Mental Health Inpatient & Residential Bed Capacity

Presentation to the Joint Executive Legislative Task Force on Mental Health Services & Funding

July 27, 2004

Wayne Kawakami, OFM

Fara Daun, SCS

ESHB 2459 Section 714: Proviso

"The joint task force shall assess and make recommendations related to:

(f) The types, numbers, and locations of inpatient psychiatric hospital and community residential beds in both the private and public sector."

Bed Issue Approach

- Mental Health Joint Task Force staff are coordinating with a DSHS workgroup and a stakeholder group.
  (Attachment A)
- Significant issues that the recommendations need to address include:
  - How does the current system work?
  - What are the critical system capacity issues, particularly the community hospitals and residential beds?
  - What is the right mix of services to best meet demands?
  - How can system improvements be effectively implemented?

Work Plan

- July - Establish background and context to the mental health bed environment.
- August – Identify significant risks, issues, capacities and location of beds.
- September – Identify significant psychiatric bed capacity and funding needs.
- October/November – Identify options and preliminary recommendations

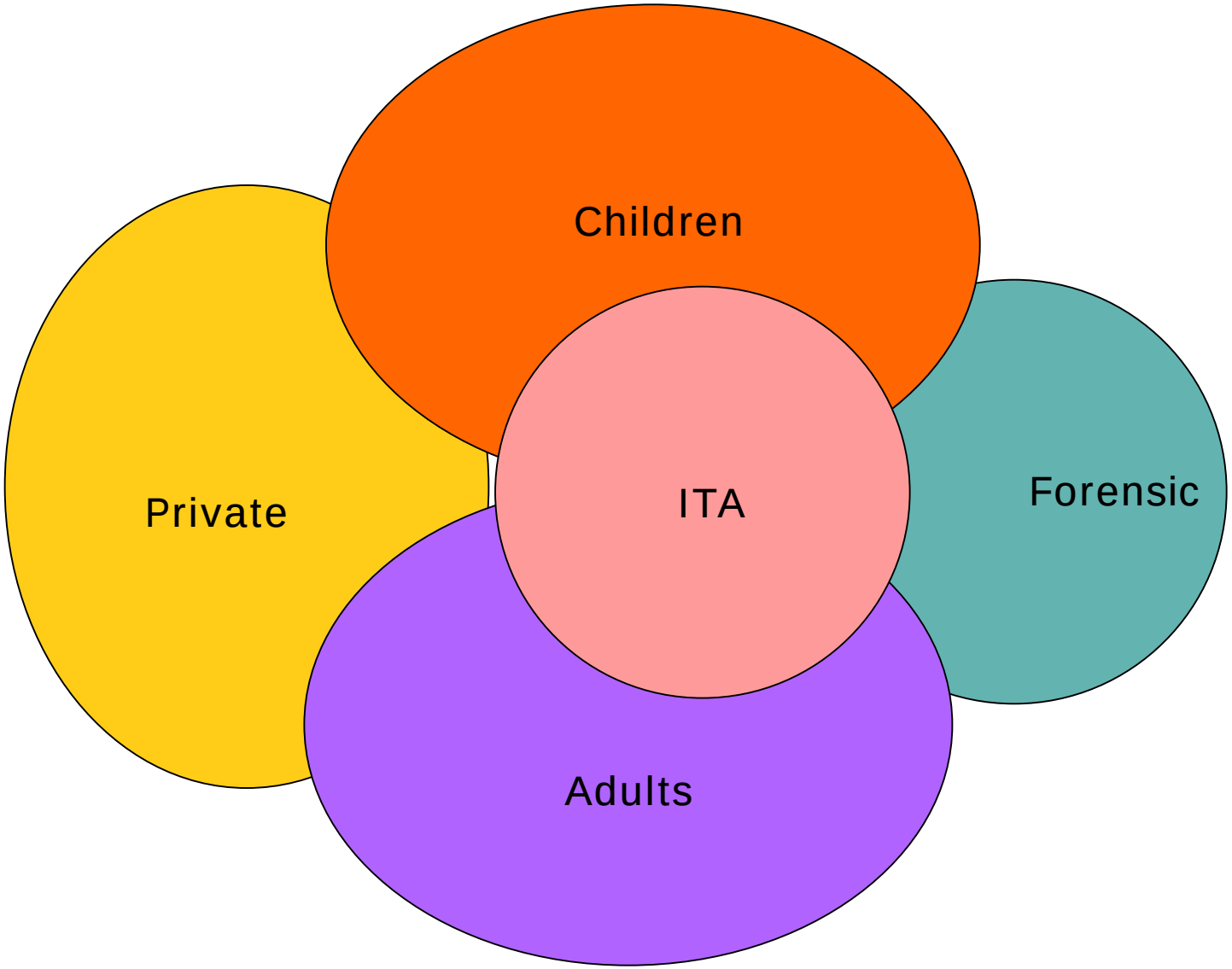
Today's Agenda for Psychiatric and Residential Beds

- Provide a framework to understand the primary system flows and interactions.

- Review the three interrelated psychiatric and residential bed systems:
  - Adult Mental Health
  - Children's Mental Health
  - Forensic Beds

  Attachment B outlines the components of these systems

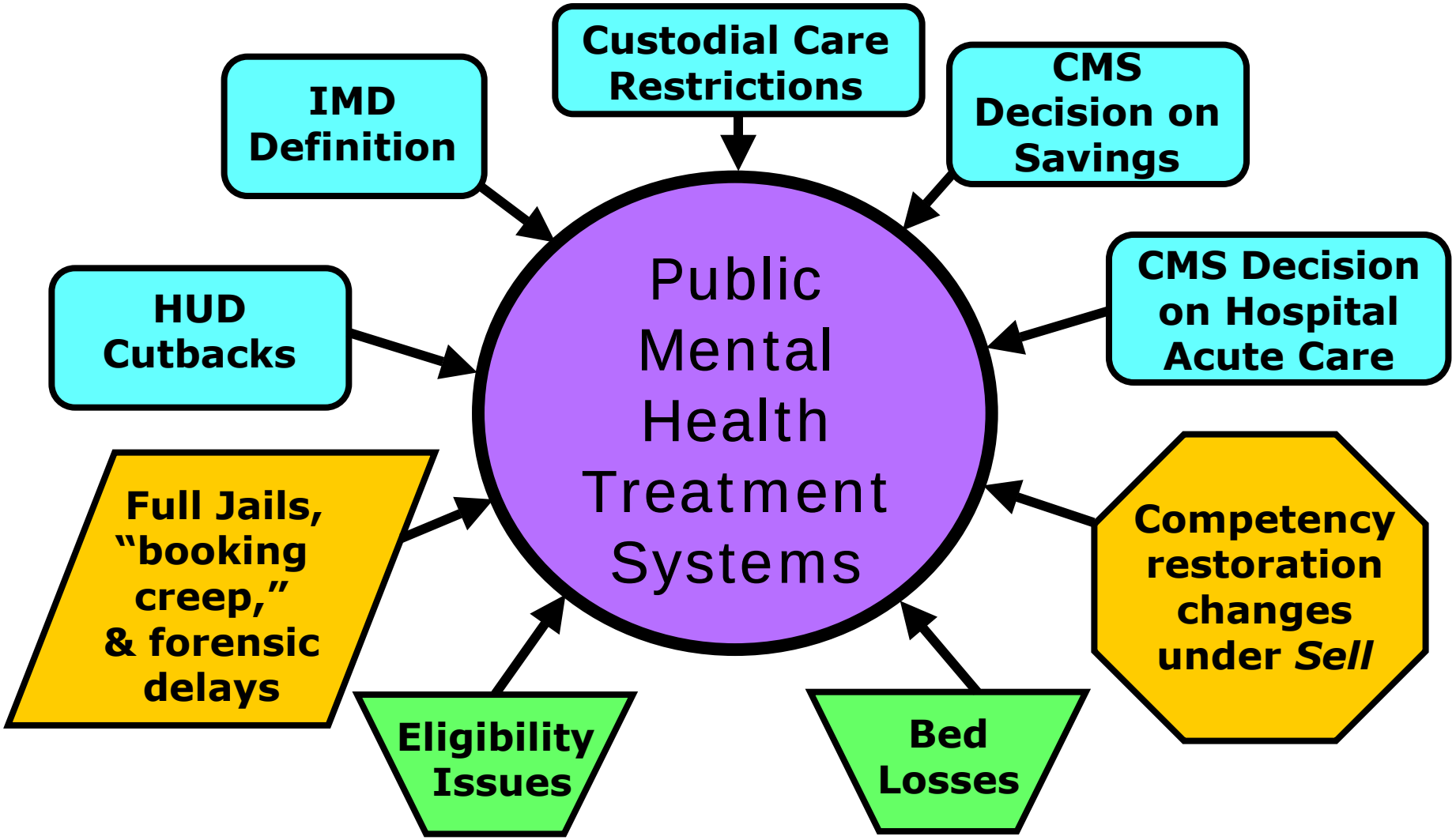
Washington Mental Health Systems



Mental Health System Discussion

- For each of the systems, identify the primary flows that include:
  - Entry points and access issues
  - Types of beds
  - Discharge and release points
  - System overlaps
  - Significant Challenges

