



Intensive Behavioral Health
Treatment Services:

A Tool Kit for Implementing
WAC 246-341-1137

Division of Behavioral Health and Recovery
Washington State Health Care Authority



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Introduction

There is a new service delivery method in Washington. Intensive Behavioral Health Treatment Facility (IBHTF) are part of Governor Jay Inslee's plan to improve the state's behavioral health system. The new delivery system will provide support to those who are no longer getting any benefit of being at a state hospital but need more treatment and support to successfully transition to the community.

Purpose of the Guide

The overall goal of this guide is to help with the startup of an IBHTF. The guide can be referenced for programmatic decisions. The guide should not be used to make clinical decisions. We recognize that issues outside of the scope of this guide will occur and this guide will change over time.

Background

The IBHTF is part of Governor Jay Inslee's plan to transition people out of the civil wards in Washington's state hospitals. The concept for the IBHTF came from an analysis of the state hospital discharge barriers. The Health Care Authority's (HCA) Division of Behavioral Health and Recovery (DBHR) worked with Departments of Social and Health Services (DSHS) and the community to identify barriers to discharging people from state hospitals and ensuring they are successful after discharge. From these analyses it was determined there was a need to support people who are no longer benefiting from the treatment at state hospitals but still require more intensive support and treatment in the community to be successful. DBHR consulted with Aging Long-Term Support Administration (AL TSA) and the behavioral health administration (BHA) to develop the prototype facility. DBHR created a proposal for the facility among with many other options in a decision package to the legislature. The legislature chose the facility and instructed Department of Health (DOH) to create a license for the facility in 2SHB 1394 and funded for the creation of 4 facilities in the operating and capital budgets.

Problem

Many people are in the state hospitals in Washington simply because there is no place for them to discharge to and be successful. This is due to the high level of behavioral health treatment needed to successfully transition to the community. Their required care does not need to be provided in a hospital setting, but there is currently no facility that can provide the level of intensity they need. This has created the problem where people are no longer getting treatment but are unable to discharge due to lack of place that will support their complex needs and provide the active treatment that will help them be successful.

Facility's Purpose

IBHTF were created to provide a place in the community to provide intensive treatment and support for those who could not be placed elsewhere. The facility focuses on the needs of the person there and will offer onsite behavioral health interventions, psychosocial rehabilitation, and the development of skills to integrate back into the community. IBHTF are not designed to care for people with dementia or with strong medical needs that prevent them from being independent in their activities of daily living (ADLs).

Scope

IBHTFs are residential facilities for individuals seeking treatment voluntarily or individuals subject to a less restrictive alternative (LRA) order. They have robust onsite outpatient behavioral health services. Behavioral health staff will provide an active recovery focused environment to help people work through their barriers. Nursing staff will help them learn more about their overall health, medications, and develop the skills necessary to be successful in the community. Facilities are required to implement limited egress through implementation of delayed and monitored egress to ensure the safety of residents in the facility.

Element 1: Intake

IBHTFs are required to serve individuals who meet one or more clinical criteria suggesting that they currently cannot be served effectively in less restrictive community-based settings. Individuals should be served in an IBHTF only if they require more intensive services due to dangerous or intrusive behaviors, complex medication needs, a history of unsuccessful residential placements, a history of hospitalizations, or a history of violent or felony offenses. Further, certain factors exclude individuals from IBHTF. Each IBHTF may use its own intake forms and health records system. However, it is important that intake forms and health records document the individual’s initial and ongoing eligibility for IBHTF services.

This element of IBHTF includes three components:

1. Comprehensive intake procedures
2. Documenting a clinical need
3. Documenting that the individual does not meet exclusion criteria

1.1: Comprehensive Intake Procedures

Residents for the facility will need to complete an intake when they take up residency. A best practice would be for members of the treatment team to outreach and start building a relationship before the resident comes to the facility. This will make the transition period easier for the resident and staff. The initial intake will need to be completed by an MHP and can be completed prior to the person taking up residency. The intake should be comprehensive and thorough with a section to highlight traumas to prevent re-traumatization of the resident. The treatment team should all review the initial intake prior to working with the new resident as much as possible. Medical staff should complete their own intake and important information about serious conditions be made available to facility staff.

The Center for Health Care Strategies has produced an excellent overview of [Screening for Adverse Childhood Experiences and Trauma](#), complete with screening tools.

1.2: Documenting Clinical Need

The intake form must document that the individual meets at least one of the criteria listed in the first column of the table below. Hints for successful documentation appear in the second column. The intake form may include information from other treatment or residential facilities or settings; other referring agencies (e.g., mental health court); or information collected from the individual.

DOCUMENTATION OF CLINICAL NEED

CLINICAL NEED	DOCUMENTATION
Self-endangering behaviors that are frequent or difficult to manage	Note any suicide attempts, other form of self-harm, neglect for personal safety, or risky behaviors. Also note how often the individual engages in these behaviors and past efforts to change behavior.
Intrusive behaviors that put residents or staff at risk	Explain the specific behaviors and when/how often they have occurred.
Complex medication needs, which include psychotropic medications	Explain why the individual’s medication needs are complex. Examples might include failure to take medication regularly, significant side effects or drug interactions, or change to a different class of medication. You may also use a tool such as the Medication Regimen Complexity Index (MRCI), which

	includes mode of administration, frequency, and special instructions such as dietary restrictions.
A history or likelihood of unsuccessful placements in other community facilities or settings such as assisted living facilities; adult family homes; permanent supportive housing; supported living; or residential treatment facilities providing a lower level of services	Note the name and type of facility or setting in which a placement has been unsuccessful, along with a reason for discharge and the dates of the unsuccessful placements.
A history of frequent or protracted mental health hospitalizations	Note the dates and length of stay for hospitalization over the last 2 years.
A history of offenses against a person or felony offenses that cause physical damage to property	Note any sexual or violent offenses, including any involving weapons or physical threats. Note any theft or destruction of property that exceeds \$750 in value. This need not be limited to offenses that resulted in criminal conviction.

1.3: Documenting Exclusion Criteria

IBHTFs may not serve an individual who meet any of the exclusion criteria listed in the first column of the table below. The second column offers advice on documenting the individual’s eligibility for IBHTF.

DOCUMENTATION OF EXCLUSION CRITERIA

IBHTFs MAY NOT SERVE AN INDIVIDUAL ...	DOCUMENTATION
Who is under 18 years of age; <i>or</i>	Date of birth
For whom a mental health disorder is not the primary care need; <i>or</i>	The intake form and medical records should include a psychiatric diagnosis and plan of care.
Who have a diagnosis of dementia or organic brain disorder and can more appropriately be served in an enhanced services facility or other long-term care facility; <i>or</i>	Review the admission criteria for enhanced services facilities , assisted living facilities , soldiers’ and veterans’ homes , and adult family homes . Generally, an individual with a diagnosis of dementia or organic brain disorder requiring daily nursing care, nutritional support, or assistance with daily living can more appropriately be served in one of these other settings.
Who cannot perform activities of daily living without direct assistance from agency staff.	Including a score on an instrument such as the Katz Index or Routine Task Inventory would be helpful to demonstrate the individual does not require assistance with activities of daily living such as feeding oneself or bathing.

