Report to the Legislature

Community Services – Regional Support Networks

RCW 71.05.214

September 1, 2014

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Protocols: Designated Mental Health Professionals

September 2014

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PREFACE

The 2014 update of the Protocols for Designated Mental Health Professionals (DMHPs) is provided by the Department of Social and Health Services (DSHS), Division of Behavioral Health and Recovery (DBHR) as mandated by RCW 71.05.214:

> *"The department shall develop statewide protocols to be utilized by professional persons and county designated mental health professionals in administration of this chapter and chapter 10.77 RCW. The protocols shall be updated at least every three years. The protocols shall provide uniform development and application of criteria in evaluation and commitment recommendations, of persons who have, or are alleged to have mental disorders and are subject to this chapter."*

In compliance with the legislative mandate, DSHS submitted the initial protocols to the Governor and the Legislature in 1999 and updated in 2002, 2005, 2008 and 2011.

DSHS and their community partners continuously work to develop appropriate treatment and diversion resources to address the needs of individuals in need of inpatient psychiatric services. These protocols are also intended to assist consumers, advocates, allied systems, courts, and other interested persons to better understand the role of the DMHP in implementing the civil commitment laws.

It is the intent of the 2014 Protocol Workgroup that the protocols help support and clarify the work of the DMHPs in the face of new legislative changes and limited resources.

The 2014 Protocol Workgroup included staff from DBHR with active collaboration from a broad stakeholder group **(Appendix A)**.

The reader should be aware of several conventions used in this update of the protocols:

1. On August 8, 2014, the Washington State Supreme Court ruled the use of Single Bed Certification (SBC) to be illegal when the reason for the SBC is the lack of a certified Evaluation and Treatment (E&T) bed. A stay of this ruling was granted until December 26, 2014, at which time these protocols will be amended.

2. Within the document are definitions of a number of important words or phrases. When the definition is taken from Washington State

law, a Revised Code of Washington (RCW) citation follows. When no citation is noted, the definition has been developed for this document and should be read as part of the guidelines and without specific statutory authority.

3. The reader should be aware that RCW citations that appear at the end of many sections are included as references only. They can provide direction to the statute for further information but should not be taken as direct sources for all of the content of the section.

4. The phrase "less restrictive alternative" is used in statute in several different contexts. In this document we distinguish between these by referring to either "less restrictive alternatives ***to involuntary detention"*** (as in Section 230) or "less restrictive alternative ***court orders*** (as in Sections 400 – 430).

5. The 2014 Protocols have limitations. It is beyond the scope of the protocols to address the myriad of clinical skills and practices required of DMHPs or the role of the DMHP in providing crisis response and resolution as a mental health professional. In addition, some of the practices followed by DMHPs are influenced by the rulings of local courts. These rulings have resulted in procedural differences across the state which are beyond the authority of the protocols to remedy. The workgroup recognized that there are significant variations between counties with respect to geography, population, resources, socioeconomic, and political factors. Notwithstanding these issues, the 2014 Protocol Workgroup is satisfied that these protocols will continue to move DMHP practices toward greater uniformity in implementation of applicable statutes across the state.

   The 2014 Protocol Work Group wishes to emphasize that regardless of differences in court rulings, local procedures, or the shortage of inpatient psychiatric beds, it is imperative to the integrity of the system and those we serve that DMHPs make their decisions based on clinical presentation, collateral information and the rules implementing RCW 71.05, RCW 71.34, and RCW 10.77.

RECENT LEGISLATION INVOLVING RCW 71.05 and RCW 71.34

Second Substitute House Bill (SSHB) 3076, Chapter 280, Laws of 2010 - On July 1, 2014, Sections two (2) and three (3) of SSHB 3076 went into effect and are codified in **RCW 71.05.212**. Provisions of SSHB 3076 allow a DMHP to consider an involuntary detention under a standard of "likelihood" of danger to self or others when an individual:

(a) Exhibits symptoms and behavior closely associated with past symptoms or behavior which preceded and led to past incident of involuntary hospitalization, severe deterioration, or one or more violent acts;
(b) These symptoms or behavior represent a marked and concerning change in baseline behavior of the respondent; and
(c) Without treatment, the continued deterioration of the respondent is probable.

These factors cannot be the sole reason for detention but must be taken into consideration**.**

Substitute House Bill (SHB) 2131, Chapter 6, Laws of 2011 is an important piece of legislation to the practice of DMHPs. This provision is also codified at RCW **71.05.212**. This legislation which went into effect on January 1, 2012 states:

(1) Whenever a designated mental health professional or professional person is conducting an evaluation under this chapter, consideration shall include all reasonably available information from credible witnesses and records regarding:
    (a) Prior recommendations for evaluation of the need for civil commitments when the recommendation is made pursuant to an evaluation conducted under chapter 10.77 RCW;
    (b) Historical behavior, including history of one or more violent acts;
    (c) Prior determinations of incompetency or insanity under chapter 10.77 RCW; and
    (d) Prior commitments under this chapter.

(2) Credible witnesses may include family members, landlords, neighbors, or others with significant contact and history of involvement with the person. If the designated mental health professional relies upon information from a credible witness in reaching his or her decision to detain the individual, then he or she must provide contact information for any such witness to the prosecutor. The designated mental health professional or prosecutor shall provide notice of the date, time, and location of the probable cause hearing to such a witness.

(3) Symptoms and behavior of the respondent which standing alone would not justify civil commitment may support a finding of grave disability or likelihood of serious harm when:
    (a) Such symptoms or behavior are closely associated

with symptoms or behavior which preceded and led to a past incident of involuntary hospitalization, severe deterioration, or one or more violent acts;

(b) These symptoms or behavior represent a marked and concerning change in the baseline behavior of the respondent; and

(c) Without treatment, the continued deterioration of the respondent is probable.

(4) When conducting an evaluation for offenders identified under RCW 72.09.370, the designated mental health professional or professional person shall consider an offender's history of judicially required or administratively ordered antipsychotic medication while in confinement.

It should be noted that this provision expires on July 1, 2015.

Substitute Senate Bill (SSB) 5187, Chapter 302, Laws of 2011 related to Parent Initiated Treatment. **RCW 71.34.375** requires facilities to provide to parents or legal guardians notice of available treatment options when the parent or legal guardian bring the youth in for assessment. If the client assessment originates in an emergency department then the hospital is required to provide the notification and proof of the notification in the client record. If the assessment originates at the community mental health center, then that CMHA is required to provide the parent notification and provide a copy in the client chart for state review.

The Washington State Division of Behavioral Health and Recovery Parent Notification form is attached to this document as **Appendix P**.

GLOSSARY OF TERMINOLOGY

Following is a Glossary of Terminology relevant to the implementation of RCW 71.05, RCW 71.34, and RCW 10.77. Each term is also included in the section(s) to which it applies. When no citation is noted, the definition has been developed for this document and should be read as part of the guidelines and without specific statutory authority.

"Affiant" means a person who signs an affidavit and swears to its truth, or who provides first-hand information to the DMHP, which is used in the petition and to which they will testify in court.

"Cognitive functions" means the capacity to accurately know or perceive reality, and to understand the fundamental consequences of one's actions.

"Court Personnel" means a judge, commissioner, clerk or bailiff of the court, the prosecuting and defense attorneys and attorneys general.

"**Credible**" means the state of being believable or trustworthy.

"**Designated Mental Health Professional**" means a mental health professional designated by one or more counties or other authority authorized in rule to perform the duties specified in this chapter, such as the applicable Regional Support Network RCW 71.05.020(11), RCW 71.34.020(4) and RCW 10.77.010(6). See Appendix K - DMHP Knowledge and Education.

"Good Faith Voluntary" Failure to be a "good faith voluntary" patient is not grounds for initial detention under RCW 71.05.150 or RCW 71.05.153. Rather, the DMHP must assess for the ability of a person to provide informed consent to proposed voluntary treatment. Whether or not a Respondent is a "good faith volunteer" is considered under RCW 71.05.230 when a petition for treatment beyond the seventy-two hour evaluation and treatment period is filed by the professional staff of the agency or facility providing evaluation services.

"Gravely disabled" means a condition resulting from a mental disorder in which a person:

(a) Is in danger of serious physical harm resulting from their failure to provide for their own essential human needs of health or safety RCW 71.05.020(17); or
(b) Manifests severe deterioration in routine functioning evidenced by repeated and escalating loss of cognitive or volitional control over his or her actions, and is not receiving such care as is essential for his or her health or safety. RCW 71.05.020(17).

However, persons cannot be detained on the basis of a severe deterioration in routine functioning unless the detention is shown to be essential for their health or safety. In re: Labelle (1986), see Appendix L.

"Grave disability" for extending a 90/180 day less restrictive alternative court order. Grave disability applies when, without continued involuntary treatment and based on the person's history, the individual's condition is likely to rapidly deteriorate and, if released from outpatient commitment, the individual would not receive such care as is essential for his or her health or safety. Grave disability does not require that the person be at imminent risk of serious physical harm.

"History of one or more violent acts" refers to the period of time ten years prior to the filing of a petition under this chapter, excluding any time spent, but not any violent acts committed, in a mental health facility or in confinement as a result of a criminal conviction; RCW 71.05.020(19).

Whenever a designated mental health professional or professional person is conducting an evaluation

under this chapter, consideration shall include all reasonably available information from credible witnesses and records regarding:

- Prior recommendations for evaluation of the need for civil commitments when the recommendation is made pursuant to an evaluation conducted under chapter 10.77 RCW;
- Historical behavior, including history of one or more violent acts;
- Prior determinations of incompetency or insanity under chapter 10.77 RCW; and
- Prior commitments under this chapter.

Credible witnesses may include:

- Family members;
- Landlords;
- Neighbors; or
- Others with significant contact and history of involvement with the person.

If the designated mental health professional relies upon information from a credible witness in reaching his or her decision to detain the individual, then he or she must provide contact information for any such witness to the prosecutor. The designated mental health professional or prosecutor shall provide notice of the date, time, and location of the probable cause hearing to such a witness.

Symptoms and behavior of the respondent which standing alone would not justify civil commitment may support a finding of grave disability or likelihood of serious harm when:

- Such symptoms or behavior are closely associated with symptoms or behavior which preceded and led to a past incident of involuntary hospitalization, severe deterioration, or one or more violent acts;
- These symptoms or behavior represent a marked and concerning change in the baseline behavior of the respondent; and
- Without treatment, the continued deterioration of the respondent is probable.

When conducting an evaluation for offenders identified under RCW 72.09.370, the designated mental health professional or professional person shall consider an offender's history of judicially required or administratively ordered antipsychotic medication while in confinement.

"**Imminence**" means 'the state or condition of being likely to occur at any moment or near at hand, rather than distant or remote." RCW 71.05.020(20).

"Information and Records Related To Mental Health Services" means a type of health care information that relates to all information and records compiled, obtained, or maintained in the course of providing services by a mental health service agency or mental health professional to persons who are receiving or have received services for mental illness. The term includes mental health information contained in a medical bill, registration records, as defined in RCW 71.05.020, and all other records regarding the person maintained by the department, by regional support networks and their staff, and by treatment facilities. The term further includes documents of legal proceedings under chapter 71.05, 71.34, or 10.77 RCW, or somatic health care information. For health care information maintained by a hospital as defined in RCW 70.41.020 or a health care facility or health care provider that participates with a hospital in an organized health care arrangement defined under federal law, "information and records related to mental health services" is limited to information and records of services provided by a mental health professional or information and records of services created by a hospital-operated community mental

health program as defined in RCW 71.24.025(6). The term does not include psychotherapy notes. RCW 70.02.010(21).

"Informed Consent" means if a patient, while legally competent or his or her representative, if he or she is not competent, signs a consent form, the signed consent form shall constitute prima facie evidence that the patient gave his or her informed consent to the treatment administered. The patient has the burden of rebutting this by a preponderance of the evidence. The consent form should contain a description, in language the patient could reasonably be expected to understand, of:

A. A description, in language the patient could reasonably be expected to understand, of:
   i. The nature and character of the proposed treatment;
   ii. The anticipated results of the proposed treatment;
   iii. The recognized possible alternative forms of treatment; and(iv) The recognized serious possible risks, complications, and anticipated benefits involved in the treatment and in the recognized possible alternative forms of treatment, including no treatment; and
   iv. The recognized serious possible risks, complications, and anticipated benefits involved in the treatment and in the recognized possible alternative forms of treatment, including no treatment;
B. Or, as an alternative, a statement that the patient elects not to be informed of the elements set forth in (a) of this subsection. RCW 7.70.060.

"**Investigation**" means the act or process of systematically searching for relevant, credible and timely information to determine if: There is evidence that a referred individual may suffer from a mental disorder; and

(a) There is evidence that the individual, as a result of a mental disorder, presents a likelihood of serious harm to themselves, other individuals, other's property, or the referred individual may be gravely disabled, and
(b) The referred individual refuses to seek appropriate treatment options. RCW 71.05.150 (1), RCW 71.05.153(1) and RCW 71.34.050.

"**Law enforcement officer**" means a member of the state patrol, a sheriff or deputy sheriff, or a member of the police force of a city, town, university, state college, or port district, or a fish and wildlife officer or ex officio fish and wildlife officer as defined in RCW 77.08.010.

"**Likelihood of serious harm"** means a substantial risk that:

(a) Physical harm will be inflicted by an individual upon their own person, as evidenced by their threats or attempts to commit suicide or inflict physical harm on themselves; or
(b) Physical harm will be inflicted by an individual upon another, as evidenced by behavior which has caused such harm or which places another individual or individuals in reasonable fear of sustaining such harm; or
(c) Physical harm will be inflicted by an individual upon the property of others, as evidenced by behavior which has caused substantial loss or damage to the property of others; or
(d) The individual has threatened the physical safety of another and has a history of one or more violent acts." RCW 71.05.020(25).

"**Mental disorder"** means any organic, mental or emotional impairment, which has substantial adverse effects on an individual's cognitive or volitional functions. RCW 71.05.020(26).

An adult cannot be detained for evaluation and treatment solely by reason of the presence of a developmental disability, chronic alcoholism or drug abuse, or dementia alone. However, such a person may be detained for

evaluation and treatment on the basis of such a sole condition if that condition causes the person to be gravely disabled, or to present a likelihood of serious harm. RCW 71.05.040.

For a minor, the presence of alcohol abuse, drug abuse, juvenile criminal history, antisocial behavior, or intellectual disabilities alone is insufficient to justify a finding of "mental disorder" within the meaning of RCW 71.34.020(13).

