Implementing Ricky's Law

Understanding and using Washington's involuntary treatment law for patients experiencing a crisis due to substance use disorder

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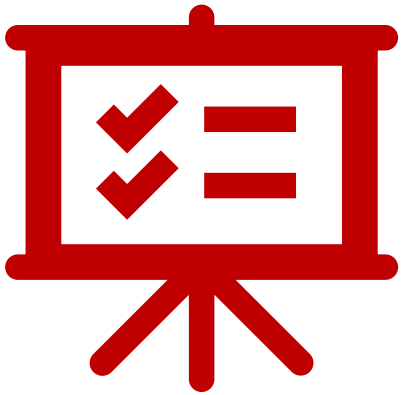
AMERICAN BEHAVIORAL HEALTH SYSTEMS

Overview

- **Ricky's Law 101 – *Allison Wedin,*** *ITA Coordinator, Health Care Authority*
- **Assessing a Ricky's Law patient – *Dr. Ryan Keay,*** *Medical Director, Emergency Department, Providence Regional Medical Center Everett & President-Elect, Washington Chapter-American College of Emergency Physicians*
- **Evaluating a Ricky's Law patient – *Jessica Shook,*** *President of the Washington Designated Crisis Responders (DCR) Association, and Crisis Manager for Olympic Health and Recovery Services*
- **Profiles of Secure Withdrawal Management Facilities (SWMS) - *Tony Prentice****, Chief Operating Officer, for ABHS Facilities in Chehalis and Spokane, and **Richard Geiger**, Vice President, Inpatient Services, Valley Cities*
- **Panelist Q&A & Resources**



Hospital considerations

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The webcast is an overview of Ricky's Law and involuntary treatment for people experiencing a substance use disorder-related crisis.

It is not intended as an exhaustive review of the law, or the civil commitment process.

Involuntary treatment practice and procedure varies by region, by county and by hospital.

WSHA recommends hospitals:

- Collect the webcast slides and recording for future reference.
- Educate your emergency department and inpatient behavioral health staff on Ricky's Law.
- Review hospital practices related to involuntary treatment with risk managers and legal counsel, as appropriate.
- Discuss your hospital's practice and capacity for involuntary treatment with your local DCRs, prosecutor's office and BH-ASOs, as appropriate.

Involuntary treatment 101

The civil commitment laws for adults and minors in a nutshell

Involuntary Treatment Act (RCW 71.05)

Excludes RCW 10.77

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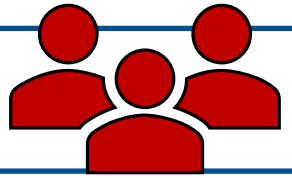
The Basics



- Adults (18+)
- Serious mental illness or substance use disorder
- Danger to self, others, other's property, or serious harm due to "grave disability"

- Initial detention (72 hours)
- Short-term commitment (14 days)
- Long-term commitment (90 and 180 days)
- Less restrictive alternatives (initial detention, court order)

- Due Process, probable cause hearing within 72 hours of initial petition
- Court order required for further treatment
- Involuntary patients have rights during involuntary evaluation and treatment

Behavioral health services for minors (RCW 71.34)

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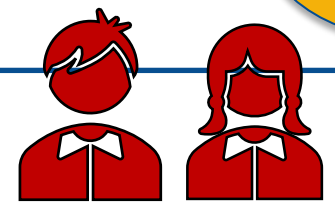
The Basics

Aged 13-17

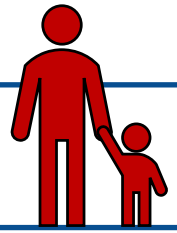
Adolescent initiated treatment

- Voluntary, inpatient, partial hospitalization, intensive outpatient, outpatient
- Parental consent not required



Family initiated treatment (FIT)

- "Voluntary" (read: no legal process)
- Inpatient, outpatient, partial hospitalization, intensive outpatient treatment



Involuntary treatment

- Similar process to adults
- Some exclusions: cannot compel antipsychotic medications

Ricky's Law/Involuntary Treatment for Substance Use Disorder

Washington State Hospital Association Webcast

December 2020

Allison Wedin
Involuntary Treatment Act Administrator
Division of Behavioral Health and Recovery
Washington State Health Care Authority

Washington State Health Care Authority

Ricky's Law Overview

Historical context

- Ricky's law (House Bill 1713) passed in 2016 ,aligns Washington's substance use and mental health statutes addressing the way we deliver care to individuals.
- The goal was to create a **unified involuntary commitment law** that **allows those who are at-risk due to a substance use disorder to get the necessary care** to protect them and the community.

Ricky's Law Overview

Historical context

- The law is named after Ricky Garcia, a young man who suffered for years from substance use disorders and was hospitalized several times due to feeling suicidal. During his last involuntary hospitalization, he agreed to go into drug treatment and has reportedly been clean and sober for many years.
- When **Secure Withdrawal Management and Stabilization (SWMS)** beds were not available, patients like Ricky ended up in emergency rooms, mental health facilities or even jail cells where they were not always able get the appropriate care.

Ricky's Law Overview

The law

- Ricky's Law moved Substance Use Disorder (SUD) involuntary treatment under RCW 71.05(adults) and RCW 71.34 (minors 13-17 yrs of age).
- Designated Mental Health Professionals (DMHPs) were renamed as Designated Crisis Responders (DCRs) and received required SUD ITA training.
- Added SUD definition and criteria, applied existing ITA criteria regarding process, evidence and risk to SUD detentions.
- An individual may be detained when they present a likelihood of serious harm to themselves or others, other's property, or are gravely disabled due to a substance use disorder.