Resources for Intake

- Suicide Prevention Resource Center, [Screening for and Assessing Suicide Risk](#)
- Schulman, M., & Maul, A. (2019). [Screening for adverse childhood experiences and trauma](#). Center for Health Care Strategies.
- George, J., Phun, Y. T., Bailey, M. J., Kong, D. C., & Stewart, K. (2004). [Development and validation of the medication regimen complexity index](#). *Annals of Pharmacology*, 38(9), 1369-1376.
- RCW 70.97.030, [Admission Criteria for Enhanced Services Facilities](#)
- RCW 18.20.020, [Definition of Assisted Living Facility](#)
- RCW 72.36.030, [Admission to State Veterans' Homes](#)
- RCW 70.128.010, [Definition of Adult Family Home](#)
- McCabe, D. (2019). [Katz Index of Independence in Activities of Daily Living. Try This, 2](#)
- Katz, N. (2017). [Routine Task Inventory-Expanded \(RTI-E\)](#)

Element 2: Staffing

An IBHTF must have personnel policies and procedures that ensure they can provide core clinical and psychosocial rehabilitation services, in accordance with the individual care plans of every individual served. At minimum, the IBHTF must demonstrate that it has sufficient numbers of appropriately trained, qualified, or credentialed staff to provide:

1. Psychosocial rehabilitation related to activities of daily living, social interaction, behavioral management, recovery, impulse control, self-management of medications, and community integration skills;
2. Service coordination by a mental health professional;
3. Psychiatric services, specifically
 - a. 24/7 psychiatric nursing coverage;
 - b. Access to a licensed prescriber (psychiatrist, psychiatric ARNP, or PA); and
 - c. A mental health professional accessible 24/7 and onsite 8 hours per day;
4. Access to intellectual and developmental disability services provided by a disability mental health specialist or person credentialed to provide applied behavioral analysis; and
5. Peer support services provided by certified peer counselors.

At all times, the IBHTF must have two staff awake and on duty. The required psychiatric nurse and mental health professional (if onsite) count toward this total. Staff are not required to be certified as nursing assistants and cannot assist with hands on transfers, bathing, toileting, or other activities of daily living. This section also includes projected costs for operations, including providing laundry, janitorial, and maintenance.

2.1: Staff Qualifications

IBHTF regulations require staffing by employees with specific credentials, but the IBHTF may hire other employees to assist required staff in providing IBHTF services and managing the facility.

Psychiatric Care Provider (PCP)

The IBHTF must have a psychiatric care provider (PCP) who is a **licensed prescriber** of psychiatric medications available on call, as needed. The PCP will need to provide medication management to the up to 16 individuals residing at the facility.

The PCP can be a psychiatrist, psychiatric advanced registered nurse practitioner (ARNP), or physician assistant (PA) operating within the scope of his or her practice certifications in the State of Washington.

Mental Health Professional (MHP)

A **mental health professional** (MHP) must be onsite 8 hours per day, 7 days per week, and must be accessible 24/7. However, it is recommended that 1 MHP be scheduled on each shift (day, swing, and night, 7 days a week). All mental health services will need to be provided under the supervision of an MHP.

MHPs function as the primary mental health providers in the IBHTF. The role of the MHP is to provide psychosocial rehabilitation, counseling, care planning, and service coordination. They are responsible to ensure the completion of the initial intake and service plan, ongoing service plan updates, and crisis plans. MHPs will provide therapeutic interventions and psychosocial rehabilitation that are appropriate for the residents. MHPs will work with nursing staff to help build skills for residents to manage medications and their own wellness.

A mental health professional (MHP) is any mental health provider who meets the criteria under [WAC 246-341-200](#), including:

- Psychiatrist
- Psychologist
- PA working with a supervising psychiatrist
- Psychiatric ARNP
- Psychiatric nurse
- Licensed independent clinical social worker (LICSW) or another state-licensed social worker
- Licensed mental health counselor (LMHC) or mental health counselor associate
- Licensed marriage and family therapist (LMFT) or marriage and family therapist associate
- A person with an advanced degree in counseling or social science with two years of experience in direct treatment of persons with mental illness or emotional disturbance, under the supervision of a mental health professional
- A person who received a waiver from the Department prior to 2001 or 1986, depending on waiver type

Program Manager

One of the MHPs should act as program manager, working full-time at the IBHTF. The program manager provides clinical and managerial oversight of the facility and manages personal decisions. They are responsible for maintaining program integrity and ensuring staff are supported.

The program manager must be an MHP licensed by DOH to practice independently, such as an LICSW, LMHC, LMFT, or other independently licensed MHP.

Registered Nurse (RN)

A **psychiatric nurse** must be onsite 24/7. Psychiatric nurse is defined in RCW 71.34.020 as “a registered nurse who has experience in the direct treatment of persons who have a mental illness or who are emotionally disturbed, such experience gained under the supervision of a mental health professional.”

RNs must be licensed by DOH and able to perform the duties of psychiatric nurse.

Mental Health Care Provider (MHCP)

MHCPs provide many of the same functions as MHPs but are not qualified to complete assessments, service plans, and crisis plans without oversight by an MHP. They can provide services in the service plan under the direction of an MHP.

An MHCP requires a bachelor’s degree in counseling or a relevant social science field, although hiring MHCPs with master’s degrees is preferable. An MHCP must be credentialed by DOH in a [behavioral health profession](#) to provide services in the facility. This credentialing process includes a review of education credentials and a criminal background check.

Certified Peer Counselor (CPC)

Certified peer counselors (CPCs) bring their own experience to communicate and empathize with residents to empower them in their recovery. Peers will function as advocates and help create a culture of recovery in the facility.

A CPC is an individual with lived experience of mental illness or substance use disorder who completes a multi-step process that includes online and in-person training and passing an exam given by the Health Care Authority. A CPC must be recognized by the authority as a peer counselor as defined in [WAC 182-538D-0200](#).

Substance Use Disorder Professional (SUDP)

A substance use disorder professional (SUDP) completes assessments for entry into SUD services and provides any necessary SUD services set out in the service plan. Facilities can choose to hire an SUDP or contract out for this position depending on population of the facility and needs. SUDP are necessary to meet the full behavioral health needs of some of the residents.

An SUDP must be certified under DOH guidelines and be licensed or credentialed to provide services by DOH. As required by DOH and [246-811 WAC](#), certification requires supervised counseling hours based on the applicant's level of education, as well as an examination.

Program Support Staff

A full-time support staff person will help the IBHTF operate efficiently. This person can assist in scheduling and coordinating the functions of the facility. They can help with correspondence and reception, billing, and required certifications and inspections. They can also help to coordinate important non-clinical functions such as building maintenance, food service, ordering supplies, etc.

The support staff does not have any specific job credentials. However, the person must be able to work in a healthcare environment. Experience with reception and insurance information is highly recommended.

STAFF ABBREVIATIONS AND CREDENTIALING REQUIREMENTS

PROFESSIONS		
APRN	Advance practice registered nurse	The Department of Health licenses these professions. Each credential has its own education and experience requirements.
RN	Registered nurse	
PA	Physician assistant	
LICSW	Licensed independent clinical social worker	
LMFT	Licensed marriage and family therapist	
LMHC	Licensed mental health counselor	
SUDP	Substance use disorder professional	
Positions in IBHTF		
PCP	Psychiatric care provider	Psychiatrist, PA, or APRN
MHP	Mental health professional	Psychiatrist, psychologist, PA, ARNP, RN, LICSW or associate, LMHC or associate, LMFT or associate, others meeting DOH standards
MHCP	Mental health care provider	Bachelor's degree in counseling or social science
CPC	Certified peer counselor	Lived experience; state training and examination

2.2: Staff Coverage

An IBHTF has some flexibility in establishing work schedules for staff, but the staff coverage must be sufficient to ensure that all necessary services are provided and that two staff (including one RN) are on duty and awake 24/7. DOH considers at least 1 mental health professional or mental health care provider, 1 nurse, and 1 certified peer per shift to be the bare minimum but suggests that the day and swing shifts provide greater staff coverage. It is recommended to have at least 5 members on day and swing shifts and at least 3 for night shift.

Below is the suggested staffing pattern for the facility. Exact staffing patterns are up to the program manager and staff. When creating a staffing pattern, organizations are encouraged to reach out to regional stakeholders, especially law enforcement, to determine a workable and efficient staffing model.

Provided below are two sample staffing plans. The first example shows a more comprehensive approach, recommended by DOH, that would enable the IBHTF to meet the complex needs of the individuals it serves. The second shows an IBHTF that is meeting the minimum staffing requirements but might experience challenges in meeting complex needs. AN IBHTF will develop—and adjust as needed—its own staffing plan, but 17.4 FTE should be considered the minimum needed to operate an IBHTF.

