THE HONORABLE ROBERT J. BRYAN

UNITED STATES DISTRICT COURT
WESTERN DISTRICT OF WASHINGTON
AT TACOMA

Sharon Allen, by and through her next friend and mother, Virginia Allen, et al.,

Plaintiffs,

v.

Western State Hospital, et al.,

Defendants.

NO. C99-5018RJB

AGREED ORDER ON JOINT MOTION TO STAY PROCEEDINGS

Having reviewed the record and files in this matter and the parties' Joint Motion to Stay Proceedings, and based upon the agreement of the parties, the Court now enters an order striking the trial date currently set for February 7, 2000, and staying all further proceedings in this case contingent on defendants' adherence to the following terms and conditions.

IT IS HEREBY ORDERED THAT:

1. The trial date currently set for February 7, 2000 is stricken and further proceedings are stayed unless otherwise ordered by this court, contingent upon defendants' implementation of the following:

a. Upon entry of this order, defendants shall commence timely implementation of the funded portions of the three-phase plan (Attachment 1) negotiated between the parties and incorporated herein by this reference, phase 1 of which is currently funded as stated in the letter from defendants to Washington Protection and Advocacy System Director Mark Stroh dated

ATTORNEY GENERAL OF WASHINGTON
670 Woodland Square Loop SE
PO Box 40124
Olympia, WA 98504-0124
(360) 459-6558

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November 18, 1999 (Attachment 2). For those parts of the plan that are not currently funded, defendants agree to request funding from the state legislature to provide for their implementation.

b. Following entry of this order defendants shall establish an interim monitoring committee to advise DSHS officials and inform plaintiffs regarding implementation of the three-phase plan. See Attachment 2. Contingent upon funding from the legislature, DSHS shall establish an ongoing monitoring committee to be organized and to function as agreed upon by the parties and incorporated in the three-phase plan.

c. Following entry of this order defendants shall establish a cross-systems committee as agreed upon by the parties and incorporated in the three-phase plan.

d. Following entry of this order defendants shall develop a process which will allow counsel for individual class members direct access to agency staff to address individual issues which could not be satisfactorily and timely resolved with treatment and/or case management staff. Defendants shall designate one staff person from the Division of Developmental Disabilities and one from the Mental Health Division to serve as agency contacts regarding services provided by the two divisions to class members. Plaintiffs shall reserve all rights to initiate independent legal action to preserve the rights of individual class members.

e. Defendants shall make reasonable efforts to keep plaintiffs informed regarding implementation of the three-phase plan and the procedures outlined in paragraphs 1(a) – (d) above. Defendants shall give plaintiffs' counsel thirty days notice and shall inform the monitoring committee of any changes to any part of the attached plan.

f. Defendants shall pre-screen all class members who have been discharged from Western State Hospital within a reasonable period of time to determine whether they are receiving reasonably adequate services in the community.

2. At any time following entry of this order plaintiffs may rescind their agreement to stay the proceedings and a new trial date will be scheduled by the Court. If requested by counsel

ATTORNEY GENERAL OF WASHINGTON
670 Woodland Square Loop SE
PO Box 40124
Olympia, WA 98504-0124
(360) 459-6558

for plaintiffs, an expedited trial schedule will be ordered which shall set the matter for trial no later than 90 days from the day the stay is lifted, subject to approval by the Court.

3. The remedy contained in paragraph (2) above shall be the sole remedy available to plaintiffs under this agreed order. The terms and conditions of the three-phase plan and the procedures outlined in paragraph 1(a) – (e) above shall not be enforceable through an action for specific performance or through other legal action by plaintiffs or third parties, except for terms and conditions that are determined by this Court to be required as a matter of law. By reaching agreement for a stay of proceedings to allow implementation by defendants of the three-phase plan, plaintiffs have not waived, forfeited, or otherwise agreed to forego any legal rights they would otherwise enjoy regarding services provided by defendants. By virtue of their agreement to seek funding to implement the three-phase plan and the procedures outlined in paragraph 1(a) – (e) above, defendants have made no commitments that adequate funding will be secured for full implementation, have waived no defenses to allegations they are violating the civil or legal rights of plaintiffs, and have admitted no liability regarding any causes of action stated in plaintiffs' complaint.

4. Defendants shall reimburse plaintiffs for attorneys' fees and costs reasonably incurred in this litigation within a reasonable period of time. The parties shall attempt to reach agreement on the amount of attorneys' fees and costs that are reasonable. If the parties are unable to reach agreement on the amount of reasonable costs and attorneys' fees, the issue shall be presented to the Court for decision. Upon entry of an order awarding attorneys' fees and costs, defendants shall make full payment of the amount ordered within a reasonable period of time, or as otherwise agreed upon by the parties or ordered by the court.

DATED this 2nd day of Dec 1999.

ROBERT J. BRYAN
United States District Judge

ATTORNEY GENERAL OF WASHINGTON
670 Woodland Square Loop SE
PO Box 40124
Olympia, WA 98504-0124
(360) 459-6558

Presented by:

CHRISTINE O. GREGOIRE
Attorney General

TERRANCE J. RYAN, WSBA #15205
Assistant Attorney General
Attorney for Defendants

EDWARD J. DEE, WSBA #15964
Assistant Attorney General
Attorney for Defendants

SUSAN L. PIERINI, WSBA #17714
Assistant Attorney General
Attorney for Defendants

JOANN SABOL, WSBA #19585
Assistant Attorney General
Attorney for Defendants

Approved for entry by counsel for plaintiffs:

DEBORAH A. DORFMAN, WSBA #23823
MICHAEL J. SMITH, WSBA #14111
ELIZABETH A. STANHOPE, WSBA #21162
Washington Protection & Advocacy System
180 West Dayton, Suite 102
Edmonds, WA 98020

JOHN H. PARNASS, WSBA #18582
MICHELE EARL-HUBBARD, WSBA #26454
Davis Wright Tremaine
1501 Fourth Avenue, Suite 2600
Seattle, WA 98101

WSBA #23823
USBA #0872
for Robert Denton
per telephonic approval

ROBERT DENTON, USBA #0872
Disability Law Center
455 East 400 South, Suite 410
Salt Lake City, UT 84111

SUPPORTS AND SERVICES FOR PEOPLE WITH DEVELOPMENTAL DISABILITIES AND MENTAL ILLNESS

COLLABORATIVE WORKPLAN

November 23, 1999

From the Division of
Developmental Disabilities/Mental Health
Division

Washington State
DEPARTMENT OF
SOCIAL & HEALTH
SERVICES

ATTACHMENT 1

GUIDING PRINCIPLES

The Division of Developmental Disabilities (DDD) and Mental Health Division will promote the development and implementation of new techniques and program approaches to ensure opportunities for positive change and for personal growth and development. The following guiding principles provide a basis for evaluation and monitoring at both an individual and system level.