Current Pressures and Impacts



Adult Mental Health

Adult Mental Health
Inpatient and Residential Services

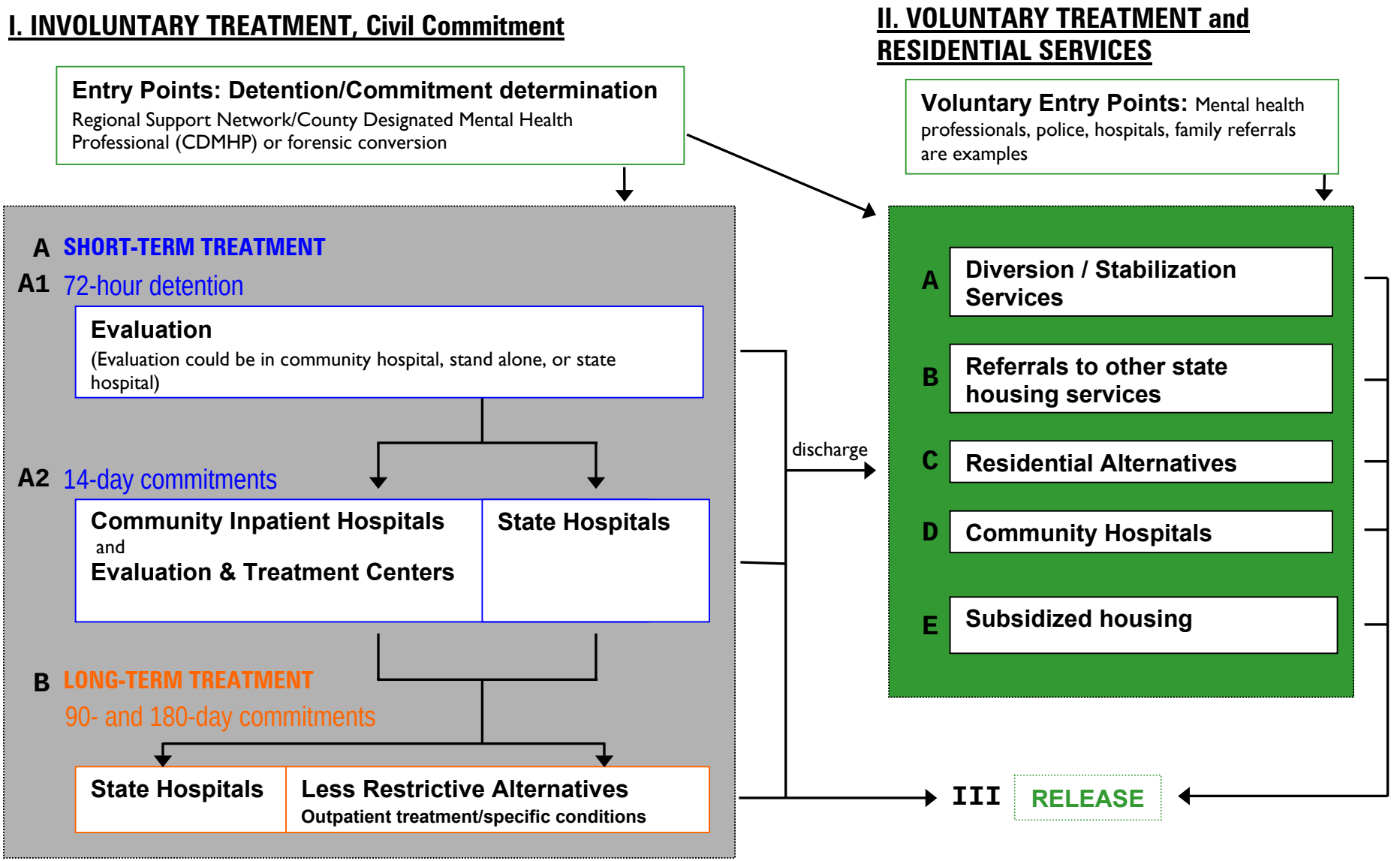
- In September, 2002, the Public Consulting Group studied inpatient and residential services. Examples of major findings from this report include:
  - State hospital records reveal a severe shortage of appropriate community residential referral alternatives.
  - There is a diminishing access to inpatient community hospital psychiatric beds to serve RSN consumers.
  - The lack of appropriate community residential alternatives results in a growing and unnecessary use of state hospital beds.
- PCG is updating this study and plans to be complete in September 2004.

Adult Mental Health
Inpatient and Residential Services

- The adult mental health bed system is comprised of two components;
  - Involuntary treatment (civil commitment)
  - Voluntary treatment and residential services

Adult Inpatient and Residential Services

Primary Involuntary and Voluntary Process Flows



Adult Mental Health: Involuntary Treatment

Involuntary Treatment (Civil Commitment)

- The basic civil commitment entry criteria is any adult (over 18) who “as a result of a mental disorder:
  - presents a likelihood of serious harm
    or
  - is gravely disabled”

Involuntary Treatment

A majority of the involuntary referrals are from the CDMHP

- Involuntary System Entry Points:
  - County Designated Mental Health Professionals (CDMHP) perform the initial investigation and referral determinations.
  - In 2003, there were approximately 30,000 investigations conducted by CDMHPs.
  - A small population of referrals come as a result of forensic conversions.
  - In 2002, there were 297 community inpatient beds and 988 state hospital beds used by the regional support networks. Attachment C contains a summary of the locations.

Involuntary Treatment

Initial treatment can contain two short-term components

1. Short-Term 72-hour detention
   - Provides initial evaluation and stabilization services.
   - The age range is primarily 18-59 (77%) but a large proportion of detainees were over 60 (17%).
   - The most frequent diagnosis was schizophrenia, followed by bipolar disorder and depression that collectively represent about 36% of this population.

Involuntary Treatment

2. Short-Term 14-day commitment
   - After initial evaluation, if further treatment is appropriate, mental health professional petitions court for additional 14 day treatment.
   - The detainee diagnosis frequency of schizophrenia, bipolar, and depression are similar to the 72 hour population but has increased acuity or whose condition has not improved.

Involuntary Treatment

After short-term, long-term treatment for intensive or extended treatment

- Long-Term Treatment, 90-180 days
  - In FY 2003, 2,400 were admitted for long-term treatment.
  - In FY 2003, the most significant diagnosis for state hospitalizations, 27%, was schizophrenia.
  - Court order also allows a detainee under specific conditions, a less restrictive alternative in a community setting.

Adult Mental Health: Voluntary Treatment

Voluntary Treatment Residential Services

- There are a number of entry points to voluntary treatment.
  - Entry to voluntary treatment can be referrals from the community designated mental health professionals for those who do not meet the civil commitment criteria.
  - Other entry points to voluntary treatment include hospitals, police, medical and mental health professionals, self-referrals, and family members.
  - In 2002 there were 1,940 residential beds, including crisis respite beds. Attachment C contains a summary of the beds by location.

Voluntary Treatment & Services;

Residential services contain five primary components that varies across the state

1. Diversion / Stabilization
   - Adult Residential Rehabilitation Centers (ARRC) – Crisis Triage and crisis respite/stabilization facilities.
2. Referrals to other state services
   - Developmental Disability beds that include respite beds and long-term supported living residential beds
   - Long-term care facilities operated and funded through other agencies.
   - Drug and alcohol treatment facilities

Voluntary Treatment & Services

3. Residential Alternatives
   - **Skilled nursing facility**;

     Primarily a nursing home setting

   - **Boarding Home**; Includes congregate care facilities, assisted living facilities and large group homes.

   - **Adult family homes**

   Cont'd…

Voluntary Treatment & Services

3. Residential Alternatives (cont.)
   - **Adult Residential Rehabilitation Centers –** Long Term and Evaluation and Treatment facilities.
   - **Transitional Housing/Living Facility**
   - **Supported housing**; supported housing/living setting that provides a range of supports.

Voluntary Treatment & Services

4. Community Hospitals
   - In 2002, there were 297 beds for both involuntary and voluntary treatment.

5. Subsidized Housing
   - Primarily the federal “Section 8” housing grants

Adult Mental Health: System Challenges

There are three fundamental challenges to the adult systems

1. System capacity
    - Where are the critical demands?

2. Fiscal Pressures
    - Reimbursement rates to community hospital and residential beds.
    - Increasing Federal funding limitations
        - Institution of Mental Disease(IMD), Medicare, Section 8 housing, and Non-Medicaid.