Ricky's Law Overview

The law

- Created Secure Withdrawal Management and Stabilization facilities (SWMS) which are where an individual can be detained for involuntary SUD treatment.
- Effective April 2018, DCRs evaluate referred individuals for involuntary treatment due to a substance use disorder to a Secure Withdrawal Management and Stabilization facility (SWMS) if there is space available.
- **If there is no SWMS facility available, there is no allowance for a Single Bed Certification (SBC) and the DCR is unable to detain the person.**
- Brought Joel's Law coverage to SUD detentions.

NOTE: **Joel's Law allows a person's immediate family member, legal guardian, conservator, or a federally recognized Indian Tribe (Tribe), if the person is a member (citizen) of such tribe, to petition the superior court for initial detention under certain conditions:**

- The person to be detained is 13 years of age or older;
- You are an immediate family member, legal guardian, conservator, or Tribe of the person that you seek to have detained. The law defines "immediate family member" as a spouse, domestic partner, child, stepchild, parent, stepparent, grandparent, or sibling;
- A Designated Crisis Responder (DCR) has conducted an investigation within ten (10) calendar days, and decided not to detain that person for evaluation and treatment. If more than ten (10) calendar days have elapsed, a new DCR investigation can be requested; or
- It has been 48 hours since the DCR received a request for investigation, and the DCR has not taken action to have the person detained.

Secure Withdrawal Management and Stabilization facilities (SWMS)

- A Secure Withdrawal Management and Stabilization facility (SWMS) is a facility certified by the Department of Health to provide withdrawal management and stabilization treatment under the supervision of a physician for individuals detained for involuntary treatment for substance use disorders.

- SWMS are different than detox facilities.

  - An individual does not have to be intoxicated or requiring detox.

  - There is **no ASAM criteria involved**. American Society of Addiction Medicine (ASAM)

  - Detox, stabilization, treatment, and engagement into long term treatment are equally important components.

SWMS facility locations

- Currently there are 3 licensed Secure Withdrawal Management and Stabilization Facilities (SWMS)
  - American Behavioral Health Systems

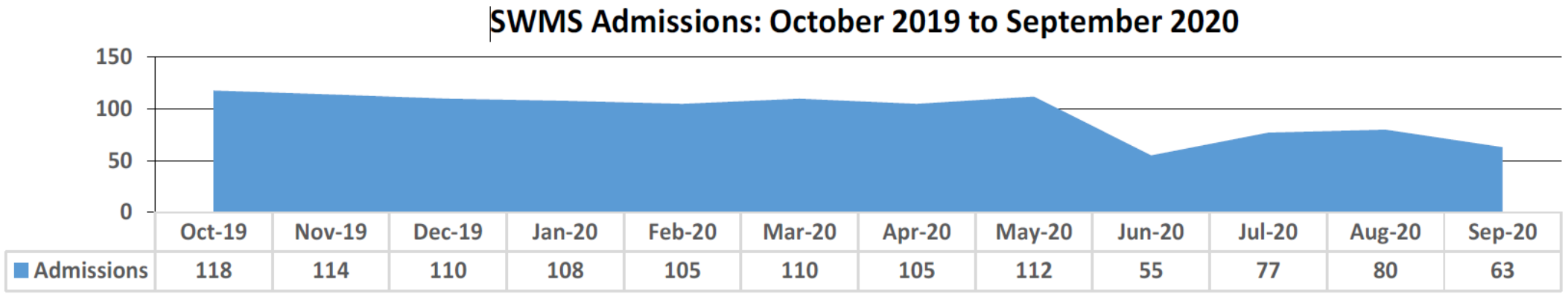
    ABHS Cozza in Spokane 24 adult beds
    ABHS Chehalis 21 adult beds
    for a total of 45 adult beds

  - Valley Cities Recovery Place Kent: 16 adult beds

  Total Current beds: 61

- Upcoming facilities
  - Excelsior in Spokane: 8 youth beds (anticipated opening first quarter of 2021)
  - Lifeline Connections in Clark Co: 16 adult beds (anticipated opening first quarter of 2021)

Total SWMS admissions Oct 2019- Sept 2020: 1157



	Oct-19	Nov-19	Dec-19	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20
Admissions	118	114	110	108	105	110	105	112	55	77	80	63

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3rd quarter 2020: 220 SWMS Admissions

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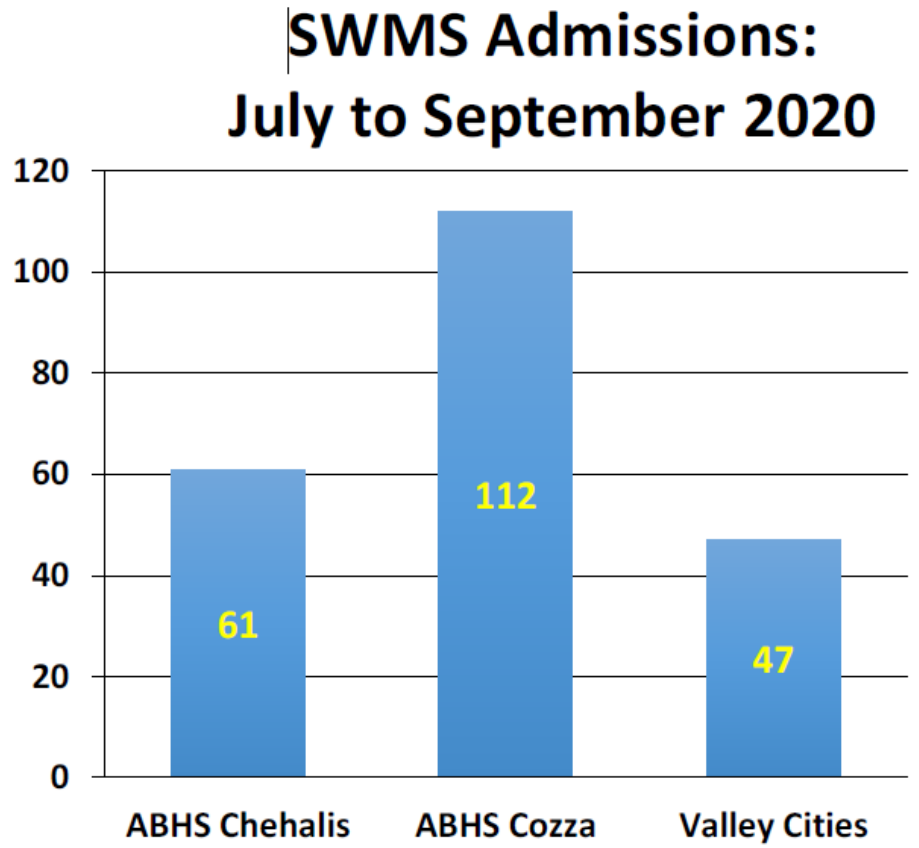

