90- and 180-Day Civil Commitment:

Best Practices Toolkit for Community Hospitals and Freestanding Evaluation and Treatment Centers

Washington State Health Care Authority
Division of Behavioral Health & Recovery
Revised August 2024
Developed by Advocates for Human Potential, Inc. (AHP)
and revised in collaboration with HCA/DBHR

AHP Advocates for Human Potential, Inc.
Real World Solutions for Systems Change

ahpnet.com

CONTENTS

INTRODUCTION

In 2018, Governor Jay Inslee announced a plan to dramatically reshape how and where individuals with mental illness are treated in Washington. The plan invests in community capacity to divert individuals from the two state hospitals and treat people in their home communities. This plan came to fruition through Second Substitute House Bill 1394. 2SHB 1394 changes the Involuntary Treatment Act (ITA), found in Chapter 71.05 of the Revised Code of Washington, by expanding treatment options for people with behavioral health conditions in community hospitals and freestanding evaluation and treatment facilities (E&Ts). Included in these changes are the addition of an option for involuntary inpatient commitments lasting either 90 or 180 days in community hospitals or freestanding E&Ts. The intention is that people should be able to obtain long-term psychiatric care in settings that are closer to their homes and more integrated into the community than if they received care in a state psychiatric hospital. To that end, 90- and 180-day beds at community hospitals and E&Ts can help fulfill the State of Washington's obligation under federal law—as interpreted by the 1999 *Olmstead v. L.C.* decision—to provide services to people with disabilities in the most integrated setting appropriate to their needs.

Implementing this paradigm of care requires flexibility on behalf of community hospitals and freestanding E&Ts. Even facilities with significant experience providing initial mental health and substance use disorder (SUD) treatment will need to make significant adjustments to effectively serve individuals over the course of 90 or 180 days.

The Washington State Department of Commerce provided funds through SHB 1102 section 1041 to the Washington State Health Care Authority (HCA) to provide technical assistance to the Behavioral Health Facilities Grants program. HCA hired Advocates for Human Potential, Inc. (AHP), a national technical assistance provider, to develop this toolkit. The intent of this guide is to help community hospitals and E&Ts provide the best possible treatment and other services over 90- or 180-day periods. The suggestions in this toolkit are based on best practices and discussions with individuals who have experienced inpatient civil commitments and the guidance except for the staffing model is not intended to be mandatory. Community hospitals and E&Ts may design their facilities, procedures, and protocols to best serve the individuals in their care, but this toolkit will help them achieve the objectives of 90- and 180-day treatment in alignment with contract expectations set forth by the HCA.

As Washington continues to implement the Governor's plan to build and sustain the capacity for 90- and 180-day inpatient treatment in community settings, an opportunity has emerged to promote a recovery philosophy within long-term inpatient treatment, rather than just stabilizing symptoms. Helpful strategies for promoting recovery during treatment and setting individuals up for success after discharge are discussed. One of the most effective strategies for promoting recovery is **peer and family involvement** (section 2), including the use of certified peer counselors (CPCs) to provide services in the inpatient setting, as well as to facilitate transition into the community. Recovery is defined in 2SHB 1394 as "a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential."

The treatment and services necessary over the course of 90 and 180 days both overlap and are in some ways unique from care provided to individuals on an initial 120 hour or 14-day civil commitment, and the community hospital or E&T should offer a home-like feel to someone staying these longer periods. The toolkit discusses some of the clinical evidence-based practices, as well as other types of **programming**

(section 3) necessary to achieve these objectives. The discussion of the treatment milieu also includes a discussion of **safety and reduction of seclusion and restraint** (section 4), including trauma-informed care, as well as making the **physical environment** conducive to 90- and 180-day treatment. Each individual has different needs. The toolkit explains how to engage individuals in **person-centered planning** (section 6), as well as **individualizing care** (section 7) to their particular needs.

The toolkit concludes by discussing the role of **working with designated crisis responders (DCRs), the superior court** (section 8) and the managed care organizations (MCOs) and behavioral health administrative service organization (BHASO) to establish smooth procedures for commitments and transitions of care, along with other **community collaborations** (section 9) that may be helpful.

PROMOTING RECOVERY

1

1. PROMOTING RECOVERY

During the course of a 90- or 180-day commitment, the facility has the opportunity to care for an individual in numerous ways that support recovery, which the Substance Abuse and Mental Health Services Administration (SAMHSA) defines as "a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential" (2012). Under the SAMHSA definition, recovery has four key domains: health, home, purpose, and community. In contrast to initial inpatient care, in which the focus is primarily on improving health through stabilization of psychiatric symptoms, long-term inpatient care presents an opportunity to address the other domains.

General Principles

What does recovery look like? Studies have shown that mental health staff in inpatient settings typically believe they provide recovery-oriented care, yet they describe recovery in vague or conflicting language (Waldemar et al., 2016). The following principles, adapted from SAMHSA's 10 Guiding Principles (2012) and Five Tips for Adopting a Recovery Framework (2016), distinguish recovery-oriented care:

1. Psychiatrist
2. A sense of hope that recovery is real
3. Individual autonomy and independence
4. Different pathways for different people
5. A holistic approach incorporating mind, body, spirit, and community
6. Support from peers and allies
7. Relationships and networks supporting social inclusion and community participation
8. Respect for cultural values, traditions, and beliefs
9. Promotion of safety and trust
10. Reliance on strength and promotion of responsibility
11. Respect for, and acceptance of, individuals with behavioral health conditions
12. Values and principles developed with individual and family input
13. Focus on long-term self-management of substance use or mental health symptoms
14. Promotion of evidence-based practices
15. Commitment to peer support
16. Providers and individuals as partners in recovery

Although recovery concepts are usually discussed in the context of outpatient community mental health services, it is also important to consider recovery during the 90- and 180-day commitment process. Chen (2012) suggests that promoting recovery in inpatient settings requires reducing three types of tension:

- **Personal tension (by relying on persuasion, not coercion, and recognizing power differentials)**

- **Environmental tension (by involving patients in physical design decisions and the establishment of ward rules)**

- **The providers' own tensions (by teaching respect for privacy and dignity, using person-first language rather than stigmatizing labels, and allowing providers time for self-reflection)**

Little research has been conducted into efforts to make inpatient psychiatric hospitalization more recovery-oriented (Kidd et al., 2014):

Our review found only 2 studies that have directly examined factors associated with the recovery orientation of psychiatric wards. One suggested that when effectively engaged in a recovery-oriented conceptualization of their illness (compared with purely medical and custodial perspectives), inpatient clients have a better quality of life, better engagement in treatment, and fewer social problems. Another strong association was between client satisfaction and staff efforts to convey empathy and actively engage in teaching about medication, illness self-management, and stress management.

Putting Principles into Practice

Promoting recovery during 90- and 180-day commitments presents contradictions. Recovery is about choice, but individuals are involuntarily committed (Waldemar et al., 2016). Recovery requires addressing trauma, but the inpatient commitment process is itself traumatizing. McKenna et al. (2014) explored these issues with psychiatric nurses serving on inpatient units. Some nurses described a role that included listening to patients' concerns, educating them about their conditions, identifying areas in which they sought increased autonomy, and advocating for those changes. In this way, they helped individuals gradually regain autonomy. They explained the importance of having time to develop a therapeutic relationship and build trust.

In contrast to initial hospitalization, in which stabilization of a crisis may be the primary focus, longer hospitalizations present an opportunity to address the issues that led to the hospitalization and make progress going forward. Waldemar et al. (2016) identified some consistent actions that staff of inpatient units can take to promote recovery, including

- **Expressing optimism**

- **Highlighting individuals' strengths and abilities**

- **Focusing on helping individuals improve their lives (as opposed to their symptoms)**

Chen (2012) suggests that fostering recovery in inpatient settings is forward-looking, characterized by helping individuals envision their lives after hospitalization, involving them in discharge planning, and helping them identify skills and strengths that will allow them to succeed in the community. Such

processes are effective only when providers take the time to understand individuals' lives in the community and devise ways for them to strengthen their personal networks.

Promoting recovery may require asking some hard questions about individuals' experiences in the unit. The following list is based on the challenges and strategies described in a comprehensive literature review (Waldemar et al., 2016).

- **Are we offering individuals genuine opportunities to participate in treatment planning?**

- **Are we providing thorough information about treatment options, medications, and side effects in terms that individuals can understand?**

- **Do we offer individuals choice in medications or therapeutic approaches?**

- **Do we offer peer support and family support?**

- **Are we helping individuals identify their strengths and ways they can use them to improve their lives once they leave the hospital?**

- **Do we offer a safe and private space to fully discuss these considerations with individuals?**

- **Do we offer calming spaces such as a meditation room or garden?**

- **Do we offer internet access to help individuals plan post-hospitalization activities?**

- **What opportunities do individuals have to explore jobs, housing, or other activities after they are released?**

- **Do we have clear guidance on how therapeutic approaches evolve over the course of inpatient treatment to prepare individuals to return to the community?**

Individual Treatment and Service Planning

Individuals and families are core participants in the development of the plans and goals of treatment. However, research has found that patients, their families, and staff often have very different perceptions of how involved people are in care planning. For example, Storm and Davidson (2010) found that individuals reported few opportunities to have meaningful input in the decision-making regarding their inpatient care, while providers reported difficulty engaging individuals in discussions about care planning. Although participants described providers as nice, understanding, and supportive, these qualities did not always translate into their feeling seen and heard as unique individuals. Staff and clinicians feel they are doing it; individuals are not experiencing it.

When providing inpatient care over 90 or 180 days, community hospitals and E&Ts have a unique opportunity to engage individuals in discussions about not only *What got you here?* but also *What do you want your life to look like?* The vision transcends crisis stabilization to helping the person restore physical and emotional equilibrium and moving toward wellness in the broadest sense of the word. Swarbrick (2009) has developed a wellness and recovery model for inpatient settings based on the widely recognized eight dimensions of wellness: emotional, environmental, intellectual, physical, occupational, spiritual, social, and financial. Swarbrick argues that when the culture of the setting is fully focused on building wellness, individuals have an opportunity to gain insight, build self-care skills, and formulate ways to promote their own recovery and hope for a better life in the community. Rather than considering

discharge planning a placement exercise, done well, it is an opportunity to help individuals maximally benefit from their hospitalization and move toward a stable and meaningful life in recovery.

Each person served is unique, so structured boilerplate approaches to care do not typically meet individual needs, circumstances, or preferences. People are often hospitalized with a host of issues, only some being psychiatric—others may include homelessness, legal involvement, family or relationship problems, financial issues, traumatic experiences, domestic violence, or physical health conditions. Studies find that individuals diagnosed with serious mental illness (SMI) are at higher risk for medical problems such as high blood pressure, heart disease, and diabetes (De Hert et al., 2011). A strong multidisciplinary service setting, focused on both physical and emotional wellness, can screen for and address a host of sociological and medical issues that compound and complicate recovery from a psychiatric episode.

Shared decision making (SDM) is an approach that can be used in most treatment settings to promote individualized care. Quickly becoming the standard of care in medical services, the approach is also gaining traction in psychiatric services. SDM assumes that both the individual and the clinician have important knowledge, not necessarily shared by the other. For care to be effective, both must communicate and make a mutual decision about the goals and direction of treatment. The emphasis is on "do with" rather than "do to" or "do for." When individuals and providers engage in SDM, more information about individual preferences, practices, and values can emerge and be taken into consideration. SDM can result in decisions that are more appropriate for individuals and lead to increased satisfaction

Figure 1: Elwyn et al., 2017

and improved follow-through and treatment adherence, and ultimately to better health outcomes. While conclusive research is slowly emerging, the SDM process can engage individuals and motivate engagement and self-care. Elwyn et al. (2017) developed a simple three-talk model of SDM (Figure 1) that can be integrated into inpatient services and most clinical discussions.
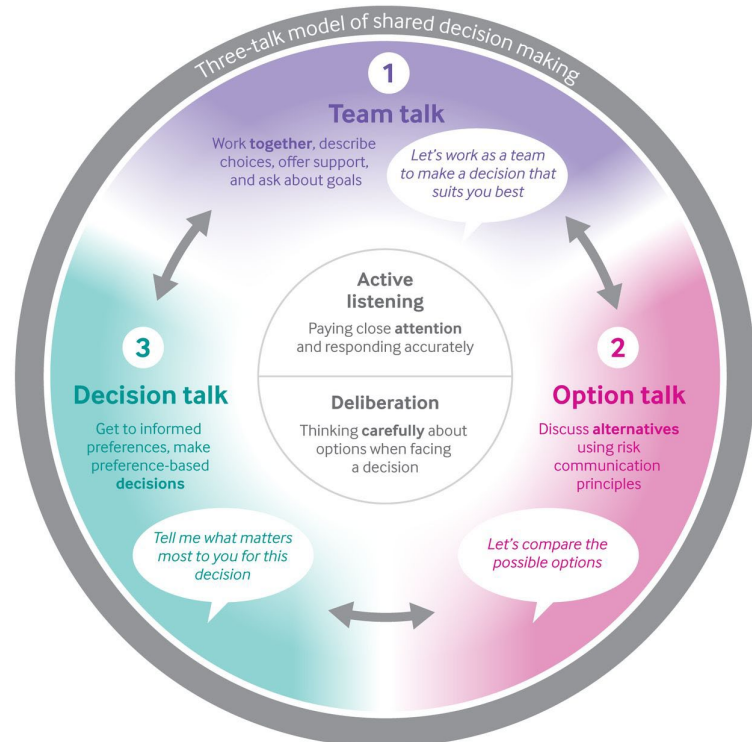
1. **Introduce a choice.**

2. **Discuss the options.**

3. **Make a shared decision.**

Rights Protection During Involuntary Treatment

Individuals subject to a 90- or 180-day commitment have numerous rights under the ITA (RCW 71.05.217), some of which are listed below.

