

Stakeholder Recommendation Report

Title 25: Stakeholder Recommendation Report Creating an Exemplary System of Care for Persons Who Need the Most Acute Level of Mental Health Services

and

Wyoming Department of Health Proposed Action Plan

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Wyoming Department of Health

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Title 25 – Creating an Exemplary System of Care for Persons
Who need the Most Acute Level of Mental Health Services
Stakeholder Recommendation Report

I. Executive Summary

Title 25 provides a foundation and structure for the State of Wyoming to evaluate, detain, and hospitalize persons who are acutely mentally ill. Several different county, state, and private agencies and organizations are involved in the Title 25 process in order to ensure that client's rights are protected and that there is consistency in the treatment of persons when they are the most vulnerable. The Title 25 process requires that these agencies collaborate and coordinate services to ensure timely and humane services for individuals who are a danger to self, danger to others, or unable to meet basic needs as a result of a mental illness.

The Wyoming Department of Health identified the need to review the Title 25 process and discover areas for strengthening the system to promote a stronger, more coordinated system of care for persons experiencing an acute psychiatric episode. The Title 25 study was conducted from a system's perspective, developing an understanding of the role of each agency in the process. The study team was comprised of Carol Day, M.P.A., Facility and Community Service Systems Coordinator from the Wyoming Department of Health, and Nancy M. Callahan, Ph.D. and John K. Whitbeck, Ph.D. from I.D.E.A. Consulting.

Over 260 persons from all 23 counties were interviewed as a part of this study. This included clients, family members, mental health examiners, Wyoming State Hospital staff, law enforcement, attorneys, judges and court commissioners, and advocacy groups.

This Title 25 Stakeholder Recommendation Report briefly describes the current Title 25 process, presents the stakeholder recommendations for addressing issues, identifies the core issues mitigated by each recommendation, and outlines an action plan for implementation. These recommendations may be implemented across several years, depending upon the availability of funding. As different components are implemented, it is expected that inpatient and state hospitalization costs will be reduced.

This document also includes the Wyoming Department of Health Proposed Action Plan for implementation of these recommendations. The Action Plan describes the proposed activities that will address the issues and recommendations in the next fiscal year. Many of these action steps do not require additional funding; they are changes in statute and modifications in rules and regulations. The development of specific policies and procedures will help implement the recommendations. The delivery of training and adoption of the communication protocol will greatly enhance and coordinate the system of care and improve services for clients.

As funding is available, other recommendations may be developed. For example, the addition of Crisis Stabilization Services statewide would significantly impact the capacity of the mental health system to respond quickly to crises and resolve problems for many clients before needing to complete an Emergency Detention. The expansion of the mental health system of care to include Crisis Stabilization will positively impact all of the agencies involved in the Title 25 process while simultaneously improving outcomes for clients during an acute crisis, when they are most vulnerable.

Summary of Title 25 Stakeholder Recommendations

Definition of Mentally Ill. Clarify the definition of “danger to self or others” in the Title 25 language regarding “unable to satisfy basic needs” in the definition of “danger to self or others”.

Treatment Guidelines. Expand the Title 25 statute language to describe standard treatment guidelines to be delivered during the Emergency Detention, Involuntary Hospitalization, and diversion services (immediate linkage to mental health services in the community).

Advance Practice Nurses. Update the statute to remove the requirement that an advanced practitioner of nursing with a clinical specialty in psychiatric and mental health nursing must work in collaboration with a licensed physician.

Wyoming State Hospital Transportation Requirement. Modify the statute that requires the Wyoming State Hospital to provide all transportation to and from designated hospitals.

Regional Transportation Teams. Modify the Title 25 statute to appoint and fund regional transportation teams.

Single Point of Responsibility. Develop a process and protocol for creating a Single Point of Responsibility within each Community Mental Health Center.

Physician Consultation Protocol. Develop a physician-to-physician consultation protocol between psychiatrists at the Wyoming State Hospital and physicians from designated hospitals, local hospitals, and the community for consultation and communication regarding medications and treatment.

Informational Brochure. Develop an informational brochure describing the components of the Title 25 process to inform clients and family members of the different steps and timelines required in the process.

Standards for Mental Health Examiners. Develop standards for mental health examiner qualifications, oversight, and response times to requests for a mental health evaluation. In addition, modify the Title 25 standard forms to make them more functional.

Voluntary Inpatient Hospitalization. Develop funding options to pay for voluntary inpatient services for those persons who are willing to be admitted to the hospital, but are unable to pay for services.

Crisis Stabilization Programs. Develop Crisis Stabilization programs in each region of the state to provide an alternative to Emergency Detention for clients in crisis.

Crisis Intervention Teams. Develop Crisis Intervention Teams in each community.

Assertive Community Treatment. Develop services similar to Assertive Community Treatment to provide intensive community-based services to high-need mentally ill persons in rural settings.

Avoid Placement of Emergency Detention in Detention Centers. Develop appropriate services in hospitals and communities to keep people from being placed in a detention center. In addition, develop in-jail mental health services for persons under an Emergency Detention who committed a crime and must be held in a detention center.

Provisions for Emergency Detention Contracts. Identify key provisions to be included in contracts with hospitals which provide Emergency Detentions.

Guidelines for Defense Attorneys. Develop guidelines for the timely appointment of defense attorneys and provide an overview of their role regarding the Emergency Detention proceedings.

Cross-County Emergency Detention Protocol. Develop a protocol to help define and describe the role of the courts for persons involved in a cross-county Emergency Detention and Involuntary Hospitalization process when the client is hospitalized in another county.

Guidelines for Title 25 Hearings. Develop guidelines for hearings, the importance of the two separate hearings, and selecting a location for the hearing that meets the needs of the host county, the client, and other stakeholders involved.

Role of Wyoming State Hospital. Define and publish the role and responsibilities of the Wyoming State Hospital in the Title 25 process, and clearly outline admission and discharge criteria and practices.

Recovery Model at Wyoming State Hospital. Conduct a review of Wyoming State Hospital policies and practices in relation to the recovery model and incorporate wellness and recovery principles throughout the service delivery system.

Role of Designated Hospitals. Define and publish the role and responsibilities of the designated hospitals in the Title 25 process, including the delivery of treatment during Involuntary Hospitalization.

Patient Assistance Program. Initiate enrollment in the Patient Assistance Program and begin the process for securing other entitlements while at the Wyoming State Hospital to expedite the client's receipt of benefits.

Wellness and Recovery Action Plans. Promote the use of a Wellness and Recovery Action Plan for Involuntary Hospitalization clients. Promote the use of psychiatric advance directives for clients in Involuntary Hospitalization.

Payment Protocol for Title 25. Secure state funding for all costs of the Emergency Detention Process. Develop payment procedures for covering the costs associated with an Emergency Detention and Involuntary Hospitalization.

Training. Develop and provide comprehensive and ongoing training for all participants in the Title 25 process to include each person's role and responsibilities, family involvement, the recovery model, legal standards, etc.

Required Minimum Data Set. Define a minimum required data set for Emergency Detentions and Involuntary Hospitalizations.

Title 25 and Substance Users. Conduct a study of the use of Title 25 for persons who are under the influence of alcohol and/or substances.

Children's Inpatient Services. Conduct a study to determine if there is a need to expand inpatient psychiatric services and community-based wraparound services for children and youth.

II. Title 25 Study - Methodology and Reporting

Methodology and Draft Summary Report

The Title 25 statute sets the foundation and structure for the State of Wyoming to evaluate, detain, and involuntarily hospitalize persons who are acutely mentally ill. A study of the Title 25 process was conducted to assess the similarities and differences in how the Emergency Detention and Involuntary Hospitalization process is administered in counties across the state.

Emergency Detention (ED) and Involuntary Hospitalization (IH) under Title 25 require the collaboration and cooperation of many different county, state, and private agencies and organizations. The consistency and predictability of that collaboration is essential to ensure clients' rights are protected and timely and humane interactions occur with individuals who are a danger to self, danger to others, or unable to meet basic needs as a result of a mental illness.

The Wyoming Department of Health (WDH) identified the need to review the Title 25 process and discover areas for strengthening the system to promote a stronger, more coordinated system of care for persons experiencing an acute psychiatric episode. The Title 25 Study was conducted from a system's perspective, developing an understanding of the role of each agency in the process. The study team was comprised of Carol Day, M.P.A., Facility and Community Service Systems Coordinator from the Wyoming Department of Health, and Nancy M. Callahan, Ph.D. and John K. Whitbeck, Ph.D. from I.D.E.A. Consulting.

The Title 25 Study team interviewed persons who are involved in the Title 25 process across the state. This process involved input from clients, family members, mental health examiners, mental health staff, law enforcement, prosecuting and defense attorneys, judges and court commissioners, and advocacy groups (NAMI and UPLIFT). In addition, staff from local and psychiatric hospitals and the Wyoming State Hospital (WSH) were interviewed. State staff from the Attorney General's Office and Department of Health - Mental Health and Substance Abuse Division also participated. Interviews were conducted in each region of Wyoming during May, June, and July of 2008. Over 260 interviews were conducted, including representatives from all 23 counties. During these interviews, the study team sought to learn about as many components of the Title 25 process as possible, including a description of how each person and/or agency was involved. At the same time, there was a discussion regarding strengths and opportunities for improvement.

The study team compiled and summarized the information from the interviews. The study team utilized this information to develop a draft Title 25 Report – *Summary of Interviews and Outline of Issues* – (available online at: <http://wdh.state.wy.us/mhsa/initiatives/Title25.htm>). The draft Summary Report summarizes the findings from the personal interviews and outlines the core strengths and issues related to the Title 25 process that were described by the key informants to the study.

Following the completion and distribution of the draft Summary Report, four meetings were held with key stakeholders to discuss the findings and to develop recommendations for strengthening the Title 25 process. The draft recommendations were presented to additional stakeholders through four regional video conferences in late 2008, allowing stakeholders to develop and

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discuss the recommendations and provide feedback. The final recommendations from these stakeholder meetings are summarized in this Title 25 Stakeholder Recommendation Report.

Recommendation Report

Following an overview of the current Title 25 process, this report presents the stakeholder recommendations for addressing current issues, identifies the core issues mitigated by each recommendation, and outlines an action plan for implementation. These recommendations may be implemented across several years, depending upon the availability of funding.

The Wyoming Department of Health's Proposed Action Plan is also included in this document. It provides an overview of the initial steps to be taken in FY 09 to implement these stakeholder recommendations. As different components of the recommendations are implemented, it is anticipated that inpatient and state hospitalization costs will be reduced.

The recommendations presented in this Title 25 Stakeholder Recommendation Report summarize all of the issues identified in the draft Title 25 Summary Report. These issues include concerns related to clients and family members, law enforcement, mental health, the legal system, local and psychiatric hospitals, and the Wyoming State Hospital. The recommendations that have been developed by the Title 25 Study through stakeholder input strive to develop a humane and compassionate involuntary commitment process that respects and values all citizens in the State of Wyoming.

III. Overview of the Current Title 25 Process



Quote:

“We cannot treat our sickest and most vulnerable citizens like this when they need our help, kindness, and treatment.” – Mental Health Therapist

Each of the 23 counties in Wyoming has developed its own practices relative to Title 25 and how it conducts the Emergency Detention and Involuntary Hospitalization process. The process works well in some counties; however, the majority of counties are struggling with one or more aspects of the process. Following is an outline of the role of each stakeholder and agency involved in the Emergency Detention and Involuntary Hospitalization process. This description includes the involvement of the detained individuals, law enforcement, mental health, local hospitals, the State Hospital, and the legal system.

Emergency Detention

When a person exhibits behavior which may cause the individual to be a danger to self or others, or the person is unable to meet basic needs as a result of mental illness, that person may be legally detained. This Emergency Detention (ED) process usually involves a number of different people, programs, and agencies. A brief outline of the Title 25 process is included below to provide a foundation for understanding the existing system and identifying the key issues. A description of how this process impacts clients, families, and the involved agencies (i.e., law enforcement, mental health examiners, local hospital emergency room staff, county attorneys, defense attorneys, judges, and court commissioners) is also outlined. This overview will provide a foundation for understanding the recommendations developed by the stakeholders involved in the Title 25 Study and the initial Plan of Action outlined by the Department of Health.

Title 25 Legislative Language: Emergency Detention: Title 25 language describes the instances when a person may be placed on an Emergency Detention (ED). A summary of the criteria that warrants detention is outlined below.

A person may be detained if law enforcement or an examiner has reasonable cause to believe a person is mentally ill (Wyo. Stats. § 25-10-109). This includes:

“Dangerous to himself or others” means that, as a result of mental illness, a person:

- A. Evidences a substantial probability of physical harm to himself ...; or*
- B. Evidences a substantial probability of physical harm to other individuals ...; or*
- C. Evidences behavior manifested by recent acts of omissions that, due to mental illness, he is unable to satisfy basic needs for nourishment, essential medical care, shelter ...*

Individuals who are in an Acute Crisis – Request for Assistance: Acute mental illness is characterized by significant and distressing symptoms which require immediate treatment. The onset of the crisis is generally sudden or rapid and the symptoms usually respond to treatment. For some persons, alcohol and/or substance use precipitates the onset of an acute episode. The individual in acute crisis may be at home, in the community, at a mental health

agency, or in the Emergency Room (ER) of a local hospital and exhibits dangerous behavior as a result of the acute episode.

The individual's behavior is brought to the attention of mental health providers and/or law enforcement in a number of different ways. If the person is at home, a family member may call the county's emergency phone line and request assistance from law enforcement. If the person is a current client, the family may call the local Community Mental Health Center (CMHC) and request assistance from a mental health therapist. The family member may also bring the person to the hospital Emergency Room for evaluation. If the individual is in the community and exhibits dangerous behavior, a community member may call the local emergency phone number and request assistance from law enforcement.

Law enforcement almost always provides the first response to a call for assistance. The local police department generally responds if the location of the person is within the city limits; the county sheriff's office responds if the person is outside the city limits. The responding officer goes to the location of the individual in crisis and makes an initial determination of the person's mental illness. The officer collects information from the person, any family member(s) present at the location, and/or other persons involved in the incident. In most instances, the officer responds to the call without the assistance of a mental health professional.

If the officer determines that an Emergency Detention is needed, he or she takes the individual into custody. The officer notifies the family, if known; and if the community has a local hospital, the officer transports the person to the ER for a physical and mental health evaluation. In most cases, the person is handcuffed to a belly chain and shackled during the transport to the ER.

The officer generally contacts the local law enforcement dispatch and requests that the mental health examiner be notified. The mental health response time ranges from 15 minutes to 2 hours, during which time the officer remains in the ER, providing supervision to the individual in crisis.

In some situations, a mental health therapist may be the first responder in the ED process. If the therapist is with an individual and recognizes that the person is exhibiting dangerous behavior, the therapist will assess the need for an Emergency Detention. If the therapist is at the clinic or in the client's home, the therapist may contact law enforcement to assist and transport the person to the local ER.

Physicians, particularly physicians working in emergency rooms, may also be first responders for persons who come directly to the ER. Hospital staff conduct the initial triage and contact law enforcement and/or a mental health examiner. In many cases, the ER physician acts as the mental health examiner.

Preliminary Mental Health Evaluation: Counties have developed processes that designate a mental health examiner or an ER physician to conduct the preliminary mental health examination. The mental health examiner must conduct a preliminary examination within 24 hours. Most mental health examiners are employed by or are under contract with the local CMHC; however, some are employed by hospitals or are private practitioners. Most examiners are licensed mental health professionals or are working toward licensure. If the examiner is not fully licensed, a licensed clinician provides oversight of the examiner's work.

Alcohol intoxication and/or substance abuse is a contributing factor in the majority of Title 25 Emergency Detentions. In these instances, the person is intoxicated and reports that they want to kill themselves, or the intoxicated person becomes violent and is a danger to self or others. When the intoxicated person is brought to the ER, it is difficult for the mental health examiner to conduct a mental health evaluation until the person is sober/clean and able to respond to questions. In this situation, the procedure for completing a mental health examination on an intoxicated individual varies across counties.

In some counties, the mental health examiner conducts the examination at the time that they are called to the ER, while the person is intoxicated. In other counties, if the person is intoxicated and/or under the influence of substances, the mental health examiner is not called to conduct the examination until the person is able to respond to questions. The intoxicated individual may be held in jail to detoxify or admitted into the hospital, depending on the availability of local resources.