"Mental Health Professional" means a psychiatrist, psychologist, psychiatric nurse, or social worker, and such other mental health professionals as defined by WAC 388-877-0200 "Mental Health Professional". RCW 71.05.020(27).

"**Minor**" means any person under the age of 18. RCW 71.34.020(15).

"**Parent**" means (a) A biological or adoptive parent who has legal custody of the child, including either parent if custody is shared; or (b) A person or agency judicially appointed as legal guardian or custodian of the child. RCW 71.34.020(17).

"Reasonably Available History" means history made available to the DMHP by:

- Referral sources;
- Risk assessments, and/or discharge summaries from the Department of Corrections (DOC);
- Law enforcement;
- Treatment providers;
- Family at the time of referral and investigation; and/or
- Other information that is immediately accessible.

Other information which may be available and include:

- Individual's crisis plan;
- Mental health advance directive;
- Other available treatment records;
- Evaluations of incompetency or insanity under RCW 10.77;
- Criminal history records;
- Risk assessments;
- Discharge summaries from DOC;
- Historical behavior including a history of one or more violent acts; and/or
- Records from prior civil commitments.

"**Reliable**" means the state of being accurate in providing facts: A reliable person provides factual information and can be expected to report the same facts on different occasions; a reliable witness is typically expected to be available if needed to consult with attorneys, treatment team members, and/or to testify in court.

"Single-Bed Certification" refers to the process or result of a Division of Behavioral Health and Recovery (DBHR) designee's request(s) for a one-time waiver that allows involuntary treatment to occur in a facility that is not certified under WAC 388-865-0500
See Section 207

"Substantial adverse effects" means significant and considerable negative impact on an individual.

"Sufficient environmental controls are in place" means that a person is receiving, or is likely to receive, such care from responsible persons as is essential to the person's health, safety, and the safety of others.

"Violent Acts" means behavior that resulted in homicide, attempted suicide, nonfatal injuries, or substantial damage to property. RCW 71.05.020(45).

"Volitional functions" means the capacity to exercise restraint or direction over one's own behavior; the ability to make conscious and deliberate decisions; and of acting in accordance with one's reasoned decisions or choices.

"**Voluntary Treatment"**: To agree to voluntary treatment implies that the individual is able to express a sincere willingness (free of coercion) to engage with the procedures and treatment plan prescribed by the treatment provider, facility and professional staff to whom the person has volunteered. To agree to voluntary treatment additionally requires that the individual is capable of providing informed consent to care as defined in RCW 7.70.060.

For a minor under the age of 13, consent for care is provided by the minor's parents or legal guardians.

When the investigation concerns a patient who is not competent to provide informed consent to less restrictive treatment options, the DMHP shall make reasonable efforts to determine whether the person's health care decision maker, as identified in RCW 7.70.065, can and will consent to the less restrictive treatment on behalf of the person.

"Nothing in this chapter shall be construed to limit the right of any person to apply voluntarily to any public or private agency or practitioner for treatment of a mental disorder, either by direct application or referral." RCW 71.05.050

Reference: Detention of Chorney, (1992), See Appendix L.
Reference: Detention of Kirby, (1992), See Appendix L.
"Witness" means any individual who provides information to the DMHP in the course of an investigation.

REFERRALS FOR ITA INVESTIGATION

100–Referrals for an ITA Investigation

"Investigation" *means the act or process of systematically searching for relevant, credible and timely information to determine if:*

(a) There is evidence that a referred person may suffer from a mental disorder; and
(b) There is evidence that the person, as a result of a mental disorder, presents a likelihood of serious harm to themselves, other persons, other's property, or the referred person may be gravely disabled, and
(c) The referred person refuses to seek appropriate treatment options.

RCW 71.05.150 (1), RCW 71.05.153(1) and RCW 71.34.050.

The following general process applies to referrals made to a DMHP for investigation:

> As quickly as possible, the DMHP assesses the degree of urgency and resources available to resolve or contain the crisis, including: (a) Whether it is appropriate to involve law enforcement;(b) Making a request to take the person into custody under RCW 71.05 or RCW 71.34; and/or (c) Calling 911 or asking the referring person to call 911, if the DMHP assesses immediate physical danger or safety concerns.

The DMHP accepts, screens, and documents all referrals for an ITA investigation. Documentation includes the:

- Name of the individual referred for an ITA investigation;
- Name of caller and relationship to individual being referred;
- Date and time of the referral;
- Facts alleged by the caller; Available personal information about the individual to be investigated including:
    - Age,
    - Ethnicity,
    - Language,
    - Whether an advance directive may exist,
    - Whatever history may be available,
    - Potential sources of support to resolve the crisis, and
    - If a minor, the name of the parent or legal guardian.
- Contact information of the referent,
- Names and contact information for potential witnesses, which may include:
    - Family members,
    - Landlords,
    - Neighbors,
    - Law enforcement,
    - Others with significant contact or history of involvement with the individual;
- The name and telephone number of the individual's guardian or other healthcare decision-maker, if applicable.

For each individual referred, the DMHP decides and documents if:

(a) Further investigation is indicated, and if so, the DMHP determines the need for a second individual to accompany the DMHP during the outreach to ensure safety needs are met;
(b) Crisis Mental Health Services or other community services are more appropriate; or
(c) No further service or investigation is indicated. RCW 71.05.700; RCW 71.05.710

Lack of resources shall not be the criteria for refusing to initiate an ITA investigation.

At the time of the referral, the DMHP provides information to the referent about DMHP procedures and protocols as they relate to the referral. This may include informing the referent whether a face-to-face interview can be expected and what further information is needed for a face-to-face interview. The DMHP discloses to the referring party additional information about an investigation only as authorized by law, including RCW 70.02.230, RCW 70.02.240, RCW 70.02.250 and RCW 70.02.320 and RCW 70.02.050.

The DMHP always attempts to conduct a face-to-face evaluation prior to authorizing police or ambulance personnel to take a person to an evaluation and treatment facility, the emergency department of a local hospital, or other authorized involuntary treatment facility. RCW 71.05.153(2).

However, a DMHP may issue an oral or written custody authorization without an in-person evaluation when:

(a) A potentially dangerous situation exists; and
(b) Failure to take the person into custody as quickly as possible poses a threat to the person and/or others. RCW 71.05.153(2).

105–DMHP Requirement to Report Suspected Abuse or Neglect

DMHPs are "mandatory reporters" of suspected abuse or neglect. Individuals filing reports in good faith are immune from liability. Knowing failure to make a mandatory report, or intentionally filing a false report, is a crime.

If a DMHP has reasonable cause to believe that abuse, neglect, financial exploitation or abandonment of an individual has occurred, the DMHP must immediately report it directly to DSHS, regardless if any other reports have been made. If there is reason to suspect that sexual or physical assault has occurred, the DMHP must also immediately make a report to the appropriate law enforcement agency as well as to DSHS.

For children, notify Child Protective Services at 1-866-END-HARM (1-866-363-4276[1]).

For adults in a Residential Care Facility, Adult Family Homes, and DDD contracted Supportive Living, facilities notify the Residential Care Services Complaint Resolution Unit Hotline at 1-800-562-6078;[2] or submitted electronically at http://www.adsa.dshs.wa.gov/APS/reportabuse.htm[3].
For adults not in either a Residential Care Facility or an Adult Family Home reports are to be made to the following regional offices:

1 Telephone number verified 5/29/2014

2 Telephone number verified 5/29/2014

3 Website verified 5/29/2014

ADULT PROTECTIVE SERVICES (APS) ABUSE AND NEGLECT COMPLAINT INTAKE LINES:

DSHS Region	Counties in Region	APS Phone Number
1	*Spokane, Grant, Okanogan, Adams, Chelan, Douglas, Lincoln, Ferry, Stevens Whitman, Pen Oreille, Yakima, Kittitas, Benton, Franklin, Walla Walla, Columbia, Garfield, Asotin, Klickitat*	*Voice: 1-800-459-0421 TTY: 509-568-3086*
2	*King, Snohomish, Skagit, Island, San Juan, Whatcom*	*Voice: 1-866-221-4909 TTY 1-800-977-5456*
3	*Pierce, Kitsap, Thurston, Mason, Lewis, Clallam, Jefferson, Grays Harbor, Pacific, Wahkiakum, Cowlitz, Skamania, Clark*	*Voice: 1-877-734-6277 TTY 1-800-672-7091*

The Department of Health (DOH) reporting numbers are:

Facility & Services Licensing: Concerns involving care or service to patient/resident in a setting licensed by DOH:
Hospitals, clinics, residential treatment facilities, etc.:
DOH FSL Hotline: 1-800-633-6828
DOH FSL Fax Number: 360-236-2626
In-home Services: home care, home health, hospice agency licensed by DOH:
DOH FSL Hotline: 1-800-633-6828
DOH FSL Fax number: 360-236-2626
Health Professionals Quality Assurance Office general reporting numbers - concerns about licensed professionals:
Phone: 360-236-4700
Fax: 360-236-4626

Reference: RCW 74.34.020(8) (Incapacitated person), RCW 74.34.035 (Reports — Mandated and permissive — Contents — Confidentiality), RCW 74.34.050 (Immunity and liability), and RCW 73.34.053 (Failure to report — False reports — Penalties); RCW 26.44.020(3) (Child protective services) and RCW 26.44.030(1)(a) (Duty to notify proper law enforcement agency or department).

To the extent permitted or required by applicable law, the DMHP should notify the Adult Protective Service, Residential Care Services Complaint Resolution, or Child Protective Services worker making the referral as to:

(a) Whether an investigation will be performed; and
(c) The date and outcome of the investigation.

Information disclosed by Adult Protective Services (RCW 74.34.095) and Child Protective Services (RCW 26.44.030) is confidential.

Reference: RCW 70.02.230

110–Referrals of a Minor

> *"**Minor**" means any person under the age of 18. RCW 71.34.020 (15)*
>
> *"**Parent**" means (a) A biological or adoptive parent who has legal custody of the child, including either parent if custody is shared; or (b) A person or agency judicially appointed as legal guardian or custodian of the child. RCW 71.34.020(17).*

Parental authorization, or authorization from a person who may consent on behalf of the minor pursuant to RCW 7.70.065, is required for inpatient treatment of a minor under the age of thirteen. The DMHP may not detain any minor under the age of thirteen. RCW 71.34.500(1).

The DMHP responds to referrals for involuntary inpatient mental health treatment, including but not limited to referrals of minors living in foster care, licensed residential care, hospitals, or juvenile correctional facilities. The DMHP confirms that the referent has considered parent initiated treatment options.

Parent Initiated Treatment is applicable if the child is under the age of 18, and the parent/guardian/ authorized individual brings the child to a mental health facility or a hospital and requests that a mental health evaluation be provided. If it is determined the child has a mental disorder, and there is a medical need for inpatient treatment, the parent/guardian may request that the child be held for parent initiated inpatient treatment at the facility providing the evaluation. RCW 71.34.600. See Appendix P.

To the extent possible, the DMHP contacts the minor's parent or legal guardian upon receipt of a referral for involuntary inpatient treatment. RCW 71.34.010.

For a minor who is a state dependent, the DMHP contacts the minor's DSHS case worker, or the DSHS case worker's supervisor if known and available, as soon as possible, and prior to contacting the minor's parent. RCW 13.34.320 and RCW 13.34.330.

115–Referrals of a Person with Dementia or a Developmental Disability

The DMHP may not rule out a referral for investigation because of the sole presence of dementia, chronic alcoholism or drug abuse, or a developmental disability. Such a person may be detained for evaluation and treatment on the basis of such a condition if that condition causes the person to be gravely disabled, or to present a likelihood of serious harm. But in such cases, the DMHP should actively pursue the identification of possible appropriate less restrictive alternatives. RCW 71.05.040 and RCW 71.05.020(20); (26).

120–Referrals of an Adult from a Licensed Residential Care Facility

The four broad categories of licensed care facilities are nursing homes, assisted living facilities, adult family homes, and residential treatment facilities.

Licensed residential care facilities are required to provide individualized services and support and may be considered a less restrictive alternative to involuntary detention. Information that may be helpful to DMHPs when assessing a referral from a facility (i.e.: a summary of residents' rights and a facility's transfer and discharge requirements) is included in Appendix C.
If there is sufficient evidence to indicate that the person, as a result of a mental disorder, is a danger to

self or others or other's property, or is gravely disabled, then the DMHP assesses whether the facility is a less restrictive alternative to detention. The facility may be considered a potential less restrictive alternative if the needs of the resident can be met and the safety of other residents can be protected through reasonable changes in the facility's practices or the provision of additional services. However, if the facility cannot protect the resident and the health and safety of all residents, the facility may not be an appropriate less restrictive alternative.

The checklists in Appendix D may help the DMHP and facility assess the causes of the reported problem and whether the services or treatment needed by the resident can be provided or arranged by the facility as a less-restrictive alternative.

The following considerations inform the response of the DMHP:

- Whenever possible, the DMHP evaluates the person at the licensed residential care facility rather than an emergency room so that situational, staffing, and other factors can be observed.

- The DMHP confers with and obtains information from the facility on the reason for the referral, the level of safety threat to residents, and alternatives that may have been considered to maintain the individual at the facility. Alternatives could include changes in care approaches, consultations with mental health professionals/specialists and/or clinical specialists, reduction of environmental or situational stressors, and medical evaluations of treatable conditions that could cause aggression or significant decline in functioning.

- When appropriate, available, and consistent with confidentiality provisions, the DMHP obtains information from a variety of sources such as the resident, family members of the resident, guardians, facility staff, attending physician, the resident's file, the resident's caseworker or mental health provider, and/or the ombudsperson. All collateral contacts are documented, including the name, phone number, and substance of information obtained.

- If the investigation does not result in detention but the resident has remaining mental health care needs, the DMHP may also provide further recommendations and resources to the facility staff and others, including recommendations for possible follow-up services.

- If the resident is being evaluated in an emergency department and the investigation does not result in detention, the resident may have re-admission rights to the long-term care facility. If the DMHP has concerns about facility refusal to re-admit the resident, the DMHP notifies the Residential Care Services Complaint Resolution Unit (CRU) Hotline at 1-800-562-6078, TTY 1-800-737-7931.

- If during the course of the investigation, the DMHP has concerns about mental health or other services provided by the facility, the DMHP notifies the Residential Care Services Complaint Resolution Unit (CRU) Hotline for follow-up at 1-800-562-6078. The website to report Adult Family Home abuse is: www.adsa.dshs.wa.gov/APS

Reference: 42 CFR 488.3; RCW 18.20.185; RCW 18.51.190; RCW 70.129.030; RCW 74.39A.060; RCW 74.42.450(7).