Average length of stay: 13 days

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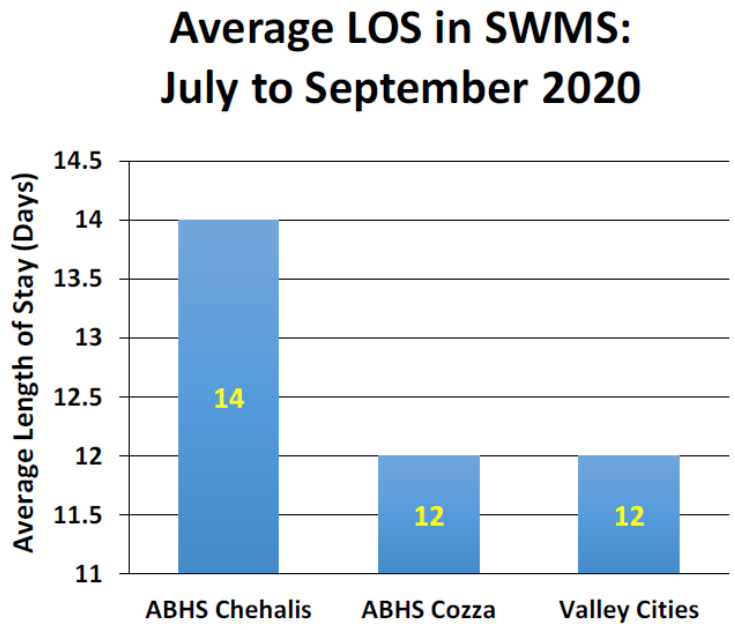
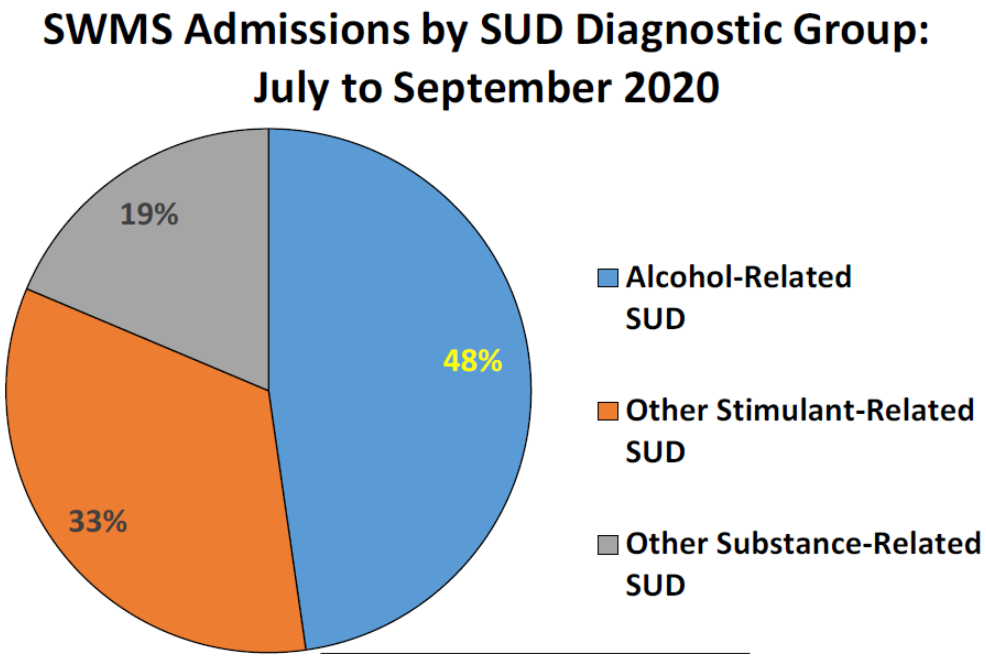
The overall **average length of stay** (LOS) was **13 days**. The LOS varies by gender and facility.



Other Stimulant-Related SUD: amphetamines, methamphetamine, other psychostimulants, including Adderall and Ritalin
Other Substance-Related SUD related to cocaine, inhalants, opioids, and sedatives/hypnotics/anxiolytics

Admissions whereby clients presented with **Alcohol-Related SUD diagnoses**[5] comprised the (**48%**) of SWMS admissions during the reporting period.