It is likely that many IBHTFs will establish a staffing pattern that falls somewhere between the two examples below. Staffing patterns may change in response to how well the IBHTF is meeting individual needs. (It should be noted that these staffing plans do not account for maintenance, housekeeping, or foodservice, which need to be accounted for separately.)

EXAMPLE ONE: RECOMMENDED STAFFING

	FTE
Day Shift (7:00 to 15:30)	
1 on-call PCP	N/A
2 MHPs	2.8
2 RNs	2.8
1 CPC	1.4
2 MHCPs	2.8
1 program manager (M-F)	1
1 program support staff (M-F)	1
1 on-call/part-time SUDP	N/A
Swing Shift (15:00 to 23:30)	
2 MHPs	2.8
2 RNs	2.8
1 CPC	1.4
2 MHCPs	2.8
Night Shift (23:00 to 7:30)	
1 MHP	1.4
1 RN	1.4
1 CPC	1.4
1 MHCP	1.4
Total FTE	27.2

EXAMPLE TWO: MINIMUM STAFFING

	FTE
Day Shift	
1 on-call PCP	
1 MHP	1.4
1 RN	1.4
1 CPC	1.4
1 MHCP	1.4
1 program manager (M-F)	1
1 program support staff (M-F)	1
1 on-call/part-time SUDP	N/A
Swing Shift	
1 MHP	1.4
1 RN	1.4
1 CPC	1.4
1 MHCP	1.4
Night Shift	
1 licensed mental health professional on call	
1 RN	1.4
1 MHCP	1.4
1 CPC	1.4
Total FTE	17.4

2.3: Personnel Planning

The initial regulations provided the following table for estimating staffing requirements. Personnel costs will of course vary by community and by experience.

PERSONNEL COST PLANNING

PROFESSIONAL STAFFING	FTE RANGE	EST. RATE	PROJECTED COST
Prescriber (ARNP, PA or psychiatrist) on call	N/A	\$65-125/hr.	
Program manager	1.0	\$51/hr.	
Mental health professional	2.8-7.0	\$34/hr.	
Psychiatric nurse	4.2-7.0	\$51/hr.	
Mental health care provider	4.2-7.0	\$21/hr.	
Certified peer counselor	4.2	\$19/hr.	
Program support staff	1.0	\$18/hr.	
SUD professional, part-time or contracted	N/A	\$30/hr.	
Total FTE	17.4-27.2		

2.4 Operational Costs

The IBHTF is required to provide food and laundry services and will have other monthly costs, such as janitorial. The following are rough estimates of these costs.

FACILITY OPERATION COSTS	EST. MONTHLY COST	PROJECTED YEARLY COST
Medical supplies	\$500	\$6,000
Food costs	\$4,867	\$58,400
Clothing and other	\$267	\$3,200
Laundry	\$1,500	\$18,000
Patient transport	\$400	\$4,800
Activities	\$133	\$1,600
Personal Care Items	\$320	\$3,840
Insurance	\$1,500	\$18,000
Licensing	\$1,700	\$20,400
Laundry	\$2,000	\$24,000
Janitorial	\$2,000	\$24,000
Utilities, internet, phone	\$2,000	\$24,000
Supplies	\$1,200	\$14,400
Other working items	\$200	\$2,400
Miscellaneous, (maintenance, etc.)	\$2,000	\$24,000
TOTAL	\$15,187	\$247,040

Resources for Staffing

- Behavioral Health Services—Definitions, [WAC 246-341-200](#)
- Department of Health, [Behavioral Health Professions, Facilities and Agencies](#)
- Behavioral Health Services—Definitions, [WAC 182-538D-0200](#)
- Chemical Dependency Professionals and Chemical Dependency Professional Trainees, [Chapter 246-811 WAC](#)

Element 3: Core Clinical Services

IBHTFs provide treatment and rehabilitative services to up to 16 adults who do not require psychiatric hospitalization but need additional support to integrate into the community.

It is imperative that treatment be coordinated across all staff and shifts. Keeping a log of the activities the resident participated in and making it available for all shifts will help support the resident. This log should include difficulties the person has been experiencing and interventions staff have used with the outcome of those interventions. To limit re-traumatization staff should note in the log anything that has brought up trauma and ways the person has identified to process it.

3.1: Service Coordination

Service coordination is an essential function of the mental health professional working in an IBHTF. Individuals require additional services and supports while residing in the IBHTF, as well as when they transition to living in more independent settings.

Service coordination requires developing relationships with other individuals and organizations in the community, including physicians, podiatrists, dentists, hospitals, housing providers, social services agencies, and transportation providers. With the resident's permission, the mental health professional can discuss the resident's needs and ensure that the resident is obtaining services that meet their needs.

Service coordination also may require, again with the resident's permission, working with the resident's family, employer, faith community leader, or future landlord to help resolve any issues related to the resident's needs outside the IBHTF.

SAMPLE LANGUAGE DESCRIBING SERVICE COORDINATION DUTIES IN JOB DESCRIPTION

- Developing relationships with key community resources
- Identifying needed services consistent with person-centered treatment plan
- Linking individuals to services consistent with their treatment plan
- Scheduling appointments
- Monitoring the delivery of services, including health care, by outside providers
- Advocating on behalf of residents to obtain needed services
- Resolving problems or disputes with providers, employers, families, or others
- Helping residents build networks of informal supports

3.2: Psychiatric Nursing

The RNs will have significant contact with individuals residing in the IBHTF, playing a role in medication management, caring for chronic health conditions, ensuring patient safety, and other routine nursing roles. Given the prevalence of trauma among individuals served by IBHTFs, as well as their intended purpose of transitioning individuals to lower levels of care, RNs will also play a role in addressing trauma and promoting community integration and recovery.

Many individuals residing in IBHTFs will receive trauma-specific therapy. However, acknowledgement of trauma histories should inform all aspects of IBHTF care. Nursing services should be designed so as not to re-traumatize the individual and to create a supportive environment that promotes healing from trauma. A helpful article on [Trauma-Informed Nursing Practice](#) suggests the following:

- Introducing oneself and the role that the nurse plays in the individual's care
- Using non-threatening body positioning

- Asking before touching
- Using plain language and teaching

It is also important for the psychiatric nurses to recognize that the purpose of the IBHTF is not to maintain individuals at their current level of functioning, but instead to improve functioning so that they can transition to more independent settings. The American Psychiatric Nurses Association offers [Recovery to Practice](#), a continuing education program covering recovery-oriented practice for acute care psychiatric-mental health nurses.

3.3: Prescription of Medications and Medication Consultation

IBHTF residents are likely to have complex needs related to their psychiatric medications. Therefore, the IBHTF is expected to provide regular access to a psychiatrist or a PA/APRN authorized to prescribe psychiatric medications.

Most IBHTFs will contract this service to an outside provider unless the IBHTF is part of a broader organization employing prescribers. Key services required in the contract include:

- Initial in-person consultations with residents to review medical history, assess current needs, and prescribe medications
- Periodic medication management visits, which may take place through telemedicine, to review the effectiveness of medications, discuss any side effects or complications, and adjust or renew prescriptions
- Ordering necessary lab tests, such as drug blood concentration, hemoglobin A1c, and lipid levels, based on the medications prescribed
- Be available to residents and IBHTF staff during business hours to discuss any concerns

Additionally, the IBHTF will need to arrange for residents to obtain their prescribed medications, through a combination of picking up from a local pharmacy, transporting residents to a pharmacy, having a pharmacy deliver medications, or mail order.

