventions and endorses ten other approaches viewed by CABTF members as important to support.

Recommendations across the continuum are represented in this plan, including prevention and early intervention; crisis diversion; psychiatric hospital discharge and re-entry; and policy changes. CABTF members used a carefully selected set of prioritization factors and a multistage process to identify these particular improvements as priorities for action.

The CABTF's top priority recommendations are below; second-tier priorities appear on the next page. (Additional recommendations and endorsements may be found starting on page 96.)

Tier 1 Top Priorities for Active Work and Promotion

- | |
|---|
| <p>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.</p> |
| <p>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.</p> |
| <p>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.</p> |
| <p>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.</p> |

Tier 1 Top Priorities with Strong Momentum toward Implementation

- | |
|---|
| <p>1e. Strengthen engagement efforts via open access intake appointments, ensuring engagement by beginning ongoing care promptly and/or providing interim support.</p> |
| <p>1f. Increase the availability, flexibility, and outreach capacity of after-hours response for enrolled outpatient clients of the integrated behavioral health system.</p> |
| <p>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.</p> |
| <p>1h. Create a secure detoxification facility and continue to evolve involuntary treatment statutes to support integrated primary and behavioral health care.</p> |

Tier 2 Priorities for Concurrent Action as Opportunities Arise

- | |
|---|
| 2a. Create a local center of excellence with specialized units to deliver best practice services to individuals with brain injuries, dementias, and developmental disabilities . |
| 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 . |
| 2c. Create residential stepdown programs specifically designed to shorten hospital length of stay and help people maintain stability in the community. |
| 2d. Establish a regional peer bridger program serving patients at all community hospitals and E&T facilities including individuals on the state hospital wait list, and identify indicators to ensure such services discontinue at an appropriate time. |
| 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. |

To support a thoughtful but timely effort to bring these changes to reality, the CABTF has identified several potential initial implementation steps for each of these 13 elevated priorities and has provided them as part of its more detailed recommendation descriptions beginning on page 75 of this report.

Next Steps

The crisis of inpatient psychiatric treatment access is not solved. Although it is and has been the policy and consistent practice of King County to detain and treat people who meet criteria for involuntary treatment in compliance with the law and the Supreme Court's ruling, many such patients are still not receiving the care that best fits their needs.

The CABTF sees great opportunity in the present crisis and intends to remain engaged in the work even as its charter concludes. Task Force members look forward to continuing their role as innovative system problem solvers, with a special focus on bringing partners together to mobilize resources for effective and expedited implementation of these essential priorities.

The Community Alternatives to Boarding Task Force

The CABTF Objective and Charter

In August 2014, Governor Jay Inslee and King County Executive Dow Constantine co-convened the CABTF in order to develop collaborative and innovative solutions to ensure that King County residents in behavioral health crisis can access community-based prevention, intervention, and least restrictive treatment services as needed, avoiding the involuntary treatment system altogether when possible.

In accordance with its charter (included as Appendix C), the task force has developed a behavioral health strategic plan, represented by this report, featuring:

- Clear linkages between the work of the CABTF that furthers existing behavioral health work and endeavors.
- Recommendations for system improvements resulting in a continuum of care that:
 - Serves consumers across all age ranges, including children and parents;
 - Reduces demand for involuntary detention;
 - Increases community alternatives to detention;
 - Prioritizes mechanisms that prevent behavioral health events from becoming crises;
 - Ensures appropriate voluntary and involuntary treatment beds are available;
 - Provides necessary resources to providers; and
 - Builds on and leverages existing successes.
- Policy and legislative changes to support system improvements and an improved continuum of care.
- Proposed oversight and reporting plans.⁴

CABTF Membership

The task force is comprised of representatives from:

- The Governor's Office;
- The King County Executive's Office;
- Washington State Division of Behavioral Health and Recovery (DBHR);
- Western State Hospital (WSH);
- Washington State Hospital Association;
- Harborview Medical Center and Navos Psychiatric Hospital and Residential Evaluation and Treatment Facility (E&T);
- Department of Community and Human Services' (DCHS) Behavioral Health and Recovery Division (BHRD) staff, including its designated mental health professional (DMHP) unit and its Diversion and Re-entry section (DRS);
- King County Superior Court;
- Office of the Prosecuting Attorney;
- Department of Public Defense (DPD); and
- King County's Provider Association, comprised of community behavioral health agencies.

⁴ As noted on page 108, the CABTF has begun working to develop milestones, indicators, and other targets to guide its current and future efforts to implement its system improvement recommendations.

The vast majority of these CABTF members participated actively in task groups that envisioned, researched, and generated the innovations and recommendations in this report. A full list of members is included as Appendix D.

CABTF Guiding Principles

As the group formed, CABTF members also articulated nine guiding principles that informed the work and recommendations of the group, most of which were intentionally reflected in the group's prioritization process that led to its final behavioral health strategic plan.

As a result, the CABTF's short- and long-term solutions are:

- Family- and individual-focused;
- Consumer-informed;
- Based in the principles of recovery and resiliency and reflect King County's behavioral health system's trauma-informed approach to services;
- Built upon shared ownership of the system and continuum by providers, consumers, and the County;
- Leveraging other resources whenever possible;
- Aligned with opportunities under the Patient Protection and Affordable Care Act (ACA) and health reform;
- Equity- and social justice-oriented;
- System-focused, emphasizing increased efficiencies and effectiveness; and
- Integrating behavioral health and primary care when possible.

The CABTF's Approach and Common Goal

The CABTF has been committed to collective problem solving since its inception. This approach has been vital to its success in collaboratively creating immediate solutions within existing resources, and in its big-picture system design work and short-term process improvements. This effort has built trust and confidence, both within the CABTF and among stakeholders, and has helped to remove or resolve longstanding barriers to treatment access and system improvements.

Within the framework of a commitment to collaborative problem solving, CABTF members bring a unique mix of system viewpoints, policy engagement, and operational knowledge to their work together, with one prominent shared aim: to improve access, care, and outcomes for individuals in crisis or at risk of crisis.

Part Two: Background and Context

Essential Laws and Definitions

Washington's Involuntary Treatment Act

Washington's Involuntary Treatment Act, also known as the ITA, was originally implemented in 1973. It provides a legal basis for the civil detention and involuntary psychiatric treatment of individuals with significant risks arising from mental health disorders. The ITA seeks to balance due process and individual rights with access to treatment and community and individual safety. Over the years, the ITA has evolved and changed as lawmakers respond to crisis events and treatment access challenges. Many of these changes involve revisions to the grounds for commitment, including expanding the criteria.

The ITA provides for people who have mental health disorders that cause certain substantial and/or imminent risks to themselves, others, others' property, or grave disability to be detained and civilly committed to involuntary treatment for certain intervals: 72 hours, 14 days, 90 days, and 180 days, with court review at each interval.⁵ The ITA law is found in Revised Code of Washington (RCW) chapters 71.05, covering adults, and 71.34, covering youth under age 18.

Investigation and Detention by Designated Mental Health Professionals

While in most states physicians have the authority to detain people for involuntary psychiatric treatment, Washington's law limits this responsibility solely to trained professionals known as designated mental health professionals (DMHPs). When a referral to a DMHP is received from a provider or community member regarding a person who may be in need of an evaluation for potential involuntary mental health care, DMHPs screen and evaluate individuals in hospitals or community settings. Whenever appropriate, they conduct thorough investigations of the level of risk resulting from a person's mental disorder, according to specified legal standards. These investigations must include:

- In non-emergent situations, interviewing the person who has been referred for involuntary treatment;⁶
- Obtaining statements (also known as "declarations") from first-hand witnesses to the person's behavior;
- Considering the observations and opinions of examining emergency room physicians when applicable;⁷ and
- Considering all reasonably available information from credible witnesses and records, including historical behavior, violent acts, history of a finding of incompetency to stand trial or previous civil commitments, as well as the perspectives of family members, landlords, neighbors, or others with significant contact and history of involvement with the person.⁸

⁵ RCW 71.05.150, 71.05.180, 71.05.230, and 71.05.280.

⁶ RCW 71.05.150.

⁷ RCW 71.05.154.

⁸ RCW 71.05.212 and 71.34.212.

Involuntary Detention Requirements

A person may be detained for involuntary inpatient psychiatric treatment in Washington State when either a likelihood of serious harm or grave disability is evident as a result of a mental disorder, when no appropriate less restrictive alternatives can be arranged to mitigate the risk, and when the person is not willing or able to accept treatment voluntarily.⁹ One or more of the following conditions must be met:

- A substantial risk that, as a result of a mental disorder, physical harm will be inflicted by a person upon himself or herself, as evidenced by threats or attempts to commit suicide or inflict physical harm on himself or herself;
- A substantial risk that, as a result of a mental disorder, the person will inflict physical harm on another person, as evidenced by behavior which has caused such harm or which places others in reasonable fear of sustaining such harm;
- A substantial risk that, as a result of a mental disorder, the person will significantly damage the property of others, as evidenced by behavior which has caused substantial loss or damage to the property of others;
- As a result of a mental disorder, the person has threatened the physical safety of another person and has a history of one or more violent acts;
- As a result of a mental disorder, the person is in danger of serious physical harm resulting from a failure to provide for his or her essential human needs of health or safety; or
- As a result of a mental disorder, the person manifests severe deterioration in routine functioning, as evidenced by repeated and escalating loss of cognitive or volitional control over his or her actions, and is not receiving care that is essential for his or her health or safety.

Emergent vs. Non-Emergent Detention

In cases where imminent danger is evident, the law requires the DMHP to detain the person immediately and place him or her into an appropriately certified facility for a 72-hour evaluation and treatment period.¹⁰ This is referred to as emergent detention and is done in order to ensure that hospitalization can proceed without delay to preserve safety. In such cases, Superior Court review occurs at the end of the initial 72-hour period to determine whether further involuntary treatment is warranted.

If the level of risk is substantial but not imminent, the DMHP petitions Superior Court for an order to detain the person under the non-emergent detention provisions of the ITA. A judge reviews the evidence gathered by the DMHP and may or may not order involuntary inpatient treatment. If treatment is ordered, the DMHP places the person into an appropriately certified facility.¹¹ It is important to note that in King County, judges make themselves available for these reviews around the clock and on a near real-time basis, allowing for expedient detention and access to care even in non-emergent cases. This level of judicial support is not in place statewide, which has limited the use of non-emergent detention in other communities.

⁹ RCW 71.05.020 and 71.34.020.

¹⁰ RCW 71.05.150 and 71.34.710.

¹¹ RCW 71.05.153.

Commitment Periods

At the end of the 72-hour period, the staff of the facility where the person is placed may petition the Court for up to 14 days of commitment if further inpatient care is needed and the person is unwilling to consent to it voluntarily, or if certain other conditions are met.¹² Furthermore, if the person requires inpatient treatment beyond the 14-day order, the facility may petition the Court to commit the person for a longer-term inpatient treatment period of 90 days, and then successive 180-day petitions may be filed. For King County residents, Western State Hospital (WSH) is the only certified long-term treatment facility available.

Less Restrictive Alternative Treatment

The Court may order the person to 90 days of less restrictive treatment (or 180 days for a youth under age 18) instead of ordering involuntary inpatient treatment, at the end of the 72-hour period, 14-day period, or any subsequent 90- or 180-day period. This requires that the person must participate in involuntary outpatient care with certain conditions, often including a specific level of attendance at treatment activities and/or compliance with a medication regimen. If a person does not comply with these terms and deteriorates to the point that they meet the detention criteria outlined above, their less restrictive order may be revoked, and they may be returned to an involuntary inpatient care setting.

New state legislation from 2015 (Engrossed Second Substitute House Bill [E2SHB] 1450) added a new category for less restrictive alternative treatment called assisted outpatient mental health treatment, and expanded the requirements for such treatment significantly. More detail about this legislation, along with information about implementation of these changes, is discussed on page 45.

Evaluation and Treatment Facilities

Washington State certifies certain programs, called evaluation and treatment (E&T), to provide short-term involuntary inpatient psychiatric treatment, as required under the ITA whenever detention standards are met and less restrictive alternative treatment is not appropriate. E&T programs are designed to provide a treatment environment that is specifically suited to the needs of people who cannot maintain safety in the community and are in need of involuntary mental health care. Usually these beds are used for the 72-hour detention and 14-day commitment periods. Many voluntary psychiatric units in community hospitals do not hold this certification for involuntary E&T services.

As of the writing of this report, there are six facilities in King County with certified E&T programs:

- Fairfax Hospital in Kirkland, serving adolescents and adults;
- Harborview Medical Center in Seattle, serving adults;
- Navos in West Seattle, serving primarily adults;
- Northwest Hospital Geropsychiatric Center in Seattle, serving almost exclusively older adults;
- Cascade Behavioral Health in Tukwila, serving adults; and
- MultiCare in Auburn, serving adults, newly opened in March 2016.

¹² RCW 71.05.280.

Institutions for Mental Disease Exclusion Rule

A Medicaid rule from 1965, meant to prevent states from shifting the costs of long-term institutionalization of people with chronic behavioral health conditions to Medicaid by moving people from state hospitals to large institutions, prohibits the use of Medicaid funds to reimburse care for adults with mental illness or drug and alcohol issues who are in behavioral health facilities with more than 16 beds. Facilities with more than 16 beds that are not part of larger medical centers are known as Institutions for Mental Disease (IMDs). For many years, this rule has forced Washington to use its scarce state funds to pay for care in its larger facilities, draining resources from crisis response systems and innovative, community-based programs.

A key exclusion in the IMD Medicaid rule is that it does not apply to people older than 65 or younger than 21; individuals in these age categories who are in IMDs can be covered by Medicaid if they are eligible. Additionally, as described in more detail on page 51, Washington received temporary and limited waiver authority in late 2014 allowing Medicaid to be used to fund short-term acute mental health care in IMDs, in lieu of more expensive hospital care.

The Recent History of Psychiatric Boarding: A Treatment Access Crisis

“Psychiatric boarding” or “boarding” became shorthand for the treatment access crisis that resulted when community need for inpatient mental health care – especially involuntary treatment – exceeded appropriate available resources. When appropriate treatment beds were not available, individuals were detained and waiting in less than optimal settings, such as emergency departments (EDs), until a psychiatric bed became available. This nationwide problem had been affecting Washington and King County since at least 2009.

In its 2014 *In re the Detention of D.W. et al* decision, the Washington Supreme Court defined psychiatric boarding as temporarily placing involuntarily detained people in emergency rooms and acute care centers to avoid overcrowding certified facilities. In doing so, it emphasized the inappropriateness of the placement, and the chief reason for not providing inpatient psychiatric care at the right time – lack of capacity.¹³ More information about this seminal court decision is available on page 20 and in Appendix E.

The CABTF recognized psychiatric boarding as a major treatment access crisis that hurts patients and drives resources away from community-based and preventive care. As a result, the CABTF has been working to bring together system changes at all levels to eliminate psychiatric boarding in King County in a sustainable way. This section outlines the national, state and local historical context of the crisis.

A National Trend: Psychiatric Care in Hospital Emergency Departments

Nationally, more and more people have begun seeking psychiatric care via hospital EDs in recent years. In 2007, 12.5 percent of adult ED visits were mental health-related, as compared to 5.4 percent just seven years earlier. Of psychiatric ED visits, 41 percent result in a hospital admission (over two and a half times the rate of ED visits for other conditions),¹⁴ and between 2001 and 2006, the average duration of such visits was 42 percent longer than for non-psychiatric issues.¹⁵ Studies show that prolonged waits in EDs for psychiatric patients are associated with lower-quality mental health care; the chaotic ED environment increases stress and can worsen patients’ conditions,¹⁶ in addition to the fact that adequate psychiatric services are often not provided.¹⁷ The growth in these figures may result from the difficulty people experience in accessing community mental health services before they are in crisis, as

¹³ *In re the Detention of D.W., et al*. Case 90110-4. Washington Supreme Court, retrieved from <http://www.courts.wa.gov/opinions/pdf/901104.pdf>.

¹⁴ Owens P, Mutter R, Stocks C. (2014). Mental Health and Substance Abuse-Related Emergency Department Visits among Adults, 2007: *Agency for Healthcare Research and Quality* (2010), as cited in Abid et al. Psychiatric Boarding in U.S. EDs: A Multifactorial Problem that Requires Multidisciplinary Solutions. *Urgent Matters Policy Brief*, 1(2).

¹⁵ Slade EP, Dixon LB, Semmel S. (2014). Trends in the duration of emergency department visits, 2001-2006. *Psychiatr Serv* 2010, 61(9), 878-84, as cited in Abid et al. Psychiatric Boarding in U.S. EDs: A Multifactorial Problem that Requires Multidisciplinary Solutions. *Urgent Matters Policy Brief*, 1(2).

¹⁶ Bender, D., Pande, N., Ludwig, M. (2008). *A Literature Review: Psychiatric Boarding*: Office of Disability, Aging and Long-Term Care Policy. Retrieved from <http://aspe.hhs.gov/daltcp/reports/2008/PsyBdLR.pdf>.

¹⁷ American College of Emergency Physicians. ACEP Psychiatric and Substance Abuse Survey (2008), as cited in Abid, Z., Meltzer, A., Lazar, D., Pines, J. (2014). Psychiatric Boarding in U.S. EDs: A Multifactorial Problem that Requires Multidisciplinary Solutions. *Urgent Matters Policy Brief*, 1(2).

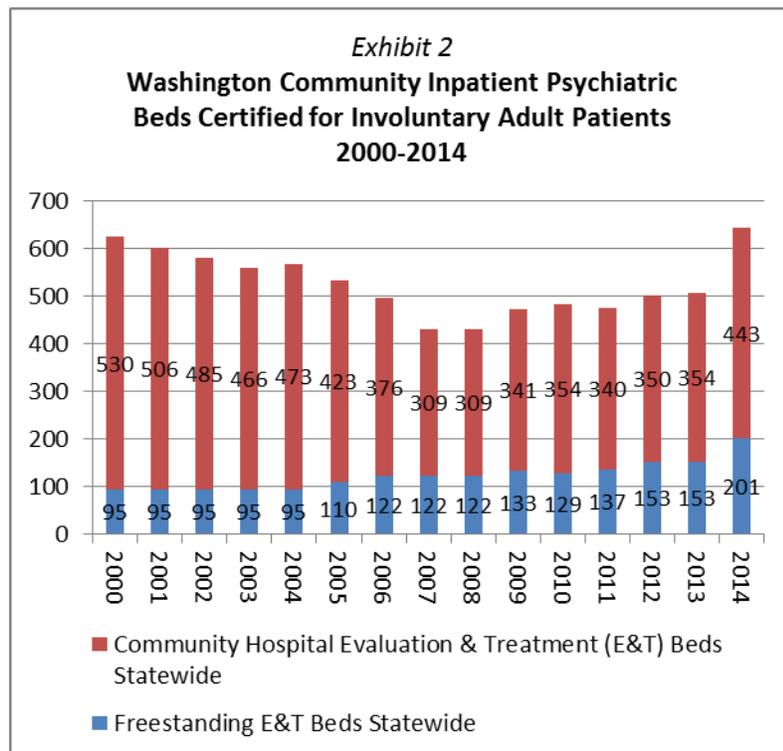
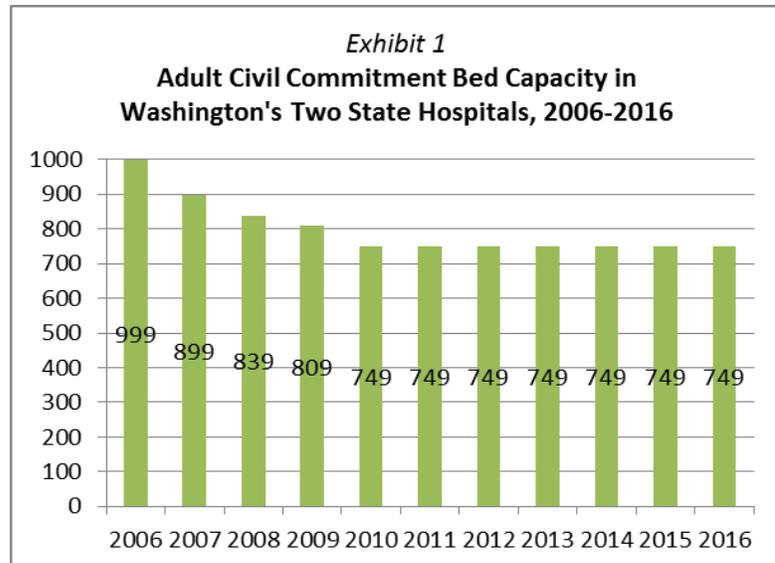
well as the dramatic reduction in inpatient psychiatric capacity nationally that began as part of deinstitutionalization in the 1960s and has continued until very recently.¹⁸

Drivers of Psychiatric Boarding in King County and Washington

In King County and Washington State as a whole, this phenomenon has been driven by a confluence of factors: community and inpatient resources are scarce, while at the same time the treatment need is very high, the population is growing quickly, and laws are changing, increasing the likelihood of involuntary detention.

Resource Scarcity

The escalation of boarding in our community in recent years has coincided with significant reductions in a variety of critical treatment resources.



As shown in Exhibit 1, the number of available civil state hospital beds (where patients committed under the Involuntary Treatment Act [ITA] receive long-term treatment if needed) dropped 25 percent between 2006 and 2011 (a loss of 250 beds). They remain at these historically low levels.¹⁹

Furthermore, as depicted in Exhibit 2, the number of community hospital and evaluation and treatment (E&T) facility beds in Washington certified for involuntary patients also fell by 31 percent (a loss of 194 beds) between 2000 and 2007, as many independent community hospitals closed their certified psychiatric units or reduced the number of available

¹⁸ Abid et al. (2014). Psychiatric Boarding in U.S. EDs: A Multifactorial Problem that Requires Multidisciplinary Solutions. *Urgent Matters Policy Brief*, 1(2).

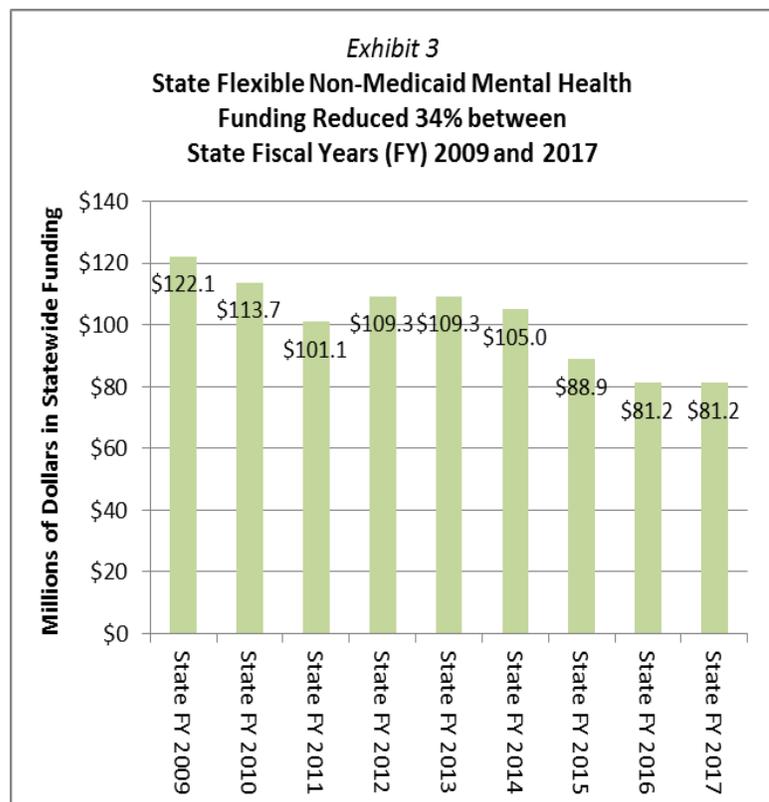
¹⁹ Legislative Evaluation and Accountability Program Committee. Operating Budgets for fiscal years 2007-16, Mental Health Program sections, retrieved from http://leap.leg.wa.gov/leap/budget/index_lbns.asp.

beds. Of these beds, 76 were gradually restored over the next few years, but this still left a net reduction of 118 beds (19 percent) as recently as 2013.²⁰ 2014 brought a major increase of 159 involuntary inpatient beds statewide, as the state and local communities have begun to add new resources to address the crisis, which brought the total number of beds statewide back to approximately the same levels as in 2000.²¹ Efforts to increase community psychiatric inpatient capacity continue statewide as hospitals and freestanding E&T providers rise to the challenge to provide care when it is needed. Current and future developments in this area in King County are discussed beginning on page 58.

The dramatic reduction in inpatient resources during the mid-2000s contributed to Washington's overall ranking of 46th among states in per capita short-term mental health facility capacity (including both community hospital beds and E&T beds), according to a 2015 analysis by the Washington State Institute for Public Policy of data from Substance Abuse and Mental Health Services Administration's (SAMHSA) 2010 National Mental Health Services Survey.²²

Major cuts to flexible non-Medicaid mental health funds from the state have also significantly affected treatment access. These non-Medicaid funds are prioritized for crisis, involuntary commitment, residential, and inpatient services and play an important role in creating and maintaining a comprehensive continuum of community-based care. They also enable King County to facilitate treatment access for individuals who do not have Medicaid.

As shown in Exhibit 3, between state fiscal years 2009 and 2016, there was a loss of \$40.9 million (34 percent) statewide for these critical services, and funding was left at the unprecedented low level of \$81.2 million statewide for state fiscal year 2017 as well.²³ Consequently, the reductions have had deep and dramatic effects on the community's ability to respond to growing need and maintain or develop creative crisis solutions to reduce involuntary treatment demand.



²⁰ Burley, M., & Scott, A. (2015). Inpatient psychiatric capacity and utilization in Washington State (Document Number 15-01-54102). Olympia: Washington State Institute for Public Policy, retrieved from http://www.wsipp.wa.gov/ReportFile/1585/Wsipp_Inpatient-Psychiatric-Capacity-and-Utilization-in-Washington-State_Report.pdf.

²¹ Burley, M. & Scott, A. (2015). Comparable statewide data for 2015 was not available at the time of this report.

²² Burley, M. & Scott, A. (2015).

²³ These funding reductions assumed that many individuals served via flexible state non-Medicaid mental health funds could be shifted to Medicaid with the implementation of the Affordable Care Act (ACA) in 2014. However, some services are ineligible for Medicaid regardless of whether the person served is a Medicaid enrollee. This is especially significant in King County. This community's allocation of flexible non-Medicaid funds is used for state-mandated priority services that are categorically ineligible for Medicaid regardless of the service participant's Medicaid status.

High Treatment Need, Law Changes, and Population Growth

This severe resource scarcity has coexisted with a very high prevalence of treatment need in Washington as compared to other states. Analysis of data from the federal SAMHSA 2010-11 Mental Health Surveillance Survey found that Washington ranked in the top three among states in the prevalence of any mental illness (24 percent of the population) and serious mental illness that substantially affected one or more major categories of functioning (7 percent).²⁴

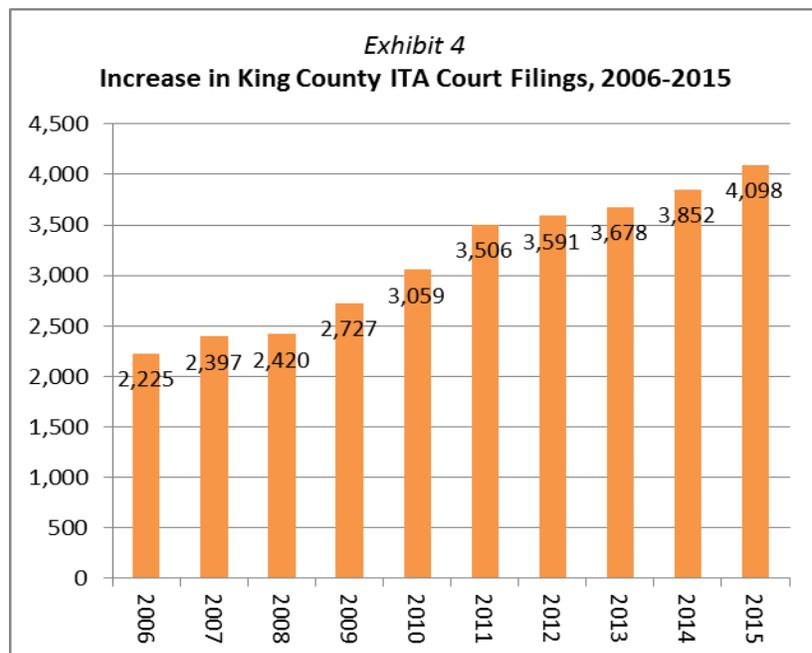
In addition, many ITA policy changes have been implemented in recent years, most of them designed to make it easier to detain people in crisis involuntarily and/or to extend inpatient stays for these individuals.

All the while, the population of King County grew by an estimated 22 percent between 2000 and 2015 – almost 380,000 people. Meanwhile, the state’s population increased by approximately 22 percent (or nearly 1.3 million) as well.²⁵ Even just this one factor alone – the addition of so many additional residents – would have placed more pressure on an overstretched inpatient treatment system.

King County ITA Court Caseload Growth

Due to the factors described above, the caseload for King County’s ITA Court has increased dramatically between 2006 and 2015 – new case filings jumped by 1,873 cases (84 percent) over nine years, as shown in Exhibit 4.²⁶

This growth translates to increased demands for staff, judicial officers, space, and other needs. The costs of ITA Court are paid using scarce non-Medicaid mental health funding, and directly impact resources available for designated mental health professionals (DMHPs) to conduct the ITA evaluation and



for treatment services. Despite the positive system impact of the CABTF, this trend of increase is likely to continue until significant changes to inpatient and community-based bed capacity are implemented.

ITA caseload growth has created additional stress on clients and their families, who may have to wait hours for their court hearings – a wait which takes clients out of the treatment setting to which they have been detained and impacts their confidence in the court. Prosecution and defense attorneys’

²⁴ Burley, M. & Scott, A. (2015).

²⁵ U.S. Census Bureau State and County QuickFacts, retrieved from <http://quickfacts.census.gov/qfd/states/53/53033.html>, and Population for the 15 Largest Counties and Incorporated Places in Washington: 1990 and 2000, retrieved from https://www.census.gov/census2000/pdf/wa_tab_6.PDF.

