



INTEGRATED CRISIS RESPONSE SYSTEM NSMHA TRAINING MODULE

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TRAINING OBJECTIVES:

1. Familiarize clinicians with tools and resources in the crisis system.
2. Facilitate clinician understanding of the voluntary hospitalization and involuntary treatment processes.
3. Provide guidance regarding the completion of an affidavit for initial detention or subsequent revocation.

GLOSSARY OF TERMS:

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

DCR: Designated Crisis Responder. A mental health clinician appointed by the County to perform the duties specified in RCW 70.96B also referred to as the Pilot Project. The DCR may detain under this law, those who display imminence of harm or grave disability as a result of their chemical dependency and those who may have co-occurring mental health and chemical dependency disorders.

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

E & T: Evaluation and Treatment Center. The North Sound Region operates 2 facilities via contract with Compass Health, one in Sedro Woolley (North Sound E&T) and one in Mukilteo (Mukilteo E&T). These programs provide involuntary evaluation and treatment to those detained by the DMHP/DCR staff. Other inpatient psychiatric facilities are licensed as Evaluation and Treatment Centers, but most often the term “E&T” refers to one of the 2 regional facilities.

ICRS: Integrated Crisis Response System. This is the service system that provides crisis response interventions throughout Island, San Juan, Skagit, Snohomish and Whatcom Counties. Service providers include the Volunteers of America, Compass Health, Snohomish County Human Services and Whatcom Counseling and Psychiatric Center.

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

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

Pilot Project: The North Sound Region is one of two sites in the state implementing RCW 70.96B as a pilot to address the need for detention of those individuals who are a danger to self, danger to others, or gravely disabled as a result of their chemical dependency. The Project is scheduled to run through June 2008 at which time a decision will be made about efficacy and statewide implementation.

Secure Detox: As part of the Pilot Project, a secure facility was developed to provide initial detox and evaluation services to those detained under RCW 70.96B. The facility in our region is known as North Cascades Secure Detox and is located in Sedro Woolley.

Triage Clinician: The mental health professional at the Crisis Line, who coordinates services, dispatches DMHP/DCRs and emergency mental health clinicians and provides telephone-based support 24 hours/day.

VOA: Volunteers of America Care Crisis Response Services. Provides telephone-based support and triage through the Crisis Line. The Triage Clinician can also schedule Next Day Appointments and dispatch local crisis response teams when face-to-face interventions are required.

INTRODUCTION

Crisis services are available to all persons physically located in the NSMHA service area that are in a self-defined state of crisis and/or who meet the WAC definition of crisis (a situation where a person is acutely mentally ill or experiencing a serious disruption in cognitive, volitional, psychosocial, or neurophysiological functioning). A person in crisis is served from a respected person orientation, which is a non-stigmatizing, person-oriented approach including responsive listening and respectful attention.¹

Crisis services include a broad array of services, from telephone-based support via the VOA through assessments for involuntary treatment done by Designated Mental Health Professionals/Designated Crisis Responders (DMHP/DCRs). Services are available regardless of enrollment status with NSMHA funded service providers, age, ability to pay, or funding source. Crisis services are offered in the least restrictive community setting possible to effectively and safely resolve the crisis, and such services are matched to the individual need and severity of the crisis. Crisis services actively involve and collaborate with family members and other natural supports during a crisis as appropriate and within limits of confidentiality.

WHAT ARE THE PRINCIPLES OF THE INTEGRATED CRISIS RESPONSE SYSTEM?

1. Crisis services include voluntary and involuntary service options.
2. Crisis services are delivered across social service systems in a fully integrated, seamless and consistent manner.
3. A person in crisis is treated as a whole person, rather than focusing on categorical problems.
4. A crisis is self-defined, rather than needing to meet categorical criteria.
5. A person in crisis will have easy and timely access to appropriate attention and care.
6. Clinicians involved in crisis response intervention will be able to refer to a complete continuum of care in order to respond to a variety of needs.
7. A person in crisis will be referred to the least restrictive resource available to effectively manage the crisis.
8. Crisis response services are community-based.
9. Crisis response services are available to both adults and children.
10. Crisis services and information will be available 24 hours a day, 365 days a year through the region.
11. Crisis services will be fully integrated and coordinated at both the local and regional level.
12. All crisis services will be culturally competent and responsive.
13. Standards of care will be adhered to throughout the region.