125–Referrals from a Medical Hospital/Emergency Department

It is best practice that a medical screening be conducted and that the individual is able to be medically discharged from the medical hospital and/or emergency department prior to referral to a DMHP.

In the event of a medical emergency, RCW 7.70.050(4) allows health care professionals to provide treatment without the Patient's consent. When the situation is not an emergency, health care providers have the option to pursue a court order seeking to:

- Deliver non-emergent medical care to an incompetent patient; or
- Appoint a legal guardian who can make medical decisions on behalf of the patient.

Reference: RCW 7.70.050(4), RCW 7.70.065, RCW 11.88.010(1)(e).

Individuals in need of ITA evaluation shall be medically ready for discharge from the hospital and able to be interviewed to assure accurate assessments. Exceptions can be made on a case-by-case basis.

The DMHP shall conduct an ITA investigation and make a determination regarding detention regardless of statutory time-lines:

For Adults**:**

- If an individual was brought to an emergency department voluntarily, the DMHP must determine whether the individual meets detention criteria within 6 hours of the emergency department staff determining that a referral to the DMHP is needed. RCW 71.05.050.
- If an individual was directed to the emergency department by peace officers, a mental health professional must examine the person within three hours of his or her arrival, and the DMHP must determine whether the person meets detention criteria within 12 hours of arrival at the facility. RCW 71.05.153(4).
- If an individual was voluntarily admitted for inpatient psychiatric treatment and requests discharge, but presents as a risk of harm or gravely disabled the DMHP must determine whether the individual meets detention criteria no later than end of the next judicial day. RCW 71.05.050.
- A DMHP conducting an evaluation of a person under RCW 71.05.150 or 71.05.153 must consult with any examining emergency room physician regarding the physician's observations and opinions relating to the person's condition, and whether, in the view of the physician, detention is appropriate. The DMHP shall take serious consideration of observations and opinions by examining emergency room physicians in determining whether detention under this chapter is appropriate. The designated mental health professional must document the consultation with an examining emergency room physician, including the physician's observations or opinions regarding whether detention of the person is appropriate. RCW 71.05.154.

For Minors:

- If a minor, thirteen years or older, is brought to an evaluation and treatment facility or hospital emergency room for immediate mental health services, the professional person in charge of the facility shall evaluate the minor's mental condition, determine whether the minor suffers from a mental disorder, and whether the minor is in need of immediate inpatient treatment. If it is determined that the minor suffers from a mental disorder, inpatient treatment is required, the minor is unwilling to consent to voluntary admission, and the professional person believes that the minor meets the criteria for initial detention set forth herein, the facility may detain or arrange for the detention of the minor for up to twelve hours in order to enable a DMHP to evaluate the minor and commence initial detention proceedings under the provisions of this chapter. RCW 71.34.700.
- The DMHP will evaluate the child at the emergency department and commence proceedings to determine whether the child meets criteria for detention within 12

hours of the referral.

130–Referrals of a Person Using Alcohol and/or Drugs

DMHPs may also be designated by the County Alcoholism and Other Drug Addiction Program Coordinator to perform the detention and commitment duties described in RCW 70.96A.

The DMHP may not rule out any referral for investigation solely because the person is under the influence of alcohol and/or drugs.

If there is sufficient evidence to indicate that the person is a danger to self or others, other's property or is gravely disabled as a result of a mental disorder, the DMHP conducts an ITA investigation under RCW 71.05 or RCW 71.34.

The DMHP evaluates the person to determine the presence of a mental disorder when it is clinically appropriate to do so or when the individual is no longer intoxicated by alcohol and/or drugs. If the person is not at imminent risk of harm to themselves or others or is not gravely disabled under RCW 71.05 or RCW 71.34, the DMHP refers the case to an appropriate treatment resource in the community or initiates a referral to the Designated Chemical Dependency Specialist as clinically indicated.

Reference: RCW 70.96A.120, RCW 70.96A.140 and RCW 70.96A.148.

135–Referrals of American Indians on Tribal Reservations

DMHPs should consult with the tribal government and the county prosecuting attorney regarding any interlocal agreements between the RSN and the tribal government. Appendix F contains a map of Federally Recognized Tribes within the RSNs in the state of Washington.

140–Referrals of a Person Incarcerated In a Jail or Prison

"No jail or state correctional facility may be considered a less restrictive alternative to an evaluation and treatment facility." RCW 71.05.157(6).

The DMHP does not rule out any referral for investigation solely because the person is incarcerated. Persons in a jail or prison who have a mental disorder can be detained to an evaluation and treatment facility with, or without, a jail hold if the required criteria are met. **Note: Only individuals who are eligible for release from the jail or prison can be detained to a treatment facility.**

The DMHP obtains information from the facility making the referral regarding: the individual's criminal charges status (felony or misdemeanor); release date; jail hold (if any); and the jail or prison's policy regarding release.

The DMHP office maintains information received in clinical records including but not limited to:

- Competency evaluations;,
- Court orders for commitment or involuntary treatment while in custody;
- Mental health evaluations by jail staff;
- Criminal history; and
- Arrest reports.

If contacted, the DMHP will evaluate the defendant or offender, who is currently incarcerated and the subject of a discharge review, for involuntary mental health treatment within 72 hours prior to release from confinement.

If the DMHP decides that a detention under RCW 71.05 or RCW 71.34 is necessary, the DMHP:

- Coordinates the process with law enforcement personnel, County Department of Corrections (DOC) representatives, representatives of the legal system and other appropriate persons to the extent permitted by applicable law, including RCW 71.05.153, RCW 70.02, RCW 70.02.230 and RCW 70.02.240, RCW 70.02.250 and RCW 70.02.320.
- Discusses arrangements for transportation to an emergency department for medical clearance and for transportation of the inmate to the evaluation and treatment facility.

If an investigation is requested for an incarcerated person who has undergone a competency evaluation under RCW 10.77 (Mentally Ill Offender), an evaluation shall be conducted of such person under RCW 71.05 and RCW 10.77.065(1)(b). To the extent possible, the DMHP, upon request of the correctional facility, will conduct the investigation shortly before the person's scheduled release date or when the correctional facility has the authority to release the person if the detention criteria are met. RCW 10.77.065.

Offender Re-entry Community Safety Program (ORCS): The Washington State Department of Corrections (DOC) may request an investigation for a DOC inmate designated as an ORCSP participant. In order to qualify under RCW 72.09.370, the offender has been designated by the DOC through the ORCSP Statewide Review Committee as meeting criterion for dangerousness and has either:

- Been diagnosed with a mental disorder under RCW 71.05.020(26); or
- Is enrolled with DSHS Developmental Disabilities Administration (DDA)

The investigation shall occur not more than ten days, nor less than five days, prior to the actual release of the Designated ORCS participant. A DMHP must conduct a second investigation on the day of release if requested by the ORCS Committee. When conducting an evaluation of an ORCS participant, the DMHP shall consider the offender's history of judicially required or administratively ordered antipsychotic medication while in confinement. The fact that an offender is identified as an ORCS participant does not change the commitment criteria under RCW 71.05.

145–Referrals of a Minor Charged with Possessing Firearms on School Facilities

The DMHP investigates and evaluates minors referred by law enforcement after being charged with the illegal possession of firearms ,as defined in RCW 9.41.010(9), on school facilities for possible involuntary detention under RCW 71.05 or RCW 71.34.

For purposes of this section only, "***Minor***" is defined as an individual between the ages of 12 and 21.

The evaluation shall occur at the facility in which the minor is detained or confined.

When practicable, and as allowed by applicable privacy laws such as FERPA, the DMHP should request from the school facility and school district all prior risk assessments and weapons or violence incident reports concerning the minor, which are in the possession of the school facility or school district.

The DMHP may refer the minor to the County Designated Chemical Dependency Specialist for investigation and evaluation under the chemical dependency commitment statute, RCW 70.96A.

The DMHP provides the result of the evaluation to the charging criminal court for use in the criminal disposition.

The DMHP, to the extent permitted by law, notifies a parent or guardian of the minor being examined of the fact of the investigation and the result.

The DMHP, if appropriate, may refer the minor to the local RSN, DSHS or other community providers for other services to the minor or family.

Reference: RCW 9.41.280(2), RCW 9.41.010(9).

INVESTIGATION PROCESS

200–Rights of an Individual Being Investigated

The DMHP will advise the individual of their legal rights before beginning an interview to evaluate the person for possible involuntary detention.

When a DMHP investigates an individual for possible involuntary detention the DMHP shall:

- Identify them self by name and position;
- Inform the individual of the purpose and possible consequences of the investigation;
- Inform the individual that they have the right to remain silent;
- Inform the individual that any statement made may be used against them;
- Inform the individual being investigated that they may speak immediately with an attorney.

- The DMHP should also consider: If the individual chooses to remain silent or requests an attorney, the DMHP is obligated to stop the interview. However, the DMHP is not obligated to stop the investigation. The individual may choose to resume the interview at any time.
- For individuals who are not proficient in English, rights should be provided in writing in a language that the individual is able to understand or read by a certified interpreter. If requested by the individual being investigated, he DMHP should read the rights to the individual in their entirety.

Neither a guardian nor any other healthcare decision-maker can consent to involuntary mental health treatment, observation, or evaluation on behalf of the individual, with the exception of Parent Initiated Treatment for minors. RCW 11.92.043(5), RCW 11.94.010(3), RCW 71.34.600.

205–Process for Conducting an ITA Investigation

The DMHP performs or attempts to perform a face-to-face evaluation as part of the investigation before a petition for detention is filed. The DMHP evaluates the facts relating to the individual being referred for investigation based on the mental health statutes and applicable case law. The DMHP may seek consultation as needed when conducting an investigation of a child, an older adult, an ethnic minority, or an individual with a medical condition or a disability.

The DMHP will attempt to determine whether there is a Mental Health Advance Directive for the individual being investigated. The DMHP will also attempt to contact any known individuals with the power to make health care decisions to inform them of the investigation and rights of the individual being investigated.

Reference: RCW 71.32.

Note: A health care decision-maker's powers depend on the authorization in the legal instrument. If the healthcare decision-maker is authorized to care for and maintain the individual in a setting less restrictive to the individual's freedom, the health care decision-maker could consent to additional treatment or placement in a less restrictive setting appropriate to his/her personal care needs.

Reference: RCW 71.05.150 (1) (a) and RCW 71.34.050.

207–Availability of Resources and Single Bed Certification Process

Immediate availability of a certified evaluation and treatment bed will not be a factor in determining whether or not to conduct an investigation. Nor shall it influence the determination if an individual meets detention criteria.

If no resources are available the DMHP will follow RSN and county practices.

If the individual meets the detention criteria the DMHP can explore the following options after determining the availability of local resources.

- Pursue resources (Certified E&T beds) in counties within close proximity
- Locate and secure Certified E&T beds elsewhere within the state
- Request a Single Bed Certification

"Single Bed Certification" refers to the process or result of a DBHR designee request for a one-time waiver that allows involuntary treatment to occur in a facility that is not currently certified under WAC 388-865-0500.

When an individual meets one of the following criteria:

1. The consumer requires services that are not available at a facility certified under this chapter or a state psychiatric hospital.

2. The consumer is expected to be ready for discharge from inpatient services within the next thirty days and being at a community facility would facilitate continuity of care, consistent with the consumer's individual treatment needs.

3. The consumer can receive appropriate evaluation and treatment in one of the following facilities and the certification will be only to that facility:
    A. A residential treatment facility, as defined under chapter 246-337 WAC;
    B. A hospital with a psychiatric unit;
    C. A hospital that can provide psychiatric services;
    D. A psychiatric hospital.

When a person is going to be detained to a Single Bed Certification bed, the DMHP will follow all applicable Washington State laws for the ITA or LRA process. The steps are as follows:

1. The DMHP determines whether or not to detain the person observing the legally required time frames.
2. If the DMHP determines that the individual meets emergent detention criteria, the DMHP locates an E&T bed and secures provisional acceptance from that facility.
3. If no E&T bed can be located, the RSN responsible for the region in which the DMHP is designated should locate an appropriate bed capable of providing individualized treatment and request single bed certification from the State Hospital which serves their RSN.
4. The Single Bed Certification Form requires that the RSN or its designee attest that the facility can provide adequate treatment services and that the facility will provisionally accept placement upon receipt

of the approved Single Bed Certification. Note: the State Hospitals will only process requests submitted on the 9/18/14 or later form.

5. The State Hospital will process the request within two hours and fax the approved request back to the RSN's representative (the requesting DMHP).
6. Upon receipt of the state hospital approved Single Bed Certification Form, the person may be served the ITA or LRA Revocation paperwork.
7. The DMHP will provide a copy of the approved Single Bed Certification Form to the facility where the person is held.
8. The DMHP will file the ITA or LRA Revocation paperwork with the Superior court of the county where the person is physically present (It is suggested that DMHP get a court certified copy of the legally filed paperwork to send with the client once an E&T bed is found). RCW 71.05.160, RCW 71.05.340 and RCW 71.34.710, RCW 71.34.780 .
9. The DMHP does not have legal authority to dismiss or "drop" the ITA or LRA hold. This must be done by the treating physician or person in charge of the facility. RCW 71.05.210 and RCW 71.34.770.

For involuntarily detained children, a hospital may request an exception to allow treatment in a facility not certified under WAC 388-865-0500 until the child's discharge from that setting to the community, or until they transfer to a bed in a children's long-term inpatient program (CLIP).

210–Evaluation to Determine the Presence of a Mental Disorder

"Mental disorder" *means any organic, mental or emotional impairment, which has substantial adverse effects on an individual's cognitive or volitional functions. RCW 71.05.020(26).*

An ***adult*** *cannot be detained for evaluation and treatment solely by reason of the presence of a developmental disability, chronic alcoholism or drug abuse, or dementia alone. However, such a person may be detained for evaluation and treatment on the basis of such a sole condition if that condition causes the person to be gravely disabled, or to present a likelihood of serious harm. RCW 71.05.040.*

For a minor, *the presence of alcohol abuse, drug abuse, juvenile criminal history, antisocial behavior, or intellectual disabilities alone is insufficient to justify a finding of "mental disorder" within the meaning of RCW 71.34.020(13).*

"Substantial adverse effects" means significant and considerable negative impact on an individual.
"Cognitive functions" *means the capacity to accurately know or perceive reality, and to understand the fundamental consequences of one's actions.*
"Volitional functions" *means the capacity to exercise restraint or direction over one's own behavior; the ability to make conscious and deliberate decisions; and of acting in accordance with one's reasoned decisions or choices.*

A formal diagnosis of a mental illness is not required to establish a mental, emotional or organic impairment as defined in RCW 71.05.020(26) or RCW 71.34.020(13), but only that the disorder has a substantial adverse effect on cognitive or volitional functioning.