²⁶ King County ITA Court data. Subsequent filings under the same case number are excluded.

efforts to negotiate less restrictive alternative arrangements or other mutually workable solutions have been curtailed by the increase in case filings.

Superior Court has been so challenged to meet capacity that it built a small second courtroom in 2013²⁷ and began implementing video hearings at all but one of the E&T facilities between 2014 and 2016.²⁸ Meanwhile, the Court, Council, and Executive continued to explore other options to address crowding and other space limitations at the ITA Court.²⁹

Single Bed Certification and the *D.W.* Supreme Court Ruling

Single Bed Certification 2009-2014 – Safe but Insufficient Treatment

In 2009, in response to the already-escalating involuntary treatment capacity problem in Washington, a new section was added to the Washington Administrative Code (WAC) to institute a single bed certification (SBC) process.³⁰ This protocol was added to provide temporary certification that allowed individual patients detained under the state's ITA to be served in non-E&T hospital settings such as medical units, voluntary psychiatric units, or when necessary, emergency departments. Psychiatric care appropriate to an involuntary patient was often lacking in these settings, with patients sometimes left strapped to gurneys in hallways without being seen often enough by mental health professionals or psychiatrists, or otherwise insufficiently treated for unacceptable periods of time.

Though this provision kept people in behavioral health crisis safe when E&T beds were not available, it also became a mechanism by which far too many people were held in settings that did not adequately meet their behavioral health care needs. The initial rule creating SBCs did not articulate any specific requirements for the person's care, making the patient's experience quite variable depending on individual hospitals' capacity and practices.

Escalation in King County SBC Use

Prior to the Court's August 2014 ruling, the use of SBCs had been escalating for several years – a sign of the treatment access crisis affecting thousands of residents with acute care needs. In King County, for example, the number of involuntarily detained individuals who did not receive direct access to an E&T facility had been growing at an alarming rate, from less than one-fifth of all detentions in 2009 to two-thirds in 2013 and 2014, as shown in Exhibit 5 on the next page.³¹

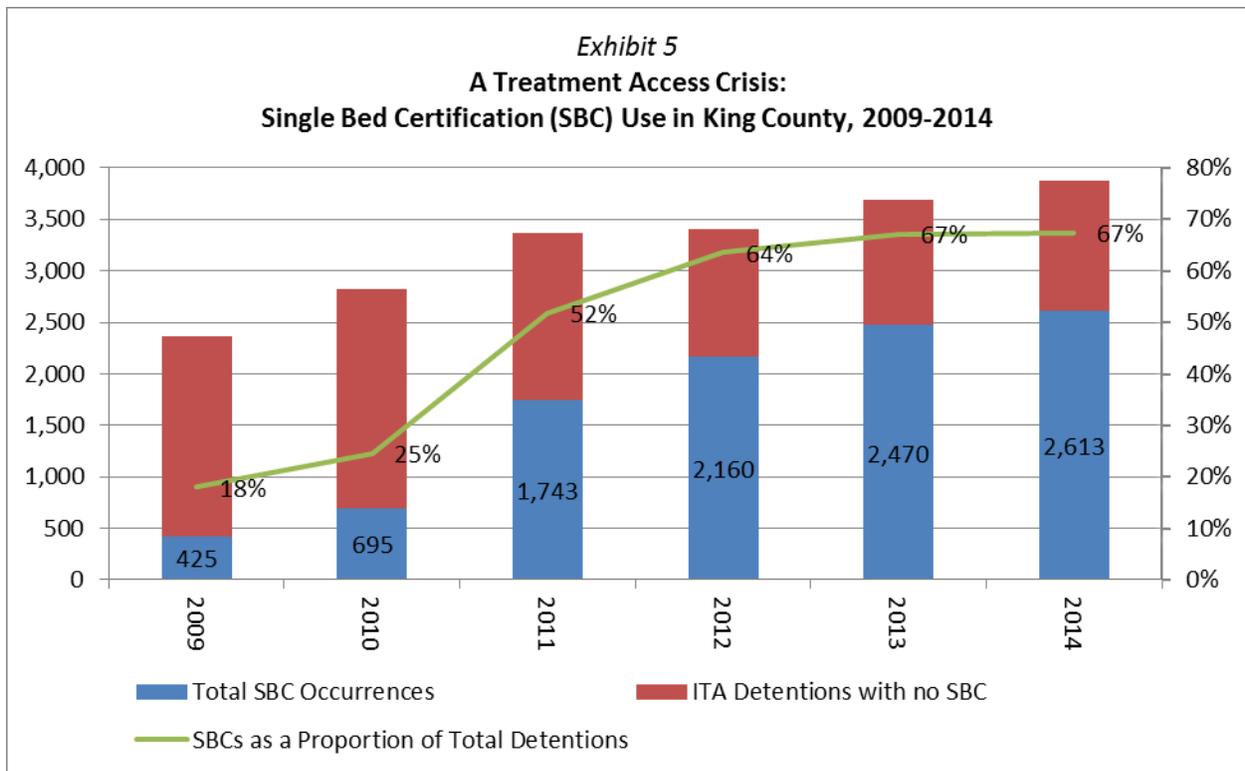
²⁷ King County Superior Court 2013 Annual Report.

²⁸ An April 2016 report from the office of the King County Executive, titled "Involuntary Treatment Act (ITA) Court Access: Ambulance Transportation and Video Hearings," addresses the expanded use of video hearings, including its benefits to patients and to system efficiency, as well as challenges presented by the video hearing approach.

²⁹ Options for expanding the ITA Court's physical space are explored in a report entitled "King County Superior Court Involuntary Treatment Act (ITA Court), Executive Response, Motion 14370," August 17, 2015.

³⁰ WAC 388-865-0526.

³¹ As discussed on page 24, SBC use dropped significantly (signaling improved E&T access) in late 2014 and early 2015 as a result of targeted interventions and system cooperation, but rose again in mid-2015 due to state hospital access challenges that had collateral effects locally. Exhibit 8 on page 32 describes SBC usage by month from January 2014 to March 2016.



A Mandate for Urgent Change: *In re the Detention of D.W. et al*

On August 7, 2014, the Washington Supreme Court's ruling in *In re the Detention of D.W. et al* prohibited holding psychiatric patients on SBCs in non-psychiatric settings solely due to lack of inpatient capacity at certified E&T facilities. The Court found that funding limitations or capacity shortages in certified E&T facilities are invalid reasons for detaining a person while delaying the provision of appropriate mental health care.³²

King County and its community partners strongly supported this ruling because it directly addressed an enduring problem and made appropriate treatment access a primary priority throughout the state, creating an environment in which creative changes could occur. This ruling went into effect December 26, 2014, and is included with this report as Appendix E.

New SBC Requirements for Timely and Appropriate Care

Since the effective date of the Supreme Court ruling on December 26, 2014, SBCs may now only be used to hold a person involuntarily when the hospital is willing and able to provide timely and appropriate mental health treatment to the person. At that time, the Washington Administrative Code (WAC) governing SBCs was revised via an emergency rule in order to ensure that proper mental health care is being provided whenever an SBC is issued. As a result, instead of being a routine method to hold people with or without treatment while awaiting an E&T bed, SBCs now depend on the voluntary participation of a community hospital or other appropriate facility in bringing psychiatric care to the person regardless of the care setting. Therefore, SBC use has varied throughout the state since the ruling, due to the fact that many hospitals in the state have not been willing or able to accept patients under the

³² *In re the Detention of D.W., et al*. Case 90110-4. Washington Supreme Court.

new conditions required for an SBC. As a result of proactive outreach and ongoing partnerships, King County hospitals were much more immediately receptive than most in the state to the added responsibility that comes with SBC requests since the *D.W.* ruling, as described in more detail on page 56.

King County Responds

The next section of this report describes at a high level King County's response to the crisis of psychiatric boarding and the opportunities presented by the Court's ruling, as well as the immediate outcomes from those efforts. (Specific details of these interventions are described beginning on page 50.)

Speedy Response Yields Significant Gains

Timely Compliance

Local efforts to respond to the crisis of psychiatric boarding began even before the Supreme Court's *D.W.* ruling and continued throughout 2014 as the CABTF was forming and beginning its work. In early 2014, the King County Department of Community and Human Services (DCHS), in partnership with the County Executive and the County Council, announced ending psychiatric boarding as a major priority. The County committed to working creatively with its partners to leverage existing resources while also seeking new avenues of funding whenever possible, in an effort to reduce demand and provide appropriate treatment.

King County's specific responses to the ruling, including a variety of new and repurposed resources, had an immediate and lasting positive impact on the involuntary treatment system. (See page 50.)

Better Access to Treatment

By mid-December 2014, before the effective date of the Supreme Court's ruling, King County was in compliance with the ruling: all individuals detained under the Involuntary Treatment Act (ITA) either were placed directly into an E&T facility or received appropriate treatment under a permissible single bed certification (SBC). This approach has remained King County's policy and consistent practice ever since.

In the first quarter of 2014, before the ruling, only 18 percent of persons detained in King County immediately accessed evaluation and treatment (E&T) services. This proportion gradually and consistently improved over the course of 2014 and early 2015. In fact, between October 2014 and May 2015, an average of 64 percent of involuntarily committed people were placed directly into E&T beds as intended by the ITA. There was a corresponding significant reduction in the use of SBCs, as they dropped by 63 percent between first quarter 2014 and first quarter 2015. The CABTF's work, along with system partners, to improve procedures and collaboration at the local level was a significant contributor to these results.³³

However, neither the CABTF members nor King County government are satisfied with merely complying with the law, as too many people continue to receive their care in emergency departments (EDs) and medical units.

Fragile Improvements

As encouraging and sizeable as these improvements were, the CABTF and its system partners all recognized that these gains were fragile. The problem of treatment access was not solved, as the number of E&T beds and community-based treatment capacity remained inadequate to meet needs. Disruption in capacity or access at any level of the involuntary system – especially in areas that are beyond the control of local communities to manage directly – could reverse these gains and restore the access crisis.

By mid-2015, unprecedented new access problems at Western State Hospital (WSH) had this very effect.

³³ The work of the CABTF to address barriers and increase efficiency in the existing involuntary treatment system is discussed starting on page 53.

A Significant Setback: State Hospital Access Challenges and Their Effects on King County Patients

By spring 2015, major gains had been made in providing direct access to involuntary treatment as a result of a wide range of innovations at the local level and strategic investments at the state level. In the second half of 2015, unfortunately, major developments in the downstream end of the involuntary treatment system – specifically Western State Hospital (WSH), on which the local involuntary treatment system depends – presented renewed challenges that eroded these earlier gains.

This section describes these conditions and provides analysis of the collateral impacts in King County.

These issues underscore the fact that the state and local communities such as King County are truly interdependent in addressing the behavioral health care needs of residents, especially for more intensive levels of care, such as short-term acute care and state hospital care. Local innovation and funding are essential, but the success of the system as a whole currently depends on partnership with state hospitals to provide intensive long-term treatment for those few patients who need it and to achieve timely discharge to the community for this population.

Ultimately, King County and the CABTF are working to address the impacts of sudden reductions in access to WSH beds and exploring ways that coordinated work locally can help to ease pressure on the system, while also seeking opportunities to consider reducing reliance on the state hospital by delivering long-term treatment for some King County patients in alternative involuntary settings closer to home.

The Role of the State Hospital as the System's Long-Term Option

In Washington, state hospitals currently occupy a pivotal role in the involuntary treatment system for all communities, as the long-term treatment option identified by statute.³⁴ Individuals who need long-term involuntary inpatient care – beyond the 72-hour and 14-day commitments for which local acute care evaluation and treatment (E&T) settings are designed – are to receive their long-term care via 90-day or 180-day commitments at a state hospital.

Washington has two state hospitals, the larger WSH that serves Western Washington and the smaller Eastern State Hospital that serves communities in central and Eastern Washington. Treatment teams at the state hospitals oversee the care of individuals. Each behavioral health organization (BHO) – a county or group of counties that administers the public behavioral health system³⁵ – is currently allocated a certain number of beds that it helps to manage. In general, local communities work to reduce their state hospital census via two main methods – employing community-based diversion strategies and less restrictive alternatives whenever possible, and working proactively to arrange appropriate community placement whenever a person is deemed ready to discharge by their state hospital treatment team. Maximizing community integration through effective diversion and discharge planning are critical to reducing the need for state hospital care, thereby ensuring state hospital access for individuals whose psychiatric conditions require long-term, high-intensity care.

³⁴ RCW 71.24 does provide for the option of long-term treatment in settings other than the state hospital, but no such facilities exist yet.

³⁵ Mental health services, now administered by BHOs, previously operated under a comparable administrative umbrella known as a Regional Support Network (RSN) until March 31, 2016. BHOs incorporate both mental health and substance use services into one organization.

Severely Reduced Access to WSH Beds

Just as the involuntary treatment system in King County was beginning to see improvements in E&T access as a result of its coordinated local system changes, access to beds at WSH for communities throughout Western Washington suddenly became severely curtailed through a series of major developments.

Admissions Closure Due to Psychiatrist Shortage

WSH was closed to new admissions from mid-February through mid-March 2015, leaving patients in need of long-term treatment waiting in local acute care E&T beds until space became available at the appropriate state hospital setting. State officials primarily attributed this closure decision to a shortage of psychiatrists – at one point during the closure, 20 percent of the staff psychiatrist positions at WSH were either vacant or about to be vacant due to recruitment challenges associated in part with lower salaries.³⁶ When the state began hiring contract psychiatrists to fill the staffing gaps, WSH was able to reopen to new admissions in the spring, easing access temporarily. However, more challenges at WSH emerged in the next few months.

Ward Expansion Problems

During summer 2015, the state began working to implement the addition of another ward of 30 civil commitment beds at WSH due to new funding from the legislature, as part of the broad-based response to the court's 2014 *In re the Detention of D.W.* decision. However, staffing challenges, including the psychiatrist shortage that caused the temporary admission stoppage, slowed the implementation of this expansion. The new ward began to open gradually in October 2015 as teams of staff were hired, but only a few beds were ever brought online.

Change in Practice by Local Courts

Also during summer 2015, Pierce County commissioners redesigned their court orders for long-term treatment to require immediate admission to WSH, meaning patients from Pierce County who received a 90-day court-ordered involuntary treatment began skipping ahead of all others on the WSH wait list, leaving many patients from other communities waiting for WSH beds even longer than they otherwise would. This approach by the Pierce County courts further exacerbated a difficult situation for the entire region. Local courts in several other communities soon followed suit.

Access to WSH was already very difficult, but this action by local courts created an inequitable system for WSH access that denied people from other communities, including King County, access to state hospital treatment when they needed it. In addition to circumventing appropriate community-based care opportunities for some Pierce County patients, access to the WSH resource became very minimal for the rest of Western Washington.

Acting on concerns expressed by multiple Regional Support Networks (RSNs)/BHOs from across the state, including Pierce County's OptumHealth, the Department of Social and Health Services' (DSHS') Behavioral Health Administration (BHA) worked with WSH to clarify, in writing, the admissions process and the decisions that go into determining the order in which individuals come into the facility. This decision-making matrix does not include accelerated admission based on courts' contempt findings. As a

³⁶ Schrader, J. (March 9, 2015). Doctor shortage keeps Western State Hospital from taking detained patients. Tacoma News-Tribune. Retrieved from <http://www.thenewstribune.com/news/local/politics-government/article26264509.html>.

result, multiple jurisdictions have begun fining WSH for failure to comply, and DSHS faces a very negative fiscal impact from this decision. However, this process is clearly necessary to preserve the integrity of a system that serves all clients appropriately and does not give preference to clients living in regions with courts most inclined to order immediate admission to WSH.³⁷

Expansion Stopped to Address Federal Immediate Jeopardy Notices Regarding Safety Issues

Most significantly, in October and early November 2015, inspectors from the Federal Centers for Medicare and Medicaid Services (CMS) responded to concerns about patient and staff safety at WSH by issuing immediate jeopardy notices that highlighted major problems and could result in the removal of all federal funds. In WSH's case, this would have amounted to about \$16 million per year unless conditions were improved very quickly.³⁸

In response, the state DSHS placed the ward expansion that had been funded by the legislature on hold while workforce shortages and safety concerns at the hospital were addressed.³⁹ By mid-November, a provisional agreement was in place with CMS to prevent the withdrawal of federal funding, allowing the state hospital to continue to operate, but this did not involve resuming the previously planned bed expansion. In fact, at that time, patients who had been moved into the new ward funded by the legislature had been moved back out.⁴⁰ By late November, WSH had been informed by CMS that all immediate jeopardy findings had been lifted.⁴¹ However, WSH remained under intense scrutiny from state and federal oversight bodies; the state Department of Health visited the hospital in March 2016 to review patient care issues, and both state and federal CMS teams also returned that same month. At the time of this writing, the hospital had received notice from CMS of an extension to their schedule for potential termination of CMS participation, which could result in the loss of federal funding for WSH, with final results anticipated by May 2016.

Continuing Workforce Recruitment Challenges

WSH struggles to maintain its workforce. As of November 2015, WSH was indicating just over 200 vacancies including 163 direct care staff.⁴² As a result of multiple new recruitment and retention strategies in place since early 2015 to address this ongoing concern, by April 2016, the hospital had achieved a net increase of 88 staff as part of targeted expansion efforts in certain aspects of its operations, and vacancies for all staff positions had decreased somewhat to 181.⁴³

³⁷ DSHS BHA, April 2015. In late December 2015 a commissioner overseeing cases from the Thurston/Mason RSN/BHO began to take a similar shortcut approach to that used in Pierce County, scheduling show cause hearings to try to force expedited WSH access for patients in that region. Although the written admissions policy prevented inequitable access for these patients, this did result in fines for the state.

³⁸ Schrader, J. (November 5, 2015). 'Immediate jeopardy' seen at Western State Hospital. *Tacoma News-Tribune*. Retrieved from <http://www.thenewstribune.com/news/local/politics-government/article43229640.html>.

³⁹ Reyes, C. (November 19, 2015). Civil Commitment and Forensic Mental Health Legislation – Updates: House Judiciary Committee. Retrieved from <https://app.leg.wa.gov/CMD/Handler.ashx?MethodName=getdocumentcontent&documentId=SvULsA9a8sl&att=false>.

⁴⁰ Reyes, C. (November 19, 2015). Civil Commitment and Forensic Mental Health Legislation – Updates: House Judiciary Committee.

⁴¹ Adler, R. (November 24, 2015). CEO Newsletter-CMS Survey Update 11/24/15.

⁴² Washington State DSHS Human Resources Division data, November 12, 2015.

⁴³ Washington State Department of Social and Health Services (DSHS) Human Resources Division data, April 8, 2016.

Legislative Response

As described on page 47, in 2016 state legislators took notice of the state hospital's struggles to ensure timely access. Via Engrossed Substitute Senate Bill (ESSB) 6656, they created a new oversight committee and mandated wide-ranging consultant studies to improve practices at the state hospital.⁴⁴

In addition, in light of implementation challenges and a policy interest in promoting safety at WSH in part via census reduction, the planned 30-bed expansion was formally canceled by the legislature, leaving the total WSH civil census at 557 beds. (Although there is broad agreement that long-term state hospital care is not the permanent solution to the inpatient capacity crisis, the ward expansion would have helped to ease capacity pressures experienced by local communities.)

Collateral Impact on Patients at Multiple Levels of Care in King County

Due to these factors, movement of patients on long-term 90- and 180-day treatment orders from local King County E&T facilities or community hospitals into long-term treatment beds at WSH has remained severely limited since mid-2015, thereby leaving fewer acute care beds available for community members who need them.

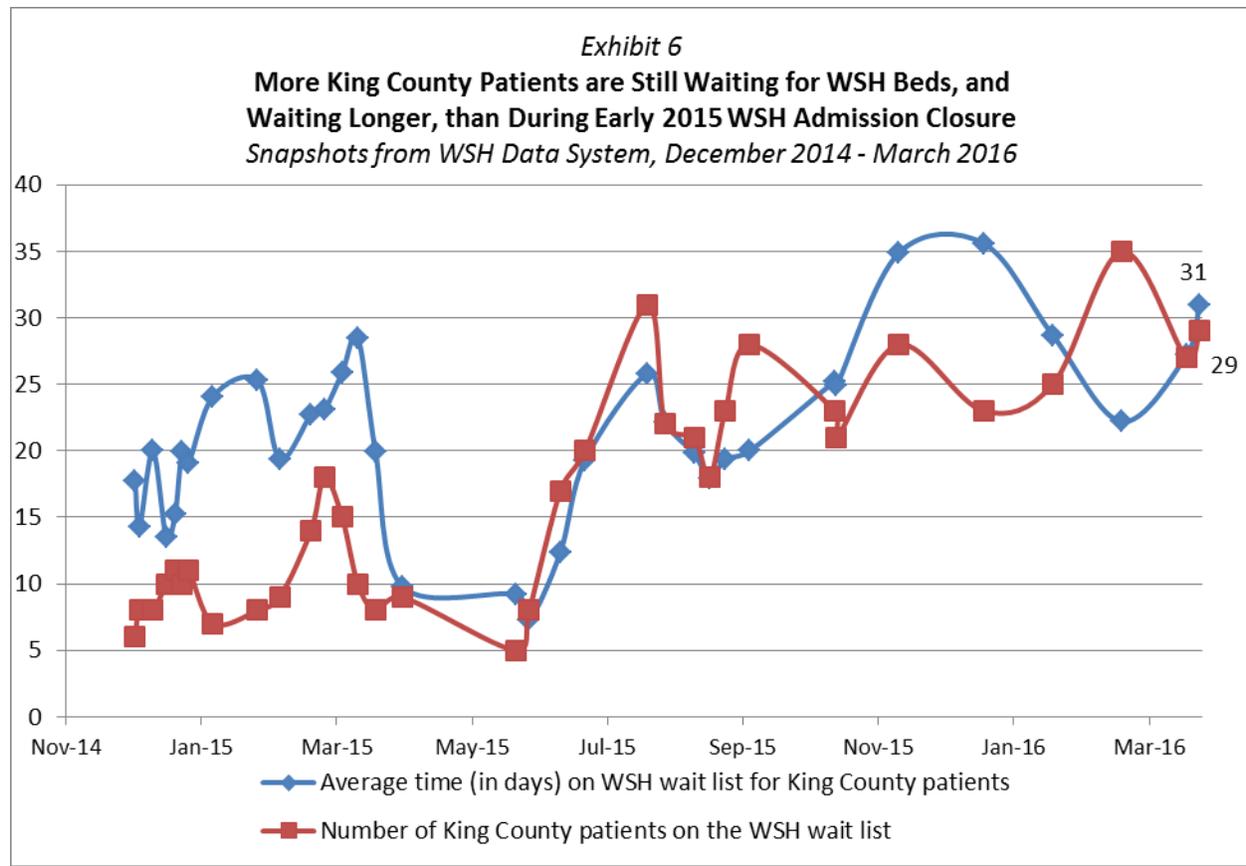
King County Patients Waiting Longer for State Hospital Beds

As a result of these unexpected and enduring constrictions in access to WSH beds, the number of King County patients held in community hospitals waiting for admission to WSH jumped dramatically in mid-2015 and reached a new peak of 35 in February 2016. In fact, ever since June 2015, there have consistently been 20 or more patients from King County waiting for WSH. By comparison, in 2014 and prior years, before the unexpected access problems that arose in 2015, the WSH wait list for King County patients rarely exceeded 10 patients at any one time.

In addition, the amount of time King County patients are waiting for beds at WSH increased to unprecedented levels, peaking at 34.9 days on average in November 2015, and remained at comparably high levels through the first quarter of 2016.

Trends between December 2014 and March 2016 in the numbers of patients waiting for WSH and the length of time they spend on the wait list are shown in Exhibit 6 on the next page, based on snapshots from the WSH data system.

⁴⁴ ESSB 6656: <http://lawfilesexet.leg.wa.gov/biennium/2015-16/Pdf/Bills/Session%20Laws/Senate/6656-S.SL.pdf>.



Limited Community Discharge Options

To keep patients moving to appropriate levels of care as quickly as possible, liaisons work on-site at WSH with state hospital treatment teams to help design and implement appropriate discharge plans for King County individuals leaving the state hospital.⁴⁵ Likewise, local community hospitals are focused on discharging individuals as safely and quickly as possible to appropriate care settings. However, specialized intensive resources in the community – that are critical to help people discharge from state and community hospitals – are severely limited, and as a result, many such programs have very long wait lists. Among these scarce resources are intensive mental health programs that often include housing and treatment services as an integrated package, as well as adult family homes administered by the state’s Home and Community Services unit.

Significant gaps remain between available resources and the discharge needs of state and community hospital patients, especially those who fall into certain special populations. Many of the recommendations outlined beginning on page 65 suggest new or expanded programs that would speed movement out of hospitals and into less-intensive care, especially for populations that no longer benefit from state and/or community hospital care but whose behaviors or risks make them challenging to discharge.

⁴⁵ See recommendation 3d on page 98 for the CABTF’s suggested improvements and enhancements to King County’s state hospital utilization management and discharge planning efforts, including the structure and scope of these liaison teams.

More Patients are in E&T Facilities on Long-Term Treatment Orders and Waiting for State Hospital Beds

This lack of community options not only affects state hospital patients, but also individuals who only need brief acute care. For the vast majority of individuals, inpatient psychiatric treatment is beneficial and necessary only for a discrete period of time. Once an individual has been determined by treatment staff to no longer need intensive inpatient services, he or she is to be discharged to a less restrictive level of care – although under current circumstances, there are frequent instances where this cannot happen in a timely way due to a lack of available options. This results in an impact to both the patient, who remains in a care setting not designed specifically for their needs, and to the individuals who do need that level of care, but must wait in another setting, most often being held on a single bed certification (SBC).

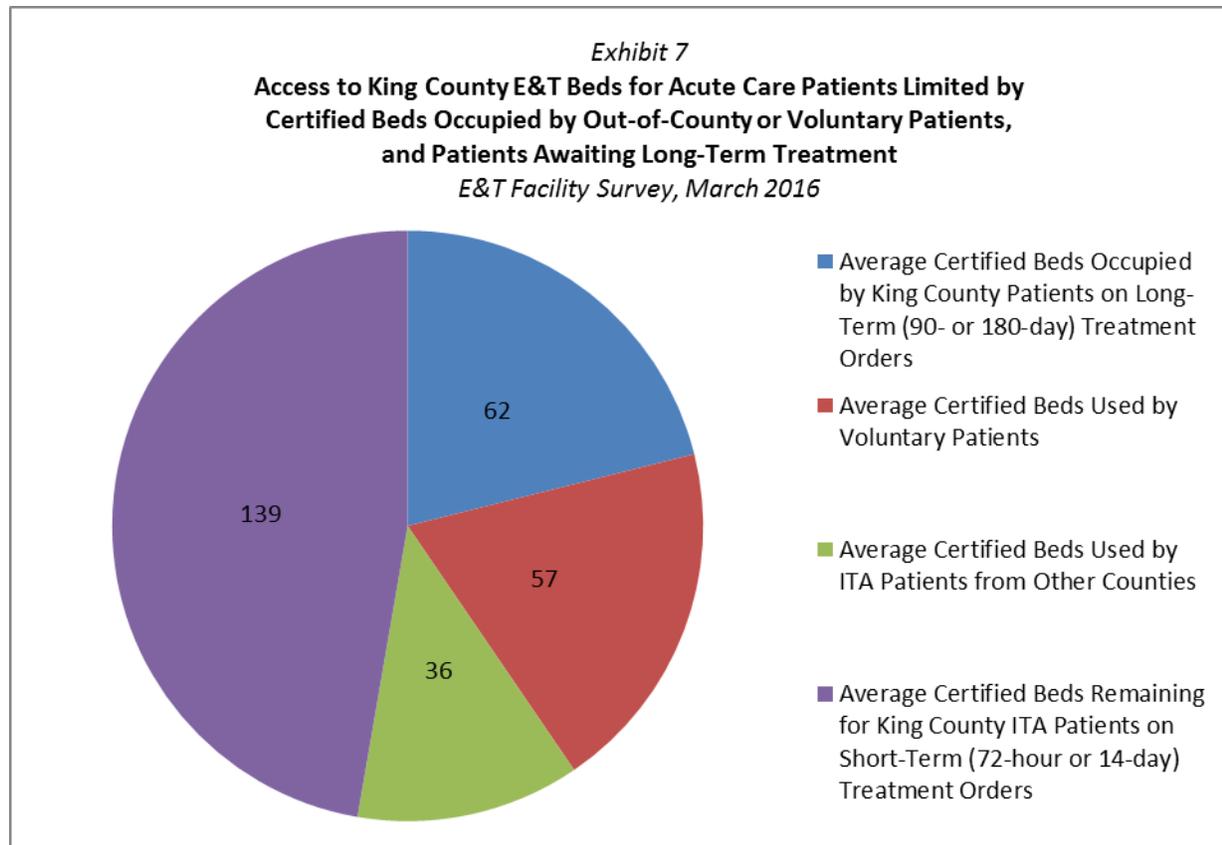
The CABTF periodically surveys E&T facilities in order to determine the number of certified beds available for recently detained King County Involuntary Treatment Act (ITA) patients, as opposed to being occupied by involuntary patients from other counties, voluntary patients, or patients on 90- or 180-day more restrictive treatment orders (meaning they have been identified by hospitals and courts as in need of a long-term involuntary care setting, often at the state hospital).⁴⁶ This survey provides a realistic count of the actual number of beds available to help place newly detained individuals from King County. It also provides a mechanism to track reports from E&T facilities beginning in late 2015 about increases in the number of patients on long-term more restrictive orders and/or waiting for WSH beds.

As shown in Exhibit 7 on the next page, as of March 2016, on average only 201 out of the 294 certified E&T beds open in King County⁴⁷ (68 percent) are actually occupied by King County short- or long-term ITA patients, with an average of 57 beds serving voluntary patients and 36 used by involuntary patients from other counties. The survey further revealed that on average 62 acute care ITA beds – or 31 percent of the 201 beds that facilities reported were typically available for King County ITA patients – were occupied by local patients on more restrictive long-term orders, up somewhat from 54 beds (26 percent of King County involuntary patient beds) in November 2015 when this systemwide data was first gathered.