3.4: Substance Use Disorder Services

An IBHTF must offer access to SUD services, whether or not any residents have been diagnosed with SUDs. Because residents can come and go from the IBHTF and receive visitors, it is possible that some residents will either develop an SUD or relapse to substance use after a period of sobriety. Therefore, essential services include:

- Screening for SUDs
- Developing policies on substance use by residents
- Educating residents about the risks involved in the use of alcohol, marijuana, and other drugs by people with SMI
- Harm reduction strategies
- Individual and group therapy provided by an SUDP
- Access to Alcoholics Anonymous, Narcotics Anonymous, and other support groups, including transportation
- Referral, if needed, for medication-assisted treatment for opioid use disorder

It is not required for an IBHTF to have an SUDP on staff. However, the IBHTF must establish relationships with SUD treatment agencies and community support groups in order to ensure access is available when needed.

3.5: Accommodation of Intellectual and Developmental Disabilities

Individuals with intellectual and developmental disabilities have the right to reside and receive services in an IBHTF with reasonable accommodation of individual needs and preferences, except when the health or safety of the individual or other individuals would be endangered.

Staff should receive training on accommodating the needs of individuals with intellectual or developmental disabilities, including differentiating among behaviors associated with intellectual or developmental disabilities, versus mental illness.

Resources for Core Clinical Services

- Centers for Disease Control and Prevention and National Institute for Occupational Safety and Health, [Workplace Violence Prevention for Nurses](#)
- American Psychiatric Nurses Association, [Recovery to Practice](#)
- Fleishman, J., Kamsky, H., & Sundborg, S. (May 31, 2019). [Trauma-informed nursing practice](#). OJIN: *The Online Journal of Issues in Nursing*, 24(2), Manuscript 3.

Element 4: Core Psychosocial Rehabilitation Services

To be successful IBHTF need to have active behavioral health treatment available to all residents. It is recommended to have a mix of group, individual, wellness, social, and skill building options. These options should start at a reasonable time in the morning after everyone has time to wake up and get ready for the day. The schedule should allow for breaks and physical activity throughout the day. It is recommended to have multiple offerings available. These offerings should be in separate places away from frequently used common areas. Active treatment can be exhausting and frustrating for residents. Let the residents set their own pace and allow for them to take downtime to process and move forward.

Residents should only be in active treatment activities when they are voluntary and it is clinically appropriate. When residents are not willing or able, they are allowed to do other activities. It is important when residents choose to not participate in active treatment activities to still support them in their recovery by still working with them and building skills through other means and being empathetic. Peers should be work with other facility staff on ways to help engage residents to help motivate them when necessary.

Staff should identify treatment goals in collaboration with residents, focusing on areas such as:

- Identifying and managing situations that make symptoms worse
- Identifying signs that symptoms are worsening and taking proactive steps
- Improving the ability to respond proactively to crisis situations
- Understanding the role that medications can play in recovery
- Increasing residents' independent living skills in areas such as transportation, shopping, cooking, maintaining a household, and protecting personal safety
- Supporting societal roles such as being a good neighbor, developing friendships, and participating in activities of interest
- Supporting the development of personal wellness plans
- Encouraging the development of natural support networks

4.1: Skills Training in Activities of Daily Living

To be admitted to an IBHTF prospective residents must be able to carry out their activities of daily living (ADL) independently with staff only cueing and supporting them to learn the skills. Staff cannot assist a resident with hands on transfers, bathing, toileting, or other ADL needs that require staff to be certified as nursing assistants.

Residents will need more than just active treatment. Supporting them in their recovery will require staff to assist the resident developing skills. These skill building activities can be anything from supporting with bathing, sleeping, and eating routines to helping learn how to take medications and navigate social skills. Staff should work with the resident on their terms to help practice skills. These skills can be skills learned in active treatment options or as identified by the resident for their recovery.

4.2: Behavior Management

Residents of IBHTF will be coming from long stays at state hospitals where they will likely have experienced seclusion and restraint due to their actions. Staff in IBHTF cannot use involuntary seclusion or restraint in the facilities. If a difficult situation arises staff will need to help the person process the situation. Safety must always be maintained and good judgement to this end should always be used first and foremost.

If safety can be maintained staff should engage the resident as much as possible. If the resident is doing a behavior that has been determined with prior clinical judgement to be a learned maladaptive coping mechanism staff should support the person with preplanned interventions. Staff should always use good judgement and if the intervention is not working be open to trying new interventions. If other residents with good relationships want to involve themselves allow them to interact in a safe manner. Calling police should be a last resort if possible, with the goal of helping people work through maladaptive behavior for managing emotional distress.

Because staff can work with individuals on a long-term basis, they should consider interventions specifically designed to improve impulse control. For example, a group at the University of Minnesota has developed and tested a [cognitive-behavioral therapy program](#) for people with behaviors such as stealing and setting fires.

4.3: Self-Management of Medications

An important part of preparing IBHTF residents to live more independently is helping them improve their ability to manage their own medication regimens. An IBHTF is required to provide 24-hour nursing coverage, and many residents will require intensive medication support when they enter the IBHTF. However, the staff should allow patients the opportunity to manage their own medications, particularly those with lower potential for abuse or overdose.

At the most basic level, teaching self-management might involve helping residents sort pills into medication organizers and following up to see if they have taken doses on schedule. It is important to use motivational interviewing and other techniques to improve medication compliance. If residents understand the importance of medication to their treatment and life goals, chances of success improve.

Another way to improve medication self-management is to involve residents in shared decision-making about their medications. The more residents feel in control of their care, the more likely they are to focus on taking medications as directed. SAMHSA offers [resources on shared decision-making](#), including an [online tool specific to antipsychotic medications](#).

4.4: Community Integration Skills

Recovery from mental illness is a holistic process. In addition to improvements in health, recovery involves establishing a home, participating in community life, and discovering meaningful activities. IBHTFs should offer supports that address the community integration aspects of recovery, including—depending on the individual's circumstances and interests—friendships, parenting, intimacy, worship, volunteering, education, and employment.

The Temple University Collaborative on Community Inclusion offers a number of helpful resources on the following topics related to community inclusion of individuals with mental illness:

- Relationships, including family, friends, and intimacy
- Parenting
- Recreation and leisure
- Employment
- Religion

4.5: Peer Support Services

Certified Peer Counselors play a crucial role in IBHTF services. In Washington State, peer counseling is an [approved Medicaid service](#), pairing individuals in recovery with trained counselors who share similar life experiences. Each IBHTF should have no less than four peer counselors on staff, with at least one available each shift. Each peer counselor must have met the state requirements through the Washington State peer certification process and passed the state exam. Peer counselors work under the supervision of a mental health professional and are considered a core member of the IBHTF care team.

Peer Counselors provide recovery support services intended to engage, activate, and support people with behavioral health conditions. Certified Peer Counselors should be a part of all group activities offered by the IBHTF and lead groups that include but are not be limited to: Wellness Recovery Action Planning (WRAP), Peer-To-Peer Support, and Promote Wellness. They may also:

- Assist an individual in identifying services and activities that promote recovery and lead to increased meaning and purpose.
- Assist individuals in developing their own goals.
- Share their own recovery stories that are relevant and helpful in overcoming the obstacles faced by individuals.
- Promote personal responsibility for recovery.
- Assist in a wide range of services to help individuals regain control and success in their own lives, such as developing supportive relationships, self-advocacy, stable housing, education and employment.
- Serve as an advocate.
- Model skills in recovery and self-management.
- Complete documentation about their services for Medicaid and employer requirements.

Mental Health Professionals supervising peer counselors should understand the unique role and needs of this workforce and ensure they are fully integrated into the IBHTF staff team. As this is a new service for many organizations, some supervisors may need additional training and support to effectively supervise peer workers. Some helpful [resources for supervisors](#) are available that include self-study materials, self-assessment tools, and additional resources.