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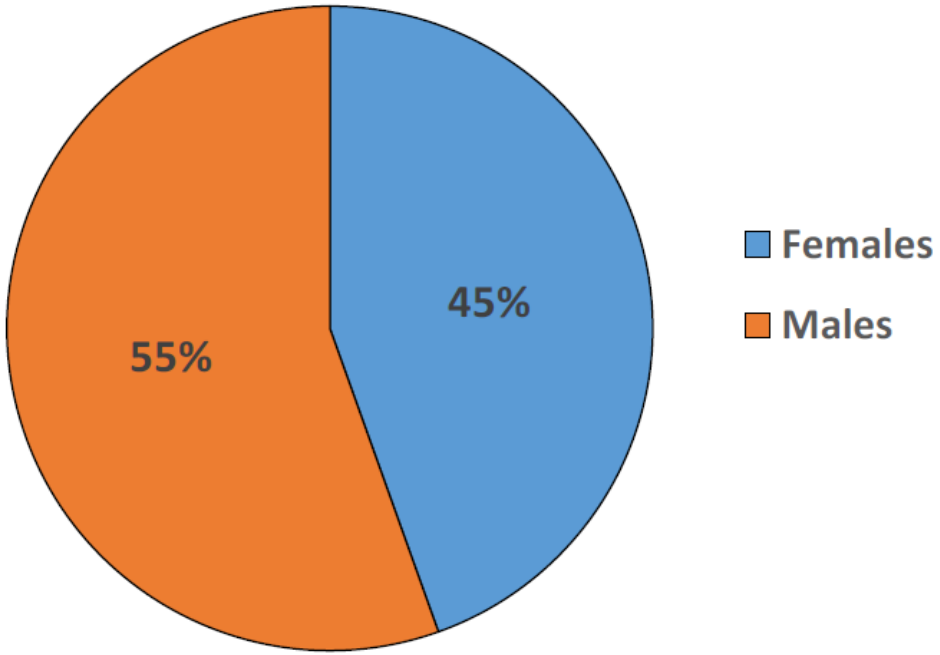
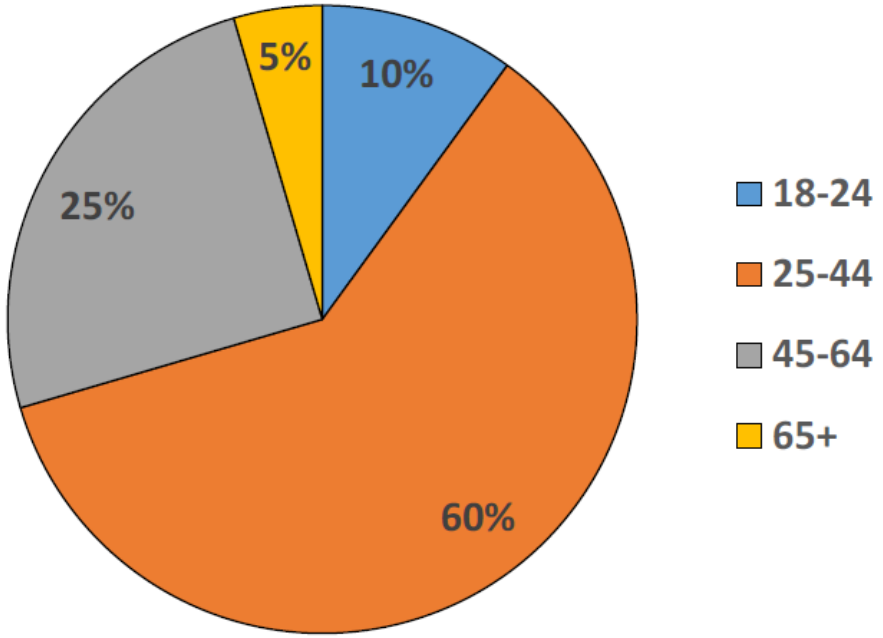
Admissions vary by gender and age grouping. **Males (55%)**, and **persons ages 25-44 (60%)** comprised most admissions during the reporting period.

SWMS Admissions by Gender: July to September 2020



SWMS Admissions by Age Group: July to September 2020



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Capacity and Average Daily Census

The SWMS bed capacity varies by facility, currently at **61 beds**. A total of **233 individuals were served** between July 1 and September 30, 2020. In the reporting period, the **Average Daily Census** (ADC) increased from **26 in July** to **36 in September**. The **bed utilization rates**[2] varied from **43%** in July to **58%** in September.

Facility	Capacity	Clients Served: Past 3 Months	July-20		August-20		September-20	
			ADC	% Capacity	ADC	% Capacity	ADC	% Capacity
ABHS Chehalis	21	61	7.613	31.72%	11.097	46.24%	10.143	42.26%
ABHS Cozza	24	118	13.774	57.39%	15.839	65.99%	15.800	65.83%
Valley Cities	16	54	4.742	29.64%	5.194	32.46%	9.633	60.21%
All Facilities	**61**	**233**	**26**	**42.83%**	**32**	**52.67%**	**36**	**58.32%**

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Addressing implementation challenges

Secure transportation to SWMS facilities proved to be a greater obstacle than anticipated.

- Less challenging as more SWMS facilities come online

Employing the term "secure detox" in WAC had unintended consequences for facility licensure and reimbursement.

- HCA changed the definition from secure detox to Secure Withdrawal Management Stabilization (SWMS) and, removed references to American Society of Addiction Medicine (ASAM) criteria from the definition.
- SWMS facilities are different than detox facilities and **do not** require an ASAM score as criteria

The criteria for ITA is based on grave disability and/or the likelihood of serious harm, these parameters set a high bar for SUD detentions.

SUD stigma may play a role in referring individuals for ITA Investigations and conducting assessments.

Bed Utilization is only 43%-58%

- HCA continues to work on these issues and is open to further discussion. Per HB 1907, HCA facilitated a workgroup to amend the DCR Protocols in order to give better guidance to DCRs conducting investigation regarding SUD.
- New DCRs receive training both from their agency and through DCR Academy training about SUD and SUD ITA.
- Representative Lauren Davis facilitated series of meetings with providers and stakeholders to identify barriers and develop solutions.
- This WSHA webcast brings together HCA, DCRs, Hospitals, and SWMS providers for education about the law and to increase skill and comfort in making DCR referrals for those with SUD placing them at serious risk or as gravely disabled.