For persons brought into the hospital ER, the person typically does not receive a mental health examination until after they are examined by a physician and have been “medically cleared”. This indicates that the individual is clean/sober of substances, able to answer questions, and has no other significant physical health conditions.

There are three potential outcomes for the person following the completion of the preliminary mental health examination:

- 1) The individual may be released, if the preliminary examination is not conducted within 24 hours, or if the examiner determines that the person is not mentally ill (is not a danger to self or others, and can meet basic needs); OR
- 2) The individual is detained for up to 72 hours (not including weekends and holidays) until a preliminary hearing is held. The preliminary hearing may result in continued detention pending involuntary hospitalization proceedings; OR
- 3) The person is found to be mentally ill and he/she consents to voluntary treatment and the Involuntary Hospitalization proceedings may be dismissed.

Mental health treatment may be provided to the person during this 72 hour time period, with their signed informed consent. However, interviewees noted that neither the hospitals nor the mental health system routinely treat individuals during this time period. Some mental health centers develop safety plans and offer diversion activities. Occasionally, therapists visit persons in detention and offer limited support and case management services. A detained individual may be medicated to prevent violent behavior, as appropriate.

Hospital/ State Hospital – 72 hour Emergency Detention Placement: Once a person has been examined and has been found to meet the Title 25 definition of mentally ill (dangerous to self or others and/or unable to meet basic needs), the person is detained for a 72-hour period (not including weekends and holidays). Once detained, a determination is made for placement, which could be in the local hospital or a detention center; or, the person could be immediately transported to a hospital with a psychiatric unit (only available to counties with a contract or agreement in place). The preferred placement choice is to admit the person to a hospital setting.

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Each hospital requires a medical clearance prior to admission; most hospitals accept the medical clearance that was completed when the person was initially examined in the ER. If the local hospital is willing to admit persons with psychiatric disorders and has the capacity to admit the person to a safe room, the detained person is admitted to the hospital. Some local hospitals do not have designated “holding” rooms and, therefore, place detained individuals in stripped down rooms.

In some cases, while hospitalized, the detained person may not be allowed visitors and may be isolated from public areas of the hospital. In most cases, the person has minimal contact with CMHC staff. Law enforcement is utilized in some counties to supervise the person while admitted to the hospital. In other counties, a community member is hired to sit outside the room to monitor the detained person. Some hospital physicians refuse to admit persons with psychiatric disorders who do not also have medical conditions that warrant hospitalization. Persons can be held in the Emergency Room, sometimes for days, until they are transported to another facility. In most cases, persons who are refused admission into the local hospitals are placed in the local detention facility, awaiting transport.

Detained individuals may also be admitted to a hospital with a psychiatric unit. Five hospitals in Wyoming have allocated staff and beds for psychiatric patients. These hospitals have agreements or contracts with surrounding counties to accept persons on Emergency Detention from those counties.

Three hospitals have been identified as designated hospitals, and have contracts with the Wyoming State Hospital. These three hospitals provide psychiatric inpatient services to persons who are involuntarily hospitalized when there are no beds available at the State Hospital. In an effort to better meet the needs of detained individuals, counties with limited or no capacity to provide inpatient (hospital) services may have an agreement with a hospital which has a psychiatric unit to admit detained individuals. In these instances, county staff (hospital or mental health personnel) contact the hospital and request admission. The hospital determines if there is a bed available and if the detained individual meets the hospital’s criteria for admission (e.g., the individual is not violent and has no significant medical conditions). Transportation to the hospital is generally conducted by law enforcement; however, some counties hire ambulances to transport the client, at the client’s expense.

If the detained individual is unable to be placed in a hospital because of lack of space, personnel, or facilities, the person is detained in the local detention center (e.g., jail). When it is necessary to place a person in the detention center, the person is usually charged with a misdemeanor offense. In some counties, the detained individual is placed in an isolation cell. In other counties, the individual is placed in an area of the jail used to house the most violent inmates.

Each detention center has its own policies on medications and when they are administered. The person may or may not receive their ongoing medications while in the detention center, depending upon the capacity and staffing of the detention center. If the detention center does not have the appropriately trained staff to administer the medication, the person does not receive his/her prescribed medications.

Involuntary Hospitalization

Legal System – Preliminary Hearing and Involuntary Hospitalization Hearing: The Title 25 statute specifies that a Preliminary Hearing must be held within 72 hours of the Emergency Detention, excluding weekends and holidays. The county attorney is notified when a person is detained. The county attorney files an application for involuntary commitment with the court. Once the court receives the application, a notice of the Preliminary Hearing is sent to the detained individual and his/her attorney. The court appoints an attorney for any detained individual who does not have legal representation. The defense attorney contacts the detained individual and meets with him/her to discuss the legal options and explain his/her rights. This meeting generally takes place just prior to the Preliminary Hearing.

The presiding judge, or appointed court commissioner, conducts the Preliminary Hearing within 72 hours of the initial detention to determine whether continued detention is required, pending involuntary hospitalization proceedings. If the court finds that the detained individual is mentally ill (i.e., continues to be a danger to self or others, or is unable to meet basic needs), an order of continued detention for 10 days is filed.

The ten-day wait period between the Preliminary Hearing and the Involuntary Hospitalization Hearing allows the detained individual to receive treatment and stabilize their symptoms. During this time period, the mental health clinician monitors the client's symptoms and determines if the person continues to meet the criteria for ED and involuntary hospitalization. If the criteria are no longer met, the ED is discontinued.

In some counties, the Preliminary Hearing is waived by the defense attorney with the consent of the client, and only one hearing is held. As a result, the Involuntary Hospitalization hearing is held in place of the Preliminary Hearing, within 72 hours of the Emergency Detention.

Most hearings for persons who are transported across county lines for Emergency Detention are held in the county providing the detention services. Some counties that provide Emergency Detention services for other counties require the detained individual to be transported home for the hearing. If the Emergency Detention is continued, transport back to the hospital must then be provided. In some cases, the examiner for persons detained in one county who are being held in another county testifies by phone during the hearing.

Alternatives to Emergency Detentions and Involuntary Hospitalizations

Diversion Activities: Across the state, few persons involved in the ED process, other than mental health professionals, were able to describe examples of instances when an individual was diverted from Emergency Detention. Most persons interviewed were not aware of services that were available in their community that could be used to help the client resolve the crisis locally. A few counties have developed community-based services, such as crisis stabilization and Crisis Intervention Teams which are available to support the client and the family.

For example, Carbon County Counseling Center and Peak Wellness Center in Laramie County have developed crisis stabilization services which have been successful in diverting clients from Emergency Detentions and Involuntary Hospitalizations. Crisis Stabilization services are effective at providing 24-hour services in a more home-like setting. Crisis Stabilization programs are located in a non-hospital facility that offers twenty-four (24) hour intensive mental

health treatment. The focus is on short-term stabilization for those persons whose psychiatric condition does not meet the criteria for Emergency Detention and admission to a psychiatric hospital or other treatment resource. Clients may stay for up to two weeks, depending upon the needs of the client. The implementation of crisis stabilization services has been effective at meeting the needs of people in crisis by offering a community-based intensive stabilization program.

Natrona County has developed Crisis Intervention Teams (CIT). These Teams are comprised of law enforcement officers who are specially trained to respond to a crisis involving mental illness. In many instances, the CIT is able to de-escalate the person and situation and prevent emergency detention. When a trained CIT responds to a crisis, it is often able to provide immediate assistance to the person. Often, a follow-up appointment the next morning at the mental health clinic provides the ongoing support needed. As a result, the crisis situation is resolved, the person is safe, and services and treatment are provided to meet the client's need to help them remain in the community, rather than having to be detained and hospitalized. CIT members attend a comprehensive training program to develop the skills necessary to meet the needs of the person in crisis, as well as work collaboratively within a multiple agency team.

Fiscal Management

The ED process and each agency's involvement have an impact on county and state budgets and ability to be fiscally solvent. The financial burden on each agency is outlined below.

Emergency Detention Process: Payment for the Emergency Detention process, up to the first 72 hours, is the responsibility of the county of residence. If the detention continues beyond 72 hours, the responsibility for payment of hospital costs, transportation, and treatment is transferred to the State of Wyoming.

Law Enforcement: The cost of an officer's time involved in the Emergency Detention, transportation costs incurred, and hour(s) of supervision in the Emergency Room or sitting with a client while he or she is in a local hospital is a component of the annual law enforcement budget received from the county. Law enforcement agencies are not specifically reimbursed for their costs incurred during each Emergency Detention.

Mental Health Services: Mental health services are supported through an annual state contract to each CMHC. The mental health services contract provides partial funding for the delivery of emergency mental health services. In some instances, counties contract with private practitioners to act as mental health examiners.

Legal Services: Each county's legal system receives an annual budget from the county to cover court and attorney costs for processing Emergency Detentions. The county is not specifically compensated for the cost of the judge, court commissioner, hearings, and attorney fees for each Emergency Detention.

Involuntary Hospitalization: The county pays for the first 72 hours of inpatient services when a person is held on an ED. In practice, if a court order is issued for an Involuntary Hospitalization prior to the end of the 72 hours, the state assumes responsibility for costs from that point forward.

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Payment Authorization: The Title 25 statute requires hospital and treatment providers to collect the cost of treatment from third party payors and the client before billing the county or the state. In many counties, the county attorney is responsible for authorizing payment for the costs of Emergency Detentions to the hospitals. Some county attorneys refuse to pay the hospital until the hospital demonstrates that multiple efforts have been made to collect from the client, expecting the hospital to provide evidence of bill collection activities, liens on homes or cars, etc.

A number of counties have been reluctant to pay the hospital for the cost of Emergency Detentions; in some counties, the local hospital has not received payment from the county for any ED hospitalization for over a year.

IV. Identification of Recommendations, Issues, and Action Plans

Section IV provides a summary overview of the recommendations that were developed from the stakeholder work groups. It presents the stakeholder recommendations for addressing current issues, identifies the core issues mitigated by each recommendation, provides a discussion regarding how this is an important area for consideration, and outlines an action plan for implementation. These recommendations and issues provide guidance for creating an exemplary system of care to meet the needs of persons in an acute crisis and support their recovery in the community, whenever possible.

A. Title 25 Statutes



Client Vignette:

A man has been diagnosed as having schizoaffective disorder. He is very paranoid about pharmacological treatment and avoids most medicines. Several months after a short stay at Wyoming State Hospital, he disappeared and walked naked to the top of a local mountain. He had not slept for 14 days, and had not eaten for a week. He was picked up by law enforcement, and taken to the hospital. They gave him medication disguised in juice, and he cleared somewhat. When the examiner came, they found him not to be a danger to himself or others and ordered him to be released. The history and background of the case was not considered, nor was the “unable to satisfy basic needs” provision for Emergency Detention.

Stakeholder Recommendation: Definition of Mentally Ill

Clarify the definition of “danger to self or others” in the Title 25 language regarding “unable to satisfy basic needs”.

Issue

Definition of Mentally Ill is unclear. The current Title 25 statute’s criteria require that a person be mentally ill in order to be detained. The majority of the Title 25 statute only refers to two of the three factors used to test for mental illness: “danger to [1] self or [2] others”. The third component of the definition, “unable to satisfy basic needs,” is not currently written in the body of the statute; it is only included in the definition section of the regulations.

Discussion

Some persons who are Seriously and Persistently Mentally Ill are not a danger to self or others, but need to be detained and hospitalized because they are so mentally ill that they are unable to meet their basic needs (e.g., obtain food, clothing, shelter). It is important that all persons who are involved in the ED process are fully aware of this criterion so that these seriously ill individuals can obtain the level of care and treatment needed.

The current language does not combine all three criteria together in the body of the language. As a result, “unable to satisfy basic needs” is not consistently used by law enforcement,

mental health staff, or courts as a reason for detaining an individual. During the study interviews, many persons were not aware of this third criterion.

Action Plan

Modify Title 25 statute language with expanded definition of criteria for detainment. Proposed language: *"Evidences behavior manifested by recent acts or omissions that, due to mental illness, he is unable to meet basic needs as exhibited through a totality of recent circumstances and the history of mental illness, including previous hospitalizations, so that a substantial probability exists that death, serious physical injury, serious physical debilitation..."* It is also recommended that "unable to satisfy basic needs" be inserted throughout the statute where references to "dangerousness to self or others" appear.

Stakeholder Recommendation: Treatment Guidelines

Expand the Title 25 statute language to describe standard treatment guidelines to be delivered during the Emergency Detention, Involuntary Hospitalization, and diversion services (immediate linkage to mental health services in the community).

Issues

The definition of "treatment" in the statute does not include all components necessary for appropriate client care. The current Title 25 statute's criteria states that the mental illness "requires treatment". The statute does not define the types of treatment to be made available to persons who are detained. It does not specify if medications or mental health services should be made available during the Emergency Detention.

Lack of mental health treatment during Emergency Detention. At the present time, facilities which hold clients during an Emergency Detention do not consistently offer mental health services while the individual is being held in a facility. Staff report that facilities are not adequately staffed and personnel are not adequately trained to deliver mental health treatment to persons with a mental illness. As a result, the detained individual may not receive any mental health services while detained. The person is simply held in a room until transferred to the State Hospital or their symptoms resolve.

Discussion

Persons are detained because they are in crisis, mentally ill, and a danger to self, others, or are unable to meet basic needs. Holding them in a stripped down hospital room or locking them up in a detention facility does not provide appropriate and humane treatment. The symptoms of acute mental illness do not respond favorably when the person is held without treatment in an isolation room in the hospital or at a detention center. It is essential to begin treatment for these individuals as quickly as possible to help mediate the crisis.

Changing the legislation to clearly describe standard mental health treatment guidelines would encourage hospitals and mental health professionals to begin treatment at the time of the Emergency Detention. This treatment would include mental health intervention (psychiatric medications, individual and group mental health counseling therapy,

psychosocial rehabilitation, illness management, and family education/therapy) and diversion activities (immediate linkage to mental health services in the community). Hospitals would be encouraged to seek consultation from psychiatrists at the State Hospital and local CMHCs to assist them in delivering quality services to clients under their care and supervision.

Action Plan

Modify Title 25 statute language regarding treatment during Emergency Detention and Involuntary Hospitalization and diversion services (immediate linkage to mental health services in the community). Proposed language: *The goal of inpatient psychiatric care is to stabilize a patient's symptoms and restore his/her ability to live independently as quickly as possible. Treatment begins immediately, at the time of the Emergency Detention and continues during the Involuntary Hospitalization process. Treatment may include close observation to ensure physical well being, medications to stabilize symptoms, individual and group mental health counseling, illness management, and/or family education and therapy.*

Stakeholder Recommendation: Advance Practice Nurses

Update the statute to remove the requirement that an advanced practitioner of nursing (APN) with a clinical specialty in psychiatric and mental health nursing must work in collaboration with a licensed physician.

Issues

The Title 25 statute has not been updated to reflect changes to other sections of the law.

There has been a recent change in the Wyoming Statute (W.S. 33-21-120) which governs the scope of practice of an Advanced Practitioner of Nursing. This statute has been revised and the requirement of collaboration with a licensed physician has been removed.

Discussion

Modifying the statute would provide consistency for Advanced Practitioners of Nursing to work within their scope of practice without collaboration with a licensed physician. The ability of APNs to operate independently greatly benefits CMHCs by expanding the capacity of persons who can treat mental health clients, who would benefit from receiving medications prescribed by APNs.

Action Plan

Update the statute to remove the requirement that Advance Practice Nurses (APNs) must operate under the supervision of a physician. This update will bring the statute in alignment with other state regulations that allow APNs to practice without physician supervision and will allow them to perform their duties quickly and efficiently.

Stakeholder Recommendation: WSH Transportation Requirement

Modify the statute that requires the Wyoming State Hospital (WSH) to provide all transportation to and from designated hospitals.

Issues

The WSH is required to provide all transportation to and from designated hospitals.

Transportation at all levels of the Title 25 process is an issue. At the present time, the WSH has three transport vans for the entire state. As a result, hospitals and detention centers must hold clients for long periods of time (two weeks or longer in some cases), waiting for transportation to WSH. In addition, there is little or no organized transportation between local hospitals and hospitals with a psychiatric unit. If a client is in an ED placement at a hospital out of their home county, there is no way for them to get back to their home county when the ED ends. The statute outlines that the county's responsibility for transporting the client ends after the first 72 hours of detention.