Resources for Core Psychosocial Rehabilitation Services

- [Boston University Center for Psychiatric Rehabilitation](#)
- Grant, J. E., Donahue, C. B., & Odlaug, B. L. (2011). [*Treating impulse control disorders: A cognitive-behavioral therapy program, therapist guide*](#). Oxford University Press.
- Grant, J. E., & Leppink, E. W. (2015). [Choosing a treatment for disruptive, impulse-control, and conduct disorders](#). *Current Psychiatry*, 14(2), 28-36.
- Substance Abuse and Mental Health Services Administration, [Shared Decision-Making Tools](#)
- Substance Abuse and Mental Health Services Administration, [The Role of Antipsychotic Medications in My Recovery Plan](#)
- Nemecek, P. B., & Furlong-Norman, K. (2014). [Best practices in psychiatric rehabilitation, 2nd Ed.](#) Psychiatric Rehabilitation Association.
- [Temple University Collaborative on Community Inclusion](#)

Element 5: Safety and Security

IBHTF will need to institute policies to ensure safety of the residents and staff. These policies will need to include the implementation of systems to allow staff to be aware of individuals in the facility. Staff should be able to communicate with each other at all times.

The design of the IBHTF should facilitate safety while also producing a feeling of safety for individuals who have trauma histories. Some physical features that can improve physical security, such as bars on windows or loud buzzers on doors, create an institutional feel that may hamper recovery. Resources such as [Laying the Groundwork for Trauma-Informed Care](#) offer advice on designing environments that balance physical security with emotional safety.

5.1: 24-Hour Supervision

IBHTFs are required to provide “twenty-four hour observation of individuals by at least two staff who are awake and on duty” (WAC 246-341-1137(2)(c)). At all times, at least one psychiatric nurse must be on duty (WAC 246-341-1137(6)(c)).

The intensity of supervision depends on numerous factors, including risk of self-harm. (Patients at imminent suicide risk may require inpatient hospitalization rather than IBHTF services.) Because the regulations are not specific, IBHTFs will need to devise policies and procedures that ensure the intensity of observation—knowing where the individual is, checking on the individual every 15 minutes, etc.—is appropriate to clinical need. This [review article](#) summarizes various approaches to observation.

The physical layout of the IBHTF should be designed to facilitate observation, eliminating areas in which individuals could deliberately obscure themselves from view of staff. This might include physical changes such as keeping custodial closets locked, eliminating unnecessary doors and curtains, and removing dividers, plants, or other objects that limit view. The [Behavioral Health Design Guide](#) is intended primarily for inpatient settings but offers guidance that would be helpful to IBHTFs, such as minimizing “blind spots.”

5.2: Monitoring Movement and Egress

The IBHTF must monitor the movement of individuals within the building, and staff must be aware when individuals leave the facility. Individuals who reside voluntarily in IBHTFs must be allowed freedom to exit the IBHTF. This requirement extends to individuals subject to an LRA order. To ensure that staff can monitor departures and follow up as needed, the IBHTF may install delayed egress doors consistent with the state building code. These doors:

- Cannot be opened for 15 seconds, except during a power failure or fire
- Sound an alarm upon an attempt to open
- Are labeled with instructions on how to operate the doors

It is preferable to have a main entrance that is monitored by staff during daytime hours so that residents, visitors, and staff may enter and exit without sounding an alarm. The staffing levels of the IBHTF must be sufficient to allow monitoring of at least one entrance/exit so that voluntary residents and their visitors have freedom to conduct normal activities without the hindrance of delayed egress and sounding an alarm. During overnight hours when staffing levels are lower, the main entrance may be set to a delayed egress mode.

5.3: Freedom of Movement for Voluntary Individual

Staff should engage residents as much as possible about the purpose of limited egress and work them in their service plan to encourage safe behavior in the community. The IBHTF's policies should be such that residents are encouraged to leave the IBHTF for activities that are consistent with their care plan. For example, they could be encouraged to check in with staff when they plan to go outside and let them know where they will be, who they will be with, what they plan to do, and when they plan to return.

The IBHTF cannot prevent a voluntary resident from leaving the IBHTF at any time. If staff feel that a resident is at risk in the community, they should follow the individual and call for support if necessary. Potential unsafe behavior should be documented, and all staff should be aware of this behavior in preparation of other times the resident chooses to leave the facility. Staff should counsel residents at behavior that puts the residents or others in the community at risk. If a pattern of such behavior is documented, staff may recommend a change to a more intensive level of care. By contrast, leaving the IBHTF regularly, without documentation of harmful behavior, does not suggest a need for a higher level of care.

The IBHTF should have policies and procedures in place for when an individual subject an LRA leaves the IBHTF. This might include staff following the individual and calling the local crisis system for assistance if there is reason to fear harm to self or others. If an individual subject to an LRA leaves the IBHTF for an extended period, the staff should attempt to locate the individual and should notify the individual's MCO and the court system as appropriate.

5.4: MOU with Local Crisis System

The agency must have a memorandum of understanding with the local crisis system, including the closest agency providing evaluation and treatment services and designated crisis responders to ensure timely response to and assessment of individuals who need a higher level of care.

5.5: Living Environment

The IBHTF should strive to make residents feel like they are living in a home rather than just a treatment facility. Soft colors and artwork can help create a welcoming feel. Other ideas include involving residents in seasonal decorations, caring for a garden or houseplants, and planning visits to thrift shops to purchase items for their rooms.

Resident Rooms and Bathrooms

It is highly recommended residents have their own rooms and not share rooms unless they are married, or it is determined a roommate is the best for the resident. Residents have the right to retain and use personal possessions, including some furnishings, and appropriate clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents.

Rooms will need to be furnished with a comfortable bed, dresser for clothing storage, secure storage that only the resident will have access to, and a place for the resident to sit and write. It is recommended the resident have a place to store clothing. Safety should be considered, and shelves may be a safer alternative to a rod with hangers. It is advised to have laundry baskets in the room for the residents to use.

Bathing facilities will be made available to residents for their access whenever they need it. Staff should support residents to get into a healthy routine for bathing and basic grooming. Cueing and support should be part of the persons care. Proper safety precautions should be taken to limit accidents and harm to residents.

Meals

Nutritious and culturally appropriate meals must be provided to the residents. The U.S. Department of Agriculture adult meal pattern guidelines are a good rule of thumb for ensuring that nutritional needs are met. Whenever possible residents should be given options and input on the meals they will be provided. Modeling healthy meals also helps prepare residents to live more independently.

Food allergies and other dietary needs (such as diabetic diets) need to be documented at intake, and food preparation staff should take proper precautions. Proper food preparation and safety protocols need to be followed to ensure the food is safe to eat.

Clothing and Laundry

Residents should be given opportunities to select their own clothing. Residents will have limited funds for clothing, and some may need to be supplied to them. Establish relationships with local charities that offer clothing to low-income members of the community.

Laundry will need to be provided or made available to residents in the facility. We encourage facilities to make laundry a normal part of the living in the facility and recommend having residents do their own laundry as much as possible. Encouraging residents to take an active role in their needs will help them take ownership of their residence and themselves. Not all residents will be ready or willing to participate in their own laundry needs and staff may need to assist them in their laundry.

Toiletries and Feminine Products

Toiletries like deodorant, toothbrush and toothpaste, bathing supplies, and hand sanitizer should be made available for those who need it. Supplying residents with basic toiletries is important to their ongoing health and wellbeing. It can be used to encourage residents to take better care of their physical health as well as prevent the spread of illness.

Feminine products need to be made available to anyone who requests them while at the facility. Residents may not have the funds to purchase these on their own and will need to be supplied them. This is a basic human dignity that should not be overlooked.

Entertainment and Leisure

Residents should have options other than television for entertainment. It is highly recommended to have books, games, and basic leisure activities available. Choices are up to the IBHTF, but giving people something to distract themselves and engross themselves in will help them to relax and make the living situation more inviting. As with clothing, local charities may be able to offer free or low-cost games, books, etc.

Resources for Safety and Security

- Beebe, C. (2018, Nov./Dec.). [Ligature-risk requirements: Separating fact from fiction in suicide prevention](#). *HF Magazine*.
- Sakinofsky I. (2014). [Preventing suicide among inpatients](#). *Canadian Journal of Psychiatry*, 59(3), 131–140.
- Hunt, J. M., Sine, D. M., & McMurray, K. N. (2019). [Behavioral Health Design Guide, 9th Ed.](#) Behavioral Health Facility Consulting, LLC.
- Schulman, M., & Menschner, C. (2018). [Laying the groundwork for trauma-informed care](#). Trauma-Informed Care Implementation Resource Center.