To evaluate the presence of a mental disorder, a DMHP assesses an individual's behavior, judgment, orientation, general intellectual functioning, specific cognitive deficits or abnormalities, memory, thought process, affect, and impulse control.

The DMHP also takes into consideration the individual's age, developmental stage, ethnicity, culture and linguistic abilities; and the duration, frequency and intensity of any psychiatric symptom.

215–Assessment to Determine Presence of Dangerousness or Grave Disability

*"**Likelihood of serious harm**" as defined in RCW 71.05.020 (25) means a substantial risk that:*
Physical harm will be inflicted by an individual upon his or her own person, as evidenced by threats or attempts to commit suicide or inflict physical harm on oneself;
Physical harm will be inflicted by an individual upon another, as evidenced by behavior which has caused such harm or which places another person or persons in reasonable fear of sustaining such harm; or
Physical harm will be inflicted by an individual upon the property of others, as evidenced by behavior which has caused substantial loss or damage to the property of others; or
The individual has threatened the physical safety of another and has a history of one or more violent acts." RCW 71.05.020(19).

Note*: This provision applies only to adults, as there is no similar criterion for minors in RCW 71.34.*

*"**Gravely disabled**" means a condition resulting from a mental disorder, in which the person:*
Is in danger of serious physical harm resulting from a failure to provide for his or her essential human needs of health or safety RCW 71.05.020(17)(a); or
Manifests severe deterioration in routine functioning evidenced by repeated and escalating loss of cognitive or volitional control over his or her actions and is not receiving such care as is essential for his or her health or safety." RCW 71.05.020(17)(b). See Appendix K.

"Imminence" *means "the state or condition of being likely to occur at any moment; near at hand, rather than distant or remote." A DMHP may take a person into emergency custody when the person presents an imminent likelihood of serious harm or is in imminent danger because he/she is gravely disabled as a result of a mental disorder. RCW 71.05.150(2).*

The DMHP assesses the available information to determine whether or not, as a result of the mental disorder, there is a danger to the individual, to others, the property of others, or the individual is gravely disabled, and if so, if it is imminent. The DMHP makes this assessment:

- Using his/her professional judgment;
- Based on an evaluation of the individual, review of reasonably available history and interviews of any witnesses; and
- Consistent with statutory and other legally determined criteria.

Symptoms and behavior of the respondent which standing alone would not justify detention may support a finding of grave disability or likelihood of serious harm when:

- Such symptoms or behavior are closely associated with symptoms or behavior which preceded and led to a past incident of involuntary hospitalization, severe deterioration, or one or more violent acts; and
- These symptoms or behavior represent a marked and concerning change in the baseline behavior of the respondent; and
- Without treatment, the continued deterioration of the respondent is probable. RCW 71.05.212(3).

However, individuals cannot be detained on the basis of a severe deterioration in routine functioning alone, unless the detention is also shown to be essential for the individual's health or safety. See In re: Labelle (1986).

A DMHP who conducts an evaluation for imminent likelihood of serious harm or imminent danger because of being gravely disabled under RCW 71.05.153 must also evaluate the individual under RCW 71.05.150 for likelihood of serious harm or grave disability that does not meet the imminent standard for emergency detention. RCW 71.05.156.

The DMHP may proceed with emergency detention if using a non-emergency detention process would cause a delay that would reasonably increase the likelihood of harm occurring before the non-emergency process could be completed.

220–Use of Reasonably Available History

"Reasonably Available History" *means history which is made available to the DMHP by:*

- *Referral sources;*
- *Risk assessments from the Department of Corrections (DOC), Law enforcement;*
- *Treatment providers and Family or credible witnesses at the time of referral and investigation; and/or*
- *Other information that is immediately accessible.*

This other information can include an individual's crisis plan or other available treatment records, forensic evaluation reports (per RCW 10.77), criminal history records, risk assessments, and records from prior civil commitments.

The DMHP searches reasonably available records and/or databases in order to obtain the individual's background and history. Possible sources of information can be found in Appendix H.

When making decisions regarding referred individuals, a DMHP considers reasonably available history regarding:

- Advance directives previously prepared by the referred individual. When the DMHP becomes aware of an advance directive, they will attempt to access and respect the criteria as it is stated in the document;
- Prior recommendations for evaluation of the need for civil commitment when the recommendation is made pursuant to an evaluation conducted under chapter 10.77 RCW;
- Violent acts, which means homicide, attempted suicide, nonfatal injuries, or substantial damage to

property. RCW 71.05.020(44) History of violent acts refers to the period of ten years prior to the filing of a petition, not including time spent in a mental health facility or in confinement as a result of a criminal conviction, but including any violent acts committed in such settings. RCW 71.05.020(19);

- Prior determinations of incompetency or insanity under RCW 10.77;
- Prior commitments made under RCW 71.05; and
- For individuals designated as participants in the Offender Reentry Community Safety program (ORCS), criminal history and a history of involuntary medications. DMHPs may attempt to obtain the pre-release risk assessments available by calling the DOC Warrant Office at (360) 725-8888[4].

Reference: RCW 72.09.370.

While a DMHP is required to consider reasonably available history when making decisions, a history of violent acts or prior findings of incompetency cannot be the sole basis for determining if an individual currently presents a likelihood of serious harm.

The DMHP's compilation of reasonably available history is always considered in light of RCW 71.05's intent to provide prompt evaluation and timely and appropriate treatment.

The DMHP reviews historical information to determine its reliability, credibility, and relevance.

DMHPs document efforts to obtain reasonably available history.

Reference: RCW 71.05.212 and RCW 71.05.245.

225–Interviewing Witnesses as Part of an Investigation

> ***Credible****" means the state of being believable or trustworthy.*
>
> *"**Reliable** means the state of being accurate in providing facts: A reliable person provides factual information and can be expected to report the same facts on different occasions; a reliable witness is typically expected to be available if needed to consult with attorneys, treatment team members, or to testify in court.*

A DMHP must consider information provided from credible witnesses. RCW 71.05.212.

For minors, the DMHP shall investigate the specific allegations and the credibility of the witnesses. RCW 71.34.710. Information obtained from the parent, legal guardian, care providers, school, juvenile justice and other involved systems may be used to further the investigation. For minors currently receiving mental health services, attempts will be made to interview the service providers for the most current information/evidence related to the investigation.

A DMHP shall:

- Interview potentially credible witnesses who may have pertinent information. Credible witnesses may include family members, landlords, neighbors or others with significant contact or history of involvement with the individual, including persons identified by the individual being investigated.
- Assess the specific facts alleged and the reliability and credibility of any individual providing information that will be used to determine whether to initiate detention;

[4] Telephone number verified 7/22/2014

- Inform the prosecuting attorney of the contact information for credible witnesses;
- Exercise reasonable professional judgment regarding which witnesses to contact before deciding if an individual should be detained. This may include whether the witness's story is consistent, plausible, free from bias or personal interest and able to be corroborated by other individuals or physical evidence; and
- Inform witnesses that they may be required to testify in court under oath and may be cross-examined by an attorney. If known, the DMHP will inform any possible witness of the date, time and location of the probable cause hearing. If unknown, the DMHP will provide any possible witness with the telephone number of the prosecuting attorney.

230–Consideration of Less Restrictive Alternatives to Involuntary Detention

When considering whether to utilize less restrictive alternatives to involuntary detention, the DMHP assesses whether the individual is willing and able to accept those services and whether sufficient environmental controls and supports are in place to reasonably ensure the safety of the individual and community. In consideration of less restrictive alternatives, the DMHP takes into account the individual's developmental age in relationship to his or her chronological age.

The lack of a voluntary bed is not grounds for involuntary detention. RCW 71.05.050.

"No jail or state correctional facility may be considered a less restrictive alternative to an evaluation and treatment facility." RCW 71.05.157(6).

235–Referring a Person for Services when the Decision is not to Detain

Whenever an investigation results in a decision not to detain an individual, the DMHP:

- Determines whether a direct referral to community support services, emergency crisis intervention services or other community services is appropriate in order to assure continuity of care; and
- Either renews or facilitates contact with the individual when requested.

DETENTIONS

300–Rights of an Individual Being Detained

If the individual meets the criteria for detention, the DMHP must inform the individual of his/her rights, as follows:

- Advise the individual being detained that he/she has the rights specified in RCW 71.05.360 or, in the case of a minor, rights specified in RCW 71.34.050.
- If the individual being detained attempts to consult with an attorney, the DMHP will stop the interview while continuing on with the detention process.
- Inform the individual of their rights in detention, either orally or in writing. For individuals who are not proficient in English, rights should be provided in writing in a language that the individual is able to understand or read by a certified interpreter, if that person is available. If requested by the individual being detained, the DMHP reads the rights to the individual in their entirety.
- As soon as possible following the detention, the DMHP advises the parents of a minor, or the guardian or healthcare decision-maker of the individual being detained of the rights of the detainee consistent with the provisions of RCW 71.05.360(5), RCW 71.34.710(2).
- When the individual appears to be cognitively impaired, the DMHP determines whether the person has a health care decision-maker listed under RCW 7.70.065, or the parent or legal guardian in the case of a minor. The DMHP proceeds with detention if the healthcare decision-maker is not available.
- As soon as is reasonably possible, the DMHP attempts to contact any known individuals with the power to make health care decisions to inform them of the detention and rights of the person being detained.

Note: A health care decision-maker's powers depend on the authorization in the legal instrument. If the healthcare decision-maker is authorized to care for and maintain the individual in a setting least restrictive to the individual's freedom, the health care decision-maker could consent to additional treatment or placement in a less restrictive setting appropriate to his/her personal care needs.

Except for Parent Initiated Treatment cases under RCW 71.34.600, neither a guardian nor any other healthcare decision-maker can consent to involuntary treatment, observation or evaluation on behalf of the individual. RCW 11.92.043(5) and RCW 11.94.010(3).

305–Detention in the Absence of Imminent Harm

> ***"Imminence"*** *means "the state or condition of being likely to occur at any moment; near at hand, rather than distant or remote."*

A DMHP may take a person into emergency custody when the person presents an imminent likelihood of serious harm or is in imminent danger because he/she is gravely disabled as a result of a mental disorder. RCW 71.05.150(1).

If an adult meets the criteria for detention, but the likelihood of serious harm presented is not imminent, then the DMHP may initiate a non-emergency detention. The DMHP petitions the Superior Court for an order directing the DMHP to detain the adult to an evaluation and treatment facility.

A DMHP who conducts an evaluation for imminent likelihood of serious harm or imminent danger because of being gravely disabled under RCW 71.05.153 must also evaluate the person under RCW

71.05.150 for likelihood of serious harm or grave disability that does not meet the imminent standard for emergency detention RCW 71.05.156
Imminent harm is not required for the emergency detention of minors. RCW 71.05.150(1).

310–Detention of an Adult from a Licensed Residential Care Facility

- The following process applies to an individual being detained from a licensed residential care facility to an inpatient evaluation and treatment facility. The DMHP: Requests the facility staff to provide the appropriate documentation, including current medication(s) and last dosage, durable medical equipment used by the individual, and relevant medical information to the psychiatric staff at the inpatient evaluation and treatment facility; and
- May arrange the transportation of an individual from a licensed residential care facility.

315–Detention to a Facility in another County

When a DMHP detains an individual to an inpatient evaluation and treatment facility in another county, the detaining DMHP must:

- Send the documentation of Petition for Initial Detention, to the admitting facility within the statutory time limit;
- Agree to testify, if necessary, at any court hearings;
- Inform any potential witness needed for the court hearings that they may need to be available to testify at the hearings;
- Contact the Office of the Prosecuting Attorney or the DMHP Court Liaison for that county, as soon as practicable, to coordinate potential witnesses and to become familiar with the procedures that will be used in court (e.g., if testimony by telephone or video, is available).

A telephone list of each County Prosecutor's Office, including those with separate ITA units, is attached as Appendix B.

320–Documentation of Petition for Initial Detention

On the next judicial day following the initial detention, the DMHP must file a copy of the petition for initial detention, proof of service of notice, and a copy of the notice of rights and notice of detention with the court and serve the individual's designated attorney a copy of these documents.

For cases involving minors**,** the DMHP must also provide the minor's parent or legal guardian with these documents as soon as possible.

Reference: RCW 71.05.160 and RCW 71.34.710(2).

325–Notification if Detained Individual has a Developmental Disability

If an individual who is either known or thought to be a client of the Developmental Disabilities Administration (DDA) is involuntarily detained, the DMHP notifies, by the next judicial day following the initial detention, a designated representative of DDA of this action. RCW 70.02.230(2)(r). See Appendix E.

330–DMHP Responsibilities if Detained Individual is a Foreign National

The Vienna Convention and related bilateral agreements place additional requirements on DMHPs when detaining an individual who is a citizen of a foreign country (foreign national). Specific information pertaining to this requirement is contained in Appendix I.

If an individual who has been detained is a foreign national, the DMHP must advise the individual of his/her rights to contact consular officials from his/her home country and helps facilitate that contact if the person being detained desires it. (Vienna Convention).

If the individual who has been detained is a foreign national and is, legally not competent the DMHP must inform the consular official from that country without delay, whether or not the detained individual wants the consular official notified. (Vienna Convention).

If the individual who has been detained is a citizen of any of the nations with Bilateral Agreements, the DMHP must inform the consular official from that country without delay, whether or not the detained individual wants the consular official notified. Nations with Bilateral Agreements, and consular contacts, are listed in Appendix I.

In all cases, the DMHP documents:

- The date and time the foreign national was informed of his/her consular rights;
- The date and time any notification was sent to the relevant consular officer; and
- Any actual contact between the foreign national and the consular officer.

Additional contact information for foreign consular offices is located at the following link: http://travel.state.gov/content/travel/english/consularnotification.html[5]

335–Detention of Individuals who have Fled from Another State who were Found Not Guilty by Reason of Insanity and Fled from Detention, Commitment or Conditional Release

DMHPs may be called upon to evaluate individuals under RCW 71.05.195. DMHPs may wish to consult their county's prosecuting attorneys for specific procedure.