1. Services should be based on an individual planning process that identifies the strengths and service needs of the individual and that promotes positive outcomes.

2. Services should be planned and provided in a manner that encourages the involvement of family, friends, advocates, community supports and allied systems in the lives of people being served.

3. Services should be provided in the least restrictive and most integrated setting as is reasonably possible.

4. Cross-system collaboration should occur between DDD, Mental Health and other involved allied systems at all levels of service planning and delivery.

5. Services should be provided to individuals in a competent manner and specialized training should be provided to those involved in the delivery of services.

6. Services should be provided consistent with public concerns with public health and safety and protection of society.

7. Services should be evaluated and monitored at both the individual and system level to determine effectiveness and efficiency.

PHASE 1 – IMPROVING CURRENT SERVICES AND BUILDING COLLABORATION

This plan addresses a population of people with developmental disabilities and mental illness and/or who present a danger to themselves or others as defined in RCW 71.05. This plan also addresses members of the class as defined by the court. In sections of this document, these individuals will be referred to as "this population."

A major emphasis of Phase 1 is increasing collaboration among the key partners in both systems. This includes the RSN liaisons, state hospital staff, and regional/local DDD and MH staff. Increasing mutual understanding of both systems is key to strengthening the regional and local relationships to develop better coordination of services for individuals with developmental disabilities and mental health issues.

Phase 1 also addresses improvements in services for individuals with developmental disabilities at Western State Hospital. Major elements of the WSH improvements are the development of a habilitative mental health care program, creation of a specialized DD/MH treatment team, expansion of day, evening and weekend programming, and staff training.

Phase 1 includes making available psychiatric and psychological expertise from the state hospitals and DDD residential habilitation centers (RHC) to DD consumers in the community. The plan calls for piloting the use of a small number of respite beds at two RHCs.

Phase 1 builds in an accountability system for program implementation, monitoring and oversight.

It is important to note here that Phase 1 is the foundation upon which Phases 2 and 3 build. Recommendations presented in the report are dependent upon implementation of Phase 1.

I. PREVENTING HOSPITALIZATION

A. Collaboration

1. At the local DDD/Regional Support Network (RSN) level, systematically educate and collaborate about individuals who are potentially nearing crisis. Although some of this is already occurring, better coordination would ensure that all parties participate actively. For smaller RSNs, it may be most cost efficient to use telephone and/or video conferencing.

2. Establish liaisons among local DDD, RSN, and state hospitals as single points of contact to improve coordination. Establish a process for RSN and DDD liaisons to communicate about specific individuals prior to the person's admission to the state hospital. Hold quarterly liaison meetings at WSH and quarterly meetings at ESH.

3. Hold quarterly local network meetings to address continuous quality improvement issues and conduct cross system training.

B Training

1. Develop a state-wide cross-system DDD and MHD training plan

2. Identify expertise (typically psychologists and behavior specialists) within existing DDD and MHD systems to provide training to families, residential providers, including adult family homes (AFH), and community mental health center (CMHC) staff in the following areas:

- Positive behavior support
- Functional assessment
- Dual diagnosis: developmental disabilities and mental illness
- Psychoactive medications
- De-escalation techniques
- Physical/manual interventions without restraints
- Community protection issues
- Sex offender treatment issues
- Communication Skills
- Avoiding power struggles
- Choices versus directives

3. Explore using blended funds to develop the statewide training plan (e.g., DDD, MHD federal block grant, Washington Institute) and to conduct priority training.

4. Within current technical assistance budgets/funds, continue targeted training related to diversion of individuals in this population from state psychiatric hospitalization.

C. Crisis Prevention: Functional Assessments and Positive Behavior Support Plans

1. Provide access for families and residential providers to behavior specialists from DDD Field Services and the RHCs to conduct functional assessments and develop positive behavior support plans.

2. Crisis prevention plans will be facilitated in collaboration with residential, day, and community mental health service providers.

D. Crisis Intervention Services

1. Provide timely access to respite beds at RHCs for individuals for whom this setting would be appropriate (i.e., voluntary, minimal restraint required). Pilot use of two (2) respite beds each at Fircrest and Lakeland Village. Individuals eligible for respite beds must have existing community placement and funding.

E. Medication Evaluation and Management

1. Increase access of DDD consumers and residential providers to consultation (face-to-face, via telephone or video conferencing, as appropriate) with psychiatrists who have expertise in developmental disabilities and mental illness. Make available psychiatrists from the RHCs for evaluation and consultation to community people with developmental disabilities. Psychiatrists from WSH will be available to consult with community physicians or other prescribing authorities for up to ninety days post psychiatric hospital discharge.

2. Increase DDD and MHD contracts with registered nurse practitioners (ARNP) to monitor medications.

F. DURING HOSPITALIZATION (WSH)

1. Develop a habilitative mental health care program

   WSH will concentrate DD patients on two wards. One 21-bed ward made up primarily of male patients and one ward that has both Mental Health and DD patients. This will facilitate habilitative programming appropriate to the population.

2. Create Specialized DD Treatment Team

   Develop an inter-disciplinary DD treatment team to include: Ph.D. Program Manager, DD/MH Psychiatrist, DD Psychologist and Social Worker.

   Provide consulting psychiatrist who has expertise in both Developmental Disabilities and Mental Health to review treatment and advise WSH psychiatric staff.

3. Expand Day Program and Evening and Weekend Program

   Expand hours of day program to 6 hours per day to include skill development in areas such as anger management, social interaction, activities of daily living, pre-vocational training and vocational experience, including work enclaves.