Discussion

While hospitals may try to make arrangements back home, this may be only a bus ticket or releasing the client to a local homeless shelter. Following an ED and involuntary hospitalization, a client is in an extremely fragile state and at high risk for decompensation and returning to the hospital. The development of regional transportation teams that would be available to transportation clients between counties and hospitals during ED and involuntary hospitalizations, as well as transporting the client back to their home county, would greatly improve client outcomes. By providing clients transportation back home, care could be coordinated between the hospital and the CMHC to ensure that treatment was initiated upon their return to the community.

Action Plan

Modify the statute to remove the requirement that the State Hospital provide all transportation to and from designated hospitals for persons under Involuntary Hospitalization. This modification would be pursued in conjunction with the funding of regional transportation teams.



Client Vignette:

A man, who was psychotic and addicted to substances, had a relapse and was detained. He was taken to a hospital in another county for the Emergency Detention. The man was discharged in the middle of winter, on a holiday, without a coat or money. He was dropped off at the local homeless shelter. The man ended up back at the hospital and was turned away. He wanted to return home and believed he could walk to get there. That night, no-one knew where he was. Later, law enforcement found him walking beside a highway going in the opposite direction of his home.

Stakeholder Recommendation: Regional Transportation Teams

Modify the Title 25 statute to appoint and fund regional transportation teams.

Issues

Transportation of clients under Emergency Detention. Transportation of clients involved in the Title 25 process has been a recurring issue throughout the state. Transportation of clients at all stages of the detention process is difficult and costly. At the time of the initial investigation by law enforcement, there is a need to transport the client from their home or community setting to the local Emergency Room or detention center for an evaluation. Depending upon where a person was taken into custody and where the hospital emergency room is located, either the police department or the sheriff's office transports the client to the Emergency Room for medical clearance. In both instances, law enforcement usually absorbs the cost of transporting the client in this initial step.

Persons who are transported across county lines under an Emergency Detention often have no way to get home once they are released. The statute does not specify which county has responsibility for the costs to transport to a detention facility, but it does identify that the county's liability for costs of detention, treatment, or transportation ends after the first 72 hours. When a person is released from an Emergency Detention at 72 hours (a common practice), hospitals usually try to make travel arrangements back to the home community. Those arrangements are sometimes bus tickets, asking family or friends to provide transport, or releasing people to the local homeless shelter to wait for a ride home. These arrangements are not reliable and, at times, individuals have tried to walk home across county lines, ended up out of state (not knowing when to get off the bus), or spent days in a homeless shelter waiting for a ride home.

Transportation to and from the State Hospital. WSH currently has three transport teams who are responsible for transporting clients to and from WSH, designated and local hospitals, and the inpatient facility / detention center where the client is detained. With only three transport teams for the entire state, transportation is not always available in a timely manner. Many counties may be required to hold a client for a few days to a couple of weeks, waiting for the WSH transport team to pick up the client. If the county feels that the client is not safe in their county facility, the county will have law enforcement or an ambulance transport the client to WSH or a designated hospital. The cost of transporting the client is significant for the county and/or the client.

Transportation protocol. When a client is transported by law enforcement officers, the client often feels like a criminal. They are placed in the back seat of the car, typically in handcuffs and shackles. If they are taken to a detention center, they are sometimes placed under arrest and subsequently treated in the same way as criminals. As one County Attorney put it, “it is a heck of a transport to Evanston [the Wyoming State Hospital] in shackles.”

Discussion

The location of the WSH makes it difficult for the two transport teams to provide timely transportation between the WSH and local communities. The WSH tries to be as efficient as possible, in trying to coordinate schedules between clients ready for discharge and requests for transportation from the county to the WSH. For example, if the WSH knows a client is about to be discharged to the northeast corner of the state, and there is a client under Emergency Detention in that area, the transport team will wait for the discharge to occur before picking up the new client. While this is efficient, it leaves the client and the county waiting, sometimes for days or weeks, to be transported to WSH.

The development of regional transport teams would provide more timely transportation between the local CMHC, local hospital, and designated regional hospital. The transport teams from different regions could work together to meet and transport across the state to the WSH.

Action Plan

The WDH modifies the Title 25 statute to identify and fund transportation teams for each region. These teams would provide transportation between communities, local hospitals, designated hospitals, and when necessary, to the Wyoming State Hospital.

B. Emergency Detention and Involuntary Hospitalization Process



Client Vignette:

A woman with suicidal ideation was detained in a psychiatric unit of a nearby hospital. She was discharged over a holiday weekend. She did not receive any written or verbal discharge instructions and was provided a one-day supply of medications. Her husband didn't know she had prescriptions until they arrived home in a small community. Neither the local pharmacy nor the local hospital carried the drug but placed the order for her. Nine days later, she died by suicide.

Stakeholder Recommendation: Single Point of Responsibility

Develop a process and protocol for creating a Single Point of Responsibility within each CMHC. The Single Point of Responsibility would provide a consistent mechanism for identifying, diverting, referring, and coordinating treatment planning and services throughout the Emergency Detention and Involuntary Hospitalization process.

Issues

Role of the CMHC in the Title 25 process. Across the counties, the role of the CMHC in the Title 25 process varies. There is no consensus on the CMHC's role during the Emergency Detention, Involuntary Hospitalization, diversion from inpatient services, or continuity of care. At the present time, there are multiple entry points into publicly-funded beds and very little oversight of those admissions. As a result, clients may be inappropriately admitted into the Wyoming State Hospital, when they could have been effectively served with local or regional services.

In many counties, the CMHC is not consistently involved in the detention process. Often, CMHCs are not informed when a person from their service area is detained and hospitalized. This makes treatment planning difficult and does not allow discharge planning to occur when the client is ready to be sent back to the community. However, most clients are referred to services upon return to the community, and if they seek care, do so through CMHCs.

Communication between the WSH and CMHCs. Communication is critical for ensuring timely access to intensive services at WSH and the coordination of outpatient services with the CMHC at the time of discharge. Many CMHC staff and community members reported that they are unable to get detained individuals admitted to WSH. When recently informed that WSH did not have a waiting list for a majority of the summer in 2008, few interviewees were aware of the availability of services.

Follow-up activities after discharge from the State Hospital. The statute does not outline any mandatory follow-up in the community or identify who is responsible for providing follow-up care. In many instances, CMHCs do not receive information regarding a client's discharge from the State Hospital. Without this communication from the State Hospital, CMHCs have not been able to plan for a client's return to the community and are not able to schedule timely appointments with psychiatrists and clinicians.

Communication between designated hospitals and the local mental health community. Some hospitals with a psychiatric unit have staff who coordinate services with the CMHC and communicate admission, treatment, and discharge planning activities with the CMHC. In contrast, other hospitals have little communication with local CMHCs or other treatment providers in the home community of the person detained. Poor communication between providers is not in the best interests of the client and can contribute to repeated detentions.

Consistent information collected for all Emergency Detentions. All law enforcement and mental health examiners collect basic information on the ED. However, this information is inconsistent across counties and there is no standard data collected, documented, or summarized across the state. As a result, there is no capacity to understand the number of times that law enforcement responds to a mental health crisis, the number of mental health evaluations, or the number of persons who are admitted under an ED.

Discharge planning between the designated hospital, the State Hospital, and the local mental health community. The lack of communication between hospitals that provide Emergency Detention and Involuntary Hospitalization services and the CMHC creates a disruption in client's continuity of care.

Discussion

By identifying a Single Point of Responsibility at each CMHC, there would be a clear mechanism for identifying, referring, and coordinating treatment planning and services throughout the Emergency Detention and Involuntary Hospitalization process. This function would ensure linkage between agencies, coordinate resources, and assist with admission and discharge activities with local, designated, and/or the State Hospital. This model does not necessarily imply that CMHC staff is the only mental health examiner or that a person must obtain services from a CMHC.

Components of this function would include:

- Developing a community coordination protocol to ensure that CMHCs, if not directly involved in an Emergency Detention, are at least aware of the ED in order to offer diversion and intervention services, as appropriate;
- Implementing the Communication Process for Continuity of Care Protocol developed by the WSH, CMHCs, and designated hospitals;
- Participating in pre-discharge treatment planning activities between the WSH, designated hospitals, and the CMHC to ensure coordination and quality services;
- Developing procedures to ensure that core information is obtained from each agency and recorded as part of the ED record; and
- Conducting follow-up activities when the client returns to the community to help link clients to needed services and ensure continuity of care to prevent future hospitalizations, as appropriate.

Action Plan

The Department of Health design and develop a process and protocol for creating a Single Point of Responsibility at each CMHC. This protocol would include an outline of core activities to be conducted as a component of this function. It would also outline the core data elements to be collected and reported to provide consistent statewide information on the ED and involuntary hospitalization process.

Stakeholder Recommendation: Physician Consultation Protocol

Develop a physician-to-physician consultation protocol between psychiatrists at the WSH and physicians from designated hospitals, local hospitals, and the community for consultation and communication regarding medications and treatment of persons under an ED or recently released from an IH. As a component of this protocol, the WSH physicians would provide information regarding client medications, side effects, and any recommended changes in type or dosage. The amount of medications routinely provided to clients at the time of discharge from WSH would include a multiple-day supply of medications (i.e., 10 days), depending upon the needs of the client. This would allow adequate time to obtain an appointment with a psychiatrist in the community and to fill the prescription at the local pharmacy.

Issues

Local physicians may not have the training to effectively manage clients in crisis.

Physicians from local hospitals reported that they do not feel that they have training to adequately treat seriously mentally ill clients who are psychotic and in crisis. As a result, they do not feel comfortable admitting them to the hospital and providing mental health treatment. Many physicians noted that if they had easy access to obtaining consultation from a psychiatrist, they would be willing to admit the client and provide treatment.

Lack of communication regarding medications. There is a lack of communication between WSH and the counties regarding medications. Medications are frequently changed when the client is admitted to WSH. When the client is discharged from WSH without a comprehensive discharge plan or communication with the local treatment provider, the local CMHC is unaware of changes in the prescription. Some physicians reported that they had to rely on client self-report after discharge to discover the types of medications prescribed while the client was at WSH.

Clients are discharged from the hospital with only 1-3 days of medications. Some clients are only given one, two, or three days of medications at the time of discharge, and no prescription or instructions for what to do when they return to the community. Often these medications are more expensive than the client can afford or may not be routinely carried by pharmacies in small communities. This practice puts the client at risk for decompensation and may result in a repeat hospitalization because the client and system are unable to maintain the prescribed medications.

Discussion

Local physicians often are trained as general practitioners and have limited training in psychiatry. By having direct access and consultation with psychiatrists at the WSH, many physicians reported that they would be willing to admit clients into the hospital and provide services during the ED, including medication management.

By providing a multiple day supply of medications at the time of discharge, clients and CMHC staff would have adequate time to arrange appointments, contact the local pharmacy to obtain the required medications, and link clients to a network of community resources. The Single Point of Responsibility would be available to work closely with hospital staff to determine if the medications will be given directly to the client, or mailed to the CMHC for dispensing.

An accessible and dependable process for obtaining physician to psychiatrist consultation would support local physicians and ensure continuity of care for the client to promote positive outcomes.

Action Plan

The Department of Health develops a psychiatric consultation network to provide 24/7 phone and/or internet consultation with local physicians across the state. The WSH reviews and modifies the discharge protocol to increase the number of days

of medications provided to the client or CMHC at the time of discharge. The Department of Health and CMHCs develop a Single Point of Responsibility to promote communication between the hospital and local agencies to improve continuity of care.

Stakeholder Recommendation: Informational Brochure

Develop an informational brochure describing the components of the Title 25 process to inform clients and family members of the different steps and timelines required in the process. Information regarding the Wyoming State Hospital would be included in the brochure.

Issues

Understanding the Emergency Detention process. Persons who are in acute crisis often do not know what is happening to them during the Emergency Detention process. They do not understand the legal system, or the significance of the behaviors that they were exhibiting when they were detained. When law enforcement responds to a crisis call, the individual in crisis feels that he/she “did something wrong.” As a result, the individual in crisis feels fear and shame for being picked up, handcuffed, and transported in an officer’s vehicle. The person and/or family may not know what is happening, where the person will be taken, or when they will be allowed to communicate with the person detained.

Client involvement in legal proceedings. Most clients who have been detained and hospitalized through the Title 25 process reported that they did not clearly understand the process and their rights. Also, individuals reported that they did not have sufficient time with their defense attorney prior to the hearing; clients often only meet with their attorneys for a short time (15 minutes) prior to the hearing. Clients are unable to clearly communicate their wishes during this brief encounter, especially when they do not understand the process of the significance of the hearing.

Family involvement in legal proceedings. There has been a lack of family involvement in the Title 25 process. Frequently, families do not understand the Title 25 process or are not involved and consulted by the legal system. Family members reported the need to have adequate information and understanding of the Title 25 process so they can help advocate for the client and help the client navigate the legal process.

Discussion

The development of a brochure that describes the Title 25 process, the legal system, and hospitalization would provide essential information to persons in crisis and their family members.

Action Plan

The Department of Health develops a brochure that describes the Title 25 process, the legal system, and hospitalization, providing essential information to clients, persons in crisis, and family members. The brochure would be written in easy-to-understand language and would be distributed at the time of the Emergency Detention to the person and his/her family. It would also be available prior to and during the court process

and at multiple community locations, including local CMHCs, law enforcement facilities, detention centers, and hospital emergency rooms. Information on the WSH and designated hospitals would also provide clear information on the role of the hospital in the Emergency Detention and Involuntary Hospitalization process. A contact number for additional information and for consumer advocacy groups would be provided.

Stakeholder Recommendation: Standards for the Mental Health Examination Process

Develop standards for mental health examiner qualifications, oversight, and response times to requests for a mental health evaluation. In addition, modify the Title 25 standard forms to make them more functional.

Issues

Oversight, standards, and qualifications for mental health examiners vary across counties. Some CMHCs require licensure or provisional licensure for mental health examiners. Due to staff shortages or recruitment issues, some CMHCs have persons who are certified but not licensed respond to the crisis call and the CMHC provides clinical supervision and oversight of the process. Some CMHCs provide no training or oversight. As a result of these factors, there is huge variability in clinical experience and judgment across examiners. Private practitioners who function as examiners generally receive no training or oversight.

When an ER physician conducts the mental health examination, he or she may have little knowledge of available community resources for diversion and there is little or no oversight to ensure that clients are admitted based upon Title 25 criteria. In addition, the ER physician and some private examiners are often employed by the hospital where the person would be detained, which may influence his/her decision regarding detainment depending on the availability of resources.

Timeliness of response by mental health examiner to initial call by law enforcement or hospital. There is substantial variability in the timeliness of response by mental health examiners to the first call for a mental health evaluation of an acute episode. The response time of examiners to calls from the ER may vary between less than 30 minutes to two hours or longer, depending on travel time from home or involvement in other activities. Often, an officer is required to stay at the ER to supervise the detained person until the mental health examiner completes the evaluation. This wait time pulls the officer away from other duties and creates a significant burden for the police department and/or sheriff's office.

Wait time for Emergency Room medical procedures and mental health examinations. The wait time for completing a mental health examination and medical clearance can be lengthy and last more than two hours. In some instances, two officers are involved in accompanying the person to the ER and are both involved in providing supervision to the client. In larger counties, there may be two or three Emergency Detentions on the same night; having to wait in the ER during the ED evaluation process removes officers from patrol duties and jeopardizes law enforcement's ability to perform their routine tasks in the community. The

Title 25 forms are also outdated and difficult to complete, which creates added burden on law enforcement and mental health examiners since it adds to the complexity of the process.

Discussion

The Emergency Detention process, including the mental health evaluation and medical clearance process, places a huge burden on the hospital, mental health staff, and law enforcement. The development of a standardized, efficient process would greatly benefit all agencies involved in the management of the crisis. Ensuring that persons are trained and knowledgeable in the process, as well as setting standards for response times, will help to alleviate the burden on these agencies. The revision of the Title 25 form to clearly document the core essential information would help expedite the process.

Action Plan

The Department of Health develops standards for mental health examiner qualifications, practices, and response times for reacting to a request for a mental health evaluation. Revise the Title 25 forms to easily document the appropriate, required information and reduce examination time.



Client Vignette:

A woman who had a history of Involuntary Hospitalizations had another acute episode. She wanted to go to the Wyoming State Hospital voluntarily but couldn't get in. "I hung on as long as I could," she said. She made a suicide attempt a month later.

Stakeholder Recommendation: Voluntary Inpatient Hospitalization

Develop funding options to pay for voluntary inpatient services for those persons who are willing to be admitted to the hospital, but are unable to pay for services.