- **To have the right to individualized care and adequate treatment**

- **To discuss treatment plans and decisions with professional persons**

- **To wear their own clothes (unless a safety hazard)**

- **To have and use personal possessions (unless a safety hazard)**

- **To keep money and use it for purchasing snacks, etc.**

- **To have space to store belongings**

- **To have visitors**

- **To be able to make telephone calls in confidence**

- **To have access to writing materials and stamps and to send and receive private correspondence**

- **To refuse antipsychotic medication during extended hospitalization, in the absence of a court order**

References and Resources for Recovery

Blankenburg, R., Hilton, J. F., Yuan, P., Rennke, S., Monash, B., Harman, S. M., Sakai, D. S., Hosamani, P., Khan, A., Chua, I., Huynh, E., Shieh, L., Xie, L, & Satterfield, J. M. (2018). Shared decision-making during inpatient rounds: Opportunities for improvement in patient engagement and communication. *Journal of Hospital Medicine*, *13*(7), 453–461. https://doi.org/10.12788/jhm.2909

Chen, S. (2012). *The development of recovery competencies for in-patient mental health providers working with people with serious mental illness* [Dissertation, Queen's University]. QSpace: Queen's Scholarship & Digital Collections. https://qspace.library.queensu.ca/bitstream/handle/1974/7012/CHEN_SHUPING_201202_PhD.pdf

De Hert, M., Correll, C. U., Bobes, J., Cetkovich-Bakmas, M., Cohen, D., Asai, I., Detraux, J., Gautam, S., Möller, H., Ndetei, D. M., Newcomer, J. W., Uwakwe, R., & Leucht, S. (2011). Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in health care. *World Psychiatry*, *10*(1), 52–77. https://doi.org/10.1002/j.2051-5545.2011.tb00014.x

Elwyn, G., Durand, M. A., Song, J., Aarts, J., Barr, P. J., Berger, Z., Cochran, N., Frosch, D., Galasiński, D., Gulbrandsen, P., Han, P., Härter, M., Kinnersley, P., Lloyd, A., Mishra, M., Perestelo-Perez, L., Scholl, I., Tomori, K., Trevena, L., . . . Van der Weijden, T. (2017). A three-talk model for shared decision making: Multistage consultation process. *BMJ*, *359*, Article j4891. https://doi.org/10.1136/bmj.j4891

Kidd, S. A., McKenzie, K. J., & Virdee, G. (2014). Mental health reform at a systems level: Widening the lens on recovery-oriented care. *The Canadian Journal of Psychiatry*, *59*(5), 243–249. https://doi.org/10.1177/070674371405900503

McKenna, B., Furness, T., Dhital, D., Ennis, G., Houghton, J., Lupson, C., & Toomey, N. (2014). Recovery-oriented care in acute inpatient mental health settings: An exploratory study. *Issues in Mental Health Nursing*, *35*(7), 526–532. https://doi.org/10.3109/01612840.2014.890684

Slade, M. (2017). Implementing shared decision making in routine mental health care. *World Psychiatry*, *16*(2), 146–153. https://doi.org/10.1002/wps.20412

Storm, M., & Davidson, L. (2010). Inpatients' and providers' experiences with user involvement in inpatient care. *Psychiatric Quarterly*, *81*(2), 111–125. https://doi.org/10.1007/s11126-009-9122-6

Substance Abuse and Mental Health Services Administration. (2012). *SAMHSA's working definition of recovery: 10 guiding principles of recovery* (PEP12-RECDEF.) https://store.samhsa.gov/sites/default/files/d7/priv/pep12-recdef.pdf

Substance Abuse and Mental Health Services Administration. (2010). *Shared decision-making in mental health care: Practice, research, and future directions* (HHS Publication No. SMA-09-4371). Center for Mental Health Services, Substance Abuse and Mental Health Services Administration. https://store.samhsa.gov/sites/default/files/d7/priv/sma09-4371.pdf

Substance Abuse and Mental Health Services Administration. (2016). Five tips for adopting a recovery framework. *Practicing Recovery: Incorporating a Recovery Orientation in Hospital Settings*, (5), 10. https://www.samhsa.gov/sites/default/files/programs_campaigns/recovery_to_practice/newsletter-5-jan-2016.pdf

Swarbrick, M. (2009). A wellness and recovery model for state psychiatric hospitals. *Occupational Therapy in Mental Health*, *25*(3–4), 343–351. https://doi.org/10.1080/01642120903084117

Waldemar, A. K., Arnfred, S. M., Petersen, L., & Korsbek, L. (2016). Recovery-oriented practice in mental health inpatient settings: A literature review. *Psychiatric Services*, *67*(6), 596–602. https://doi.org/10.1176/appi.ps.201400469

PEER AND FAMILY INVOLVEMENT

2

2. PEER AND FAMILY INVOLVEMENT

People with mental health issues have long helped and supported each other, whether in the community, in hospitals, or in other institutional settings. In recent decades, some aspects of peer support have become more formalized, leading to structured programs, training, certification, and significant roles in service delivery across the behavioral health field.

Similarly, families have developed structured ways to help each other when a loved one is experiencing significant mental health challenges. Paralleling these developments, provider organizations and oversight entities have recognized the value and importance of peer and family voice in guiding the development, management, and evaluation of services for people with disabilities. Service relevance, delivery, quality, and outcomes may be improved with family and consumer involvement.

With the shift toward more recovery-oriented approaches throughout behavioral health, interest and information are growing about why and how to engage peers and families in inpatient and forensic settings. Common strategies include advisory and oversight councils, participation in evaluation, quality improvement and research activities, direct service delivery, and increased attention to person-centered and person-driven treatment planning.

Advisory and Oversight

Consumers and families play an important role in helping to improve services and facilities. Their input is important when designing new facilities and services. The National Partnership for Women & Families (2013) notes that establishing a consumer and family advisory council can "improve quality, efficiency, and patients' and families' experiences" and help healthcare providers "not only gain a better understanding of their experiences but also . . . partner with them to improve processes, procedures, care delivery and outcomes."

Advisory councils provide a key mechanism for community hospitals to partner with people who are invested in the quality of the services offered. Typically, council members are individuals who have received care at the hospital and who can offer insights and input to help the hospital deliver treatment and services that are based on patient- and family-identified needs rather than assumptions about what patients and families want. Effective peer and family advisors help identify what the hospital is doing well and help pinpoint areas for improvement. Advisors can help the hospital move beyond the "what is wrong" stage and toward developing effective solutions. Additionally, many federal and state grant applications require peer and family involvement as a criterion for funding.

The Agency for Healthcare Research and Quality (AHRQ, 2017) developed the *Guide to Patient and Family Engagement in Hospital Quality and Safety*, which offers evidence-based resource to help community hospitals work as partners with patients and families to improve quality and safety. This document describes opportunities for community hospitals to create partnerships between patients, families, and hospitals around common goals, offers strategies for engagement, discusses common challenges, and outlines strategies and tools for the successful implementation of peer and family advisory groups.

AHRQ reports that working with peer and family advisors results in positive improvements in overall hospital systems and processes of care. Longer-term benefits can include

- **Better health outcomes**
- **Reduced errors and adverse events**
- **Increased loyalty**
- **Reduced risk of malpractice**
- **Increased employee satisfaction**
- **Improved financial performance**

Continuous Quality Improvement: Evaluation and Satisfaction

Peer (and family) satisfaction is an imperative and commonly used indicator for measuring the quality of psychiatric healthcare services. Research finds that satisfaction with service quality not only reflects on the hospital itself, but also influences multiple clinical areas including treatment adherence and personal outcomes (Woldekidan et al., 2019).

The most effective healthcare organizations use a feedback loop to elicit and evaluate patient (and family) satisfaction with services. Analysis of satisfaction patterns can yield important information for shaping and improving services (Frakt et al., 2017). While satisfaction ratings can be impacted by multiple factors (expectations, overall experience with the service system, individual clinical considerations, etc.), they remain one of the most effective ways to gather direct information about what is working and what is not working within a service setting. Data gathering must be followed by objective analysis, trend identification, and systematic review of the findings by hospital administrators. For the data to be meaningful, the hospital needs to use it to guide quality improvement efforts.

The Perceptions of Care (PoC) survey is one example of a tool that can be used with people using inpatient services and their families (Eisen et al., 2002). Used by multiple hospitals, the PoC is designed specifically for inpatient psychiatric use. A standardized public domain measure of consumer perceptions of the quality of inpatient mental health or substance abuse care, it was developed as a low-cost, low-burden survey that would address important quality domains, allow for inter-program comparisons and national benchmarks, be useful for quality improvement purposes, and meet accreditation and payer requirements. McLean Hospital, for example, uses the PoC in its inpatient, residential, and partial hospital programs. Developed at McLean, the survey plays a central role in hospital-wide patient care improvement. New York has developed a [version](#) that is used statewide, and Teague and Caporino (2008) describe other instruments.

Peer Support Services (Including Family Supports)

Peer support services (PSS) are now a recognized part of multidisciplinary team-based care for people with behavioral health conditions. SAMHSA defines PSS as specialized assistance that is delivered by a person in recovery from SMI, substance use, or co-occurring mental and substance use conditions, before, during, and after treatment to facilitate a recipient's long-term recovery in the community (Chinman et al., 2014).

In 2007, the Centers for Medicare & Medicaid Services (CMS) determined PSS to be a reimbursable service for states that choose to incorporate them into their state Medicaid plan. More than 35 states have established statewide certification programs for peer counselors, and about 40 states (including Washington) have built PSS into their state Medicaid plans. HCA trains adults and parents of children with mental illness and SUDs to be CPCs, and offers numerous resources to support CPCs.

The goal of PSS is to assist with the development of strategies to promote coping, problem-solving, and self-management of a person's behavioral health condition. The CPC draws upon their own lived experience and empathy to help others by promoting hope, developing skills and insights, fostering treatment engagement, accessing community supports, and building a satisfying life. A 2015 study from Office of the Assistant Secretary for Planning and Evaluation (ASPE) found that peer support resulted in multiple positive outcomes, including reduced re-hospitalization rates, improved engagement rates, overall satisfaction with services, and improvement in quality of life and other wellness measures.

Informal mutual peer support and PSS are not the same. PSS are intentional services based on the lived experience, training, and certification of the provider and designed to promote engagement, facilitate recovery, and support resiliency. In contrast to mutual support, in PSS the relationship is not reciprocal, and the skill and degree of recovery is not the same between the provider and recipient (Davidson et al., 2006).

Peer Support Activities

PSS are most effective at providing one-to-one and group supports that focus on recovery skills and building a positive life in the community. PSS supplement existing treatment approaches by helping to engage individuals who may be reluctant to fully engage with traditional clinicians; helping to enhance social networks by role modeling and facilitating self-care activities; enhancing self-agency, coping, and hope; assisting with system navigation; and sometimes functioning as a liaison between the person and the system.

As a best practice, CPCs **should be integrated** into the treatment team and participate in treatment planning meetings, not a separate ancillary service. Many of the specific treatments offered during inpatient treatment are enhanced when peer counselors are part of the treatment delivery. Peer support is helpful in addressing factors that contribute to poor treatment outcomes—factors such as social isolation, disconnection with outpatient treatment, service fragmentation, and lack of emphasis on recovery approaches.