   Expand weekend and evening program to include, supportive counseling, coping skills and relaxation training, appropriate sexual behavior training and recreation activities.

Individuals will have the opportunity, when clinically appropriate to participate in all activities, which are part of the hospital milieu.

4. Training

All staff who have, as their primary responsibility working with people in this population will complete training requirements established in the hospital training plan.

Training will include but will not be limited to:

i. the development and implementation of treatment plans for individuals with developmental disabilities
ii. the development of and implementation of positive behavioral supports;
iii. recognition and reporting of abuse and neglect;
iv. medication use including benefits and risks, side effects, appropriate use of prns;
v. seclusion and restraint policies and alternatives;
vi. basic counseling skills;
vii. crisis prevention, intervention, management;
viii. data collection; and
ix. CPR and first-aid

2. All people will have individual behavioral support plans, developed with consultation from experts in positive behavioral support and implemented immediately upon completion.

3. Accurate, consistent, objective data will be collected and monitored to evaluate the effectiveness of treatment and behavioral support plans.

4. A cooperative process shall be developed between DDD and MHD regarding the sharing of relevant information when an individual is admitted to WSH.

5. All individuals and their guardians shall be invited to participate in the treatment planning process.

6. Eastern State Hospital is implementing an active day program for people in this population.

G. **PLANNING FOR DISCHARGE**

The Cross-System Committee shall establish a process for the coordination of the discharge of appropriate people to appropriate less restrictive alternative placements in the community. The Committee shall develop a process for ensuring that discharges will occur promptly and that linkages are made with community services. The Monitoring Committee shall provide the Cross-System Committee with recommendations for this process, and shall review any changes made in the processes. Each month, the Cross-System Committee will provide

the Monitoring Committee with a status report on the effectiveness of the discharge process and planned improvements or adjustments.

Following admission, convene a team that includes the person, family, residential provider, DDD, RSN liaison, hospital staff and others as appropriate. This team will meet regularly to maintain active participation in the planning and treatment process and:

- Develop individualized discharge criteria that are objectively defined and agreed upon by hospital staff, person, family, residential provider, DDD, and the RSN liaison.

- Begin immediate placement planning at the time of admission.

- Develop a long-term support plan for the person that emphasizes positive behavior support and minimizes the use of restrictive and/or intrusive interventions.

- Develop post-discharge plans for medication monitoring, technical assistance, and mental health services that will be available and accessible to the person in their community:

    Enroll the person with the RSN in their community for follow-up services prior to discharge.

    Ensure the person is discharged with a two-week supply of medications (if applicable).

    Confirm an appointment with an out patient MH provider for post discharge follow-up and prescription renewal (if applicable) within two weeks of discharge.

- Identify available resources for employment opportunities, day programs and activities the person can participate in on discharge (funding for this is typically included in placement costs; there may be a small number of individuals who will require additional funding).

- Develop a written plan for times of crisis:

    Identify places in the community for periodic respite, especially for individuals who cycle through bad periods and may need a safer, more secure place to help make it through difficult periods.

    Identify resources in the community who can assist when the person is in crisis.

DDD and MHD will develop a joint database and tracking system that will monitor key variables and movement of individuals through the mental health and developmental disabilities systems.

G. PROGRAM OVERSIGHT

A Monitoring Committee will be established to monitor the implementation of this plan and convened within 60 days of an agreement between Washington Protection and Advocacy and DSHS. The Washington Protection and Advocacy System (WPAS) and DSHS will agree upon the composition of this committee. DDD and MHD will provide staff support. The Monitoring Committee will provide recommendations for implementation of the plan and will review materials and reports produced by the Cross-System Committee, which will be described below. The Monitoring committee will meet every two months for the first year and quarterly thereafter. The Monitoring Committee will continue for three years following the implementation of Phase 3. Special meetings may occur at the agreement between WPAS and DSHS. At the end of this period, the Monitoring Committee may make recommendations for a further extension.

The Monitoring Committee shall provide accountability for the implementation of this plan and shall provide recommendations for systemic changes. The Monitoring Committee will provide their recommendations to the Cross-System Committee.

Additionally, the responsibilities of the Monitoring Committee will include:

a. Review the implementation plan and instructional materials to be used by staff serving people in this population.
b. Review the appropriateness and implementation of the treatment recommendations for a sample of people in this population. The Monitoring Committee will determine the sample.
c. Review the reports of the Cross-System Committee relating to cases of suspected abuse and neglect, and incident reports. The Monitoring Committee shall have authority to receive and review all such reports and cases, within legal confidentiality rights. The Monitoring Committee has access to all class member records, incident reports, and related documents unless producing the requested information would be cost prohibitive or is not reasonably available.
d. The Chairperson of the Monitoring Committee shall bring to the attention of all parties, information concerning suspected non-compliance with this plan.

DSHS will bear the reasonable and necessary expenses of the Monitoring Committee within budgetary constraints.

Cross-System Committee

A Cross-System Committee will be established which is made up of representatives from the Mental Health Division (MHD), Division of Developmental Disabilities (DDD), Regional Support Networks (RSNs) and contracted providers of mental health or developmental disabilities services. The directors of DDD and MHD will chair this committee. This committee will promote cross-system collaboration so as to improve the quality and availability of services for people in this population. The

committee shall be responsible for delegation of tasks and duties and the development of policies, procedures and protocols necessary for the implementation of this plan and shall report to the Monitoring Committee in fulfilling this responsibility. This committee has the following major purposes:

- ensure that mental health and developmental disabilities staff are working together cooperatively to provide services to people in this population.
- report to the Monitoring Committee regarding the implementation, and respond to the Monitoring Committee's recommendations and advise.
- create a statewide training plan for those who work with people in this population.
- initiate a continuous quality improvement process.

Mental Health and DDD shall make a good faith effort to reach a cross-system agreement that includes all RSNs that serve people in this population.