[5] Functioning hyperlink as of 6/2/2014

LESS RESTRICTIVE ALTERNATIVE COURT ORDERS

400–Rights of an Individual being Detained for a Revocation Hearing

When a DMHP conducts a revocation detention, all of the rights discussed in Section 300 are available to the individual being detained. In addition, the DMHP informs the individual, in writing or, if possible, orally in a language understood by the individual, that:

- A revocation hearing to determine whether he/she will be detained for up to the balance of his/her commitment must be held within five days following the date of the petition to revoke the CR/LRA Court Order RCW 71.05.340(3)(c)
- For minors, a revocation hearing must be held within seven calendar days following the date of petition to revoke the CR/LRA Court Order. RCW 71.34.780(3)

NOTE: Consult with prosecutor of local jurisdiction for clarification regarding judicial versus calendar days.

405–Advising Licensed Mental Health Outpatient Treatment Providers in Documenting Compliance with CR/LRA Court Orders

The office of the DMHP advises licensed mental health outpatient providers to document the individual's compliance with his/her CR/LRA Court Order and stresses the importance of:

- Closely monitoring CR/LRA Court orders by documenting in the individual's clinical record the need for revocation; and
- Providing DMHPs with information needed to support petitions for further court-ordered less restrictive treatment.

The office of the DMHP maintains a system, which tracks CR/LRA Court Orders as provided by any evaluation and treatment facility, or hospital.

If requested by the outpatient provider, the DMHP may evaluate for a petition to extend. Petitioning to extend the CR/LRA Court Order should occur whenever the individual continues to meet the criteria for further commitment and when further less restrictive treatment is in the individual's best interest. An investigation process may be initiated two to three weeks prior to the expiration of the CR/LRA Court Order. This investigation may involve consultation with the treatment provider(s) and other possible witnesses to determine if further involuntary treatment by extending the CR/LRA Court Order is warranted. The individual's past history of decompensation without continued involuntary outpatient treatment is important to consider when determining if the criteria for grave disability can be met.

Reference: RCW 71.05.320 and WAC 388-877A-0195

410–Criteria for Extending LRA Court Orders for Adults

***Grave disability"**, when being considered for extending a LRA Court Order, does not require that the person be imminently at risk of serious physical harm. Grave disability applies when, without continued involuntary treatment and based on the person's history, the individual's condition is likely to rapidly deteriorate and, if released from outpatient commitment, the individual would not receive such care as is essential for his or her health or safety.*

a. The following criteria apply for extending LRA Court Orders for adults: During the current period of court ordered treatment the individual has threatened, attempted, or inflicted physical harm upon the person of another, or substantial damage upon the property of another, and as a result of mental disorder presents a likelihood of serious harm; or

b. Was taken into custody as a result of conduct in which he or she attempted or inflicted serious physical harm upon the person of another, and continues to present, as a result of mental disorder a likelihood of serious harm; or

c. Is in custody pursuant to RCW 71.05.280(3) and as a result of mental disorder presents a substantial likelihood of repeating similar acts considering the charged criminal behavior, life history, progress in treatment, and the public safety; or

d. Continues to be gravely disabled while on a LRA Court Order.

e. Individuals previously committed by a court detention for involuntary treatment in the previous 36 months (exclusive of hospitalization or incarceration time) that preceded the individuals initial detention date, and is unlikely to voluntarily participate in out-patient treatment without an order, and outpatient treatment is necessary to prevent relapse, decompensation, or deterioration that is likely to result in the individual presenting a likelihood of serious harm or the individual becoming gravely disabled, within a reasonably short period of time. RCW 71.05.320

Reference: RCW 71.05.320(3)

415–Petitions for Extending a LRA Court Order for adults

Prior to expiration of a CR a new LRA petition may be filed under RCW 71.05.320(3) or (4).

The following are the procedures to follow when evaluating an adult for extending a LRA Court Order: Successive 180-day commitments are permissible on the same grounds and pursuant to the same procedures as the original 180-day commitment. However, a commitment is not permissible if 36-months have passed since the last date of discharge from detention for inpatient treatment that preceded the current less restrictive alternative order (LRA).

Extension cannot be based solely on harm to the property of others. RCW 71.05.320(6)

The DMHP:

- Evaluates the individual's current condition;
- Considers the cognitive and volitional functioning of the individual prior to court ordered treatment;
- Assesses if the individual would accept treatment, or take medication if not on a court order and whether the individual has a history of rapid decompensation when not in treatmen; and

- Considers the individual's history as well as their pattern of decompensation.

If the petitioning DMHP is to provide a declaration as an examining mental health professional, the case manager shall include a declaration by an examining physician. If the petitioning DMHP is not providing a declaration, the case manager is to include either declarations from:

- Two examining physicians;
- An examining physician and an examining mental health professional;
- Two psychiatric advanced nurse practitioners;
- A psychiatric advanced nurse practitioner and an examining mental health professional.

RCW 71.05.290(2).

The DMHP may file a petition for extending a LRA Court Order on the grounds of grave disability if:

a. The individual is in danger of serious physical harm resulting from a failure to provide for his/her essential human needs of health or safety, or **for a minor,** is not receiving such care as is essential to his/her health and safety from a responsible adult; or
b. The individual manifests severe deterioration in routine functioning evidenced by repeated and escalating loss of cognitive or volitional control over his/her actions and is not receiving such care as is essential to his/her self and safety.

- For extending a LRA Court Order, the DMHP gives great weight to evidence of prior history or pattern of decompensation and discontinuation of treatment resulting in: Repeated hospitalizations; and
- Repeated police intervention resulting in juvenile offenses, criminal charges, diversion programs or jail admissions. RCW 71.05.285.

420–Criteria for Revoking CR/LRA Court Order for Adults

If an individual meets criteria for revocation but also meets criteria for a new initial detention, a DMHP has the option of initiating a new 72-hour detention rather than revoking a CR/LRA court order. **Superior Court Rule MPR 4.4.**

RCW 71.05.340 (3) establishes two sets of criteria for possible revocation of an adult on a LRA Court Order.

1. The DMHP may file a petition to revoke the CR/LRA order of an individual, take them into custody, and temporarily detain them in an evaluation and treatment facility in or near the county in which he or she is receiving outpatient treatment, if the DMHP determines:
    a) The individual fails to comply with the terms and conditions of his/her CR/LRA Court Order;
    b) The individual experiences substantial deterioration in his/her condition;
    c) There is evidence of substantial decompensation with a reasonable probability that the decompensation can be reversed by further inpatient treatment; or
    d) The individual poses a likelihood of serious harm.
2. It is appropriate for the DMHP to file a revocation of the individual's CR/LRA when the case manager, designated to provide the outpatient treatment, notifies the DMHP that the individual on a CR/LRA failed to comply with the terms and conditions of his/her CR/LRA or has experienced a substantial deterioration in his/her condition **and** presents an increased likelihood of serious harm. The DMHP files a revocation petition, takes the individual into custody, and

temporarily detains the individual in an evaluation and treatment facility in or near the county in which he or she is receiving outpatient treatment. The DMHP may rely solely on the determination made by the case manager to file the petition.

- The case manager will provide a written statement, affidavit or declaration that includes the date and time the case manager last personally evaluated the individual, the specific conditions of the CR/LRA that have been violated, specific behaviors that demonstrate substantial deterioration, and how the violations or deterioration indicates an increased likelihood of serious harm. The case manager will also include the "lesser restrictive" actions taken by the case manager to avoid the revocation.
- If the subsequent revocation hearing is required, the case manager is expected to testify at the hearing to their statement, affidavit or declaration.
- If the county where the hearing is to occur requires in-person testimony, the DMHP will inform the case manager of the date of the hearing and the telephone number of the prosecutor. The DMHP will inform the prosecutor of the name and telephone number of the case manager.

425–Procedures for Revoking a CR/LRA Court Order for Adults

When the DMHP files a petition for revocation of a CR/LRA Court Order, the DMHP:

- Under criteria RCW 71.05.340 (3)(a), documents the facts used to make the determination to detain, including names and contact information for all witnesses;
- Under criteria RCW 71.05.340 (3) (b), based on information from the outpatient treatment provider, attaches the facts demonstrating that the individual presents an increased likelihood of serious harm to self or others, and attaches the supporting documents or declaration of the treatment provider, including the names and contact information for all witnesses;
- Serves the individual copies of their legal paperwork and takes them into custody;
- Completes and files the Petition for Revocation and accompanying paperwork indicating which grounds are being relied upon for revocation, and attaches a copy of the CR/LRA Court Order;
- Informs the outpatient treatment provider and other potential witnesses that their court testimony may be required at a subsequent revocation hearing. If the county where the hearing is to occur requires in-person testimony, the DMHP informs the potential witnesses of the date, time and place of the hearing and telephone number of the prosecutor's office.

Reference: RCW 71.05.212 (2).

430– Procedures for Revoking a CR/LRA Court Order for Minors

When the DMHP files a petition for revocation of a CR/LRA Court Order, the DMHP:

- Or the professional person in charge of an outpatient treatment program, or the secretary determine that a minor is failing to adhere to the conditions of the court order for less restrictive alternative treatment or the conditions for the conditional release, or that substantial deterioration in the minor's functioning has occurred;
- Or the secretary may order that the minor be taken into custody and transported to an inpatient evaluation and treatment facility;
- Or the secretary shall file the order of apprehension and detention and serve it upon the minor and notify the minor's parent and the minor's attorney, if any, of the detention within two days of return

- Shall inform the minor at the time of service of the right to a hearing and to representation by an attorney;
- Or the secretary may modify or rescind the order of apprehension and detention at any time prior to the hearing.

The hearing must be set within seven calendar days from the time of detention.

Reference: RCW 71.34.780

Refer to Appendix J for sample forms that may be used in the Conditional Release/Less Restrictive Alternative (CR/LRA) Court Order process.

CONFIDENTIALITY

500–General Provisions on Confidentiality

Information gathered by DMHPs is confidential under Washington State law and may not be disclosed to anyone unless specifically permitted by law, by a signed release, or by a court order signed by a judge. Statutory provisions related to confidentiality of mental health information and records can be found in multiple locations including, but not limited to RCW 70.02; RCW 70.02.230, RCW 71.05.445, RCW 71.05.620; RCW 10.77.065 and RCW 10.77.210, RCW 71.24; In the case of minors, RCW 70.02.240, RCW 70.02.250 and RCW 70.02.320.

In addition to mental health information under RCW 71.05 and RCW 71.34, state and/or federal laws also protect the confidentiality of health care information under RCW 70.02; information about HIV or sexually transmitted diseases under RCW 70.24; and drug and alcohol abuse treatment information under RCW 70.96A.150 and 42 CFR Part 2. These laws generally regulate the release of such information without written authorization. The DMHP will advise the individual of their rights under HIPAA. The unauthorized release of confidential information may subject DMHPs to civil liability and penalties.

Additional information regarding medical records – health care information access and disclosure can be found in Chapter 70.02 RCW. It may be necessary, however, to divulge limited information to third parties in order to complete an investigation. For example, when verifying a witness' allegations, the DMHP may need to demonstrate an awareness of the problem so that the witness will talk about the situation.

Referents may be advised that the investigation has been completed.

505–Sharing Information with Parents, Responsible Family Members, Other Legal Representatives

Whenever any person is detained for evaluation and treatment pursuant to this chapter, both the person and, if possible, a responsible member of his or her immediate family, personal representative, guardian, or conservator, if any, shall be advised as soon as possible in writing or orally, by the officer or person taking him or her into custody or by personnel of the evaluation and treatment facility where the person is detained that unless the person is released or voluntarily admits himself or herself for treatment within seventy-two hours of the initial detention. RCW 71.05.360(5).

For cases involving the detention of minors**,** the parent(s) or legal guardian of the minor must be notified of the fact of detention. Notice must include information regarding the patient's rights and the court process and notification should occur as soon as possible after the detention. RCW 71.34.710(2).

510–Sharing Information with Law Enforcement

> *"**Law enforcement officer**" means a member of the state patrol, a sheriff or deputy sheriff, or a member of the police force of a city, town, university, state college, or port district, or a fish and wildlife officer or ex officio fish and wildlife officer as defined in RCW 77.08.010.*

Information may be shared with law enforcement in the following situations:

- If there is a crisis or emergent situation that poses a significant and imminent risk to the public. In this case, any information considered relevant to the situation or necessary for its resolution may be shared with corrections or law enforcement. RCW 70.02.230.
- If an individual being evaluated has threatened the health and safety of another, or has repeatedly harassed another. In this case, the date of commitment, admission, discharge, or release may be disclosed, as well as any absence from a facility (authorized or unauthorized), may be shared with the appropriate law enforcement agency. Any information that is pertinent to the threat or harassment may also be disclosed. RCW 70.02.230.
- If law enforcement made the referral, and they make a request to find out the results of the investigation. In this case, the results shall be disclosed in writing if requested, including a statement of the reasons why the individual was or was not detained. A written disclosure shall occur within 72 hours of the completion of the investigation or the request from law enforcement or corrections representative, whichever occurs later. RCW 70.02.230.
- If an individual escapes from custody. In this case, as much information may be disclosed as is necessary for law enforcement to carry out their duties in returning the patient. RCW 70.02.230.
- If law enforcement requests information to help them carry out their duties. The fact, place, and date of involuntary commitment may be disclosed, as may the date of discharge or release and last known address. Additional information may be disclosed if notice is given to the individual and his or her attorney, and a showing is made by clear, cogent, and convincing evidence that the information is necessary for law enforcement to carry out their duties and that law enforcement will maintain appropriate safeguards for strict confidentiality. RCW 70.02.230.
- If law enforcement requests information as part of an investigation of an Unlawful Possession of a Firearm case [RCW 9.41.040(2)(a)(ii)]. In this case, the only items that may be disclosed are the fact, place, and date of involuntary commitment; an official copy of the commitment orders; and an official copy of any notice (written or oral) given to the individual that they are now ineligible to possess a firearm. RCW 70.02.230.

515–Sharing Information with Department of Corrections Personnel

Information must be shared with the Department of Corrections (DOC), including Community Corrections Officers, regarding individuals supervised by DOC who have failed to report or who are involved in an emergent situation that poses significant risk to the public or the offender.
At DOC's oral request for information, the DMHP shall provide information regarding:

- Where the individual may be found, including his/her address; and
- A statement as to whether the individual is or is not being treated.

At DOC's written request for information, DMHPs shall release "information related to mental health services" for DOC personnel to carry out their duties. This includes all "relevant records and reports" (i.e. all information and records compiled, obtained, or maintained in the course of providing services to either voluntary or involuntary recipients of services by a mental service provider." RCW 70.02.250

and WAC 388-865-0610.
Information that DOC must include in a written request is found in WAC 388-865-0640. See Appendix M.

Guidance as to the age of records that must be released is found in WAC 388-865-0620. See Appendix M.

Timelines for disclosing the requested information are found in WAC 388-865-0630. See Appendix M.