There are three fundamental challenges to the adult systems

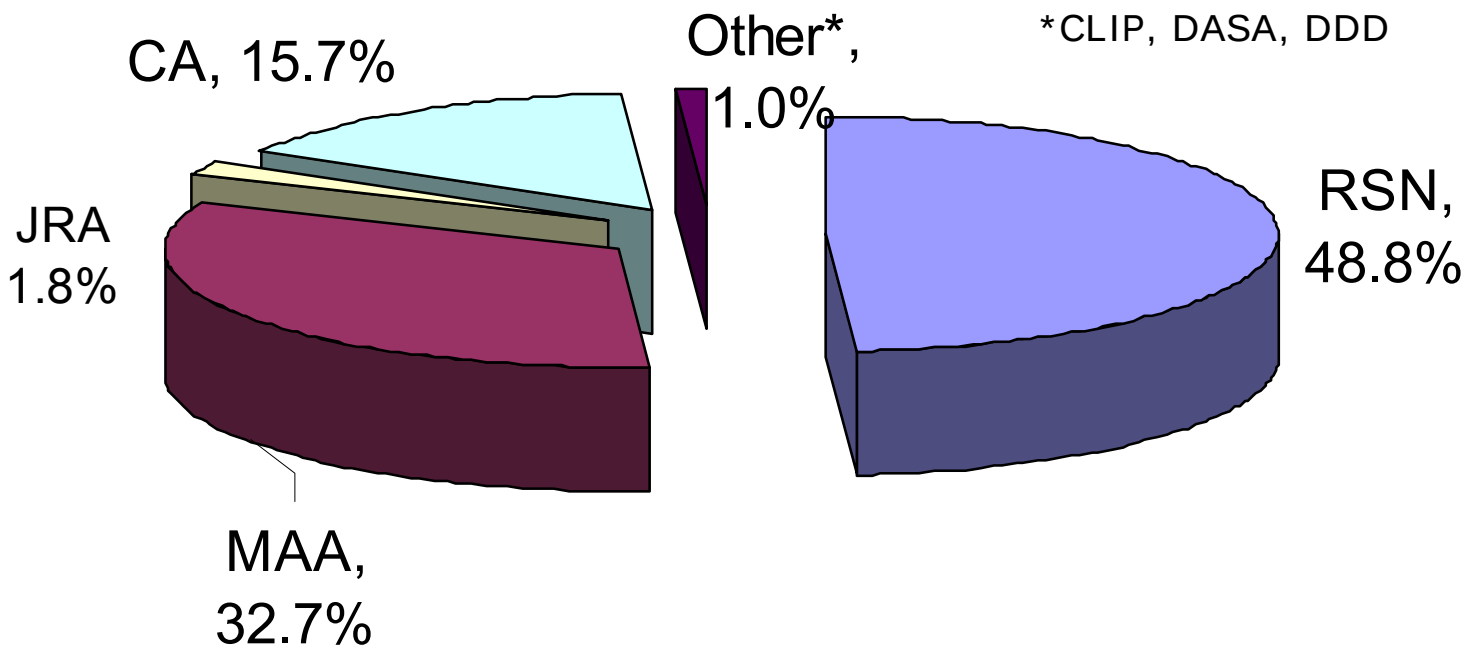
- Access barriers
  - Placements of people with the following:
    - Co-occurring disorders
    - Behavioral issues.
    - Aging and dementia
    - Medically intensive needs

Children's Mental Health

Children's Mental Health

- Voluntary Services
- Involuntary Treatment
- Acute Inpatient Treatment
- Long-Term Inpatient Placement
- Residential
- Special Issues with Children

Children's Mental Health Service Source



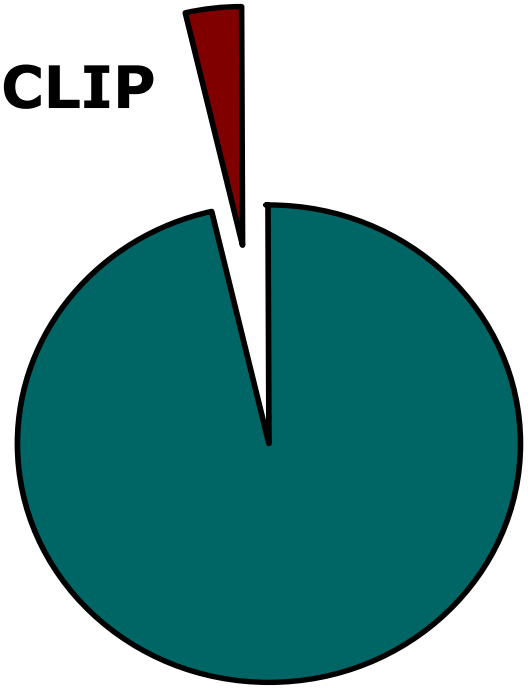
Children Receiving DSHS Mental Health Services in FY2000

JLARC, *Children's Mental Health Study,* August 2002

Medicaid Eligible Children Proportion of Inpatient & CLIP

Inpatient or CLIP Treatment as a Portion of Total Medicaid Eligible Children Treated

Inpatient & CLIP
(n=1,226)



Outpatient
(n=31,460)

July 2001-June 2002 Data

A Closer Look at the Slice

- Inpatient & CLIP Beds may be used for either voluntary or involuntary clients.
- Access to CLIP beds for voluntary clients follows centralized screening by the CLIP administration and a separate Medicaid approval. Strictly follows federal Medicaid necessity guidelines.

Children's Mental Health: Involuntary Treatment

Involuntary Treatment

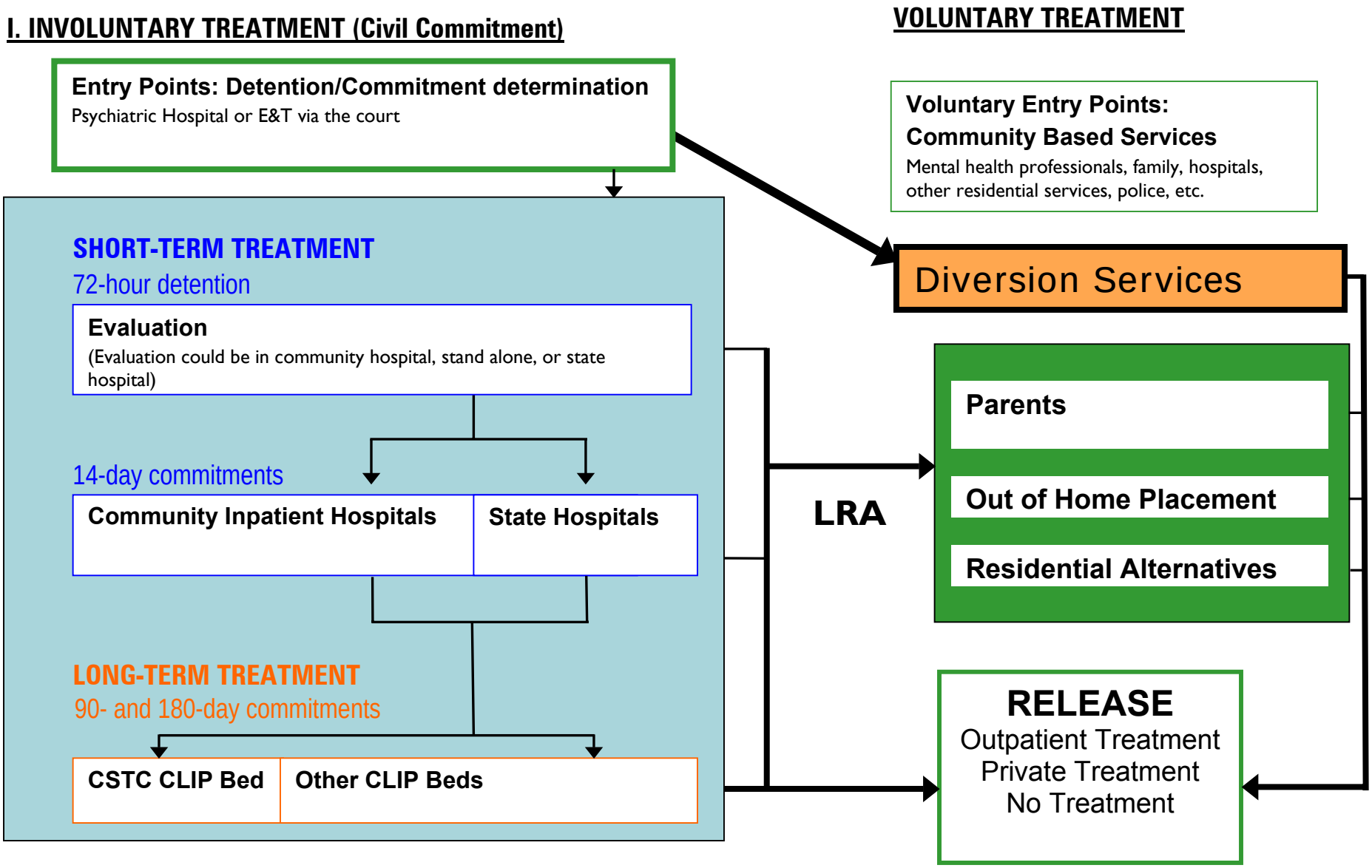
Standard for Involuntary Treatment

- Child has a Mental Disorder
- that causes
- a likelihood of serious harm or grave disability