Of these, facilities reported in March 2016 that on average 38 beds were occupied by people who were either on the WSH waiting list or pending approval for the WSH wait list, with others waiting for other scarce placement options including beds administered by Home and Community Services. Though the WSH wait list total in spring 2016 was similar to the 37 patients waiting for WSH in the earlier November 2015 survey, it represented a lower percentage of the growing number of patients on long-term orders.

⁴⁶ Some beds that are certified for involuntary treatment at E&Ts are occupied by voluntary patients, who have not been committed under the ITA, and some are occupied by patients from other counties. Hospital-based beds and freestanding E&Ts other than Navos, which contracts directly with King County, are treated as a regional resource accessible across county lines. Furthermore, most King County E&T facilities have operated at or near capacity on a daily basis for several years.

⁴⁷ All data described in this paragraph and the next one are drawn from King County Behavioral Health and Recovery Division (BHRD) surveys of evaluation and treatment (E&T) facilities, November 2015 and March 2016. There is some expected variation in the total number of certified beds online at King County E&T facilities at different points in time. For example, when this survey was conducted in November 2015, facilities reported a total of 305 beds online with 208 available for King County involuntary patients. One notable factor in the change in availability was the decision of King County's largest E&T, Fairfax Hospital, to temporarily close one of its units, designed for individuals with more intensive needs, due to concerns about patient acuity and staff safety related to staffing challenges. In November 2015, Fairfax Hospital reported that it was working strategically to restore these beds, but a 20-bed unit at the facility remained closed as of April 2016.



Because access to the state hospital has been so severely restricted, there are anecdotal indications that some E&T providers may now be more often seeking to discharge individuals on long-term orders, or not attempting to secure long-term treatment orders at the end of patients' 14-day commitment periods, rather than referring them for the WSH wait list, even in cases where WSH may be a clinically appropriate placement.

As a result of all of these factors, local E&Ts' capacity to admit and treat new King County patients has been significantly reduced. As a result, like E&Ts seeking fewer long-term orders and pursuing WSH placement at a reduced rate, community hospitals serving people on SBCs at times continue to hold patients themselves without making referrals to E&Ts due to their low level of confidence that a bed will be available. This can result in less stable patients being discharged to the community sooner than they would be in a fully resourced system, sometimes without strong enough transition plans to succeed and avoid returning to the hospital.

Corresponding Increase in Single Bed Certification Use

As noted on page 22, when an E&T bed cannot be located immediately, King County patients are placed on SBCs in community hospital settings, where timely and appropriate – but not optimal – psychiatric care must be provided in accordance with state law and the *D.W.* ruling. This approach to care, although legal, is almost never the best way to meet the patient's care needs, so the treating hospital and the county-contracted patient placement team continue to work together to locate and arrange the desired placement in an E&T facility as soon as possible.

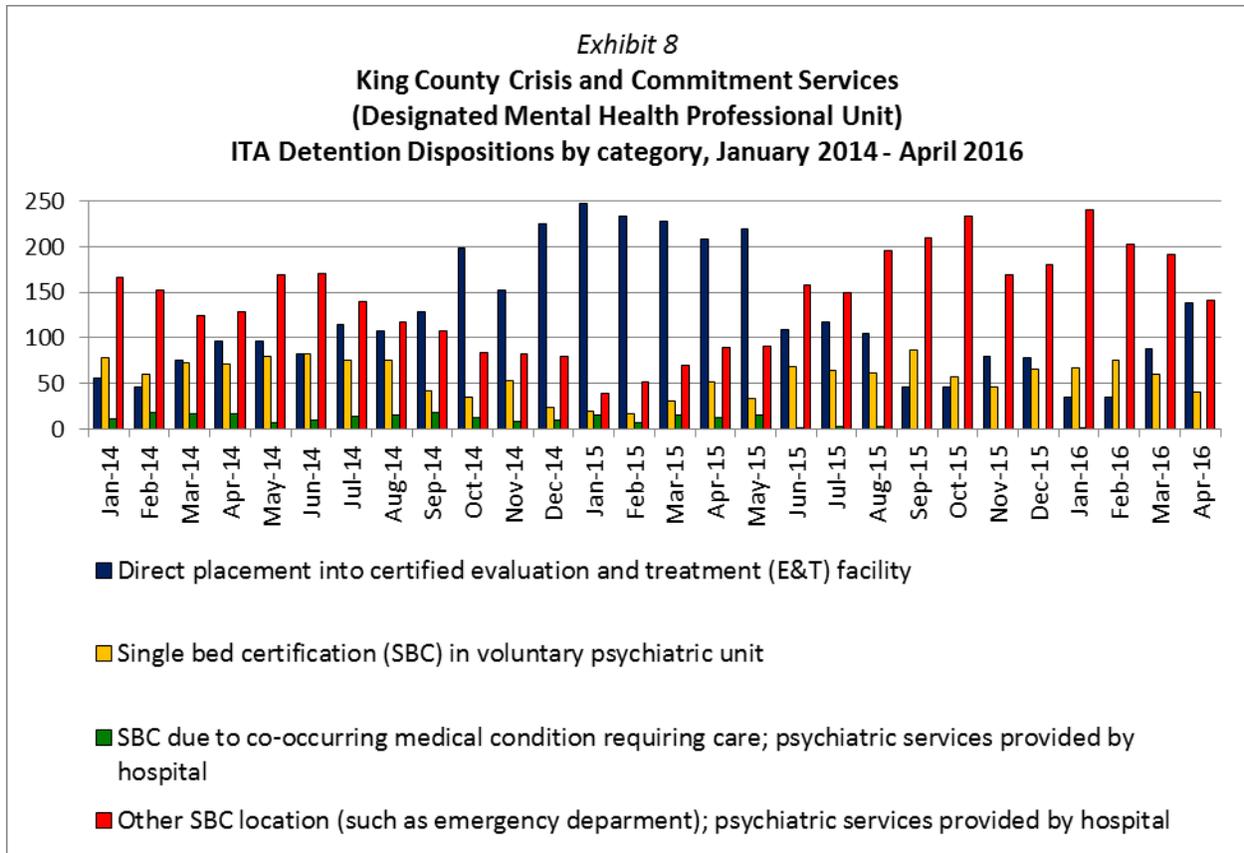


Exhibit 8 shows the complete history of direct E&T placement and SBC use on a monthly basis since January 2014. Early in the CABTF’s work, between October 2014 and May 2015, there was a period of great success – denoted by the significant rise in the blue bars in the chart during that time. Significant local innovation and the launch of new specialized resources contributed to this improvement, as described beginning on page 50.

But SBC use in King County has risen again, despite the fact that there was no change in the detention rate for local designated mental health professionals (DMHPs). The timing of the recurrence of increasing SBC use in King County corresponds exactly with the escalation in the number of people waiting for WSH beds: both started in June 2015.

As noted on page 28, more individuals have been waiting in King County’s E&Ts for beds at WSH – despite having been identified by local inpatient providers and courts as in need of long-term treatment at the state hospital. As a result, there has been less space in E&T facilities to accommodate individuals in the community or in emergency departments (EDs) who need emergency and acute E&T services.

Patients who would be treated at WSH if a bed were available are instead treated on an involuntary basis in local settings, including E&Ts and community hospitals. Based on the typical length of an acute care stay as compared to the average length of the WSH wait list, each patient waiting in an acute care bed for access to long-term care at WSH currently prevents two to three emergency or acute patients from getting needed care in a certified E&T program.

The Current State: The Crisis of Treatment Access Has Recurred

Even though legal compliance remains a systemwide commitment and detained patients are receiving better care in non-preferred settings than they did before the *D.W.* ruling, remarkable but fragile gains in direct access to E&T care from late 2014 and early 2015 have been eroded by a series of barriers causing delays in securing access to state hospital beds.

As a result of ongoing concerted problem solving by the CABTF and other system partners, the current situation is significantly better than it would be otherwise, but an unavoidable fact remains: the inpatient psychiatric treatment access crisis has recurred.

Other systemic developments, including an industrywide behavioral health workforce shortage, have contributed significantly to this current reality. At the same time, transformative changes within Washington's behavioral health system present many exciting opportunities to improve care at all levels through innovative system design and financing, as do opportunities for behavioral health system improvements resulting from new legislative policies and investments in 2015 and 2016.

The next three sections outline these current larger contextual factors, before the specific innovations and recommendations of the CABTF are described.

The Public Behavioral Health Workforce Shortage

As described in the previous section, one of the major drivers of access challenges at Western State Hospital (WSH) is an enduring and widespread workforce shortage that is creating challenges with maintaining patient and staff safety and effective treatment.

Though shortages are quite acute at the state hospital, the workforce crisis crosses all levels of care. Insufficient recruitment and retention of qualified behavioral health workers is also presenting significant problems for community providers and local hospitals, and the problem is getting worse. It is a concern of providers and public behavioral health systems both nationally and in Washington State, where it has been a focus of attention for the Adult Behavioral Health System Task Force Workforce Development Workgroup,⁴⁸ the Washington Community Mental Health Council,⁴⁹ and the Washington State Hospital Association.⁵⁰

Factors that Contribute to the Behavioral Health Workforce Shortage

A confluence of competing factors is contributing to the behavioral health workforce crisis. Studies of the situation in Washington have found that there is now a greater awareness of behavioral health needs among human service providers, faith communities, medical providers, and housing providers; an aging population coping with chronic conditions including mental health and substance abuse issues; and greater attention to the behavioral health needs of veterans. Also, there is increasing need for workers with multiple credentials in order to serve clients who have multiple behavioral health treatment needs or who are receiving care in integrated care settings. At the same time, many longtime behavioral health professionals are retiring or nearing retirement, and fewer younger workers are seeking a career in human services, leading to significant competition in the labor market.⁵¹

This has an especially large effect on the community behavioral health system. Trained, licensed, and qualified staff are difficult to find and/or retain in community provider organizations, as they are recruited away by entities like the Veteran's Administration and private health care systems that can pay more and/or forgive student loans. It is also difficult to recruit psychiatrists, nurse practitioners, and nurses to public sector behavioral health due to a small candidate pool and challenges in offering competitive salaries. The behavioral health workforce, particularly in public sector settings, also experiences high turnover due, in part, to burn out, stress, and lack of social support. Ongoing reductions in funding for public behavioral health also contribute to staff turnover and recruitment challenges.

⁴⁸ Excerpt from the 2SSB 5732 Report to the Governor and Legislature. (June 2014). Presented to Adult Behavioral Health System Task Force, July 24, 2015. Retrieved from <https://app.leg.wa.gov/CMD/Handler.ashx?MethodName=getdocumentcontent&documentId=SaPxhsSWbJM&att=false>.

⁴⁹ Christian, A. (July 24, 2015). Washington Community Mental Health Council: Adult Behavioral Health System Task Force 7/24/15, The Community Behavioral Health Workforce. Retrieved from <https://app.leg.wa.gov/CMD/Handler.ashx?MethodName=getdocumentcontent&documentId=rvfuBcZu20w&att=false>.

⁵⁰ Whiteaker, C. (July 24, 2015). Washington State Hospital Association: The Behavioral Health Workforce in Washington State, Adult Behavioral Health System Task Force 7/24/15. Retrieved from <https://app.leg.wa.gov/CMD/Handler.ashx?MethodName=getdocumentcontent&documentId=W9HEpD6ldfA&att=false>.

⁵¹ Christian, A. (July 24, 2015). Washington Community Mental Health Council: Adult Behavioral Health System Task Force 7/24/15, The Community Behavioral Health Workforce. Retrieved from <https://app.leg.wa.gov/CMD/Handler.ashx?MethodName=getdocumentcontent&documentId=rvfuBcZu20w&att=false>.

This increases the likelihood that people will require inpatient care, as it is difficult to maintain therapeutic relationships and implement evidence-based practices when clinicians do not stay at agencies to work with clients over time. Furthermore, staffing vacancies in outpatient settings make it difficult for patients to access services, leading individuals to seek care in emergency departments (EDs).

Most studies of this issue at the state level cite low core Medicaid and non-Medicaid payment rates as key driving factors in workforce challenges. Nonprofit community behavioral health providers often report that low rates directly impact their ability to recruit and retain qualified staff, since hospitals, for-profit organizations, private practice settings, and governments are often able to offer higher compensation, richer benefits, or both. Low payment rates contribute to higher caseloads in two ways:

- Providers are unable to retain staff over the long term, leading to a reduction in the typical skill level of staff due to a relative lack of experience; and
- Vacant staffing positions lead to distribution of cases to other case managers, swelling their caseloads with clients with whom they may not be as familiar.

Larger caseloads can diminish the services offered to a given person in treatment, which in turn contributes to less prevention and early intervention, more people seeking care at EDs, and more people being hospitalized, rather than being served in the community.

Increasing Demand for Behavioral Health Care and a Qualified Workforce

As Medicaid expansion continues to provide coverage for more previously uninsured individuals and families thanks to the Patient Protection and Affordable Care Act (ACA) of 2010, and behavioral health screening in primary care settings also helps identify new potential clients, more people are receiving behavioral health supports earlier, before they are in crisis – a welcome development. However, a corresponding increase in community mental health and substance abuse service demand follows, which must be met by a qualified workforce.⁵²

Locally, King County actively promoted Medicaid enrollment around the onset of Medicaid expansion in January 2014. Meanwhile, providers and King County have engaged in proactive investment and planning since the beginning of 2014 to meet the expected service need, but the ability to respond to community behavioral health needs continues to be limited by available staff and funding.

A larger service-eligible population, combined with Washington's core rates existing at very low levels, results in providers being challenged to serve more people who are entitled to services without the adequate resources to do so. These factors have perpetuated the trend of higher caseloads and, as a result, less service provided (on average) to each client, which in turn reduces client satisfaction and increases employee burnout and turnover.

To explore the nature and extent of workforce challenges in its own outpatient system, the King County Department of Community and Human Services (DCHS) surveyed behavioral health provider agencies in early fall 2015 about recruitment and retention issues.⁵³ Of 29 responding agencies, 23 had vacant clinical positions, most often for four to seven weeks but some for 15 or more weeks. Most of the vacant positions were for psychiatrists, advanced registered nurse practitioners (ARNPs), or counseling

⁵² Hyde, P.S. (January 24, 2013). U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration (SAMHSA) Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues. Retrieved from <https://store.samhsa.gov/shin/content/PEP13-RTC-BHWORK/PEP13-RTC-BHWORK.pdf>.

⁵³ Workforce Shortage Survey, King County DCHS, September 28 through November 2, 2015.

staff. Over 80 percent of responding agencies reported that they lost employees to programs that offered better pay or benefits.

Despite continued low per capita rates from the state, King County has worked within limited available funding to help mental health providers respond to these recruitment and retention problems as well as the 27 percent increase between 2013 and 2015 in the number of Medicaid clients they were serving after the implementation of the ACA.⁵⁴ Specifically, local provider agencies received two permanent rate increases in 2015 totaling just over 11 percent, after receiving no rate increases at all since 2007. However, this rate still falls well short of the rising cost of living in King County, which has gone up 22 percent during that same eight-year period.⁵⁵ Most providers used these funds to boost compensation for direct service clinical staff, or to hire additional staff to meet community needs and decrease caseloads,⁵⁶ although the rate increase still fell well short of the system's needs.

System Improvements Depend on an Available Workforce

With workforce challenges a consistent undercurrent that must be addressed to support implementation, a number of broad systemic change processes are under way in Washington and locally. These hold promise for improvements to care, and place the CABTF's recommendations and potential innovations in context. They are discussed in the following section.

⁵⁴ King County Mental Health Plan Report Card, Second Quarter 2015.

⁵⁵ King County Office of Economic and Financial Analysis (OEFA), based on multiple regional economic factors.

⁵⁶ King County Behavioral Health and Recovery Division (BHRD) provider survey, December 2015 and January 2016.

Engagement with Broad System Change Processes

A number of significant system change initiatives under way at the state level and locally are helping to shape the evolving policy environment to address the needs of individuals currently affected by the involuntary psychiatric treatment system, while also strengthening the behavioral health system at all levels.

The CABTF endeavors to leverage existing system change processes and special local resources, and initiate other focused collaborations, in order to improve care quality and efficiency and promote innovation across the behavioral health system.

In order to reduce the number of people in King County who are detained for involuntary psychiatric treatment, the CABTF is working to ensure that adequate, easily accessible resources exist across the community for early diagnosis, early intervention, and necessary treatment and supports for ongoing recovery. To do this, a behavioral health system must promote the health and well-being of all residents and result in a significant reduction in the number of residents experiencing psychiatric crisis.

As a result of the Federal Patient Protection and Affordable Care Act of 2010 (ACA), health care reform has taken hold in the State of Washington, including Medicaid expansion and various forms of delivery system redesign. Key initiatives already in progress have the potential to enable King County to achieve population-based health system improvements that will benefit the CABTF's target population. Alongside these broader policy processes are unique local resources that can help King County bring to fruition a more complete service continuum, including prevention, early intervention, diversion, and crisis resources.

These initiatives also ground in a system context the specific recommended programs, strategies, and policy changes that are identified beginning on page 65.

Healthier Washington

The State Health Care Innovation Plan, called Healthier Washington, is supported by foundational legislation signed by Governor Jay Inslee in 2014 and a \$64 million federal grant from the Center for Medicare and Medicaid Innovation. The goals of Healthier Washington are to:

- Build healthier communities and people through prevention and early attention to disease;
- Integrate care and social supports for individuals who have both behavioral and physical health needs; and
- Reward quality health care over quantity, with the state government leading by example as Washington's largest purchaser of health care.

As Healthier Washington is operationalized, the CABTF supports payment mechanisms and incentives that prioritize value over volume, while giving significant weight to social determinants of health. This could include seeking ways to base reimbursement more on outcomes than utilization, or including incentives for helping individuals to graduate to less intensive levels of care. The CABTF also supports assuring that the statewide common core set of measures evolves to include, track, and make use of meaningful behavioral health system measures.

Global Medicaid Waiver

In August 2015, the Washington State Health Care Authority (HCA) submitted a proposal to the Centers for Medicare and Medicaid Services (CMS) in the U.S. Department of Health and Human Services that would allow our state additional flexibility in how we spend Apple Health (Medicaid) funds to help ensure better health for Medicaid clients. If approved, the waiver would provide additional support in achieving the goals of Healthier Washington.

The waiver application has four goals:

- Reduce avoidable use of intensive, high-cost services, such as acute care hospitals, psychiatric hospitals, and nursing home facilities.
- Improve population health, with a focus on prevention and proactive management of diabetes and cardiovascular disease, pediatric obesity, smoking, mental illness, and substance abuse for Apple Health clients.
- Accelerate Medicaid payment reform to pay providers for better health outcomes.
- Bend the Medicaid cost curve by 2 percentage points below the national trend.

The waiver, if approved, includes a Medicaid supported housing and supported employment benefit for people who are most at risk. The application notes that housing and employment are two key social determinants of health and that both are strongly linked to improved quality of life and lower health care costs. King County currently provides supported housing and employment services through multiple funding sources and community partnerships. A defined Medicaid benefit would stabilize these services and support recovery for people with behavioral health challenges. This waiver opportunity may present a chance to promote and disseminate low-barrier, harm reduction-oriented Housing First approaches throughout King County's service systems.

At the time of this writing, the state was still negotiating with CMS, with discussions focused on financing questions related to the federal requirement to maintain cost neutrality, as there was general agreement on the state's vision and programmatic approach.⁵⁷

Accountable Communities of Health

The Medicaid waiver proposal, if granted, would also allow for greater flexibility in how the health care delivery system is transformed to better meet the needs of residents. The Healthier Washington proposal recognizes and leverages innovation and collaboration already occurring in local communities by bringing public and private entities together to work on shared health goals via Accountable Communities of Health (ACHs). ACHs play integral roles in both the proposed waiver and Healthier Washington. Specifically, ACHs will:

- Establish collaborative decision-making on a regional basis to improve health and health systems, focusing on social determinants of health, clinical-community linkages, and whole person care.
- Bring together all sectors that contribute to health in order to develop shared priorities and strategies for population health, including improved delivery systems, coordinated initiatives, and support for value-based payment models.

⁵⁷ Medicaid Transformation Update, April 1, 2016. http://www.hca.wa.gov/hw/Pages/medicaid_transformation.aspx.

- Supporting physical and behavioral health care integration, including financing and delivery system adjustments, starting with Medicaid.

The CABTF looks to the work of the King County ACH as an opportunity to provide local oversight and support for funding flexibility to launch and sustain innovative and coordinated care models that have a potential for significant impacts on system resource utilization.

Physical and Behavioral Health Integration Design

In March 2014, the Washington State Legislature passed legislation, Engrossed Second Substitute Senate Bill (E2SSB) 6312, that is fundamentally changing the way Medicaid-funded health services are purchased and delivered in the state. The legislation established integrated purchasing of behavioral health services through a single managed care contract beginning in April 2016, and calls for the full integration of physical health and behavioral health by January 2020.

An overarching goal of physical and behavioral health integration is to ensure more focus on whole-person health, including prevention and early intervention services, which will ultimately lead to fewer crises and reduced pressure on the crisis system. This work represents an opportunity to make front-end investments to reduce episodes of crisis, inpatient hospitalization, and incarceration.

One of the key priorities for the King County ACH is to endorse a model of care for full physical and behavioral health integration that recognizes that new designs working to improve health outcomes must be developed in ways that simultaneously pursue three dimensions: improving population health and well-being; improving the individual experience of care (including quality and satisfaction); and reducing the per capita cost of health care for individuals receiving services.⁵⁸

Physical and behavioral health integration is moving forward under the auspices of King County's Physical and Behavioral Health Integration Design Committee, a formal subgroup of the King County ACH. This committee is responsible for developing a regional model of fully integrated physical and behavioral health for both children and adults.

Behavioral Health Organization Implementation

As a major positive step toward full integration by 2020, King County's Behavioral Health Organization (BHO) launched in April 2016. Integrating mental health and substance use disorder (SUD) services into a single oversight and payment structure will strengthen both treatment systems and support coordination of care for people who receive both SUD and mental health treatment.

King County has a long history of supporting integrated and coordinated treatment and care. Development of the BHO is expected to further these long-term strategies:

- Progress toward the goal of "whole-person" care;
- Increased flexibility in how services are provided, especially for those with SUDs;
- Improved health and social outcomes;
- Improved coordination of care;
- Increased access to co-occurring disorder treatment; and
- Better experiences for clients.

⁵⁸ This "triple aim" of integrated care is reflected in the prioritization criteria used by the CABTF to sort its recommendations, as discussed on page 64.

Challenges with integrating the mental health and SUD treatment systems that affect efforts to integrate behavioral health care include:

- The need for sufficient rates to support a robust treatment system;
- Workforce shortages in all sectors of health care, including behavioral health;
- Data infrastructure needs at the provider level, especially among smaller agencies and SUD providers; and
- The need for a more clearly defined co-occurring disorder service in the Medicaid State Plan that addresses both mental health and SUD treatment needs.

The CABTF supports King County's efforts to give broad-based support to providers undergoing more significant change as a result of BHO implementation, including smaller agencies and SUD providers who are adjusting to new data systems and fundamentally different payment approaches.

Health and Human Services Transformation Plan and Familiar Faces

The King County Health and Human Services Transformation Plan's overall aim is to realize significant gains in health and well-being as a result of collective work to shift from a costly, crisis-oriented response to health and social problems, to a focus on prevention, recovery, and elimination of disparities. Two core approaches of the plan are to move services from silos that are difficult for people to navigate to a coordinated approach that is more efficient and more convenient, and to use data-informed approaches to ensure that the best evidence is being employed to achieve outcomes.⁵⁹

Familiar Faces is one of the "go-first" strategies under the Health and Human Services Transformation Plan. The lives of community members who deal with mental illness, SUDs, and other chronic health conditions, and who are booked into jail multiple times – referred to as Familiar Faces – clearly have complex circumstances to navigate. Equally complex is the web of programs, care plans, and data systems that support these individuals.⁶⁰

Familiar Faces are considered a sentinel population. Given the complexity of needs and high service utilization, the hypothesis is that improvements made to services and supports for these individuals will help to inform system improvements generally.

Familiar Faces, especially those who get caught up in courts' competency evaluation processes, may impact the involuntary commitment system even if they are never hospitalized.⁶¹ Designated mental health professionals (DMHPs) are called upon to evaluate these individuals frequently, and must prioritize responding to the jail over community referrals due to response timeline rules, even if other cases in the community may present greater risk. Jail psychiatric services and release planners also spend a great deal of their time responding to the behavioral health needs of Familiar Faces. Also, although data do not show a high level of inpatient psychiatric utilization for this population, frequent

⁵⁹ Health and Human Services Transformation. Retrieved from <http://www.kingcounty.gov/elected/executive/health-human-services-transformation.aspx>.

⁶⁰ Familiar Faces Initiative. Retrieved from <http://www.kingcounty.gov/elected/executive/health-human-services-transformation/familiar-faces.aspx>.

⁶¹ Some specific aspects of Familiar Faces work received some interest from the CABTF because they were determined by members to be likely to have an impact on crisis and inpatient psychiatric system utilization. The aspects of Familiar Faces endorsed by the CABTF are described in recommendations 4a and 4g on pages 101 and 103.

jail bookings and more time spent behind bars likely suppress their hospital use due to less community tenure and corresponding crisis system contact.⁶²

Dedicated Local Resources

The CABTF recognizes and supports several targeted local investments as means to design a robust system of care specific to King County's unique needs, supplementing core state and federal services by creating or expanding innovative, community-driven programs and services that can prevent or interrupt crises. Such resources should continue to be deployed strategically in order to help address capacity needs in the short term, and also to allocate resources upstream toward early intervention efforts that can reduce the need for involuntary treatment over the long term.

Mental Illness and Drug Dependency (MIDD) Sales Tax

King County's MIDD is a countywide sales tax generating approximately \$60 million per year.⁶³ As required by state legislation,⁶⁴ revenue raised under the MIDD is to be used for certain mental health and SUD services, including King County's therapeutic courts. King County's MIDD was passed by the King County Council in 2007, and MIDD-funded services began in 2008. Unless renewed by the Council, the MIDD will expire on December 31, 2016. King County is one of 23 jurisdictions in Washington State that has authorized this tax revenue.⁶⁵

CABTF recommendations, along with other key stakeholder and community input, were used to inform and scope proposed programs and services for possible funding under a potential MIDD II for 2017 and beyond. The CABTF work has influenced the development of the key components of MIDD renewal planning, including its four overarching strategies:

- Prevention and Early Intervention: People get the help they need to stay healthy and keep problems from escalating.
- Crisis Diversion: People who are in crisis get the help they need to avoid unnecessary hospitalization or incarceration.
- Recovery and Re-entry: People become healthy and safely reintegrate into community after crisis.
- System Improvements: The behavioral health system is strengthened to become more accessible and deliver on outcomes.

MIDD renewal planning included a broad-based community input process, which included an open call for new concepts, facilitated regional community conversations and population-specific focus groups, a wide-ranging survey, and community member review panels of briefing papers on all current programming and new concepts. At the conclusion of this work, early draft recommendations as of spring 2016 included new and continued investments that address access and capacity, treatment on demand, and re-entry services as part of MIDD II's potential package of services across the continuum of care. These recommendations will be considered throughout 2016 by the MIDD Oversight Committee,

⁶² Analysis of 2013 Familiar Faces cohort by the King County Behavioral Health and Recovery Division (BHRD).

⁶³ MIDD Action Plan. Retrieved from <http://www.kingcounty.gov/depts/community-human-services/mental-health-substance-abuse/midd-plan.aspx>.

⁶⁴ Revised Code of Washington (RCW) 82.14.460. Retrieved from <http://apps.leg.wa.gov/RCW/default.aspx?Cite=82.14.460>.

⁶⁵ Tax Distributions – All Locations, Distribution: Table 13 – Sales and Use Tax for Mental Health. Retrieved from <http://www.dor.wa.gov/content/aboutus/statisticsandreports/TID/DistAllResults.aspx?Year=2016&Month=MarApr&Table=13&Format=HTML>.

the King County Executive, and the King County Council, as well as other stakeholders, before finalization.

Veterans and Human Services Levy

The Veterans and Human Services Levy is another local resource that is dedicated in part to addressing the needs of people in behavioral health crisis. Among other priorities, the current levy's Council-adopted 2012-2017 Service Improvement Plan directs investments towards residents who are involved in the homelessness, criminal justice, or emergency medical systems, and families and individuals for whom early intervention can prevent involvement in crisis systems. Levy-funded strategies include outreach, prevention, permanent supportive housing, supported employment, promotion of the integration of medical and behavioral health services, and assistance for families at risk.⁶⁶ The levy includes services for individuals with mental health needs in community health centers; provides home-based services for older adults with mild depression; and provides services for new mothers experiencing postpartum depression. In 2016, the Veterans and Human Services Levy will begin a review process for potential renewal as its current authorization ends in 2017. There will be a community engagement process to identify unmet needs and emerging practices for veterans, their families, and others in need.

Best Starts for Kids Levy

The newest option for funding innovative upstream prevention approaches is the Best Starts for Kids (BSK) levy, authorized for the first time by King County voters in November 2015. This levy is in its early planning stages and is engaged in active coordination with work around MIDD II. Its guiding strategies are to invest early, with half of its funding going to programs for children under age five and pregnant women. Thirty-five percent of BSK dollars will be dedicated to strategies that help sustain gains achieved through these early intervention programs by supporting children and youth ages 5-24 and focusing on key developmental stages and transition points. Ten percent of funds will support the Health and Human Services Transformation Plan's Communities of Opportunity strategy, which aims to help create safe and healthy communities in accordance with research on the impact of place on a child's success. Five percent of the revenue will support evaluation, data collection, and improving the delivery of services and programs for children and youth, to ensure that BSK strategies are tailored for children from every background and deliver on results for every child in King County.⁶⁷

Other System Change Processes

In addition to the change efforts discussed above, CABTF also identified linkages to allied or related local and statewide groups with which members either had direct involvement or significant knowledge and access – among these are the statewide Adult Behavioral Health System Task Force, the Association of County Human Services, and the Speaker's Mental Health Task Force. Members brought the CABTF's work and recommendations to those groups, and kept other CABTF members updated about significant developments or opportunities as they arose in those venues. The CABTF remains committed to working in partnership and coordination with other groups and stakeholders undertaking related efforts.

⁶⁶ Veterans and Human Services Levy Service Improvement Plan 2012-2017. Retrieved from <http://www.kingcounty.gov/operations/DCHS/Services/Levy/ServiceImprovementPlan.aspx>.