The Cross-System Committee will look at the following provisions:

a. Address access to services such as the following:
i. vocational and other day services as appropriate
ii. crisis prevention and response services, including philosophy and practices
iii. emergency placement respite services for people in this population
iv. housing and housing support, including pre-screening and intakes
v. medication and medication management
vi. personal services
vii. transportation
viii. hospitalization
ix. medical and dental service
x. mental health treatment
xi. sexual offender treatment
xii. positive behavioral support, including concepts and practices
xiii. case management
xiv. family support
xv. treatment for criminal offenders
xvi. sex education
xvii. substance abuse/chemical dependency services

b. a plan for ensuring that incidents of abuse, neglect, abandonment and exploitation are reported as required by law. This will include training as outlined in the statewide training plan.

Monthly DDD/MHD Reporting

DDD and MHD shall furnish WPAS, the Monitoring Committee and the Cross-System Committee a monthly report regarding the number of admissions and discharges of people in this population to WSH. This report shall also contain information regarding the number of individuals

discharged to a community placement, the number discharged to a RHC, and other reasonable information as agreed to by WPAS and DSHS.

PHASE 2 – BUILDING A COMMUNITY INFRASTRUCTURE

Phase 2 builds upon Phase 1 by developing a community infrastructure that infuses significant more diversion and placement capacity into a habilitative mental health care model. The major emphasis of Phase 2 is implementation of a variety of strategies aimed at diverting individuals in this population from psychiatric hospitalization. Phase 2 proposes increased contracting for technical assistance and medication evaluation and monitoring, as well as the addition of psychologists and/or behavioral specialists in DDD Field Services. Recommendations for eighteen (18) diversion beds and expanded community placement for 70 individuals are also included. Improvements implemented in Phase 1 continue. Phase 2 implementation begins July 1, 2000 contingent upon legislative approval and funding. An implementation plan for Phase 2 will be developed and reviewed by the Monitoring Committee and the Cross-System Committee prior to July 1, 2000.

Phase 2 provides for an increase in several key services such as crisis prevention, behavioral support and technical assistance, respite bed capacity and medication evaluation and management. Phase 2 also provides a solution to a long-standing problem: individuals who lack funds for residential placement end up staying at the state hospitals for longer periods of time and beyond the point they are determined psychiatrically stable. Expanded community placement capacity will provide funds in advance for people coming out of the hospitals.

The importance of diversion in reducing the state hospital census is critical. Without sufficient community resources and linkages available and accessible to individuals in crisis, people will continue to go to the state hospitals. Phase 2 focuses on developing strategies for achieving the systems integration and partnerships between mental health staff, developmental disabilities staff and community-based organizations and programs to ensure adequate resources, coordination, and follow-up.

II. PROMOTING GOOD CARE TO PREVENT HOSPITALIZATION

A. Crisis Prevention: Functional Assessments and Positive Behavior Support Plans

1. Improve capacity for diagnostic evaluation and treatment planning.

2. Make person-specific technical assistance for individuals with developmental disabilities and mental illness readily available to mental health providers, families, residential and vocational providers.

3. Add five (5) staff psychologists and/or behavioral specialists to DDD Field Services (Regions 1, 2, 3, 5, and 6) to conduct functional

assessments, develop positive behavior support plans, collaborate with mental health to develop individual crisis plans, and provide training and technical assistance. These individuals will provide consultation and link with mental health treatment teams to support integrated approaches.

The psychologist and/or behavior specialists will work closely with the Cross-System Committee, and will report gaps in service, problem with services, and other quality related information to the Cross-System Committee.

4. DDD and MHD will work together to support individuals to remain in their homes during a crisis, and in the event that an individual must enter a more restrictive setting, to assist in returning the individual to a community setting as quickly as possible, consistent with the individuals needs and safety.

5. Individual Treatment Plans will include a Crisis Response Plan, which will provide relevant information and a plan of action in the event of a crisis.

B. Crisis Intervention Services

1. Add eighteen (18) DDD diversion beds to serve people with developmental disabilities and mental illness in the five counties with the highest state hospital utilization (Clark, King, Pierce, Spokane, and Thurston). These diversion beds would be voluntary and for short-term use with maximum length of stay criteria. Involve residential providers in the treatment planning while person is in diversion.

2. Enhance ability of local crisis prevention and response systems to respond to emergencies by providing DD specialist to selected Regional Support Networks.
Explore replication of successful crisis intervention models.

3. Regional Field Service staff will coordinate access to diversion resources, including respite availability and technical assistance and maintain a current list of trained specialists to go into a home or agency to provide temporary support.

4. Support development of two new crisis triage centers, one in eastern Washington and one in southwest Washington.

5. Evaluate local crisis and triage response and determine reasonable response.

C. Expand Residential and Day Program Capacity for People with Developmental Disabilities and Mental Illness

1. Provide funding to serve 70 individuals in this population in intensive tenant support (ITS) services in the community. Funding will include a vocational program or an appropriate day program, depending upon the recommendation of their multi-disciplinary team. These placements would be further defined in the following two groups:

   - Pre-admission Placements: these would be voluntary, long-term placements for individuals diverted from state hospitals through various diversion strategies.

   - Mental Health Outplacements: these would be voluntary, long-term placements for individuals coming out of state hospitals or similar secure setting.

2. Review day service programs for people in this population.

3. Increase funding in DDD Field Services for resource development and implementation support for the transition from hospitalization or diversion to community placement.

4. Determine and implement appropriate case management caseload capacity.

D. Training

1. Increase technical assistance capacity within DDD and MHD to provide training to families, residential providers, vocational/employment providers, DDD and MHD staff, criminal justice staff, CMHC staff, and Evaluation and Treatment Centers (E&T). It is an expectation that staff who work with people in this population will be trained in the following areas:

   - Positive behavior support
   - Functional assessment
   - Dual diagnosis: developmental disabilities and mental illness
   - Psychoactive medications
   - De-escalation techniques
   - Physical/manual interventions without restraints
   - Community protection issues
   - Sexual Inappropriate treatment issues
   - Communication skills
   - Avoiding power struggles
   - Choices versus directives
   - Victimization of people with developmental disabilities
   - Stress management and self-care for residential providers
   - Other training as agreed to by The Monitoring Committee and DSHS

2. Develop a process for allocating technical assistance dollars in DDD and MHD equitably among regions and a method for prioritizing training for targeted populations.