RCW 71.34.050

- The standard is tested against constitutional requirements

Children's Civil Commitment Process



Children's Mental Health: Voluntary Treatment

Voluntary Treatment

- Voluntary Treatment Preferred
  - No Constitutional issues or court processes
  - Less expensive
- Includes Inpatient & Residential as well as outpatient
- Services may be provided through:
  - RSNs & Contractors
  - Residential Settings in Other Systems

Entry Points for Residential & Inpatient Treatment

The largest entry points are:

- Psychiatric Hospitals or E&T (29%)
- Family referral (24%)

Referral can also come from:

- The criminal justice system
- A different Social Service

Acute Inpatient Bed Availability for Publicly Funded Minors

Provider	Location	Number of beds
Children's Hospital	Seattle	15
*Fairfax Hospital**	*Kirkland*	*44 for children & teens*
Lourdes Counseling	Tri-Cities	10
Sacred Heart	Spokane	24
	STATEWIDE TOTAL	**93 Beds**

**Fairfax Hospital has been negotiating with DSHS to determine whether they can continue providing services based on the criteria set by their Board.*

Acute Inpatient Treatment

- Access is through the RSN
- Must meet access to care standards and medical necessity
- Inpatient placements are generally state-wide
  - Facility must have a child psychiatrist on staff (DOH has shown some flexibility)
  - Some Hospitals have refused to treat children and adolescents

Evaluation & Treatment Center Beds

2 Certified Stand Alone E&T Centers for Children

- Kitsap Mental Health—10 beds
  Serves Peninsula RSN
- West Seattle Psychiatric—2 beds
- Occasional 1-bed certifications

Crisis Respite Beds

- Purpose: To provide temporary respite while a crisis is resolved in order to prevent need for more intensive/expensive services
- A few small programs (2-3 beds)
  e.g., Kitsap Mental Health (2)
- Sometimes single bed in a crisis triage center

Long-Term Inpatient Placement (CLIP)

- Centralized Administration
- Access:

  RSN Screening (with DSHS)
  + Independent Medicaid determination

- Adhere strictly to Medicaid criteria

  Medical necessity
  Serious psychiatric illness
  No less restrictive setting appropriate
  Inpatient care is expected to result in improvement

- Which facility depends on:

  family
  treatment needs
  locations
  bed availability

Washington CLIP Beds

Provider	Location	Beds
(CSTC) Child Study & Treatment Center	Steilacoom (WSH)	47
McGraw	Seattle	19
Tamarack	Spokane	13
Pearl Street	Tacoma	12
	STATEWIDE TOTAL	**91**

Services Provided in CLIP beds

Core Services

- Education
- 24-hour Psychiatric & Nursing
- Chemical Dependency Svcs.
- Behavior Management
- Group/Individual Therapy
- Family Supports/Therapy
- Case Management
- Occupational & Physical Therapy
- Social Skills Development
- Recreational, Expressive & Leisure Therapy
- Brokering & Advocacy
- Community Consultation

Specialty Services

- Non-facility-based services by contract
- Some Private client capacity

CSTC Services

- Hospital level services
- Competency evaluation
- Competency restoration
- Some capacity for DD and sexually intrusive youth
- Close attention program
- Longitudinal Study of Early Onset Schizophrenia
- Dialectical Behavioral Therapy

Children's Residential Placements

- RSNs are not required to fund residential services
- Some RSNs co-fund some therapeutic foster care beds with Children's Administration
- Some RSNs provide supplemental services to other residential placements

Residential Beds: Children's Administration

Children's Admin. Funded Services

Type	Scale
Behavioral Rehabilitative Services (BRS)	~875 Children (Sept. 2003) 80% also have RSN contact in the same year
Children's Hospital Alternative Program (CHAP)	~75 Children served during Sept. 2003 (not bed days)
Totals	~950 Children (Sept. 2003) 47% in group care or staffed residential care 44% in treatment foster care 9% in home (own or relative placement)

Services for children in out-of-home placements or dependencies

Residential Beds: DASA Funded Services to Minors

- DASA provides residential treatment services to:
  - Children and adolescents
  - Pregnant & parenting girls
  - Young children of women in perinatal programs
- DASA provides limited onsite mental health treatment for children and adolescents with co-occurring disorders

Special Issues for Children

- Legal Custody

	Parental	State	Parent/State	Custody Change
Voluntary	58%	36%	5%	17%
ITA	75%	20%	5%	

- Co-Occurring Drug Use
- Majority of children in special education at time of admission.
- Age of Consent & Parent-Initiated Admission

Consent Related Issues

Age of Consent

(RCW 71.34.030 & 71.34.042)

Children may consent to treatment at 13

Parent-Initiated Treatment

(RCW 71.34.052 & 71.34.054)

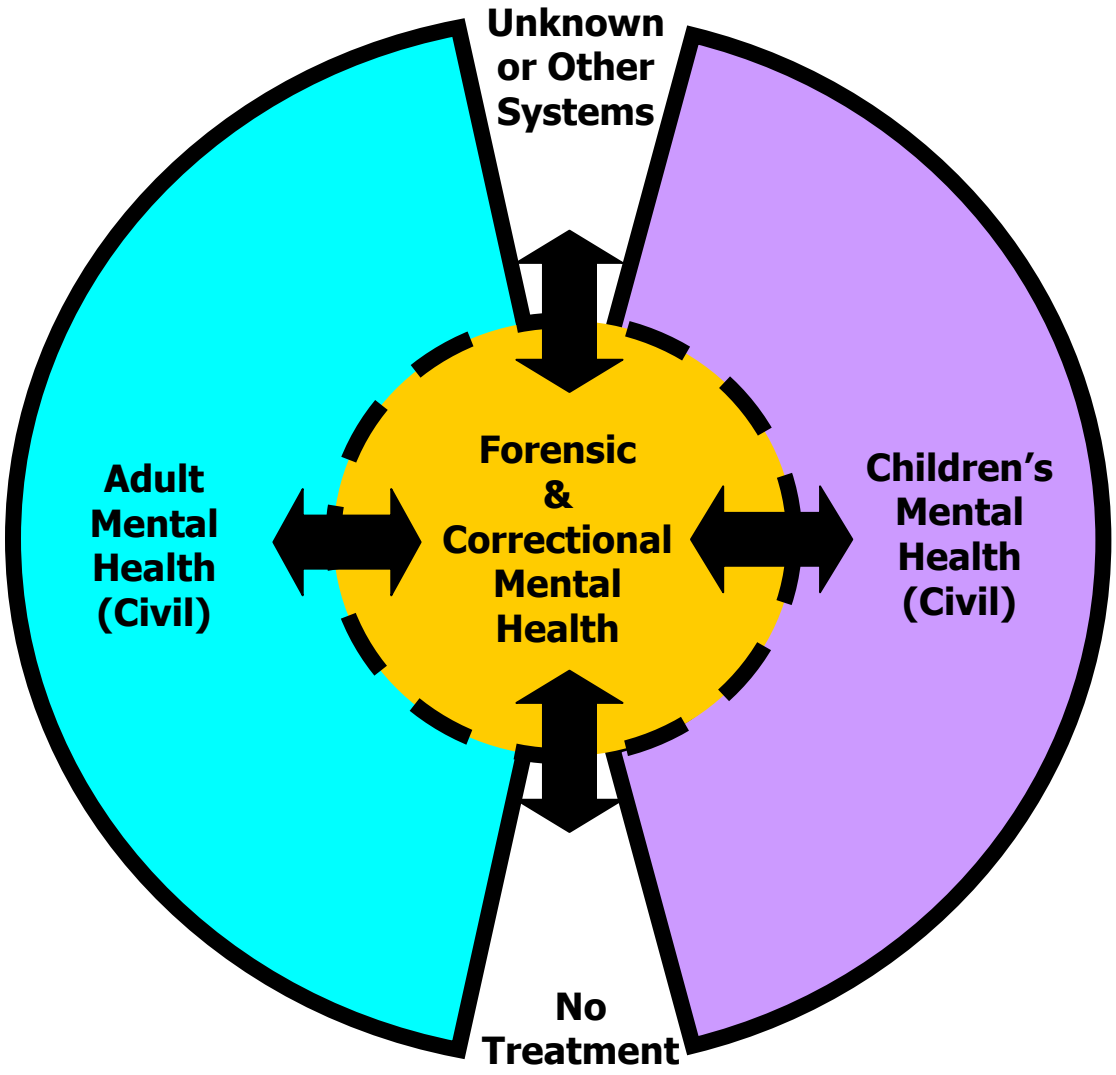
After a child reaches age 13,
parents have difficulty accessing mental health services for their children without their child's consent, despite the statutory provision that the child's consent is not necessary.