Element 6: Rights Protection

The agency must protect and promote the rights of each individual and assist the individual to exercise their rights as an individual, as a citizen or resident of the United States and the state of Washington. Because residents of an IBHTF are in a vulnerable position, the IBHTF must take active steps to protect each individual's right to a dignified existence, self-determination, and all statutory rights.

To accomplish this objective, the IBHTF must train all staff in the rights of residents, provide residents with information about their rights and access to advocates, and establish a fair process for residents to file grievances and appeal any decisions.

6.1: Staff Training

An IBHTF must train staff on resident rights and how to assist individuals in exercising their rights. The IBHTF must provide initial training to all new employees and contracted providers so that they understand the rights of IBHTF residents, all of whom reside at the IBHTF voluntarily.

After completing the training staff should:

- Understand that all residents are voluntarily seeking services and treatment.
- Acknowledge the residents have the right to leave the IBHTF, choose their own activities, and otherwise have control over their lives, even when staff does not support such decisions.
- Be able to use basic motivational techniques to support health and safety and improve compliance with recommended treatment, including prescribed medications.
- Know the procedure for documenting and reporting any resident concerns or complaints.
- Understand the need for the resident's consent to share information with family, friends, or others, along with the procedures for obtaining consent.
- Understand, and be able to explain to residents, how to contact the Department of Health, the relevant ombuds program, and the protection and advocacy systems.
- Be able to use basic de-escalation techniques as an alternative to restraint and involuntary seclusion, which may not be used in an IBHTF.
- Understand the grievance process, including residents' rights to file a grievance directly with the Department of Health.
- Understand the procedure for reporting any rights violations the staff person might witness, including reporting the violations to the Department of Health.

6.2: Restraint and Seclusion

Residents have a right to be free from restraint and involuntary seclusion. They also have the right to be free from verbal, sexual, physical, and mental abuse and corporal punishment. Therefore, the IBHTF may not use mechanical or other restraints and may not seclude a resident from other residents.

It is important for all staff to receive training in crisis de-escalation and behavior management as an alternative to the use of restraint or seclusion. The National Association of State Mental Health Program Directors has developed [Six Core Strategies for Reducing Seclusion and Restraint Use](#), which is a helpful resource.

6.3: Access to Information and Advocates

Residents of an IBHTF have the right to receive information about their treatment, IBHTF policies, and their rights, and they have the right to know about advocacy and ombuds programs and contact these resources.

To protect these rights, the IBHTF must:

- Provide a means for each individual to contact people outside the agency, by telephone or in writing, about conditions in the IBHTF or their individual treatment, including without limitation:
 - Representatives of the Department of Health or other state entities;
 - The individual’s medical provider;
 - Ombuds programs;
 - Protection and advocacy systems; and
 - Family or friends;
- Post names, addresses, and telephone numbers of the state survey and certification agency, the state licensure office, the relevant ombuds programs, and the protection and advocacy systems;
- Allow family, friends, and people who provide health, social, legal, or other services to residents to have a reasonable opportunity to contact residents or meet with them in the IBHTF, so long as the resident consents to this contact;
- Allow the resident, the resident’s designated or legal representative, or (with permission) representatives of appropriate ombuds to access the resident’s records; and
- Not require residents to sign liability waivers covering loss of personal property, injury, or violations of rights.

The IBHTF must also take steps to inform residents and their families or legal representatives of their rights and issues that affect them, including:

- Notifying, in plain writing, the individual and the individual’s representatives of the individual’s rights and documenting at intake that the individual has received this notification;
- Notifying the individual and the individual’s representatives of the agency’s policy on accepting Medicaid as a payment source;
- Notifying representatives of any accident that requires or has the potential for requiring medical intervention;
- Notifying representatives of a significant change in the individual’s physical, mental, or psychosocial status;
- Notifying representatives of any change in room or roommate assignment; and
- Notifying representatives regarding transfer or discharge.

6.4: Grievances and Appeals

The IBHTF must offer a formal procedure for filing grievances and appealing decisions. However, a resident is not required to follow any specific procedure to have a right to be heard. The IBHTF is responsible for promptly addressing any grievances raised formally or informally by residents regarding:

- Treatment that was furnished;
- Treatment that was not furnished;
- Other actions of staff; or
- Behavior of other residents.

Residents have the right to file a complaint with the Department of Health at any time, and for any reason, whether or not they have first filed a grievance with the IBHTF. Residents also have the right to examine the results of the most recent survey or inspection of the agency conducted by federal or state surveyors or inspectors and plans of correction in effect with respect to the agency.

Resources for Rights Protection

- National Association of State Mental Health Program Directors, [*Six Core Strategies for Reducing Seclusion and Restraint Use*](#)
- Washington Department of Social and Health Services, [*A Guide to Programs and Services*](#)

Element 7: Community Integration

In the 1999 *Olmstead v. L.C.* decision, the U.S. Supreme Court upheld the federal requirement (under the Americans with Disabilities Act) that people with disabilities receive treatment and services in the most integrated setting appropriate to their needs. As applied to IBHTFs, this means that the program has a duty to ensure that residents have the opportunity to interact with people outside of the program, they have the right to explore employment and educational opportunities, and perhaps most importantly, they have the right to transition to more independent settings as their needs and interests evolve.

7.1: Personal Privacy and Autonomy

Individuals who reside in an IBHTF have all the same rights as other residents of the State of Washington. Residents have the right to do all the following:

- Make decisions about their treatment and personal affairs without undue interference, coercion, discrimination, or reprisal by staff
- Select a personal representative to help them exercise their rights
- Have access to their own funds and manage their own finances
- Receive reasonable accommodations for their disabilities
- Maintain the privacy of medical care received outside of the IBHTF
- Have what they say to staff or in groups remain confidential
- Meet privately with friends and family
- Maintain control over who personal and clinical records are released to
- Organize and participate in groups of residents

Residents may not be aware of these rights when they arrive at the IBHTF, and it is the duty of the IBHTF to inform residents of their rights, as well as to train staff in observing and upholding residents' rights.

7.2: Personal Communications

The IBHTF should facilitate personal communication with people outside the IBHTF. Connecting residents to their outside support system is important to preparing residents to live independently, the central role of the IBHTF. Therefore, the IBHTF should:

- Supply residents with pen, paper, and stamps
- Allow them to write correspondence without staff reading it
- Allow them to receive mail and read it without staff opening it or reading it
- Make a telephone available in a private location for residents to make and receive calls

7.3: Social Interaction

Enabling people with disabilities such as mental illness to interact with people who do not have disabilities “to the fullest extent possible” is a key obligation placed on states by the Americans with Disabilities Act and confirmed by the U.S. Supreme Court in the 1999 *Olmstead v. L.C.* decision. For social interaction to be meaningful, IBHTF residents need the opportunity to control their activities and relationships.

Residents have the right to do all of the following:

- Choose activities, schedules, and health care consistent with the individual's interests, assessments, and plans of care
- Interact with members of the community both inside and outside the IBHTF

- Make choices about significant aspects of their life in the IBHTF
- Participate in social, religious, and community activities that do not interfere with the rights of staff or other residents

Residents will be living together for an extended timeframe. Building a sense of community among residents or groups of residents depending on preference. Use CPCs to build a sense of community that will help with recovery by creating a supportive environment based on peer support for residents. Activities and treatment options should encourage a sense of community in the facility. Residents will be able to support and advocate for each other as the sense of community grows. This should be encouraged as a healthy form of peer support. As always use good clinical judgement when residents are interacting with someone who is not doing well and when there could be vulnerable people involved. Residents who have healthy relationships with each other will be the best foundation for recovery.