Issue

There is no statutory obligation for the county or any other public source to pay the hospital for voluntary inpatient treatment for indigent clients. Most hospitals with psychiatric units refuse to accept persons into treatment if they do not have a pay source. All persons who are admitted to the Wyoming State Hospital are also involuntary, as the WSH does not currently accept voluntary clients. The only option for accessing inpatient treatment is to initiate the Emergency Detention process and subsequently place the person under an Involuntary Hospitalization. In these situations, the client agrees to a 'voluntary' involuntary commitment in order to have the treatment paid.

Discussion

Some clients may voluntarily request hospitalization for treatment of their mental illness. In these instances, the client is aware of the need for inpatient services, as a result of acute symptoms or the need for a change in psychiatric medications. However, if the client does not have insurance or Medicaid, the hospital has to try to collect from the client or absorb the

cost of the inpatient treatment (because the state does not pay for voluntary inpatient treatment). As a result, most hospitals refuse to admit a client on a voluntary basis.

The state recently initiated a pilot project in the southeast region of the state by purchasing beds from Cheyenne Regional Medical Center for voluntary inpatient care. Preliminary data suggests that the pilot project is successful in reducing admissions to the Wyoming State Hospital, resulting in shorter lengths of treatment for these clients who received community-based inpatient services. However, this is the only resource in the state where a person who cannot afford to pay for their treatment can still receive voluntary inpatient services.

Action Plan

The Department of Health develops a protocol to pay for persons who are acutely mentally ill and voluntarily agree to inpatient psychiatric services at designated hospitals and WSH.

C. Diversion Activities



Quote:

“A husband and wife, who both have serious mental illness, are committed about once a year. Last time, the proceedings were suspended since they agreed to participate in local services. The county attorney has initiated review hearings periodically to check on how they are doing. The format is ‘what can we do for you to keep you well?’ rather than ‘report to us what you are doing.’” – Judge

Stakeholder Recommendation: Crisis Stabilization Programs

Develop Crisis Stabilization programs in each region of the state to provide an alternative to ED for clients in crisis.

Issues

Statewide, there are few crisis stabilization services available which can help divert clients from an Emergency Detention and Involuntary Hospitalization. Many persons who are detained could otherwise be cared for at the local level if a sufficient number and array of services were available. Smaller counties that lack resources often have no option other than to place a person under Emergency Detention. Persons who live in a larger county may not have access to limited resources because the program is at capacity. Some counties immediately transport persons in an acute crisis to a hospital in another county with a psychiatric unit. Immediate transportation eliminates the possibility of providing diversion services and may subject the person to unnecessary detention.

Community services and supports for diversion and continuity of care. Many CMHCs will develop safety plans and intense “wraparound” services that include multiple contacts per day, medication management, and case management. After a person is released from detention or discharged from an inpatient facility following an Involuntary Hospitalization, it is essential that community services be available to continue care in the community. The

development of Crisis Stabilization services also provides a ‘step-down’ resource in the community to continue the treatment received during the involuntary hospitalization and continue to work closely to stabilize clients on their medications.

WSH is in a remote location. WSH is the only state-operated psychiatric facility in Wyoming, and is located in the southwest part of the state. Due to waiting lists, communication issues, and persons returning to the community who are not stable, many areas of the state do not consider the WSH as a resource. Community members in remote areas reported that WSH is not a realistic resource for the system of care because of the distance and resources needed to transport a client to the facility. The development of regional crisis stabilization programs would provide more convenient resources for these distant communities and would help keep clients closer to their homes and families.

Discussion

A pilot project has been conducted over the past two years to study the effectiveness of a Crisis Stabilization program (*Casa de Paz*) at Peak Wellness Center in Cheyenne. In one year, the Crisis Stabilization Program effectively diverted over 100 clients from inpatient hospitalization. By pairing mental health and law enforcement to respond to a crisis call, providing early mental health treatment, and bringing the client to the Crisis Stabilization program, Peak Wellness Center was able to prevent Emergency Detentions and subsequent Involuntary Hospitalizations. Over 90% of these diverted clients remained in the community and were never hospitalized. The cost savings include not only a reduction in expenditures for inpatient services, but also savings to law enforcement, courts, the designated hospital, and the State Hospital.

The highest priority identified by key informants in this study was to develop local or regional Crisis Stabilization programs that offer effective, community-based services that help keep clients closer to their homes and families. The development of Crisis Stabilization Programs in each region and statewide will make the greatest impact on reducing Emergency Detentions and Involuntary Hospitalizations, saving dollars and positively impacting lives.

Action Plan

Fund and develop local or regional Crisis Stabilization programs, using the Peak Wellness Center’s *Casa de Paz* program as a model.

Stakeholder Recommendation: Crisis Intervention Teams

Develop Crisis Intervention Teams (CIT) in each community.

Issue

Law Enforcement and mental health staff could benefit from crisis intervention training.

Overall, the law enforcement officers who were interviewed for this study were compassionate and caring about detained individuals. Many of the officers interviewed were extremely experienced and knowledgeable of mental illness and identified the need to de-escalate the crisis and manage the situation non-violently.

Some clients who were interviewed reported that they experienced more force than they felt was necessary to resolve their crisis. These clients reported that officers did not treat them with respect and were forceful in detaining them. Some of the law enforcement officers interviewed stated that their training in mental health issues is inadequate and recommended additional training for officers to help them respond appropriately to crisis situations involving persons with a mental illness. Some communities are currently participating in an intensive training which supports the development of a Crisis Intervention Team (CIT) which is staffed by police officers with special training in mental health issues. Frequently, a mental health counselor will accompany the officer or team. The specialized training develops the officer's skills in providing an appropriate response to the crisis calls of persons who are acutely mentally ill.

The CIT training provides skills to the officer for assessing the situation to determine the nature of the complaint and the degree of risk. The officer's intervention is determined by the situation, with the officer intervening as necessary to ensure the safety of anyone involved. This strategy facilitates an appropriate disposition. The officer may resolve the situation at the scene through de-escalation, negotiation, or verbal crisis intervention. In many situations, the client's behavior is de-escalated and an ED is not required to manage the situation.

Discussion

The CIT training is an intensive five-day training program that develops excellent skills. It is targeted to training law enforcement officers and has been positively received by the officers in Wyoming who have been involved in the training. Officers and mental health clinicians are trained to work as a team to de-escalate the individual, when possible, and divert into appropriate, community-based services. The CIT model is currently being developed and implemented in some areas of the state, but needs additional funding for statewide implementation.

Action Plan

Develop and provide funding for statewide CIT training for law enforcement and mental health professionals in all counties. This training would develop skilled early response teams that are able to effectively respond to emergency calls involving mental health issues. These teams learn to work together to de-escalate crisis situations and divert clients from Emergency Detention and Involuntary Hospitalization, when possible.

Stakeholder Recommendation: Assertive Community Treatment

Develop services similar to Assertive Community Treatment (ACT) to provide intensive community-based services to high-need mentally ill persons in rural settings.

Issue

There is a lack of specialized community services and supports for Seriously and Persistently Mentally Ill persons who are acutely ill. Many persons who are detained could

be served in the community at the local level if a sufficient number and array of specialized services were available. Smaller counties that lack resources often have no option other than to place a person under Emergency Detention.

Discussion

After a person is released from detention or discharged from an inpatient facility following an Involuntary Hospitalization, it is essential that intensive, specialized services be available to continue care in the community. Services needed to maintain recovery in the community are not available in all counties. A few CMHCs have developed creative and innovative programs that are similar to the evidence-based practice Assertive Community Treatment (ACT) teams. These intensive case management programs have proven helpful in assisting people to consistently follow their treatment plan and reduce their use of psychiatric inpatient services.

These specialized services include daily monitoring and follow up of persons returning to the community from inpatient psychiatric hospitalization. These intensive services are highly effective in reducing repeated Emergency Detentions and are very successful at helping persons with a serious mental illness.

Action Plan

The Department of Health develops a protocol and model for a functional program similar to Assertive Community Treatment (ACT) that can be implemented in rural communities with a limited number of staff. In addition, statewide funding is needed to provide staff training to help CMHCs develop skills in using this model.

Stakeholder Recommendation: Avoid placement of ED in the Detention Centers

Develop appropriate services in hospitals and communities to keep people from being placed in a detention center. In addition, develop in-jail mental health services for persons under an Emergency Detention who committed a crime and must be held in a detention center.

Issue

Detaining mentally ill persons in detention centers. One of the problems faced by counties, especially counties with limited access to a hospital, is finding a place for individuals once they are detained. When there is no hospital bed available to the county, the person is taken to the local detention center. The person is often charged with a crime to justify their placement in the detention center. This practice may give the detained person a permanent criminal record.

Lack of standard practices at detention centers. When a mentally ill person is violent and acting out, they are taken to the local detention center. Even though they have not committed a crime, hospitals are sometimes not willing to admit them into their facilities. In some counties that do not have a local hospital, or when the local hospital is not willing to admit

persons with mental illness, both violent and nonviolent individuals with mental illness are placed in detention centers.

Discussion

Persons who are mentally ill should not be detained in jail. There is no mental health treatment in the detention center and many clients who are on psychiatric medications do not receive their medications while placed in the detention center. Medicaid will not pay for mental health services when a client is in the detention center. Alternative services may include providing inpatient services in local hospitals, developing Crisis Intervention Teams, funding local and regional Crisis Stabilization programs, and developing Intensive Case Management Services. Developing a broader range of service options that promote recovery and support the client and family within the community are effective at meeting the needs of clients who are in crisis, and help prevent the use of detention centers for ED.

Action Plan

Develop policies that discourage placing persons on an ED in the detention center. Provide in-jail mental health and medication services for persons who committed a crime and are being held under an Emergency Detention in a detention center. Expedite their transfer to the State Hospital where they can receive appropriate treatment.

D. Local and Designated Hospitals: Emergency Detentions



Quote:

“Clients are placed in jail unless health concerns require hospitalization. The county pays for the first 72 hours of a hospital admission, but it is free if the client is in jail. Placement in the jail is not good or therapeutic for clients.” – Judge

Stakeholder Recommendation: Provisions for ED Contracts

Identify key provisions to be included in contracts with hospitals which provide Emergency Detention services.

Issue

Lack of clarity regarding the role of the local hospital and designated hospital in the Title 25 Emergency Detention process. Some hospitals with a psychiatric unit have staff who coordinate services with the community mental health center (CMHC) and communicate admission, treatment, and discharge planning activities with the CMHC in the county. Other hospitals have little communication with local CMHCs or other treatment providers. There is no systematic process to ensure communication between the hospital and the CMHC.

There are differences between hospital admission and discharge policies amongst hospitals. Some hospitals will accept clients with health problems, while others will only take a client if they are ‘golden’, with no medical issues and no history of violence. If a person on an Emergency Detention has a medical condition, the person may be sent to a detention center to be held until their hearing, when they can be transported to the State Hospital.

In some counties, ER physicians conduct the Emergency Detention evaluation and do not involve CMHC staff or others trained in mental health to provide input into the ED process. There is some concern that some of these individuals have little psychiatric experience and have not been trained in conducting mental health evaluations.

Discussion

At times, counties do not know what expectations are reasonable for hospitals providing ED services. Providing guidance and expectations for communication, processing, and discharge practices would facilitate the Title 25 process, including the mental health evaluation, admission to inpatient services, and coordination at the time of discharge.

Action Plan

The Department of Health provides guidance to counties to identify key provisions to be included in contracts with hospitals who conduct Emergency Detentions.

These provisions may include, but are not limited to, the following:

- Participation in collaborative meetings with mental health, law enforcement, probation, and allied agencies to promote the development of a comprehensive, coordinated system of care that includes referral, admission, and discharge criteria;
- Implementation of the Communication Process for Continuity of Care between communities, hospitals, and the WSH;
- Development of a system to expedite persons held under an Emergency Detention to be processed as quickly as possible; and
- Development of qualifications and training of persons conducting mental health evaluations in the hospital.

E. Legal System



Quote:

“I have been detained three times. Each time, I was not given an attorney. For all three detentions, I did not see my attorney until the day of my hearing. I saw the attorney for 15 minutes. He decided what would happen.” – Client

Stakeholder Recommendation: Guidelines for Defense Attorneys

Develop guidelines for the timely appointment of defense attorneys and provide an overview of their role regarding the Emergency Detention proceedings.

Issues

Client participation in Preliminary Hearing and Involuntary Hospitalization Hearing.

Detained individuals usually meet with their court-appointed defense attorney for the first time for a brief period (15 minutes) immediately prior to the Preliminary Hearing. Clients felt that 15 minutes was an insufficient amount of time with their attorney. Clients do not have sufficient time to meet with their attorney, understand the legal proceedings, discuss their rights, and have a voice in the Emergency Detention proceedings.

Role of Defense Attorney is Unclear. Many court-appointed attorneys assume the traditional defense attorney role in accordance with the directives of the client. Others act in an expanded role by doing what they consider is “best” for the client regardless of the client’s wishes.

Burden on county court system and attorneys. Conducting Title 25 activities is reported to be cumbersome for county attorneys in terms of the time commitment and financial burden.

Discussion

Clients and family members are unfamiliar with the Title 25 process, the timelines for attending hearings, court procedures, and/or the criteria for Emergency Detention and Involuntary Hospitalizations. Many clients felt that they were not adequately represented by their attorney. While attorneys may spend time reviewing the client’s legal records prior to meeting with the client, clients need sufficient face-to-face time with the attorney to fully understand the proceedings and express their wishes before going into the courtroom. The development of clear guidelines for the timely appointment of defense attorneys and the overview of their role in the Title 25 process would provide clients and family members with added opportunities to understand the proceedings and have an opportunity to be involved in their court case and voice their concerns and wishes.

Action Plan

The Department of Health and representatives from the legal system work collaboratively to develop guidelines for the timely appointment and role of defense attorneys and outline the role of the legal system in working with the client and family to help them better understand the legal proceedings associated with the Emergency Detention process.

Stakeholder Recommendation: Cross-County ED Protocol

Develop a protocol to help define and describe the role of the courts for persons involved in a cross-county Emergency Detention and Involuntary Hospitalization process when the client is hospitalized in another county.

Issue

Lack of cross-county agreements for holding hearings for persons from other counties.

Some counties with designated hospitals have developed agreements with surrounding counties to hold the Preliminary Hearing and Involuntary Hospitalization hearing in their local courtroom. This cross-county agreement saves time and money for the smaller counties that have fewer resources and do not have the facilities needed for adequately holding persons during an Emergency Detention. It also reduces the burden for the smaller, neighboring county and the client by not requiring the person to be transported across county lines to attend the hearings. However, this cooperative agreement has not been adopted statewide and there are no clear guidelines on how smaller counties may reimburse the larger county for conducting the hearings.

Discussion

The development of a cross-county protocol would benefit the clients, families, and county staff involved in the Emergency Detention process. The development of guidelines would provide a core set of practices to follow during the Emergency Detention process for local hospitals, designated hospitals, courts, attorneys, and CMHCs. Hearings would be conducted in locations that would facilitate the timely processing of legal requirements. Local judges, attorneys, mental health examiners, and staff from non-designated hospitals could be involved via telephone and/or internet.

Action Plan

The Department of Health develops a protocol that outlines the role and function of the courts and legal system in the cross-county detention process and develops options for involving hospitals, local legal representatives, mental health examiners, clients, and families.

Stakeholder Recommendation: Guidelines for Title 25 Hearings

Develop guidelines for hearings, the importance of the two separate hearings, and selecting a location for the hearing that meets the needs of the host county, the client, and other stakeholders involved.

Issues

Waiver of hearings. In some counties, it is standard practice to waive the Preliminary hearing and conduct the Involuntary Hospitalization hearing after 72 hours. As a result, the two hearings become one.

Location of hearings. Some counties hold the hearings in the hospital, so the person does not need to be transported to the courthouse. In these counties, the judge or court commissioner, District and Defense Attorneys, and other court personnel utilize a room in the hospital for holding the hearing. The proceedings are generally more informal than those held in courts, reducing the anxiety of the person detained. At times, hearings are held in detention centers.

Discussion

Clients lose their rights when one hearing is waived. Some counties would never waive a hearing, noting the importance of complying with the statute and assuring a client's rights. Other counties routinely combine hearings, stating that it is in the best interest of the client to get 'treatment' as quickly as possible.

Regarding the location of the hearing, when the hearing is held in the hospital, the client does not need to be shackled and transported by the police to the court room. Instead, court personnel set up court in a room at the hospital, where the client can easily attend the hearing.