¹ See Journal of Psychiatric Practice, Vol. 9, No. 1: *Consumers' Wants and Needs During a Psychiatric Emergency*.
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14. Individuals experiencing a psychiatric crisis will be stabilized in the least restrictive setting, in the person's home or in any in vivo setting.
15. Crisis services will be provided in a seamless manner recognizing the uniqueness of each individual case.
16. The integrated crisis system will utilize a flexible array of services and supports, formal and informal, which fit the needs of the individual.
17. The integrated crisis system will be responsive and supportive of family members and persons experiencing a crisis.

WHAT TOOLS ARE AVAILABLE FOR MANAGING CRISES?

Crisis Plans:

The crisis plan is a document that the consumer's outpatient clinician develops in collaboration with the consumer and his/her family and/or other natural supports. The plan is intended to help both the consumer and the clinician in the event that the consumer experiences a crisis during treatment. Working together, the outpatient clinician and the consumer "anticipate" potential problems that might create a crisis for the consumer. The outpatient clinician helps the consumer identify his/her specific triggers or "red flags", early warning signs that alert the consumer that trouble may be developing. The outpatient clinician and the consumer then make a plan for what the consumer will do when he/she sees these early warning signs. The plan starts with low intensity interventions that the consumer can probably accomplish on their own, then progresses to interventions of increasing intensity that include family, natural supports, and possibly professional staff. A copy of the crisis plan is kept in the consumer's chart, a copy is given to the consumer, a copy is given to identified family or natural supports with the consumer's approval, and an electronic copy is available to the VOA Care Crisis Response Services. If the consumer or a family member/natural support calls the Crisis Line during a crisis, the staff can access the crisis plan and provide assistance based on the information in the crisis plan. When responding to a crisis, clinicians, Volunteers of America Care Crisis, and crisis services workers will continue to work with family members and other natural supports to best support the consumer within limits of confidentiality.

Crisis Alerts:

Crisis alerts contain important information about individuals already receiving services who are in a current crisis state and who have been identified as likely to require crisis services within the next 10 days. Crisis alerts are created by a clinician and contain information pertinent to the current crisis situation, in contrast to crisis plans, which contain long term strategies. VOA Care Crisis Response Services receives, stores, and utilizes this time-sensitive information, and makes it available to emergency mental health clinicians and DMHP/DCR staff when necessary. Crisis alerts should contain up-to-date information that helps emergency mental health clinicians assess risk and conduct intervention strategies based on the most current and accurate information available. Crisis alerts are kept on file for 10 days.

Mental Health Advance Directives:

A written document, consistent with the provisions of RCW 71.32, in which a person makes a declaration of instructions or preferences and/or appoints an agent to make decisions on her or his

behalf regarding that person's mental health treatment during times when he or she is incapacitated by a mental disorder and cannot give informed consent.

If the clinician has received a consumer's advance directive, it will become part of the consumer's medical record and the clinician will be considered to have actual knowledge of its contents. The clinician must act in accordance with the directive to the fullest extent possible, unless compliance would violate the accepted standard of care established in RCW 7.70.40, the requested treatment is not available, compliance would violate applicable law, or it is an emergency situation and compliance would endanger any person's life or health. More information regarding compliance and conditions for noncompliance can be found in RCW 71.32.150.

Wellness Recovery Action Plan (WRAP):

This is a program designed by Mary Ellen Copeland in the 1990s after she interviewed hundreds of people with mental illness. They described their strategies for getting by on a daily basis, while experiencing psychiatric symptoms.

A written document created by the consumer, which provides structure that helps the person monitor uncomfortable and distressing symptoms and plan responses to those situations. It also includes plans for responses from others who serve as supports, when the symptoms make it impossible for the person to continue to make decisions, take care of themselves and keep themselves safe.

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

WHAT IS THE ROLE OF THE VOA CARE CRISIS RESPONSE SERVICES?