E. Medication Evaluation and Management

1. In consultation with a psychiatrist, increase community capacity to provide medication monitoring to people in this population by adding more registered nurse practitioners (ARNP) with psychiatrist supervision.

2. In consultation with a psychiatrist, increase DDD contracts with ARNPs to monitor medication with psychiatrist supervision.

PHASE 3 – SPECIALIZED STABILIZATION PROGRAM FOR INDIVIDUALS WITH DEVELOPMENTAL DISABILITIES

Phase 3 introduces a new model that proposes to serve individuals in this population in specialized secure settings as an alternative to state hospitals. Individuals will at times continue to be detained under Chapter 71.05 RCW, the Involuntary Treatment Act. People with developmental disabilities will receive 72 hour and 14 day treatment in psychiatric hospitals and evaluation and treatment facilities. Long-term involuntary commitments for 90 and 180 days will be transferred to specialized DDD settings.

The DDD residential treatment settings for short-term crisis and stabilization or longer treatment, as appropriate, will have the ability to hold people involuntarily.

Phase 3 implementation runs concurrent with Phase 2. People with developmental disabilities at the state hospitals begin moving to DDD Residential Stabilization/Treatment settings in November 2000. By the end of Phase 3 implementation, the only individuals with developmental disabilities who will continue to be served at the state hospitals are legal offenders detained under RCW 10.77 and those individuals detained for 72 hour and 14 day treatment. A small number of individuals who require confinement in a secure setting due to their status as legal offenders will always remain at the state hospitals. An implementation plan for Phase 3 will be developed and reviewed by the Monitoring Committee and Cross-System Committee prior to November 1, 2000.

Impact on State Hospital Census:
The population of individuals with developmental disabilities at the state hospitals declines to approximately 10 by December 2000. Individuals with developmental disabilities and mental illness will receive 72 hour and 14 day treatment in psychiatric hospitals and evaluation and treatment facilities. The remaining population of people with developmental disabilities would be individuals detained under RCW 10.77, estimated to be ten or fewer individuals.

PROGRAM MODEL

Following is a brief description of the DDD Residential Stabilization/Treatment setting model.

Description of DDD Residential Stabilization/Treatment Settings

Populations served: All individuals with developmental disabilities and mental illness detained under RCW 71.05

Operated by: DDD

Site Configuration: Typically 12-bed site, separated into two six-bed units, located in eastern and western Washington

Provide living arrangements and staffing patterns for adequate protection from physical and psychological harm and freedom from restraint. Programming within the sites will allow for smaller treatment programs, such as two 6-person units.

Structure:

Secure with door/window alarms, fencing; single bedrooms, kitchen, dining room, laundry room, therapy rooms, quiet room, day rooms, outdoor recreation area

Program Emphasis for Short Term Crisis and Stabilization:

- Establish clear entry and exist criteria
- For individuals who present recurring behavioral concerns, develop behavior management and positive behavior support plans based on functional assessments
- Use therapy and teaching methods appropriate for people with limited cognitive skills and chronic problems of impulse control
- Use of objective data collection
- Involvement of family members and community care providers in the treatment plan
- Medication evaluation and management

Program Emphasis for Longer Residential Treatment (Greater than 90 Days):

- Establish clear exit criteria
- Heavy focus on habilitation and individualized treatment
- Individual habilitation/treatment plan objectives, associated therapies and training programs based on comprehensive functional assessments

- Involvement of family members and community care providers in the treatment plan
- Separate sexual behavior unit with focus on sex offender issues and therapy

COST ESTIMATES OF PHASES

PHASE 1
(Now through 6/30/00)

I. PREVENTING HOSPITALIZATION - WITHIN EXISTING RESOURCES

I.A. Collaboration

I.A. 2. Western State Hospital: 4 DDD STAFF (Regions 3,4,5,6), 1 DDD & 1 MHD headquarters staff, 2 WSH staff and 9 RSN staff - cost out staff time and travel for 4 meetings/year @ 2 hours each.

17 staff @ $50 each for 4 meetings = $3,400 ($6,630 GF-S) annually. The finance team recommends teleconferencing @ the 2 state hospitals, which would significantly reduce these costs.

Eastern State Hospital: 2 DDD staff (Regions 1,2), 1 DDD & 1 MHD headquarters staff, 1 ESH staff and 6 RSN staff - cost out staff time and travel for 4 meetings/year @ 3 hours each.

11 staff @ $50 each for 4 meetings = $2,200 ($1,430 GF-S) annually. The finance team recommends teleconferencing @ the 2 state hospitals, which would significantly reduce these costs.

I.A. 3. Quarterly Network Meetings: 2 DDD staff & 2 MHD/RSN staff per region (plus CMHC staff, as appropriate) - cost out staff time and travel for 4 meetings/year @ 3 hours each.

4 staff x 6 regions x 4 meetings x $50 travel = $4,800 ($3,120 GF-S) annually.

I.B. Training

I.B. 2. Cost out staff time (use Psych 5) and travel for 20 hour/month each from DDD & MHD (statewide total).

2 Psych 5 staff @ $36.82/hr x 20 hours x 12 months, plus 2 staff x 12 months x $50 travel = $18,874 ($12,268 GF-S) annually.

I.C. Crisis Prevention: Functional Assessments and Positive Behavior Support Plans

I.C. 1. Cost out staff time (use Psych 5) and travel for 8 hours/month from FHMC and 16 hours/mo. each from Fircrest, Lakeland Village and Rainier.

1 Psych 5 staff @ $36.82/hr x 8 hours x 12 months, plus 3 Psych 5 staff @ $36.82/hr x 16 hours x 12 months, plus 4 staff x 12 months x $50 travel = $27,143 ($17,643 GF-S) annually.

I.D. Crisis Intervention Services

I.D. 1. Cost out existing respite beds @ full capacity. **Respite stays at ICF/MRs can be for 30 days. Respite stays at NFs can be for 14 days. There are a total of 26 designated RHC respite beds.**

a. Fircrest: 2 respite beds @ $406.34/day x 365 days = $296,628 ($142,382 GF-S) annually.

b. Lakeland: 2 respite beds @ $369.22/day x 365 days = $269,531 ($129,375 GF-S) annually.