⁶⁷ BSK. Retrieved from <http://www.kingcounty.gov/elected/executive/constantine/initiatives/best-starts-for-kids.aspx>.

Among other benefits, this placed CABTF members in a position to have significant influence with policymakers as they developed new legislation aimed at improving the mental health system, as described in the next section.

Key Results from the 2015 and 2016 Legislative Sessions

The state legislative sessions in 2015 and 2016 included an unprecedented amount of activity on issues of interest to the CABTF. A number of strategic investments were made, important Involuntary Treatment Act (ITA) policy passed, and reform legislation was adopted to shape efforts to address emerging state hospital access and safety issues. In this section, the CABTF examines select outcomes from the 2015 and 2016 legislative sessions that were most relevant to its work.

In 2015, major new investments were made, especially to support the inpatient mental health system, although the benefits of these dollars to King County have been only partially realized to date. Several capital projects are still in the formative phases, and as of early 2016, the state still had not paid out many operating funds, due in some cases to complex reimbursement procedures. These capital investments related to civil commitment were in addition to the state's major investments already underway to improve access to forensic evaluations and related services in response to a separate ruling by a federal court, commonly known as *Trueblood*,⁶⁸ and to address state hospital safety and staffing issues.

However, state budget results were more mixed regarding support for community-based care services that provides opportunities to intervene earlier before individuals are in crisis. Flexible funding streams that support critical community-based resources, including potential diversion and discharge options, were reduced significantly in 2015, and then held steady at those reduced levels in 2016 while some specific new targeted diversion funding was made available. In addition, several notable policy bills brought new funds to communities – intended to implement changes to the ITA. These were designed to ease access to involuntary treatment, including an involuntary outpatient option and an integrated civil commitment approach that addresses risks arising from substance abuse. Other policy legislation promoted a broad range of reforms at the state hospital and aimed to explore significant structural and utilization management changes.

Specific outcomes from the 2015 and 2016 session, including available information to date about implementation, are summarized below.

Significant New Operating and Capital Budget Investments in 2015 and 2016

Specific Capital Projects to Increase Community Inpatient Psychiatric Capacity in King County

As part of an overall statewide capital investment of nearly \$36 million for behavioral health projects, the 2015 state legislative session's capital budget included \$8 million specifically designated for community inpatient psychiatric facilities in King County. This investment includes \$5 million for the Woodmont/Kent⁶⁹ facility (under development by Valley Cities Behavioral Health Care) and \$3 million for the Swedish Ballard site, where a psychiatric unit for individuals with co-occurring medical conditions

⁶⁸ Civil commitment is based on certain standards of risk of harm, as described in Revised Code of Washington (RCW) 71.05 or RCW 71.34, and does not involve criminal charges. The 2014 *In re the Detention of D.W. et al* ruling, which precipitated the formation of the CABTF and helped to define the group's scope of work, pertained to access to care for civilly committed individuals. By contrast, the 2015 *Trueblood* ruling focused on access to evaluations and restoration treatment for individuals who may be deemed incompetent to stand trial for criminal charges under RCW 10.77. The *Trueblood* ruling and related policy legislation is described later in this section.

⁶⁹ When siting challenges later in 2015 caused the services originally slated for Woodmont to be relocated to Kent, the legislature switched this investment accordingly during the 2016 session so the funding could follow the project.

is being built. Please see page 58 for more detail about these and other forthcoming inpatient capacity increases.

Capital Funding Pool for State Hospital Diversion including Community Bed Capacity

In the 2016 session, the legislature's capital investment in community behavioral health bed capacity expanded further via a \$12.4 million statewide increase. The bulk of these funds, \$7.6 million, were designated specifically for state hospital diversion projects, and may include funding for development of community inpatient and evaluation and treatment (E&T) capacity, crisis triage and stabilization facilities, secure detoxification facilities, co-occurring treatment facilities, or other transitional facilities that provide for the diversion or transition of state hospital patients.⁷⁰ In addition, new funding was added to a competitive grant program for behavioral health beds that had been launched the previous year. Unlike 2015, however, none of 2016's new funding was earmarked for King County projects specifically.

Major Appropriation but Slow Reimbursement for Increased Inpatient Utilization (Single Bed Certification Funds)

The final biennial budget adopted at the end of the 2015 session included \$48.3 million statewide for increases in inpatient psychiatric treatment costs as compared to state fiscal year 2014 that were associated with implementation of involuntary treatment under the ITA. The dollars from the 2015 session were commonly referenced in state budget summary documents and by Department of Social and Health Services (DSHS) officials as "Single Bed Certification (SBC) funds," indicating that the intent of these resources was to help the state come into compliance with the Supreme Court's *D.W.* ruling and to maintain these improvements. This funding, the largest new behavioral health investment in the 2015 budget, was specifically designated for expenditures in the most acute and expensive settings.

This significant investment in the acute care system, which accompanied a statewide emergency fund allocation by the Governor of \$30 million in late 2014, has been released more slowly than expected to local communities as the state's cost demonstration requirements have been rolled out and implemented. In fact, King County has billed \$5.1 million so far and is still awaiting its first payment, after which it expects to invoice the state for several million dollars more to receive reimbursement for eligible non-Medicaid expenditures. As a result of this early delay in distribution of funds, the 2016 state legislature removed \$4.4 million of this funding, reducing the total investment to \$43.9 million for the biennium.

Behavioral Health Innovation Fund

In 2016, the legislature created a \$6.8 million Behavioral Health Innovation Fund as an operating budget commitment to its new state hospital reform policy which focused on improving quality of care, patient and staff safety, and efficiency of operations. Although many of these dollars may be allocated for improvements within the state hospital, some funding may be available to help underwrite community-based programs that aim to move some state hospital patients back to their home communities and treat them locally. Working with the CABTF and its state partners, King County hopes to explore the possibility of piloting such a program locally, as discussed in priority 1c on page 77.

⁷⁰ http://leap.leg.wa.gov/leap/Budget/Detail/2016/CCBill_0328.pdf, section 1007.

Other Targeted Diversion Investments

In addition, the 2016 supplemental operating budget included modest targeted investments in certain categories of special interest to the CABTF, including expanding and enhancing mobile crisis teams (MCTs) (\$2.9 million statewide), adding peer bridgers to state hospital discharge planning teams (\$1.8 million statewide⁷¹), and establishing housing and recovery support teams to assist with diversion and discharge from inpatient behavioral health treatment (\$2.8 million statewide). Based on information available from the state at the time of this report, a portion of the funding from each of these three service expansion efforts was expected to come to King County, although implementation details were not yet known.

Notable Reductions to Important Funding Streams for Community Care

Medicaid Rate Reduction

Core Medicaid mental health rates – which determine the amount of funding that is provided to community agencies to deliver outpatient care and other essential services – were lowered to the lowest actuarially permitted level statewide as part of the 2015 budget negotiations, with biennial reductions totaling \$33 million total statewide. Although the effect of this action on King County is modest in comparison to other parts of the state because King County's rates were already near the lower limit,⁷² it further restricts the ability of behavioral health providers to respond to increasing demand for services, and curtails their ability to respond to market conditions that make it difficult to recruit and retain staff.

New combined behavioral health rates associated with the launch of behavioral health organizations (BHOs) in April 2016 did result in some helpful rate increases, but these rates still fall well short of the cost of providing essential services and making community behavioral health agencies competitive in the employment marketplace. Core rates and their impact are described at length on page 33 and in the discussion of priority 1d on page 79.

Deeper Reductions to Flexible Non-Medicaid Funds

Yet another statewide reduction of \$7.7 million in flexible non-Medicaid mental health funding in 2015 further eroded the most critical fund source available to address crisis needs and divert people from inpatient care. In addition, a change to the distribution formula made it so these reductions struck King County more deeply than other communities. These essential funds have been gradually reduced in recent years to unprecedentedly low levels. As shown in Exhibit 3 on page 17, across the state, 34 percent less flexible non-Medicaid mental health funding per year is available now as compared to just eight years ago.⁷³ This cut was left in place in 2016, but no further reductions were made.

⁷¹ Block grant funds were reallocated from other purposes to support state hospital peer bridgers.

⁷² The size of payments from the State to a BHO like King County for Medicaid-reimbursable mental health services is determined by two factors: (1) an actuarially determined "rate range," within which every BHO's rate must fall (this has typically varied between communities based on local conditions), and (2) the number of people in that community who are eligible for Medicaid. A BHO's Medicaid funding is determined by multiplying that BHO's assigned rate (within the allowable range) by the number of Medicaid-eligible people in that community. Unlike many other BHOs, King County's rate has been set near the bottom of the allowable rate range for many years. This meant that the legislature's 2015 decision to bring all Medicaid rates to the bottom of the allowed rate range affected other BHOs much more significantly than King County, although it still is projected to cost King County about \$800,000 over the 2015-17 state fiscal biennium.

⁷³ Legislative Evaluation and Accountability Program Committee. Enacted Budget Bills, 2008-2015, Mental Health Program sections (204), retrieved from http://leap.leg.wa.gov/leap/budget/index_lbns.asp.

King County is already making progress in mitigating these cuts by seeking new opportunities to shift services to Medicaid whenever possible, but these funds remain critical to support flexible services that support people in the community and help them avoid involuntary treatment. As discussed on page 65, reversing the continuing reduction of this funding, and supporting access to other essential flexible sources, is a fundamental value of the CABTF that underpins the system improvement recommendations articulated later in this report.

Program for Adaptive Living Skills Funding Eliminated

Historically, \$10.4 million statewide per biennium – \$3.5 million in King County – was allocated for specially tailored services to stabilize high-risk clients who have committed serious offenses such as arson, sex offenses, and murder, who no longer need or can benefit from state hospital services but who do need intensive supports to remain safe in the community. These funds were eliminated by the legislature in 2015, but specialized services are still needed for this population to obtain the care they need and avoid a return to the state hospital or prison, as discussed in recommendation 3b on page 96.

Major Policy Legislation Passed in 2015

Engrossed Second Substitute House Bill (E2SHB) 1450: Assisted outpatient mental health treatment

This law, which went into effect in July 2015, created a new commitment category in state statute called assisted outpatient mental health treatment (AOT). This category is for individuals who have been hospitalized at least twice in a three-year period and meet certain other conditions.⁷⁴ Individuals found to meet the standard for assisted outpatient mental health treatment must participate in an outpatient evaluation and may be ordered for subsequent periods of outpatient treatment that align in duration with the existing ITA, but cannot be ordered to inpatient hospitalization.

Significantly, this legislation also modified involuntary treatment act provisions governing not only assisted outpatient mental health treatment but also other forms of less restrictive alternative (LRA) treatment orders.⁷⁵ It created a complex but clinically flexible new modification/revocation system, to be applied to all LRA treatment orders AOT, and prescribed a range of treatment plan elements for all LRA treatment orders, including access to a care coordinator with specified duties. As refined by 2016's Substitute House Bill (SHB) 2541, the policy also instituted new mechanisms to support court oversight of the services provided on such orders. This legislation has the potential to make less restrictive treatment more robust across the state.

In the 2015 budget, this bill was supported with \$18.7 million statewide in new funds. King County and the CABTF look forward to the implementation of new resources, possibly including expedited outpatient evaluation, to enable effective implementation of assisted outpatient mental health treatment in this community as an alternative to inpatient care for some individuals, a way to provide for earlier intervention for others, and as a mechanism to strengthen LRA services.

Despite designated mental health professionals' (DMHPs') enthusiasm to start using this option, rollout of the policy has been slower than expected statewide, as the state contract that will guide assisted

⁷⁴ The conditions for AOT are described in Revised Code of Washington (RCW) 71.05.020(21).

⁷⁵ "A less restrictive alternative is outpatient treatment provided to an individual who meets criteria for [involuntary] commitment but is not residing in a facility providing inpatient treatment. If the court finds that the individual meets the criteria for [involuntary] commitment, the court can either authorize commitment of the individual for inpatient treatment or for a less restrictive alternative treatment. Release under a less restrictive alternative is subject to conditions set by the court." Retrieved from <https://www.dshs.wa.gov/faq/what-less-restrictive-alternative-lra>.

outpatient mental health treatment implementation by BHOs was only recently finalized. In alignment with state guidance, King County has issued a preliminary implementation plan to the state to pay an enhanced rate to agencies that accept individuals on AOT/LRA orders and provide them with a high-intensity service, including the availability of multiple contacts per week when clinically indicated.⁷⁶

Second Engrossed Second Substitute Senate Bill (2E2SSB) 5177 and Substitute Senate Bill (SSB) 5889: Timeliness of competency evaluation and restoration services

Bills 2E2SSB 5177 (effective August 2015) and SSB 5889 (effective July 2015) together sought to address the state's delays in competency evaluation and/or subsequent competency restoration treatment⁷⁷ for individuals who may be incompetent to stand trial, as addressed by the U.S. District Court's April 2015 ruling in the *Trueblood* lawsuit.⁷⁸

Specifically, SSB 5889 attempted to address related state hospital capacity issues by funding 60 new forensic beds, as well as competency evaluators at state-operated facilities, including most notably Western State Hospital's (WSH's) Center for Forensic Services facility (which operates separately from the civil part of hospital). Maximum time limits by which competency evaluations must be completed and state hospital admission provided were set by SSB 5889. Implementation of some of these behavioral health system assets has been delayed alongside other planned state hospital changes, as described in detail later in this report.⁷⁹

A partner policy, 2E2SSB 5177, provided funding and a policy framework for the potential role of local communities in conducting competency restoration in locations other than state hospitals, including outpatient settings and/or jails, and implementing prosecutorial diversion strategies. State officials are consulting with local workgroups, including groups in King County that include CABTF members, as they consider how the funds will be distributed. This policy received \$2.8 million in initial funding statewide, but \$1.1 million was removed in 2016 due to underspending associated with a slowed rollout, leaving a total investment of \$1.7 million for the biennium, of which nearly half was awarded to King County.⁸⁰

Engrossed Second Substitute Senate Bill (E2SSB) 5269: Court review of detention decisions under the ITA (Joel's Law)

"Joel's Law," which went into effect in July 2015, created a formal legal mechanism by which family members, guardians, or conservators can directly petition the ITA Court when a DMHP has decided not to detain an adult, or when a DMHP's investigation is not completed within 48 hours.

Multiple members of the CABTF worked together with other state and local partners to design implementation procedures for this new law for the King County ITA Court and King County's DMHP unit. One key approach King County has adopted is proactively educating concerned family members and the general public, not only about their rights under E2SSB 5269, but also the opportunities they

⁷⁶ King County Behavioral Health Organization E2SHB 1450 AOT and LRA Implementation Plan.

⁷⁷ RCW 10.77.

⁷⁸ *Trueblood v. WA State Dept. of Social and Health Serv.* Case C14-1178 MJP. U.S. District Court, Western District of Washington at Seattle. Retrieved from <http://www.disabilityrightswa.org/sites/default/files/uploads/AB%20Jail%20Delay%20Court%20Order.pdf>.

⁷⁹ Reyes, C. (November 19, 2015). Civil Commitment and Forensic Mental Health Legislation – Updates: House Judiciary Committee. Retrieved from <https://app.leg.wa.gov/CMD/Handler.ashx?MethodName=getdocumentcontent&documentId=SvUlsA9a8sl&att=false>.

⁸⁰ King County was notified in March 2016 of an award of \$791,854 in 2E2SSB 5177 funds for a pilot project to divert from prosecution individuals with behavioral health disorders who have committed misdemeanors and less serious felonies. The pilot will serve approximately 50 individuals and will be based out of the King County Regional Mental Health Court.

have to re-refer an individual to the DMHPs for a new evaluation when his or her circumstances change. Perhaps in part due to this effort to educate and divert when legally appropriate, as of the writing of this report, there have been relatively few Joel's Law cases (family member appeals to the court) to date in King County.

It is notable that the new 48-hour timeline for completing investigations of community-based cases presents a new challenge for King County given the many other competing timelines already included in the ITA law. As a result, in King County, state funds related to this law were combined with local dollars to enable the addition of several more DMHP staff.

E2SSB 5649: ITA procedures and timelines

The main aspects of this 2015 law that were of interest to King County and the CABTF were the revisions to both timelines and rules for DMHP responses to hospital-based cases. In particular, DMHPs are now permitted to presume that SBCs will be approved and move on to other cases, and DMHP response time frames to hospitals are adjusted to begin at the point of medical clearance instead of upon arrival at a hospital emergency department (ED), when they may not yet be ready for DMHP evaluation. This permission to presume approval immediately eliminated the SBC approval bottleneck that had existed at WSH prior to the change process implemented by CABTF members during early 2015, discussed in greater detail on page 52. In addition, beginning hospital response timeframes at the point of medical clearance improved King County DMHPs' ability to respond to cases and complete their investigations in time to support the legal procedures of involuntary commitment.

Major Policy Legislation Passed in 2016

Engrossed Substitute Senate Bill (ESSB) 6656: State hospital practices

This new law aims to initiate major reforms in state hospital practices via a number of targeted interventions. First, it establishes a new legislative oversight body for state hospital quality improvement and requires consultants under the direction of this select committee to examine a range of practices with a special focus on discharge planning, models of care, and safety. The bill aims to support strategic changes at the state hospital via the Behavioral Health Innovation Fund referenced above. Finally, the bill mandates the discharge or diversion of a group of patients with long-term care needs from WSH as a means to reduce the overall census. This legislation begins to address some of the state hospital access issues that have profoundly impacted psychiatric bed access and presents opportunities that may relate to several CABTF recommendations. (See also further discussion on pages 26, 78, 93, and 104.)

In addition to the enacted provisions above, Governor Inslee vetoed four sections of the bill that would have set in motion planning for transitioning financial and utilization responsibility for state hospital beds to BHOs; outlined certain specific uses for the Behavioral Health Innovation Fund including community alternatives; required expedited implementation of several new state hospital policies; and created a new job classification for mid-level medical professionals at the state hospital. The message that accompanied the Governor's partial veto indicated broad support for the goals of these sections, but sought to allow consultant work and collective bargaining rules to inform decisions in these areas.

Engrossed Third Substitute House Bill (E3SHB) 1713: Integrating the involuntary treatment systems for mental health and substance abuse

This important legislation sets a course for phased integration of mental health and substance abuse involuntary commitment processes and launch of secure detoxification facilities to serve individuals

whose acute risk arises primarily from substance abuse. Initially introduced in 2015 and deferred due to fiscal concerns, it passed in 2016 after two years of work by several CABTF members and other stakeholders alongside the bill's prime sponsor. As part of the gradual rollout of this policy in different communities between now and 2026 as secure detoxification capacity comes online, the state is projecting the launch of nine secure detoxification facilities statewide, the first in 2018 and the second in 2019.⁸¹ As described in greater detail in the discussion of priority 1h on page 87, the CABTF strongly supports this policy, as integrating crisis systems will deliver more tailored care, promote earlier intervention, and save millions of dollars by diverting people with primarily substance abuse-related risk from involuntary psychiatric beds. However, additional dedicated operating and capital funding will be needed beyond 2016's initial modest operating appropriation for training and ombuds services. It is notable that some portion of 2016's new capital funding for diversion projects could potentially be used for secure detoxification facilities.

Second Engrossed Substitute House Bill (2ESHB) 1553: Encouraging certificates of restoration of opportunity

This policy, passed in 2016 after several years of advocacy by a broad range of partners, including King County, will ease access to housing and employment for individuals with criminal histories who have achieved rehabilitation. Under this legislation, an individual with a criminal history will be able to apply for a Certificate of Restoration of Opportunity (CROP) in Superior Court. This civil motion will show that a required amount of time has passed, there were no new arrests or convictions, and that the individual has met or is meeting the terms of the sentence, and is intended to assuage concerns of landlords and employers about a person's past crimes.

Unfortunately, the compromise version of the bill that passed in 2016 excluded the CROP from consideration around state licensing and certification for certain professions, including those serving vulnerable adults. With this amendment, the CROP became irrelevant for behavioral health hiring. Still, it will serve as an important tool in promoting stability via employment and housing for people in behavioral health recovery who have criminal backgrounds.

2015-16 in Summary: Welcome Momentum Toward System Improvement

On the whole, the legislature showed greatly increased attention to mental health service needs in 2015 and 2016, resulting in part from the urgent mandates of the *D.W.* and *Trueblood* rulings as well as the threats of removal of federal funding from WSH. This high level of legislative activity resulted in focused investments in essential areas and welcome momentum toward needed system improvement.

In this environment of great need and great change alongside elevated policymaker engagement, King County and the CABTF have been working to build new partnerships, innovate, find efficiencies, build capacity, and develop recommendations that together can have a lasting effect on reducing involuntary treatment demand and improving access to appropriate care for people in crisis. These efforts are detailed in the next part of this report.

⁸¹ http://leap.leg.wa.gov/leap/Budget/Detail/2016/HOAgencyDetail_0329.pdf, page 165. King County hopes to be one of the communities where the policy can be implemented early, and already is working to launch a secure detoxification facility.

Part Three: Short- and Long-Term Sustainable Solutions

King County's Immediate Response to the Crisis

As noted on page 22, immediately after the *D.W.* ruling, King County prioritized addressing the inpatient psychiatric treatment access crisis via a range of immediate interventions to address both hospital diversion and discharge while also working to expand local inpatient capacity. The CABTF was formed in part to provide leadership to these efforts and to continue to build on them with additional improvements.

This section outlines the specific interventions launched at the time of the ruling that continue to have a positive system effect nearly two years later.

New Community-Based Programs and Strengthened Crisis Response

New community-based programs were implemented, while others were expanded or otherwise changed, to impact the boarding crisis specifically. Some of these initiatives were possible thanks to grants and targeted funding from the state.

- The **Transition Support Program (TSP)** helps to speed discharge and ensure linkage between hospitalized individuals and community providers.
- The **Peer Bridger program** assists clients with the transition from hospital to community and to help implement discharge plans after release.
- Previously reduced funding for **Next Day Appointments (NDAs)** was restored, making it easier for people in crisis to access urgent care without seeking hospitalization.
- The **Mobile Crisis Team (MCT) doubled in size** and expanded its role to provide faster access to crisis support and community resources including the Crisis Solutions Center (CSC), in order to reach people before they require involuntary commitment.
- King County's designated mental health professional (**DMHP**) unit **expanded** beginning in summer 2014, to improve responsiveness to people in crisis in the community, in hospitals, and in jails.⁸²

New Inpatient Resources

Additional evaluation and treatment (E&T) resources were brought online in late 2014 and early 2015 by King County and community partners to increase and improve access to inpatient care. With the opening of Cascade Behavioral Health in Tukwila in early 2015, 24 new E&T beds were added to the system. Navos and Harborview Medical Center also each made available a modest number of additional involuntary psychiatric beds.

In addition, plans were set in motion to launch even more certified involuntary psychiatric treatment beds at a variety of new and existing facilities countywide, including two freestanding E&T projects initiated by King County. The current status of involuntary inpatient bed capacity expansion at various sites throughout King County is detailed starting on page 58.

⁸² Additional positions were added through 2015 and more are planned for 2016. In all, once all positions are filled, the DMHP workforce in King County will have grown by nearly 32 percent, to a total of more than 38 full-time equivalents (FTE), including permanent and temporary staff.

Critical Support from State and Federal Partners

Many of the innovations and coordinated actions above would not have been possible without emergency funding and policy decisions from state and federal partners who were coordinating actively with King County's work to address psychiatric boarding.

Emergency State Funding for Inpatient Expenditures

As mentioned on page 43, in response to the Supreme Court ruling, the Governor authorized \$30 million statewide in emergency state funding to support increases in inpatient expenditures resulting from expanded capacity developed to ensure access to acute care throughout the state. This influx of resources supplemented previous targeted funding that helped to launch some of the community-based initiatives described above. Although distribution of these dollars to local communities was slower than expected, the promise of these funds allowed King County to proceed with its many plans to implement capacity expansion.

Medicaid Waiver Authority

The October 2014 renewal of the state's mental health managed care waiver with the Centers for Medicare and Medicaid Services (CMS) granted the state new authority to use Medicaid funds to pay for short-term stays in facilities larger than 16 beds when those services are provided in lieu of more costly hospital services. This waiver of the Institutions for Mental Disease (IMD) exclusion rule under limited conditions allows costly inpatient psychiatric stays in IMD facilities to be covered by Medicaid, freeing up limited non-Medicaid funds for other essential or innovative services that may in turn reduce the need for hospitalizations.⁸³

CABTF Participation

Several key state government partners also committed two years of their time to contributing actively to the work of the CABTF to improve involuntary treatment access via community alternatives.

The next section of this report addresses several of the main ways the CABTF built on these initial steps by developing effective procedural innovations and initiating important new partnerships initiated that have also contributed significantly to improved treatment access for involuntarily committed patients in King County.

⁸³ Early results show that as a result of the waiver authority, King County has been able to shift to Medicaid more than \$7 million per year in inpatient costs previously paid with scarce state non-Medicaid funds. So far, this has helped to delay or avert cuts to state-funded community-based crisis and diversion programs that otherwise may have been curtailed due to the recent reductions in state flexible non-Medicaid funding. It is important to note that the waiver does not represent a complete or permanent solution, however, because it applies only to short-term acute care mental health services and is subject to biennial renewal. Also, ongoing state funding is still needed to ensure treatment access for undocumented individuals and others who are ineligible for Medicaid, and for previously eligible Medicaid participants for whom sizeable matching state funds are required.

CABTF Short-Term Solutions Already Showing Results

One of the major strengths of the CABTF since its inception has been its role as a forum for immediate cross-system problem solving around emerging issues. Many of its immediate interventions continue to have an ongoing positive effect on the acute care system.

The CABTF's early focus during fall 2014 was to monitor and build on King County's immediate response to the psychiatric boarding ruling by identifying complementary efficiencies and improvements that could be implemented immediately and without new funding, to maximize the availability of existing limited inpatient resources. These strategically significant innovations led to greater access to timely and appropriate care for people in crisis, and helped to bring King County quickly into compliance with the Supreme Court's ruling.

These short-term efforts also established a solution-seeking approach within the CABTF team. Members with a variety of perspectives, sometimes including competing interests, brought new ideas and a collaborative approach to addressing the issues. This has resulted in the CABTF becoming a table where concerns and barriers can be pointed out and jointly explored in order to develop solutions that keep the system moving forward toward shared desired outcomes.

Effective Collaborative Innovations Initiated by the CABTF

The CABTF embraced innovation, pursuing a range of different ideas at multiple points in the involuntary treatment system, and as such pursued some ideas that worked very well and some that were less successful. A few ideas – such as an executive expeditor process to promote flexibility among evaluation and treatment (E&T) facilities in accepting challenging placements, and work to expand the use of a centralized real-time bed tracking system – did not yield immediate results despite rigorous efforts by CABTF members.

However, a number of the CABTF's short-term interventions are having an enduring effect by making the system more efficient, collaborative, and focused on patient needs. A sample of CABTF-initiated changes that have shown evidence of a sustained impact are described below.

Eliminating Single Bed Certification Approval Delays

Early in its work together, single bed certification (SBC) approval at Western State Hospital (WSH) was cited by multiple CABTF members as a significant obstacle to helping detained people access appropriate treatment quickly, as the legal authority to hold the person is not in place until the SBC is in place. In 2014, designated mental health professionals (DMHPs) had to wait in hospitals, sometimes for hours, until a response arrived from the WSH unit that reviewed and approved SBC forms. This kept DMHPs from moving on to other referrals, thus slowing their overall response time.

CABTF members tackled this problem in two different ways, including data-driven process improvement and legislative advocacy.

Members from King County visited WSH to investigate the delays, and along with task force members representing the state Division of Behavioral Health and Recovery (DBHR) and WSH, worked with the staff responsible for reviewing and approving SBC requests to educate them about the link between this activity and timely patient care, and to provide training and improve processes to ensure that SBC requests are reviewed promptly. Along with these efforts to remove administrative and logistical delays

came tracking mechanisms to measure improvement. As a result, the rate of approval of SBCs within 15 minutes increased dramatically, from 53 percent at the end of December 2014 to 89 percent in March 2015, and remained high during April 2015 at 85 percent. In March and April 2015, 97 percent of SBCs were approved within 30 minutes. Together, these process changes very quickly expedited treatment access and greatly reduced the time DMHPs had to wait in hospitals for SBC approval before moving on to serve other people in crisis.⁸⁴

In addition, many CABTF members strongly supported 2015's Engrossed Second Substitute Senate Bill (E2SSB) 5649 (described on page 47), which eliminated this point of delay by allowing DMHPs to presume approval of SBC requests and move on to other cases. After the effective date of this law in May 2015, SBC processing time at WSH no longer needed to be tracked by the CABTF because it no longer stands in the way of DMHPs' ability to respond to patient referrals.

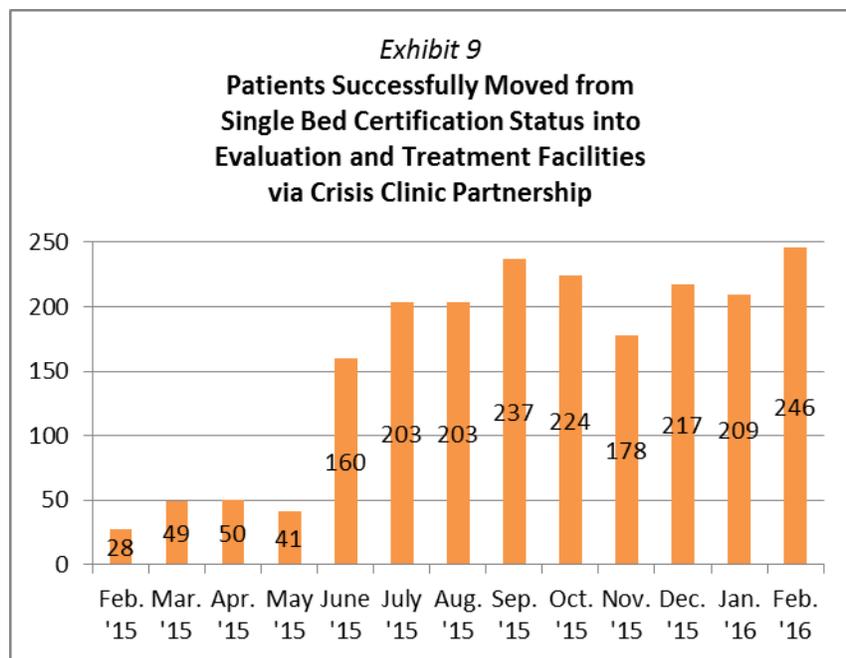
Extended Patient Placement Hours

One of the first areas identified by the CABTF for potential immediate improvement was the removal of delays in the inpatient placement processes for involuntary patients, most notably placement of patients into E&T beds only during weekday business hours.