SAMHSA's overview of the value of peers (2017) describes the many ways in which peers and families can provide formal peer support. Numerous formal models exist. For example:

- **The Wellness Recovery Acton Plan (WRAP) is a peer-led group model that focuses on ways to self-regulate, manage difficulties, and move toward a life in recovery.**

- **The National Alliance on Mental Illness (NAMI) Family-to-Family program is a well-known model of family support. This program is a structured 9-week psychoeducation program offering families mutual support, information, and strategies for caring for a loved one with SMI.**

- **Hearing Voices is a peer support group for individuals who hear voices and their families, with meetings in several cities in western Washington.**

- **[Alcoholics Anonymous](), [Narcotics Anonymous](), and [Dual Recovery Anonymous]() are examples of self-help for SUD and co-occurring disorders.**

Peer Bridger

A well-known model of peer support highly relevant to inpatient settings is the "Peer Bridger" approach. It was developed in New York State in 1994 to provide support for individuals with long or repeated psychiatric hospitalizations as they made transitions back to their home communities. It is a manualized program that focuses on outreach and engagement, crisis stabilization, wellness and self-management skills, and community support. It is generally considered a level-of-care transition program and uses a peer support specialist to help an individual "bridge" the gap between the institution and the community. Studies of Peer Bridger programs found that they positively and significantly impact community tenure without readmission; managed care payers have also reported reductions in hospital length of stay and high satisfaction rates with the program (Mental Health America, 2018).

Washington has implemented the Peer Bridger model using CPCs for several years within the two state hospitals; King County has implemented Peer Bridger services within local psychiatric hospitals. Peer Bridgers are hired through local licensed community behavioral health agencies and work closely with social workers, hospital liaisons, and discharge planners. Among the functions they play in hospital settings and during the transition to the community are

- **Getting to know individuals while in community hospitals and providing support**
- **Participating in discharge planning**
- **Linking individuals to outpatient behavioral health treatment through "warm handoffs," including accompanying them to intake appointments if requested**
- **Linking them to housing, employment opportunities, and other needed supports**
- **Arranging transportation to outpatient appointments**
- **Providing peer support related to reentry into the community**
- **Leading recovery groups, WRAP training, and other group activities**
- **Offering training in illness self-management and self-advocacy**

References and Resources for Peer and Family Involvement

Agency for Healthcare Research and Quality. (2010). *Supporting patient and family engagement: Best practices for hospital leaders.* https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/systems/hospital/engagingfamilies/howtogetstarted/Best_Practices_Hosp_Leaders_508.pdf

Agency for Healthcare Research and Quality. (December 2017). *Guide to patient and family engagement in hospital quality and safety.* https://www.ahrq.gov/professionals/systems/hospital/engagingfamilies/guide.html

Chinman, M., George, P., Dougherty, R. H., Daniels, A. S., Ghose, S. S., Swift, A., & Delphin-Rittmon, M. E. (2014). Peer support services for individuals with serious mental illnesses: Assessing the evidence. *Psychiatric Services*, *65*(4), 429–441. https://doi.org/10.1176/appi.ps.201300244

Davidson, L., Chinman, M., Sells, D., & Rowe, M. (2006). Peer support among adults with serious mental illness: A report from the field. *Schizophrenia Bulletin*, *32*(3), 443–450. https://doi.org/10.1093/schbul/sbj043

Dirik, A., Sandhu, S., Giacco, D., Barrett, K., Bennison, G., Collinson, S., & Priebe, S. (2017). Why involve families in acute mental healthcare? A collaborative conceptual review. *BMJ Open*, *7*(9), Article e017680. https://doi.org/10.1136/bmjopen-2017-017680

Eisen, S. V., Wilcox, M., Idiculla, T., Speredelozzi, A., & Dickey, B. (2002). Assessing consumer perceptions of inpatient psychiatric treatment: The perceptions of care survey. *The Joint Commission Journal on Quality Improvement*, *28*(9), 510–526. https://doi.org/10.1016/s1070-3241(02)28056-6

Frakt, A. B., Trafton, J., & Pizer, S. D. (2017). The association of mental health program characteristics and patient satisfaction. *The American Journal of Managed Care*, *23*(5), Article e129–e137. https://www.ajmc.com/journals/issue/2017/2017-vol23-n5/the-association-of-mental-health-program-characteristics-and-patient-satisfaction?p=2

Javed, A., & Herrman, H. (2017). Involving patients, carers and families: An international perspective on emerging priorities. *BJPsych international*, *14*(1), 1–4. https://doi.org/10.1192/s2056474000001550

Mental Health America. (May 2018). *Evidence for peer support.* https://www.mhanational.org/sites/default/files/Evidence%20for%20Peer%20Support%20May%202018.pdf

National Alliance on Mental Illness. (n. d.). *NAMI Family-to-family*. https://www.nami.org/Support-Education/Mental-Health-Education/NAMI-Family-to-Family

National Partnership for Women & Families. (April 2013). *Key steps for creating patient and family advisory councils in CPC practices.* https://www.rmhpcommunity.org/sites/default/files/resource/Key%20Steps%20for%20Creating%20PFACS%20in%20CPC%20Practices.pdf

Office of the Assistant Secretary for Planning and Evaluation. (2015, December 1). An assessment of innovative models of peer support services in behavioral health to reduce preventable acute hospitalization and readmissions. 1. Environmental Scan Report. https://aspe.hhs.gov/report/assessment-innovative-models-peer-support-services-behavioral-health-reduce-preventable-acute-hospitalization-and-readmissions#

Pillars of Peer Support. (n. d.). *Transforming mental health systems of care*. http://www.pillarsofpeersupport.org/

Priebe, S., & Miglietta, E. (2019). Assessment and determinants of patient satisfaction with mental health care. *World Psychiatry*, *18*(1), 30–31. https://doi.org/10.1002/wps.20586

Ruter, T. J., & Swarbrick, P. (November 2010). *Consumer involvement with state mental health authorities.* National Association of Consumer/Survivor Mental Health Administrators (NAC/SMHA) and National Association of State Mental Health Program Directors (NASMHPD) Medical Directors Council. https://nasmhpd.org/content/consumer-involvement-state-mental-health-authorities

Samartzis, L., & Talias, M. A. (2019). Assessing and improving the quality in mental health services. *International Journal of Environmental Research and Public Health*, *17*(1), 249. https://doi.org/10.3390/ijerph17010249

Shipley, K., Hilborn, B., Hansell, A., Tyrer, J., & Tyrer, P. (2000). Patient satisfaction: A valid index of quality of care in a psychiatric service. *Acta Psychiatrica Scandinavica*, *101*(4), 330–333. https://doi.org/10.1034/j.1600-0447.2000.101004330.x

Substance Abuse and Mental Health Services Administration. (2017). *Family, parent, caregiver peer support in behavioral health.* https://www.samhsa.gov/sites/default/files/programs_campaigns/brss_tacs/family-parent-caregiver-support-behavioral-health-2017.pdf

Substance Abuse and Mental Health Services Administration. (2017). *Value of peers*. https://www.samhsa.gov/sites/default/files/programs_campaigns/brss_tacs/value-of-peers-2017.pdf

Substance Abuse and Mental Health Services Administration. (2020, April 16). *Guidelines for consumer and family participation*. https://www.samhsa.gov/grants/applying/guidelines-consumer-participation

Substance Abuse and Mental Health Services Administration. (2020, April 22). *Person- and family-centered care and peer support*. https://www.samhsa.gov/section-223/care-coordination/person-family-centered

Teague, G. B., & Caporino, N. E. (2008). Patient perceptions of care measures. In A. J. Rush, Jr., M. B. First, & D. Blacker (Eds.), *Handbook of psychiatric measures* (pp. 163–191). American Psychiatric Publishing, Inc.

Washington State Health Care Authority. (2020). *Peer support.* https://www.hca.wa.gov/billers-providers-partners/behavioral-health-recovery/peer-support

Woldekidan, N. A., Gebresillassie, B. M., Alem, R. H., Gezu, B. F., Abdela, O. A., & Asrie, A. B. (2019). Patient satisfaction with psychiatric outpatient care at University of Gondar Specialized Hospital: A cross-sectional survey. *Psychiatry Journal*, *2019*, Article 5076750. https://doi.org/10.1155/2019/5076750

PROGRAMMING

3

3. PROGRAMMING

Community hospitals and E&Ts that provide inpatient care for individuals on an initial civil commitment e.g. 120 hour or 14-day hold may need to diversify their programming to accommodate 90- and 180-day commitments. Although community hospitals and E&Ts might be serving the same individuals they would have served for shorter stays, these individuals' needs are far more complex over the longer period. Further, the facilities will have a patient mix that includes some who require initial stabilization and others who have been patients for weeks or months. As a result, the hospital or E&T will need to offer programming for a wide range of clinical needs and also understand that individuals receiving treatment on a 90-180 day order may experience a change in condition resulting in increased acuity and a need for psychiatric restabilization.

Facilities have flexibility in designing the mix of treatment and other activities. Nonetheless, it is important to ensure that all services are delivered in a trauma-informed manner, that individuals have choice in programming (employing, for example, a "treatment mall" approach), and that interventions are evidence-based. Smaller facilities will need to be more intentional with this approach compared to larger state hospitals. The following table represents a minimum staffing model to meet the unique and complex needs of individuals in an LTCC facility,

Minimum Staffing Model

The following schedule is based off an 8-hour shift pattern. Facilities operating on a 12-hour shift pattern, should adjust the 8-hour table to maintain the staffing ratio indicated below. This pattern is based on existing staffing models and the interpretation of best practices.

Shift	Staff	Time
Day Shift 1	Direct Care Staff: 3 Mental Health Technicians, 2 Nurses - 2 Registered Nurses (RNs) or 1 RN and 1 Licensed Practical Nurse (LPN), 1 Peer Counselor, 1 Activities and Recreation Therapist	6:30am – 3pm
Day Shift 2	Direct Care Staff: 1 Case Manager/ Discharge Planner, 1.5 Mental Health Professional/Therapist (non-medical)	9am – 5pm
Swing Shift	Direct Care Staff: 3 Mental Health Technicians, 2 Nurses – 2 RNs or 1 RN and 1 LPN, 1 Peer Counselor (eligible for negotiation)	2:30pm- 11:00 pm

Nocturnal (night) Shift	Direct Care Staff: 3 Mental Health Technicians, 1 licensed Nurse	10:30pm – 7am
On Call and Varied Schedule	.5 Program Administrator, 1 dedicated LTCC Clinical Director, 1 dedicated LTCC Nurse Manager, 1 Psychiatrist, Psychiatric Nurse Practitioner or Physician Assistant	Varied

Alternative Staffing Model

An acceptable alternative to the above Table is as follows. Contracted facility will present an alternate plan prior to contract execution.

- Contracted facility will provide recreational therapy as part of active treatment including exercise and leisure activities. These activities will be led by a variety of staff disciplines including Recreational Therapists, Occupational Therapists, Creative Arts Therapists, Social Workers, Registered Nurses, Mental Health Technicians, CNAs, and NACs.

- Contracted facility will use Peer Bridger services, conduct Peer led treatment groups, and not later than 180 days will add an additional full time Peer Counselor position to conduct groups and individual support to patients, and provide to input into treatment plans.

Flexibility in Treatment and Services

In contrast to initial hospitalization, with stabilization as the primary goal, hospitalization for 90 or 180-days provides an opportunity to continue to work on stabilization as well as other clinical outcomes. The prescriber has an opportunity to develop, in collaboration with the individual, a more effective medication regimen. Other clinicians and CPCs can address other issues, such as coping strategies, healing from trauma, and skills for employment, for example. Because these desired outcomes will vary from individual to individual, the hospital or E&T will need to offer flexibility in the treatment and services it provides.