Thank you

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Washington State Health Care Authority

Ricky's Law – an ED provider perspective

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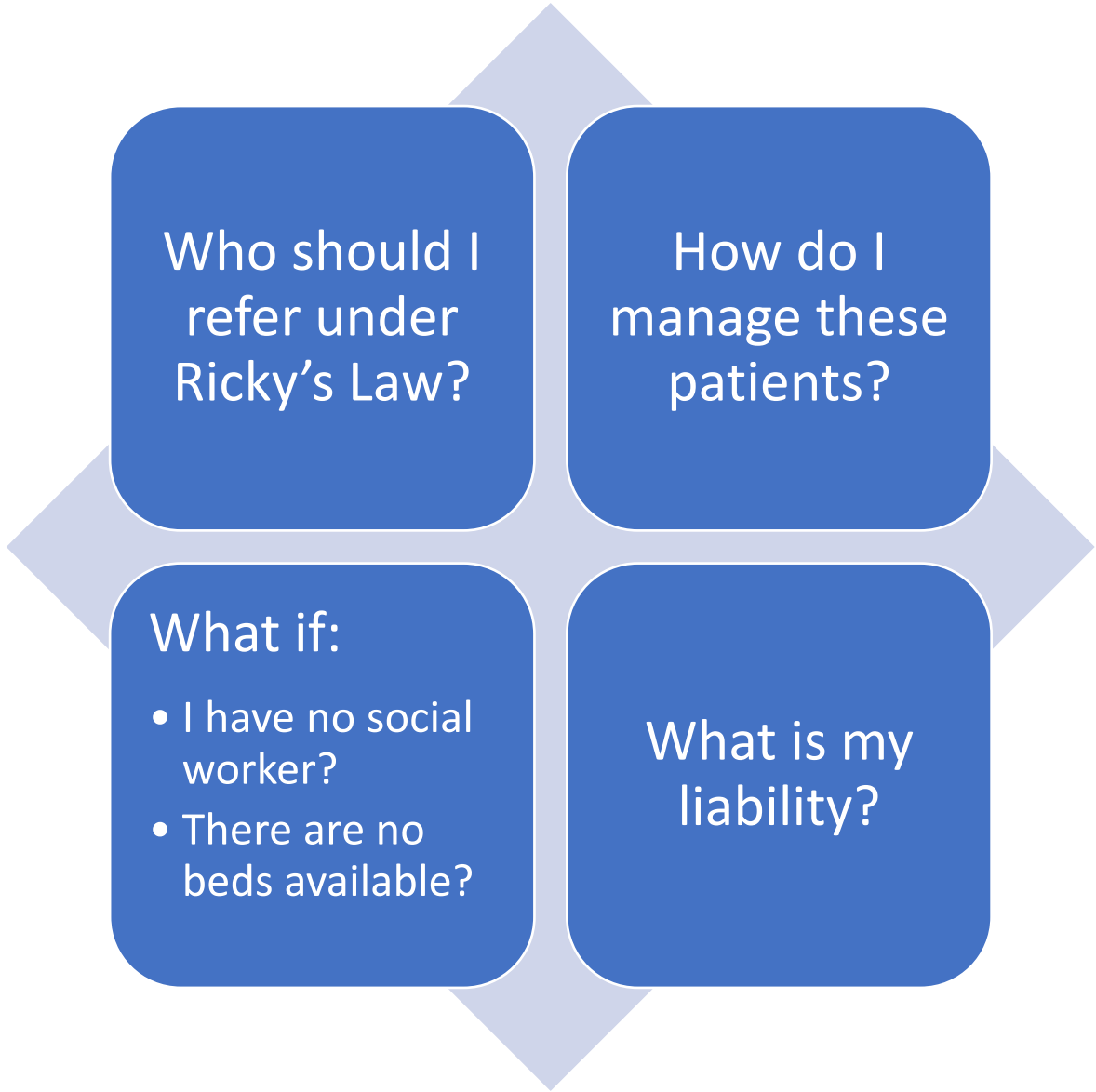
ED Medical Director

Providence Regional Medical Center Everett

WA-American College of Emergency Physicians, President-Elect

Ricky's Law for the ED – Who, How, What?



Who?

The Threshold of Dysfunction

- “Jack” presents to the ED repeatedly with acute alcohol intoxication
  - Each time he is watched until he is sober by clinical assessment and released
  - Occasionally ”Jack” is admitted for withdrawal
  - He repeatedly declines offers for treatment

Pre-Ricky's Law

- "Jack" cycles through the hospital, law enforcement, EMS, friend's houses on a circuit of self-destruction and substance abuse
- ED has limited interventions to offer.
  - If patients amenable to treatment – can begin the search for detox and treatment facilities
  - Highly dependent on payor

Post-Ricky's Law

- "Community members who are a **danger to themselves or others, other's property, or gravely disabled due to a drug or alcohol problem may be involuntary detained to a secure withdrawal management (SWM) and stabilization facility**—also known as secure detox"
  - Any healthcare provider can identify the patient as needing an assessment for grave disability, danger to self, and/or danger to others
  - Designated crisis responder (DCR) is called to assess the patient
- Attempt to find involuntary placement in a SWM facility

Post-Ricky's Law

- **"Jack" does not want to stay – what are next steps?**
  - Can hold patient up to 12 hours for DCR assessment
  - Do not wait for sobriety – can request concurrent assessment
  - If you have a secure room:
    - try de-escalation techniques,
    - seclusion is an option – you have a legal obligation to have patient assessed.
  - If you have no secure room:
    - try de-escalation techniques,
    - Utilize specialized scrubs and secure belongings
    - Recruit friends/family to sit with patient
    - If patient elopes, coordinate with local police

How do I manage these patients with limited ED bed capacity?