When a person receiving court-ordered treatment or treatment ordered by the Department of Corrections discloses to his or her mental health service provider that he or she is subject to supervision by the department of corrections, the mental health service provider shall notify the:

- Department of Corrections that he or she is treating the offender;
- Offender that his or her community corrections officer will be notified of the treatment, provided that if the offender has received relief from disclosure pursuant to RCW 9.94A.562, 70.96A.155, or 71.05.132 and the offender has provided the mental health service provider with a copy of the order granting relief from disclosure pursuant to RCW 9.94A.562, 70.96A.155, or 71.05.132, the mental health service provider is not required to notify the Department of Corrections that the mental health service provider is treating the offender. The notification may be written or oral and shall not require the consent of the offender. If an oral notification is made, it must be confirmed by a written notification. For purposes of this section, a written notification includes notification by email or facsimile, as long as the notifying mental health service providers are clearly identified.

520–Sharing Information to Protect Identified Persons

An individual's confidentiality is subject to less protection when he/she is known to have made threats to or repeatedly harassed another. Whenever a DMHP investigates someone who has made threats to, or repeatedly harassed another reasonably identifiable victim, the DMHP must:

- Call the individual/victim who has been threatened or harassed;
- Release information as is pertinent to the threat or harassment and date of detention if applicable;
- Inform the accepting facility of the threat and the identified victim's contact information;
- Document the notifications in the case write up;
- Make sure that the fact of release is noted in the case; and
- Call appropriate law enforcement agencies (both the law enforcement agencies of the victim and of the suspect).

Reference: RCW 70.02.230(2)(h)(i) and RCW 70.02.240 see Appendix O.

APPENDICES

Appendix A: 2014 Designated Mental Health Professionals Protocol Workgroup Members

Washington Association of Designated Mental Health Professionals:
Ian Harrel – President Emeritus WADMHP, Emergency Services Director, Behavioral Health Resources
Luke Waggoner – Sr. Team Leader – Acute Care Services, Walla Walla Center, Comprehensive Mental Health

Designated Mental Health Professionals
Sandarah Abrahamson-Amun – Integrated Crisis Response Services Supervisor, Whatcom Counseling
Marlene Burrows – Clark County, Director of Crisis Services
Gordon Cable - Integrated Services Manager, Benton\Franklin Counties Crisis Response Unit
Staci Cornwell – Director of Crisis Response Services Spokane County, Frontier Behavioral Health
Nate Hinrichs – Pierce County Crisis and Commitment Services Manager
Pam Hutchinson – Skagit County Mental Health Outreach Crisis Services Manager, Compass Health
Drew McDaniel – Director of Crisis Response Services, Cowlitz County Guidance Association
Heather McKay – Crisis Services Manager, Pend Oreille County Counseling
Stacey Okhara – Supervisor, Crisis Response Services Spokane County, Frontier Behavioral Health
Annabelle Payne – Director, Pend Oreille County Counseling
Jennifer Ross = Crisis Services Director, Chelan/Douglas Counties, Catholic Family and Childrens Services
Carola Schmid – Supervisor, Involuntary Treatment and Community Mental Health Services, Snohomish County
JoEllen Watson – King County Crisis and Commitment Services
Allison Wedin – King County Crisis and Commitment Services, Supervisor

Department of Social and Health Services:
Jennifer Bliss – Division of Behavioral Health and Recovery, Office of Consumer Partnership
LaRessa Fourre – Division of Behavioral Health and Recovery, Children's Mental Health Program Administrator
Wanda Johns –Division of Behavioral Health and Recovery, Administrative Assistant 3
Monica Jordan –Division of Behavioral Health and Recovery, Program Administrator
David Kludt –Division of Behavioral Health and Recovery, Program Administrator
Ruth Leonard – Division of Behavioral Health and Recovery, Behavioral Health Treatment Manager
Anthony O'Leary – Division of Behavioral Health and Recovery, Compliance Manager
Dan Peterson –Developmental Disabilities Administration, Mental Health Resource Manager
Karie Rainer – Department of Corrections, Mental Health Director
Mario J. Williams-Sweet – Aging and Long Term Services Administration/Home and Community Services, Behavioral Specialist

Community Stakeholders:
Cassandra Ando – NAMI Washington, Policy Analyst
Christopher Jennings – Pierce County Office of Assigned Counsel
Anne Mizuta - King County Senior Specialist Deputy Prosecuting Attorney
Gregory Robinson - Washington Community Mental Health Council, Senior Policy Analyst
Sandy Whitcutt – North Sound Mental Health Administration, Quality Specialist

Observers with Comments:
Kevin Black - Counsel for Senate Committee Services

Appendix B: County Prosecutor's Office Phone List

County	Prosecuting Attorney	Telephone/Fax	Email Address
Adams	Randy J. Flyckt	*(509) 659-3219* *Fax (509) 659-3224*	randyf@co.adams.wa.us
Asotin	Benjamin C. Nichols	*(509) 243-2061* *Fax (509) 234-2090*	bnichols@co.asotin.wa.us
Benton	Andrew K. Miller	*(509) 735-3591* *Fax (509) 222-3705*	andy.miller@co.benton.wa.us
Chelan	Douglas Shae	*(509) 667-6202* *Fax (509) 667-6490*	douglas.shae@co.chelan.wa.us
Clallam	William Payne	*(360) 417-2301* *Fax (360) 417-2469*	wpayne@co.clallam.wa.us
Clark	Anthony F. Golik	*(360) 397-2261* *Fax (360) 397-2230*	tony.golik@clark.wa.gov
Columbia	Rea Culwell	*(509) 382-1197* *Fax (509) 382-1191*	rculwell@waprosecutors.org
Cowlitz	Susan I. Baur	*(360) 577-3080* *Fax (360) 414-9121*	baurs@co.cowlitz.wa.us
Douglas	Steven M. Clem	*(509) 745-8535* *Fax (509) 745-8670*	sclem@co.douglas.wa.us
Ferry	Michael Sandona	*(509) 775-5206* *Fax (509) 775-5212*	msandona@wapa-sep.wa.gov
Franklin	Shawn P. Sant	*(509) 545-3543* *Fax (509) 545-2135*	ssant@co.franklin.wa.us
Garfield	Matthew Newberg	*(509) 843-3082* *Fax (509) 843-2337*	mnewberg@co.garfield.wa.us
Grant	D. Angus Lee	*(509) 754-2011 xt 450* *Fax (509) 754-3449*	dlee@co.grant.wa.us
Grays Harbor	Gerald Fuller	*(360) 249-3951* *Fax (360) 249-6064*	gfuller@co.grays-harbor.wa.us
Island	Gregory M. Banks	*(360) 679-7363* *Fax (360) 240-5566*	gregb@co.island.wa.us
Jefferson	Scott Rosekrans	*360) 385-9180* *Fax (360) 385-9186*	srosekrans@co.jefferson.wa.us
King	Dan Satterberg	*(206) 296-9067* *Fax (206) 296-9013*	Dan.satterberg@kingcounty.gov
Kitsap	Russell D. Hauge	*(360) 337-7174* *Fax (360) 337-4949*	rhauge@co.kitsap.wa.us
Kittitas	Gregory L. Zempel	*(509) 962-7520* *Fax (509) 962-7022*	gregz@co.kittitas.wa.us
Klickitat	Lori L. Hoctor	*(509) 773-5838* *Fax (509) 773-6696*	lorih@co.klickitat.wa.us
Lewis	Jonathan L. Meyer	*(360) 740-1240* *Fax (360) 740-1497*	jonathan.meyer@lewiscountywa.gov
Lincoln	Jeffrey S. Barkdull	*(509) 725-4040* *Fax* (509) 725-3478	jbarkdull@co.lincoln.wa.us

County	Prosecuting Attorney	Telephone/Fax	Email Address
Mason	Michael Dorcy	*(360) 427-9670 xt 417* *Fax (360) 427-7754*	michaeD@co.mason.wa.us
Okanogan	Karl F. Sloan	*(509) 422-7280* *Fax (509) 422-7290*	ksloan@co.okanogan.wa.us
Pacific	David J. Burke	*(360) 875-9361* *Fax (360) 875-9362*	dburke@co.pacific.wa.us
Pend Oreille	Thomas A. Metzger	*(509) 447-4414* *Fax (509) 447-0235*	tmetzger@pendoreille.org
Pierce	Mark Lindquist	*(253) 798-7400* *Fax (253) 798-6636*	mlindqu@co.pierce.wa.us
San Juan	Randall K. Gaylord	*(360) 378-4101* *Fax (360) 378-3180*	randyg@sanjuanco.com
Skagit	Richard Weyrich	*(360) 336-9460* *Fax (360) 336-9347*	richardw@co.skagit.wa.us
Skamania	Adam N. Kick	*(509) 427-3790* *Fax (509) 427-3798*	kick@co.skamania.wa.us
Snohomish	Mark K. Roe	*(425) 388-6330* *Fax (425) 388-7172*	mroe@snoco.org
Spokane	Steven J. Tucker	*(509) 477-3662* *Fax (509) 477-3409*	stucker@spokanecounty.org
Stevens	Timothy D. Rasmussen	*(509) 684-7500* *Fax (509) 684-8310*	trasmussen@co.stevens.wa.us
Thurston	Jon Tunheim	*(360) 786-5540* *Fax (360) 754-3358*	tunheij@co.thurston.wa.us
Wahkiakum	Daniel H. Bigelow	*(360) 795-3652* *Fax (360) 795-6506*	dbigelow@wapa-sep.wa.gov
Walla Walla	James L. Nagle	*(509) 524-5445* *Fax (509) 524-5485*	jnagle@co.walla-walla.wa.us
Whatcom	David S. McEachran	*(360) 676-6784* *Fax (360) 738-2532*	dmceachr@co.whatcom.wa.us
Whitman	Denis P. Tracy	*(509) 397-6250* *Fax (509) 397-5659*	denist@co.whitman.wa.us
Yakima	Jim Hagarty	*(509) 574-1210* *Fax (509) 574-1211*	james.hagarty@co.yakima.wa.us

Appendix C: Requirements of Licensed Residential Care Facilities

This Appendix is intended only as a brief overview of the rules and regulations concerning mental health services in adult family homes, assisted living facilities and skilled nursing facilities. Current federal and/or state law requires licensed residential care facilities to conduct assessments and provide or arrange for services if reasonably possible in order to meet residents' needs.

Residents have a legal right to remain at licensed residential care facilities if their needs can be met. In certain circumstances, residents may also have a right to have their bed held during a temporary hospitalization. If the health or safety threat of the individual can be adequately reduced or the resident's care needs met through reasonable changes in the facility's practices or the reasonable provision of additional available services at the facility, then the facility is not permitted to transfer or discharge the resident, and the facility may be considered a less restrictive alternative. The facility is legally permitted to transfer or discharge a resident if necessary for the resident's welfare and the resident's needs cannot be met in the facility; the safety of individuals in the facility would otherwise be endangered and or the health of individuals in the facility would otherwise be endangered. RCW 70.129.110 and RCW 74.42.450(7).

Licensed residential care facilities that serve residents with dementia, mental illness, or a developmental disability are required to receive training to provide individualized services to these populations. However, the availability and capacity of staff resources to offer additional services in response to emergent needs varies in residential environments and is relevant when the DMHP is considering if the services and treatment needed by the resident can be provided by the facility as a less-restrictive alternative.

Following hyper-links lead to websites with information on laws and regulations for licensed residential care facilities: :

- Adult Family Homes http://www.adsa.dshs.wa.gov/professional/afh.htm
- Assisted Living Facilities http://www.adsa.dshs.wa.gov/Professional/bh.htm
- Skilled Nursing Facilities http://www.adsa.dshs.wa.gov/professional/nh.htm

Descriptions of Adult Family Homes, Assisted Living Facilities and Skilled Nursing Facilities: http://www.adsa.dshs.wa.gov/pubinfo/housing/other

- Resident rights provisions in statute: http://apps.leg.wa.gov/RCW/default.aspx?cite=70.129
- Adult Family Home Professionals: http://www.adsa.dshs.wa.gov/professional/afh.htm
- Assisted Living Facilities Professionals: http://www.adsa.dshs.wa.gov/professional/bh.htm
- Skilled Nursing Facility Professionals: http://www.adsa.dshs.wa.gov/professional/nh.htm

Appendix D: DMHP Intervention Checklist

Following are guidelines and questions that may be helpful to DMHP's in evaluating an individual in a licensed residential care facility. For example, the dangerous behavior may not be due not to a mental disorder but to other factors, such as an infection (e.g., UTI's in residents with dementia), constipation, respiratory disorders, medication interactions, or environmental stressors.

Note: Speed of access to medical resources, e.g. lab work, can vary by facility type.

1. Has the facility nurse or resident's treating physician been consulted regarding the resident's needs? What recommendations were provided? How has the resident responded? If recommendations have not been implemented, what is the reason?
2. What lab work, if any, has been done to rule out medical issues? Example: UA, electrolytes, TSH, B12, diagnosis, folic acid, medication levels.
3. Has a pain assessment been completed?
4. Is there any possibility of constipation, dehydration, GI distress or 02 deficiency?
5. What medications does the resident receive? Have there been any medication changes recently? If so, do they correlate in any way to the behavioral changes?
6. Has the resident experienced any environmental or social changes recently? For example, any recent losses, change of residence?
7. Are PRN medications being used as ordered? Are they effective? If so, has the treating physician considered ordering as routine medications?
8. Are behavior changes documented? What interventions have been attempted and what is the documented outcome? Does documentation address duration, intensity and frequency of the behaviors as necessary to assess effectiveness of current interventions? For an individual in a skilled nursing facility, has the individual been identified as having indicators of mental illness on the Pre-Admission Screening Resident Review (PASSR) evaluation?
9. What specifically deescalates the behaviors? Example: staff or family attention or presence, being left alone, removal from/of visual or auditory stimuli. Have all alternatives utilizing these options been explored?
10. Has the family, as appropriate, been notified of the problem and involved in interventions or response plans?
11. Have hospice services been considered as a resource to assist in end-of-life concerns?

BEHAVIORAL INTERVENTION SUGGESTIONS

1. Remove the resident from excessive auditory and visual stimuli. Provide a calm, quiet, peaceful space for the resident to regroup.

2. Use a calm, quiet voice, no matter what the resident's voice tone or level is.

    a. Allow time for the resident to vent before trying to intervene, unless danger to self or others is involved.
    b. Offer time for the resident to communicate his/her concerns, even if they are irrelevant or delusional.