VOA Crisis Line Services:

VOA Care Crisis Response Services provides the 24-hour a day, 7 day a week, professionally staffed crisis line system. When someone is in distress and is seeking assistance with a crisis situation, he/she should call the Crisis Line at 1-800-584-3578. Crisis line staff are mental health clinicians who accept calls from the general public and other professionals. They provide a range of support and referral services including,

- A. Screening calls and passing acute situations to the Triage Clinician
- B. Making requested mental health referrals to the community
- C. Having access to language bank interpreters and TDD equipment
- D. Assuring referral to age and culturally appropriate services and specialists
- E. Scheduling crisis appointments
- F. Providing telephone stabilization and intervention services for non-acute consumers

VOA Triage Services:

VOA Care Crisis Response Services Triage Clinicians are Masters-level mental health professionals. When a professional wishes to speak with someone at the crisis line, they can

contact the Triage Clinician directly at 1-800-747-8654. Triage Clinicians perform all of the following functions:

- A. Assure timely and consistent crisis response.
- B. Provide telephone consultation, intervention and stabilization for consumers and/or family members/natural supports as appropriate and within limits of confidentiality.
- C. Determine when face-to-face services are needed, both voluntary and involuntary, and dispatch a DMHP/DCR or emergency mental health clinician.
- D. Track the outcome of face-to-face services and see if further services are warranted.
- E. Decide when cross-system services are needed.
- F. Decide when joint outreach between voluntary and involuntary services is indicated.
- G. Work closely with law enforcement when appropriate.
- H. Consult with detox providers, nursing homes, hospitals and other community providers.
- I. Troubleshoot cross-system referrals in which there is a difference of opinion of appropriate services or system response.
- J. Provide telephone follow-up with consumers after-hours as part of an individual crisis plan

Emergency mental health clinicians and DMHP/DCRs may not decline a referral for services from the Triage Clinician.

WHAT FACE-TO-FACE SERVICES ARE AVAILABLE?

Crisis Services Appointments:

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

Emergency Psychiatric Services:

Emergency psychiatric medication evaluations are available on a one-time basis for those that have been assessed by an emergency mental health clinician or DMHP/DCR and deemed at risk of imminent hospitalization.

Voluntary Outreach:

Outreach is the provision of face-to-face evaluation and/or intervention services (voluntary or involuntary) in community locations. The expectation is that all clinicians providing crisis response services will give first consideration to taking services to the person in crisis before requesting that the person present themselves at a facility to receive services. Outreach services are an important and available service, both when necessary to support the person in crisis and to provide services in the least restrictive, appropriate manner, with the use of family and natural

supports within limits of confidentiality. The intent, however, is never to promote outreach at the expense of anyone's safety – including consumer, staff, family/natural support, and the public.

Emergency mental health clinicians must respond to pages from the VOA within 10 minutes. Once dispatched, the emergency mental health clinician must be on-site with the person in crisis within 2 hours. Within 1 hour following the completion of any outreach, the emergency mental health clinician calls the Triage Clinician to relay the disposition of the case back to the Triage Clinician and, when appropriate, the referral source.

Specialized Services for Children and Families:

A. Skagit County:

Skagit County manages children's crisis primarily through the position of Children's Crisis Response Specialist. The Children's Crisis Response Specialist currently works from 9:30 a.m.-6:00 p.m. Monday through Friday. The Children's Crisis Response Specialist is the first response to children/adolescent crisis calls coming in through Care Crisis Response Services. This clinician, trained in child crisis intervention and stabilization, travels to multiple settings, performs an assessment of risk, consults with appropriate others and provides alternatives to hospitalization whenever possible using behavioral aides, urgent follow up, natural supports, and remediation of the causes leading to crisis. During off-hours, DMHP/DCR or emergency mental health clinicians handle children's crises.

B. Snohomish County:

The Compass Health Children's Crisis Team (CCT) provides crisis services to Snohomish County consumers ages 0-17. The CCT provides a full range of voluntary services to children and their families, including phone intervention, outreach, and in-office appointments. When a child is a consumer of Compass Health, the CCT is the primary responder to crisis events after-hours and provides back up for the child's treatment team when crisis events occur during business hours. Cases are rarely held by clinicians of the CCT, but are quickly referred to ongoing services and supports.

WHAT SERVICES ARE AVAILABLE FOR ADULTS ENROLLED WITH THE DIVISION OF DEVELOPMENTAL DISABILITIES (DDD)?