One leading model for promoting recovery during long-term hospitalization is the treatment mall. As described by Riley (2009), the basic concept of the treatment mall is to physically separate treatment activities, residency in the hospital, and leisure activities. In the hospital design Riley describes, this is operationalized at a state psychiatric hospital as:

- **"House"—the unit where individuals sleep, bathe, and do laundry, along with space to respond to clinical needs that arise while individuals are in the residential unit,**

- **"Neighborhood"—the area in which individuals from multiple units eat meals and participate in active treatment, rehabilitation, and some recreational activities, and**

- **"Downtown"—the area in which the store, hair salon, and gym are located, each of which serve as an incentive for participating in treatment.**

Full implementation of this model, of course, requires considerable resources and is appropriate when patients receive treatment in a single location. However, E&Ts and smaller community hospitals can learn from this approach by

- **Setting aside blocks of time when patients are not in their rooms, in addition to the time needed for active treatment,**

- **Offering a variety of activities that are sufficient to meet the minimum daily treatment requirements, while also providing for recreational and leisure activities, and**

- **Working with patients to schedule appropriate activities.**

Evidence-Based Practices (EBPs)

A number of evidence-based practices, including some that are typically used in an outpatient setting, may be appropriate for 90- or 180-day inpatient treatment. Treatment should consist of an appropriate mix of individual and group interventions. Interventions for consideration include the following:

- **Cognitive Behavioral Therapy for Psychosis (CBTp). CBT use can prevent the first episode of psychosis in ultra-high risk (UHR) and is effective in improving depression, self-esteem, and psychological well-being. Its use is associated with positive changes in thinking and mood, and sleep quality leading to improved everyday life.**

- **Cognitive Therapy for Recovery (CT-R). CT-R is a hospital-based cognitive therapy approach for individuals with SMI, based on well-established cognitive behavioral therapy principle. The therapist and the individual work together on treatment goals based on an individual's interests, values, and aspirations for a meaningful life.**

- **Collaborative Assessment and Management of Suicidality (CAMS). CAMS is a suicide-specific intervention that includes both assessment and treatment. The clinician uses a supportive and non-judgmental therapeutic framework.**

- **Co-Occurring Disorder Treatment. There is a high incidence of co-occurring disorders in adults with SMI. SAMHSA offers a toolkit that would be helpful in running integrated groups focusing on both substance use and mental health issues.**

- **Dialectal Behavior Therapy (DBT). Although DBT was originally developed (at the University of Washington) for individuals with borderline personality disorder, DBT is now used nationally for treatment of posttraumatic stress disorder (PTSD), SUDs, depression, and other behavioral health conditions.**

- **Illness Management and Recovery. SAMHSA created a toolkit on evidence-based approaches to illness management and recovery, which encompass key activities such as learning to identify triggers and signs of relapse, as well as understanding how to use medication effectively.**

- **Motivational Interviewing (MI). Appropriate for all types of behavioral health issues, MI is based on a recognition that individuals progress (or regress) through stages of change. The key elements of MI include expressing empathy, developing discrepancy between the individual's desires and current actions, avoiding argumentation or conflict, rolling with the individual's resistance, and supporting the individual's belief that they can make changes.**

- **Supported Education.** Although [supported education](#) was originally designed for community-based settings, distance learning now makes supported education possible in inpatient facilities, minimizing the disruption to education.

- **Supported Employment.** By contrast, [supported employment](#) relies on competitive employment (i.e., jobs not reserved for people with disabilities) and cannot be fully implemented in an inpatient setting. However, New Jersey established a pilot program in July 2015 to provide in-reach concerning supported employment services to individuals in state psychiatric hospitals who are expected to be discharged soon. While hospitalized, individuals learn job-finding skills and get to know the supported employment providers in the community.

Wellness Recovery Action Plan (WRAP). WRAP guides participants through the process of identifying and understanding their personal wellness resources ("wellness tools") and then helps them develop an individualized plan to use these resources on a daily basis to manage their mental illness.

Health and Wellness

People with SMI and SUDs have high rates of chronic disease and a shorter life expectancy. Additionally, some antipsychotic medications are associated with weight gain, diabetes, and other health problems. The length of a 90- or 180-day stay presents an opportunity to influence health-promoting behaviors. For example:

- **Helping the individual understand how to maintain a healthier diet, including shopping for food and preparing meals**

- **Providing exercise opportunities, such as yoga or other group activities**

- **Educating the individual on diabetes self-management, including monitoring blood sugar and taking medications as directed**

- **Guidance with smoking cessation, which is particularly helpful during an extended period of inpatient treatment**

Further, many patients will need basic dental, podiatric, and medical care during their 90- or 180-day commitment. The volume of such needs will dictate whether it is more advantageous to transport individuals into the community for treatment or bring the providers into the facility on designated days. The commitment period may present an opportunity to address long-neglected problems, particularly dental problems.

Recovery-Oriented Activities

When treating an individual over a period of 90 or 180 days, it is important to provide opportunities for education, enrichment, and leisure, rather than offering only "down time" when active treatment is not occurring. It is recommended that participants engage in treatment no less than 32 hours per week. Examples may include:

- **Arts and crafts**

- **Therapy with support animals, music, movement, horticulture, or art**

- **Outings into the community with staff or with family and friends, when appropriate**

- **Life skills education, such as budgeting or managing a household**

- **Outings to identify choice in housing environments**

Community hospitals and E&Ts can offer opportunities to explore interests that can carry over to reentry into the community. Interests such as spiritual practices, gardening, body building, yoga or meditation, writing stories and poems, standup comedy, or social activism can help with establishing new supports and social network opportunities.

References and Resources for Programming

Advocates for Human Potential, Inc. (n.d.). *WRAP is . . .* https://mentalhealthrecovery.com/wrap-is/

Bartholomew, T., & Cook, R. (2013). Toward a fidelity scale for inpatient treatment malls. *American Journal of Psychiatric Rehabilitation*, *16*(3), 179–197. https://doi.org/10.1080/15487768.2013.813872.

Ballard F. A. (2008). Benefits of psychosocial rehabilitation programming in a treatment mall. *Journal of Psychosocial Nursing and Mental Health Services*, *46*(2), 26–32. https://doi.org/10.3928/02793695-20080201-01

CAMS-care. (2020). *What is the "Collaborative Assessment and Management of Suicidality" (CAMS)?* https://cams-care.com/about-cams/

Carey, K. B., Leontieva, L., Dimmock, J., Maisto, S. A., & Batki, S. L. (2007). Adapting motivational interventions for comorbid schizophrenia and alcohol use disorders. *Clinical Psychology: Science and Practice*, *14*(1), 39–57. https://doi.org/10.1111/j.1468-2850.2007.00061.x

Chukwudi Agbor, Garima Kaur, Fareena M Soomro, Victor C Eche, Alexsandra Urhi, Oghenetega E Ayisire, Akinkunmi Kilanko, Funmilola Babalola, Chioma Eze-Njoku, Ngozi J Adaralegbe, Bialo Aladum, Oluwabukola Oyeleye-Adegbite, and Gibson O Anugwom (2022). **The role of cognitive behavioral therapy in the management of psychosis.** *Cureus, 14(9),* **e28884. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9541382/**

Coleman, J.C. & Paul, G.L. (2001). *Relationship between staffing ratios and effectiveness of inpatient psychiatric units. Psychiatric Services, (52(10).* https://doi.org/10.1176/appi.ps.52.10.1374

Collins, A. L. (2010). *Dialectical behavior therapy in state hospitals: Does it work and what moderates the outcomes?* [Doctoral dissertation, University of Nebraska at Lincoln]. DigitalCommons@University of Nebraska - Lincoln. https://digitalcommons.unl.edu/cgi/viewcontent.cgi?article=1013&context=psychdiss

Deegan, P. E., & Drake, R. E. (2006). Shared decision making and medication management in the recovery process. *Psychiatric Services*, *57*(11), 1636–1639. https://doi.org/10.1176/ps.2006.57.11.1636

Dual Recovery Anonymous. (n.d.). *Index of registered DRA 12-step meetings*. http://www.draonline.org/meetings.html

Feldman, J., Best, M., Beck, A. T., Inverso, E., & Grant, P. (2019, March 7). *What is recovery-oriented cognitive therapy (CT-R)?* Beck Institute for Cognitive Behavior Therapy. https://beckinstitute.org/what-is-recovery-oriented-cognitive-therapy-ct-r/

Glassheim, B. (April 2016). *A guide to evidence-based wellness practices*. Saginaw County Community Mental Health Authority. https://www.sccmha.org/userfiles/filemanager/1058/

Hearing Voices Network USA. (n.d.) *HVN-USA groups map*. https://www.hearingvoicesusa.org/find-a-group

Matthews, A. N., Beecher, B., Hofer, P. J, & Short, R. A. (2015). An exploratory evaluation of a treatment mall at a state psychiatric hospital. *American Journal of Health Sciences*, *6*(1), 83–90. https://doi.org/10.19030/ajhs.v6i1.9272

Motivational Interviewing Network of Trainers. (2020). *Welcome to the Motivational Interviewing Network of Trainers (MINT)*. https://motivationalinterviewing.org/

National Alliance on Mental Illness Washington. (2020). *Local affiliates*. https://www.namiwa.org/index.php/about-nami/local-affiliates

New Jersey Division of Mental Health and Addiction Services. (2020). *Supported employment: Annex A to mental health fee for service contract.* https://www.nj.gov/humanservices/dmhas/provider/contracting/contracting_info/Sup_Emp_Annex.pdf

Riley, S. V. (2009, September 1). Building a treatment mall. *Behavioral Healthcare Executive*. https://www.psychcongress.com/article/building-treatment-mall

Substance Abuse and Mental Health Services Administration. (2024) *SAMHSA encourages use of life-changing wellness strategies.* https://mfpcc.samhsa.gov/ENewsArticles/Article03b_2018.aspx.

Substance Abuse and Mental Health Services Administration. (2010). *Illness management and recovery evidence-based practices KIT*. https://store.samhsa.gov/product/Illness-Management-and-Recovery-Evidence-Based-Practices-EBP-KIT/SMA09-4462

Substance Abuse and Mental Health Services Administration. (2010). *Integrated treatment for co-occurring disorders evidence-based practices KIT*. https://store.samhsa.gov/product/Integrated-Treatment-for-Co-Occurring-Disorders-Evidence-Based-Practices-EBP-KIT/SMA08-4366

Substance Abuse and Mental Health Services Administration. (2010). *Supported employment evidence-based practices (EBP) KIT*. https://store.samhsa.gov/product/Supported-Employment-Evidence-Based-Practices-EBP-Kit/SMA08-4364

Substance Abuse and Mental Health Services Administration. (2012). *Supported education evidence-based practices (EBP) KIT*. https://store.samhsa.gov/product/Supported-Education-Evidence-Based-Practices-EBP-KIT/SMA11-4654

Substance Abuse and Mental Health Services Administration. (2018, May 31). *Empowering change: Motivational Interviewing*. https://www.samhsa.gov/homelessness-programs-resources/hpr-resources/empowering-change

Substance Abuse and Mental Health Services Administration. (June 2018). Practicing recovery: Medication as a tool for recovery. *Recovery to Practice*, (15)*. https://www.samhsa.gov/sites/default/files/programs_campaigns/recovery_to_practice/newsletter-15-june-2018.pdf

Substance Abuse and Mental Health Services Administration. (September 2019). SAMHSA Advisory: Implementing tobacco cessation treatment for individuals with serious mental illness: A quick guide for program directors and clinicians (SAMHSA Publication No. PEP19-02-00-001). https://store.samhsa.gov/sites/default/files/d7/priv/pep19-02-00-001_0.pdf

Substance Abuse and Mental Health Services Administration. (2019). *TIP 35: Enhancing motivation for change in substance use disorder treatment*. https://store.samhsa.gov/product/TIP-35-Enhancing-Motivation-for-Change-in-Substance-Use-Disorder-Treatment/PEP19-02-01-003

Substance Abuse and Mental Health Services Administration. (2020). *TIP 42: Substance use treatment for persons with co-occurring disorders*. https://store.samhsa.gov/product/tip-42-substance-use-treatment-persons-co-occurring-disorders/PEP20-02-01-004

SAFETY AND REDUCTION OF SECLUSION AND RESTRAINT

4

4. SAFETY AND REDUCTION OF SECLUSION AND RESTRAINT

Community hospitals and E&Ts are limited in their use of involuntary seclusion, physical restraint, or chemical restraint—they may use it only when necessary to prevent harm to patients, staff, or property, and only for as long as necessary. Such practices are traumatizing, and every effort should be made to minimize their use.

It is important for all staff to receive initial and ongoing training in crisis de-escalation and behavior management as an alternative to the use of seclusion and restraint. The National Association of State Mental Health Program Directors (NASMHPD) has developed Six Core Strategies for Reducing Seclusion and Restraint Use, which is a helpful resource. The six strategies include

1. Organization leadership on reducing seclusion and restraint

2. Using data to inform practice, such as setting goals and working toward them

3. Workforce development, including on how to promote choice, respect, dignity, partnerships, self-management, and full inclusion

4. Use of specific tools for identifying risk of violence, history of trauma, and risk of injury from restraint (e.g., heart conditions or asthma)

5. Hiring peers to work in inpatient settings

6. Debriefing from events in which seclusion or restraint was used, to change future practice

Trauma-Informed Care

Under SAMHSA's definition, "individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being" (SAMHSA's Trauma and Justice Strategic Initiative, 2014). Because trauma is so common among people requiring long-term inpatient care, and because the involuntary commitment process is itself traumatizing, the assumption of treatment providers should be that people on 90- and 180-day commitment orders have trauma issues to work on and that they are susceptible to re-traumatization.