Total for 4 respite beds = $566,159 ($271,757 GF-S) annually.

NOTE: Fircrest states that when new people are admitted in respite, they always use 1:1 staffing minimum for the first 2-3 days until it is determined that regular staffing levels are sufficient. Only the current average daily rate for each facility was used in the above cost estimates.

I.E. Medication Evaluation and Management

I.E. 1. a. RHC psychiatrist/physicians
Cost out staff time for 20 hours/month (combined RHC statewide total).

20 hours x $64.34 Psychiatrist 2 Range 87-K **x 12 months = $15,442 ($10,037 GF-S).**

I.E. 1.b. State hospital psychiatrists
Western State Hospital: cost out staff time for 40 hours/month.

40 hours x $64.34 Psychiatrist 2 Range 87-K **x 12 months = $30,000.**

Eastern State Hospital: cost out staff time for 20 hours/month.

20 hours x $64.34 Psychiatrist 2 Range 87-K **x 12 months = $16,000.**

I.E. 2. Increase DDD contracts with registered nurse practitioners (ARNP) to monitor medications.
Cost out 10 hours/month per 6 regions (720 hours/year total) @ $60/hour.

10 hours x 12 months x 6 regions x $60 = $43,200 ($28,080 GF-S) annually.

I.F DURING HOSPITALIZATION AT PSYCHIATRIC STATE HOSPITALS

I.F.1a Cost out current ward operation at Western State Hospital.

WSH ward costs = $1,890,408 ($850,684 GF-S) annually.

I.F.1b Cost out expanded habilitation program for individuals with developmental disabilities residing at WSH. (Department enhancement)

Ward enhancement - Total cost beginning April 1, 2000 thru June 2001 = $699,564 (GF-S funds)

I.F.6 Cost out day program to serve DDD individuals at Eastern State Hospital.

4 FTEs @ $169,866 plus 15% indirect = $195,346 ($126, 975 GF-S) annually.

I.G PROGRAM OVERSIGHT

I.G Cost out consultants time (5 total) for program monitoring and oversight.

First year six visits (every two months) total - 2nd and 3rd year quarterly sight visits annually.

a. February 1, 2000 – June 30, 2000 = $25,000 (GF-S funds)
b. July 1, 2001 – June 30, 2003 = $200,000 (GF-S funds)

PHASE 2 – WITH ADDITIONAL RESOURCES
(Begins 7/1/00))

II. PROMOTING GOOD CARE TO PREVENT HOSPITALIZATION

II.A Crisis Prevention: Functional Assessments and Positive Behavior Support Plans

II.A 2. Cost out 3 hours/month per region @ $60/hour + 25% per diem and travel expenses.

3 hours x 12 months x 6 regions x $60 hours x 25% for travel expense = $16,200 ($10,530 GF-S) annually.

II.A 3. Cost out 5.0 FTE (use Psych 5).

5 Psychologists 5s @ $75,795 = $378,975 ($246, 334 GF-S) annually (doesn't include goods/services, travel, equipment, rents, etc.)

II.B Crisis Intervention Services

II.B 1. Cost out 18 diversion beds statewide.

18 beds x 365 days x $170, plus 18 beds x 12 months x $200 retainer fee = $1,160,100 GF-State funds annually.

II.B 2. Cost out specialized DD services to enhance RSNs crisis prevention and response service

Varying rate between $25,000 - $50,000 x 6 regions = $225,000 (GF-S funds)

II.C Diversify Models of Residential Settings and Expand Capacity

II.C. 1. Cost out 70 people in ITS phased in over two years beginning 7/1/00.

70 people @ $254 residential daily rate, $23 day program, $25 therapies phased in over 2 years. Includes one time $2500 start-up per individual, $5 per day for technical assistance/residential evaluations, and staffing at 50:1. First year cost = $2,169,114 ($1,117,452 GF-S). 2001-2003 bow-wave cost = $14.0M ($7.0M GF-S).

II.C. 2. Review of class members. Cost out day training for this population.

10 individuals @$536/mo x 12 = $64,320 ($31,517 GF-S) annually

II.C. 3. Cost out 1.0 Case Resource Manager FTE per Region for resource development.

1.0 FTE (Range 48-K) @ $72,074 (Includes rent, supplies, equipment, travel) x 6 regions = $432,444 ($281,089 GF-S) annually. (6 FTEs)

II.C. 4 Cost out 6.0 Case Resource Manager FTE for intensive case management specifically for individuals with developmental disabilities and/or mental illness and dangerous behaviors, for 6 regions phased in over 29 months.

Average new FTE cost is $73,796 ($47,902 GF-S)
Total cost of phasing in 6FTE's from February 1, 2000 to June 2001 is $317,055 ($202,673 GF-S)

II.D. Training

1. Cost out 24 hours/month per region @ $60/hour + 25% per diem and travel expenses.

24 hours x 12 months x 6 regions x $60 x 25% for travel expense = $129,600 ($84,240 GF-S) annually.

II.E. Medication Evaluation and Management

II.E. 1. Cost out 5.0 FTE (statewide total).

5 RN2s (Range 50-N) @ $62,162/year (plus 5 staff x 12 months x $200 travel = $322,810 ($158,177 GF-S) annually.

II.E 2. Cost out 100 hours/month per region @$60/hour.

12 months x 100 hours x 6 regions x $60 = $432,000 ($280,800 GF-S) annually. (assumes travel included)

PHASE 3
(11/1/00 – onward)

III.A DD Residential Stabilization/Treatment Settings

III.A 1. Develop and phase in an alternative specialized residential stabilization/treatment setting for individuals with developmental disabilities.

State-Operated Stabilization Program in Community
12-bed units (36 beds total) $5,549,229 GF-State. (see attached spreadsheet)
2001-2003 bow-wave cost = $13,754,579 GF-S.

III.A 2. Cost out 0.5 attorney general FTE for legal support

0.5 FTE @75,000 ($48,750 GF-S) annually, including paralegal, .5 clerical support and overhead.

III.A 3. Cost out Court Costs.