For adults who are enrolled with the DDD, there are additional services that are available during times of crisis. This includes the availability of crisis stabilization aides to provide additional support and safety in the person's home (including residential programs). Crisis stabilization aides can also be accessed to provide additional staff support during an inpatient stay when necessary to facilitate admission to a local inpatient facility. Crisis stabilization aides can be accessed during the business day through the DD Crisis Stabilization staff at Compass Health or by calling the VOA Triage Clinician. Region 3 DDD also has access to a Hospital Diversion bed located in North Seattle. Referrals for hospital diversion bed services should be made to the DDD Mental Health/Developmental Disability Resource Manager.

During evenings, weekends and holidays, services through this program are accessed through DMHP/DCRs and emergency mental health clinicians. All of these programs can be accessed through the VOA Triage Clinician.

Note: These services are only available to adults (18 years of age or older) who are currently enrolled with the Division of Developmental Disabilities. Information about enrollment status is available through the VOA Triage Supervisor.

WHAT RESIDENTIALLY BASED CRISIS SERVICES EXIST IN THE REGION?

Crisis respite facilities for adults are located in Whatcom, Skagit, and Snohomish counties. These programs typically provide short-term support (up to 5 days) in a staffed facility for adults who are in or at high risk of experiencing a mental health crisis. The programs in Whatcom and Skagit Counties are also able to provide limited (non-medical) detoxification services for chemically abusing or dependent individuals. When an outpatient clinician believes that their consumer would benefit from crisis respite, they may call the facility directly to make the referral. After hours, the emergency mental health clinician will facilitate the referral. Staff at each facility are trained to review the presenting information and establish whether placement is appropriate.

A. Whatcom County Behavioral Health Triage Center (WCBHTC)

Pioneer Human Services and Whatcom Counseling and Psychiatric Clinic operate the Triage Center. It is located in Bellingham in the same building as the minimum-security jail. It provides 24-hour emergency outpatient response services to all Whatcom County residents experiencing a mental health or substance abuse crisis. The facility provides a single point of access to mental health crisis assessment and stabilization and chemical dependency crisis assessment and treatment referral services including: crisis intervention counseling, mental health and substance abuse crisis screening and assessment, crisis stabilization, referral to services such as psychiatric hospitalization and ITA evaluation, admission to Substance Abuse Protective Custody (SAPC; up to an eight-hour hold), admission to Social Detox Unit (up to five days), admission to crisis respite (up to five days). To use the services an individual must be 18 years of age, voluntary, in crisis and/or intoxicated or in withdrawal from alcohol or other substances, noncombative, capable of being calmed by others, and not requiring medical care.

B. Compass Health Crisis Respite Facilities

The Skagit County Behavioral Health Crisis Center and Compass Health Crisis Beds provide short-term stabilization services for individuals who are experiencing an acute mental health crisis or are intoxicated and require detoxification services. A Mental Health Professional or medical professional will evaluate and refer these consumers for admission. Both facilities are non-medical, community-based programs that offer a less restrictive placement option than inpatient hospitalization. The duration of stay can range from one to five days; the need for continued services will be evaluated on a daily basis.

Referral Process for Mental Health Placement:

- A Mental Health Professional or a clinician completes a face-to-face assessment. If crisis respite is deemed to be the best option, the referral source will assess whether the

consumer meets the inclusion/exclusion criteria.

- The referral source will contact either facility regarding the availability and the appropriateness of the placement.
- If the placement is appropriate and the facility agrees to accept the consumer, the referral source would then complete the necessary documentation.

Referral Process for Sub Acute Detoxification Placement (Skagit County Crisis Center only):

- Sub Acute Detoxification placement is only offered at our Skagit County Behavioral Crisis Center. As with other non-medical, detoxification service facilities, Skagit County Behavioral Health Crisis Center is unable to accept consumers that are detoxing from benzodiazepines or barbiturates.
- A face-to-face assessment is necessary and completed by medical personnel to determine the appropriateness of placement in a non-medical setting.
- The referral source will then contact the Skagit County Behavioral Health Crisis Center regarding the availability and the appropriateness (review inclusion/exclusion criteria) of the placement.
- If the placement is appropriate and the Skagit County Behavioral Health Crisis Center agrees to accept the consumer, the referral source or Skagit County Behavioral Health Crisis Center staff will arrange for appropriate transportation.
- Skagit County Behavioral Health Crisis Center is a combined facility for both mental health and chemical dependency consumers. We are unable to accept consumers that are sexual offenders, violent, assaultive or have a history of fire setting.