Summary Points

- There is a capacity shortage and an ongoing loss of residential and acute care beds
- Part of the loss of beds may be due to reimbursement rates
- Some facilities are not licensed to care for children
- Inability to effectively use the parent-initiated provisions to access services creates a barrier to service

Forensic & Correctional Mental Health

Civil & Criminal System Interaction



Terminology

- "**Forensic**" is being used to describe the competency evaluation and restoration process as well as those who have been found "Not Guilty by Reason of Insanity" and committed to Western or Eastern State Hospital

- "**Correctional**" is being used to describe the persons and services in jails & prisons

Why discuss forensic systems?

- State Hospitals impacted in both forensic and civil wards
- Full jails result in “booking creep” which more felony restorations with longer length of stay
- Longer length of stay clogs state hospital beds & creates waiting lists in jails, further pressuring jail capacity
- Failure to restore usually results in “forensic conversion” evaluation and civil commitment under 71.05 RCW
- Most of these offenders are not new to public mental health

Why discuss correctional systems?

- This represents a significant number of persons:
  - About 15% of jail inmates have an Axis I disorder & Jail ADP in December 2003 was 11,521 inmates = ~1725 offenders
  - About 12-15% of DOC population is seriously mentally ill & DOC population was 17,205 in June 2004 = ~2064-2581 offenders
- This is not a “new” population:
  - Most mentally ill offenders had contact with public mental health systems before incarceration
  - Most mentally ill offenders will continue to need public mental health services on release
  - Under the current system, Medicaid eligibility terminates while incarcerated and re-establishing eligibility delays needed treatments
- Mentally ill offenders often have complex cases that create residential placement challenges

Forensic Mental Health In the Adult System

Forensic Mental Health

- Competency to Stand Trial
  - Evaluation
  - Restoration
- Commitment after a finding of "Not Guilty By Reason of Insanity"

Competency To Stand Trial

Competency Components

- Constitutional Issues
  - Must be competent to stand trial
  - Speedy Trial Rights Implicated
- Evaluation
  - Outpatient (in jail or community)
  - Inpatient (state hospital)
  - Timelines
- Restoration
  - Timelines
  - Medication
  - Decompensation & re-restoration
- Failure to Restore
  - Dismissal
  - Referral to Civil Commitment

What is Competency?

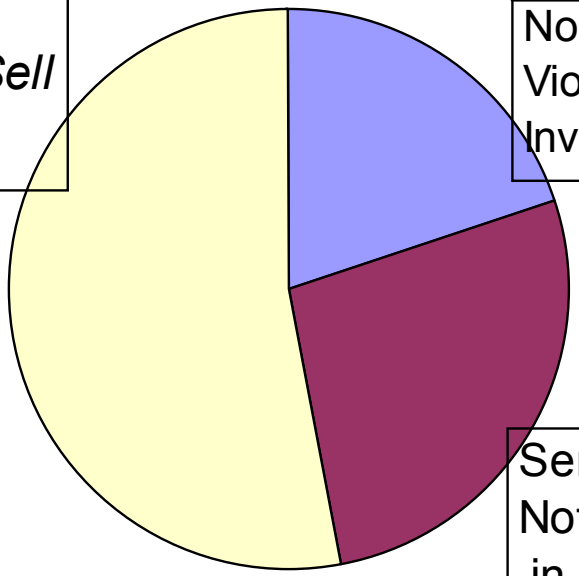
Competency means that, *at the time of trial*, the defendant can:

- understand the nature & object of the trial;
- understand that he or she has been charged with a crime;
- consult with his or her attorney; and
- assist in his or her own defense.

Why are we discussing that here?

- If incompetent, defendant must be restored or case dismissed.
- State hospitals are responsible for evaluation and restoration
- It must be done within timelines that the hospitals can't control
- Hospitals can't control how many are referred
- Failure to restore usually results in civil commitment evaluation

Competency Restoration: Who Receives Restoration



Sell Factors:

1. State has strong governmental interest in prosecuting THIS case
2. Substantially Likely to restore AND Substantially UNLIKELY to impair defense
3. Medically appropriate
4. Less intrusive treatment not likely to restore

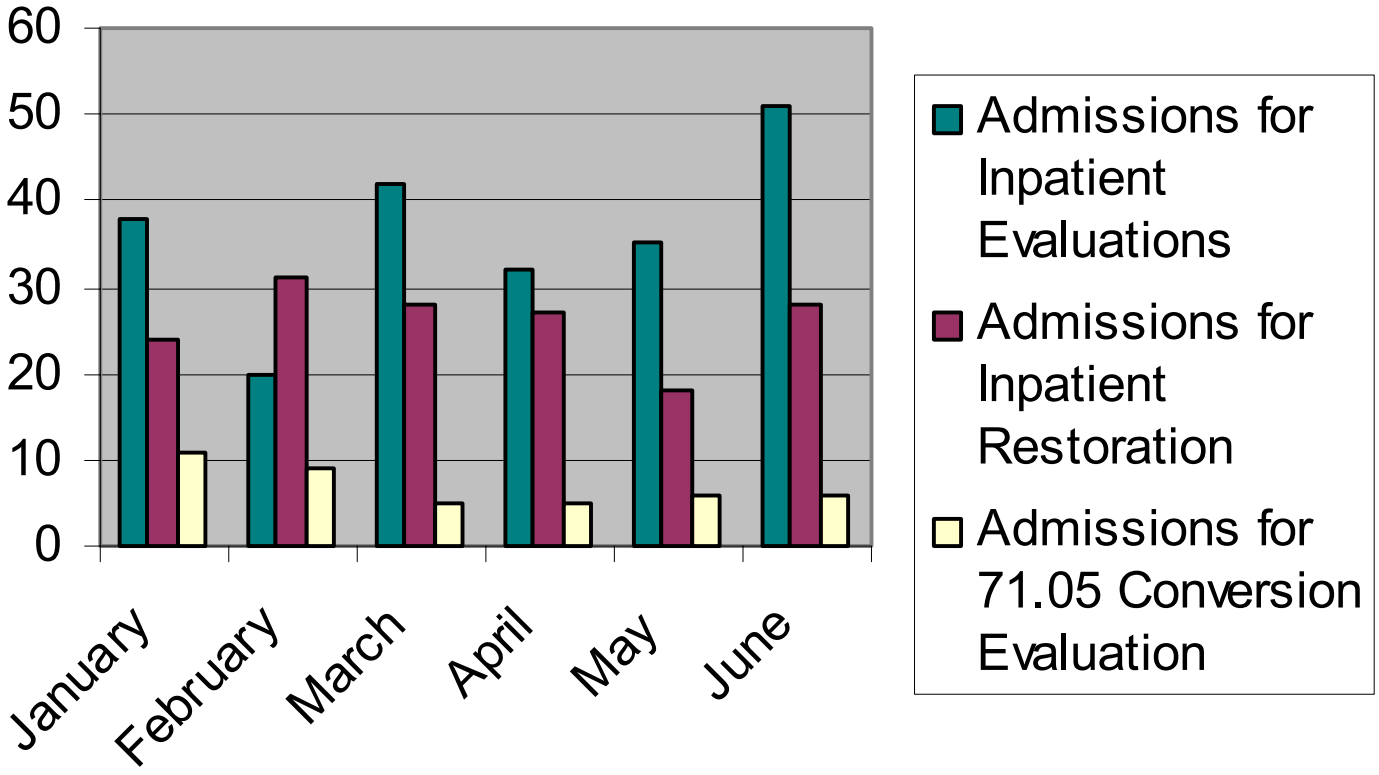
Process

- By Court Order (DSHS has no control)
  - 80% of Western Washington evaluations are outpatient (jail or other)
  - Eastern Washington beginning regular outpatient evaluations: at 15-18 referrals/month & growing
- If incompetent to stand trial, restoration is an inpatient process
  - Misdemeanors = <29 days
  - Felons 90 +90 Days
- Failure to restore = dismissal of case & referral for civil commitment evaluation