Residents will have limited funds to participate in many of the activities that most are privileged to. It is important that the facility make available activities that will enrich the lives of the residents. These can be communal or individual activities done by a set schedule or made available to residents to do on their own.

The IBHTF should assign a staff person, such as a CPC or MHCP, to act as an activity coordinator in addition to their other duties. The role includes the following functions:

- Identify opportunities for low-cost activities in the community.
- Discuss these opportunities with residents to gauge their interest.
- Explore the residents' other ideas for activities.
- Look for creative ways to fulfill these needs.

If residents are interested in going to movies, the local library might host movie nights, or if they are interested in shopping, a thrift shop might have half price days. The activity coordinator might be able to obtain free or reduced-cost tickets to events because of residents' limited resources.

Resources for Community Integration

- Baron, R. C. (2007). [*Promoting community integration for people with serious mental illnesses: A compendium of local implementation strategies.*](#)
- Baron, R. C. (2018). [*Jump-starting community living and participation.*](#)

Element 8: Person-centered Planning

Person-centered, strengths-based, recovery-oriented, and trauma-informed care should be the overarching framework that informs and guides all aspects of IBHTF service delivery and care planning. IBHTF are facilities for active treatment with the end goal of helping each resident to live a personally meaningful life. Residents can live in the facility as long as necessary for them to stabilize themselves for the next step of their recovery. The person-centered plan creates both a vision and a pathway for moving forward. Treatment and services should be framed as tools and support for helping the person attain and ultimately maintain a full life outside the facility.

Person-centered planning requires that individuals be wholly involved in and directing their treatment and service planning. The only exception is if a person is formally adjudged incompetent or otherwise found to be legally incapacitated. In this circumstance, the IBHTF staff will involve the individual to the greatest degree possible and support their participation in the planning process. Residents of IBHTF have the right to refuse any particular service so long as such refusal is documented in the record of the individual.

The Yale Program for Recovery and Community Health has developed a number of resources on [person-centered recovery planning](#) which have been adapted into services in multiple states and programs.

8.1: Treatment Planning

All IBCHF residents should have a person-centered service plan which focuses on each person's vision for their future and how treatment and services support attainment of that vision.

A service plan will need to be completed before the resident participates in any active treatment. This person-centered service plan should look into all aspects of the person's recovery and work with them to be self-directed. The service plan will need to be updated regularly at least every 6 months or when new services are added or removed. Different staff should be in charge of elements of the care plan as appropriate. All services must be overseen by appropriate staff for the services provided. Specific measurable goals should be called out in the service plan. These goals should be front and center in all treatment interventions and support activities. Residents must be full partners in co-creating their service plan.

8.2: Support and Recovery Planning

In behavioral health, the concept of recovery does not equate with "cure," but is about each person living a satisfying, hopeful and contributing life, even when there may be limitations caused by mental health problems and illnesses. Each person's treatment and support plan should focus on their personally meaningful goals and their own vision of life in the community. It is the IBHTF team's responsibility to help individuals explore and identify their personal goals and recovery vision, and to think beyond services offered by the facility.

Support and recovery plans should help individuals to identify their strengths and build on them to attain desired outcomes. A net planning process will be used, i.e., the plan begins with what the resident can do for himself/herself. Then it adds community-focused resources and support from family, friends, and other community resources. Lastly, IBHTF services are integrated into the plan to help individuals develop confidence and ability to attain and sustain broader recovery goals.

In recovery-oriented, person-centered care, individuals should be

- Supported and encouraged to fully participate in all decisions about their treatment, services, and recovery planning,

- Provided with full, accurate, objective, and understandable information,
- Respected by having their personal goals and concerns honored.

[Basic standards for support and recovery planning](#) developed by the Yale Program for Recovery and Community Health include the following:

- Individuals can bring family members or allies to the planning meetings.
- Each person is offered a copy of his or her plan to keep.
- Treatment goals are written in each person's own words.
- Each person's strengths, interests, and talents are integrated into the plan.
- Cultural factors such as spiritual beliefs and culture-based preferences are explored and considered in planning.
- Staff offer education about personal wellness and self-determination tools such as WRAP and advance directives as part of the planning process.
- Residents are supported to pursue personal goals such as housing or employment, even if they are still struggling actively with medication adherence, sobriety, or clinical symptoms.

Regular use of a tool such as [Wellness Recovery Action Planning \(WRAP\)](#) can help both residents and staff think about recovery and self-care from a highly personal perspective, outside formal treatment and service planning. Each IBHTF should offer weekly WRAP groups, facilitated by [certified WRAP facilitators](#) to help residents understand, develop, and use personal WRAP plans.

Resources for Person-centered Planning

Yale Program for Recovery and Community Health has developed a number of resources on [person-centered recovery planning](#)

- Connecticut Department of Mental Health and Addiction Services, [What Is Recovery?](#)
- Connecticut Department of Mental Health and Addiction Services, [Person-Centered Planning](#)
- Symanski-Tondora, J. L., Miller, R., Slade, M., & Davidson, L. (2014). *Partnering for recovery in mental health: A practical guide to person-centered planning*. John Wiley & Sons.
- Wellness Recovery Action Plan, [WRAP Is ...](#)

Element 9: Discharge and Transition to Community

Discharge planning is an essential part of the service plan, and immediately upon intake, goals should be tailored towards the resident resolving barriers to living in the community. Active discharge planning should begin once it is identified the resident could discharge from the facility within the next 2 service plan cycles (between 6-12 months prior to discharge).

Discharge planning should start with the resident identifying the next steps in their recovery. These steps should identify the placement after discharge and what supports will need to be in place to ensure successful transition. Staff should work with the resident to normalize the new setting and help the resident explore their options. During the final service plan cycle, staff and the resident should work together on the specific skills to be successful. This should include reinforcing skills that the resident learned and helping them establish support networks in their community. For a period after discharge staff should continue to work with the resident and their new supports to ensure a smooth handoff and allow the resident to have a familiar person to reach out to if needed.

9.1: Discharge Policies

An IBHTF must develop discharge policies that comply with the IBHTF regulations. The table below provide an overview that can be used as a checklist to ensure that the facility's policies are compliant.

OVERVIEW OF REQUIRED DISCHARGE POLICIES

REQUIRED PROVISION	DETAILS
1. Policies limit discharge to another level of care to allowable situations:	a. Must have another placement for the individual b. One or more of the following conditions must be met: <ul style="list-style-type: none"> • Care objectives met and individual no longer needs this level of care • Individual needs direct assistance with activities of daily living • Individual needs medical care that cannot be provided • Behavioral health needs increase and cannot be met • Conditional release revoked • Less restrictive alternative order revoked • Conviction/nolo plea of violent offense against staff or other residents, and a continuing danger to safety
2. Policies allow readmission when required:	Individual must be readmitted when medically, clinically, legally, and contractually appropriate and when reason for discharge had been: <ul style="list-style-type: none"> • Individual needs direct assistance with activities of daily living • Individual needs medical care that cannot be provided • Behavioral health needs increase and cannot be met • Conditional release revoked • Less restrictive alternative order revoked
3. Policies prohibit discharge to another IBHTF unless the individual requests transfer	
4. Follows all documentation requirements:	WAC 246-341-0640(15) requires documenting, within 7 working days: <ul style="list-style-type: none"> • A statement if the individual left without notice • The following for individuals who left with notice: <ul style="list-style-type: none"> ○ Date of discharge ○ Continuing care plan ○ Legal status ○ Current prescribed medication

	<ul style="list-style-type: none"> When transferring to another service provider, documentation that records were forwarded with the individual's permission
5. Requires documentation of time and date of discharge	
6. Provides required information to individual, representative, and family or guardian:	<ul style="list-style-type: none"> Name, address, and telephone number of the applicable ombuds Mailing address and telephone number of protection and advocacy agency for individuals with mental illness Mailing address and telephone number of protection and advocacy agency for individuals with developmental disabilities, if applicable
7. Requires the coordination of transportation and notification of all parties involved in coordinating care	

9.2: Discharge Planning

Each IBHTF may use its own forms and protocols for developing discharge plans. However, it is important for programs to consider the purpose of IBHTF services—to assist individuals in transitioning to lower levels of care—when designing forms and protocols. The following should be considered minimum standards for discharge planning:

1. Every individual with the possibility of discharge within 6 months has a discharge plan.
2. Each discharge plan includes, *at minimum*:
 - a. The individual's *current goals* for living independently in the community, including:
 - i. Where and with whom they want to live
 - ii. The physical and behavioral health outcomes they want to achieve
 - iii. Their employment and/or educational aspirations
 - iv. The relationships that are important to them
 - b. The *specific arrangements* they need to achieve these goals, including
 - i. Plans for taking any needed medication
 - ii. Connection to outpatient care
 - iii. Additional support services, including peer support
 - iv. Benefits and health insurance applications
 - v. Transportation to needed services
 - c. A *target date* for discharge to the community that is based on the individual's needs, rather than a standard period
3. Staff document at least monthly that they have reviewed each individual's treatment plan with the individual and noted any changes to the plan.
4. Staff are taking active steps to fulfill the plan, including working with the individual on medication self-management and initiating "warm handoffs" for continuity of care.