SAMHSA (2014) identifies the following six key principles for trauma-informed care:

1. Safety: Staff and patients feel safe, and the environment conveys a feeling of safety.

2. Trustworthiness and Transparency: Activities are designed to inform and gain the trust of patients and families.

3. Peer Support: Individuals with lived experience of trauma help patients heal.

4. Collaboration and Mutuality: All staff, whether or not they are involved in treatment, show respect and empathy, and power differentials are not expressed.

5. Empowerment, Voice, and Choice: Both staff and patients are empowered, and patients are supported in shared decision-making and taught self-advocacy.

6. Cultural, Historical, and Gender Issues: The organization recognizes cultural differences and provides culturally accessible services, including recognition of the value of traditional cultural practices and the role of historical trauma.

Specific Interventions

In addition to making the treatment environment and interventions generally more supportive of healing from trauma, facilities have options for trauma-specific interventions.

Short-Term Assessment of Risk and Treatability

The [Short-Term Assessment of Risk and Treatability](#) (START), developed at a Canadian hospital in conjunction with British Columbia's behavioral health agency, is a 20-item tool for assessing risks across 7 domains. Designed for adults with behavioral health conditions in both inpatient and outpatient settings, it focuses on individual client strengths and vulnerabilities to guide treatment and care management decisions.

The START tool

•   **Is effective for evaluating safety throughout treatment**

•   **Assists in planning for identified risks**

•   **Is helpful in evaluating readiness for discharge**

The Sanctuary Model®

Dr. Sandra L. Bloom developed the [Sanctuary Model](#) in the 1980s, based on the recognition that trauma is a pervasive experience among people with behavioral health conditions. The model has a clinical and organizational structure that promotes recovery and has been adapted for use in inpatient settings. It is based on four "pillars": shared knowledge, shared values, shared language, and shared practice.

References and Resources for Safety

British Columbia Mental Health and Substance Use Services. (n.d.). *Risk assessment: START manuals*. http://www.bcmhsus.ca/health-professionals/clinical-professional-resources/risk-assessment-start-manuals

Community Works, Inc. (n.d.). *The Sanctuary Model.* http://www.sanctuaryweb.com/TheSanctuaryModel.aspx

National Association of State Mental Health Program Directors. (2006). *Six core strategies for reducing seclusion and restraint use.* https://www.nasmhpd.org/sites/default/files/Consolidated%20Six%20Core%20Strategies%20Document.pdf

Substance Abuse and Mental Health Services Administration Trauma and Justice Strategic Initiative. (2014). *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach*. https://www.nasmhpd.org/sites/default/files/SAMHSA_Concept_of_Trauma_and_Guidance.pdf

Substance Abuse and Mental Health Services Administration. (2014). *TIP 57: Trauma-informed care in behavioral health services*. https://store.samhsa.gov/product/TIP-57-Trauma-Informed-Care-in-Behavioral-Health-Services/SMA14-4816

Schulman, M., & Menschner, C. (January 2018). *Laying the groundwork for trauma-informed care*. Trauma-Informed Care Implementation Resource Center, Center for Health Care Strategies, Inc. https://www.traumainformedcare.chcs.org/wp-content/uploads/2018/11/Brief-Laying-the-Groundwork-for-TIC.pdf

Sweeney, A., Filson, B., Kennedy, A., Collinson, L., & Gillard, S. (2018). A paradigm shift: Relationships in trauma-informed mental health services. *BJPsych Advances*, *24*(5), 319–333. https://doi.org/10.1192/bja.2018.29

PHYSICAL ENVIRONMENT 5

5. PHYSICAL ENVIRONMENT

Designing a space where people will stay for 90 or 180 days requires considerations that may not be applicable to short term treatment stays. Over the longer term, people benefit from a more homelike environment. During the development of the initial toolkit, AHP held a focus group with people who have experienced 90- and 180-day commitments (some in state-run hospitals); their comments about the physical environment are incorporated here.

This section provides guidance on improving patient experiences, rather than meeting mandatory requirements. It is based on best practices and focus group suggestions. The facility requirements for inpatient psychiatric care are detailed and are not covered here. Instead, the focus is on how community hospitals and E&Ts can make individuals more comfortable and feel more supported, while at the same time protecting everyone's physical safety.

Design the Environment

An open layout of common areas facilitates observation by staff. Possible changes to an existing unit include eliminating unnecessary doors and curtains and removing dividers, plants, or other objects that limit view. However, lines of sight are not the only consideration. One comment from the focus group was that removing plexiglass dividers around nurse stations or otherwise reducing the physical separation of staff and individuals could help increase individuals' feelings of self-worth. The *Behavioral Health Design Guide* (Hunt et al., 2019) offers suggestions about designing nurse stations in such a manner, for example installing counters that are difficult to jump and increasing patient–staff interaction by locating recreational space near the nurse station.

It is possible to design spaces that meet federal safety requirements (such as those designed to reduce ligature risk) while simultaneously increasing emotional safety. Some physical features that can improve physical security, such as bars on windows or loud buzzers on doors, create an institutional feel that may hamper recovery. Resources such as *Laying the Groundwork for Trauma-Informed Care* (Schulman & Menschner, 2018) offer advice on designing environments that balance physical security with emotional safety.

The hospital or E&T should strive to make residents feel at home, but they of course must balance aesthetic considerations with durability and ease of maintenance. Hunt et al. (2019) suggests finishes that provide a more homelike feel, such as durable synthetic baseboards that are designed to look like those found in homes. The Facility Guidelines Institute (Hunt & Sine, 2015) suggests avoiding the 2-by-4-foot fluorescent lights found in many general hospitals and opting instead for fixtures with a more residential feel. At the same time, the Institute cautions that everyone has a different concept of home, and the goal should be to create a non-threatening environment rather than trying to achieve any specific décor.

Soft colors, wood accents, and artwork can help create a welcoming feel. Some options for artwork when safety is a concern include murals and pre-printed sheet art that is adhered to walls. The *Behavioral Health Design Guide* cautions against carpeting that can create any type of optical illusions, such as a floating effect. It also offers some detailed guidance on furniture. The focus group specifically mentioned plastic furniture as a feature that can create a cold, institutional feel.

The focus group made some additional suggestions for the design of areas serving individuals on 90- and 180-day stays. They suggested increasing the amount of natural light and fresh air and having higher ceilings. Such changes may not be possible when expanding an existing facility to accommodate longer-stay patients, but they should be considered in new construction. It is particularly important to allow individuals access to outdoor spaces that include some covered space to allow use during rain.

Addressing noise levels may also help to improve patient experience. Regulating the volume of televisions in common areas, limiting use of overhead paging systems, and installing carpet wherever possible are ways to reduce noise levels, in addition to soundproofing technologies. Some consumers suggested a "quiet room" where people can meditate, self-soothe, gather their thoughts, or read.

Accommodating Longer Stays

Individuals on 90- and 180-day commitment orders will not only be in the care of the community hospital or E&T for longer periods of time, but also have different clinical needs that cannot be addressed in the same way they might be during short term stays. Over the long term, individuals benefit from increased privacy, the opportunity to personalize their space, greater access to visitors, and opportunities for exercise and recreation. Providing long-term treatment will require the hospital or E&T to designate adequate space for treatment groups.

Private rooms are not a requirement for 90- and 180-day treatment facilities, but providers are urged to ensure that rooming arrangements are appropriate for achieving therapeutic goals. The Facility Guidelines Institute suggests limiting the number of people per room to two but does not designate a preference between private and semi-private rooms, instead leaving it to the facility (Hunt & Sine, 2015). Eshel et al. (2016) suggest semi-private rooms may provide some benefits, such as mutual support, but describe the following benefits of private rooms:

- **Reduction in anxiety and sleep disruption**

- **Greater willingness to discuss trauma, substance use, and other sensitive topics**

- **A buffer against others' problem behaviors**

- **Improved patient satisfaction**

During short stays for initial care, patients may have little need to personalize their space. During stays that are expected to last for several months or longer, by contrast, many will want to personalize their space with items such as family photos, cards, drawings, religious symbols, plants, and other personal items. Facilities are encouraged both to design spaces that allow for this type of personalization (such as a shelf or bulletin board) and to adopt policies on what items are acceptable. Considerations for whether items are acceptable may include:

- **Risk of harm to the owner or other patients (e.g., a photo framed under glass)**

- **Potential to upset staff or other patients (e.g., vulgar materials)**

- **Interference with staff or other patients (e.g., large houseplants)**

- **Inconsistency with therapeutic goals (e.g., electronics)**

- **Potential for misuse to damage property (e.g., permanent markers)**

- **Potential for misuse as an intoxicant (e.g., solvent-based glue)**

Residents should have options other than television for entertainment. It is highly recommended to have books, games, and basic leisure activities available, based on individual preferences. Giving people something to distract themselves and engross themselves in will help them to relax and make the living situation more inviting.

References and Resources for Physical Environment

Eshel, N., Marcovitz, D. E., & Stern, T. A. (2016). Psychiatric consultations in less-than-private places: Challenges and unexpected benefits of hospital roommates. *Psychosomatics*, *57*(1), 97–101. https://doi.org/10.1016/j.psym.2015.09.007

Hunt, J. M., & Sine, D. M. (May 2015). *Common mistakes in designing psychiatric hospitals: An update.* Facility Guidelines Institute. https://fgiguidelines.org/wp-content/uploads/2015/07/FGI_CommonMistakesPsychiatricHospitals_1505.pdf

Hunt, J. M., Sine, D. M., & McMurray, K. N. (November 2019). *Behavioral health design guide* (9th ed.). Behavioral Health Facility Consulting, LLC. https://fb708656-5e29-4908-8b3f-76a7eb2f68c4.filesusr.com/ugd/038373_4d3f238d61f740858728472abfc90265.pdf

Schulman, M., & Menschner, C. (January 2018). *Laying the groundwork for trauma-informed care*. Trauma-Informed Care Implementation Resource Center, Center for Health Care Strategies, Inc.. https://www.traumainformedcare.chcs.org/resource/laying-the-groundwork-for-trauma-informed-care/

PERSON-CENTERED CARE PLANNING

6

6. PERSON-CENTERED CARE PLANNING

Person-centered care planning (PCP) is an approach that that focuses on two parallel aspects of health care: care processes (the way care is organized) and staff interactions with individuals and their families (human interactions). The approach puts individuals at the center of care planning and related decisions, seeing them as experts and equal partners in planning, developing, and monitoring their care.

PCP enables people to manage their health and recovery on a day-to-day basis. Every day, individuals make decisions, take actions, and manage a broad range of factors that contribute to their well-being. PCP offers the individual a collaborative process in which they develop a vision for the future, prioritize goals aimed at achieving that vision, prioritize viable options to meet objectives, and develop a plan of action to achieve their goals.

Team-Based Approach

PCP involves a collaborative process between the individual and their care team, which includes people in the individual's life whom they identify as supportive of recovery, including clinical practitioners, other mental health staff involved in the person's care, peer specialists, and natural supports (e.g., friends, family members, and representatives from faith communities).

Providers support individuals and care team members in articulating and understanding the individual's vision, developing goals grounded in the individual's values, brainstorming options to meet the individual's goals, and reaching a decision that honors the individual's preferred course of action. The conversation brings together the healthcare professional's expertise—such as the treatment options, risks, and benefits—with the individual's expertise regarding their own preferences, personal and social circumstances, goals, values, and beliefs (Stanhope et al., 2015).

The recovery-oriented approach of PCP results in an overarching plan of care inclusive of actionable plans (treatment plan, safety plan, discharge plan) that assist the individual in achieving their unique personal goals along the journey of recovery. It is endorsed by the individual; driven by their needs, preferences, and desired outcomes; and tailored to address any specific mental health or substance use barriers or other challenges interfering with their goal achievement (Miller et al., 2017). Together, the team co-creates a plan of care that is reflective of the individual's unique goals and strengths and leverages the professional and natural supports and resources in their life.