Action Plan

WDH provide oversight and coordination for counties to assist them to examine their use of waived hearings and develop a protocol for waiving hearings, specifying situations where it is appropriate and not appropriate. In addition, develop a protocol for holding hearings in the hospital, whenever possible.

F. Wyoming State Hospital and Designated Hospitals: Involuntary Hospitalization



Quote:

“When I arrived at the Wyoming State Hospital, I was put in Johnson Hall. I felt threatened; I had never been in jail and Johnson Hall is a lot like jail. I didn’t understand what was going on and it took a while for people to tell me. At times I felt like I was thrown into a dark hole and everyone forgot about me.” – Client

Stakeholder Recommendation: Role of Wyoming State Hospital

Define and publish the role and responsibilities of the WSH in the Title 25 process, and clearly outline admission and discharge criteria and practices.

Issues

Role and expectations of the Wyoming State Hospital. There is no clearly defined consensus on the vision, mission, or role of the Wyoming State Hospital in the greater mental health system in Wyoming. When interviewing people across the state, it was clear that there are differing expectations of the WSH’s role in the system of care for mental health and substance abuse services.

Defining the WSH’s target population. WSH has a critical responsibility to serve the most acute and seriously mentally ill persons in the state. However, without a clear consensus of the role and responsibilities of WSH and the appropriate target population to be served, communities are involuntarily hospitalizing individuals to WSH who may receive limited benefit from the services provided there.

Admission practices. Many of the clients who have been admitted in the past year were first placed into a detention cell in Johnson Hall, the forensic unit of the hospital. Clients and community members both expressed concern that it is inappropriate and inhumane for clients who are mentally ill, not violent, and have not committed a crime to be placed in a forensic cell when they are first admitted to WSH. Hospital staff indicate that placement in Johnson Hall occurs when a person is determined to need a high-level of security or when beds on the Adult Psychiatric Services unit are full.

Convalescent Leave and/or Conditional Outpatient Treatment. The statute does not clearly specify or define convalescent leave or conditional outpatient treatment and these options are not widely utilized. Convalescent leave allows a client to leave the State Hospital with clear behavioral guidelines for positive outcomes in the community. If at any time the client

begins to decompensate and does not continue to meet the guidelines (e.g., take medications, keep mental health appointments), the client is returned to the State Hospital. This expedites the client's return to the hospital, and could by-pass the need to initiate an Emergency Detention and/or return to court. Conditional outpatient treatment can be used in place of hospitalization, with the consent of the client and community service providers.

Discussion

County staff were unclear about the role of the WSH in the system of care. They were not clear on admission criteria or criteria for when discharges occurred. The common perception from persons interviewed was that the client received treatment and was discharged when stable. WSH staff report that treatment while hospitalized is voluntary, and so some clients do not consent to treatment. Clients are discharged when they are no longer a danger to self, others, and/or able to meet basic needs.

Clearly defining the role of the WSH in the Title 25 process and providing oversight to the process will help ensure continuity and collaboration across stakeholder agencies. In addition, it is recommended that the WSH publish the mission and vision for the agency and include recovery and wellness as an integral component of their treatment models.

Action Plan

The Department of Health and WSH work together to collaboratively define, write, and publish a document that outlines the role, mission, vision, and responsibilities of the WSH. This protocol would include clear admission and discharge criteria and practices, define the target population, and outline the range of services offered to clients. It would also examine the delivery of treatment at the WSH and develop clear protocols for providing treatment to persons who are involuntary clients. These protocols include the development of clear language regarding how treatment staff are not held civilly or criminally liable for providing treatment during an ED and/or involuntary hospitalization. Protocols would also include guidelines for convalescent leave and conditional outpatient treatment.

Stakeholder Recommendation: Recovery Model at State Hospital

Conduct a review of WSH policies and practices in relation to the recovery model and incorporate wellness and recovery principles throughout the service delivery system. In addition, develop full-time consumer advocate/peer specialist positions at the WSH to promote recovery, wellness, and the development of rehabilitation skills to ensure that clients are prepared to live successfully in the community at the time of discharge.

Issue

Mental health treatment at the State Hospital. The main emphasis of treatment at WSH utilizes a medical model, with an emphasis on medications. Feedback from consumers indicated that some felt that the medical model devalues clients and is inconsistent with the recovery model being developed in the community.

Discussion

There is concern that treatment is limited at WSH and that clients are only medicated and sent home. Some persons felt that clients are released from WSH too quickly, before enough time has elapsed to ensure that they are stable on their medications. When a client is discharged before being stable on their medications, they are at risk of decompensating. When this occurs, the client may need to be detained and returned to the hospital within a short period of time. This is not quality care for the client and does not benefit the CMHCs or the WSH.

By creating positions and hiring consumer advocate/peer specialists, these individuals would work closely with staff and clients to develop skills which would help promote wellness and recovery. Through this consumer leadership, clients can develop the core skills needed to live successfully in the community.

Action Plan

The Department of Health and WSH staff work collaboratively to review policies and practices and update them to incorporate the recovery model, and wellness and recovery principles for all levels of care at the WSH. In addition, WSH develop positions for consumer advocate/peer specialist staff at the WSH to promote recovery, wellness, and the development of rehabilitation skills to ensure that clients are prepared to live successfully in the community at the time of discharge.

Stakeholder Recommendation: Role of Designated Hospitals in Involuntary Hospitalization process

Define and publish the role and responsibilities of the designated hospitals in the Title 25 process, including the delivery of treatment during Involuntary Hospitalization. In addition, provide oversight to the process to ensure continuity and collaboration, including the development of standards for promoting recovery and wellness as an integral component of treatment models.

Issues

Role and expectations of the designated hospitals. There is no clearly defined consensus on the role of the designated hospitals in the mental health system of care in Wyoming. When interviewing stakeholders across the state, it was apparent that there are differing expectations of the designated hospital's role in the system of care for mental health and substance abuse services. In most instances, a client is placed at a designated hospital when the WSH is at capacity and does not have bed space to provide the Involuntary Hospitalization. In these instances, the WSH calls different designated hospitals until an available bed is found; the WSH then authorizes the designated hospital to provide treatment. When a bed at the WSH becomes available, the client may then be transferred to WSH for additional services. In many instances, the client receives treatment from the designated hospital and is discharged back to the community.

In other instances, the client is admitted to a designated hospital for an Emergency Detention. When the client requires continued Involuntary Hospitalization, the client remains at the designated hospital, even if the WSH has available beds.

Defining the designated hospitals' target population, admission practices, and treatment of clients. The designated hospitals provide an important function within the mental health system of care. They serve persons who are seriously mentally ill. However, some of the hospitals will only admit certain clients, or will admit clients under an ED from only a few counties with which they have contracts. In some instances, when the psychiatric unit of the hospital is full, the client is placed on the medical unit for the Emergency Detention, and remains on the medical unit for the Involuntary Hospitalization. In these situations, the client may not receive the same level of psychiatric treatment before stabilizing and being discharged to the community.

Discussion

The use of the designated hospitals is not well defined or clearly communicated to the counties. There are several different arrangements across the state between a county and a neighboring designated hospital. Counties refer clients to designated hospitals with which they have contracts. If no contract for Involuntary Hospitalization is in place with a local designated hospital and the hospital cannot or will not admit the referred client, the client may be transported hundreds of miles to a designated hospital that will accept the placement. This practice creates problems for the client, the family, the CMHC, and the agency providing transportation. It is not a best practice model of care for Involuntary Hospitalization.

Developing standard guidelines and written materials on admission, treatment, and discharge policies and practices will help the counties understand the role of the designated hospitals and the services provided within the system of care.

Action Plan

The Department of Health and representatives from the designated hospitals work collaboratively to define, write, and publish a document that outlines the role and responsibilities of the designated hospitals. This protocol would include clear admission, treatment, and discharge criteria and practices, define the target population, and outline the range of services offered to clients.

Stakeholder Recommendation: Patient Assistance Program

Initiate enrollment in the Patient Assistance Program and begin the process for securing other entitlements while at the WSH or designated hospitals to expedite the client's receipt of benefits.

Issue

Clients are unable to pay for the medications. Many clients are unable to pay for their medications when they are discharged from the hospital. However, they need their medications in order to remain stable and out of the hospital. The Patient Assistance

Program helps low income people pay for their prescriptions. However, the forms are complex to fill out and it may take several weeks to qualify for the program.

Discussion

When clients are able to maintain their medications, they are much more likely to achieve positive outcomes. If the WSH and designated hospitals initiate enrollment and complete the Patient Assistance Program forms while the client is still in the hospital, the client will be more likely to have the benefit approved and ready to pay for medications when they are discharged. By starting the enrollment process while the client is still in the hospital, the client is more likely to get their medications paid for in a timely manner and more likely to achieve positive outcomes.



Action Plan

Develop standards for enrolling clients in the Patient Assistance Program and other benefit programs at the time of admission to the WSH or designated hospital in order to expedite access to pharmacy and other financial benefits.

Stakeholder Recommendation: Wellness and Recovery Action Plans

Promote the use of a Wellness and Recovery Action Plan (WRAP) for clients. Promote the use of psychiatric advance directives for clients.

Issue

Medical model for treatment. The traditional mental health service delivery system has been built upon a medical model where the psychiatrist and clinician decide on the client's course of treatment and determine the client's goals for treatment. This system does not empower clients to take charge of their lives or give them control or input into their treatment and services. When clients are hospitalized, especially for long periods of time, they are often unable to say what they want to have happen to their belongings, pets, and finances. This creates chaos in their lives at a time when they are experiencing an acute crisis.

Discussion

There are a number of different tools and techniques that help empower clients and teach recovery and self-management skills in dealing with mental health difficulties, and that help clients develop a plan for managing their lives in the event they are hospitalized. The development of a Wellness and Recovery Action Plan (WRAP) for clients helps to teach them recovery and self-management skills and strategies for dealing with mental health problems. It is effective in helping clients achieve higher levels of wellness, stability, and quality of life. It empowers clients to have hope and take personal responsibility for their care. It provides skills in helping to manage their symptoms and medications.

Mental health staff can also work closely with clients when they are stable, to help them complete an Advanced Directive. The development of this document helps to identify what the client wants to have happen in the event of a crisis. The client can specify who is notified, who takes care of children and/or pets, and who will manage their finances while hospitalized. When a client has an Advanced Directive in place and subsequently

experiences an acute crisis, they are assured that their advanced planning will be implemented. These tools help shift the focus of mental health care from ‘symptom control’ to prevention and recovery.

Action Plan

The WDH and advocacy group promote the use of Wellness and Recovery Action Planning and Advanced Directives at the CMHCs and at the WSH to help clients learn skills to manage their illness and symptoms and develop a plan to be implemented in cases of crisis.

G. Fiscal Management



Client Vignette:

A college student had a psychotic break. He has been involuntarily detained three times in two years. Each time he is detained, he is taken to the local emergency room and receives a bill from the hospital and the ER physician. The hospital wrote off the bill, however, the ER physician refuses to do so. The young man, unable to hold a job, has had to file for medical bankruptcy. He states that he would have paid if he had the resources.

Stakeholder Recommendation: Payment Protocol for Title 25

Develop payment procedures for covering the costs associated with an Emergency Detention and Involuntary Hospitalization as follows:

- 1. Insurance companies are billed whenever the client has insurance.**
- 2. Clients are billed for services delivered during an Emergency Detention on a sliding fee scale, based on their ability to pay.**
- 3. The State of Wyoming pays all remaining costs of the Emergency Detention.** (Note: Clients / insurance companies would pay full cost of ancillary medical care not associated with the Emergency Detention.)

Issues

Client payment for Emergency Detention, Involuntary Hospitalization, and transportation costs. In order to receive payment from the county for Emergency Detention and Involuntary Hospitalization services, hospitals are required to demonstrate that attempts have been made to collect money from the detained individual. Some counties require proof that the detained individual was billed; others want the hospital to sue the detained individual for payment, or put a lien on their property.

Many counties do not have the financial resources to pay for the rising costs of Emergency Detention and associated transport costs. Some counties reported that they waive hearings under Title 25 to save money; others transport clients immediately to an out-of-county facility at the first sign that a detention may be required, eliminating any opportunity for diversion or de-escalation of the crisis. Other counties are increasingly shifting costs of

transportation onto the clients by hiring ambulance companies to transport; the ambulance companies then bill the clients for their services.

Clients receive bills from the hospital and ambulance company after being detained and involuntarily hospitalized. Many counties and hospitals make multiple efforts to collect payment from persons who have been involved in an Emergency Detention for the services that they received during the Involuntary Hospitalization. Some hospitals send bills to the detained individuals for their care regardless of their ability to pay. Unfortunately, being billed for services after being involuntarily detained is a huge trauma and shame for clients.

A few hospitals in the state do not follow this procedure. For example, one hospital noted that their policy is to bill the client, but will discharge the obligation if the detained individual is unable to pay. This hospital does not continue to try to collect money from the individual and does not place a lien on the person's car or property.

Other hospitals and county attorneys are more aggressive at trying to collect from the client. Some hospitals employ collection agencies to try to recoup money from the client. Some detained individuals are told that they have six months to pay thousands of dollars, or they will be taken to court and sued for payment. If there are repeat episodes of Emergency Detentions, some hospitals become more and more aggressive in attempting to recover payment.

Ambulance involvement in transportation. In some counties, ambulance services are utilized to provide transportation to a designated hospital and/or WSH. If an ambulance is used, the cost of the service, which may be several thousand dollars, is typically billed to the client. The Title 25 statute does not include ambulance rides as a covered cost for which the county is responsible. As a result, clients often receive a bill for the cost of the ambulance, even though the trip was involuntary and the client did not have a choice of transportation.

Discussion

In most states, Emergency Detentions and Involuntary Hospitalizations are paid for by the state. This practice ensures equal treatment and reimbursement for all costs across the state. It also ensures that clients are not further traumatized by receiving a bill for services that they are unable to pay. Insurance companies also pay for services, when the client has coverage.

Action Plan

The Department of Health develops a protocol for payment to hospitals for Emergency Detentions and Involuntary Hospitalizations. This modification would include an examination of Emergency Detention payment practices and revision of the statute to move responsibility to the state for all costs of an Emergency Detention that the client is unable to pay and that are not covered by insurance.

H. Training



Quote:

“My officers follow the same policies as they do with all of their detainees: leg shackles, belly handcuffs. They don’t like to do it, but don’t know what else to do, since their role/responsibility is not clearly defined.” – Sheriff

Stakeholder Recommendation: Training

Develop and provide comprehensive and ongoing training for all participants in the Title 25 process to include each person’s role and responsibilities, family involvement, the recovery model, legal standards, etc.

Issues

Variability in the implementation of the Title 25 statute. There is huge variability across the counties in how Title 25 is implemented. This includes the ways in which law enforcement responds to the crisis; the fidelity of the mental health examination; the response of the staff in the ER; the availability of diversion activities to keep people in the community; the testimony of examiners at hearings; and the treatment practices and length of stay in inpatient facilities. Statewide training on Title 25 has been infrequent in the past several years, so there is little consistency in how it is conducted, documented, and implemented.

There is variability in clinical experience and judgment across mental health examiners. Training for examiners varies widely across the state. Some CMHCs provide extensive training in the Title 25 process before sending a person out on a crisis call. In addition, the CMHC offers ongoing supervision and oversight to those who are on-call and responding to crises. Some require a period of ‘shadowing’ more experienced examiners before responding to calls on their own. Other CMHCs provide minimal training and oversight of their on-call staff. Among private practitioners and physicians who act as examiners, there is little oversight or training.

The inconsistency in training and expertise is reflected on the information provided on Form 3-81. Some judges noted that at times there is insignificant documentation of the detained person’s mental illness; as a result, individuals have been released because of insufficient evidence.

Training mental health examiners. The training requirements of mental health examiners vary across counties and CMHCs. Some CMHCs provide extensive training and supervision of staff prior to responding to an emergency crisis alone. Other counties do not have a protocol for training staff. Some ER physicians or other hospital staff may conduct the mental health evaluation without receiving prior training. Some county judges provide training to the mental health examiner on techniques for testifying, which helps the examiner learn what is important to present during the testimony.

Discussion

Some counties are participating in an intensive training which supports the development of a Crisis Intervention Team which is staffed by police officers with special training in mental

health issues. Some CMHCs provide extensive training in the Title 25 process before sending a person out on a crisis call. In addition, the CMHC offers ongoing supervision and oversight to those who are on-call and responding to crises. Some counties have developed cross agency teams to routinely discuss the coordination of care for Title 25 clients. The development of standards for training mental health examiners would ensure consistency across examiners and facilities.