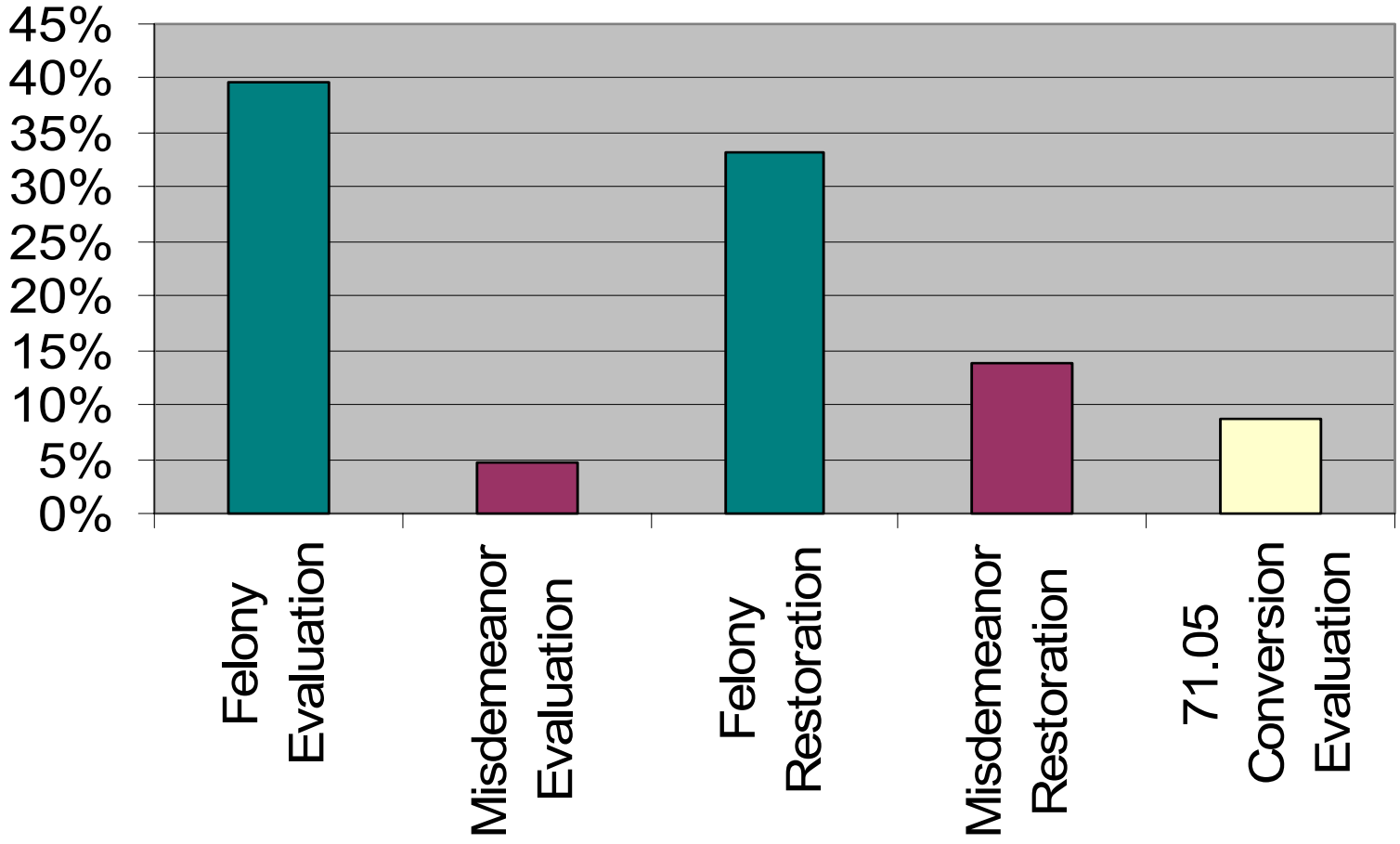
Forensic Waiting Times

- E. Washington:
  - Currently 3 weeks from referral to evaluation but all current referrals have been scheduled
- W. Washington:
  - 100+ waiting list with 3-4 week wait for outpatient evaluation
- Dismissals
  - *Mink v. Oregon Appellate Advocacy*
- Show Cause & Contempt Orders
  - WSH threatened with $1000/day fine

WSH Forensic Admissions 2004



WSH Admission Types by %



Impact on Civil Beds

- Failure to restore competency results in civil commitment in most cases through a “71.05 Conversion” Evaluation process
- Currently this is a small number.
  - That may change under *Sell v. U.S.* limits on involuntary medication
  - That may change if courts start dismissing cases under *Mink v. Oregon Appellate Advocacy*
- Courts have threatened or issued contempt and show cause orders because of delays.

Competency Restoration Outcomes: Misdemeanants 1999-2000

	Eastern State Hospital	Western State Hospital	Total
Received Competency Restoration Treatment	22	104	126
Competency Restoration Treatment Results			
Restored to competency	3 (14%)	54 (52%)	57 (45%)
Incompetent after treatment	19 (86%)	50 (48%)	69 (55%)
Convicted of Competency Restoration Offense			
Restored to competency	1	33	34 (61%)*

Washington State Institute for Public Policy, *Mentally Ill Misdemeanants*, January 2004
*Denominator is 55; missing adjudication data for 2 cases.

Civil Commitment Conversions: Misdemeanants 1999-2000

	Eastern State Hospital	Western State Hospital	Total
Incompetent After Competency Restoration	19	50	**69**
Civil Commitment			
No record of civil commitment proceedings	1 (5%)	5 (10%)	**6 (9%)**
Detained for civil commitment proceedings	18 (95%)	45 (90%)	**63 (91%)**
Civilly committed	17 (89%)	41 (82%)	**58 (84%)**
Civil commitment mean days	103	222	**187**
Civil commitment median days	57	97	**87**

Washington State Institute for Public Policy, *Mentally Ill Misdemeanants*, January 2004

Not Guilty By Reason of Insanity: Civil Detention following Trial

Not Guilty by Reason of Insanity

Standard:

- At the time of the commission of the offense, as a result of mental disease or defect, the mind of the actor was affected to such an extent that:
- He was unable to perceive the nature and quality of the act with which he is charged; or
- He was unable to tell right from wrong with reference to the particular act charged

(RCW 9A.12.010)

Not Guilty by Reason of Insanity

- Found beyond a reasonable doubt to have committed the crime, but was “criminally insane”
- Sentenced to civil commitment at Western or Eastern state hospital
- Cannot be committed for longer than statutory maximum sentence under 10.77 RCW
  - Must be released earlier if no longer criminally insane
  - May be CIVILLY committed at end of sentence if he or she meets the standard under 71.05 RCW.

Forensic Mental Health In the Juvenile System

Juvenile Forensic Mental Health

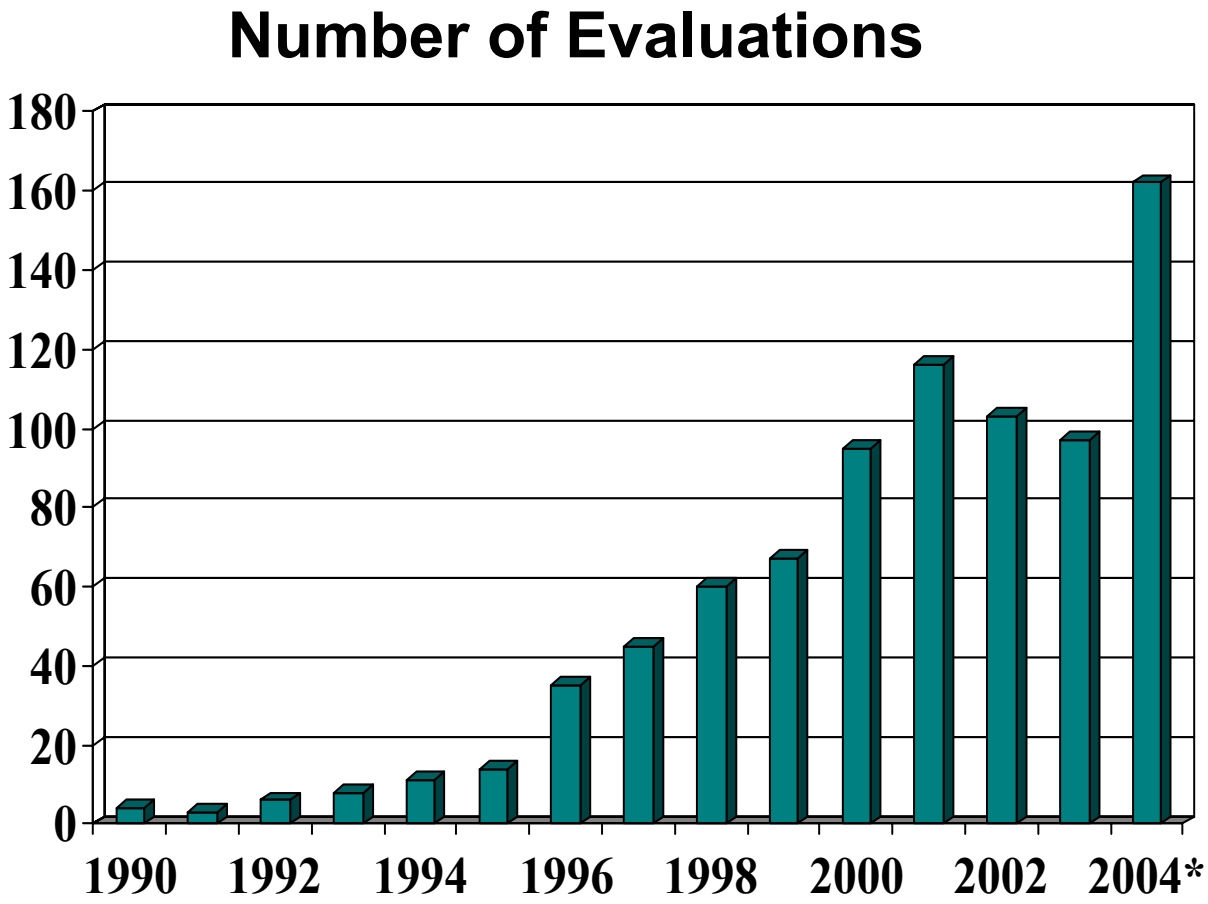
- Competency to stand trial
  - Evaluation
  - Restoration