Estimated @ $12,000 (GF-S) annually

STATE OF WASHINGTON

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

Mental Health Division • PO Box 45320 • Olympia WA 98504-5320 • (360) 902-8055

November 18, 1999

Mark Stroh, Executive Director
Washington Protection and Advocacy
180 West Dayton, Suite 102
Edmonds, Washington 98020

Dear Mr. Stroh:

This letter concerns the Mental Health Division's (MHD) and the Division of Developmental Disabilities' (DDD) plan to improve services to persons with developmental disabilities and mental illness. In addition, MHD and DDD intend to implement the plan for all members of the class as defined by the court. The letter also addresses a process for monitoring the implementation of the plan. Please see the enclosed full text of the plan. The collaborative plan is summarized as follows:

PHASE 1 – Improving Current Services and Building Collaboration

A major emphasis of Phase 1 is increasing collaboration among the key partners in both systems. This includes the Regional Support Network (RSN) liaisons, state hospital staff, and regional/local DDD and MHD staff. Increasing mutual understanding of both systems is key to strengthening the regional and local relationships to develop better coordination of services for individuals with developmental disabilities and mental health issues.

Phase 1 also addresses improvements in services at Western State Hospital (WSH). Major elements of the WSH improvements are the development of a habilitative mental health care program, creation of a specialized DD/MH treatment team, expansion of day, evening and weekend programming, and staff training. These improvements at WSH are projected to cost $700,000 in the 2000-2001 biennium. The department has agreed to cover the added cost of the improvements from current resources. In greater detail, the WSH plan is as follows:

1. Develop a Habilitative Mental Health Care Program

   WSH will concentrate DD patients on two wards - one 21-bed ward made up primarily of male patients and one ward that has both MH and DD patients. This will facilitate habilitative programming appropriate to the population.

2. Create Specialized DD Treatment Team

   Develop an inter-disciplinary DD treatment team to include: Ph.D. Program Manager, DD/MH Psychiatrist, DD Psychologist and Social Worker.

   Provide consulting psychiatrist who has expertise in both developmental disabilities and mental health to review treatment and advise WSH psychiatric staff.

ATTACHMENT 2

3. Expand Day Program and Evening and Weekend Program

Expand hours of day program to six hours per day to include skill development in areas such as anger management, social interaction, activities of daily living, pre-vocational training and vocational experience, including work enclaves.

Expand weekend and evening program to include supportive counseling, coping skills and relaxation training, appropriate sexual behavior training and recreation activities.

Individuals will have the opportunity, when clinically appropriate, to participate in all activities, which are part of the hospital milieu.

4. Training

All staff who have, as their primary responsibility, working with people in this population will complete training requirements established in the hospital training plan.

Training will include but will not be limited to:

a. the development and implementation of treatment plans for individuals with developmental disabilities
b. the development of and implementation of positive behavioral supports
c. recognition and reporting of abuse and neglect;
d. medication use including benefits and risks, side effects, appropriate use of prns
e. seclusion and restraint policies and alternatives
f. basic counseling skills
g. crisis prevention, intervention, management
h. data collection, and
i. CPR and first aid

5. All people will have individual behavioral support plans, developed with consultation from experts in positive behavioral support and implemented immediately upon completion.

6. Accurate, consistent, objective data will be collected and monitored to evaluate the effectiveness of treatment and behavioral support plans.

7. A cooperative process shall be developed between DDD and MHD regarding the sharing of relevant information when an individual is admitted to WSH.

8. All individuals and their guardians shall be invited to participate in the treatment planning process

PHASE 1 – Oversight

An interim monitoring committee will be established to monitor implementation of Phase 1. The department will cover the cost of this interim committee. A cross-system committee will also be established under Phase 1 to facilitate implementation and monitoring. For a detailed description and monitoring schedule, see **PROGRAM OVERSIGHT**.

PHASE 2 – Building a Community Infrastructure (contingent upon legislative approval and funding)

Phase 2 builds upon Phase 1 by developing a community infrastructure that infuses significantly more diversion and placement capacity into a habilitative mental health care model. The major emphasis of Phase 2 is implementation of a variety of strategies aimed at diverting individuals in this population from psychiatric hospitalization. Phase 2 proposes increased contracting for technical assistance and medication evaluation and monitoring, as well as the addition of psychologists and/or behavioral specialists in DDD Field Services. Recommendations for eighteen (18) diversion beds and expanded community placement for 70 individuals are also included. Improvements implemented in Phase 1 continue. Phase 2 implementation begins July 1, 2000 contingent upon legislative approval and funding. An implementation plan for Phase 2 will be developed and reviewed prior to July 1, 2000.

Phase 2 provides for an increase in several key services such as crisis prevention, behavioral support and technical assistance, respite bed capacity and medication evaluation and management. Phase 2 also provides a solution to a long-standing problem - individuals who lack funds for residential placement end up staying at the state hospitals for longer periods of time and beyond the point they are determined psychiatrically stable. Expanded community placement capacity will provide funds in advance for people coming out of the hospitals.

PHASE 3 – Specialized Stabilization Program (contingent upon legislative approval and funding)

Phase 3 introduces a new model that proposes to serve individuals in this population in specialized, secure settings as an alternative to state hospitals. Individuals will at times continue to be detained under Chapter 71.05 RCW, the Involuntary Treatment Act. People with developmental disabilities will receive 72-hour and 14-day treatment in psychiatric hospitals and evaluation and treatment facilities. Long-term involuntary commitments for 90 and 180 days will be transferred to specialized DDD settings.

The DDD residential treatment settings for short-term crisis and stabilization or longer treatment, as appropriate, will have the ability to hold people involuntarily.

Phase 3 implementation runs concurrent with Phase 2. People with developmental disabilities at the state hospitals begin moving to DDD residential stabilization/treatment settings in November 2000. By the end of Phase 3 implementation (November 2001), the only individuals with developmental disabilities who will continue to be served at the state hospitals are legal offenders detained under RCW 10.77 and those individuals detained for 72-hour and 14-day treatment. A small number of individuals who require

confinement in a secure setting due to their status as legal offenders will always remain at the state hospitals. An implementation plan for Phase 3 will be developed and reviewed prior to November 1, 2000.