The following principles (Tondora et al., 2005) guide PCP:

- **Oriented toward promoting recovery rather than only minimizing illness and symptoms**

- **Based on the person's own unique life goals and aspirations**

- **Focuses and builds on the person's capacities, strengths, and interests**

- **Articulates the person's own role and the role of both paid practitioners and natural supports in assisting the person to achieve his or her own goals**

- **Emphasizes the use of natural community settings rather than segregated program settings**

- **Anticipates and allows for uncertainty, setbacks, and disagreements as inevitable steps on the path to greater self-determination**

Incorporating Best Practices

To ensure effective care planning, all staff should be trained in the key principles and skills of person-centered care, shared decision making, and fostering individual self-direction in treatment planning. Training should cover awareness of and sensitivity to issues of race, ethnicity, age, sexual orientation, and gender identity. Providers facilitating person-centered care team meetings, especially, should be trained in

- **A PCP framework that includes the following key elements:**
  - **Establishing a PCP facilitator**
  - **Engaging in pre-planning**
  - **Facilitating care planning meetings**
  - **Developing written plans of care (treatment plan, safety plan, discharge plan)**
  - **Monitoring progress on care plan tasks**
- **Shared decision making tools**
- **Trauma-informed care**
- **Culturally relevant care planning**
- **Engagement of natural supports and peer specialists in the care planning process**
- **Mental health advance directives**
- **WRAP advance crisis planning tool**

Don't We Already Do PCP?

It is important to understand each team member's (including the individual's) orientation to care planning, recognizing that some may continue to approach the process as the expert crafting the plan rather than as a co-contributor developing a plan that reflects the individual's expertise about themselves as well as the professional's clinical expertise. Some care team members may benefit from the opportunity to learn more about PCP and their role in it prior to participating in the care planning process. Sensitivity to this is paramount, as some providers may believe that their current approach is person-centered only to find that they are actively diminishing the individual's role in the care planning process. Successful implementation and establishment of new practices can be difficult to maintain even with strong intention to do so. A sustained shift in practice often requires training, coaching, and supervising the workforce in the new model (Stanhope et al., 2015). Transformational leadership is often required to provide ongoing support of policy and procedures that reinforce new beliefs, new attitudes, and a recovery orientation in which staff demonstrate a belief that people can and do recover, that people can and should self-determine to the greatest extent possible, and that living in the community is a fundamental right for all people, no matter their disability or cultural background.

Additionally, PCP involves the use of tools and strategies that may not yet be familiar to all providers on the care team but are critical to the person-centered planning process. This includes the use of

- **Natural supports (partner, family, friends) and peer specialists in the care planning process**

- **Articulation of the individual's vision and clearly defined goals with measurable objectives co-created and endorsed by the individual, to include participation in treatment planning meetings**

- **Assignment of responsibility for different tasks and action steps to different members of the care team, including the individual**

- **Projecting a hopeful vision for the future**

- **Tools such as mental health advance directives, shared decision-making aids, and supported employment, housing, socialization, and education coaches (Stanhope et al., 2015).**

Talking with care team members ahead of the care planning process can help establish them as champions of PCP who understand that the process is as much about the way professionals and individuals think about how care as it is about the care that is provided. Champions understand that person-centered care is not just about giving people whatever they want. It is about seeing the person as an individual, considering their clinical needs, desires, values, family situations, social circumstances, and lifestyle and working together to develop appropriate solutions. Champions know that the reduction of symptoms is not necessarily the desired "outcome" but rather a way to help facilitate achievement of the individual's recovery goals, such as returning to work or finishing school. To this end, champions of PCP hone their skills in

- **Demonstrating respect of the individual's values and priorities**

- **Putting individuals at the center of their care**

- **Considering individuals' preferences and expressed needs**

- **Promoting hopefulness**

- **Shared decision making**

- **Supporting all team members, especially the individual, in having opportunity to provide input**

- **Promoting dialogue in a neutral, respectful manner**

Applying the PCP Framework in the 90- and 180-Day Setting

The following is a general guiding framework for conducting PCP that results in the development of a person-centered treatment plan or care plan. This framework is also used for developing person-centered safety plans and discharge plans.

Step 1: Establish a team

- **Identify a facilitator who will work with the individual to co-create the plan.**

- **Identify team members, including community-based providers.**

- **Team members should include a liaison from the managed care organization or the behavioral health administrative service organization**

Explain the facilitator role to the individual and answer any questions.

Step 2: Prepare

- **Explore the individual's vision for the future and recovery goals.**

- **Explore topics the individual wants to discuss and co-create a PCP team agenda.**

- **Explore important people in the individual's life and make a plan to invite them to the PCP team meeting.**

- **Explore any questions or concerns the individual wants to discuss with the care team.**

- **Prepare care team members to participate: explain what to expect and their role in the care planning process (PCP principals, role on the team, task assignment process).**

Step 3: Facilitate the PCP team meeting

- **Share the individual's vision for the future and stated recovery goals.**

- **Brainstorm viable objectives/pathways to meeting those goals.**

- **Identify potential barriers and ways to overcome them.**

- **Prioritize options: determine which options the individual would like to try first, second, etc.**

- **Determine how the team will know if the chosen options are working.**

- **Assign team members tasks that need to occur to carry out the chosen option.**

- **Schedule a follow-up meeting.**

Step 4: Follow up after meeting

- **Meet with the individual to debrief after the PCP team meeting. Explore what worked, what they would like to do differently next time, concerns, and questions.**

- **Monitor each care team member's progress on their assigned task. Contact them in between meetings to inquire about progress and troubleshoot barriers.**

What About Risk and Liability?

Circumstances may arise in which care team members may not support a person's expressed goals and priorities. They may feel that the individual's goals, priorities, or decisions place them at risk. The care team must seek to balance supporting their dignity of risk (acknowledging that opting to take a risk is a normal, life growth experience) with the obligation to keep the individual and the community safe. The PCP process offers the PCP team and the individual the opportunity to understand the context around such choices as well as the concerns and possible solutions.

Teams may find it helpful to make a clear distinction between "risk" versus "safety" issues. "Risk" involves decisions that may jeopardize the individual's recovery (e.g., discontinuing attendance to a particular group, requesting a medication reduction, etc.), yet there are no imminent safety issues (e.g., dangerousness to self or others) present (Burns-Lynch et al., 2011). PCP anticipates and plans for responsible risk-taking and should be both tolerated and encouraged as a mechanism for growth and recovery. "Safety" issues refer to unique circumstances, narrowly defined by the Involuntary Treatment Act (ITA), where an individual is an imminent risk to self or others when in psychiatric crisis. In these circumstances, PCP does not override a provider's ethical and societal obligation to intervene when necessary for risk management. When safety issues present themselves, PCP frameworks may utilize recovery-oriented risk-management tools such as mental health advance directives and the advance crisis planning tool of WRAP to give individuals more control over future instances of safety issues.

Transitioning to the Community

For many, care transition from the hospital to the community is a challenging period. Nearly one of every two individuals covered by Medicaid or Medicare health maintenance organizations (HMOs) does not attend a single outpatient visit within the first 30 days following discharge from inpatient behavioral health care, compared to about one of three individuals with private insurance (National Committee for Quality Assurance, n.d.). One key feature of this challenging period is the transfer of care from one entity to another.

To bridge this gap, inpatient and outpatient providers in concert with the MCO, BHASO, and or Private insurance liaison must collaborate. Instead of viewing inpatient and outpatient services as distinct entities, they should work as a unified team, actively including both settings in PCP. Such planning includes the individual, significant others, and natural supports and peer supports. They will work together in partnership with the treating facility, the insurance company, or BHASO, and outpatient providers to help individuals safely navigate the gap between inpatient and outpatient care. This provides the opportunity for the individual to continue on the path towards sustained mental health and recovery. Peer Bridgers can also play a helpful role in these transitions.

Successful transition to the community is a central goal of care planning. It requires linkage to the right community-based services, resources, benefits, and supports at the right time. This includes formal services, informal resources, and peer support. To facilitate such linkage, the National Action Alliance for Suicide Prevention (2019) provides useful guidance for transitioning individuals safely to the community:

- *Cultivate human connection.* **Consider the transition planning process as part of a larger, holistic practice aimed at promoting health and safety by cultivating connections with others. Encourage contact between the outpatient providers and the individual prior to discharge. Build connections between the individual and their natural supports. Use peer specialists and others with lived experience to support the individual during the transition to the community and throughout recovery.**

- *Build an enduring structure for effective and safe care transitions.* **Establish, implement, and develop protocols and procedures for safe and rapid referrals to outpatient providers and resources. Revise protocols and formal agreements as needed to improve the care transition process and ensure that the needs of individuals, as well as the partnering organizations, are met. Include protocols for sharing electronic records (e.g., treatment plans, transition/discharge plans,**

medications list, crisis/safety plan, releases of information, emergency contacts) with
outpatient providers.

- **Establish a formal working relationship in partnership with outpatient provider
organizations, and the insurance provider liaison. Discuss roles, responsibilities, and
commitments to rapid referral and triage appointments. Specify care coordination
expectations, a process for expedited medical records sharing (e.g., for transition
plans, medications list, treatment plans, crisis/safety plans), follow-up after discharge
activities, no-show follow-up protocols, and a communication plan and meeting
schedule between organizations.**

- *Begin discharge planning upon admission.* **Begin transition planning within 24 hours
of admission. Set a clear expectation of the anticipated period of treatment (90 or 180
days) and establish initial discharge goals (which may initially be brief and develop
during the course of treatment, building on the needs, desires, and resources of the
individual over time). Include the individual, family, outpatient providers, insurance
company liaison, and natural supports in the development of the transition plan.**

- *Ensuring the individual maintains or is enrolled in an eligible health plan.* **Additionally,
all potential benefits or community resources must be explored and the individual
supported in the application process when needed, e.g. social security, DSHS benefits,
etc.**

- *Schedule an outpatient appointment.* **Explore the individual's willingness to return to a
previous outpatient behavioral health provider. If they prefer not to return to that
provider or have no existing outpatient provider, discuss available outpatient
providers with the individual. Secure an outpatient appointment at a date and time that
the individual can attend, ideally within 72 hours of discharge and no later than 7 days
after discharge. Explore and resolve potential barriers to attending the outpatient
appointment (e.g., transportation, childcare, waitlists) prior to discharge. If the
outpatient provider has a waitlist, determine wait time. Place the individual on the
waitlist within 24 hours of admission or at such time as to coincide with the target
discharge date.**

- *Partner with the outpatient provider.* **Speak directly with the outpatient behavioral
health providers. Provide them with history on the individual's presenting problem,
course of treatment, and clinical approach (e.g., DBT, CAMS). Invite them to participate
in the development of the safety plan. If they are unavailable, discuss the safety plan
with them once it is complete. Discuss any barriers to outpatient care and plans
established with the individual and work together to address them. Ease the
paperwork burden during the individual's first appointment by offering to work with
the individual to complete outpatient paperwork that can be done prior to discharge
and send it to the outpatient provider.**

- *Initiate personal contact between* **the** *individual and the outpatient provider.* **Look for
ways to connect the individual and outpatient provider prior to discharge. Invite the
individual's outpatient team (e.g., peer support specialist, case manager, therapist,
natural supports) to meet with them at the hospital prior to discharge. If an in-person
meeting is not possible, consider a short phone conversation or videoconference with
the therapist and other members of the outpatient care team to help bridge services**

and begin to build rapport. Doing so triples the likelihood of the individual engaging in outpatient care once discharged (Boyer et al., 2000).

- *Consider step-down care.* Determine the level of care that may be most appropriate to meet the individual's clinical needs and personal preferences following discharge. Discuss available step-down options and individual preferences. For some, success may hinge on a step-down approach, with an intermediate level of service that is less restrictive than inpatient care but more intensive than typical once-weekly outpatient therapy {such as

- **Intensive Behavioral Health Treatment Facilities (IBHTF). These facilities have beds for up to 16 people to live in and receive active rehabilitative treatment.**

- **Program for Assertive Community Treatment (PACT). PACT has been proven to improve people's quality of life, reduce hospitalizations and incarcerations, and help people maintain independence. PACT services are provided by a multidisciplinary team of professionals. Services are evidence-based, recovery-oriented, and provided through a team approach.**

- *Encourage participation by natural supports.* **Include natural supports or significant others that the individual identifies as important to them, such as a spouse, a partner, family, and friends. Natural supports can provide perspective on challenges and offer support and caring while in the hospital setting and upon discharge, especially during the gap period between discharge and an initial outpatient appointment.**

- *Include peer specialists.* **Peer specialists are trained to use their lived experience with purpose and intent. Having had personal experience with mental health care recovery themselves, peer specialists can engage from a personal perspective, provide social and emotional support, answer questions, offer hope for recovery, and help individuals access local supports, navigate the system of care, and problem solve around things such as transportation, insurance coverage, and medication refills. Information is available from HCA's Peer Support Program.**

- *Facilitate coordination with housing resources.* **Individuals exiting inpatient settings are at high risk of becoming homeless within a year. Each community in Washington has a coordinated entry system to coordinate the access, assessment, prioritization, referral, and delivery of housing resources. The Washington State Department of Commerce offers a directory of coordinated entry programs by county. Additional resources for transitioning individuals from inpatient settings can be accessed through programs such as Housing and Recovery through Peer Services (HARPS) and Foundational Community Supports (FCS). Both programs provide supportive housing services to help individuals obtain and maintain housing. Currently, Intensive Behavioral Health Treatment Facilities (IBHTF) are providing ongoing care to individuals who no longer require involuntary inpatient treatment but need further treatment and support to fully integrate back into their community.**

- *Collaboratively develop a safety plan as part of pre-discharge planning.* **Work collaboratively with the individual, their chosen natural supports, peer specialist, and outpatient providers to develop a safety plan or written strategy for coping with difficult thoughts (including but not limited to suicidal thoughts), emotions, symptoms,**

and triggers. For those enrolled in Apple Health managed care organization (MCO) plans or behavioral health administrative service organizations (BHASOs), utilize care coordinators to the extent possible. Include them in the safety planning process, as they may have perspective and knowledge about strategies that have and have not worked in the past and may be valuable contributors when brainstorming potential future strategies. Include coping strategies, natural supports, services, and resources such as crisis lines. Explore and address any lethal means (i.e., items or methods) in the safety plan, and follow up with significant others to confirm they have secured or reduced access to such means prior to the individual's discharge.