Through a new partnership with Crisis Clinic to provide after-hours patient placement coordination in collaboration with DMHPs, greatly expanded placement hours were piloted in December 2014 and fully implemented by February 2015, including morning,

evening, weekend, and holiday staffing. In late spring 2015, the Crisis Clinic expanded its work from early morning and evening hours only to cover the 16 hours per day when the vast majority of placement requests and facility transitions for psychiatric patients occur. As shown in Exhibit 9, between February 2015 and February 2016, this partnership facilitated a total of 2,045 E&T placements.

The immediate impact of this process change was that patients no longer had to wait overnight or over the weekend for proper placement. This resulted in shortening or avoiding altogether SBCs for certain individuals, while freeing up beds for others. Since summer 2015, fewer patients have been able to fully avoid SBC status due to the backlog at WSH, but still, the Crisis Clinic continues to play a key part in expediting access to appropriate treatment, keeping patients' length of time on SBCs as short as possible before their placement into E&T facilities.



⁸⁴ Department of Social and Health Services (DSHS) State Hospitals SBC Databases and WSH 24-hour SBC Reports, May 4, 2015.

Patient Placement Decision Guidelines

As part of its early work to provide the right placement for the right patient, the CABTF partnered with area E&T facilities and hospitals to develop clinically driven guidelines to help patient placement coordinators and DMHPs ensure that patients are referred to the E&T facility that best matches their particular needs, rather than placing each patient in any available bed. This is especially important in making sure that individuals with more acute or complex needs, including co-occurring medical needs, can be referred to an appropriate facility, while referring individuals with slightly less intensive needs to facilities that provide for their particular requirements. By triaging patients for placement based on clinical presentation and facility level of care, the process encourages appropriate bed availability across the system.

These guidelines, attached as Appendix G, spell out prioritization and exclusionary criteria for every E&T. Implementing these guidelines has resulted in patients triaged to the most appropriate treatment setting that best matches the patient's care needs.

For example, a newly detained patient with a new-onset psychosis or unexplained change in mental status may require a more extensive medical workup for clinical reasons. These patients need to be prioritized to an E&T that offers this service. Also, patients with significant co-occurring medical conditions will be triaged to a hospital-based E&T that can provide medical care on the psychiatric unit. At the other end of the complexity spectrum, a patient who may be well known to the system and does not have major medical concerns may be effectively treated in a freestanding E&T. Each E&T also has other subspecialties, such as adolescent care, geriatric care, or co-occurring substance use disorder (SUD) treatment. Making these triage decisions at the time of detention contributes to more efficient throughput and transfer to an inpatient setting, as well as promoting quicker access to the hospital-based E&Ts.

To achieve these outcomes, E&Ts such as Harborview and Navos that are set up to care for the most complex patients had to take the risk to transfer their less acute patients to other E&Ts, permanently increasing the overall acuity of their patient population – a risk that was made possible via the cooperative context of the CABTF. As a result of this effort, patients are getting better care, and complex patients are now receiving specialized treatment sooner.

These guidelines continue to shape decision-making on individual cases by placement coordinators and DMHPs, subject to the availability of optimal resources. They also continue to be refined in response to feedback from E&Ts and referring hospitals. For example, special consideration of extenuating circumstances has been added, to allow for prioritization of patients coming from a hospital emergency department (ED) that has a relatively high volume of patients on SBCs.

Further revisions to the guidelines are planned for 2016, as part of efforts to include new providers MultiCare and Swedish in the coordinated placement partnership used by King County's other five E&Ts.

The patient placement guidelines are closely related to the CABTF's priority goal of establishing inpatient stepdown arrangements to move patients within and/or between E&Ts during the course of their commitment based on their changing level of acuity, in order to improve flow within the system and reduce overall demand. See priority 1c on page 77 for more information about further improvements and recent developments in this area.

Monitoring E&T Decline Decisions and Standardizing Exclusionary Criteria

The CABTF initiated systematic monitoring of E&T facilities' decline frequency and decline reasons, making this data public in order to promote transparency and encourage conversations about shared standards, E&T facilities' needs, and any potential mitigation strategies to facilitate successful placement and treatment of higher-acuity patients. A summary of E&T declinations was disseminated regularly to E&T leadership and social work managers at community hospitals in an effort to highlight the broad range of stated and unstated exclusionary criteria that impact the efficiency of patient placement.

The systematized data tracking and discussion by CABTF members generated increasing awareness of the differences between different E&T admissions policies and practices. In turn, this collective information and assessment created an avenue for coordinated feedback and advocacy with facilities whose decline reasons were explored by the CABTF.

Themes in E&T exclusionary criteria that arose through this process included:

- E&Ts' stated limits in caring for patients with additional care needs, often related to medical needs, medical equipment, or ability to perform basic functions such as activities of daily living;
- Unstated limits cited during the actual referral process, including HIV status, transgender identification, behavioral issues, acuity, or cognitive impairment; and
- Frank denials for persons diagnosed with dementia or developmental disability.

System change is already evident. Providers have been very receptive to this more transparent process. E&Ts are sharing more details as to why they are declining patients; some facilities have been actively following up to find out why their institution declined to accept a person; and some hospitals appear to be accepting more acute patients than they did previously.

CABTF members reached out to King County's E&Ts individually to explore these trends and convened monthly meetings with medical directors from all facilities starting in October 2015. Most of the E&T medical directors agreed that standardized exclusionary criteria would be helpful, and began working toward consensus on this subject as well as beginning to address variations in facilities' willingness and ability to accept individuals with dementia or developmental delay. This work to establish common ground among E&T medical directors has great promise for continued process change in this area.

In addition, CABTF members have met with representatives from the Washington State chapter of the American College of Emergency Physicians, who interface with psychiatric patients in community hospital EDs, to engage them in discussions about standardized medical exclusionary criteria and to learn about their processes for working with clients on SBCs.

Promoting ITA Court Collaboration

The ITA Court faces a unique challenge of working together within the involuntary legal system to facilitate wise and timely health care and safety decisions that balance individual due process rights with treatment need.

Toward this end, building on the cooperative efforts of the CABTF, the ITA Court has implemented several strategies for increasing collaboration among Involuntary Treatment Act (ITA) stakeholders, including DMHPs, attorneys, and hospital staff. Since 2014, the ITA Court has hosted monthly stakeholder meetings at which DMHP staff, attorney supervisors, hospital liaisons, and judicial officers participate.

Stakeholders discuss emerging court process issues, such as:

- Fairly and effectively expanding use of video to conduct hearings from E&T facilities;⁸⁵
- Expediting processing of court orders to support faster turnover of E&T beds;
- Improving communication between attorneys at outlying hospitals and the court;
- Improving technical access at hospitals for on-site defense attorneys; and
- Cost-effective interpreter scheduling.

ITA Court stakeholders further plan to seek feedback from ITA respondents' family members in order to assess what changes could be made to improve the public's experiences at the court. The court's past Lean⁸⁶ process has informed and continues to guide these improvement discussions.

In fall 2015, clinical experts from Harborview Medical Center and King County Behavioral Health and Recovery Division (BHRD) trained ITA Court staff on mental illness and on the social services available to respondents in court proceedings, and plans are in place to repeat these trainings annually to educate new staff, including the six new attorneys who were recently assigned to expand public defense staffing for ITA Court.

Finally, the four CABTF members from ITA Court have also hosted and participated in a new effort by the task force to coordinate across King County stakeholders regarding legislative advocacy.

Building Strong Partnerships with Community Hospitals to Implement SBCs

Coming alongside King County and the CABTF in their commitment to ensure that any person who meets the ITA's detention criteria receives timely and appropriate care, almost all community hospitals in our county have accepted the SBC as a mechanism to temporarily and legally meet patients' medical and psychiatric needs and to ensure continuity of care. Even though they do not all have certified E&T beds (or adequate capacity of certified E&T beds), these facilities, including their psychiatric units, medical units, and EDs, have opted to join in the effort to provide timely and appropriate involuntary mental health care to all people who need it.

This success is due in large part to CABTF members' efforts just after the *D.W.* ruling to build collaborative relationships wherein hospitals took ownership of their role in assisting with this treatment access crisis by agreeing to provide psychiatric care to individuals temporarily held on SBCs. In fact, in this spirit of partnership, hospitals have influenced each other to do their part to shoulder this responsibility, and King County hospitals have been a statewide leader in this area.

Community hospitals voluntarily participate in this community response – by accepting SBCs and bringing psychiatric care to their patients wherever they are. Counting on these partners, King County DMHPs' typical practice is to request SBC authorization whenever a patient cannot be placed into an E&T within three hours, to ensure that timely and appropriate care is provided while an optimal placement is secured. To keep these collaborations strong, King County actively coordinates with many of these hospitals through a regular task force focused on patient placement and works to address any concerns quickly as they arise.

⁸⁵ An April 2016 report from the office of the King County Executive, titled "Involuntary Treatment Act (ITA) Court Access: Ambulance Transportation and Video Hearings," addresses the expanded use of video hearings, including its benefits to patients and to system efficiency as well as challenges presented by the video hearing approach.

⁸⁶ Lean is a process improvement approach being implemented internationally, and across many departments and units in King County, to deliver better value for customers. More information about Lean is available at <http://www.lean.org/WhatsLean/> and <http://leaninkingcounty.com/about-lean-in-king-county/>.

Many other behavioral health organizations (BHOs) in Washington do not have the luxury of many strong community hospital partners who are willing to take on this extra challenge. Although more community hospitals in Washington have begun accepting SBCs, a sizeable minority still opt out of taking patients on SBCs due to a lack of qualified staff or other key resources.⁸⁷ These BHOs are left without alternatives when an E&T bed is not immediately available and, in some cases, they cannot legally detain individuals who are at great risk. This disparity in community hospital participation is the primary reason why King County continues to employ SBCs at a disproportionately high rate as compared to other communities. (As of February 2016, King County's SBC requests constitute 55 percent of all such requests statewide.)⁸⁸

A greatly strengthened system of community alternatives and/or consistent state hospital bed access is the key to reduction of SBC use over the long term. In the meantime, however, these strong relationships with community hospitals remain absolutely essential to King County's compliance with the *D.W.* ruling and the delivery of legally required timely and appropriate psychiatric treatment to every King County resident who meets detention criteria under the ITA.

As state hospital and intensive community resources continue to be insufficient to meet the need and/or are difficult to access, this increases the demands on community hospitals with regard to the number of patients on SBCs that they are asked to accept, including the proportion of people on their units who are in psychiatric crisis. Although all community hospitals in King County are still willing to assist with this work, most report that they are feeling overstretched, vulnerable, and concerned about the safety of their patients and staff. As a result, the shared partnership in serving SBC patients is at risk.

Increased inpatient and community capacity with a goal of easing access to alternative placement choices, along with working toward consistent state hospital bed access for patients who need it, are critical to hospitals' continued partnership in this effort.

Continued Problem-Solving Around Emerging Issues and Needs

The CABTF continues to devote a significant portion of its work together to addressing emergent needs in a rapidly changing system. This has been especially essential in light of the recent escalation in challenges with state hospital bed access, which have placed even more pressure on the local system and have highlighted the opportunity presented by the CABTF to bring together the expertise, information, and influence of state and local partners to solve problems as they arise.

Meanwhile, the CABTF has also worked actively to support the effective and timely launch of additional inpatient capacity in King County, and to envision and recommend a set of system design recommendations that, if implemented in King County, would likely have a lasting effect on reducing overall involuntary treatment demand in our community. These aspects of the CABTF's work are outlined in the coming sections.

⁸⁷ Of Washington's 99 community hospitals, the number accepting patients on SBCs increased from 36 to 69 between February and October 2015. However, this left 30 hospitals statewide that are not willing or able to serve such patients. Washington State DBHR data reports, March 17, 2016. "SBC, DMHP Report of No Available Bed, and State Hospital Update." Earlier estimates of this phenomenon provided by Washington State Hospital Association, May 2015, and DBHR, December 3, 2015.

⁸⁸ Washington State DBHR data report, March 17, 2016. "King SBC Charts_03-30-2016: SBCs – Statewide and King Co."

Bringing More Local Acute Care Beds Online

As one part of the solution to this ongoing short- and long-term inpatient treatment access crisis, King County and the CABTF are actively partnering with several providers to increase the number of certified evaluation and treatment (E&T) beds in King County. In March 2016, 10 beds for individuals with co-occurring medical concerns at MultiCare in Auburn were the first to become available – with an additional 10 likely to open at that same facility this summer, as it ramps up to its full capacity of 20 beds. There will also be a net increase in summer 2016 of 12 medically complex beds at Swedish Ballard as an older Swedish unit is closed and a new 22-bed facility opens. Finally, existing facility Cascade Behavioral Hospital in Tukwila was recently certified for 14 additional beds and will be working to bring them online as soon as feasible. Although they will be certified E&T beds, none of these three new resources will be solely for involuntary patients, as some will be used by voluntary or out-of-county patients.

Two freestanding (non-hospital) E&Ts in south King County, initiated by King County in partnership with the state and community providers, are in development and could become available between late 2016 and spring 2017. These facilities will be operated by Valley Cities Behavioral Health Care as well as the Telecare Corporation, and will admit exclusively involuntary patients. Both the Valley Cities and Telecare facilities are currently planned for 16 beds, with the Valley Cities site to be paired with a secure detoxification facility serving patients detained under newly passed Engrossed Third Substitute House Bill (E3SHB) 1713.⁸⁹

All King County E&T projects known to be expanding or in development as of spring 2016 are shown in the table below.⁹⁰

Estimated Number of New E&T Beds	Provider Agency	Planned Location	Specialty Care, if any	Estimated Time Frame for Bed Availability
20 ⁹¹	MultiCare	Auburn	Medically complex	Spring / Summer 2016
12 (net) ⁹²	Swedish	Ballard (Seattle)	Medically complex	Summer 2016
16	Valley Cities	Kent ⁹³	None	Late 2016 to Early 2017
16	Telecare	Federal Way	None	Spring 2017
14	Cascade	Tukwila	None	2016 or 2017 ⁹⁴

⁸⁹ Please see page 48 as well as priority 1h on page 88 for further discussion of this law.

⁹⁰ Bed counts and timeframes in this chart, and in the discussion above, were current as of April 2016. In addition to the King County projects shown in the table, Fairfax's Monroe facility recently added an estimated 30 beds to serve older adults, while MultiCare's Tacoma facility is working to bring on 27 psychiatric beds for adolescents. Although these beds likely will serve relatively few King County patients, these new resources, along with the current and oncoming beds at King County, will help ease access to inpatient psychiatric care throughout the region.

⁹¹ 10 of MultiCare Auburn's projected total of 20 new beds are already open and serving patients as of March 2016.

⁹² As part of Swedish's transition into its planned new 22-bed unit at its Ballard location, 10 beds will be closed at Swedish Cherry Hill, for a net increase of 12 beds in the number of potentially available beds. As of this writing, the new unit was scheduled to open in June 2016.

⁹³ In response to siting challenges at its originally planned Woodmont behavioral health campus site in Des Moines, an alternative location for the Valley Cities E&T facility and services was located at a former Recovery Centers of King County site in Kent. The plan is to develop the site to include both E&T and secure detoxification services, at 16 beds each.

⁹⁴ Cascade Behavioral Hospital reported it had been certified for 14 additional beds in March 2016. However, it continues to face workforce challenges and other ramp-up delays in bringing online all of the beds for which it was already certified, so it is unclear at this time when it will be able to operate at its full projected capacity.

As with many major behavioral health resource development projects, implementation has been slower, and/or capacity increases somewhat smaller, than originally projected for almost all of these projects. Siting and/or funding challenges are significant contributing factors to construction delays, while workforce recruitment difficulties impact the speed with which facilities can be brought up to full operating capacity. However, the overall anticipated capacity increase locally is still a major step forward, at 78 new acute psychiatric care beds in this county set to be available by mid-2017, with 66 of those in south King County.

In addition, inpatient capacity expansion projects are under way or anticipated in neighboring Pierce and Snohomish Counties as well as Spokane and Clark Counties. Once available, this additional capacity may reduce the number of patients from these areas who currently come to King County E&Ts for treatment. Also, overall pressure on the statewide E&T network may likewise subside somewhat as a result of these projects as well as the new beds expected to come online in King County in 2016 and 2017.⁹⁵

Even so, yet more beds are needed to rectify Washington's extremely low per capita ranking among states in psychiatric bed capacity, so King County and the CABTF will continue to seek opportunities to engage state and local partners and funding sources to boost the ability of the inpatient system to meet demand, even as community alternatives remain a preferred option.

⁹⁵ Washington State Hospital Association (WSHA), May 2016.

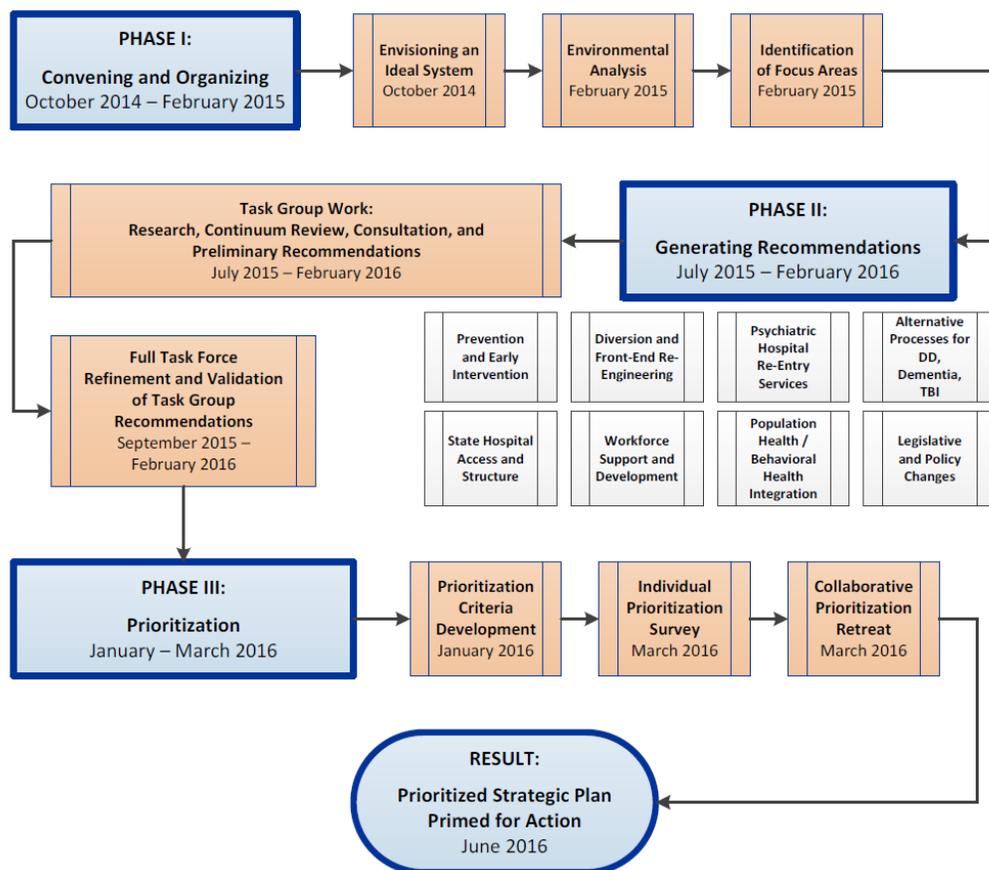
The CABTF’s Process for Developing Sustainable Long-Term Improvement Recommendations

Despite the planned new beds coming online over the next two years, and the ongoing collaboration around process improvements, the CABTF finds that it is unrealistic and ultimately not desirable simply to add enough inpatient capacity to meet current involuntary treatment demand. It is critical to focus upstream, with the intent of preventing or interrupting crisis events for individuals when possible, and providing effective crisis intervention outside the hospital as much as possible.

The CABTF has embraced its charge to envision and develop innovative community-based solutions across the continuum of care that together can address these long-standing challenges. Members understand the need for a special focus on working with policymakers and across systems to increase community-based diversion options to reduce involuntary treatment need while also reducing demands on the overall crisis system by boosting the diversity and quantity of appropriate discharge options from short-term and long-term inpatient care.

Building on the short-term interventions described starting on page 52, the CABTF’s work to develop long-term system improvement recommendations occurred via a multistage approach, as summarized in the diagram below, and detailed on the following pages.

Overview of CABTF Recommendation Development Process, 2014-2016



The CABTF's method leveraged the expertise, capacity, varied perspectives, and unique interests of the various task force members and incorporated sufficient flexibility to respond to changing conditions. This method enabled all members to work together to generate potential recommendations, vet those recommendations with others within and beyond the CABTF, make needed refinements, and finally prioritize certain interventions and policies for action.

Subgroup Work in Defined Areas of Focus

Following an initial October 2014 exercise to envision an ideal system for this population and subsequent environmental analysis, the CABTF's primary organizing principle for long-term system design work was the use of member-driven, subject-focused task groups. Subgroups were initially formed around high-yield priority areas for investigation and recommendation that had been identified at its February 2015 retreat. In early summer 2015, CABTF members established a robust work plan to bring together preliminary system design conversations into a set of draft recommendations.

Subgroups conducted extensive, open-ended design conversations to hear input from the full CABTF as they began to consider their recommendations. In follow-up to these conversations, subgroups worked independently and in consultation with more than 45 stakeholders and subject matter experts to assess community needs and barriers, research best practices, and develop proposed interventions.

In accordance with the requirements of Motion 14225, subgroup efforts also specifically included the development of an inventory of certain existing prevention, intervention, least restrictive alternative, and psychiatric hospital re-entry services across the continuum that are relevant to the involuntary treatment system scope of the CABTF. This continuum overview is presented in Appendix F.

Subgroups engaged in a variety of informal, collaborative prioritization and feedback processes to validate and hone their recommendations and ensure concreteness. Draft recommendations from each subgroup were presented to the full CABTF for discussion, refinement, and endorsement, and many subgroups brought their recommendations back to the full group yet again after making further improvements.

After initial groups completed their work in late 2015, as reflected in the form of draft recommendations in the task force's second progress report, subgroups were then reformulated in early 2016 around specific identified areas for further work. These reorganized groups were tasked with developing additional recommendations in certain areas, as well as reviewing and refining initial draft recommendations, in order to ensure that the set of options for potential final recommendation were as comprehensive as possible.

In all, CABTF subgroup work in 2015 and 2016 addressed the following eight topic areas:

- Prevention and early intervention services;
- Diversion and front-end reengineering;
- Psychiatric hospital re-entry services;
- Alternative processes and resources for patients with dementia, developmental disabilities, and traumatic brain injury;
- State hospital access and structure;
- Workforce support and development;
- Population health, including behavioral health integration; and
- Legislative and policy changes.

As subgroup recommendation design work concluded in early 2016, all active members of the CABTF participated in a multi-stage facilitated prioritization process based on defined criteria.

Prioritization Criteria Development and Application

First, using Motion 14225 and the CABTF charter as its guides, the task force developed a specific set of prioritization criteria to use in its deliberations about which draft recommendations to elevate for priority action. Factors to be used in deliberations were divided into two categories: a main group of seven criteria, which received further definition and were the primary drivers of sorting decisions, and another set of eight factors that members also considered, which are shown in the table on page 63.

In order to support a collaborative, interactive process based on a common understanding of the prioritization approach among individuals with otherwise disparate viewpoints, no concrete scores or ratings against criteria were involved. Instead, the criteria were used as guideposts for members' deliberations and conversations. Taken together, these criteria demonstrate the CABTF's commitment to providing a focused set of actionable recommendations that are expected to have a direct impact on the inpatient capacity crisis.

As part of its prioritization criteria development process, the CABTF came to consensus around focusing its final recommendations on concrete, actionable interventions and policies that had specific relevance to the Council's mandate and the task force charter. Therefore, members decided jointly to categorically remove from the final recommendation set all draft recommendations around engagement with broader system change efforts that had been articulated earlier. However, it remains a high value for the CABTF to anchor its recommendations in relevant system change processes, and to provide specific input into such efforts when appropriate. Therefore, discussion of key system change processes as they relate to the scope of the task force was included in this report as essential context, starting on page 35.

This decision to focus on more concrete recommendations still left a large number of interventions and policies remaining for consideration using the prioritization criteria. Next, to ensure equitable and optimal participation and input from the full task force through a variety of methods, the criteria were applied in two phases: an individual online survey and a facilitated retreat.

The survey, conducted in March 2016, was designed intentionally as a starting point for the in-person retreat discussion, and was not used as a formal decision-making tool. It gathered input from all participating task force members around three questions:

- Which recommendations, if any, should be removed from consideration?
- Which recommendations, if any, should be elevated based on the criteria?
- Which recommendations, if any, raise significant concerns or questions?

The CABTF reviewed survey results to help members see different points of view and promote discussion around areas of significant agreement, varying perspectives, and potential revisions that were needed to ensure broad endorsement of certain recommendations. Although no recommendations were included, excluded, or elevated based on these results, this data provided an organizing framework for the CABTF's subsequent refinement of its recommendation set.

The CABTF's Primary Prioritization Criteria and Definitions
<p>How does the intervention/policy address involuntary psychiatric inpatient access specifically?</p> <ul style="list-style-type: none"> ➤ The intervention policy is likely to have a direct impact on improving access to inpatient psychiatric care for those who need it, especially for those committed involuntarily.
<p>How does the intervention/policy address involuntary psychiatric inpatient access specifically?</p> <ul style="list-style-type: none"> ➤ The intervention policy is likely to have a direct impact on improving access to inpatient psychiatric care for those who need it, especially for those committed involuntarily.
<p>How does the intervention/policy create or promote community-based alternatives?</p> <ul style="list-style-type: none"> ➤ The intervention/policy enables more patients to be served in the community by avoiding involuntary hospitalization altogether or returning to community settings faster.
<p>How high is the expected return on investment from this intervention/policy?</p> <ul style="list-style-type: none"> ➤ The intervention/policy is expected to deliver strategically significant outcomes commensurate with its implementation cost. ➤ The intervention/policy is financially sustainable over the long term. ➤ The intervention/policy is likely to improve: (a) patient satisfaction among those affected by the inpatient care access crisis; (b) the overall health of this population; and (c) the per capita cost of their health care.
<p>How feasible is the intervention/policy to implement?</p> <ul style="list-style-type: none"> ➤ Barriers to implementation can be overcome with reasonable coordinated effort. ➤ The intervention/policy can be implemented within a reasonable timeframe.
<p>How effective is the intervention/policy, as demonstrated by its reflection of best, promising, or evidence-based practices?</p> <ul style="list-style-type: none"> ➤ As a result of the intervention/policy, individuals or groups are or will be better off than before. ➤ Reliable information makes it clear that the intervention/policy is a worthwhile use of resources.
<p>How does the intervention/policy further social justice and equity?</p> <ul style="list-style-type: none"> ➤ The intervention/policy contributes to conditions under which individuals, families, and/or communities can succeed – regardless of race, culture, wealth, ability, gender, or place of residence.
<p>How is the intervention/policy consumer-informed?</p> <ul style="list-style-type: none"> ➤ The perspectives and/or felt needs of people who use the service, and/or affected community members, help to determine how the intervention/policy is designed or delivered.
Secondary Prioritization Criteria
How does the intervention/policy address immediate needs?
How does the intervention/policy address key issues of workforce?
How does the intervention/policy align with the Affordable Care Act (ACA) and health reform?
How is the intervention/policy based on recovery and resiliency principles and trauma-informed services?
How does the intervention/policy integrate behavioral health and primary care?
How does the intervention/policy leverage existing resources?
How is the intervention/policy person- and family-centered?
How is the intervention/policy system-focused, with shared ownership across the service continuum and partners?

The CABTF then gathered in person for an all-day retreat to discuss and prioritize its draft recommendations. Members collaboratively assessed potential interventions and policies to determine the degree to which they fulfilled the identified criteria, and began discussions about potential implementation steps for certain actions that emerged as priorities.

The CABTF's approach to its final recommendation set included the following nine components:

1. Identifying which draft recommendations could be removed based on the criteria.
2. Identifying which recommendations were important to endorse, but were either less specifically focused on psychiatric inpatient care access or were primarily the work of others.
3. Combining certain recommendations that overlapped significantly or were substantively similar.
4. Elevating certain recommendations for priority action.
5. Dividing elevated recommendations into top priorities and next-tier priorities.
6. Further dividing top-priority recommendations into two groups, based on which interventions and policies should be the focus of active work and promotion by the task force and which appeared to have strong momentum toward implementation.
7. Identifying initial steps toward successful implementation for top-priority and next-tier interventions, including legislative action where necessary.
8. Including among its recommendations other programs and policies on the horizon for future action.
9. Identifying one foundational value that undergirds all other recommendations.

Result: A Prioritized Strategic Plan Primed for Action

At the end of a comprehensive discussion, the CABTF's final system design recommendation set was unanimously approved by all participating members. To fully reflect the CABTF's review of the interventions and policies that affect the involuntary psychiatric treatment system and associated community alternatives, 29 different topics are discussed in all.

However, these recommendations are meaningfully sorted as follows to promote strategic action, with each tier including interventions across the continuum:

- Four top priority recommendations for focused action including CABTF promotion and advocacy;⁹⁶
- Four top priority recommendations identified as having strong momentum toward implementation;⁹⁷
- Five next-tier priorities for concurrent action as opportunities arise;⁹⁸
- Six interventions on the horizon for future action;⁹⁹ and
- Ten endorsements of work primarily done by others or less specifically focused on inpatient psychiatric care access.¹⁰⁰

The next sections of this report include presentations of these recommendations in various forms, including an overview, summary tables, and detailed information about each one.

⁹⁶ Detailed discussion of these Tier 1 top priorities for active work and promotion begins on page 76.

⁹⁷ Detailed discussion of these Tier 1 top priorities with strong momentum toward implementation begins on page 84.

⁹⁸ Detailed discussion of these Tier 2 priorities begins on page 91.