Action Plan
The WDH develops training modules and offers statewide and regional training on implementing various components of the Title 25 process. These trainings would be developed to target specific professions, for example: crisis training for law enforcement; conducting mental health examinations for mental health clinicians and Emergency Room physicians; and the development of diversion activities to keep people out of the hospital, when appropriate. The WDH develops standards for training mental health examiners to ensure consistency across counties, regions, and facilities.

I. Data Collection

Stakeholder Recommendation: Required Minimum Data Set

Define a minimum required data set for Emergency Detentions and Involuntary Hospitalizations.

Issue

The Title 25 Study team was not able to collect consistent, reliable data for determining the number of Emergency Detentions and Involuntary Hospitalizations, or the use of designated hospitals in place of WSH. There was no consistent data on clients, admission and discharge dates, length of stay, or reasons for the Emergency Detention. There is limited capacity to collect information on the costs of Emergency Detentions, Involuntary Hospitalizations, or services delivered by the WSH.

Discussion

The collection and analysis of consistent, statewide data on Emergency Detentions and Involuntary Hospitalizations would provide ongoing information on the use, cost, and outcomes of these intensive services.

Action Plan
The WDH develops a minimum required data set for submitting data on Emergency Detentions and Involuntary Hospitalizations. The data would be collected and reported by local, designated hospital, and WSH staff to identify core demographic data and service utilization data. This activity would include revising the standard Title 25 forms that are utilized by law enforcement, mental health examiners, and the courts; the forms would collect key indicators in order to provide information on inpatient service utilization.

J. Future Studies



Quote:

“Wyoming needs a Substance Abuse program that doesn’t require involvement in the criminal justice system. We make these people felons for life in order to get them into treatment through the Addicted Offenders Treatment Act. Or, they are taken to the State Hospital and considered mentally ill.” – Judge

Stakeholder Recommendation: Title 25 and Substance Users

Conduct a study of the use of Title 25 for persons who are under the influence of alcohol and/or substances. Depending upon the findings of the study, develop legislation to provide for a safe and humane approach to detaining individuals who are under the influence of alcohol and/or drugs and who are a danger to self or others.

Issue

Persons who are detained and are under the influence of alcohol and/or substances. There is no standard across counties for conducting an Emergency Detention for persons who are detained and under the influence of drugs and/or alcohol. Some counties will detain and immediately assess the intoxicated individual when brought to the Emergency Room and/or detention center. Other counties have a policy to wait until the person is clean/sober and can respond to questions.

Many law enforcement departments feel that the responsibility for the safety of persons who are under the influence of drugs and/or alcohol resides with the officer until they are able to involve the Title 25 process. When law enforcement is called out on an emergency and the individual in crisis is under the influence of drugs and/or alcohol, the individual is frequently placed in jail. When the person is placed in the detention center, there is limited medical treatment for these individuals and few resources for providing treatment.

Discussion

It is estimated that more than half of all Emergency Detentions are related to substance abuse. Persons are detained under Title 25 and held in jail or the hospital until they are no longer intoxicated. Once the person clears, they are generally released back to the community and the ED is dropped. The Title 25 process is used because there are few safe alternatives for persons who are under the influence of alcohol and/or drugs.

Action Plan

The WDH conducts a study of the use of Title 25 with persons who are under the influence of alcohol and/or substances. The study would examine the use of substance abuse detention laws in other states. Depending upon the findings of the study, develop legislation to provide for a safe and humane approach to detaining individuals who are under the influence of alcohol and/or drugs and who are a danger to self or others and make recommendations to the legislature in 2010.

Stakeholder Recommendation: Children's Inpatient Services

Conduct a study to determine if there is a need to expand inpatient psychiatric services and community-based wraparound services for children and youth.

Issue

Children and Youth with Acute Care Needs. There are very limited resources for meeting the needs of children and youth with acute psychiatric needs. In addition, there are a limited number of inpatient psychiatric beds for children and youth across the state. The WSH does not admit anyone under 18 years of age. As a result, many children and youth are placed in inpatient facilities in other states, placing the child a great distance away from family and their community.

Discussion

There is only one psychiatric inpatient facility in the state that admits children and youth who are titled. This facility is only able to serve a few youth at a time, with a limited number of beds. It is very difficult for children to be placed out of the state, and equally hard on their family members. Continuity of care back to the community is also difficult for CMHC staff, when close relationships are not formed between agencies.



Action Plan

The WDH conducts a study of the current and projected needs and resources in the state for children and youth who need psychiatric inpatient services.

V. Final Summary

The Wyoming Department of Health identified the need to review the Title 25 process and discover areas for strengthening the system to promote a stronger, more coordinated system of care for persons experiencing an acute psychiatric episode. This Title 25 Stakeholder Recommendation Report briefly describes the current Title 25 process, presents the stakeholder recommendations for addressing current issues, identifies the core issues mitigated by each recommendation, and outlines an action plan for implementation. These recommendations may be implemented across several years, depending upon the availability of funding. As different components are implemented, it is expected that inpatient and state hospitalization costs will be reduced.

The recommendations presented in this Stakeholder Recommendation Report summarize all of the issues identified in the full Title 25 Report, *Summary of Interviews and Outline of Issues*. These issues include concerns related to clients and family members, law enforcement, mental health, the legal system, local and psychiatric hospitals, and the Wyoming State Hospital. The recommendations that have been developed by the Title 25 Study through stakeholder input strive to develop a humane and compassionate involuntary commitment process that respects and values all citizens in the State of Wyoming.

The Wyoming Department of Health Proposed Action Plan provides an outline of the next steps toward implementing the recommendations of the Title 25 study. This Action Plan describes the issues and goals for activities that will begin addressing the issues and recommendations in the next fiscal year. Many of these action steps do not require additional funding. They are changes in statute and modifications in rules and regulations. The development of specific policies and procedures will help implement the recommendations. The delivery of training and adoption of the communication protocol will greatly enhance and coordinate the system of care and improve services for clients.

As additional funding is available, the development of Crisis Stabilization Services will significantly impact the capacity of the mental health system to respond quickly to crises and resolve problems for many clients before needing to complete an Emergency Detention. The expansion of the mental health system of care to include Crisis Stabilization will positively impact all of the agencies involved in the Title 25 process while simultaneously improving outcomes for clients during an acute crisis, when they are most vulnerable.



Quote:

“We need a unified, predictable system. We need monies and resources that are clearly identified, that the money can’t be used for something else and to be targeted to a region to insure compassionate, predictable services and resources for Title 25 patients.” – Sheriff

VI. Wyoming Department of Health Proposed Action Plan



Title 25 Proposed Action Plan Wyoming Department of Health

The Wyoming Department of Health (WDH) entered into an initiative in the spring of 2008 to examine the processes currently utilized for the Emergency Detention (ED) and Involuntary Hospitalization (IH) of persons with mental illness who are judged to be a danger to themselves or others. WDH staff and contractors met with over 260 people representing all 23 counties during the summer of 2008. A draft summary report was issued entitled, *“Title 25: Creating an Exemplary System of Care for Persons Who Need the Most Acute Level of Mental Health Services: Summary of Interviews and Outline of Issues.”* Following the distribution of the report, four statewide meetings were convened during which stakeholders developed solutions that address the identified issues. Opportunities for additional input from interested parties were provided through four video conferences.

Following is the Wyoming Department of Health’s proposed plan of action supporting many of the recommendations developed by the stakeholder group. This plan does not address the entire scope of issues surrounding Title 25, but are only initial steps towards creating an exemplary system of care for persons who need the most acute level of mental health services.

FUNDING

- The WDH proposes to collect data and cost information from counties on a voluntary basis in order to estimate statewide costs for each segment of the Title 25 process.**

The stakeholder group recommended full funding of the Title 25 process by the state in order to standardize processes, eliminate inconsistencies, and ensure a predictable process statewide and across time. Although there is consensus among stakeholders that state funding of the Emergency Detention process is needed, it is not realistic to request full funding given the uncertain economic climate, particularly in the absence of data showing actual costs. Collecting cost information from counties on a voluntary basis is the first step toward requesting state funding of the process.

STATUTE CHANGES

2. **Stakeholders and the WDH recommend clarification of the definition of “dangerous to himself or others” (W.S. 25-10-101(a)(ii)(C)) to allow for consideration of a totality of circumstances, both past and present, including the person’s history of mental illness and previous hospitalizations for mental illness. The WDH also recommends that “unable to satisfy basic needs” be inserted throughout the statute where references to “dangerousness” appear.**

Currently, the definition of “dangerousness” includes an inability to satisfy basic needs as a result of mental illness. This aspect of dangerousness is not consistently used by law enforcement, mental health examiners, or courts as a reason for detaining an individual. Many persons are not aware that this provision exists and those who are aware are unclear as to its meaning. Some persons with serious and persistent mental illness may not be immediately dangerous to themselves or others; however, they may be unable to meet their basic needs for food, clothing, or shelter, which may indicate danger to themselves over time. This suggested addition provides additional guidance to law enforcement, examiners, and county attorneys to consider history, previous detentions, and other considerations that together indicate dangerousness.

3. **The WDH recommends updating the definition of “examiner” (W.S. 25-10-101(a)(iv)) to remove the requirement that an advanced practitioner of nursing with a clinical specialty in psychiatric and mental health nursing must work in collaboration with a licensed physician.**

This update to the statute will create consistency with W.S. 33-21-120 governing the scope of practice of an Advanced Practitioner of Nursing. That statute has been revised removing the requirement of collaboration with a licensed physician.

4. **Stakeholders and the WDH recommend that the definition of “treatment” (W.S. 25-10-101(a)(xiii)) be revised to include intervention (psychiatric medications, individual and group mental health counseling, illness management, and family education/therapy) and diversion services (immediate linkages to mental health services in the community).**

Stakeholders and the WDH also recommend that W.S. 25-10-112(e) be revised to include a statement saying that treatment begins at the time of the detention and continues during the involuntary hospitalization process.

The definition of “treatment” in the statute does not include all components necessary for effective care. Diversion and intervention are an important component of the Title 25 process. Adding them to the statute recognizes their importance, legitimizes the provision of these services to persons who are detained, and creates an expectation that these services should be provided. Currently, many persons who are detained do not receive intervention or diversion services other than medications during their detention.

The absence of treatment during an Emergency Detention is not best practice and is not humane.

5. **Stakeholders and the WDH recommend that the statute be revised to include a Single Point of Responsibility established through community mental health centers (CMHCs) as a clearer mechanism to identify, make referrals, intervene, and connect with community resources prior to and after an Emergency Detention (ED) or Involuntary Hospitalization (IH).**

A single point of responsibility in each county would provide a mechanism for identifying, diverting, referring, and coordinating treatment and the provision of other services throughout the ED and IH process. Some persons who are detained and involuntarily hospitalized could be served on the local level if CMHCs were consistently involved in the detention process. The model ensures that all opportunities for diversion are explored prior to an ED, and that mechanisms for coordination of continuing care are in place prior to discharge from an inpatient psychiatric hospital. This model does not necessarily imply that CMHC staff is the only examiner or that a person must seek care through a CMHC. If a person chooses to see a provider other than the CMHC, this model would allow them to do so. Most clients upon return to the community, if they seek care, do so through CMHCs.

RULE MAKING

6. **The WDH proposes to examine current rules authorized by W.S. 25-10-104 regarding designation of hospitals to assess the potential of revising those rules to include a broader definition of “designated hospitals” that includes hospitals which provide detention services.**

The WDH will work closely with the Wyoming Hospital Association, individual hospitals, the Wyoming State Hospital (WSH) and other providers in examining the rules and, should the rules be revised, in rules development. The goal is to create statewide comparability and predictability in the Title 25 process.

7. **The WDH will exercise its authority granted in W.S. 25-10-104(a)(vii) to promulgate rules and regulations regarding reimbursement under W.S. 25-10-112, liability for costs of detention and involuntary hospitalization. Topics to be considered for these rules are restrictions on billing of clients and provisions for timely payment of costs by counties and the state.**

The authority granted in W.S. 25-10-104(a)(vii) for rule making is regarded by the WDH as a mechanism to implement recommendations made by the stakeholder group and which will assist in creating continuity and facilitate the appropriate care of clients in the Title 25 process. Rules will be developed with the input of hospitals, county attorneys, clients, and other stakeholders.

8. **Stakeholders recommend and the WDH proposes to establish rules to more fully define the processes of convalescent leave (W.S. 25-10-127) and conditional outpatient treatment (W.S. 25-10-110(j)(ii)). The WDH requires Legislative authority to write rules in these areas.**

The areas of convalescent leave and conditional outpatient treatment are vague in the statute, particularly in the area of revocation. Stakeholders believe that with consensus-based guidance, these placements in the community can be more widely used. Such placements are better for the client, cost less than inpatient hospitalization, and can increase the availability of beds at the WSH. Rules will be developed with the input of judges, court commissioners, county attorneys, defense attorneys, WSH staff, treatment providers, clients, and other stakeholders.

9. **Stakeholders recommend and the WDH proposes to develop standards for mental health examiners to include training and expectations of their role and responsibilities. The WDH requires legislative authority to develop standards in this area.**

During the Title 25 survey, it was very apparent that the experience and training of mental health examiners varies widely. Some examiners receive no training, have little understanding of mental illness, have no knowledge of community resources that may be available to serve the individual as an alternative to inpatient care, and are not aware of the legal standards required under Title 25. Some examiners are employed by the hospital where a person would be detained, creating a potential conflict of interest. Rules in this area will create some consistency and promote better client care. Rules will be developed with the input of mental health examiners, county attorneys, treatment providers, clients, and other stakeholders.

DIVERSION SERVICES

10. **The WDH recognizes the need and supports the development of diversion services as an alternative to ED and IH as recommended by the Stakeholders. These services are less costly and are better for the client. Funding for these services is not being requested as part of this action plan due to the state's uncertain economic future.**

Many persons who are detained can be diverted into less costly and more appropriate services at the local level. The addition of the following services will reduce the number of persons who enter the ED and IH process.

a. **Crisis Stabilization**

Crisis stabilization services are provided in a community environment and are designed to reduce unnecessary hospitalizations, emergency detentions, and incarceration. Crisis stabilization services can also be used as a “step-down” or

transitional service for individuals who are returning to a community following a stay at the Wyoming State Hospital or other inpatient facility. Crisis stabilization services operated in Laramie County have shown to reduce the need for inpatient services.

b. Crisis Intervention Teams (CIT)

Crises Intervention Teams include specialized training for law enforcement and the development of partnerships with mental health, mental health advocates, and mental health consumers, so that law enforcement officers can more effectively respond to emergency calls involving mental health issues. The focus is de-escalation and diversion into appropriate services. The model has been shown to be effective in reducing arrest rates of persons with mental illness, diverting them into treatment and reducing hospitalizations. The model is currently implemented in Natrona County.

c. Modified Assertive Community Treatment services.

These services include daily monitoring and follow up of persons returning to the community from inpatient psychiatric hospitalization and are effective in reducing repeated emergency detentions. These services also help to maintain persons with serious and persistent mental illness in the community, eliminating or minimizing the need for inpatient psychiatric services.

WDH ACTIVITIES

11. **As recommended by the Stakeholders, the WDH will implement the Communication Process for Continuity of Care by developing:**

- **Policy at the WSH**
- **Contract provisions with designated hospitals**
- **Memorandums of Understanding between CMHCs and the WSH**

This protocol developed in 2008 will ensure consistent and timely communication between the WSH, CMHCs, and designated hospitals. It defines processes for entry into the WSH and designated hospitals, and creates mechanisms for discharge planning involving communities upon release from inpatient care. Full implementation of this protocol will provide continuity of care and will increase opportunities for the recovery of persons returning to the community following an involuntary hospitalization.

12. **As recommended by Stakeholders, the amount of medication received by clients upon discharge from the WSH and designated hospitals will be based on the amount the client needs until he or she can meet with a physician in the community, rather than a predetermined amount. The amount of medication needed will be determined through discussion by WSH or designated hospital staff and CMHC staff, as prescribed by the Communication Process for Continuity of Care protocol.**

Currently, patients are discharged from the WSH and designated hospitals with medication for only three days. This is generally an insufficient amount of medication to last until the person can be seen by a psychiatrist or general physician locally. This

practice puts the client at risk for decompensation and repeat hospitalizations. Often these medications are not routinely carried by pharmacies in small communities, requiring these pharmacies to order the prescription which takes additional time.