- Ensure outpatient providers and MCO/BHASO liaisons have information necessary to bridge effective clinical interventions from one setting to the next. Make sure all pertinent information has been sent to all relevant outpatient providers (authorization permitting) prior to discharge and no later than 24 hours before the first outpatient appointment. Identified MCO/ASO hospital liaison contact information is provided to each HCA contracted LTCC facilities to assist in this process.

- *Make a discharge follow-up plan*. Identify in the discharge plan who will be conducting post follow up to hospitalization behavioral health care coordination.

References and Resources for Person-Centered Care Planning

Amado, A. N., & McBride, M. (2001). Increasing person-centered thinking: Improving the quality of person-centered planning: A manual for person-centered planning facilitators. University of Minnesota Institute on Community Integration. https://rtc.umn.edu/docs/pcpmanual1.pdf

Boyer, C. A., McAlpine, D. D., Pottick, K. J., & Olfson, M. (2000). Identifying risk factors and key strategies in linkage to outpatient psychiatric care. *The American Journal of Psychiatry*, *157*(10), 1592–1598. https://doi.org/10.1176/appi.ajp.157.10.1592

Burns-Lynch, B., Salzer, M. S., & Baron, R. (January 2011). *Managing risk in community integration: Promoting the dignity of risk and supporting personal choice*. Temple University Collaborative on Community Inclusion of Individuals with Psychiatric Disabilities. http://www.tucollaborative.org/sdm_downloads/risk-community-inclusion/

James, J. (2013, February 14). Patient engagement: People actively involved in their health and health care tend to have better outcomes—and, some evidence suggests, lower costs. *Health Affairs Health Policy Brief*. https://www.healthaffairs.org/do/10.1377/hpb20130214.898775/full/healthpolicybrief_86.pdf

Miller, E., Stanhope, V., Restrepo-Toro, M., & Tondora, J. (2017). Person-centered planning in mental health: A transatlantic collaboration to tackle implementation barriers. *American Journal of Psychiatric Rehabilitation*, *20*(3), 251–267. https://doi.org/10.1080/15487768.2017.1338045

National Action Alliance for Suicide Prevention. (2019). *Best practices in care transitions for individuals with suicide risk: Inpatient care to outpatient care*. https://theactionalliance.org/sites/default/files/report_-_best_practices_in_care_transitions_final.pdf

National Committee for Quality Insurance. (n.d.) *Follow-up after hospitalization for mental illness (FUH)*. https://www.ncqa.org/hedis/measures/follow-up-after-hospitalization-for-mental-illness/

National Resource Center on Participant-Directed Services & CSWE Gero-Ed Center. (October 2015). *Person-centered and participant-directed services and supports bibliography*. https://www.cswe.org/CMSPages/GetFile.aspx?guid=0fe3976d-1a41-4852-a926-41017609b412

Parks, J., Radke, A. Q., & Haupt, M. B. (July 2014). *The vital role of state psychiatric hospitals.* National Association of State Mental Health Program Directors. https://www.nasmhpd.org/sites/default/files/The%20Vital%20Role%20of%20State%20Psychiatric%20HospitalsTechnical%20Report_July_2014.pdf

Paul V. Sherlock Center on Disabilities. (n. d.). *Rhode Island person-centered thinking guide*. http://www.ric.edu/sherlockcenter/events/ripctguide.pdf

Positive Supports Minnesota. (n.d.). *Learn more about person-centered planning*. https://mnpsp.org/portfolio-items/person-centered-planning-big-picture/

RI International. (n.d.). *Peer Bridger Program*. https://riinternational.com/our-services/washington/peer-bridger-program/

Stanhope, V., Tondora, J., Davidson, L., Choy-Brown, M., & Marcus, S. C. (2015). Person-centered care planning and service engagement: A study protocol for a randomized controlled trial. *Trials*, *16*, Article 180. https://doi.org/10.1186/s13063-015-0715-0

Substance Abuse and Mental Health Services Administration. (2019). A practical guide to psychiatric advance directives. https://www.samhsa.gov/sites/default/files/a_practical_guide_to_psychiatric_advance_directives.pdf

Substance Abuse and Mental Health Services Administration. (2020, April 22). *Care coordination agreements and care transitions*. https://www.samhsa.gov/section-223/care-coordination/agreements-transitions#requirements

Tondora, J., Pocklington, S., Gorges, A. G., Osher, D., & Davidson, L. (2005). *Implementation of person-centered care and planning: From policy and practice to evaluation*. Substance Abuse and Mental Health Services Administration.

Washington State Department of Commerce. (n.d.). *Coordinated entry programs by county*. https://deptofcommerce.box.com/s/8nt4mgmr3izkj9juizisji9w6igdgjd6

Washington State Health Care Authority. (December 2017). *Foundational community supports*. https://www.staging.hca.wa.gov/assets/program/foundation-community-supports-faq.pdf

Washington State Health Care Authority. (December 2018). *Housing and Recovery through Peer Services (HARPS) program*. https://www.hca.wa.gov/assets/program/fact-sheet-housing-recovery-through-peer-services-program.pdf

Washington State Health Care Authority. (n.d.). *Peer support*. https://www.hca.wa.gov/billers-providers-partners/behavioral-health-recovery/peer-support

INDIVIDUALIZING CARE

7

7. INDIVIDUALIZING CARE

Following recovery principles and a PCP approach helps ensure care is individualized. Treatment and recovery represent a personal journey. Individualized care plans and treatment approaches allow an individual to recover in a way that is the best fit for them emotionally, socially, and cognitively. Some individuals may feel a sense of relief when they enter treatment, whereas others may experience overwhelming feelings associated with loss, shame, or guilt. Some may have had positive experiences with treatment in the past, and others may not have. Two people may have the same diagnosis and yet experience and adapt to symptoms in different ways.

Some individuals may require a more comprehensive treatment approach in terms of medical evaluations to address medical comorbidities and the impact of mental health symptoms on self-maintenance. In other cases, a medical consult is necessary to rule out a medical condition that could be contributing to psychological symptoms. These and many other experiences underscore the need for highly individualized care planning and therapeutic approaches.

These emotional, physical, social, and psychological experiences are unique to the individual; therefore, it is not only important but also necessary to develop treatment plans that complement the individual and their personal recovery needs. The goal of treatment is sustained recovery and learning new ways in which to manage life and corresponding stressors. How one reaches this goal will vary depending on a multitude of interrelated factors such as individual need, readiness, resources, experiences, perspectives, support network, therapeutic relationship, cognitive limitations, manifestation of symptoms, and functional impairment.

Selecting the Right Treatment Approach

Selection and recommendation of the most appropriate clinical treatment approach or evidence-based practice must account for the unique needs and preferences of the individual. The American Psychiatric Association (APA) Work Group on Psychiatric Evaluation (2016) suggests that a comprehensive evaluation, clinical formulation, and diagnostic clarity are informed by a review of the following factors for each individual:

- **Mood and level of anxiety**

- **Thought content and process, perception, and cognition**

- **Trauma history**

- **Past and current psychiatric diagnoses**

- **Past psychiatric treatments (type, duration, and, where applicable, dose)**

- **Adherence to past and current pharmacological and non-pharmacological psychiatric treatments**

- **Response to past psychiatric treatments**

- **History of psychiatric hospitalization and emergency department visits for psychiatric issues**

- **Suicide risk**

- **Risk for aggressive behaviors**

Ongoing comprehensive assessment, clinical formulation, and diagnostic clarity are foundational components of the clinical expertise providers bring to the care planning process. Treatment recommendations are made based on best fit to meet the needs and readiness of the individual. Special attention should be paid to the need to modify or augment traditional approaches for populations with a developmental delay, autism spectrum disorder, fetal alcohol spectrum disorder, or brain injury, as well as those experiencing acute exacerbation of incapacitating symptoms related to psychiatric illness.

The APA Work Group notes, "Recommended treatments also need to be feasible and tolerable as well as to show a preponderance of benefit over harm for the patient. Information about the patient's past treatment provides information on the prior benefits and tolerability of specific interventions but may also be relevant to the likely benefits and adverse effects of similar treatments."

Providers should be knowledgeable of a range of evidenced-based practices and specialized treatment approaches for consideration when tailoring treatment to meet specific individual needs. Examples of issues that may require specialized behavioral health treatment include the following:

- **Intellectual or developmental disabilities. Accessible [approaches](#) to PCP for individuals with intellectual or developmental disabilities include the Map Action Planning System (MAPS) and Planning Alternative Tomorrows with Hope (PATH).**

- **Family issues. Families can support recovery, but they can also hinder it; family psychoeducation can improve outcomes. SAMHSA's [Family Psychoeducation Evidence-Based Practices (EBP) KIT](#) offers evidence-based practices to help public officials develop family psychoeducation mental health programs.**

- **Chronic pain. Treating chronic pain and an SUD simultaneously may be complicated by the abuse potential of prescription pain medications. A SAMHSA [guide](#) equips clinicians with information for treating chronic pain in adults living with a history of substance use. The guide discusses chronic pain management, including treatment with opioids. It also includes information about substance use assessments and referrals.**

- **First episode of psychosis. Treating a first episode of psychosis according to evidence-based guidelines is particularly important for an individual's long-term prognosis. However, substance use often complicates treatment. This SAMHSA [guide](#) to first-episode psychosis and co-occurring SUDs describes relevant research, examines emerging and best practices, identifies knowledge gaps and implementation challenges, and offers resources.**

References and Resources for Individualizing Care

The American Psychiatric Association (APA) Work Group on Psychiatric Evaluation. (2016). *The American Psychiatric Association practice guidelines for the psychiatric evaluation of adults*. American Psychiatric Association. https://psychiatryonline.org/doi/pdf/10.1176/appi.books.9780890426760

Oldham Council. (March 2015). *SEND guidance: Person centred planning toolkit.* https://www.oldham.gov.uk/download/downloads/id/3779/send_guidance_person_centred_planning_toolkit.pdf

Substance Abuse and Mental Health Services Administration. (2010). *Family psychoeducation evidence-based practices (EBP) KIT*. https://store.samhsa.gov/product/Family-Psychoeducation-Evidence-Based-Practices-EBP-KIT/SMA09-4422

Substance Abuse and Mental Health Services Administration. (2012*). TIP 54: Managing chronic pain in adults with or in recovery from substance use disorders*. https://store.samhsa.gov/product/TIP-54-Managing-Chronic-Pain-in-Adults-With-or-in-Recovery-From-Substance-Use-Disorders/SMA13-4671

Substance Abuse and Mental Health Services Administration. (2019). *First-episode psychosis and co-occurring substance use disorders*. https://store.samhsa.gov/product/First-Episode-Psychosis-and-Co-Occurring-Substance-Use-Disorders/PEP19-PL-Guide-3

U.S. Department of Veterans Affairs National Center for PTSD. (2020). *Assessment overview*. https://www.ptsd.va.gov/professional/assessment/overview/index.asp

WORKING WITH DESIGNATED CRISIS RESPONDERS AND THE SUPERIOR COURT

8

8. WORKING WITH DESIGNATED CRISIS RESPONDERS AND THE SUPERIOR COURT

Whether or not a community hospital or E&T has existing 120 hour and 14-day commitment beds, the establishment of 90- and 180-day commitment beds requires designated staff to have expertise in the requirements of the Involuntary Treatment Act (ITA), which, for adults, is incorporated into Chapter 71.05 of the Revised Code of Washington (RCW). Specifically the LTCC facility will need to have knowledge and understanding related to statutory and legal requirements when compelled medications are needed as they differ from 120 hour and 14 day civil commitment rules. Facilities will find it helpful to have staff with a firm understanding of the ITA's standards and procedures. Ideally, staff who participate in court proceedings will have clinical expertise and experience working with the designated crisis responder (DCR). However, any staff treating individuals under involuntary commitment also need to understand what they need to document if they believe that someone requires continued treatment.