⁹⁹ Discussion of these Tier 3 recommendations begins on page 97.

¹⁰⁰ Discussion of these Tier 4 endorsements begins on page 101.

An Overview: Recommendations Across the Continuum

In accordance with the CABTF's charter and prioritization criteria, members developed recommendations across the continuum that impacts the involuntary treatment system, encompassing four major categories: prevention and early intervention, crisis diversion, psychiatric hospital re-entry, and policy changes. Recommended interventions within these four areas touch on the following primary themes:

- **Prevention and Early Intervention:** Facilitate earlier treatment access via innovative service delivery and outreach.
- **Crisis Diversion:** Grow the capacity and reach of proven or promising diversion resources in order to connect or re-connect people in crisis with needed supports and keep them out of inpatient settings and involuntary treatment.
- **Psychiatric Hospital Discharge and Re-Entry:** Add critical community-based discharge options to improve movement through the inpatient system, facilitating faster transition of patients out of acute care settings and delivering long-term treatment in state hospitals or alternative settings when necessary.
- **Policy Change:** Improve involuntary care for vulnerable or underserved populations, and support the development of a robust public behavioral health workforce that is effective in reducing emergency system use.

Recommendations within this framework are all expected to reduce involuntary treatment demand, some by preventing crises, some by diverting patients before an inpatient stay begins, some by shortening inpatient stays, and some by adding needed discharge resources that can prevent future rehospitalization. Some recommendations are likely to have the greatest impact on patients of certain ages, including young people and older adults. Some approaches would result in increases in certain types of inpatient capacity that are most needed. Many recommendations involve strategically expanding or enhancing existing programs that have a track record of success.

In addition to the specific interventions and policies that members determined were most likely to impact the inpatient psychiatric access crisis, the CABTF also broadly agreed upon a foundational value that undergirds the group's recommendation set and aligns with its chartered aim to provide necessary resources to providers.

In addition to the need to continue working to improve systems and processes that can deliver better care and outcomes even without new financial resources, members agreed upon the critical role of state and local funding in supporting innovative prevention, early intervention, diversion, and outreach and engagement services that are not reimbursable under the Medicaid state plan. The types of interventions most likely to be effective in reducing the need for involuntary treatment almost always require creative, nimble services and investments that go beyond the strict rules that govern Medicaid expenditures. State and local governments are essential partners in the effort to address the crisis, not only in administering programs but also in providing flexible resources.

The next sections includes recommendations organized into two tables, first by priority level and then by category. After that, the subsequent sections provide additional information about each recommended action, including for higher-priority interventions some initial implementation strategies.

Table of Recommendations by Priority Level

Tier 1 Top Priorities, part 1					
Top priorities for active work and promotion by the CABTF	Prevention and Early Intervention	Crisis Diversion	Psychiatric Hospital Discharge and Re-Entry	Policy Change	More Info.
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.	X		X		Page 75
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.		X	X		Page 77
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.			X		Page 77
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 .				X	Page 77

Tier 1 Top Priorities, part 2					
Top CABTF priorities that have strong momentum toward implementation	Prevention and Early Intervention	Crisis Diversion	Psychiatric Hospital Discharge and Re-Entry	Policy Change	More Info.
1e. Strengthen engagement efforts via open access intake appointments , ensuring engagement by beginning ongoing care promptly and/or providing interim support.	X				Page 83
1f. Increase the availability, flexibility, and outreach capacity of after-hours response for enrolled outpatient clients of the integrated behavioral health system.	X				Page 84
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.		X			Page 85
1h. Create a secure detoxification facility and continue to evolve involuntary treatment statutes to support integrated primary and behavioral health care.		X		X	Page 87

Tier 2 Priorities					
For concurrent action as opportunities arise	Prevention and Early Intervention	Crisis Diversion	Psychiatric Hospital Discharge and Re-Entry	Policy Change	More Info.
2a. Create a local center of excellence with specialized units to deliver best practice services to individuals with brain injuries, dementias, and developmental disabilities .	X			X	Page 90
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 .	X		X		Page 91
2c. Create residential stepdown programs specifically designed to shorten hospital length of stay and help people maintain stability in the community.			X		Page 92
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.			X		Page 93
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.				X	Page 94

Tier 3 Recommendations					
On the horizon for future action	Prevention and Early Intervention	Crisis Diversion	Psychiatric Hospital Discharge and Re-Entry	Policy Change	More Info.
3a. Develop appropriate community alternatives to reduce admissions of young adults ages 18-26 to the state hospital.		X			Page 96
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.			X		Page 96
3c. Provide specialized integrated care to support placement for people with behavioral and medical conditions.			X		Page 97
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.			X		Page 97
3e. Make regulatory changes to ease access to enhanced services facilities for community hospital patients.				X	Page 98
3f. Make certain exceptions to the DSHS Secretary’s disqualifying list of crimes and negative actions for certified peer specialists.				X	Page 99

Tier 4 Endorsements					
Primarily addressed by others or less focused on inpatient psychiatric care access	Prevention and Early Intervention	Crisis Diversion	Psychiatric Hospital Discharge and Re-Entry	Policy Change	More Info.
4a. Support Familiar Faces’ flexible care management model .	X				Page 100
4b. Support Wraparound with Intensive Services (WISe) implementation for youth.	X				Page 100
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.	X				Page 101
4d. Increase early identification and referrals for young people experiencing a first episode of psychosis via implementation of the state’s Early Psychosis Initiative.	X				Page 101
4e. Maintain 2-1-1 services and make them more robust.	X				Page 102
4f. Support the existing crisis intervention training program for first responders, and enhancements that will better serve fire department personnel and paramedics.		X			Page 102
4g. Support Familiar Faces diversion innovations that would also benefit the civil commitment population.		X			Page 102
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.		X			Page 103
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.				X	Page 103
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 .				X	Page 104

Table of Recommendations by Category

Note: Some recommendations that cross two categories appear twice in this table.

Prevention and Early Intervention Recommendations		
Recommendation	Priority Level	More Info.
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.	TIER 1 TOP PRIORITY for Active Work and Promotion	Page 75
1e. Strengthen engagement efforts via open access intake appointments , ensuring engagement by beginning ongoing care promptly and/or providing interim support.	TIER 1 TOP PRIORITY Strong Momentum for Implementation	Page 83
1f. Increase the availability, flexibility, and outreach capacity of after-hours response for enrolled outpatient clients of the integrated behavioral health system.	TIER 1 TOP PRIORITY Strong Momentum for Implementation	Page 84
2a. Create a local center of excellence with specialized units to deliver best practice services to individuals with brain injuries, dementias, and developmental disabilities .	Tier 2 Priority	Page 90
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 .	Tier 2 Priority	Page 91
4a. Support Familiar Faces' flexible care management model .	Tier 4 Endorsement	Page 100
4b. Support Wraparound with Intensive Services (WISe) implementation for youth.	Tier 4 Endorsement	Page 100
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.	Tier 4 Endorsement	Page 101
4d. Increase early identification and referrals for young people experiencing a first episode of psychosis via implementation of the state's Early Psychosis Initiative.	Tier 4 Endorsement	Page 101
4e. Maintain 2-1-1 services and make them more robust.	Tier 4 Endorsement	Page 102

Crisis Diversion Recommendations		
Recommendation	Priority Level	More Info.
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.	TIER 1 TOP PRIORITY for Active Work and Promotion	Page 77
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.	TIER 1 TOP PRIORITY Strong Momentum for Implementation	Page 85
1h. Create a secure detoxification facility and continue to evolve involuntary treatment statutes to support integrated primary and behavioral health care.	TIER 1 TOP PRIORITY Strong Momentum for Implementation	Page 87
3a. Develop appropriate community alternatives to reduce admissions of young adults ages 18-26 to the state hospital.	Tier 3 Recommendation	Page 96
4f. Support the existing crisis intervention training program for first responders, and enhancements that will better serve fire department personnel and paramedics.	Tier 4 Endorsement	Page 102
4g. Support Familiar Faces diversion innovations that would also benefit the civil commitment population.	Tier 4 Endorsement	Page 102
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.	Tier 4 Endorsement	Page 103

Psychiatric Hospital Discharge and Re-Entry Recommendations		
Recommendation	Priority Level	More Info.
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.	TIER 1 TOP PRIORITY for Active Work and Promotion	Page 75
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.	TIER 1 TOP PRIORITY for Active Work and Promotion	Page 77
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.	Tier 2 Priority	Page 91
2c. Create residential stepdown programs specifically designed to shorten hospital length of stay and help people maintain stability in the community.	Tier 2 Priority	Page 92
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.	Tier 2 Priority	Page 93
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.	Tier 3 Recommendation	Page 96
3c. Provide specialized integrated care to support placement for people with behavioral and medical conditions.	Tier 3 Recommendation	Page 97
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.	Tier 3 Recommendation	Page 97

Policy Change Recommendations		
Recommendation	Priority Level	More Info.
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 .	TIER 1 TOP PRIORITY for Active Work and Promotion	Page 79
1h. Create a secure detoxification facility and continue to evolve involuntary treatment statutes to support integrated primary and behavioral health care.	TIER 1 TOP PRIORITY Strong Momentum for Implementation	Page 87
2a. Create a local center of excellence with specialized units to deliver best practice services to individuals with brain injuries, dementias, and developmental disabilities .	Tier 2 Priority	Page 90
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.	Tier 2 Priority	Page 94
3e. Make regulatory changes to ease access to enhanced services facilities for community hospital patients .	Tier 3 Recommendation	Page 98
3f. Make certain exceptions to the DSHS Secretary's disqualifying list of crimes and negative actions for certified peer specialists .	Tier 3 Recommendation	Page 99
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.	Tier 4 Endorsement	Page 103
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 .	Tier 4 Endorsement	Page 104

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
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.	Policy Change

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.

Part Four: Next Steps and Conclusion

The CABTF's Next Steps

Building on its history of success as a problem-solving group with a high commitment to productive, shared problem solving around difficult issues, the CABTF intends to continue to meet regularly even beyond its chartered conclusion, with a focus on implementation of its recommendations and innovations.

The specific purposes of the CABTF's continued work together will be fourfold:

- To work strategically as a team to influence funders, policymakers, systems, and providers to bring the CABTF's top priorities toward implementation as quickly and effectively as possible;
- To continue to develop and refine procedural innovations to maximize efficiency in the use of currently available resources in King County; and
- To continue to promote the addition and effective implementation of new inpatient psychiatric capacity in King County; and
- To monitor key indicators of the status of inpatient treatment access locally and at the state hospital, and to intervene to prevent or stem the escalation of any emerging challenges.

Continued Oversight and Periodic Reporting

The CABTF has begun work to develop a dashboard of milestones and indicators to use to continue to track progress on key system design recommendations and overall involuntary treatment access in our community. Some of the key data elements featured in this report are being considered for inclusion, alongside measures specific to particular recommended interventions.

The CABTF's plan is to produce and monitor this dashboard on a quarterly basis. The CABTF will design its dashboard during the second half of 2016. As each quarterly dashboard is generated, it will be made available to the public via the CABTF's website, www.kingcounty.gov/cabtf. It is the hope of the CABTF that this recurring report can serve as a resource for policymakers, providers, and system partners who are working alongside task force members to address involuntary treatment demand and access.

Conclusion

The significant new innovations and partnerships established through the CABTF have had real influence on the involuntary treatment system already. Data have shown that work to address psychiatric boarding in King County achieved real results for patients, even as there is more work to be done to deliver the right care at the right time for every patient.

Unfortunately, state hospital access constrictions brought back a serious treatment access crisis that still remains. In light of this, the CABTF recognizes that new partnerships and innovative efficiencies do not represent the end of the work, but rather the beginning.

A Vision of an Improved System

Through its rigorous collaborative process, the CABTF has come to a clear consensus and common vision around needed interventions to reduce involuntary treatment demand via a range of proven programs and innovations encompassing prevention and early intervention, crisis diversion, psychiatric hospital discharge and re-entry, and policy changes. The CABTF has also continued to work to address short-term needs and make procedural improvements and to launch a significant expansion of inpatient psychiatric bed capacity in our community.

Bringing new resources to reality will involve developing a system that features:

- Community-based treatment on demand that can prevent crises from occurring, including outreach;
- Expanded crisis diversion capacity, growing proven programs and launching innovative models;
- New specialized hospital discharge resources, alongside greater capacity in established models, to give as many patients as possible an appropriate community-based placement option;
- Policy changes to support a distressed workforce and address barriers to effective involuntary care;
- Increased inpatient psychiatric capacity commensurate with King County's population; and
- Continuous quality improvement within the involuntary treatment system to eliminate places in the involuntary system where patients currently get stuck.

By intervening creatively at all levels of care, the recommendations in this report, once implemented, will help to free up involuntary treatment capacity and allow for significant and lasting improvements in service delivery across many levels of behavioral health care in King County.

A Call to Action

The continuing crisis of treatment access is very serious, but it presents an extraordinary opportunity.

An ongoing shared commitment among King County, the state, local communities, and cross-sector groups like the CABTF to bring resources to support the implementation of these priority programs and policies is essential. Such partnerships will result in a stronger care continuum that better serves the needs of people who currently come into contact with the involuntary treatment system.

Innovation is happening. Capacity is building. But we must continue to work together urgently to create a robust, resilient, and nimble community response to people in behavioral health crisis in King County.

This will require both new ways of doing business and the mobilization of new resources. As a community, with our state partners, we can and will build a system that delivers the right care at the right time. We invite you to join us in this effort.

Appendices

Appendix A: Index of Motion 14225 Requirements

This table describes specifically where in this report the requirements of Motion 14225 are addressed.

Motion Requirement	Pages
A. Assist the task force to find short- and long-term sustainable solutions that:	
Increase the use of least restrictive alternatives for individuals in crisis, thereby reducing the demand for involuntary treatment, including the demand for involuntary treatment court services.	50, 65-104
Provide for successful re-entry into the community for individuals who have received services from psychiatric hospitals, including mental health and substance abuse.	50, 65-66, 68-69, 73, 75-79, 91-94, 96-98
Focus especially on the continuum of prevention and intervention services.	50, 65-68, 70-71, 75-76, 83-85, 90-92, 100-102
B. Findings and recommendations on the following matters:	
B.1. Identification of services, programs, and protocols necessary for King County to reduce demand for involuntary treatment services, including involuntary treatment court services.	50-59, 65-104
B.2. Identification of the continuum of re-entry services from psychiatric hospitals into the community, including mental health and substance use treatment services.	50, 65-66, 68-69, 73, 75-79, 91-94, 96-98, 134-143
B.3. Identification of prevention and intervention services and least restrictive alternatives for individuals in crisis.	50, 65-68, 70-71, 75-76, 83-85, 90-92, 100-102, 134-143

Appendix B: Motion 14225



KING COUNTY

1200 King County Courthouse
516 Third Avenue
Seattle, WA 98104

Signature Report

September 16, 2014

Motion 14225

Proposed No. 2014-0383.1

Sponsors Lambert

1 A MOTION requesting that the executive utilize an
 2 existing task force convened to develop sustainable
 3 solutions to the psychiatric boarding crisis, to review and
 4 recommend short- and long-term sustainable solutions for
 5 prevention, early intervention and least-restrictive
 6 alternatives for individuals in mental health and substance
 7 abuse crisis.

8 WHEREAS, the personal and public tolls related to individuals experiencing
 9 mental health and substance abuse crises are growing each year, and

10 WHEREAS, the boarding of psychiatric patients in hospital emergency rooms and
 11 acute care centers because space is not available at certified psychiatric treatment
 12 facilities is a major problem in King County, with over sixty-four percent of involuntarily
 13 detained individuals held on single bed certifications in 2012, and

14 WHEREAS, Washington state has broadened the criteria for involuntary
 15 commitment of people with mental illness, while simultaneously closing hospital wards,
 16 cutting state funding for mental health treatment and failing to fund bed space for
 17 inpatient psychiatric treatment, and

Appendix B: Motion 14225

Motion 14225

18 WHEREAS, since 2007 the caseload for King County's involuntary treatment
19 court has grown faster than any other category of superior court cases, increasing by
20 fifty-four percent according to 2013 data, and

21 WHEREAS, Washington state ranks near the bottom of the country for
22 psychiatric treatment beds per capita, ranking forty-seventh of all states, and

23 WHEREAS, on August 7, 2014, the Washington state Supreme Court ruled that
24 hospital boarding of individuals in mental health crisis, absent medical need, is unlawful,
25 and

26 WHEREAS, through policy, programs and services, including the programs and
27 services funded in part by the mental illness dependency sales tax, King County is taking
28 action to increase mental health and substance abuse treatment capacity to prevent mental
29 health and substance abuse crises from occurring and to provide treatment in the
30 appropriate setting, and

31 WHEREAS, without a reduction of demand for, and adequate funding of, mental
32 health and substance abuse crisis services, the mental health and substance abuse systems
33 of King County and the Washington state face both human and fiscal crises, and

34 WHEREAS, the King County executive and the Governor of Washington state
35 have jointly convened a task force to work with hospitals and mental health and
36 substance abuse treatment providers and other community stakeholders to develop and
37 bring to state lawmakers short- and long-term sustainable solutions to address psychiatric
38 boarding;

39 NOW, THEREFORE, BE IT MOVED by the Council of King County:

Motion 14225

40 A. The executive is requested assist the task force to find short- and long-term
41 sustainable solutions that: increase the use of least restrictive alternatives for individuals
42 in crisis, thereby reducing the demand for involuntary treatment, including the demand
43 for involuntary treatment court services; provide for successful reentry into the
44 community for individuals who have received services from psychiatric hospitals,
45 including mental health and substance abuse treatment; and focus especially on the
46 continuum of prevention and intervention services.

47 B. The task force is requested to submit a final report to the executive and the
48 council on June 30, 2016, detailing findings and recommendations on the following
49 matters:

50 1. Identification of services, programs, and protocols necessary for King County
51 to reduce of demand for involuntary treatment services, including involuntary treatment
52 court services

53 2. Identification of the continuum of reentry services from psychiatric hospitals
54 into the community, including mental health and substance abuse treatment services; and

55 3. Identification of prevention and intervention services and least restrictive
56 alternatives for individuals in crisis.

57 C. The task force is requested to provide progress reports to the executive and the
58 council describing the progress and findings of the task force as it develops and reviews
59 recommendations for the final report. The progress reports are due June 30, 2015, and
60 January 30, 2016. The reports to the council must be filed in the form of a paper original
61 and an electronic copy with the clerk of the council, who shall retain the original and

62

Appendix B: Motion 14225

Motion 14225

63 provide an electronic copy to all councilmembers.

64

65

Motion 14225 was introduced on 9/8/2014 and passed by the Metropolitan King County Council on 9/15/2014, by the following vote:

Yes: 8 – Mr. Phillips, Mr. Gossett, Ms. Hague, Ms. Lambert, Mr. Dunn,
Mr. McDermott, Mr. Dembowski, and Mr. Upthegrove

No: 0

Excused: 1 – Mr. von Reichbauer

KING COUNTY COUNCIL
KING COUNTY, WASHINGTON



Larry Phillips, Chair

ATTEST:



Anne Noris, Clerk of the Council

Attachments: None

Appendix C: Task Force Charter

Objective: Ensure that all King County residents experiencing mental health and/or substance abuse crises have access to prevention, intervention, and least restrictive treatment services as needed and to community alternatives as appropriate.

Charge: This task force is charged with developing solutions for individuals in mental health and substance abuse crisis focusing on prevention, intervention, and least restrictive alternatives. Reflective of the statewide nature of this group, the members of this task force will collaboratively seek solutions for broad policy issues, solicit and generate creative ideas, and develop and share recommendations that may be implemented in King County and in other communities. Task force members commit to developing broad partnerships, creating bigger and achievable goals, using and sharing better data, and being prepared to take bold action that delivers results for the most vulnerable in our communities.

Task Force Guiding Principles: The work and recommendations of this Task Force will be informed by the following guiding principles:

1. Family, and individually focused;
2. Consumer informed;
3. Based in the principles of recovery and resiliency and reflect King County's behavioral health system's trauma informed approach to services;
4. Shared ownership of the system and continuum by providers, consumers, and the County;
5. Leverage other resources whenever possible;
6. Aligned with opportunities under the Affordable Care Act and health reform;
7. Equity and social justice oriented;
8. System focused, emphasizing increased efficiencies and effectiveness; and
9. Integrates behavioral health and primary care when possible.

Background and Overview: Crisis is costly for individuals who find themselves in a mental health or substance abuse crisis: costly in both human and financial terms. The publically funded behavioral health system that is responsible for serving individuals in crisis is complex, involving multiple systems (medical, criminal justice, and federal, state, and local governments) and stakeholders (providers, advocates, families). The involuntary treatment system is perhaps the most intimidating and rigid for individuals and families who find themselves in its midst.

The Washington State Involuntary Treatment Act (ITA) allows for people with mental disorders to be civilly committed against their will for defined periods of time – 72 hours, 14 days, 90 days, and 180 days¹³². In King County, a Superior Court adjudicates the civil commitment cases in the county's ITA Court, while ITA Court operations occur in partnership between the Superior Court, the Department of Public Defense, the Prosecutor's Office, the Department of Community and Human Services, the Department of Judicial Administration and the Sheriff's Office.

¹³² RCW 71.05 (adults) and RCW 71.34 (youth under 18)

Appendix C: Task Force Charter

The Process of Mental Health Involuntary Commitment: Under state mental illness laws, there are specific circumstances where a person can be considered for involuntary psychiatric hospitalization if, as the result of a mental disorder, one of the following circumstances exists:

1. If someone presents a substantial risk of harm towards others or themselves; or
2. If someone presents a substantial risk of damaging someone else's property; or
3. Someone is in danger of serious physical harm because he or she cannot provide for his or her essential needs of health and safety.

King County's Crisis and Commitment Services section of the Mental Health, Chemical Abuse and Dependency Services Division of the Department of Community and Human Services conducts evaluations of people for possible involuntary detention in psychiatric facilities for mental health treatment. The Crisis and Commitment staff who perform these duties are all employed by the county and are referred to as Designated Mental Health Professionals (DMHPs). The evaluation by DMHPs is intended to protect the rights of individuals while assuring prompt evaluation and treatment for persons with serious mental disorders who pose a danger to themselves or others. Anyone who is within the boundaries of King County can be referred for involuntary treatment services.

Under Washington State law, the County, as the Regional Support Network, is legally obligated to evaluate individuals within statutorily defined timeframes and detain anyone who meets the statutory criteria for involuntary commitment and whose needs cannot be met by any less restrictive alternative. Furthermore, the County is required to detain the person in a facility in which the person can receive adequate psychiatric care. These are Evaluation and Treatment (E&T) facilities certified by the state. The County risks significant liability if the person who has been determined to be a danger to him/herself or others is not detained.

Since 2007, the caseload for King County's ITA Court has grown faster than any other category of Superior Court cases, increasing by 1,303 filings or 54 percent from 2007 to 2013. The growth translates to increase demands for staff, judicial officers, space and other costs that are borne by the mental health fund making less funding available for DMHP staff and/or treatment. The caseload increase is also directly related to the demand for involuntary treatment psychiatric beds.

The Process of Substance Abuse Involuntary Commitment: Substance abuse ITA laws fall under a separate statute (RCW 70.96A.140) and differs significantly from the mental health ITA process. When a designated chemical dependency specialist receives information alleging that a person presents a likelihood of serious harm or is gravely disabled as a result of chemical dependency, the designated chemical dependency specialist, after investigation and evaluation of the specific facts alleged and of the reliability and credibility of the information, may file a petition for commitment of such person with the superior court, district court, or in another court permitted by court rule.

Boarding: Washington ranks 47th in the nation in inpatient psychiatric beds per capita, and there has been a significant reduction in psychiatric hospital bed capacity in the state in recent years while the population has grown.¹³³ This has created a severe shortage of inpatient psychiatric beds and a crisis of access to the care that people detained under the Involuntary Treatment Act (ITA) desperately need. The lack of inpatient beds, ITA law changes, and other factors have resulted in the use of single bed certifications (SBCs) for individuals temporarily detained in hospital emergency rooms and medical units

¹³³ M. Burley. (2011). *Inpatient Psychiatric Capacity in Washington State: Assessing Future Needs and Impacts* (Document No. 11-10-3401). Olympia: Washington State Institute for Public Policy.

Appendix C: Task Force Charter

while awaiting an appropriate bed to which the person can be transferred – a phenomenon that occurred 2,469 times in King County alone in 2013.

The State Supreme Court ruled in August 2014 that using SBCs solely due to insufficient inpatient capacity – commonly known as “boarding” – is illegal. The Court’s ruling created a unique opportunity to address this crisis.

Drivers: There are a number of factors motivating the focused effort of this task force to address prevention, early intervention, and least restrictive alternatives for individuals in crisis. These elements offer multiple opportunities to achieve behavioral health system changes. They include but are not limited to:

- *New parity legislation:* The Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 requires health insurers and group health plans to provide the same level of benefits for mental and/or substance use treatment and services that they do for medical/surgical care.
- *Affordable Care Act:* The Affordable Care Act further expands the MHPAEA’s requirements by ensuring that qualified plans offered on the Health Insurance Marketplace cover many behavioral health treatments and services. It also includes prevention, early intervention, and treatment of mental and/or substance use disorders as an “essential health benefit” (EHB) that must be covered by health plans that are offered through the Health Insurance Marketplace. The ACA also significantly expanded Medicaid coverage. In Washington State, a potential enrollment increase of about 325,000 new clients over several years is anticipated.
- *Mandated integration of behavioral and physical healthcare:* During the 2014 legislative session, the Legislature passed Senate Bill 6312 that integrates how the state purchases mental health and substance abuse services. The legislation mandates that primary care services be available in mental health and chemical dependency treatment facilities and vice versa. It also creates financial incentives for local governments to “opt in” to full integration of behavioral health with physical health care as early adopters. And it requires that our new behavioral health system provide access to recovery support services, such as housing, supported employment and connections to peers.
- *Dual Eligibles health reform:* The dual eligibles demonstration project involves individuals eligible for both Medicare and Medicaid (“dual eligibles”). The demonstration project includes an integrated finance and service delivery care model in which medical, mental health, substance abuse, and long-term care services are purchased through a managed care organization.
- *Recent and pending judicial decisions:* (1) On August 7th, 2014, the Washington State Supreme Court ruled that hospital boarding of individuals in mental health crisis, absent medical need, is unconstitutional. A stay was granted by the Court in September stating that this ruling will go into effect on December 26, 2014; and (2) In October, the courts imposed sanctions on the state healthcare authority regarding delays in performing forensic mental health evaluations. Additional decisions may be forthcoming.

King County, with its robust history of behavioral health innovation and leadership, is uniquely positioned to build on and leverage these reform efforts to deliver the identified outcomes.

Appendix C: Task Force Charter

Timeline: Start Date: October 2014 – End Date: October 2016

Deliverables: Behavioral Health Strategic Plan

1. Recommend system improvements resulting in a continuum of care that:
 - a. Serves consumers across all age ranges, including children and parents;
 - b. Reduces demand for involuntary detention;
 - c. Increases community alternatives to detention;
 - d. Prioritizes mechanisms that prevent behavioral health events from becoming crises;
 - e. Ensures appropriate treatment beds available, voluntary and involuntary;
 - f. Provides necessary resources to providers, including state and county services; and
 - g. Builds on and leverage existing successes.
2. Identify policy or legislative changes that support system improvements and drive toward a continuum of care.
3. Specify how this work links with and furthers existing behavioral health work and endeavors.
4. Develop proposed performance targets and oversight/reporting plans.
5. Respond to King County Council Motion 14225-Reports due
 - a. June 30, 2015 Progress report to the Council
 - b. January 30, 2016 Progress report to the Council
 - c. June 20, 2016 Final Task Force Report to the Council

Motion 14225 states:

The executive is requested to assist the task force to find short- and long-term sustainable solutions that: increase the use of least restrictive alternatives for individuals in crisis, thereby reducing the demand for involuntary treatment, including the demand for involuntary treatment court services; provide for successful reentry into the community for individuals who have received services from psychiatric hospitals, including mental health and substance abuse treatment; and focus especially on the continuum of prevention and intervention services.

The task force is requested to submit a final report to the executive and the council on June 30, 2016, detailing findings and recommendations on the following matters:

1. Identification of services, programs, and protocols necessary for King County to reduce of demand for involuntary treatment services, including involuntary treatment court services
2. Identification of the continuum of reentry services from psychiatric hospitals into the community, including mental health and substance abuse treatment services; and
3. Identification of prevention and intervention services and least restrictive alternatives for individuals in crisis.

The task force is requested to provide progress reports to the executive and the council describing the progress and findings of the task force as it develops and reviews recommendations for the final report. The progress reports are due June 30, 2015, and January 30, 2016.

Appendix C: Task Force Charter

Sponsors:

Office of the Governor
King County Executive Office
King County Council
Department of Community and Human Services

Membership:

This task force focuses on King County solutions, though statewide membership will be sought to address broad policy issues, solicit creative ideas and share recommendations that may be implemented in other communities. Task force members will commit to develop broad partnerships, create bigger and achievable goals, use and share better data and be prepared to take bold action that delivers results.

Subject matter experts or others may be asked to participate in Task Force meetings and or work groups as needed as subject matter experts.