PROGRAM OVERSIGHT

A Monitoring Committee will be established to monitor the implementation of this plan. The Washington Protection and Advocacy System (WPAS) and the Department of Social and Health Services (DSHS) will agree upon the composition of this committee. DDD and MHD will provide staff support. The Monitoring Committee will provide recommendations for implementation of the plan and will review materials and reports produced by a Cross-System Committee, which will be described below. The Monitoring Committee will meet every two months for the first year and quarterly for three years following the implementation of Phase 3. This time period is from January 2000 through December 2003. Special meetings may occur with the agreement of WPAS and DSHS. At the end of this period, the Monitoring Committee may make recommendations for a further extension.

The Monitoring Committee shall provide accountability for the implementation of this plan and shall provide recommendations for systemic changes. The Monitoring Committee will provide recommendations to the Cross-System Committee.

DDD and MHD will consider all requests for information made by the monitoring committee and will provide the information unless it is not reasonably available or unless producing the requested information would be cost prohibitive.

Additionally, the responsibilities of the Monitoring Committee will include:

a. Review the implementation plan and instructional materials to be used by staff serving people in this population.
b. Review the appropriateness and implementation of the treatment recommendations for a sample of people in this population. The Monitoring Committee will determine the sample.
c. Review the reports of the Cross-System Committee relating to cases of suspected abuse and neglect and incident reports. The Monitoring Committee shall have authority to receive and review all such reports and cases, within legal confidentiality rights.
d. The Chairperson of the Monitoring Committee shall bring to the attention of all parties, information concerning suspected non-compliance with this plan.

INTERAGENCY COOPERATION

Cross-System Committee

A Cross-System Committee will be established which is made up of representatives from MHD, DDD, Regional Support Networks (RSNs) and contracted providers of mental health or developmental disabilities services. The directors of DDD and MHD will chair this committee. This committee will promote cross-system collaboration so as to improve the quality and availability of services for people in this population. The committee shall be responsible for delegation of tasks and duties and the development of policies, procedures and protocols necessary for the implementation of this plan and shall

report to the Monitoring Committee in fulfilling this responsibility. This committee has the following major purposes:

- Ensure that mental health and developmental disabilities staff are working together cooperatively to provide services to people in this population,
- Report to the Monitoring Committee regarding the implementation and respond to the Monitoring Committee's recommendations and advice,
- Create a statewide training plan for those who work with people in this population, and
- Initiate a continuous quality improvement process.

Mental Health and DDD shall make a good faith effort to reach a cross-system agreement that includes all RSNs that serve people in this population.

The Cross-System Committee will look at the following provisions:

Address access to services such as the following:

1. vocational and other day services as appropriate
2. crisis prevention and response services, including philosophy and practices
3. emergency placement respite services for people in this population
4. housing and housing support, including pre-screening and intakes
5. medication and medication management
6. personal services
7. transportation
8. hospitalization
9. medical and dental service
10. mental health treatment
11. sexual offender treatment
12. positive behavior support, including concepts and practices
13. case management
14. family support
15. treatment for criminal offenders
16. sex education
17. substance abuse/chemical dependency services

A plan for ensuring that incidents of abuse, neglect, abandonment and exploitation are reported as required by law. This will include training as outlined in the statewide training plan.

DSHS will bear the reasonable and necessary expenses of the Monitoring Committee within budgetary constraints.

The schedule for the monitoring committee is as follows:

Interim Monitoring

1. February 2000 site visit by Dr. Fahs and Dr. Gardner
2. March 2000 teleconference with either Dr. Fahs or Dr. Gardner and representatives of the Cross-System Committee
3. April 2000 site visit by Dr. Fahs

Monitoring Committee

4. July 2000 regular monitoring schedule begins. (See enclosed plan). If defendants do not have the funds for the full monitoring plan, continue with above plan and seek funding for the full monitoring committee as agreed upon by WPAS and DSHS.

Monitoring includes submitting regular monthly reports to plaintiffs and defendant's counsel from the Monitoring Committee and the Cross-System Committee.

We want to assure WPAS that we intend to make a good faith effort to accomplish the collaborative plan and to keep WPAS informed of progress toward this goal.

Sincerely,

Pat Terry, ACSW, Ph.D., Acting Director
Mental Health Division

TIMOTHY R. BROWN, Ph.D., Director
Division of Developmental Disabilities

Enclosure

cc: Ed Dee, Assistant Attorney General
Terry Ryan, Assistant Attorney General

car

United States District Court
for the
Western District of Washington
December 2, 1999

* * MAILING CERTIFICATE OF CLERK * *

Re: 3:99-cv-05018

True and correct copies of the attached were mailed by the clerk to the following:

Deborah A Dorfman, Esq.
WASHINGTON PROTECTION & ADVOCACY SYSTEM
STE 102
180 W DAYTON
EDMONDS, WA 98020
FAX 425-776-0601

Michael Jay Smith, Esq.
WASHINGTON PROTECTION & ADVOCACY SYSTEM
STE 102
180 W DAYTON
EDMONDS, WA 98020
FAX 1-425-776-0601

Elizabeth A Stanhope, Esq.
WASHINGTON PROTECTION & ADVOCACY SYSTEM
STE 102
180 W DAYTON
EDMONDS, WA 98020

Robert B. Denton, Esq.
STE 410
455 EAST 400 SOUTH
SALT LAKE CITY, UT 84111

John Hitchcock Parnass, Esq.
DAVIS WRIGHT TREMAINE LLP
STE 2600
1501 4TH AVE
SEATTLE, WA 98101-1688
206-622-3150

Michele Earl Hubbard, Esq.
DAVIS WRIGHT TREMAINE LLP
STE 2600
1501 4TH AVE
SEATTLE, WA 98101-1688
206-628-7636

Susan L Pierini, Esq.

ATTORNEY GENERAL'S OFFICE
SOCIAL & HEALTH SERVICES
PO BOX 40124
OLYMPIA, WA 98504-0124

JoAnn Sabol, Esq.
ATTORNEY GENERAL'S OFFICE
SOCIAL & HEALTH SERVICES
PO BOX 40124
OLYMPIA, WA 98504-0124
FAX 1-360-407-0433

Judge Bryan