Expansion of 14-Day Commitment Bed Program to Include 90- and 180-Day Beds

The infrastructure in place for holding probable cause hearings will serve as a solid foundation for expansion into hearings for 90- and 180-day inpatient commitments. However, the ITA has stricter requirements for 90- and 180-day commitments. Additionally, Ricky's Law (2018) expanded the ITA's applicability to people with SUDs. These differences will require some preparatory work on the part of community hospitals and E&Ts.

Key Differences

Community hospitals and E&Ts that have had 14-day commitment beds will be accustomed to working with their county's DCR (RCW 71.05.760) and to probable cause hearings in front of a mental health commissioner appointed by the superior court (RCW 71.05.137). However, they will find that the process under the ITA for 90- and 180-day commitments has a few important differences from the 14-day commitment process:

- *Right to a jury trial.* **The individual may request a jury trial (RCW 71.05.240) for a 90- or 180-day commitment. In the initial implementation of community-based 90- and 180-day treatment beds, this right has been invoked far more frequently in some counties than in others.**

- *Higher burden of proof.* **The hospital or E&T must present "clear, cogent, and convincing evidence" of the need for additional involuntary treatment (RCW 71.05.310), as opposed to the "preponderance of the evidence" standard used in probable cause hearings for 14-day commitments.**

- *Court order for continued involuntary medication.* **During the first 30 days of treatment, involuntary administration of antipsychotic medication requires the signature of two authorized prescribers. Beyond 30 days, involuntary administration of antipsychotic medication requires a court order (RCW 71.05.217).**

- *Dismissal/conversion to less restrictive alternative (LRA) order.* **Depending on progress, a person subject to a 90- or 180-day commitment order may reach a point at which they no**

longer require inpatient care. The hospital or E&T may—in consultation with the consumer, the DCR, and the prosecuting attorneys—submit a stipulated agreement to the superior court asking that the individual be released early, or that the remaining period under the inpatient commitment order be converted to an LRA order (RCW 71.05.330).

Important Steps

Expansion into 90- and 180-day commitment beds will require some actions to ensure that the process runs smoothly and people receive needed care.

1. Meet with the DCR and update any memorandum of understanding (MOU) as needed.

Bringing additional 90- and 180-day commitment beds into the county will affect the DCR, so it is a good idea to meet with the DCR to discuss implementation. Topics for conversation should include the increase in bed capacity and the option for 90- or 180-day treatment within the community, along with how the community hospital or E&T should communicate with the DCR about anyone who could be released early under an LRA order administered by the DCR. If needed, the relevant MOU should be updated. (Community hospitals and E&Ts should have an existing MOU with the county's DCR to cover such topics as response times, staff points of contact, backup plans, and so forth.)

2. Meet with the superior court (or its appointed mental health commissioner), prosecutors, and public defenders.

The staff who will coordinate the commitment hearings should clarify with the mental health commissioner or other superior court personnel the procedural requirements for 90- and 180-day commitments. Issues to address during the meeting include the following:

- **The process for filing a petition at least 3 days before the end of the 14-day commitment, including how weekends and holidays affect filing procedures**

- **The needed elements of a petition to the court, and any special considerations in preparing these petitions**

- **The process for the court to appoint an independent professional to examine the individual and testify whether the individual would benefit from an LRA**

- **Whether the current hearing setup (at the facility, at the courthouse, or by video link) and schedule will be adequate to accommodate hearings for 90- and 180-day commitments**

- **The responsibilities of the facility if an individual requests a jury trial, including transportation to and from court, testimony by facility staff, and supervision of the individual while at court**

- **How long jury trials are expected to last (including the selection of the jury), and how much involvement is expected of the clinical staff**

- **The standards under which the court will order involuntary administration of antipsychotic medication for more than 30 days**

3. Revise internal procedures for documenting criteria for extended commitment with higher burden of proof.

Participating in hearings for 90- and 180-day commitments will require new or revised internal procedures. For example, it would be helpful to have templates for petitioning the court for 90- and 180-day commitments, similar to the templates currently used by DCRs for 90- and 180-day LRA orders.

A petition for a 90- or 180-day commitment should include, at minimum, the following elements, along with any other elements required by the superior court:

- **Identifying information about the individual (full name, age, gender, home address, etc.)**

- **Basis for inpatient commitment (imminent likelihood of serious harm to self, others, or the property of others; gravely disabled by virtue of failure to provide for their essential human needs of health or safety; and/or gravely disabled by manifestation of severe deterioration in routine functioning, loss of cognitive or volitional control)**

- **Behavioral health diagnosis and symptoms**

- **History of treatment at the facility (intake date, etc.)**

- **Course of illness and progress of treatment**

- **Observed behaviors that support the basis for inpatient commitment**

- **Evidence of unwillingness to participate in treatment voluntarily**

- **Prior history indicative of imminent likelihood of harm or grave disability**

- **LRAs under consideration and whether they would be appropriate**

- **Other persons responsible for care (family, guardian, etc.)**

- **Request for hearing**

- **Notarized signature of two behavioral health professionals, at least one of whom is a prescriber**

The basic criteria (grave disability or serious risk of harm) for 90- and 180-day commitments are identical to those for 14-day commitments. However, the petition to the court should address LRAs and explain why they would not be appropriate under the circumstances.

General Requirements for Working with the Superior Court

Community hospitals and E&Ts that have not offered 14-day beds, including new facilities, will need to establish a relationship with the superior court serving the county to hold commitment hearings, including probable cause hearings for 14-day commitments and hearings or jury trials for 90- and 180-day commitments. Several issues require attention.

First, it is important to recognize and support individuals' right to a fair hearing, including

- **To be informed of the need for treatment and be given opportunity to consent**

- **To participate in hearings to the extent they are able**

- **To be represented by an attorney**

- **To have less LRAs considered**

- **To be informed that involuntary commitment results in the loss of firearm rights**

- **To refuse psychiatric medications for 24 hours prior to any hearing**

The format for the hearings must be established for each type of hearing. Options include

- **Onsite, with court personnel visiting**

- **By video**

- **At court**

- **By telephone (for witnesses only)**

Hearings conducted by video must meet certain requirements under the ITA:

- **The technology must be secure, allow for real-time interaction, and allow all parties (judge or commissioner, consumer, attorneys, witnesses, and interpreters) to be seen when speaking. State telehealth guidance may be helpful in selecting technology.**

- **The hearing format must allow for the individual's attorney to be physically present with the consumer.**

- **An in-person alternative must be available if the court determines there is good cause to require so, such as if the individual is not able to comprehend the proceedings via video.**

- **Participation by telephone (without a video link) is allowed only for witnesses, consistent with court rules.**

Designated staff will need to learn to write and file with the court petitions that meet the requirement for each type of inpatient commitment. Staff who have worked with the DCR on petitions for initial detention will be generally familiar with the process, which is the responsibility of the DCR. For longer inpatient commitments, the responsibility for writing and filing the petition falls to the facility.

References and Resources for Working with the Courts

Luxton, D. D. (2017). *Washington State telehealth implementation guidebook.* Washington State Department of Social and Health Services. https://www.dshs.wa.gov/sites/default/files/BHSIA/FMHS/DSHSTelehealthGuidebook.pdf

Revised Code of Washington. (n.d.). Involuntary Treatment Act. Chapter 71.05, Mental Illness. https://app.leg.wa.gov/RCW/default.aspx?cite=71.05

Washington State Health Care Authority. (n.d.). *Designated crisis responders (DCR)*.
https://www.hca.wa.gov/billers-providers-partners/behavioral-health-recovery/designated-crisis-responders-dcr

Washington State Health Care Authority. (n.d.). *Ricky's Law: Involuntary Treatment Act*.
https://www.hca.wa.gov/about-hca/behavioral-health-recovery/ricky-s-law-involuntary-treatment-act

COMMUNITY COLLABORATIONS

9

9. COMMUNITY COLLABORATIONS

The development of 90- and 180-day beds in smaller community hospitals and E&Ts throughout the state allows people to remain closer to their communities than they would if they were in a state hospital. A key goal of the initiative is to help people participate more fully in their communities. This goal can be achieved only through collaborations with community resources. Some of the collaborations between inpatient providers and community resources will be time limited to address the needs of a specific individual, while others will be ongoing. For example, a hospital or E&T may need to establish a relationship with a landlord in another part of the county to meet an individual's housing preferences. Referring individuals to community support groups such as Alcoholics Anonymous and Narcotics Anonymous where peers support peers in staying clean and sober may assist in creating a successful support network to assist in reducing recidivism.

The University of Kansas Community Tool Box provides a wide range of resources and checklists to support collaborations in general. Section 7 of the Tool Box provides a framework for collaboration among community partners. Examples of more focused collaborations are briefly highlighted here along with related sources.

The American Hospital Association's Health Research & Education Trust (2017) developed the Playbook for Fostering Hospital-Community Partnerships to Build a Culture of Health with methods and tools to create community-oriented partnerships. Resources in this publication can be retooled to build models to address systemic and/or case-specific challenges that can best be addressed by engaging partners in ad hoc community problem solving meetings.

Collaborations with law enforcement, other community-based first responders, and hospital-based emergency departments can help to expand the safety net for individuals with behavioral health disorders. Identifying and analyzing factors that drive admissions to inpatient psychiatric facilities and the perspectives of these safety net stakeholders will obviously strengthen partnerships and assure that those who can benefit from inpatient psychiatric care can access services in an efficient and person-centered manner. Effective strategies for work with law enforcement partners are featured in the U.S. Department of Justice's *Collaboration Toolkit for Community Organizations*, a publication on community-oriented police work (McCampbell, 2014).

Collaboration with MCOs prior to discharge should begin upon admittance. MCO liaison or care manager should participate in ongoing treatment and discharge planning. MCOs are a critical piece of ensuring post hospitalization success for the individual. For instances where an individual is uninsured, coordinate with the BHASO as above. Regardless of insurance coverage, collaboration with an external entity to ensure continuation of care is essential.

Memoranda of Understanding (MOUs)

Community hospitals and E&Ts may wish to develop MOUs with key community partners to clarify their respective roles and ensure effective communication. The Municipal Research and Services Center (MRSC) helps local governments across Washington by providing legal and policy guidance on any topic, including this listing of resources and community examples from across the state utilizing interlocal agreements to support collaboration with law enforcement. Looking at samples of MOUs to partner with local courts or improve follow-up care may be helpful.

References and Resources for Community Collaborations

Cravens, S. (February 2018). Up close with Colorado Springs' community response team. *EMS World*. https://www.emsworld.com/article/219668/close-colorado-springs-community-response-team

Health Research & Educational Trust. (July 2017). *A playbook for fostering hospital-community partnerships to build a Culture of Health*. The American Hospital Association. https://www.aha.org/partnershipplaybook

McCampbell, M. S. (2014). *The collaboration toolkit for community organizations: Effective strategies to partner with law enforcement*. Office of Community Oriented Policing Services, U.S. Department of Justice. https://rems.ed.gov/docs/COPS_CollaborationToolkit_CommunityOrgs.pdf

Municipal Research and Services Center. (2019, November 22). *Interlocal cooperation in law enforcement*. http://mrsc.org/Home/Explore-Topics/Management/Service-Delivery/Interlocal-Contracting-for-Law-Enforcement-Service.aspx

National Drug Court Institute. (2019). *Sample memorandum of understanding*. www.ndci.org/wp-content/uploads/2019/02/Sample-MOU.docx

National Suicide Prevention Lifeline. (May 2017). *Memorandum of understanding between Western Mental Health Institute and Centerstone of Tennessee*. https://followupmatters.suicidepreventionlifeline.org/wp-content/uploads/2017/05/Inpatient-Psychiatric-Facility-MOU-Western.pdf

People should be able to obtain long-term psychiatric care in settings that are closer to their homes and more integrated into the community than if they received care in a state psychiatric hospital.

Advocates for Human Potential, Inc.
Real World Solutions for Systems Change

ahpnet.com