13. **The WDH, Office of Healthcare Licensing and Surveys, will enforce, through Certification, the Emergency Medical Treatment and Active Labor Act (EMTLA), which requires hospitals to treat and stabilize conditions of persons who present to the ER or to transfer the person to an appropriate facility. This includes persons with a sole diagnosis of a psychiatric illness.**

Some physicians are uncomfortable admitting a person with a sole diagnosis of a psychiatric illness into a general care hospital, because they have little mental health training and/or the hospital does not have a lock down room. In these instances, the person is placed in a detention center. Many general care hospitals do admit these clients and provide the care and oversight needed until the person can be transferred to a more appropriate facility. The Emergency Medical Treatment and Active Labor Act, which applies to all hospitals that participate in the state Medicaid program, states that if a person presents to an ER and has a medical condition, the hospital must treat and stabilize that condition or transfer that person to an appropriate facility.

General care physicians may be more willing to admit persons with a sole diagnosis of a psychiatric illness into hospitals if psychiatric consultation was available. This consultative process is the following action item.

14. **Stakeholders recommend and the WDH/WSH will develop and implement a physician to physician consultation protocol between psychiatrists at the WSH and physicians in designated hospitals, local hospitals, and communities for consultation and communication regarding medications and treatment of persons with mental illness.**

Some physicians in communities reported that they do not feel they have the training to adequately treat mentally ill clients who are psychotic and in crisis and, therefore, do not feel comfortable admitting them into a hospital. Many physicians indicated that if they had easy access to obtaining consultation from a psychiatrist, they would be willing to admit the client and provide treatment. An understanding of psychotropic medications and mental health treatment is especially important when a client returns to a community following an involuntary hospitalization. An easy to use and dependable process for physician to psychiatrist consultation would provide needed support to local physicians and enhance opportunities for recovery.

15. **The WDH/WSH proposes to include in existing contracts between the Wyoming State Hospital and designated hospitals a provision requiring safe and appropriate transport home from an ED. This proposal may result in increased costs to the WSH.**

Transportation at all levels of the Title 25 process is an issue, especially transport home from an Emergency Detention in an out of county placement. Currently, persons who are transported across county lines for an ED often have no way to get home. The statute says the county's liability for costs of detention, treatment, or transportation ends after the first 72 hours of detention (W.S. 25-10-112). When a person is released from detention at 72 hours (a common practice), hospitals usually try to make travel arrangements back to the home community. Those arrangements are sometimes bus tickets, asking family or friends to provide transport, or releasing people to the local homeless shelter. Occasionally, a law enforcement officer from the home county will provide transport. Clients, family members, and therapists interviewed during the Title 25 survey spoke of instances when people tried to walk home across county lines, ended up out of state (not knowing when to get off the bus), or spent days in a homeless shelter waiting for a ride home.

Stakeholders recommended funding of regional transport teams to provide all out-of-county transports for emergency detention and involuntary hospitalization. While the approach proposed by the WDH is not optimal, it will address transport home for a number of persons detained in an out of county hospital. Full funding of transport to and from out of county EDs is needed statewide. The collection of data and cost information from counties will result in statewide cost estimates of transportation related to Title 25.

16. **Stakeholders recommend and the WDH, WSH supports the development of policy and amendments to contracts with designated hospitals to initiate enrollment in the Patient Assistance Program and other entitlements for clients whose length of stay at the WSH or designated hospital allows these processes to begin.**

Many clients are unable to pay for their medications when they are discharged from the WSH. The Patient Assistance Program helps low income people pay for their prescriptions. However, the forms are complex to fill out and it may take several weeks to qualify for the program. By starting the enrollment process while the client is still in the hospital, the client is more likely to get their medications paid for in a timely manner and more likely to achieve positive outcomes.

17. **The WDH/WSH will develop and disseminate material on a regular basis, which outlines the role, responsibilities and activities of the WSH, and outlines admission and discharge criteria, defines the target population, and outlines the range of services offered to clients. The material will be disseminated to agencies and individuals participating in the Title 25 process.**

During the Title 25 interviews, many people were unclear about the role of the WSH, were not aware of the services provided, and were uncertain about its policies regarding admissions and discharges. Clearly defining the role of the WSH in the Title 25 process will help ensure continuity and collaboration across stakeholder agencies.

18. **Stakeholders recommend and the WDH proposes to develop and sponsor comprehensive training for all participants in the Title 25 process. Online training and training during existing professional meetings and other events are low cost options that will be considered. Trainers will be drawn from professionals throughout the state.**

Across the state there is extensive variation in the understanding and implementation of Title 25 processes and each entity's role in that process. During the Title 25 interviews, training was consistently mentioned as necessary for all participants in the Title 25 process.

19. **Stakeholders recommend and the WDH will implement the development and dissemination of a brochure which explains the Title 25 process and services of the WSH in easy to understand language for use by clients and family members. The brochure will be made available at CMHCs, law enforcement centers, detention centers, and hospital emergency rooms.**

The development of a pamphlet that describes the Title 25 process and services of the Wyoming State Hospital will provide essential information to help clients and families navigate the legal system and will offer basic information about the process and what to expect. A contact number for additional information and consumer advocacy groups will be included in the brochure.

20. **The WSH, consumer advocates, and WDH staff will work collaboratively to review WSH policies and practices and update them to incorporate the recovery model and wellness and recovery principles for all levels of care at the WSH.**

The main focus of treatment at the WSH utilizes a medical model, with an emphasis on medications. Feedback from consumers indicated that some felt that the medical model devalues clients and is inconsistent with the recovery model being developed in the community. There is also concern that treatment is limited at the WSH and clients are only medicated and sent home.

21. **The WDH, Mental Health and Substance Abuse Services Division, in collaboration with advocacy and consumer groups, will continue to promote the use of Wellness Recovery Action Plan and psychiatric advanced directives.**

Wellness Recovery Action Planning (WRAP) and psychiatric advanced directives are tools for clients to use to describe their wishes and preferences should they experience an acute psychiatric crisis and be unable to communicate or articulate their wishes. These are important tools for client directed care.

22. **Stakeholders recommend and the WDH will conduct a review of alternatives to utilizing Title 25 to detain persons who are under the influence of substances. This process will include a review of practices in other states, the collection of data from counties on a voluntary basis, and the development of recommendations.**

A majority of EDs involve substance abuse. Many examiners conduct assessments while the person is intoxicated then hold the person in jail or, less frequently, in a local hospital until they are detoxed. Some counties place the intoxicated person in jail without an ED and conduct an assessment once they are no longer inebriated. A safe and humane approach to detaining persons who are intoxicated would assist law enforcement and provide a more appropriate avenue for the detention of persons under the influence of alcohol or drugs.

23. **Stakeholders recommend and the WDH supports the need for an examination of the psychiatric service needs of children and adolescents and how those services are currently being utilized.**

The Title 25 process for children and adolescents, although covered under the same statute as adults, is very different. The Title 25 study did not address this population; however, during interviews with community representatives, several issues were articulated regarding the process for children and adolescents, including issues regarding custody and the lack of appropriate services.

24. **Stakeholders recommend and the WDH supports counties addressing issues surrounding the waiving of hearings under Title 25 by developing protocol or plans governing this issue.**

Counties vary widely in their perspectives on waiving hearings. Some counties waive hearings as a matter of routine, others waive hearings to expedite admission into treatment, and some counties rarely, if ever, waive hearings. The stakeholder group recommended that each county look at their own practices of waiving hearings and determine if the practice is in the best interest of the client.

VII. Appendices

Appendix A: Flowchart of Title 25 Procedures and Participating Agencies

Appendix B: Key Title 25 Legislation

Appendix C: Wyoming Department of Health Stakeholder Meetings – List of Attendees

Emergency Detention – First 72 Hours

	Client	Law Enforcement/ Court	Mental Health/ Examiner	Possible Outcomes
Initial 24 Hours	A person may be detained if law enforcement or examiner has reasonable cause to believe a person is mentally ill under W.S. 25-10-101.	<ul style="list-style-type: none"> - Law enforcement officer or examiner detains “client.” - Law enforcement officer informs client of their Miranda rights. - Law enforcement officer notifies the person responsible for the care and custody of the detained person, if known. - Law enforcement officer writes report about the facts of the emergency detention and provide it to the examiner. 	<ul style="list-style-type: none"> - Examiner or law enforcement officer detains “client.” - Examiner notifies the person responsible for the care and custody of the detained person, if known. - Examiner writes report about the facts of the emergency detention. - Conduct a preliminary examination (Form 3-81) within 24 hours. - Treatment may be provided with client’s informed consent. 	<ol style="list-style-type: none"> 1. Client may be released: <ul style="list-style-type: none"> - If a preliminary examination is not conducted within 24 hours; or - The examiner determines it is not necessary to detain client any longer. 2. Client may need to participate in preliminary hearing.
Next 48 Hours		<ul style="list-style-type: none"> - Court will send out notice of preliminary hearing to detained person and his/her attorney. - Court shall conduct a preliminary hearing within 72 hours of the initial detention to determine whether continued detention is required pending involuntary hospitalization proceedings. - Court may order continued detention. 	<ul style="list-style-type: none"> - File application for involuntary commitment to the court (Form 7-81 & Form 8-81). The application shall be accompanied by either: <ol style="list-style-type: none"> 1. A certificate of an examiner stating: <ol style="list-style-type: none"> a. That he has examined the proposed patient not more than fifteen (15) days prior to the date the application is [was] filed under this subsection; b. His findings and the proposed patient's history; and c. His opinion that the proposed patient is mentally ill; or 2. A written statement by the applicant and by an examiner that the proposed patient has refused to submit to examination by an examiner, together with a statement of the facts and circumstances supporting the application. 	<ol style="list-style-type: none"> 1. Client may be released if: <ul style="list-style-type: none"> - If the court finds the client is not mentally ill; or - If the client is mentally ill and volunteers admission to a hospital. 2. If the client is mentally ill and will not volunteer for treatment, he/she will participate in involuntary hospitalization proceedings.

Involuntary Hospitalization Proceedings

	Client	Court	Mental Health/ Examiner	Possible Outcomes
10 Day Hold + Possible Extended Detention (Involuntary Hearing)	The client is held in: a hospital, State Hospital, crisis center, jail, or other facility.	<ul style="list-style-type: none"> - If the court finds the person is mentally ill, it shall order continued detention of the person for not more than ten (10) days. The court may extend the detention period at the request of the proposed patient or his attorney. 		<ol style="list-style-type: none"> 1. The client may be released at any time if they are determined to be not mentally ill. 2. Client participates in involuntary hearing.
	The client is held in: a hospital, State Hospital, crisis center, jail, or other facility.	<ul style="list-style-type: none"> - Court will send out involuntary hospitalization hearing notice to detained person and his/her attorney. - Court shall appoint one or more examiner(s) to examine the client and write a report of the findings for the court. - Within 5 days of receipt of the involuntary hospitalization hearing notice, the client and his/her counsel may request a hearing before a jury OR the court may decide it is necessary if the court concludes that the client does not understand his/her rights. - The court may decide there is no need for a jury and the court will make the determination and disposition. - If the court or jury finds that the client is mentally ill, the court may: <ol style="list-style-type: none"> 1. Order his hospitalization <ol style="list-style-type: none"> a. Send client file with report b. Specify where client will be detained if transportation pending c. Order transportation d. Notify next of kin or person responsible e. May order medication 2. Suspend the proceedings if client voluntarily agrees to treatment 	<p>Examiner(s) are appointed by the court to examine the client and write a report of the findings for the court no later than 7 days from the date of the involuntary hospitalization hearing notice.</p> <p>This report will be used for the involuntary hospitalization hearing.</p>	<ol style="list-style-type: none"> 1. Client may be released if: <ul style="list-style-type: none"> - If the court finds the client is not mentally ill; or - If the client is mentally ill and volunteers admission to a hospital. 2. If the client is mentally ill and will not volunteer for treatment, the court will order involuntary admission.

Ongoing Involuntary Hospitalization

	Client	Court	Hospital	Possible Outcomes
Involuntary Hospitalization - Periodic Examinations	<p>The client is involuntarily admitted to the psychiatric hospital or state hospital.</p>	<ul style="list-style-type: none"> - When the head of the hospital determines that the client no longer needs to be involuntarily hospitalized, the court, county attorney, district attorney, family members, and mental health center involved in the initial proceedings are notified. - The court may order a hearing on continuing the client's hospitalization. If there will be a hearing, it will be held as soon as practicable. 	<ul style="list-style-type: none"> - 3 months after the client's admission, the head of the hospital evaluates the client's progress. - The client's treatment and progress are re-evaluated every 6 months thereafter, by the head of the hospital. - When the client no longer needs involuntary treatment, the head of the hospital reports his/her findings to the court, county attorney, district attorney, family members, and mental health center involved in the initial proceedings. The client is released to the community - If the head of the hospital determines after examination that the conditions justifying involuntary commitment still exist, he/she shall send his/her determination to the court, the client, and the person responsible for the client's care or custody. The court may order a hearing to review the determination. 	<ol style="list-style-type: none"> 1. The client may be discharged if the head of the hospital finds that the client no longer needs treatment AND the court does not order a hearing on continuing the client's involuntary hospitalization. 2. The client may need continual hospitalization and may contest this decision.

25-10-109. Emergency detention.

(a) When a law enforcement officer or examiner has reasonable cause to believe a person is mentally ill pursuant to W.S. 25-10-101, the person may be detained.

(b) Immediately after detaining the person, the officer shall contact an examiner. A preliminary examination of the person shall be conducted by an examiner within twenty-four (24) hours after the detention. If a preliminary examination is not conducted within twenty-four (24) hours the detained person shall be released. If the examiner giving the preliminary examination finds that the person:

(i) Is not mentally ill, the person shall be released immediately;

(ii) Was mentally ill, but is no longer dangerous to himself or others, the person shall be released immediately; or

(iii) Is mentally ill, the person may be detained for seventy-two (72) hours excluding Saturdays, Sundays and legal holidays.

(c) No person shall be detained for more than seventy-two (72) hours, excluding Saturdays, Sundays and legal holidays, without a hearing under subsections (h) through (k) of this section.

(d) A person taken into custody under this section may be detained in a hospital or other suitable facility which is appropriate under the circumstances. The person shall not be detained in a nonmedical facility used for detention of persons charged with or convicted of penal offenses except in extreme emergency or if there are no other reasonable alternatives. The law enforcement officer who detained the person shall immediately notify the person responsible for the care and custody of the detained person, if known, of the time and place of detention.

(e) The law enforcement officer or examiner who initially detained the person shall make a written statement of the facts of the emergency detention. A copy of the statement shall be given to the detained person and to any subsequent examiner.

(f) When a person is detained under emergency circumstances, treatment may be given during the emergency detention period if the person voluntarily and knowingly consents. The parent or guardian of a minor or incompetent person may consent to treatment. Treatment may be given without the consent of the detained person or his parent or guardian when treatment is limited to diagnosis or evaluation or when treatment is necessary to prevent immediate and serious physical harm to the person or others. Prior to treatment, the person shall be fully advised of the scope of treatment, and a report of the treatment shall be filed with the court if involuntary hospitalization proceedings are commenced. An examiner or a physician who provides treatment in good faith pursuant to this subsection shall be immune from civil liability for the treatment except there shall be no immunity from liability for negligent acts or deliberate misconduct.

(g) At the time of emergency detention the person shall be informed orally and in writing of his right to contact his family and an attorney, of his right to appointed counsel if he is indigent, of his right to remain silent and that his statements may be used as a basis for involuntary hospitalization.

(h) When a person is detained in emergency detention and an application for involuntary hospitalization is filed, the court shall appoint an attorney to represent the detained person unless he has his own attorney, and the court shall conduct a hearing within seventy-two (72) hours, excluding Saturdays, Sundays and legal holidays, of the initial detention to determine whether continued detention is required pending involuntary hospitalization proceedings. Notice of the preliminary hearing shall be given to the detained person and his attorney. The court may delay the hearing only at the request of the detained person or his parent, guardian or his attorney.

(j) At the hearing the court shall advise the detained person and his parent, guardian or attorney of the contents of the written statement of emergency detention required in subsection (e) of this section and the application for involuntary hospitalization.