3. Increase consistent structure in the resident's daily routine.

4. Redirect the resident toward a new interest, rather than away from the object, person or topic involved in the behavior. Reorient the resident without disagreeing with him/her.

5. Offer rest and position change. Change the surrounding, the resident's room assignment or roommate.

6. Assign the resident tasks that meet their strength and history. Short, repetitive tasks are often best.

7. Go along with, or accommodate a fixed delusion or perseverative thought rather than fight it.

8. Let the resident tell you what will help and work with the family or support system to find creative ways to make it happen. Example: "I want to go home"—allow the family to recreate as much as possible the one room or space in the house that resident found the most comfortable.

Utilize PRN medications as ordered.

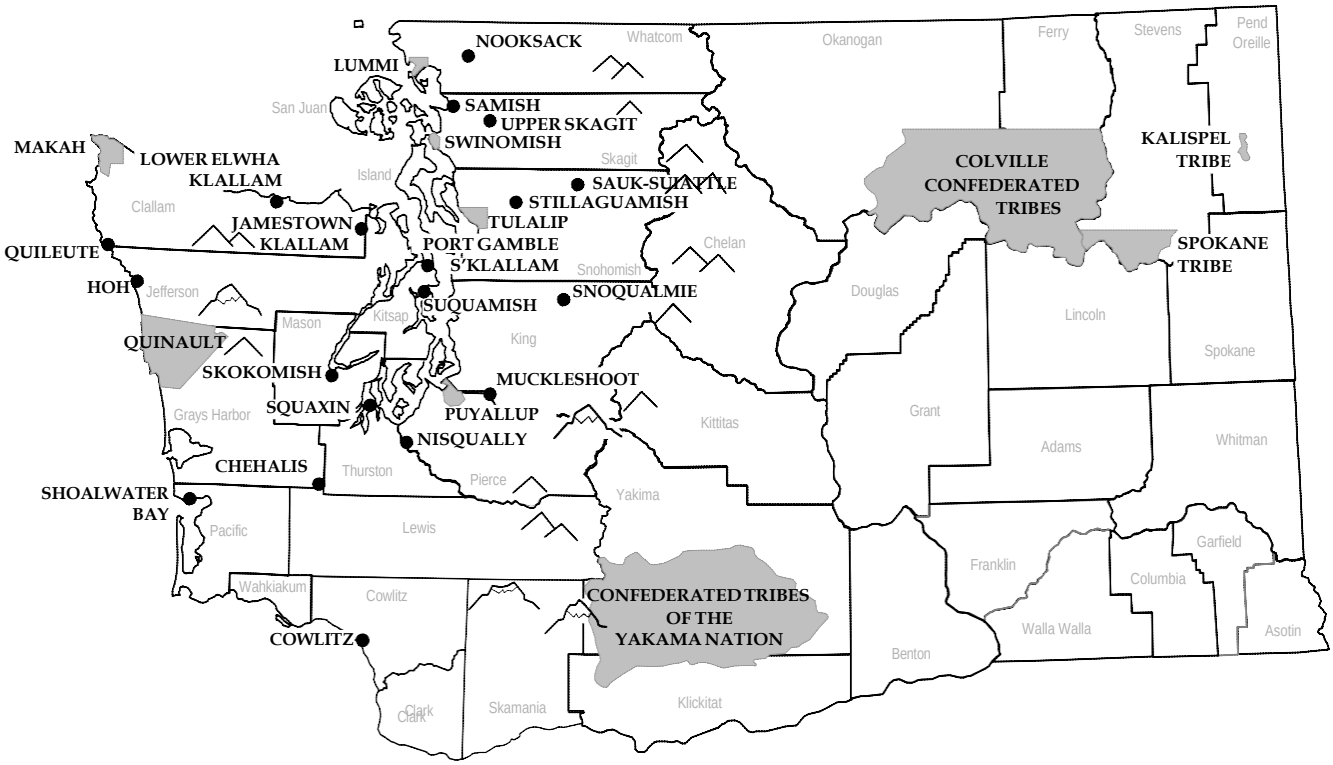
Appendix E: DDA Contacts Listed by RSN and County - for DMHPs[6]

RSN	DDA Staff Contacts	DDA FAX/Cell #
Chelan-Douglas	Risa Salters – 509-665-5296 Tory Fiedler – 509-225-4626	fax-509-374-7103 cell-509-308-1228
Grays Harbor	Jeff Green – 360-725-4305 Amee Kile – 360-725-4282	fax-360-568-6502
Greater Columbia		
TriCities/Walla-Walla	Nikki Reed – 509-374-2122 Tory Fiedler – 509-225-4626	fax-509-574-5607 cell-509-728-4203
Asotin & Pullman	Tory Fiedler – 509-225-4626	fax-509-574-5607 cell-509-969-9049
Yakima/Ellensburg	Itza Reyes – 509-225-4636 Tory Fiedler – 509-225-4626	fax-509-574-5607 cell-509-840-4472
King	Dan Peterson – 206-568-5670 Gene Mcconnachie – 206-568-5718	fax-206-720-3038
North Sound	Sue Halle – 425-339-4887 Kristin Ihrig – 425-339-4828	fax-425-339-4856
Pierce	Katie Kimball - 253-404-5594 Amee Kile – 360-725-4282	fax-253-593-2052
Peninsula	Jeff Green – 360-725-4305 Amee Kile – 360-725-4282	fax-360-568-6502
Except Kitsap	Katie Kimball - 253-404-5594 Amee Kile – 360-725-4282	fax-253-593-2052
Spokane	Karen Lantz – 509-329-2956 Tory Fiedler – 509-225-4626	fax-360-568-6502
Except Okanagan/Grant	Risa Salters – 509-665-5296 Tory Fiedler – 509-225-4626	fax-509-374-7103 cell-509-308-1228
Southwest WA Behavioral Health	Jeff Green – 360-725-4305 Amee Kile – 360-725-4282	fax-360-568-6502
Thurston Mason	Jeff Green – 360-725-4305 Amee Kile – 360-725-4282	fax-360-568-6502
Timberlands	Jeff Green – 360-725-4305 Amee Kile – 360-725-4282	fax-360-568-6502

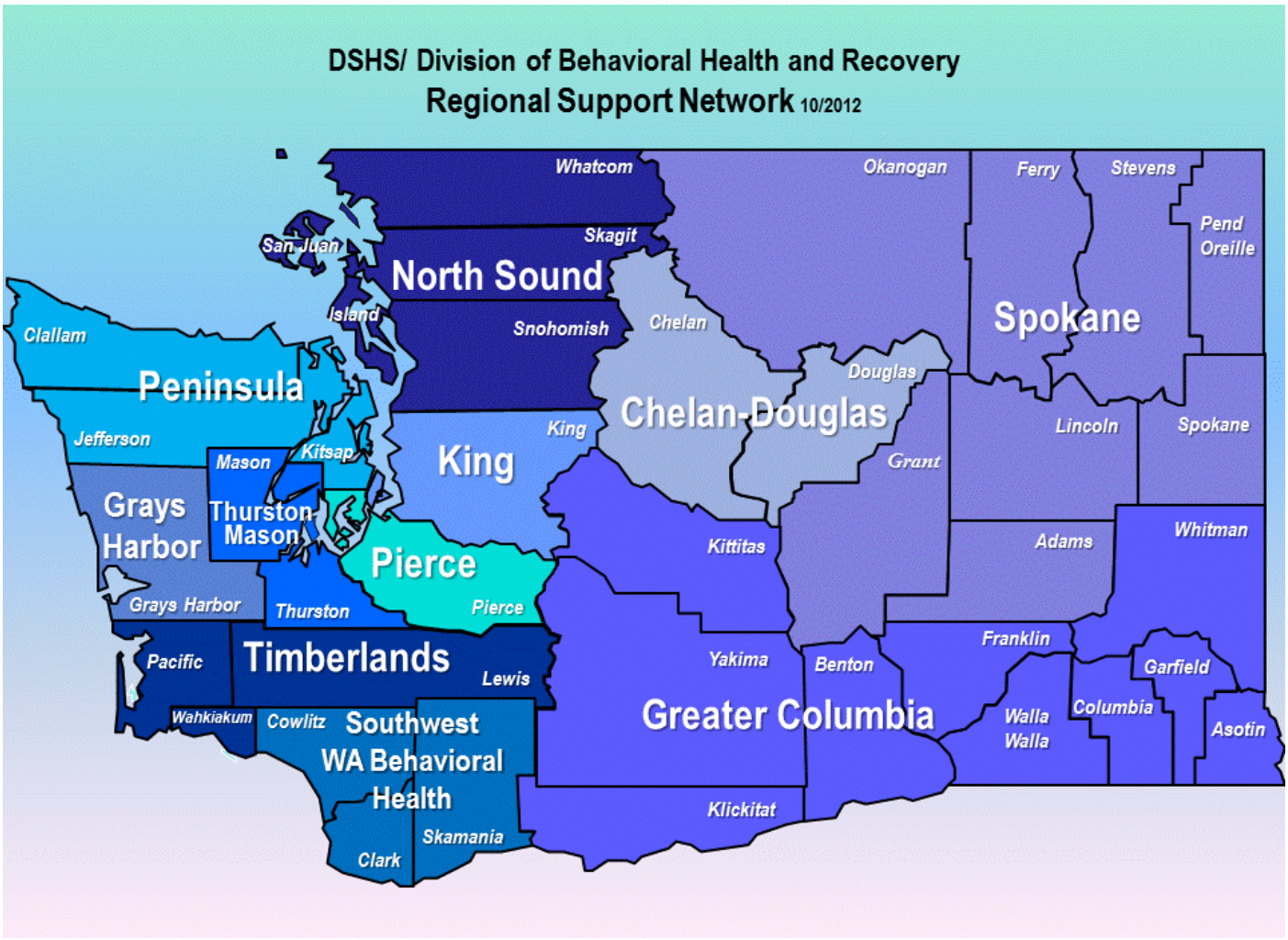
[6] Updated 7/22/2014

Appendix F: Federally Recognized Tribes of Washington State

FEDERALLY RECOGNIZED TRIBES OF WASHINGTON STATE



Appendix G: Regional Support Networks



Appendix H: List of Resources for "Available History"

Accessing potentially relevant information and records, including information and records that, if reasonably available, must be considered (RCW 71.05.212) may be challenging.

Possible resources include:

- County or local law enforcement records. Some local law enforcement offices, jails and juvenile detention authorities may be able to share criminal history information.
- Washington State Patrol (WSP) information. The WSP provides criminal history information via the Internet through the Washington Access To Criminal History (WATCH) Program. A $10 fee is charged for each criminal history search.
    - For additional information contact the WSP Identification and Criminal History Section by telephone at (360) 534-2000 and press option 2.
    - By internet at http://www.wsp.wa.gov/crime/chrequests.htm.
- DMHP office records. In addition to information regarding prior investigations and detentions under RCW 71.05, these records may include additional relevant information. Since 1998 copies of evaluation reports conducted under RCW 10.77 have been sent to the DMHP office in the county where the criminal offense occurred. These reports contain recommendations regarding civil commitment.
- Case Manager Locator database. This may identify current or prior outpatient treatment providers who may have relevant information.
- State psychiatric hospital records. The state psychiatric hospitals (Western State Hospital and Eastern State Hospital) maintain records of persons that have been committed to the hospital under civil (RCW 71.05) and criminal (RCW 10.77) statutes. Staff (Medical Records Office, Admitting Nurse or other Admissions personnel) are available 24 hours each day at:
    - Western State Hospital: (253) 582-8900.
    - Eastern State Hospital: (509) 565-4000.
- Community support service provider, residential facility, or treating physician clinical records may contain relevant information.

Appendix I: Steps to Follow When a Foreign National is Detained

This information is from the U.S. State Department web site. Additional information on the Vienna Convention and related bilateral agreements can also be found at the U.S. State Department web site: http://www.state.gov/www/global/legal_affairs/ca_notification/ca_prelim.html [7]

Determine the foreign national's country. In the absence of other information, assume this is the country on whose passport or other travel documents the foreign national travels.

- If the foreign national's country is **not** on the mandatory notification list, offer, without delay, to notify the foreign national's consular officials of the arrest/detention

  For a suggested statement to the foreign national, see **Statement 1** on the web site's Part 1 Basic Instructions at: http://www.state.gov/www/global/legal_affairs/ca_notification/part1.html [8]

  Translations of the statement into selected foreign languages are in Part Four of this publication.

- If the foreign national asks that consular notification be given, notify the nearest consular officials of the foreign national's country without delay.

  For phone and fax numbers and email addresses for foreign embassies and consulates in the United States, see: http://www.state.gov/www/global/legal_affairs/ca_notification/part1.html#statements The website includes hyperlinks to the embassies and consulates. Each consulate or embassy website contains a "Contact Us" hyperlink, which produces further contact information.

- If the foreign national's country **is** on the list of mandatory notification countries, notify that country's nearest consular officials, without delay, of the arrest/detention.

  Phone and fax numbers are found at: http://www.state.gov/www/global/legal_affairs/ca_notification/part1.html Further information, including a suggested fax sheet for making the notification, may be found at: http://www.state.gov/www/global/legal_affairs/ca_notification/part1.html#statements

- Tell the foreign national that you are making this notification.

A suggested statement to the foreign national, with translations into other languages, is found at: http://www.state.gov/www/global/legal_affairs/ca_notification/part1.html#statements

- Keep a written record of the provision of notification and actions taken.

[7] Hyperlink functioning as of 7/3/2014
[8] Hyperlink functioning as of 7/3/2014

Antigua and Barbuda	Guyana	Saint Lucia
Armenia	Hong Kong[2]	Saint Vincent and the Grenadines
Azerbaijan	Hungary	Seychelles
Bahamas, The	Jamaica	Sierra Leone
Barbados	Kazakhstan	Singapore
Belarus	Kiribati	Slovakia
Belize	Kuwait	Tajikistan
Brunei	Kyrgyzstan	Tanzania
Bulgaria	Malaysia	Tonga
China[1]	Malta	Trinidad and Tobago
Costa Rica	Mauritius	Turkmenistan
Cyprus	Moldova	Tuvalu
Czech Republic	Mongolia	Ukraine
Dominica	Nigeria	United Kingdom[3]
Fiji	Philippines	U.S.S.R.[4]
Gambia, The	Poland (Non-permanent residents only)	Uzbekistan
Georgia	Romania	Zambia
Ghana	Russia	Zimbabwe
Grenada	Saint Kitts and Nevis	

[1] Notification is not mandatory in the case of persons who carry "Republic of China" passports issued by Taiwan. Such persons should be informed without delay that the nearest office of the Taipei Economic and Cultural Representative Office ("TECRO"), the unofficial entity representing Taiwan's interests in the United States, can be notified at their request.