Co-Conveners: Betsy Jones - King County Executive Office
 Andi Smith - Office of the Governor

Members: Kelli Carroll – Department of Community and Human Services
 Dave Chapman – Director, Department of Public Defense
 Laura Collins - Harborview Medical Center
 Chris Imhoff - Division of Behavioral Health and Recovery
 Darcy Jaffe - Harborview Medical Center
 David Johnson – Navos
 Dan Satterberg - King County Prosecuting Attorney
 Jim Vollendroff - Department of Community and Human Services
 Chelene Whiteaker - Washington State Hospital Association
 Dr. Maria Yang – Medical Director, King County MHCADSD

Stakeholders: King County Executive Office
 King County Council
 Office of the Governor
 Department of Community and Human Services
 Harborview Medical Center
 Division of Behavioral Health and Recovery
 Washington State Hospital Association
 Washington Community Mental Health Council
 Law Enforcement
 Criminal Justice – courts, prosecution, defense
 Jail Health Services
 Designated Mental Health Professional Staff

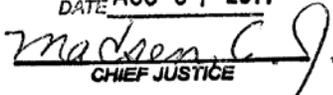
Appendix D: Task Force Membership

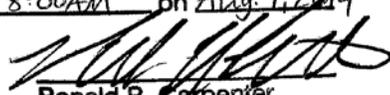
Task Force Member	Affiliation	Role
Graydon Andrus	Downtown Emergency Service Center	Director of Clinical Programs
Johanna Bender	King County Superior Court	Former District Court Regional Mental Health Court Judge
Holly Borso	Department of Social and Health Services (DSHS), Division of Behavioral Health and Recovery (DBHR), Behavioral Health Administration (BHA)	Behavioral Health Program Manager, State Hospital Special Populations
Jeanne Camelio	King County Department of Community and Human Services (DCHS), Behavioral Health and Recovery Division (BHRD)	Hospital and Forensic Services Diversion and Re-Entry Coordinator
Kelli Carroll	King County DCHS, BHRD	Strategic Advisor
Laura Collins	Harborview Medical Center	Psychiatry Administrator
Charlotte Daugherty	King County Superior Court	ITA Court Program Manager
Mike DeFelice	King County Department of Public Defense (DPD), Civil Commitment Division	Supervising Attorney
Patty Hayes	Public Health – Seattle and King County	Director
Carrie Huie-Pascua	DSHS, DBHR	Inpatient and Acute Care Treatment Manager
Chris Imhoff	DSHS, DBHR	Director
Darcy Jaffe	Harborview Medical Center	Chief Nursing Officer
David Johnson	Navos	Chief Executive Officer
Betsy Jones	Office of the King County Executive	Health and Human Potential Policy Advisor
Anita Khandelwal	King County DPD	Policy Director
Rick Lichtenstadter	King County DPD, Defender Association Division	Acting Interim Director
Leesa Manion	King County Prosecuting Attorney's Office	Chief of Staff
Terry Mark	King County DCHS	Deputy Director

Appendix D: Task Force Membership

Task Force Member	Affiliation	Role
Anne Mizuta	King County Prosecuting Attorney's Office, Involuntary Treatment Unit	Deputy Prosecuting Attorney, Senior Specialist
Adrienne Quinn	King County DCHS	Director
Denise Rothleutner	King County Developmental Disabilities Division	Division Director
John Ruhl	King County Superior Court	ITA Court Judge
Dan Satterberg	King County Prosecuting Attorney's Office	Prosecuting Attorney
Susan Schoeld	King County DCHS, BHRD	Crisis Diversion Program Manager
Ken Schubert	King County Superior Court	Former ITA Court Judge
Andi Smith	Office of the Governor	Senior Policy Advisor
Gail Stone	Office of the King County Executive	Law and Justice Policy Advisor
Diane Swanberg	King County DCHS, BHRD	Coordinator, Crisis and Commitment Services
Chris Verschuyll	King County DCHS, BHRD	Strategic Program Planner
Jim Vollendroff	King County DCHS, BHRD	Division Director
Chelene Whiteaker	Washington State Hospital Association	Policy Advisor, Member Advocacy
Dr. Maria Yang	King County DCHS, BHRD	Medical Director, Managing Psychiatrist
Lorinda Youngcourt	King County DPD	Director

Appendix E: Washington Supreme Court Ruling *In re the Detention of D.W. et al*

FILE
 IN CLERKS OFFICE
 SUPREME COURT, STATE OF WASHINGTON
 DATE AUG 07 2014

 CHIEF JUSTICE

This opinion was filed for record
 at 8:00AM on Aug. 7, 2014

 Ronald R. Carpenter
 Supreme Court Clerk

IN THE SUPREME COURT OF THE STATE OF WASHINGTON

IN THE MATTER OF THE)	
DETENTION OF: D.W., G.K., S.B.,)	No. 90110-4
E.S., M.H., S.P., L.W., J.P., D.C.,)	
and M.P.,)	
)	
Respondents,)	
)	
and)	
)	
FRANCISCAN HEALTH CARE)	
SYSTEMS and MULTICARE,)	En Banc
HEALTH SYSTEM,)	
)	
Respondents/Intervenors,)	
)	
v.)	
)	
THE DEPARTMENT OF SOCIAL)	
AND HEALTH SERVICES and)	Filed <u>AUG 07 2014</u>
PIERCE COUNTY,)	
)	
Appellants.)	

GONZÁLEZ, J.—Washington State’s involuntary treatment act (ITA), chapter 71.05 RCW, authorizes counties to briefly detain those who, “as the result of a mental disorder,” present an imminent risk of harm to themselves or others, or are gravely disabled. RCW 71.05.153(1), .230. The initial brief

**Appendix E: Washington Supreme Court Ruling
*In re the Detention of D.W. et al***

In re the Detention of D.W., et. al., No. 90110-4

detention is for the limited purpose of evaluation, stabilization, and treatment, and once someone is detained under the ITA, he or she is entitled to individualized treatment. RCW 71.05.153, .230, .360(2). Pierce County frequently lacks sufficient space in certified evaluation and treatment facilities for all those it involuntarily detains under the ITA. It regularly resorts to temporarily placing those it involuntarily detains in emergency rooms and acute care centers via “single bed certifications” to avoid overcrowding certified facilities. Such overcrowding-driven detentions are often described as “psychiatric boarding.” DAVID BENDER ET AL., A LITERATURE REVIEW: PSYCHIATRIC BOARDING 4 (2008). Patients psychiatrically boarded in single bed certifications generally receive only emergent care. After 10 involuntarily detained patients moved to dismiss the county’s ITA petitions, a trial judge found that psychiatric boarding is unlawful. We agree and affirm.

FACTS

Our current involuntary civil commitment system has been regularly overwhelmed since it was first enacted by the legislature in 1979. Mary L. Durham & John Q. La Fond, *The Empirical Consequences and Policy Implications of Broadening the Statutory Criteria for Civil Commitment*, 3 YALE L. & POL’Y REV. 395, 411-12 (1985). By 1981, Western State Hospital, which at the time acted as an evaluation and treatment center, was filled to capacity and refused to accept more patients until it was ordered to by this

**Appendix E: Washington Supreme Court Ruling
*In re the Detention of D.W. et al***

In re the Detention of D.W., et. al., No. 90110-4

court. *Id.* at 412-13 & n.104 (citing *Pierce County v. W. State Hosp.*, 97 Wn.2d 264, 644 P.2d 131 (1982)).

Overcrowding has continued. In early 2013, Pierce County detained the 10 respondent patients before us under the ITA. In most cases, the respondents were initially held in hospital emergency rooms or in local acute care medical hospitals. None of these sites were certified as evaluation and treatment centers under the ITA. In all cases, the county, through one of its designated mental health providers, filed petitions to hold the respondents for up to 14 more days. Several of the involuntarily detained patients moved to dismiss these 14-day petitions on the grounds that they had not been, and believed they would not be, detained in a certified evaluation and treatment facility. On February 12, 2013, Mental Health Commissioner Adams heard the motions to dismiss two of these petitions. At this hearing, the prosecutor informed the commissioner that Pierce County had eight other single bed certifications pending in local medical facilities. Upon learning this, Commissioner Adams set the matter over for an evidentiary hearing on February 27, 2013. Concerned that he lacked necessary briefing and parties, the commissioner invited the Department of Social and Health Services (DSHS) and several of the hospitals who had housed involuntarily detained patients to participate.

One of the witnesses at the February 27 hearing was Nathan Hinrichs, the supervisor of the designated mental health professionals (DMHP) in Pierce

**Appendix E: Washington Supreme Court Ruling
*In re the Detention of D.W. et al***

In re the Detention of D.W., et. al., No. 90110-4

County. Hinrichs testified that once a DMHP determined that someone should be involuntarily detained for evaluation, “we try and locate a bed. We’ll call up to five local hospital evaluation and treatment centers to try and find a bed, sometimes more.” Clerk’s Papers (CP) at 117.¹ If no bed is available, the DMHP would “seek to obtain a single bed cert[ification] to detain them at the community hospital.” *Id.* at 118. To do that, the DMHP would fill out a certification form and “fax that to Western State” Hospital. *Id.* Western State Hospital “never asked” why Pierce County was seeking a single bed certification; it would almost always simply approve the request. *Id.* at 119. Indeed, Hinrichs could remember only one time a request was denied: when the county sought a single bed certification in the Special Commitment Center on McNeil Island. Hinrichs also testified that those patients involuntarily held in single bed certifications “are getting less care than they would if they were in an evaluation and treatment center [and] it’s actually a more restrictive environment.” *Id.* at 124. He testified that on the day of the hearing, there were 11 people in Pierce County held on single bed certifications. The State’s witness, David Reed from DSHS’s Division of Behavioral Health and Recovery, testified consistently. Reed also testified that the use of single bed certifications had “within the past seven years . . . pretty much exploded and is

¹ While Hinrich did not say specifically those five evaluation and treatment centers he would contact would be certified, the context suggests they would have been.

**Appendix E: Washington Supreme Court Ruling
*In re the Detention of D.W. et al***

In re the Detention of D.W., et. al., No. 90110-4

continuing to increase.” *Id.* at 171. After the hearing, Commissioner Adams found that a patient involuntarily detained in a single bed certification “gets no psychiatric care or other therapeutic care for their mental illness” and that the practice of using single bed certifications to avoid overcrowding certified evaluation and treatment facilities is unlawful. *Id.* at 48, 192, 54-55.

Pierce County moved to revise Commissioner Adam’s decision. While still technically appearing as an amicus, DSHS challenged the commissioner’s power to hear the case and argued that psychiatric boarding to avoid overcrowding certified facilities was allowed by both the ITA and its implementing regulations, especially WAC 388-865-0526. Judge Nelson vacated the commissioner’s decision, but she reached the same conclusion in her own extensive written ruling. She also granted the amici’s motions to intervene.²

DSHS and Pierce County appealed. On the Court of Appeals’ own motion, the 10 cases were consolidated and, after the briefs were filed,

² The hospitals’ interest in intervening is clear. At the hearing below, the hospital interveners’ counsel informed the trial judge:

We operate three hospitals that have undergone, if you will, single-bed certifications. We have no psychiatrists. We have no psychiatric nurses. We have no orderlies. We have no ability to provide any of the treatment that is mandated under the statute. We are basically warehousing these people, including kids. I mean, we had a kid in the ER at Mary Bridge for 10 days the other day, or last month.

VRP (Mar. 29, 2013) at 16.

**Appendix E: Washington Supreme Court Ruling
*In re the Detention of D.W. et al***

In re the Detention of D.W., et. al., No. 90110-4

transferred to this court.³ The respondent patients are supported on review by interveners MultiCare Health System and Franciscan Health System; by amici curiae Disability Rights Washington, the National Alliance on Mental Illness Washington, and the American Civil Liberties Union of Washington in one brief; and by amici curiae the Washington State Hospital Association, the Association of Washington Public Hospital Districts, the Washington State Medical Association, the Washington Chapter of the American College of Emergency Physicians, the Northwest Organization of Nurse Executives, the Washington State Nurses Association, SEIU Healthcare 1199NW, and the Washington Council of Emergency Nurse Association in another.

ANALYSIS

We review questions of law de novo and findings of fact for substantial evidence. *Soltero v. Wimer*, 159 Wn.2d 428, 433, 150 P.3d 552 (2007) (citing *Nordstrom Credit, Inc. v. Dep't of Revenue*, 120 Wn.2d 935, 942, 845 P.2d 1331 (1993)). The ITA impacts liberty interests and thus is strictly construed. *In re Det. of G.V.*, 124 Wn.2d 288, 296, 877 P.2d 680 (1994) (quoting *In re Det. of Swanson*, 115 Wn.2d 21, 31, 804 P.2d 1 (1990)).

The State's lawful power to hold those not charged or convicted of a crime is strictly limited. *Oviatt ex rel. Waugh v. Pearce*, 954 F.2d 1470, 1474

³ The record on appeal was sua sponte sealed by the Court of Appeals under RCW 71.05.620. No one has asked us to consider the propriety of this action.

**Appendix E: Washington Supreme Court Ruling
*In re the Detention of D.W. et al***

In re the Detention of D.W., et. al., No. 90110-4

(9th Cir. 1992) (citing *Baker v. McCollan*, 443 U.S. 137, 144, 99 S. Ct. 2689, 61 L. Ed. 2d 433 (1979)). However, “[a] state has a legitimate interest in treating the mentally ill and protecting society from their actions.” *In re Albrecht*, 147 Wn.2d 1, 7, 51 P.3d 73 (2002) (citing *Addington v. Texas*, 441 U.S. 418, 426, 99 S. Ct. 1804, 60 L. Ed. 2d 323 (1979)). Civil commitment is permitted, but the commitment system “must require that an individual be both mentally ill and dangerous for civil commitment to satisfy due process.” *Id.* (footnote omitted) (citing *Addington*, 441 U.S. at 426); *Foucha v. Louisiana*, 504 U.S. 71, 80, 112 S. Ct. 1780, 118 L. Ed. 2d 437 (1992)). Anyone detained by the state due to “incapacity has a constitutional right to receive ‘such individual treatment as will give each of them a realistic opportunity to be cured or to improve his or her mental condition.’” *Ohlinger v. Watson*, 652 F.2d 775, 778 (9th Cir. 1981) (quoting *Wyatt v. Stickney*, 325 F. Supp. 781, 784 (M.D. Ala. 1971)). Patients may not be warehoused without treatment because of lack of funds. “‘Lack of funds, staff or facilities cannot justify the State’s failure to provide [such persons] with [the] treatment necessary for rehabilitation.’” *Or. Advocacy Ctr. v. Mink*, 322 F.3d 1101, 1121 (9th Cir. 2003) (alterations in original) (quoting *Ohlinger*, 652 F.2d at 779).

The ITA itself embraces these principles. It says that “[e]ach person involuntarily detained or committed pursuant to [the ITA] shall have the right to adequate care and individualized treatment.” RCW 71.05.360(2). The ITA

**Appendix E: Washington Supreme Court Ruling
*In re the Detention of D.W. et al***

In re the Detention of D.W., et. al., No. 90110-4

also repeatedly provides that those involuntarily detained for evaluation, stabilization, and treatment are to be held in certified evaluation and treatment facilities. *E.g.*, RCW 71.05.150(4) (“The designated mental health professional may notify a peace officer to take such person or cause such person to be taken into custody and placed in an evaluation and treatment facility.”), .153(1) (providing that “the designated mental health professional may take such person, or cause by oral or written order such person to be taken into emergency custody in an evaluation and treatment facility”), .210 (“Each person involuntarily detained and accepted or admitted at an evaluation and treatment facility . . .”), .220 (“[a]t the time a person is involuntarily admitted to an evaluation and treatment facility . . .”). There are exceptions, but they are limited.⁴

The act defines “evaluation and treatment facilities” as

any facility which can provide directly, or by direct arrangement with other public or private agencies, emergency evaluation and treatment, outpatient care, and timely and appropriate inpatient care to persons suffering from a mental disorder, *and which is certified as such by the department*. A physically separate and separately operated portion of a state hospital may be designated as an evaluation and treatment facility. A facility which is part of, or operated by, the department or any federal agency will not require certification. No correctional institution or

⁴ The ITA does authorize transfer to a chemical dependency treatment facility if the medical staff determine “that the initial needs of the person would be better served” in one or to a hospital if the patient’s “physical condition reveals the need for hospitalization.” RCW 71.05.210. Those are the only exceptions in the ITA itself for involuntarily detaining someone in a 72-hour or 14-day detention outside of a certified evaluation and treatment facility that have been called to our attention.

**Appendix E: Washington Supreme Court Ruling
*In re the Detention of D.W. et al***

In re the Detention of D.W., et. al., No. 90110-4

facility, or jail, shall be an evaluation and treatment facility within the meaning of this chapter.

RCW 71.05.020(16) (emphasis added). This definition does not include hospital emergency rooms or acute care centers unless they are specifically certified as evaluation and treatment centers, which no one in this case contends they were. We find that the act itself does not authorize single bed certifications to avoid overcrowding certified evaluation and treatment facilities.

Properly read, the administrative regulations at issue are in accord. The most relevant regulation provides:

At the discretion of the mental health division, an exception may be granted to allow treatment to an adult on a seventy-two hour detention or fourteen-day commitment in a facility that is not certified under WAC 388-865-0500;

. . . .

(3) The request for single bed certification must describe why the consumer meets at least one of the following criteria:

(a) The consumer requires services that are not available at a facility certified under this chapter or a state psychiatric hospital; or

(b) . . . being at a community facility would facilitate continuity of care

(4) . . . The single bed certification must not contradict a specific provision of federal law or state statute.

**Appendix E: Washington Supreme Court Ruling
*In re the Detention of D.W. et al***

In re the Detention of D.W., et. al., No. 90110-4

WAC 388-865-0526; *accord* WAC 388-865-0500. The State argues that this rule authorizes single bed certification both when the involuntarily detained patient needs medical care that is not available at a certified evaluation and treatment center and when there is no room in a certified evaluation and treatment center where appropriate treatment would be otherwise available. We disagree. Properly read, this rule allows single bed certifications when, in the exercise of professional judgment, a properly qualified agent of the mental health division determines that there is either a medical justification for involuntarily detaining a patient outside a certified facility or that the single bed certification would facilitate continuity of care. For example, the rule would allow a single bed certification when a patient “requires services that are not available” at an evaluation and treatment center, such as dialysis or chemical dependency treatment. WAC 388-865-0526(3)(a). By its plain terms, this rule does not authorize a single bed certification merely because there is no room at certified facilities with which the county already has a contractual relationship.⁵

The county argues we should show appropriate deference to the professional judgment of psychiatric professionals and not substitute our judgment for theirs. Br. of Appellant Pierce County DMHPs at 22 (citing *Youngberg v. Romeo*, 457 U.S. 307, 322-23, 102 S. Ct. 2452, 73 L. Ed. 2d 28 (1982)). We agree that exercises of professional judgment of qualified

⁵ If it did, it may violate both the ITA and constitutional rights of the patients.

**Appendix E: Washington Supreme Court Ruling
*In re the Detention of D.W. et al***

In re the Detention of D.W., et. al., No. 90110-4

professionals are entitled to substantial respect. *See generally Braam ex rel. Braam v. State*, 150 Wn.2d 689, 701, 81 P.3d 851 (2003). We would generally not disturb the decision of a qualified person that a patient had an individual need for services not available at any certified evaluation and treatment center. However, this record does not show that the decisions to involuntarily detain these patients outside of certified facilities was the result of an exercise of professional judgment about the needs of the individual patient. Instead, the record demonstrates that a DMHP did not find room in a certified evaluation and treatment facility and that some person at Western State Hospital approved a request for a single bed certification without knowing whether there was a medical justification for involuntarily detaining that individual patient outside of a certified facility. We find that the ITA authorizes single bed certifications for statutorily recognized reasons individual to the patient, but not merely because there is a generalized lack of room at certified facilities.⁶

CONCLUSION

We affirm the trial judge's ruling that the ITA does not authorize psychiatric boarding as a method to avoid overcrowding certified evaluation and treatment facilities.

⁶ The State and county brought many challenges to the trial judge's authority to hear the case. We find the judge had authority to consider the lawfulness of the county's actions under the ITA and find the other challenges unavailing. Given our disposition, we do not reach the remaining challenges brought by the respondents.

Appendix E: Washington Supreme Court Ruling
In re the Detention of D.W. et al

In re the Detention of D.W., et. al., No. 90110-4

Conzalez, J.

WE CONCUR:

Madsen, C. J.

Plum

Owens, J.

Fairhurst, J.

Stephens, J.

Wiggin, J.

Holsell, J.

Lyne, J.

Appendix F: Inventory of Existing Service Continuum

As part of an overall system review and in accordance with Motion 14225 requirements, the CABTF's task group work included identification of the continuum of existing services that relate to its charter and mandate, specifically addressing prevention and intervention services, least restrictive alternatives (LRAs) for individuals in crisis, and reentry services from psychiatric hospitals into the community.¹³⁴

This effort provided context for development of the CABTF's set of recommendations around long-term system design. The system improvement priorities and recommendations detailed beginning on page 65 of this report would work in tandem with these existing programs.

The established continuum described in brief in this section, is also considered by the CABTF to be an essential part of the foundational service mix required to reduce involuntary treatment demand effectively, even though it is not sufficient on its own to meet community needs. This section is not intended as an exhaustive study of all programming available, but highlights in summary form a range of current services viewed by CABTF members as having notable impact on the need for involuntary treatment in King County.¹³⁵

The CABTF's inventory captured services in five broad categories: prevention and early intervention, hospital diversion, hospital discharge and re-entry, longer-term community-based engagement, and essential safety net services, with some featured services crossing multiple categories.

The CABTF's approach to this inventory addressed prevention and early intervention services, and conceived the continuum of reentry services from psychiatric hospitals into the community as having two aspects: assisting people as they discharge from hospitals, as well as intervening before involuntary system contact to attempt to prevent an inpatient stay. Programs described in the inventory include some crisis services that are specialized for individuals with substance use disorders (SUDs).

The inventory also includes a range of interventions that can prevent hospitalization for individuals with significant behavioral health needs and risk through engaging with participants in the community over a longer term, not solely during a crisis event. Outreach programs to engage individuals who are homeless and who also have serious mental health and substance abuse issues, who are unable to effectively access more mainstream services, are among these.

Safety net programs in this overview, many of which relate to shelter, provide access to services and support that address additional quality of life needs impacting individuals with mental health disorders. They can help provide stability and connection to service providers who can identify and address needs prior to an increase in symptoms or decompensation.

As some services intervene at multiple points on this continuum, they are shown in a table beginning on the next page, with additional information provided about each program or service in the pages that follow.

¹³⁴ Motion 14225, section B.2 and B.3.

¹³⁵ Some of these services directly address the population most at risk of involuntary treatment system contact, while most have broader target populations or impacts but are still considered by the CABTF to be essential.

Appendix F: Inventory of Existing Service Continuum

Existing Continuum Inventory Summary Table

Service Name or Type	Intervention Categories				
	Prevention and Early Intervention	Hospital Diversion	Hospital Discharge and Re-Entry	Community-Based Engagement	Essential Safety Net Services
After hours crisis response for behavioral health organization (BHO) enrollees	X	X			
Assisted living programs (such as group homes, adult family homes, skilled nursing facilities)			X	X	
Children's Crisis Outreach Response System (CCORS)	X	X			
Community-based outpatient mental health and substance use disorder (SUD) treatment	X			X	
Crisis Clinic	X				
Crisis diversion bed		X			
Crisis Respite Program (CRP)		X	X		
Crisis Solutions Center (CSC) including Crisis Diversion Facility		X			
Day service and support centers				X	
Detoxification services		X			
Dutch Shisler Sobering Center (DSSC)		X			
Emergency Department (ED) High Utilizer Case Management Program		X	X		
Emergency Services Patrol (ESP)		X			
Homeless Outreach Stabilization and Transition (HOST)				X	
Intensive treatment teams, including Program for Assertive Community Treatment (PACT), Forensic Intensive Supportive Housing (FISH), and Forensic Assertive Community Treatment (FACT)				X	
Law Enforcement Assisted Diversion (LEAD)				X	
Least Restrictive Alternative (LRA) orders		X	X		

Appendix F: Inventory of Existing Service Continuum

Service Name or Type	Intervention Categories				
	Prevention and Early Intervention	Hospital Diversion	Hospital Discharge and Re-Entry	Community-Based Engagement	Essential Safety Net Services
Medical Respite Program			X		
Medication-assisted treatment (MAT)				X	
Metropolitan Improvement District Outreach Team				X	
Mobile Crisis Team (MCT)		X			
Next day appointments (NDAs)		X			
Older adult prevention, early intervention, and crisis services	X	X			
Open access intake appointments	X				
Overnight shelters					X
Partnership Access Line (PAL)	X				
Peer Bridger program			X		
Permanent supportive housing				X	X
Project for Assistance in Transition from Homelessness (PATH)				X	
REACH				X	
School district-based mental health and substance abuse services and school-based suicide prevention	X				
Screening, Brief Intervention, and Referral to Treatment (SBIRT)	X				
Seattle Police Department Crisis Response Unit		X			
Transitional Support Program (TSP)			X		
Vocational support and training	X				
Wraparound	X	X		X	
10.77 triage pilot		X			

Summary information about each of the programs in this table is available on the following pages.

Appendix F: Inventory of Existing Service Continuum

Additional Information about Existing Services on the Continuum

King County outpatient behavioral health providers currently either directly provide or arrange subcontracts to provide telephonic and in-person, **after-hours crisis response** to individuals enrolled with their agency.¹³⁶

Assisted living programs (including group homes, adult family homes, and skilled nursing facilities), support individuals whose medical, behavioral health, or personal care needs present significant barriers to living independently, but who do not require psychiatric care in an inpatient setting. These resources are scarce, and many of them are administered by the state's Home and Community Services unit or other allied systems.

The **Children's Crisis Outreach Response System (CCORS)** offers short-term, community-based, and family-centered services with the goal of crisis prevention and placement stabilization for children, youth and families 24 hours per day, 7 days per week, year-round.¹³⁷ Efforts via CCORS and other programs to enhance services to children and youth in recent years have shown a reduction in youth psychiatric inpatient utilization, both voluntary and involuntary.¹³⁸

Core community based outpatient mental health and substance use disorder (SUD) treatment, funded via Medicaid as well as non-Medicaid sources, present an ongoing opportunity for relatively early identification that can reduce the rate of hospitalization by addressing needs earlier on in a person's crisis cycle. There are multiple behavioral health providers serving communities throughout King County. Some of these agencies provide services specialized to certain cultural or ethnic populations, and many provide integrated mental health and SUD treatment within the same agency. However, because of low Medicaid payment rates, caseloads are too high at most programs, limiting the degree to which these programs can nimbly and proactively identify behavioral health and physical health instability. Although these programs include some after-hours crisis response for clients with mental health conditions, most programs are primarily office-based and cannot effectively do community-based outreach to serve people in their environments, also due largely to insufficient rates.

The **Crisis Clinic** provides several crisis services for individuals living in King County. It operates the 24-hour crisis line and the 2-1-1 Community Resources Online program,¹³⁹ which is a comprehensive database of health and human services available in the region. The Crisis Clinic is also the access point for Next Day Appointments (NDAs), authorization for voluntary psychiatric hospitalizations, and a source of referrals for the Mobile Crisis Team (MCT). These services help people access voluntary services sooner so their symptoms are less likely to escalate to the point that involuntary hospitalization is required.

King County's one **crisis diversion bed** provides diversion from an episode of inpatient hospitalization for adults and older adults facing immediate voluntary or involuntary psychiatric hospitalization. These beds provide community-based treatment 24 hours per day, 7 days per week for persons in crisis who would otherwise be hospitalized. Crisis Diversion Beds services include intensive case management and

¹³⁶ Proposed improvements to this system are described in priority 1f above (page 85).

¹³⁷ This program is highlighted in endorsement 4h (page 104) as a current service that is important to maintain or expand.

¹³⁸ 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.

¹³⁹ The CABTF's support for the continuation and strengthening of the 2-1-1 service is discussed in endorsement 4e on page 103.

Appendix F: Inventory of Existing Service Continuum

prescriber access, to ensure adequate and appropriate programming for individuals needing crisis respite who are at risk of hospitalization, regardless of funding.

The existing **Crisis Respite Program (CRP)** is a single 20-bed program that provides 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 access to appropriate treatment services as needed.¹⁴⁰

The **Crisis Solutions Center (CSC)** is a jail and hospital diversion facility that also includes respite beds.¹⁴¹ This facility serves residents of King County who have had either contact with first responders or called the Crisis Clinic. Designated mental health professionals (DMHPs) can also refer people they did not detain to the CSC. For some individuals the CSC can serve as early intervention, particularly for people struggling with lack of housing or financial resources. The CSC includes a 16-bed Crisis Diversion Facility (CDF), which stabilizes and supports people in the least restrictive setting possible, while identifying and directly linking them to ongoing services in the community. Specifically, programming includes crisis and stabilization services, case management, evaluation and psychiatric services, mental health and SUD assessments, peer specialist services, and linkage to community-based services.

Day service and support centers, most of which are in and around downtown Seattle, play an important role in offering opportunities for successful stabilization and service linkage. Many of them have a specific clientele focus and eligibility criteria, and services vary widely.

King County's **detoxification center** medically supervises withdrawal from alcohol and other drugs. The goal of withdrawal management, or detoxification, is to keep people medically stable and safe during the withdrawal, and then assist people to ongoing treatment and recovery. Individuals are offered the opportunity to be referred to inpatient or outpatient treatment after completing detoxification. People usually stay between three and five days, but length of stay varies depending on the substance(s) they were using, how sick they became when they quit drinking or using the substance(s), and other factors. A person may also stay longer when clinically appropriate, based upon the American Society of Addiction Medicine (ASAM) patient placement criteria. There is a current 16-bed capacity for withdrawal management services that is contracted specifically for Medicaid and low-income clients in King County.

The **Dutch Shisler Sobering Center (DSSC)** is a safe and secure place for individuals to sleep off the acute effects of alcohol or other drug intoxication, available 24 hours per day, seven days per week. The DSSC, located in downtown Seattle, is open all day, every day of the year and can have up to 60 people at any one time (about 2,000 people total per year). On-site case management, nursing, and outpatient SUD services are available.¹⁴² Sobering Center services are a critical part of the continuum of care for individuals with the most chronic SUDs, because they assist people into recovery systems that help them access case management services, find suitable housing, and access preventative health care. Additionally, the DSSC is also home to a Neighborcare and Healthcare for the Homeless primary care facility that is co-located on site to provide integrated whole person care to program participants.

Harborview's **Emergency Department (ED) High Utilizer Case Management Program (HUP)** serves individuals who are frequently seen at Harborview's ED or psychiatric emergency service (PES). It provides intensive case management for those patients who most frequently utilize the ED, assisting people in the midst of their crisis by delivering flexible and individualized service beginning in the ED or

¹⁴⁰ Expansion and enhancement of this program are highlighted as priority 1b on page 78.

¹⁴¹ Proposed replication of this program is discussed as priority 1g on page 86.

¹⁴² King County Department of Community and Human Services (DCHS) Program Sheet: Detox/sobering/emergency services.