(k) The standard of proof in an emergency detention hearing shall be by a preponderance of the evidence. If the court finds at an emergency detention hearing that:

(i) The person is not mentally ill, the court shall order the person released;

(ii) The person is mentally ill and has applied for voluntary admission, the court may dismiss the proceedings; or

(iii) The person is mentally ill, it shall order continued detention of the person for not more than ten (10) days. The court may extend the detention period at the request of the proposed patient or his attorney.

(m) If the court finds the person is mentally ill pursuant to paragraph (k)(iii) of this section, the court shall make findings as to the person's competence to make informed choices regarding treatment and the person's need for prescribed psychotropic medication. If the court finds the person incompetent to make an informed decision, the court may order the administration of prescribed psychotropic medication for the period of the emergency detention for restabilization of the person's mental health.

25-10-110. Involuntary hospitalization proceedings.

(a) Proceedings for the involuntary hospitalization of a person may be commenced by the filing of a written application with the court in the county in which the person is initially detained. Proceedings may also be initiated in the county in which there is a designated hospital if there is a written agreement executed by the county in which the person resides and the designated hospital stating that the county in which the person resides will be responsible for costs of treatment under W.S. 25-10-112(e) that are not covered by the state. The application shall be accompanied by either:

(i) A certificate of an examiner stating:

(A) That he has examined the proposed patient not more than fifteen (15) days prior to the date [that] the application is [was] filed under this subsection;

(B) His findings and the proposed patient's history; and

(C) His opinion that the proposed patient is mentally ill; or

(ii) A written statement by the applicant and by an examiner that the proposed patient has refused to submit to examination by an examiner, together with a statement of the facts and circumstances supporting the application.

(b) Unless the proposed patient is represented by counsel, the court shall appoint an attorney to represent him.

(c) Proceedings under this section shall be entitled "In the Interest of". The county attorney of the county where the application is filed shall appear in the public interest. The court shall expedite the proceedings.

(d) Upon receipt of an application, the court shall issue notice thereof to the proposed patient, the person responsible for the care or custody of the proposed patient and other persons designated by the court. The notice shall be served as provided by the Wyoming Rules of Civil Procedure. The notice shall apprise the proposed patient:

(i) Of the purpose of the proceeding;

(ii) Of the identity of the appointed examiner, and his authority to conduct an examination;

(iii) Of his right to counsel, the identity of counsel appointed by the court to represent him and his right to counsel of his own selection;

(iv) Of the requirements for an involuntary hospitalization order under subsection (j) of this section;

(v) Of the basis for the proposed hospitalization, including a detailed statement of the facts and supporting testimony; and

(vi) That a hearing will be held if warranted by the report of the examination of the proposed patient.

(e) The court shall appoint one (1) or more examiners to examine the proposed patient and to make a written report to the court of the findings as to the history and mental illness of the proposed patient. The court may order the proposed patient to appear for examination and if the proposed patient does not appear the court may compel his appearance. The examination shall be held at a hospital, a medical facility, the home of the proposed patient or any other suitable place which will not have a harmful effect on his health. The examination shall be conducted no later than seven (7) days from the date of the notice. If the examination is conducted by an examiner other than a licensed physician or psychiatrist, the court shall appoint a licensed physician or psychiatrist to review the findings of the examiner and conduct a further examination, if indicated, and to report to the court.

(f) If the examiner reports the proposed patient is not mentally ill, the court shall terminate the proceedings. If the examiner reports the proposed patient is mentally ill, the court shall fix a date for and give notice of a hearing to be held as soon as possible. The notice shall satisfy the requirements of paragraphs (d)(i) through (vi) of this section.

(g) Within five (5) days of receipt of the notice of hearing, the proposed patient or his counsel may request a hearing before a jury. If upon the basis of the appointed examiner's report or from other information available to the court, the court concludes that the proposed patient does not understand his rights, the court may call a jury upon its own motion or upon the request of the person responsible for the care and custody of the proposed patient. A jury shall be selected pursuant to W.S. 1-11-101 through 1-11-129, and the proceedings shall follow the Wyoming Rules of Civil Procedure.

(h) The proposed patient, the applicant, and all others to whom notice is required may appear at the hearing to testify and may present witnesses. The court may receive the testimony of other persons. The proposed patient shall be present at the hearing unless he waives his right to appear. All persons not necessary to protect the rights of the parties shall be excluded from the hearing. The hearing shall be conducted in as informal a manner as is consistent with orderly procedure and in a physical setting which will not have a harmful effect on the mental health of the proposed patient. Any hearing conducted under this subsection shall be recorded by the court reporter or by electronic, mechanical or other appropriate means.

(j) If, upon completion of the hearing and consideration of the record, the court or the jury finds by clear and convincing evidence that the proposed patient is mentally ill the court shall consider the least restrictive and most therapeutic alternatives and shall:

(i) Order his hospitalization, assign him to a hospital, and:

(A) Send to the hospital, with the patient a certified copy of the findings of fact and order and a copy of the examiner's report;

(B) Specify where he will be detained pending transportation to the hospital. No person shall be detained in a nonmedical facility used for detention of persons charged with or convicted of penal offenses except during an extreme emergency;

(C) Order his transportation to the hospital with proper clothing and personal effects;

(D) Notify his next of kin or the person responsible for his care and custody and the proposed treatment provider or hospital of the court's order;

(E) Make findings as to his competence to make informed choices regarding treatment and his need for prescribed psychotropic medication. If the court finds the person incompetent to make an informed decision, the court may order the administration of prescribed psychotropic medication. The order for medication shall be reviewed by a physician upon commitment and by a psychiatrist upon admission to the hospital. The prescribed medication shall be continued if found medically appropriate by the investigation review committee of the hospital or institution, subject to review by the medical director of the hospital or institution. Any action by the medical director of the hospital or institution shall be reviewable pursuant to the Wyoming Administrative Procedure Act.

(ii) Suspend the proceedings pending voluntary treatment as approved by the examiner and by the facility or individual who will provide the treatment. If the court finds that the proposed patient does not require continuous inpatient hospitalization, would be more appropriately treated in an outpatient treatment program or a combination of outpatient and inpatient treatment or will be able to appropriately control his illness by following a prescribed treatment plan, the court shall consider such treatment options. If the court finds that the proposed patient does not require continuous hospitalization and the funding is available, it shall consider conditional outpatient treatment for a period of time deemed appropriate and may designate an outpatient care provider, including mental health centers. Conditional outpatient treatment may require periodic reporting, continuation of medication and submission to testing and restriction of travel, consumption of alcoholic beverages or drugs, associations with other persons or other reasonable conditions as the court may specify provided the court may suspend the imposition of the conditional outpatient treatment order for failure to meet the conditions and order involuntary hospitalization under this section; or

(iii) Order any disposition for which private resources are available and which is consistent with the best interests of the proposed patient and with public safety.

(k) The court is authorized to appoint a special commissioner to assist in the conduct of hospitalization proceedings. In proceedings under this act, regularly appointed court commissioners may exercise the authority granted by W.S. 5-3-307. In any case in which the court refers an application to the commissioner, the commissioner shall conduct the involuntary hospitalization proceedings under this section and on the basis thereof shall either recommend

dismissal of the application or hold a hearing as provided in this section and make recommendations to the court regarding the disposition of the proposed patient and of the proceedings.

(m) An appointed examiner shall receive for his services in each court ordered examination a reasonable fee fixed by the court.

(n) The court shall inquire into the medical condition of every patient found to be mentally ill. If the court determines based upon the advice of a physician, that the patient's present primary need is for medical treatment or care and whose need for psychiatric care is secondary, the court may delay ordering the commitment of the patient to the Wyoming state hospital until such time as the patient receives medical care and the patient's need for psychiatric care is primary.



TITLE 25
Wyoming Department of Health
Stakeholder Meetings
 List of Attendees

The Wyoming Department of Health hosted a series of four statewide meetings in Riverton, Wyoming, to draft recommendations addressing the issues identified during its survey of Title 25 processes in each county. The meetings were held on September 24, October 9, October 29, and November 13, 2008. Four video conferences were also held on December 16 and 17, 2008, to gather additional input and suggestions regarding the recommendations. The following individuals participated in these processes.

Riverton Meetings

Acker, Linda	Executive Director, Southwest Counseling Service; Sweetwater County
Adamson, Jane	Fremont County Commissioner
Allan, John	Sergeant, Jackson Police Department, Teton County
Archibald, Tammi	Lincoln County Commissioner
Baldes, Ranae	Victim Witness Coordinator, Hot Springs County Attorney's Office
Bankert, Greg	Acting Chief of Police, Worland; Washakie County
Bauer, Mike	Outpatient Mental Health Services Manager, Southwest Counseling Service, Sweetwater County
Blackburn, Ken	Sheriff, Big Horn County
Blumenshine, Ron	Detention Sergeant, Fremont County Sheriff's Office
Boyce, Linda	CARES, Big Horn County
Callahan, Nancy	Consultant
Casciato, Toni	Social Worker, Hot Springs County Memorial Hospital
Clabots, Lee	Deputy Director, Wyoming Department of Health
Claudson, Jackie	CEO, South Big Horn Hospital District, Big Horn County
Conder, John	Deputy County Attorney, Uinta County
Cook, Debbie	Captain, Big Horn County Sheriff's Office
Corsi, Steve	Executive Director, High County Resource Center, Lincoln & Sublette Counties
Cox-Mills, Anita	Facility Manager, Wyoming Retirement Center
Day, Carol	Facility and Community Services Coordinator, Wyoming Department of Health
Duncan-Malone, Heather	Deputy County Attorney, Natrona County
Edwards, Anna	Executive Director, NAMI, Wyoming
Emmert, Lori	Chief of Police, Douglas, Converse County
Flanderka, Mary	Administrator, Mental Health and Substance Abuse Services Division
Fredstrom, O'Ann	Psychiatrist, Jackson Hole, Teton County
Graham, Kelly	Human Resources, Solutions for Life, Converse County
Graves, Wayne	Mental Health Coordinator, Laramie County Sheriff's Department
Griffith, Laura	Community Services and Treatment Manager, Mental Health and Substance Abuse Services Division
Hanson, Randy	Sergeant, Rock Springs Police Department, Sweetwater County
Hayes, Chuck	Consultant

Wyoming Title 25

Hloucal, Jim	Lieutenant, Gillette Police Department, Campbell County
Humphries-Wadsworth, Steve	Clinical Director, Yellowstone Behavioral Health Center, Park County
Huston, Mike	Executive Director, Central Wyoming Counseling Center, Natrona County
Jansen, Troy	Lieutenant, Lincoln County Sheriff's Office
Jeffers, Sara	Detention Sergeant, Evanston, Uinta County
Johnson, Shane	Sheriff, Lincoln County
Kearns, Sue	Deputy County Attorney, Sweetwater County
Kinner, Charlotte	Advocate, Natrona County
Lancaster, Becky	UPLIFT, Fremont County
Marchisio, ReaAnna	Detention R.N., Sweetwater County Sheriff's Office
McAdams, Jerry	Executive Director, Fremont Counseling Service, Fremont County
McKee, Mike	Program Manager, Peak Wellness Center, Laramie County
Mertz, Helen	Manager, Adult Psychiatric Services, Wyoming State Hospital
Naman, Darold	Big Horn County Sheriff's Office
Nelson, Eric	Natrona County Attorney
Oedekoven, Byron	Executive Director, Wyoming Assoc of Sheriffs and Chiefs of Police
Parker, Gary	Manager, Social Work Department, Wyoming State Hospital
Patterson, Casey	Patrol Officer, Cheyenne Police Department, Laramie County
Pead, Sam	Deputy County Attorney, Uinta County
Pinter, Jean	CNO, Star Valley Medical Center, Lincoln County
Rakness, Steve	Sheriff, Washakie County
Rardin, Don	Manager, Psychology Department, Wyoming State Hospital
Rector, Phil	Forensic Psychologist, Indian Health Service, Fremont County
Richards, Julie	Group Home staff, Solutions for Life, Converse County
Robertson, Kathy	Advocate, Teton County
Rockvam, Perry	Chief of Police, Cody, Park County
Russler, Mark	Executive Director, Cloud Peak Counseling Service, Washakie County
Saprony, Tom	Lieutenant, Uinta County Sheriff's Office
Scarborough, Roger	Manager, Extended Psychiatric Services, Wyoming State Hospital
Smith, Emily	Program Manager, Peak Wellness Center, Laramie County
Smith, Marla	Research and Data Manager, Mental Health and Substance Abuse Division
Sprague, Deb	Executive Director, Jackson Hole Community Counseling, Teton County
Sprabery, Carol	County Coordinator, Peak Wellness Center, Albany County
Stahl, Bob	Interim Superintendent, Wyoming State Hospital
Stiffarm, Kevin	CEO, Weston County Health Services
Thamm, Helen	Mental Health Therapist/R.N., Hot Springs County Counseling, Hot Springs County
Thoma, Stacie	Mental Health Therapist, Solutions for Life, Converse County
Titus, Dean	Lieutenant, Sweetwater County Sheriff's Office
Ward, Shea	Business Development Director, Wyoming Behavioral Institute, Natrona County
Wartman, Tony	Social Worker, Wyoming Retirement Center
Whitbeck, John	Consultant
Whittington, Lynne	Interim Director, Northern Wyoming Mental Health Center, Sheridan County

Video Conference Participants

Armseth, Matt	Converse County
Alles, Mike	Mental Health and Substance Abuse Services Division
Barron, Joe	Crook County Attorney
Bauer, Mike	Outpatient Mental Health Services Manager, Southwest Counseling Service, Sweetwater County
Beck, Carolyn	Wyoming Behavioral Institute, Natrona County
Biggs, Glenn	Mental Health Therapist, Carbon County
Callahan, Nancy	Consultant
Carlman, Len	Defense Attorney, Teton County

Wyoming Title 25

Casciato, Toni	Social Worker, Hot Springs County Memorial Hospital
Christiansen, Pam	Mental Health Therapist, Northern Wyoming Mental Health Center, Sheridan County
Cook, Debbie	Captain, Big Horn County Sheriff's Office
Cooley, Robin	Deputy Attorney General, State of Wyoming
Cox-Mills, Anita	Facility Manager, Wyoming Retirement Center
Crowder, Yolanda	Case Manager, Sweetwater County Memorial Hospital
Day, Carol	Wyoming Department of Health
DeLancey, Cindy	Carbon County Attorney
Edwards, Anna	Executive Director, NAMI, Wyoming
Faber, Julie	Detention Officer, Big Horn County Sheriff's Office
Fredstrom, O'Ann	Psychiatrist, Teton County
Hayes, Chuck	Consultant
Hayes, Peggy	Clinical Director, Carbon County Counseling Center
Horton, Lisa	Director of Case Management, Powell Valley Healthcare, Park County
Humphries-Wadsworth, Steve	Clinical Director, Yellowstone Behavioral Health Center, Park County
Jenkins, Robin	Discharge Planner, Memorial Hospital of Sweetwater County
Johnson, Irene	Mental Health Therapist, Peak Wellness Center, Albany County
Koehler, Todd	Protection and Advocacy
Lavine, Rob	Carbon County Attorney's Office
LeFevre, Dick	Protection and Advocacy
Nelson, Mark	Chief of Police, Thermopolis, Hot Springs County
Nelson, Steve	Psychologist, Teton County
Oelschlager, Kristy	Advocate, Park County
Purcell, Mike	Executive Director, Mental Health Services, Campbell County Hospital, Campbell County
Ratigan, Mike	County Coordinator, Northern Wyoming Mental Health Center, Weston County
Regnier, Lori	Protection and Advocacy
Sievers, Doris	Discharge Planner, West Park Hospital, Park County
Segar, Carol	Campbell County Attorney
Solyst, Jerry	County Coordinator, Northern Wyoming Mental Health Center, Crook County
Sprabery, Carol	County Coordinator, Peak Wellness Center, Albany County
Sprague, Deb	Executive Director, Jackson Hole Counseling Center, Teton County
Stancliff, Terry	Mental Health Therapist, Northern Wyoming Mental Health Center, Sheridan County
Swisher, Randy	Converse County
Van Norman, Rita	Mental Health Therapist, Northern Wyoming Mental Health Center, Crook County
Ward, Shea	Business Development Director, Wyoming Behavioral Institute, Natrona County
Walter, Mark	Psychiatrist, Cheyenne Regional Medical Center, Laramie County
West, Jeannie	Discharge Planner, Sweetwater County
Whitbeck, John	Consultant
Whittington, Lynne	Interim Director, Northern Wyoming Mental Health Center, Sheridan County
Willoughby, Phil	Defense Attorney, Natrona County