Length of Stay/Discharge Planning:

- The length of stay is limited; up to 5 days
- The discharge planning will be completed at the time of initial placement

WHAT IS THE PROCESS FOR PSYCHIATRIC HOSPITALIZATION?

Voluntary Hospitalization:

The VOA Hospital Certification Team provides pre-certification for voluntary psychiatric hospitalization for all Medicaid and Medicaid-eligible residents of the North Sound region. The program is available 24 hours per day, 7 days per week. When a clinician feels that the consumer they have assessed requires psychiatric hospitalization they must first contact a psychiatric hospital and secure a bed. Once a bed has been identified, but before admission, the assessing clinician must call 1-800-707-4656 and request the certification. The assessing clinician will have to provide clinical and demographic information and be prepared to discuss whether less restrictive options might meet the consumer's needs. If the consumer meets medical necessity criteria the hospitalization episode will be certified and arrangements for admission can be made.

Assessments for Involuntary Treatment:

Persons who are alleged to be a danger to themselves or others or are gravely disabled (unable to take care of their basic needs) as the result of a mental disorder or chemical dependency may be assessed for involuntary treatment. DMHP/DCRs do all assessments for involuntary treatment. In assessing whether or not a person should be detained against their will to an inpatient psychiatric

unit or secure detoxification facility, DMHP/DCRs focus their evaluations on the following questions:

- A. Is the person suffering from a mental disorder or chemical dependency? RCW 71.05.020(22) defines mental disorder as “any organic, mental or emotional disorder which has substantial adverse effects on an individual’s cognitive and volitional functions.” RCW 70.96b.010(5) defines chemical dependency as “alcoholism, drug addiction or dependence on alcohol and one or more psychoactive chemicals, as the context requires.”
- B. Is there evidence that the person, as the result of mental disorder or chemical dependency:
 - (1) Presents a likelihood of serious harm to him or herself, other persons, or the property of others; or
 - (2) May be gravely disabled?
- C. Does an imminent danger exist?
 - (1) According to 71.05.150(2), a DMHP/DCR should take a person into emergency custody only when the person presents an imminent likelihood of serious harm or is in imminent danger because they are gravely disabled.
 - (2) Before filing the petition, the DMHP/DCR must personally interview the person, unless the person refuses an interview, and determine whether the person will voluntarily receive appropriate evaluation and treatment at an evaluation and treatment facility, a detoxification facility or other certified chemical dependency provider.
- D. Does the person present, as a result of a mental disorder or chemical dependency, likelihood of serious harm, or grave disability, but without imminent danger?
 - (1) If the person does meet criteria for detention, but no imminent danger exists, then the DMHP/DCR may initiate a non-emergent detention by petitioning the superior court for an order directing the referred person to appear at an inpatient evaluation and treatment facility, certified detoxification facility, or outpatient treatment provider within 24 hours after the order is served. RCW 71.05.150(1). Note: Imminent danger is not required for the emergency detention of minors.
- E. What appropriate alternatives to involuntary hospitalization exist? Will the person voluntarily accept appropriate, available, less-restrictive treatment options? RCW 71.05.150 (1)(a), RCW 71.34.050, and RCW 70.96b.050(b)(i)(A).

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

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

When a person is detained, he or she is entitled to a court hearing within 72 hours of the initial detention. This is called a probable cause hearing. Weekends and holidays are excluded in the calculation of the initial 72 hours. The focus of the probable cause hearing is to determine if the person continues to require involuntary treatment by meeting detention criteria. Based on testimony and other available information, the court will determine one of the following outcomes of the hearing:

- A. Order the detention on an inpatient basis for an additional period of up to 14 days;
- B. Order the person to a 90-day Less Restrictive Order (“LRO”); or
- C. Dismiss the petition.

WHAT HAPPENS AFTER AN INVOLUNTARY ADMISSION TAKES PLACE?