The following checklist is a helpful tool for ensuring that every individual has a functioning discharge plan. By focusing on five key components—current goals, specific arrangements, target date, frequent review, and active steps—staff can help individuals transition to lower levels of care. These five key components and the checklist are adapted from the [May 20, 2016 guidance](#) on discharge planning issued to nursing homes by the U.S. Department of Health and Human Services Office of Civil Rights.

QUICK DISCHARGE PLANNING CHECKLIST

CURRENT GOALS	<ul style="list-style-type: none"> • Did the individual develop the goals with staff? • Do they relate to discharge into the community?
SPECIFIC ARRANGEMENTS	<ul style="list-style-type: none"> • Does the plan address medications, treatment and supports, housing, and medications?
TARGET DATE	<ul style="list-style-type: none"> • Is the date in the immediate future? • Is it specific to the individual's need?
FREQUENT REVIEW	<ul style="list-style-type: none"> • Have the staff and individual reviewed the plan in the last 2 weeks?
ACTIVE STEPS	<ul style="list-style-type: none"> • Are staff taking <i>active</i> steps to arrange medical care, housing, transportation, etc.?

9.3: Discharge Practices/Documentation of Discharge

All discharges must comply with the IBHTF's written policies and the IBHTF regulations. The following checklist may be helpful in reviewing each planned discharge:

Note the type of discharge:
<ul style="list-style-type: none"> <input type="checkbox"/> Voluntary departure; no placement requested <input type="checkbox"/> Transfer to another IBHTF <input type="checkbox"/> Transfer to higher/lower level of care
For voluntary departures without placement in another facility, verify the following:
<ul style="list-style-type: none"> <input type="checkbox"/> Individual left voluntarily, and circumstances or statement are documented. <input type="checkbox"/> Date and time of departure are recorded in chart. <input type="checkbox"/> Notice was given to family, guardian, or representative
For transfer to another IBHTF, verify the following:
<ul style="list-style-type: none"> <input type="checkbox"/> Individual requested transfer, and circumstances or statement are documented. <input type="checkbox"/> Date and time of departure are recorded in chart. <input type="checkbox"/> A continuing care plan has been sent to the other IBHTF <input type="checkbox"/> The legal status (conditional release, less restrictive order, etc.) is recorded in chart. <input type="checkbox"/> Current prescribed medications are recorded in chart. <input type="checkbox"/> Records forwarded with individual's permission.

For transfer to higher/lower level of care, verify the following:

- Reason for discharge (note all that apply):
 - Care objectives met and individual no longer needs this level of care
 - Individual needs direct assistance with activities of daily living
 - Individual needs medical care that cannot be provided
 - Behavioral health needs increase and cannot be met
 - Conditional release revoked
 - Less restrictive alternative order revoked
 - Conviction/nolo plea of violent offense against staff or other residents, and a continuing danger to safety
- Date and time of departure are recorded in chart.
- A continuing care plan has been sent to the other IBHTF
- The legal status (conditional release, less restrictive order, etc.) is recorded in chart.
- Current prescribed medications are recorded in chart.
- Records forwarded with individual's permission.

9.4: Best Practices in Transition to Outpatient Care

Research into transitions from intensive levels of care to less restrictive care whether at home or through another facility has identified a number of best practices. The following chart presents some of these practices adapted for IBHTF.

BEST PRACTICE	DESCRIPTION
Comprehensive discharge planning	Prior to discharge, IBHTF staff organize follow-up services, address the individual's financial and psychosocial barriers to receiving needed care and draw on community resources as needed. IBHTF staff call or visit people following discharge to address individual's questions, assess symptoms and medications, and offer messages of support and encouragement.
Complete and timely communication of information	The IBHTF should send discharge summaries to outpatient providers one to two days after discharge, using standardized formats. Essential information includes diagnosis and strengths, medication lists, rationale for medication changes, crisis plans and emergency contracts, advance directives, personal support network information, contact information for the discharging physician, and any suggested follow-up care necessary for continuity. It should be noted whether individuals also have a WRAP plan and how the individual uses it.
Medication reconciliation	IBHTF clinicians should reconcile check the accuracy of medication lists and dosages and look for contraindications. Medication reconciliation involves creating an accurate list of all of the medications a person is taking (including drug names, dosage strengths, the frequency of dosing, and routes of administration) and comparing this list against a prescriber's admission, transfer, and/or discharge orders. Clinicians also assess any financial barriers or other limitations to filling prescriptions and provide up-to-date and complete medication lists to outpatient providers.
Education and information using the "teach back" method	In this method, residents are asked to restate instructions or concepts in their own words. Education can be supplemented by illustrations and written materials at appropriate reading levels. Education focuses on medication management, time of

	follow-up appointments, self-care and recovery tools, warning signs, and what to do if problems arise.
Open communication between providers	Communication occurs between care settings and among multidisciplinary teams within each setting. Responsibilities are clearly defined for the discharging provider and the subsequent provider. The IBHTF clinician confirms that the subsequent provider received the discharge summary and other pertinent information and responds to questions promptly. Digital communication is useful, but does not substitute for direct personal communication between providers.
Prompt follow-up visit with an outpatient provider after discharge	The IBHTF staff ensure that individuals meet with new service providers quickly upon discharge through a “warm handoff”. Some individuals may need personal assistance to ensure a smooth transition. Such visits are generally recommended within seven days of discharge. IBHTF staff should ensure individuals have follow-up care, ongoing symptom and medication management, and 24/7 phone access.

The IBHTF should also acknowledge and celebrate the person’s transition within the IBCHF community. A goodbye party, a card signed by residents and staff, and a small practical gift appropriate to the new setting are usually appreciated. In many situations the IBHTF has become a person’s home and their departure is not just from the residents, but from friends and staff who may constitute a family for the person. The IBHTF should offer ways for the person to maintain connection with friends at the IBCHF as desired by the individual. This may include visits, invitations to holiday parties or special events, permission to call and talk to friends, and support for community socializing.

Resources for Discharge and Transition to Community

Center for Health and Research Transformation. (January 15, 2014). [Care Transitions: Best Practices and Evidence-based Programs](#).

Institute for Healthcare Improvement. (2020). [Medication Reconciliation to Prevent Adverse Drug Events](#).

The Joint Commission Center for Transforming Healthcare. (2012). [Transitions of care: The need for a more effective approach to continuing patient care](#).

Mansukhani, R. P., Bridgeman, M. B., Candelario, D., & Eckert, L. J. (2015). Exploring transitional care: Evidence-based strategies for improving provider communication and reducing readmissions. *P & T: A Peer-Reviewed Journal for Formulary Management*, 40(10), 690–694.

Agency for Healthcare Research and Quality. (December 2017). [Strategy 4: Care Transitions from Hospital to Home: IDEAL Discharge Planning](#).