- Cohort patients in a monitored internal group room, subwaiting room – can be therapeutic
- **Being sober is not a requirement for referral to the DCR.**
- Frequent and early engagement with SWM facilities to understand bed capacity.
- Develop a strong relationship with DCRs and communicate concerns about patients.

emPATH Units as a Solution for ED Psychiatric Patient Boarding
https://www.psychiatryadvisor.com/home/practice-management/empath-units-as-a-solution-for-ed-psychiatric-patient-boarding/

High acuity psychiatric emergency care and emPATH units: Effective, Humane Alternatives to ED psychiatric patient boarding
https://www.bwbr.com/empath-units-improving-psychiatric-emergency-care/

What if I don’t have a social worker?

- The law requires evaluation by a mental health professional (MHP) when a patient is brought in by police. This is typically a social worker. MHP definition includes others, for instance, psychiatric ARNP and psychiatric nurse.
- **There is no need for MHP evaluation prior to calling a DCR** if the provider is concerned for the possibility grave disability, harm to self, harm to others.
- Family/friends can be corroborating witnesses and facilitate evaluation.
- In some areas of the state, the DCR functions as the MHP.
- Telehealth psych – if appropriately credentialed – can function as the MHP.

What is my liability?

- Always fulfill legal EMTALA obligation to stabilize and treat
- “I have no basis to hold them if they want to leave.”
  - If you determine patient meets criteria grave disability/harm to self/harm to others from substance use disorder (SUD), **you are obligated to refer to DCR and the Law authorized holding a patient up to 12 hours for DC to conduct an investigation.**
- DCR determines they should be detained to a SWM and no bed is available.
  - Work with your hospital legal counsel to determine best steps.
  - Ricky’s Law does not currently allow for single-bed certification

DCR Perspective on SUD Detention

Jessica Shook LMHC, DCR

Crisis Services Manager

President, WA DCR Association

OLYMPIC HEALTH & RECOVERY SERVICES

Symptoms & Risk: What are DCRs looking for?

- Just like for mental health disorder, detention due to substance use disorder requires the intersection of:
  - **Symptoms & Presentation of a Disorder**
    - Evidence or report of intoxication, withdrawal, tolerance, or craving
    - Substance use causes interpersonal, social, legal, or occupational problems
    - Substance used in larger amounts and for longer than intended
    - Unsuccessful attempts to stop
    - Use in physically hazardous situations
    - Substance use causes or exacerbates a physical or psychological problem
  - **Risk**
    - Harm to Self
    - Harm to Others
    - Harm to Other's Property
    - Grave Disability

A diagnosis is not required for detention.

Gathering Information: Symptoms, Presentation, and Risk

- **Observed and reported symptoms, behaviors, statements**
  - What is the individual doing and saying?
  - How do they respond to offers of help?
  - What event/situation brought them to your attention?

- **History and patterns of behavior**
  - What do we know about this individual's life/treatment/diagnosis?
  - What happened the last time they were in crisis?
  - Do they have a history of doing dangerous things?

Evaluating for Detention: Symptoms, Presentation, and Risk

- 3 Case Studies
  - Bob: Alcohol Use
  - Jane: Opiate Use
  - John: Methamphetamine Use & Schizophrenia (co-occurring)

Bob: Alcohol Use

- **Observed and reported symptoms/behaviors/statements:**
  - Bob is brought to the ER by law enforcement after his family called 911 due to concerns that he was suicidal.
  - Bob was found alone at home attempting to hang himself. He has rope burns on his neck, is acutely intoxicated, uncooperative, angry, tearful, and continues to report suicidal ideation on arrival at the ER.
  - As he sobers up over the course of several hours, he becomes more emotionally controlled, states he is “fine”, refuses all referrals to treatment, and states he wants to go home.
- **History and patterns of behavior:**
  - Family reports Bob drinks every day, and becomes suicidal when intoxicated “at least once a week”.
  - Bob has had escalating conflict with his family, who are now avoiding him. He’s lost his job and his car, and has been more isolated and drinking alone for the past few months.
  - Law enforcement reports previous contacts to Bob’s home when he has been intoxicated and depressed.

Bob: Danger to Self

- **Symptoms & presentation of a disorder:**
  - Acutely intoxicated, drinks daily
  - Becomes suicidal when intoxicated
  - Conflict with family, loss of job and car, increased isolation
- **Risk:**
  - Found in suicide attempt, history of suicidal ideation
  - Emotional instability, poor insight, refusing treatment
  - No current support, would be alone upon discharge
- **Considerations:**
  - **Does Bob's BAL have to be below .08 before he can be referred?**
    - No, depending on Bob's presentation, likelihood of withdrawal, and any co-occurring disorders, it may be better to assess Bob for SUD detention while he is still intoxicated and experiencing acute symptoms of a substance use disorder. This will be a matter for consultation between ER and DCR office.
  - **Can Bob be referred to the DCR by an ER physician if he is not seen by an MHP or SUDP?**
    - Yes, an assessment by a MHP or SUDP within 3 hours is referenced in RCW 71.05, but this assessment is not a prerequisite in the statute for a referral to a DCR. Anyone can make a referral to a DCR.

Jane: Opiate Use

- **Current observed and reported symptoms/behaviors/statements:**
  - Jane self presented to the ER requesting treatment for opiate withdrawal. She is irritable, anxious, paranoid, and reports nausea.
  - She reports that she had a fight with her father a few hours ago, and he told her he would never speak with her again. She reports an overdose of Benadryl and alcohol after the fight, but that she got scared and made herself throw up.
  - When told that a treatment bed will not be available for at least a week, she becomes agitated, states she will “go to the bridge and jump” and tries to walk out of the ER. She will not communicate further with ER staff.
- **History and pattern of behavior:**
  - Per documentation from previous ER visits, Jane has a history of escalating opiate use following a car accident 18 months ago. She has been using heroin and prescription medication in increasing amounts for the past year.
  - Jane has been staying with friends and living out of her car for the past 6 months after losing her job and home.
  - She has been referred to treatment twice in the past 3 months, and has left within a few days each time.
  - Last week she was brought in by law enforcement after being found on a bridge, reporting suicidal ideation.