- *Currently* "Not Guilty By Reason of Insanity" is not a practice in the juvenile justice system

Competency For Juveniles

- Same constitutional issues as for adults
- Done at CSTC whether minor is being tried as an adult or a juvenile
- On a case by case basis, a juvenile may be evaluated by WSH forensic personnel.

Forensic Evaluations at CSTC 1990 – 2004



*Projected

Correctional Mental Health JRA

JRA:
Mental Health Target Population

Any youth within JRA that has:

- A current DSM-IV Axis I diagnosis

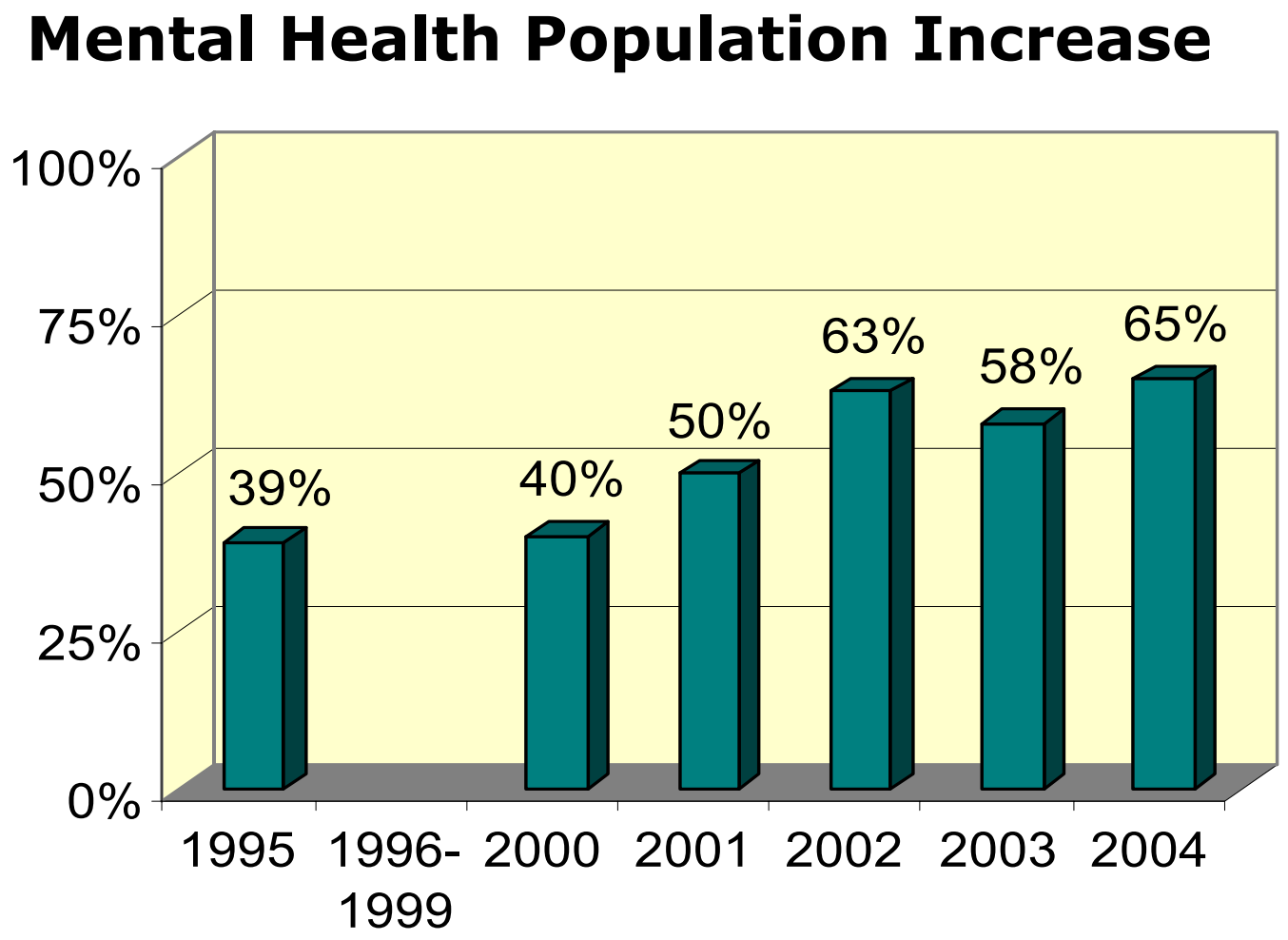
  (NOT SOLELY: Conduct Disorder, Oppositional Defiant Disorder, Pedophilia, Paraphilia, or Chemical Dependency)

- Is currently prescribed psychotropic medication

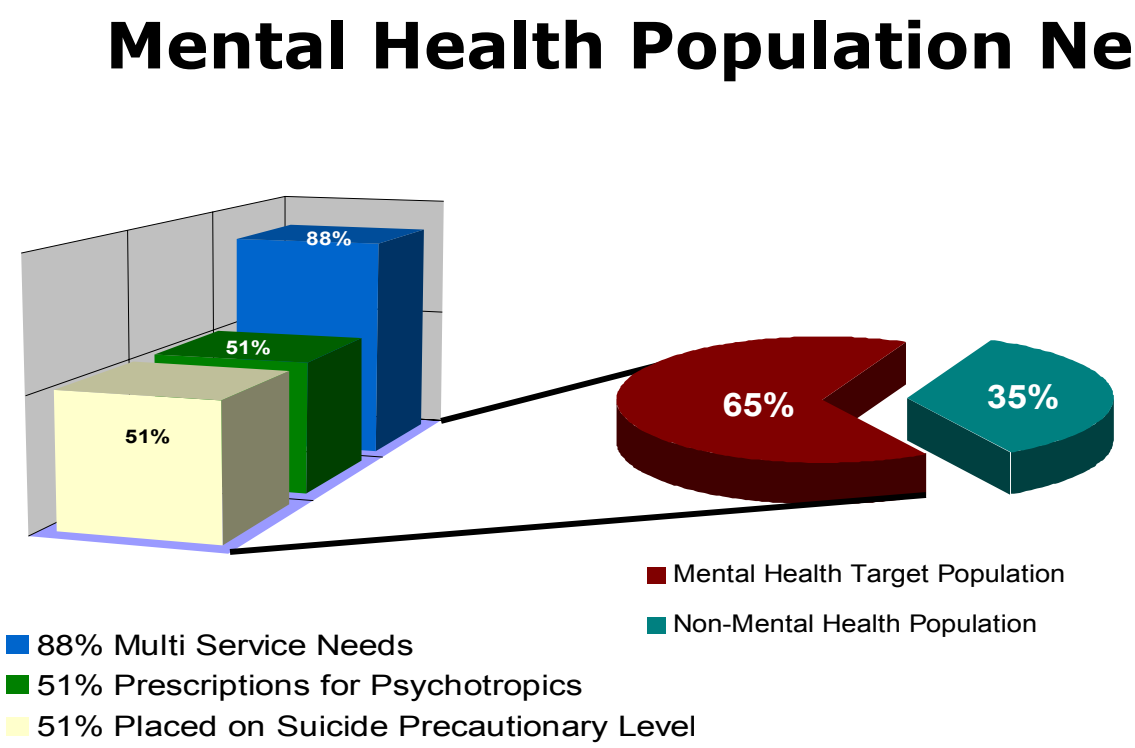
or

- Has demonstrated suicidal behavior within the last six months

Changes in JRA Mental Health Target Population



Changes in JRA Mental Health Target Population



Mental Health & the Jails

Jail Mental Health

- Not a single system
  - 38 County Jails
  - 19 City Jails
- Each Jail is run by the Sheriff or a Jail Administrator
- Funded largely by County Budget
- Every city and county jail has different:
  - Capacity
  - Booking restrictions
  - Ability to treat mental illness