Appendix F: Inventory of Existing Service Continuum

hospital inpatient unit. The program builds on this initial supportive contact to help people reintegrate safely into the community after their immediate crisis, and to help them acquire and engage with stabilizing resources such as housing and community-based care, thereby reducing future emergency system use. Due to the intensity of service as well as the complex needs of program participants, the program has prioritized serving people with eight or more ED visits in six months. The HUP team has the capacity to serve about 100 people per year (about 30 to 40 people at a time), but HUP staff report that as of December 2015, nearly five times as many people meet the program's priority eligibility criteria.¹⁴³

The **Emergency Services Patrol (ESP)** helps people in the downtown Seattle area who are under the influence of alcohol and other drugs. Drivers get calls from the emergency system and patrol a limited area to identify and assist persons in need of help. ESP drivers are on duty 24 hours per day, seven days per week to perform a basic screening of a person's needs and take them to a safe location, including helping agencies such as the DSSC or to hospitals or other health centers if there are medical problems. The drivers also take clients who have finished sobering services back into the community.

The **Homeless Outreach Stabilization and Transition (HOST)** program has a multi-disciplinary team of 15 workers who provide intensive outreach and engagement to individuals with severe mental health disorders and co-occurring mental illness and SUDs. HOST services include engagement, psychiatric treatment, comprehensive case management, housing acquisition, entitlements acquisition, connection to primary care, and transition to on-going services/treatment in the community. The program services approximately 180 people at a given time, for approximately 300 individuals served annually. The team accepts referrals from program staff at hospitals, jails, shelters, and also contacts people at risk on the streets for enrollment into the program. It is anticipated that the unmet need is at least equivalent to the number of individuals who are currently served by program.

Intensive treatment teams, including the Program for Assertive Community Treatment (PACT), Forensic Intensive Supportive Housing (FISH), and Forensic Assertive Community Treatment (FACT) have low caseloads (one staff person per 10 or 15 clients) which allows them greater access on a day-to-day basis to manage the needs of their clients, and to accept clients back from hospitalizations with increased levels of treatment and support to maintain their tenure in the community. The multi-disciplinary composition makes these teams quite nimble and responsive.

Law Enforcement Assisted Diversion (LEAD) is a pre-booking diversion program that offers individuals who are engaging in low-level drug and prostitution offenses harm reduction-oriented case management and legal services as an alternative to incarceration and prosecution. The primary aim of the LEAD program is to reduce criminal recidivism. Secondary aims include reductions in criminal justice service utilization and associated costs as well as improvements for psychosocial, housing, and quality-of-life outcomes. A recent evaluation of the LEAD program indicated positive effects of the LEAD program on reducing average yearly criminal justice and legal system utilization and associated costs.¹⁴⁴ Historically LEAD has been available only in certain defined geographical locations, during defined hours, to individuals referred by officers specially trained in the program, but many policymakers and program planners are working to expand its availability.

¹⁴³ Data provided by Harborview Medical Center, December 2015.

¹⁴⁴ Collins, S.E., Lonczak, H.S., Clifasefi, S.L. (June 24, 2015). LEAD Program Evaluation: Criminal Justice and Legal System among Utilization and Associated Costs. A subsequent evaluation is anticipated in 2016 that will report on within-subjects changes LEAD participants on psychosocial, housing and quality-of-life outcomes following their participation in LEAD. Retrieved from <http://static1.1.sqspcdn.com/static/f/1185392/26401889/1437170937787/June+2015+LEAD-Program-Evaluation-Criminal-Justice-and-Legal-System-Utilization-and-Associated-Costs.pdf>.

Appendix F: Inventory of Existing Service Continuum

As described on page 13, a court may issue a **least restrictive alternative (LRA) order** to ensure that a person experiencing a psychiatric emergency or discharging from an inpatient stay participates in services at a community provider agency, where assessment, stabilization, and treatment may be provided even if a person is otherwise unwilling to enter community-based care.¹⁴⁵ An outpatient LRA order outlines certain conditions the patient must meet while receiving court-supervised treatment. These conditions may include attending regular appointments with a caseworker or therapist, taking medications as prescribed, agreeing to drug and alcohol testing, and developing an individual crisis plan. In King County in late 2015 and early 2016, a range of 115 to 152 individuals were served in the community via such orders. As described on page 45, as part of its implementation of Engrossed Second Substitute House Bill (E2SHB) 1450, the state is working to make LRA services more robust.¹⁴⁶

The **Medical Respite Program** cares for homeless persons needing a safe place to recuperate after an acute hospital stay; provides case management to transition patients to housing, social services, and ongoing primary care; and addresses both acute and chronic behavioral health needs, including mental health and SUDs. The program targets those individuals who are not sick enough to be in the hospital, but too sick to be released to the streets/shelters. Medical respite programs provide short-term residential care, on-site medical and behavioral health services, linkage to regular primary care and mental health/substance abuse services, assistance with benefits, case management, and housing. Medical respite has a 34 bed capacity; in 2015 the program totaled 453 admits with an average length of stay of 23 days.

Medication assisted treatment (MAT) programs, including King County's eight opiate treatment clinic sites at five locations that primarily dispense methadone, have proven very successful for people addicted to opiates by offering an opportunity to block the effects of opiates and stop withdrawal symptoms. Other medical treatments, such as buprenorphine (Suboxone), may also be available to help stabilize individuals who suffer from opiate addiction from individual doctors in the community.

The **Metropolitan Improvement District Outreach Team** works to connect individuals who are homeless and mentally ill in downtown Seattle with services, housing, treatment, employment and other basic needs. The team consists of three full-time outreach workers and a manager, but has no medical staff.

The **Mobile Crisis Team (MCT)**, associated with the CSC but responding to clients' home or community environments, is comprised of clinicians with both mental health and SUD training. First responders, such as fire and police officers, and the Crisis Clinic can contact the MCT to provide intervention and resources, including admission to the CSC, to individuals experiencing a behavioral health crisis who are not already enrolled in the publicly funded system. Over time, first responders have contacted the MCT with greater frequency for services. Because the MCT is intervening before the client reaches an ED, the MCT can help reduce the number of people who may be referred for involuntary treatment. Furthermore, because the MCT can offer information and resources, such as a diversion bed at the CDF unit of the CSC, people may not need the intensity of resources and reduction in civil liberties to address their crisis. The MCT provides community-based immediate follow up on first responder contacts, with one to four teams available at any given time to serve all of King County.

¹⁴⁵ Washington State Institute for Public Policy, December 2015. Washington's Involuntary Treatment Act: Use of Non-Emergent Petitions and Less Restrictive Alternatives to Treatment.

¹⁴⁶ King County Behavioral Health Organization E2SHB Assisted Outpatient Treatment (AOT) and Least Restrictive Alternative (LRA) Implementation Plan.

Appendix F: Inventory of Existing Service Continuum

Next Day Appointments (NDA) are appointments that occur the next day for people who present to emergency departments or the MCT in mental health crises. The target population includes people who are not already formally enrolled in the publicly funded system. Individuals who are not already enrolled in mental health services may not realize that hospital-level care may not be necessary to treat their conditions. NDAs can help people connect with outpatient services to help prevent future crises.

Some, but not all, agencies in King County are currently operating under an **open access intake appointment** model. Open access intake appointments are intended to expedite access to appropriate services at a community mental health agency.¹⁴⁷

Similarly, King County currently provides **prevention and early intervention behavioral health services, along with crisis intervention and linkages to services, to older adults**. Screening for behavioral health services occurs in primary care clinics, thus helping to identify individuals who would benefit from services well before involuntary psychiatric hospitalization may be necessary.

Overnight shelters help large numbers of homeless individuals avoid showing up at EDs for reasons related to living/sleeping outdoors. Shelters can help people make connections to other services and treatment, provides some nutrition and hygiene services, and identify people in acute need and refer them to necessary care when possible.

The **Partnership Access Line (PAL)** receives funding from the state and operates out of Children's Hospital. It is a telephone-based child mental health consultation system for primary care providers. If any primary care provider has questions or concerns about behavioral health issues in children, youth, or families, then they can call PAL for consultation with a child psychiatrist. This resource provides support to primary care providers and offers interventions to youth and families so more intensive psychiatric resources may be unnecessary.

The **Peer Bridger** program uses peer counselors to provide effective transition and reentry support for people who are being discharged from inpatient services. Peer Bridger program services connect program participants to mental health and/or SUD treatment, primary care, and other supportive services in the community. The current program is available at Navos and Harborview hospitals, part of a two-year grant and has funding/priority population restrictions.¹⁴⁸

Usually, **permanent supportive housing** facilities offer various degrees of on-site staff support to help residents maintain their housing and address emerging health and other service needs. The availability of permanent supportive housing is a critical variable in planning and sustaining interventions aimed at stabilizing the lives of people most likely to be hospitalized for psychiatric conditions and/or SUDs. Efforts to maintain appropriate treatment and community supports are far more efficient and reliable when a person does not need to live in a shelter, sleep on the street, or move frequently from one friend's home to another. On the other hand, the loss or lack of housing is a significant crisis and can result in people entering the involuntary treatment system.

A very small team of federally funded **Project for Assistance in Transition from Homelessness (PATH)** workers in south and east King County serves 250 to 375 people per year with serious mental illness or persons with co-occurring serious mental illness and SUD who are homeless or at risk of becoming homeless. It provides coordinated transitional support services to connect people to long-term

¹⁴⁷ Further discussion of the open access intake model, including recommended expansion of the practice, is discussed in priority 1e on page 84.

¹⁴⁸ Recommended expansion and broadened eligibility are described in priority 2d (page 94).

Appendix F: Inventory of Existing Service Continuum

community-based care when possible and help them minimize dependence on public safety and acute care resources.

REACH provides outreach and intensive case management to individuals who are experiencing homelessness and addiction. Using a variety of harm reduction approaches, REACH meets clients where they are and works with them to achieve stability and improve quality of life. REACH services are not contingent upon a client's sobriety or abstinence, and connect participants with existing resources in the community, such as legal advocacy, job training or placement, housing assistance, or counseling.

King County currently provides support for **school district-based mental health and substance abuse services** and suicide prevention in the form of consultation and technical assistance. It also provides support for **school-based suicide prevention**. Because school staff and students learn about behavioral health conditions and suicide, the school community can monitor for concerning behaviors and intervene before struggling students experience crisis. This educational prevention effort and early intervention can reduce the likelihood that youth will encounter the involuntary treatment system. Mental Health First Aid, an eight-hour course that provides education to the general public about recognizing and intervening in a behavioral health crisis, can also help people identify symptoms in people before they escalate to the point of referral for involuntary treatment.

Screening, Brief Intervention, and Referral to Treatment (SBIRT) is an evidence-based practice used to help identify, reduce, and prevent SUDs. Clinicians screen clients for alcohol and drug use disorders, provide brief interventions, and refer to more intensive treatment, if indicated. SBIRT services in King County occur in several EDs and primary care clinics. The current target is to screen about 4,000 people for SUDs in a six-month period. Because SBIRT can identify people who may be developing problems with substance use and provide early intervention, it can divert people from ever encountering the involuntary treatment system.

The small **Crisis Response Unit (CRU)** of the Seattle Police Department (SPD) is organized into two teams to provide a robust and sensitive response individuals in behavioral health crisis. The Crisis Response Team (CRT) pairs an SPD officer with a mental health professional (MHP) and the team is available to respond to in-progress incidents. The Crisis Follow-Up Team (CFT) is responsible for all of the post-incident follow-up and care coordination. Additionally, the majority of SPD officers, assigned to patrol operations, are certified by the Washington Criminal Justice Training Commission (CJTC) in Crisis Intervention Training (CIT), a model of police-based crisis intervention with community behavioral health care and advocacy partnerships.¹⁴⁹

The **Transitional Support Program (TSP)** is a post-hospitalization program, geared towards connecting people to services and supports in the community to reduce the likelihood of the individual needing psychiatric hospitalization level of care in the future. TSP currently allows for extended engagement efforts for both individuals currently enrolled in behavioral health organization (BHO)-funded services but disengaged from these services, as well as for people who are not enrolled with the BHO, with the intention of connecting/reconnecting them to services in their community. A fully staffed TSP can serve approximately 95 participants at a time, for an average of 460 unduplicated individuals annually. Services are available during weekday business hours for individuals who are involuntarily detained at any King County hospital or evaluation and treatment (E&T) facility.

¹⁴⁹ The CABTF's support for crisis intervention training is highlighted earlier in this report as endorsement 4f on page 103.

Appendix F: Inventory of Existing Service Continuum

Vocational support and/or training that results in employment for people with behavioral health conditions has evidence that it can help reduce psychiatric hospitalization. Supported employment and vocational rehabilitation are offered in King County and can help people avoid both voluntary and involuntary hospitalization.

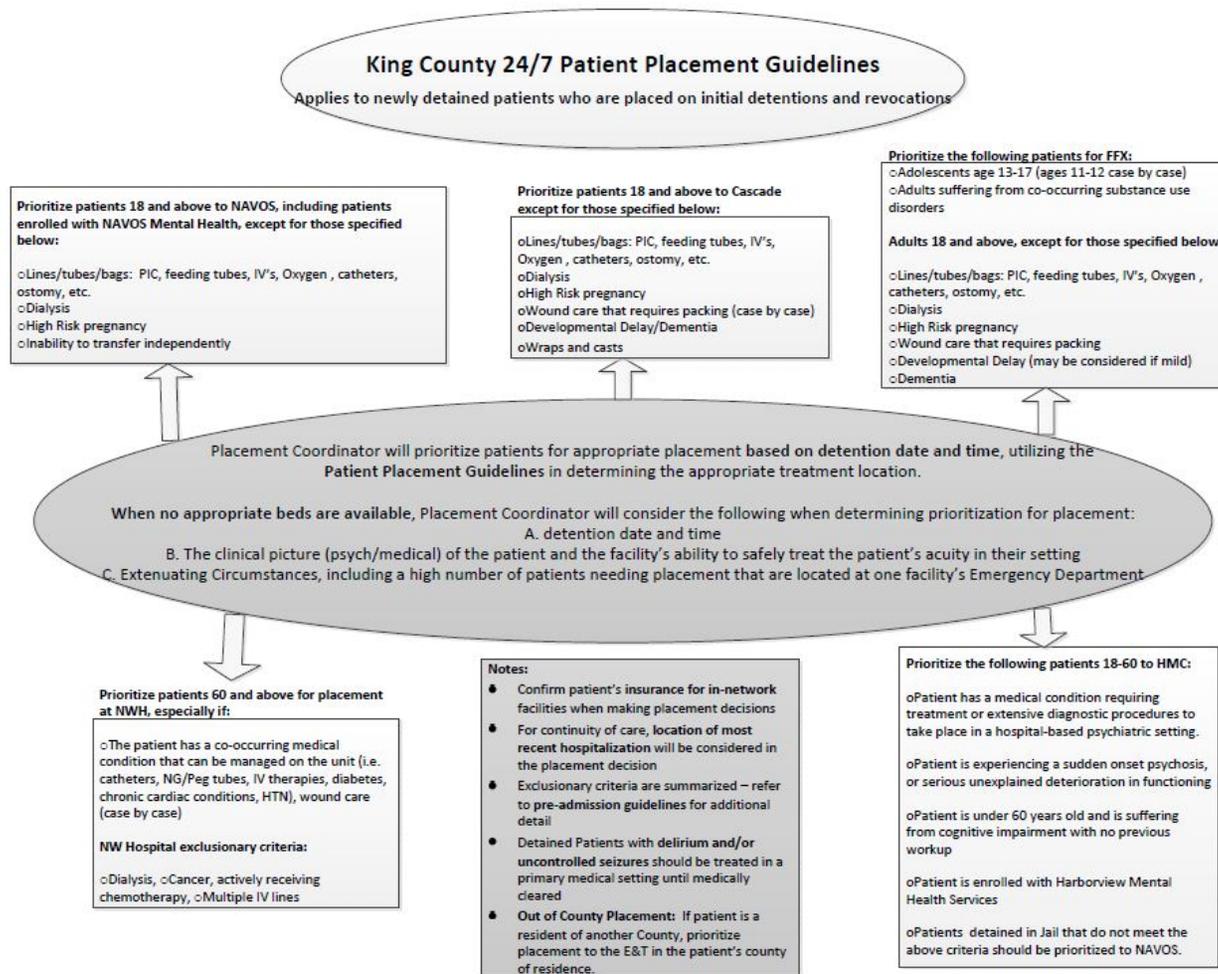
As currently implemented in King County, **Wraparound** is intended to provide process facilitation for multi-service involved youth with a serious emotional disturbance and their families according to a high fidelity model. It is also the gateway for access to the Children's Long Term Inpatient Program (CLIP).¹⁵⁰

The **10.77 Triage Pilot** serves individuals within King County who have committed a serious misdemeanor offense, have been deemed by the court not competent to assist in their defense and not able to have their competency restored, and have been referred for an assessment for civil commitment. Through a combination of charge dismissal, triage evaluation, and court approval, such individuals may be released to the care of community providers when appropriate. The triage process allows for more appropriate use of beds at Western State Hospital (WSH) as well as local E&T beds.

¹⁵⁰ WISE, a state-funded expansion of wraparound services for children receiving Medicaid-funded mental health services, is highlighted as endorsement 4b on page 101.

Appendix G: Patient Placement Guidelines

The guidelines are a living document, adjusted as needed in partnership with E&T providers. The version shown here was most recently revised on November 30, 2015, and was still in effect at the time of this report. Further amendments were expected to show the patient profiles most appropriate for the resources available at the two new E&T providers coming online in spring 2016.



Appendix H: Public Comment

While this report was in draft form in late April and early May 2016, it was posted along with high-level recommendation summaries at the CABTF's website, www.kingcounty.gov/cabtf, for a period of public comment. All input received via the public comment process are included here.

Angela Heald, Asian Counseling and Referral Service

"The list of priorities covers many improvements that will help consumers avoid and/or curtail hospitalizations. I would like to comment that a number of our clients would benefit greatly from options 2a and 2b and without these options currently we as providers and the families of these clients struggle to provide enough support for them. I would like to see these as higher priorities because of the disproportional amount of time and resources supporting these clients takes. In addition to more residential options and step-down/up programs which will be helpful, I think expansion of PACT (like) services to support high needs consumers where they live (and where they will ultimately return after hospitalization/step-down) will go a long way to stabilize consumers in the community."

Shana Cantoni

"I am a psych ARNP who is leaving my PT job at a small community based mental health agency located in Seattle. I am not leaving b/c I don't like my patients and don't think that the work isn't valuable. I am leaving b/c there is absolutely no medical infrastructure and support at the agency. About 300 clients, all with SMI, 5% on clozaril, 20% on LAI and one LPN who gives injections 2hrs/week. No nurses, no electronic health record and no plan to get any of those things. There is no effort to provide evidenced based medicine. Lots of pts on several different antipsychotics with no supporting documentation. The agency also has no medical director and no oversight. My license is in jeopardy working in this environment. They have hired a locums psychiatrist (at great expense), instead of putting things in place to make working there sustainable. If we want to keep people out of the hospital they need to have quality care in the community. Quality care is not bandaids applied by an overworked and unsupported ARNP. I would strongly recommend oversight by the county to create some general guidelines on how community MH agencies should deliver psychiatric care. And, those guidelines, should be created by and overseen by an MD not a social worker."

Ann Allen

"It seems all of the underfunded needs in the mental health system are on the list of objectives. Not focused enough on inpatient access and capacity, including voluntary placements. We are 46th in the nation for inpatient beds, shouldn't we be doing something about that?"

Nancy Dow, Harborview Medical Center Peer Bridger Program and King County Behavioral Health Advisory Board

"I have read the CABTF Final Report. I highly commend the CABTF for developing and prioritizing recommendations, next steps and a plan of action to resolve the legal boarding crisis by making a broad and unflinching assessment of existing and needed services and resources at all levels of care for all age groups and special needs for the individuals that are impacted by psychiatric care deficits and mental illness. I work on the front lines with these individuals and I found the detail and vision in this report complete down to the level of my own personal "Wish List" of services and resources needed by the people I serve. The assessment and recommendations in this report were presented in a straight

Appendix H: Public Comment

forward, concise and professional manner that often made me forget the magnitude of challenge of getting from where we are to where we need to be in Washington state and King County. To say this another way, this represents a hugely daunting challenge that reads like a simple, direct guide to meet that challenge and beyond. This is an amazing body of work, presented in a way that makes me believe this can happen for the benefit of the individuals I serve, in my life time. Thank you.”

Claudia Sanders, Washington State Hospital Association

“On behalf of our member hospitals in King County and throughout the state, and as a member of the Community Alternatives to Boarding Task Force, the Washington State Hospital Association (WSHA) wishes to express appreciation for the work on this comprehensive draft report. WSHA also offers the following comments:

- “WSHA supports the depth and breadth of priorities identified in this report and appreciates the thoughtful identification of areas for improvement. WSHA supports the emphasis on improvements along a full continuum of behavioral health services as identified in the top priorities. Improvements are needed at every level of care from community-based services to step-down and post-discharge support to fully address the needs for systemic improvement.
- “WSHA agrees with the report’s emphasis on the significance of the *In re the Detention of D.W.* case, but is worried gains made are being compromised by continuing access to care problems. This unanimous decision of the Washington State Supreme Court makes clear that a patient may not be detained without receiving meaningful mental health treatment. WSHA helped to lead several advocacy groups in an amicus brief in the case and was very pleased at the clear direction from the court. WSHA was just as pleased to see the response to the case, which included increased funding from the state and changes to rules on “single bed certifications” which were being used as a means to board patients in emergency departments while patients awaited treatment. For a period of time the number of single bed certifications decreased. However, WSHA and its member hospitals are very concerned that system improvements in patient access to care that were made as a result of the ruling are being eroded due to lack of access to treatment in the system, particularly downstream at Western State. With the state hospitals’ continuing challenges, the entire system is not functional.
- “WSHA agrees with the portion of the report that describes the Western State Improvements Bill SB 6656. The bi-partisan bill contains important provisions for shoring up mental health delivery at one of the state’s most important institutions. However, WSHA suggests that the report be updated to include discussion of the impact of the Governor’s veto of portions of the bill. WSHA supports continued work by the executive and legislative branches to see the remainder of the bill fully implemented.
- “WSHA agrees with the report’s emphasis on ensuring an adequate mental health work force. There is a need for qualified staff across behavioral health settings. The system must be willing to rely on service delivery from qualified mid-level providers such as Psychiatric Advanced Registered Nurse Practitioners (ARNPs). In addition, WSHA is pleased with the passage of SB 6445, which allows physician assistants to deliver mental health services under the Involuntary Treatment Act and suggests reference to this expansion of the mental health workforce be included in the report.

Appendix H: Public Comment

- “WSHA agrees with the report’s support for work under the Global Medicaid Waiver and in particular support for work which focuses on mental health, substance abuse, and supportive housing.
- “WSHA believes the report appropriately highlights the current Medicaid funding mechanisms for Institutes for Mental Disease as a particular challenge to opening more treatment beds in Washington State. WSHA supports continuation of the Medicaid waiver that allows reimbursement at these facilities at regular Medicaid rates, or a change in the law itself to fund fully care at these facilities.
- “WSHA appreciates the report’s recognition of the important role that will be played by Accountable Communities of Health (ACH) in health care delivery. WSHA believes mental health should be a high priority of every ACH in the state. WSHA believes that to be effective the ACHs must have focus and buy-in on specific priorities from all participants.
- “WSHA agrees with the report about the significance of the capital and operating budget investments in mental health services made in the 2016 Washington State legislative session. WSHA is particularly pleased with the capital budget investment of \$12.4 million in community behavioral health bed capacity and new grant funding for adding behavioral health beds. It also notes the importance of the \$6.8 million investment in the Behavioral Health Innovation Fund supporting state hospital reform, including staffing and quality of care. WSHA believes that this type of support from the state, along with reasonable reimbursement levels, will promote adequate acute care bed capacity in King County in other areas of the state.
- “WSHA notes the report covered several pieces of legislation related to mental health services delivery, but wishes to identify E3SHB 1713, integrating the voluntary treatment systems for mental health and substance abuse, as an area of both opportunity and concern. WSHA supports the intent of the legislation to break down barriers between the treatment systems for mental health and substance abuse, but is concerned about the number of additional involuntary commitments that could arise under the new integrated system and the ability of the current system – already so stretched thin for resources – to respond. Another bill worth mentioning in the report is HB 2439, which increases access to adequate and appropriate mental health services for children and youth. WSHA supports this legislation and its focus on increasing access to important mental health care early in life.
- “WSHA suggests that, in addition to noting the impact of evaluation and treatment bed occupancy by patients from other counties and the plans to expand capacity in King County, the report also reference the significant planned expansion of inpatient psychiatric hospital beds elsewhere in the state. The certificate of need inpatient capacity in Pierce, Spokane and Snohomish Counties, and certificate of need applications to expand capacity in Clark County, may offset some of the out-county migration and associated pressure in King County.
- “WSHA agrees with the Tier 2 priority of creating or improving the legal process to allow for Medicaid applications and/or facility transfers for a patient who lacks capacity and lacks a surrogate decision maker. Increasing access to guardians and clarifying the role and powers of guardians ad litem are areas of interest for WSHA.
- “WSHA believes the report’s priorities should include establishing the core infrastructure and capacity needed to address current and future patient population needing behavioral health

Appendix H: Public Comment

services. In order to effectively serve this patient population, systems and processes are needed to manage the growing population that needs these services.

- “WSHA agrees and supports the approach to increase funding to support a more robust behavioral health program to serve King County residents.

“Again, thank you for the opportunity to submit comments. Any questions may be directed to Claudia Sanders, Senior Vice President, Policy Development at 206-216-2508 or claudias@wsha.org.”

Rachelle Wright, Washington State Criminal Justice Training Center

“The CIT [Crisis Intervention Training] program has just begun to implement training for Corrections and Fire/EMS. We are definitely in support of continuing the programs to help develop user specific training that will create a better collaboration between the first responders. We also support the creation of a CDF in south sound as agencies across the county use the MCT's and the CDF. Also, creating a detox facility will be an asset. We also support continuing support of services like GRAT and CCORS which are key components of the CIT training providing supports and now, as a result of our training, have become even more popular crisis services due to the increased referrals. We strongly encourage continuing those programs as well. The CIT program is continuing to grow and provide as much training as possible. As the user group grows with implementation of new subgroups (fire, corrections, etc) we must meet their needs for training. We see benefits across the county and see benefits to agencies that have implemented CIT training into their agency structure. With the ability to provide even more supports to first responders of available resources and alternatives it would strengthen knowledge and understanding of supports even further.”

Steven Mitchell, Harborview Medical Center

“I am encouraged by this process as patients with acute mental health issues are currently inadequately resourced resulting in downstream strain on public institutions such as the Harborview Emergency Department.

“In particular, I would strongly support modifying the system of evaluation and intake to more fully reflect the 24/7 nature in which these acutely ill patients present. With the current system - and independent of bed availability - the system of outreach and evaluation is focused on "daytime" hours solutions and has difficulty providing services during "off" hours. The downstream impact forces patients to be maintained in emergency departments for extended periods of time until any interventions from community resources can be utilized. We routinely hold patients in our emergency department waiting for a case manager to start their workday or open their doors. This leads to substantial delays and impacts on both the acutely ill mental health patient but on other patients trying to access emergency care.

“Thus, I would strongly support items 1B and 1F as a means of better addressing this issue.”

Lauren Davis, King County Behavioral Health Advisory Board

“Fantastic work! I would recommend taking a look at the "Crisis Now" document produced by the National Action Alliance on Suicide Prevention <http://actionallianceforsuicideprevention.org/sites/actionallianceforsuicideprevention.org/files/CrisisNow.pdf>. It provides an excellent framework to strive for for crisis services. Thank you!”

Karina Uldall, Virginia Mason Medical Center

“Virginia Mason Medical Center (‘Virginia Mason’) appreciates the opportunity to comment on the Community Alternatives to Boarding Task Force Draft Report (‘Report’) and commends all who have contributed to producing this document.

“Virginia Mason supports the direction and emphases of the Report, the depth and breadth of priorities identified, and the identification of areas for improvement. We commend the Report’s recognition of the great need for additional resources across the entire community and care continuum. We particularly agree with the top priorities’ focus on enhancing outpatient care and improving less restrictive treatment alternatives, as opposed to an emphasis on the (definite) need for additional inpatient beds. We also recognize and agree with the Washington State Hospital Association comment that ‘improvements are needed at every level of care from community-based services to step-down and post-discharge support to fully address the needs for systemic improvement.’

“We note the following points which are of particular interest to our organization:

- “We support the Tier 1 priority recommendation to address the need for improved, enhanced coordination. This is of vital importance, in part to correctly utilize current inpatient resources as a solution for Single-Bed Certification (SBC) days (the need for this is in many ways just as valid as the need for additional new beds). We support the development of 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 be discharged to the community. (See Report pages 8, 67 and 78-80; Appendix G).
- “We agree that Washington Involuntary Treatment Act (ITA) Court communication -- a focus of involvement among stakeholders in King County -- has been improved. Virginia Mason has emphasized this work for more than five years and appreciates its strong working relationship with both the offices of the King County prosecutor and the public defender (see pages 56-57).
- “Virginia Mason has been active on the Patient Placement Task Force and appreciates the Task Force’s coordination efforts with many of the region’s hospitals. (See page 57).
- “In recent years, we have had contact with the vast majority of the programs in Appendix F on behalf of patients. We have found them in general to be a strong regional resource and to be appropriately collaborative. We will be improving our internal resources in order to enhance our collaborations with these programs.

“One point that we want to note is the need to improve system-wide, point of care decision-making, e.g. decreasing ‘door to dosing’ time of antipsychotic medications, as one strategy to decrease the need for prolonged ED stays and use of involuntary treatment services. At Virginia Mason, patients will be offered antipsychotic medication on arrival to the Emergency Department when clinical decision-making deems that an appropriate intervention. This is similar to reducing ‘door to dosing’ time when addressing stroke or heart attack in patients presenting to the ED with serious medical conditions. We believe this is the proper patient-centered approach for our patients living with serious mental illness.

“Thank you for the opportunity to comment on this report. We look forward to the county’s work on this critical issue and look forward to participating in that work moving forward.”

Kim McClain, CHI Franciscan Health

“Some of the issues for long term patients are that no one wants to take DD patients that have ADL issues, health problems, and mental health issues. We also have one in our facility long term that is not necessarily mental health but has multiple medical issues so family can't take him home, and he is not eligible for Medicaid because he is alien status. We seem to have this issue in both King and Pierce county.”