Court Orders (Less Restrictive Order and Conditional Release):

Once an involuntary admission takes place, the person being detained is entitled to a judicial hearing within 72 hours (*note: usually this excludes weekends and holidays*). This hearing is used to determine whether the initial commitment was appropriate and, if so, does the person still present a danger to themselves or others as the result of a mental disorder. Family member/natural support input is generally encouraged in preparation for these hearings. The judge has the option of continuing the detention, discharging the individual back home on a voluntary basis, or releasing the person on a Less Restrictive Order (LRO), also known as a Less Restrictive Alternative (LRA). An LRO is a court order telling the patient and mental health professionals what things need to occur or not occur for the person to remain in the community. These are called the “conditions” of the Less Restrictive Order. Examples include not using non-prescribed drugs, not using alcohol, refraining from threats or acts of harm toward themselves or others, attending mental health appointments and not having access to weapons.

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

There is another type of court order called a Conditional Release (CR). When an individual is committed to the hospital for 14 days or 90 days (this is called the MRO, More Restrictive Order) the treating physician can decide to discharge the person on a CR. He/she must have an accepting outpatient provider to follow up on the CR. The physician writes a document outlining the conditions the person agrees to follow. This document is given to the receiving outpatient provider, the individual on the CR and is filed with the court. There is not a court hearing with a CR as there is with an LRO.

Sometimes, however, people either do not follow through on the conditions of their LRO/CR or experience substantial deterioration in their functioning even when following the conditions. Under these circumstances, a DMHP/DCR can return the person to the inpatient unit. This is called a “revocation” of a Less Restrictive Order or Conditional Release. If such an assessment is needed, DMHP/DCRs are accessed by calling the Volunteers of America Crisis Triage Supervisor.

When serving a person on a LRO/CR, it is required to keep a copy of the court document listing the conditions in the clinical record. It is important to provide this document to the DMHP/DCR if requested. It is also necessary that the person communicating with the DMHP/DCR has specific knowledge about how the person on the LRO/CR has violated the order, problems they have experienced that are causing the concerns, and what steps have been taken or considered to help support the person in a less restrictive way. This information is crucial in determining whether a revocation is appropriate and necessary. Family members/natural supports are often the first persons to identify the consumer’s non-adherence or deterioration and can share this information with the clinician without compromising confidentiality requirements. If the consumer has not authorized the release of information, the clinician may simply listen to the family’s concerns without revealing protected information.

A revocation occurs when someone on an LRO/CR is returned to an inpatient unit. They are entitled to a court hearing within 5 days and, in many ways, this hearing is similar to the one leading to the initial release. Whenever possible, the person will be stabilized and released back to where they were living, often on another LRO.

Integrated Crisis Response NSMHA Training Module

Post-Test

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

1. T / F Consumers and the general public should be instructed to call the VOA Triage Clinician if they feel that they are in crisis.
2. T / F Crisis alerts expire after 10 days if they are not renewed.
3. T / F Crisis services appointments are only for consumers who are currently enrolled in services.
4. T / F When requesting admission for voluntary hospitalization, one should be prepared to discuss what less restrictive options have been considered.
5. T / F When Designated Mental Health Professionals/Designated Crisis Responders are doing an assessment for initial detention they are required to consider reasonably available history.
6. T / F When someone is on a Less Restrictive Order or Conditional Release, it is not important to keep a copy of the order.
7. T / F Any person who is in crisis and who is physically located within the North Sound region is eligible for crisis response services
8. T / F Once a person is detained, a court hearing must be held within 48 hours to determine if he/she continues to meet commitment criteria.

For enrolled consumers needing voluntary crisis response services, please list the following parties in order of their responsibility for serving the consumer. 1 (first option), 2 (second option) or 3 (back-up):

- _____ The treatment team
- _____ The outpatient clinician
- _____ Crisis Response staff

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

1. Once dispatched, crisis response staff must make face-to-face contact within _____ hours.
2. What type of service should be considered when a consumer is unwilling to accept voluntary services and presents a likelihood of serious harm to themselves as the result of a mental disorder but is not in imminent danger? _____

3. When a person is discharged from an evaluation and treatment center on a Less Restrictive Order (LRO), the requirements/constraints on their behavior are referred to as the _____ of their release.
4. When someone is returned to an inpatient unit for not complying with an LRO, the process is called a _____.

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

1. How can crisis plans assist enrolled consumers who are in crisis?
2. Provide 3 situations in which using a crisis alert would be appropriate.
3. What is the clinician's role when voluntary hospitalization may be needed to support a person on his/her caseload