Jail Mental Health Challenges

- “Frequent Flyers”
- Constitutional Requirements to treat
- Medicaid eligibility cuts off after 30 days and no Medicaid during periods of incarceration
- Psychotropic medications are bulk of prescription budget
  - Some use offender’s meds if can be verified
  - Offender must be discharged with medications
- Medical Complications

Discharge Planning Challenges

- Frequently no warning of release
- Termination of Medicaid eligibility delays ability to re-connect on release
- Likely to have a chemical dependency
- May have hepatitis or other complicating conditions
- Release with medications issues
- Behaviors and criminal history restrict ability to place in residential or skilled nursing facility

Mentally Ill Offenders & Release from Prison

Mental Health at DOC

- Statewide system for felons sentenced to over one year incarceration
- Run by the Department of Corrections
- Funded largely by the state
- Mentally ill usually part of general population
  - Some mental health beds in major facilities
  - Special Offender Unit at Monroe

Discharge Planning

- Release typically planned in advance
- Many offenders under DOC supervision
- Termination of Medicaid eligibility delays ability to re-connect on release
- Likely to have a chemical dependency
- May have hepatitis or other complicating conditions
- Release with medications issues
- Behaviors and criminal history restrict ability to place in residential or skilled nursing facility

DMIO Determination

- Screened for serious mental illness
- If also presents a danger to self or others, case is reviewed by program manager
- Presented to Multi-Disciplinary team for determination
- If determined to be DMIO, then may be referred for:
  - Involuntary Commitment
  - Voluntary Services
- Receive substantial pre-release planning

DMIO Releases

- Committee Reviews 12-15 per month
- Determines 8-10 are DMIO
- To Date: 229 DMIO Releases
- State provided funding

Barriers to Community Treatment

- Provider liability concerns
- Lack of housing
- Behavioral & Criminal History barriers
- Frequently, not a priority population
- Offenders leave prison stable, but decompensate before connection to community services

Summary
Forensic & Correctional Issues

- These clients are generally not “new” to the system
- While this is not the largest population, it is significant & impacts both civil and criminal inpatient & residential services
- Bottlenecks in this system exacerbate jail capacity issues and jail capacity, in turn, impacts mental health capacity
- This population often has complex situations and barriers to service
- Current Medicaid practice creates service gaps that can cause a stable offender to decompensate, needing more expensive services

Adult Mental Health Attachments

- **A. Mental health bed needs stakeholder and technical workgroups**
- **B. Outline of inpatient and residential bed system components**
- **C. Adult inpatient and residential bed numbers from 2002 Public Consulting Group Report**
  - **Attachment C.1: Summary**
  - **Attachment C.2: Bed Locations**

Attachment A1

- **Stakeholder Workgroup members**

Bed Needs - staff contacts: Fara Daun, Senate daun_fa@leg.wa.gov ; Wayne Kawakami, OFM wayne.kawakami@ofm.wa.gov

Mental Health Bed Needs Stakeholder workgroup

- Pam Sogoian, WA Behavioral Health Inpatient Assn. pam.sagoian@ardenthealth.com
- Mark Freedman, freedmm@co.thurston.wa.us
- Darcy Jaffe, Harborview; dmjaffe@u.washington.edu
- David Johnson, Highline West Seattle Mental Health Center, davidj@highlinementalhealth.org
- David Lord, WPAS, davidl@wpas-rights.org
- Eleanor Owen, Citizen Activist; eleanor_owen@mindspring.com
- Scott Bond, St. Peter's Hospital; scott.bond@providence.org
- Jeffrey Uyyeck; WSHA, jeffreyu@wsha.org
- Peter Lukevich, Partners in Crisis, pic@wapic.org
- Laurie Lippold, Children's Home Society; Lippoldlau@aol.com
- Fran Lewis, flewis@co.pierce.wa.us
- Tami Green, SEIU, tamig@seiu1199nw.org
- Cathy Gaylord; cgaylord@wcmhcnet.org
- Kathleen Carter, NAMI Western State hospital; carteka@dshs.wa.gov

Attachment A2

- **Technical Workgroup members**
  - David Weston; DSHS Mental Health Division
  - Mark Freedman; Thurston/Mason County Administrator
  - Bill Hardy; North Central RSN
  - Larry Keller; Kitsap Mental Health
  - Shirley Havenga
  - Fran Lewis
  - Norm Webster
  - Frank Jose
  - David Johnson
  - Jeff Uyyek; Washington State Hospital Association

Attachment B

Washington's Mental Health System

Adult Mental Health

Voluntary Treatment
- *Outpatient **
- Residential
- Inpatient

Involuntary Treatment
- Inpatient—State Hospital
- Inpatient—Community Hospital
- Inpatient—E&T
- LRA—Residential Facility
- *LRA—Outpatient **

Children's Mental Health

Voluntary Treatment
- *Outpatient **
  - ? *Child Initiated*
  - ? *Parent Initiated*
- Residential
- Inpatient
  - ? Child Initiated
  - ? Parent Initiated

Involuntary Treatment
- Inpatient—State Hospital
- Inpatient—Community Hospital
- Inpatient—E&T
- LRA—Residential Facility
- *LRA—Outpatient **

Forensic Mental Health

Competency To Stand Trial
- Evaluation—Jail
- Evaluation—WSH/ESH
- Restoration—WSH/ESH

Involuntary Treatment
- Not Guilty by Reason of Insanity
- Inpatient—State Hospital
- LRA

Mentally Ill Offenders (Adult)
- Jail
- Prison
- Transition
  - ? Involuntary Treatment
  - ? DMIO
  - ? Community Protection

Mentally Ill Offenders (Juvenile)
- Detention
- JRA
- Transition to Community

*Outpatient services are not included in this analysis

Attachment C1

Table I-1. Summary of Adult Psychiatric Inpatient, Residential, and Crisis Respite Beds

Services	Total Available Beds	Total Beds Currently Used	Number of Providers
Crisis Respite	122	120	31
Residential	1,818	1,766	96
I/P Community Hospital	297	288	59
State Hospital	981	988	2

1. *Data Source: RSNs and MHD*
2. *Provider counts and bed counts for each service category are unduplicated.*
3. *"I/P Community Hospital" category includes Evaluation and Treatment facilities and acute care hospitals that have provided inpatient psychiatric services.*
4. *"Residential" category is defined as residential staffed beds and adult family homes, which are either paid for and/or authorized by the RSN or its agent. The residential categories include: boarding homes, adult residential, transitional housing, adult family homes, and "other." "Other" includes an adult rehabilitation facility for Spokane RSN.*
5. *"Crisis Respite" category includes crisis respite facilities providing at least 24 hour care to a patient.*
6. *Data represent counts as of June, 2002.*
7. *This report includes adults only. "Adult" is defined as any consumers 18 years and over.*

Attachment C2

Table I-2. Summary of Number of Beds Available to RSN Adult Consumers

RSN	Residential	Crisis Respite	*Community Inpatient*		*State Inpatient*
			Evaluation & Treatment Centers	Community Hospitals	State Hospitals
Chelan-Douglas	36	4	0	1	12
Clark	46	5	0	11	45
Grays Harbor	5	10	0	1	20
Greater	181	21	0	15	75
King	579	22	65	52	259
North Central	40	0	0	2	18
North Sound	226	39	30	19	98
Northeast	8	4	0	1	11
Peninsula	30	0	15	4	49
Pierce	401	6	0	43	213
Southwest	0	0	0	7	17
Spokane	235	8	0	23	103
Thurston-Mason	22	0	0	6	38
Timberlands	9	3	0	2	23
TOTAL	**1,818**	**122**	**110**	**187**	**981**

1. Data Source: RSNs and MHD
2 Provider counts and bed counts for each service category are unduplicated.
3. This report includes adults only. "Adult" is defined as any consumers 18 years and over.
4. Data represent a current snapshot of the approximate number of beds available for use by each RSN's consumer, as of June 2002.
5. "Residential" category is defined as residential staffed beds and adult family homes, which are either paid for and/or authorized by the RSN or its agent. The residential categories include: boarding homes, adult residential, transitional housing, adult family homes, and "other." "Other" includes an adult rehabilitation facility for Spokane RSN.
6. I/P community hospital available beds (187) plus the E & T available beds (110) equal the total I/P community available beds in Table I-1 (297).
7. RSNs do not contract with community hospitals for a specific number of beds. RSNs can only use community I/P beds when they become available on an as needed basis.