Jane: Danger to Self

- **Symptoms & presentation of a disorder:**
  - Irritable, anxious, paranoid, nauseated
  - Recent fight with her father, loss of job and home
  - Two previous attempts at treatment, and a current request for treatment
  - Increase in use
- **Risk:**
  - Escalating suicidal ideation, recent attempt
  - Emotional instability, paranoia, poor insight and judgment
  - Recent stressor and loss of support – fight with father
- **Considerations:**
  - **How important is history for SUD detentions?**
    - Because Jane's risk and presentation can change dramatically with intoxication and withdrawal, history and patterns of behavior are very important for establishing if someone meets criteria for detention due to SUD.
    - A snapshot view of Jane in the ER, without the information about her history of substance use and life circumstances would give a DCR a different perspective on her risk.

John: Methamphetamine Use & Schizophrenia (co-occurring)

- **Current observed and reported symptoms/behavior/statements:**
  - John is brought to the hospital by law enforcement after he was found in the middle of the street, throwing rocks and yelling at cars. He required restraint as he was physically agitated and aggressive toward staff.
  - John received medication and was able to calm a little and provide labs after several hours. His UA is positive for methamphetamines.
  - He continues to be unable to answer ER staff's questions, and continues to present paranoid and fearful, refusing offered medication and food.
- **History and patterns of behavior:**
  - The staff at John's adult family home reports that he has a diagnosis of schizophrenia, and takes his medication sporadically. At baseline, he presents with disorganization and delusional thought process, and requires supportive living services. John has a known history of methamphetamine use, and his most recent use was one month ago.
  - For the past three days, John has been angry, paranoid, aggressive with staff, refusing to eat or take his medication, and stealing knives from the kitchen area. Last night he refused to come inside, but stood out on the lawn in the rain (approximately 40 F) and told staff he was "watching for the super soldiers".

John: Grave Disability/Danger to Others

- **Symptoms & presentation of a disorder:**
  - Current methamphetamine intoxication, repeated use of methamphetamine
  - Physical agitation, requiring restraint
  - Engaging in dangerous behavior in his adult family home, unable to care for himself, even with support
- **Risk:**
  - Aggression toward staff and requiring restraint
  - Paranoia, fearfulness, poor insight, increasing delusional thought process
  - Outside in the rain and cold, stealing knives, refusing to eat or take medication
- **Considerations:**
  - **Can people be detained for methamphetamine use?**
    - Yes, because methamphetamine use causes John to meet criteria for detention. A need for withdrawal management is not required in statute for detention to a SWMS facility.
  - **How long can the ER hold on to John?**
    - Because John was brought to the ER by police, the ER can hold John for 12 hours (not including time for medical clearance) once a referral to the DCR is made.
    - The DCR has 12 hours from the time they receive the referral to complete an investigation.

Thank you.

Washington State Designated Crisis Responders: Office Contacts by County

https://www.hca.wa.gov/assets/billers-and-providers/designated-crisis-responders-contact-list.pdf

IMPLEMENTING RICKY'S LAW

SECURE WITHDRAWAL AND STABILIZATION FACILITIES (SWMS)

RPK VALLEY CITIES AND ABHS

Richard Geiger, Vice-President, Inpatient Services, Recovery Place Kent (Valley Cities)

Tony Prentice, Chief Operative Officer, American Behavioral Health Systems

WASHINGTON STATE SECURE MANAGEMENT WITHDRAWAL PROGRAMS

American Behavioral Health Systems:

- Chehalis: 21 beds
- Spokane (Cozza): 24 beds

Valley Cities- Recovery Place Kent: 16 beds

MYTHS AND FACTS OF SECURE MANAGEMENT WITHDRAWAL PROGRAMS

- Myth: “There aren’t enough beds to meet the need, so we wouldn’t be able to get our referral a placement”
- Fact: From July 2020 through August 2020, SMSWs Facilities only used 49% of the available bed capacity. Recovery Place Kent Valley Cities has had at least 50% or more, capacity available.
- Myth: “ The criteria to get a SWMS referral accepted is too narrow so I’m also getting turned down”
- Fact: RPK Valley Cities has accepted 75% of the referrals called | ABHS has accepted 84% of the referrals called in.

SWMS facilities are free standing Behavioral Health facilities, so the medical support resources are primarily limited to those needed for typically non-medically complex patients, who don’t need a higher level of medical support.

ABHS facilities are licensed as a Substance Use Disorder program only.

RPK Valley Cities is licensed as a Co-Occurring facility, therefore able to evaluate and treat both Substance Use and Psychiatric Disorders.

However, all the freestanding facilities have admission criteria to ensure that we are accepting referrals that are appropriate to the resources available at that facility and can be treated safely within that environment of care.

RPK VALLEY CITIES ADMISSION CRITERIA (HIGHLIGHTS)

- SWMS referrals must present with issues related to substance use and are unwilling to seek services voluntarily.
- Active Detox IS NOT a requirement for a SWMS referral.
- Must be referred by a Designated Crisis Responder and on an Involuntary detention.
- Must be medically cleared for Substance Use Disorder services (not requiring other acute or intrusive medical services)
- Able to be behaviorally managed within a secure facility (not assaultive to Healthcare staff)

AMERICAN
BEHAVIORAL HEALTH SYSTEMS

ABHS ADMISSION CRITERIA (HIGHLIGHTS)

- SWMS referrals must present with issues related to substance use and are unwilling to seek services voluntarily.
- Active Detox IS NOT a requirement for a SWMS referral.
- Must be referred by a Designated Crisis Responder and on an ITA hold.
- Must be medically cleared for Substance Use Disorder services (not requiring other acute or intrusive medical services)
- Not on oxygen

PROFESSIONAL STAFF AND SERVICES OFFERED AT RPK

- RPK Services Offered:
  - Integrated case management
  - Substance Use Assessment
  - Substance Use Group and Individual Counseling
  - Cognitive Behavioral Groups
  - Psychopharmacology
  - Anonymous Groups (AA, NA)
  - Discharge Planning
  - Peer Counseling

- Professional Staff includes Substance Use and Psychiatric Providers

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BEHAVIORAL HEALTH SYSTEMS

PROFESSIONAL STAFF AND SERVICES OFFERED AT ABHS

- ABHS Services Offered:
  - Substance Use Disorder Assessment
  - Mental Health Assessment
  - Brief Intervention Therapy
  - MEE Interactive Journaling
  - CMRPT Relapse Prevention
  - Integrated case management
  - Substance Use Group and Individual Counseling
  - Mental Health Individual Counseling
  - Cognitive Behavioral Groups
  - Psychopharmacology
  - Discharge Planning

- Professional Staff:
  - Substance Use Disorder Professionals
  - Mental Health Professionals
  - Psychiatric Advanced Practice Registered Nurse
  - Advanced Practice Registered Nurses
  - Registered Nurses
  - Licensed Practical Nurses
  - Psychiatric Security Assistants
  - Behavioral Health Technicians
  - Certified Nurse Assistants

RPK CLIENT JOURNEY

- Pre-screening for admission
- Within 24 hours, meets with Attending (including History & Physical), which may also include a psychiatric consultation, and a SUD assessment is initiated (depending on level of detox).
- If the Client is presenting with issues more appropriate to a Mental Illness Detention, then they can be re-assigned to a Psychiatric Attending and to an E&T bed (and program) within the facility.
- Within 72 hours, the Client's Interdisciplinary Master Treatment Plan is developed, including Individualized Discharge Planning. A Legal determination is made whether to petition to the Courts for further treatment.
- As the Client is able, they are encouraged (and expected) to participate in the Group and Activities therapies.
- Most Clients are discharged prior to the Court's dismissal of the Involuntary Hold, to voluntary Outpatient or Residential treatment.

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BEHAVIORAL HEALTH SYSTEMS

ABHS CLIENT JOURNEY

- ITA Admission Process
- Within 24 hours Client is met with by ABHS Provider, offered SUD/MH Services and oriented to the unit.
- Initial 72 Hours- client will be evaluated by a Medical provider, MHP and SUDP for recommendation to the most appropriate level of care (to include after care planning) Attorney appointment is provided, and the court date is set prior to court the patient will have completed consultation with Public Defender's office and the petition will be presented to the Court for either: Continuance of Legal Hold for another period as agreed upon by Defense and Patient, a Dismissal of the Involuntary Hold, by the Court, or up to 14 day hold.
- While in ABHS SWMS program clinical programming is offered each day. To include Brief Intervention therapy, educational group, individual service planning, motivational interviewing as well as check in group and reflections at the end of each day.
- ABHS provides discharge transportation to every client. Discharge is planned according to each client's specific needs and positively planned with the Primary Counselor and Case Management starting from the day of admit to ensure safety planning and all aspects within the Individual Service plan in the court order are being implemented.

THANK YOU

Valley Cities/Richard Geiger | Vice President-Inpatient Services

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Admissions phone- 206-408-5223

After Hours- 253-266-5729

ABHS/Tammie Pennypacker

505 E Adams Ave Chehalis, WA 98532

360-266-5026

After hours- 360-523-8916

ABHS/David Robinson

44 East Cozza Dr., Spokane, WA 99208

509-325-6800

After hours- 509-590-6536

Resources & Q&A

Involuntary Treatment - Laws & Resources

Washington State Hospital Association

Ricky's Law

- WSHA Bulletin (2018)
- Considerations in Managing Substance Use Disorder Patients (2018)
- Study on treatment outcomes for involuntary SUD patients - Washington State Institute for Public Policy (2011)

Existing Laws

71.05 RCW – Involuntary Treatment Act

71.34 RCW – Behavioral Health Services for Minors

Single Bed Certification

RCW 71.05.745 and RCW 71.34.420

Emergency rule – WSR 20-20-070 (effective now)

WAC 182-300-0100 – WSR-20-24-082 (effective Dec 26, 2020)

COVID-19

Washington Supreme Court Order – Civil commitment proceedings – ***in effect now***

WSHA 2020 Bulletins

- Key Changes
- Video evaluation
- Alignment of RCW 71.34 with ITA

New Laws (2020)

- 2E2SSB 5720 – Concerning the Involuntary Treatment Act
  - Formatted with Table of Contents
  - Summary with amended statutes and effective dates
- ESHB 2099 – Concerning the use of video technology under the Involuntary Treatment Act

Joel's Law

- WSHA Bulletin (2015)
- Process
- Court forms

The Duty to Warn or Protect

- WSHA/WSMA/PI Guidance - the Duty to Warn or Protect (2017)
- Bree Collaborative Recommendations – Risk of Violence to Others (2020)

Family Initiated Treatment

- WSHA Bulletin (2019)
- Webcast Slides (2019)

Thank you!

Washington State Hospital Association

Panelist Q&A

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Allison Wedin, ITA Coordinator, Health Care Authority

Dr. Ryan Keay, Medical Director, Emergency Department, Providence Regional Medical Center Everett; President-Elect, Washington Chapter-American College of Emergency Physicians

Jessica Shook, LMHC, DCR, President, Washington DCR Association; Crisis Services Manager, Olympic, Health and Recovery Services

Richard Geiger, Vice President-Inpatient Services, Recovery Place Kent, Valley Cities

Tony Prentice, Chief Operating Officer, American Behavioral Health Services