[2] Hong Kong reverted to Chinese sovereignty on July 1, 1997, and is now officially referred to as the Hong Kong Special Administrative Region, or quote; SAR." Under paragraph 3(f) (2) of the March 25, 1997, U.S.-China Agreement on the Maintenance of the U.S. Consulate General in the Hong Kong Special Administrative Region, U.S. officials are required to notify Chinese officials of the arrest or detention of the bearers of Hong Kong passports in the same manner as is required for bearers of Chinese passports--*i.e.*, immediately, and in any event within four days of the arrest or detention. [3] British dependencies also covered by this agreement are Anguilla, British Virgin Islands, Bermuda, Montserrat, and the Turks and Caicos Islands. Their residents carry British passports.

[4] Although the USSR no longer exists, some nationals of its successor states may still be traveling on its passports. Mandatory notification should be given to consular officers for all nationals of such states, including those traveling on old USSR passports. The successor states are listed separately above.

Suggested Statements to Arrested or Detained Foreign Nationals

Statement When Consular Notification is at the Foreign National's Option
(For Translations, See Part Four)

Statement 1:

When Consular Notification is at the Foreign National's Option (For Translations, See Part Four) As a non-U.S. citizen who is being arrested or detained, you are entitled to have us notify your country's consular representatives here in the United States. A consular official from your country
may be able to help you obtain legal counsel, and may contact your family and visit you in detention, among other things. If you want us to notify your country's consular officials, you can request this notification now, or at any time in the future. After your consular officials are notified, they may call or visit you. Do you want us to notify your country's consular officials?

Statement 2:

When Consular Notification is Mandatory
(For Translations, See Part Four)

Because of your nationality, we are required to notify your country's consular representatives here in the United States that you have been arrested or detained. After your consular officials are notified, they may call or visit you. You are not required to accept their assistance, but they may be able to help you obtain legal counsel and may contact your family and visit you in detention, among other things. We will be notifying your country's consular officials as soon as possible.

Suggested Fax Sheet for Notifying Consular Officers of Arrests or Detentions

Date: _____ Time:_____

To: Embassy of_____,Washington, DC

or

Consulate of_____,_____, _____ (Country) (City) (State)

From: Name: _____

Office: _____

Street Address: _____

City:_____State: _____

_____ ZIP Code: _____

Telephone: (____)_____

Fax: (____)_____

Subject: NOTIFICATION OF ARREST/DETENTION OF A NATIONAL OF YOUR

COUNTRY

We arrested/detained the following foreign national, whom we understand to be a national of your country, on_____,_____.

Mr./Ms. _____

Date of birth: _____

Place of birth: _____

Passport number: _____

Date of passport issuance: _____

Place of passport issuance: _____

To arrange for consular access, please call_____between the hours of_____and_____.

Please refer to case number_____when you

call. Comments:

Appendix J: Sample Forms for Less Restrictive Alternative Process

(See Section 400)

NOTICE NOT TO EXTEND LESS RESTRICTIVE ALTERNATIVE (LRA)

COUNTY INVOLUNTARY TREATMENT

PHONE: (____)____-_____
FAX: (____)____-_____

Case Manager:

_____

Agency: _____ Phone Number: _____

Will **not** request a LRA extension of:

Client:

_____

Address:

_____

DOB: _____ SS # _____

LRA Expiration Date

_____

Circle One: 90- 180- day

THIS FORM MUST BE SUBMITTED FOUR (4) WEEKS PRIOR TO THE EXPIRATION DATE OF THE LRA

The following clinical review provides descriptive documentation indicating that the above named individual no longer meets the criteria of outpatient civil commitment (RCW 71.05.320) and is not considered to be a risk of harm to others, self, property and is not gravely disabled due to a mental disorder.

_____

_____

_____

_____

Case Manager: _____ Date _____

Case Manager Supervisor: _____ Date _____

LESS RESTRICTIVE ALTERNATIVE (LRA) EXTENSION REQUEST

_____COUNTY INVOLUNTARY TREATMENT
PHONE: (____)____-_____
FAX: (____)____-_____

DMHP Assigned: _____

CLIENT NAME: _____
Address: _____

_____

Telephone #: ( ) DOB: _____

_____

Case Manager: _____ (Name)

_____
(Agency Name) (Telephone #)

Attached is the Petition and Co-Affidavit/ Declaration to extend the current LRA for (Circle one) 90- 180- days.

Current 90- 180- day LRA will expire _____
(Date)

GENERAL QUESTIONS:

When is the best time to make contact with client and how?

_____

_____

_____

_____

Additional information:

_____

_____

_____

_____

LESS RESTRICTIVE ALTERNATIVE (LRA)
EXTENSION REQUEST

_____COUNTY INVOLUNTARY TREATMENT
PHONE: (____)____-_____
FAX: (____)____-_____

Case Manager _____

Agency: _____Phone Number: _____

Requests an Extension for an additional_____(90 or 180) days involuntary treatment

for: Client:

_____

Address:

_____

DOB: _____SS # _____

(Circle one) 90- 180- day current LRA
Current Expiration Date: _____

THIS FORM MUST BE SUBMITTED FOUR (4) WEEKS

PRIOR TO THE EXPIRATION DATE

A. Case Manager provides the information in Section 1 – 9
B. Physician evaluates consumer, completes and signs co-affidavit. See Section 10

1. Threatened, attempted or inflicted physical harm **upon someone?** What were the circumstances? When did this occur? Include recent history/past 3 years.

2. Threatened, attempted or inflicted physical harm upon herself/himself? What were the circumstances? When did this occur? Include recent history/past 3 years.

3. Threatened, attempted do inflicted damage upon the property of another? What were the circumstances? When did this occur? Include recent history/past 3 years.

4. Is there a history of violent acts? Document history of one or more violent acts for the past ten years, excluding time spent (but not excluding any violent acts committed) incarcerated or in a mental health facility.

5. Was the client's current LRA revoked at any time? What were the conditions violated and what were the circumstances?

6. Does the client remain gravely disabled? Explain the specifics of the dysfunction.

7. Does the client continue to exhibit a mental disorder? If so, how? Is the disorder in remission?

8. Is the client willing to continue with outpatient treatment on a voluntary basis? Would the voluntary status be appropriate? Why or why not? If the person is cognitively impaired, is the healthcare decision-maker willing to consent to less restrictive treatment on behalf of this person?

9. Please specify all proposed conditions for the future LRA.

10. The physician and the mental health professional evaluates the consumer face-to-face prior to completing the co-affidavit/declaration. The co-affidavit/declaration is to be signed by physician and mental health professional and provided to the DMHP prior to evaluation of consumer by DMHP.

Case Manager:_____ Date: _____

OFFICE ( )

FAX ( )

DATE: _____

TO: _____

_____

Telephone:_____

Enclosed with this letter is a copy of the petition, attached affidavits/declarations and order setting hearing, which has been filed with the court, requesting an extension of your Less Restrictive Order. A court date of_/ _/__has been set for this matter. The filing of this petition extends the effective date of your current Less Restrictive Order until the court date.

Please contact your attorney regarding this matter at the Office of Public Defense's telephone number listed below.

If you fail to follow the conditions of your order during this time, your case manager may request that a Designated Mental Health Professional see you to evaluate for possible revocation to inpatient treatment.

If you have any questions, please contact a Designated Mental Health Professional at (__)_____-__or your case manager.

Sincerely,

X_____
Designated Mental Health Professional

cc: Office of Public Defense:_____( )

Case Manager: _____( )

Enclosures

Appendix K: DMHP Knowledge and Education

Qualifications as defined in statute:

"Designated Mental Health Professional" means a mental health professional designated by the county or other authority authorized in rule to perform the duties of the Involuntary Treatment Acts. RCW 71.05.020(11) and RCW 71.34.020(5)

RCW 71.05.020(27) "Mental Health Professional" means a psychiatrist, psychologist, psychiatric advanced registered nurse practitioner, psychiatric nurse, or social worker, and such other mental health professionals as may be defined by rules adopted by the Secretary pursuant to this chapter.

Knowledge Base:

Applicable statutes (Revised Code of Washington and Washington Administrative Code); and applicable court decisions.

Education/Training:

- Psychopathology and psychopharmacology
- Knowledge of individual and family dynamics, life span development, psychotherapy and family crisis intervention
- Crisis intervention and assessment of risk, including suicide risk assessment, assessment of danger to others and homicide risk assessment
- Assessment of grave disability, health and safety, cognitive and volitional functions
- Competency with special populations: Chemical dependency, co-occurring disorders, developmental disabilities, ethnic minorities, children and adolescents, older persons, and sexual minorities
- Training in adolescent mental health issues, the mental health civil commitment laws, the criteria for civil commitment, and the systems of care for minors. Reference RCW 71.34.805
- Knowledge of local/regional mental health and chemical dependency treatment resources
- Professional ethics and knowledge of consumer rights
- Petition writing: factors, elements, and content
- Continuing Education: Clinical/legal/forensic education related to DMHP function/knowledge base

Appendix L: References and Resources

1. Current Diagnostic and Statistical Manual

2. Washington State DMHP Protocols, updated September 2014

3. Washington Administrative Code: WAC 388-865 "Community Mental Health and Involuntary Treatment Programs" and WAC 388-877 Behavioral Health Services

4. Revised Code of Washington
   Medical Records – Healthcare Information Access and Disclosure – RCW 70.02
   Adult Involuntary Treatment – Chapter 71.05 RCW
   Mental Health Services for Minors – Chapter 71.34
   RCW Criminally Insane – Chapter 10.77 RCW
   Treatment for Alcoholism, Intoxication and Drug Addiction – Chapter 70.96A
   RCW Interstate Compact on Mental Illness – Chapter 72.27 RCW
   Indian Lands Jurisdiction – Chapter 37.12
   RCW Developmental Disabilities – Chapter
   71a RCW
   Fire Arms and Dangerous Weapons – Chapter 9.41 RCW
   Guardianship – Chapter 11.88 RCW

5. Washington Court Rules - State Rules

Superior Court Mental Proceeding Rules (MPR)
- Includes approved forms for petitions.
- found at pages 479-492 of 2007 version of Washington Court Rules

6. Washington State Case Law - Index to Cases

   Detention of A.S., 138 Wn.2d P.2d.___(1999).
   898, Defective Petitions. pp.
   911-914. Expert Witness pp.
   915-922.
   Gravely Disabled. pp. 901-906.

   Detention of Chorney, 64 Wn. App. 469, 825 P.2d 330 (1992)
   Good Faith Volunteer. pp.478-479.
   Burden of proof to show good faith volunteer. pp. 477-478.

   Det. Of C.K., 108 Wn.App. 65, P.2d (2001).
   Legislative intent. pp. 73-4, 76.
   Decompensation as evidence of grave disability. pp.72-73,
   75-77, Less restrictive alternative. pp. 74- 77.

   Detention of D.F.F., 144 Wn.App 214, 183 P.3d 302 (2008)
   Court rule which automatically made all ITA hearings closed hearings (MPR 1.3) declared unconstitutional.
   pp 219-227
   Factors ITA court should weight in deciding whether to close hearing on case-by-case basis listed. pp 222-223.

   Detention of Dydasco, 135 Wn.2d 943,_____P.2d____. (1998).
   File petition three days before the end of the prior period for 90 and 180 commitment whether inpatient or less restrictive alternative is requested. pp. 950-952.

   Detention of G. V., 124 Wn.2d 288,_____P.2d_____. (1994).
   Remedy for a potential interference with right to refuse medication prior to 180 day hearing. pp. 293, 296.

   Detention of Kirby, 65 Wn. App. 862, 829 P.2d 1139 (1992).
   Examples of evidence insufficient to support finding that person is not a good faith volunteer. pp. 870-871.

Detention of J. R., 80 Wn. App. 947, 912 P.2d 1062. (1996).
Affidavits by treating and examining physicians. pp. 956-57.

Detention of J. S., 124 Wn.2d 689, 880 P.2d 976 (1994).
Power of court to order less restrictive alternatives. Note: DDD case. p. 698.
Less restrictive alternatives not required by constitution or statute. pp. 699-701.
Less restrictive alternative not available. p. 701.

Detention of J.S., 138 Wn.App.882, 159 P.3d 435 (2007)
Ability of patient to proceed as own attorney (pro se) in court hearings. pp 890-898.

Detention of R. A. W. 105 Wn. App. 215, P.2d (2001).
Least restrictive alternative. p 222-226.
Jury instructions. p. 223-24.
Gravely disabled. p. 224-26.

Detention of R. P., 89 Wn. App. 212, 948 P.2d 856. (1997).
Petitions for 180 day commitment must be accompanied by two affidavits. p. 216.
Contents of affidavits provide notice. pp. 216-17.

Detention of R. R., 77 Wn. App. 795, 895 P.2d 1. (1995).
The DMHP was also employed as a case manager and the question was whether the employment as a case manager interfered with the DMHP's ability to properly evaluate RR's condition. pp. 799-301.
Burden of proof to show conflict of interest in revocations. p. 801.

Detention of R.S., 124 Wn.2d 766, 881 P.2d 972 (1994).
Discusses RCW 71.05.040 detention of an individual on the basis of developmental disability. pp. 770-71, 776.

Detention of R.W., 98 Wn. App. P.2d___.(1999).
Comment on the evidence. pp.141, 144-45. Role of the jury. p.144.

Detention of V. B., 104 Wn. App. 953, __.(2001).
_____P.2d_ Peace officer testimony. pp. 963-64.
Adequacy of due process procedures. pp. 953. State interest in use of officer. pp. 965.

Detention of W., 70 Wn. App.279, P.2d . (1993).
Placement in certified facility. p.284.

Dunner v. McLaughlin, 100 Wn.2d 832,676 P.2d 444 (1984). Jury verdict. pp. 844-45.
Burden of proof. pp. 845-46.
Right to remain silent. pp. 846-47.
Amendments to 90 day petitions. pp. 848-849.
Admission at trial of prior commitment orders. Note: This holding differs from recent legislation. pp. 851-852.

Harper (Washington v. Harper). 494 US 210 (1990). Right to refuse antipsychotic medications.

In Re Harris, 98 Wn.2d 276, 654 P.2d 109 (1982).
Imminent danger. pp. 282-84.
Standard of dangerousness. pp. 284. Recent overt act. pp. 284-85.
Non emergency summons procedure. pp. 287-289.

In Re LaBelle, 107 Wn.2d 196, 728 P.2d 138 (1986).
Imminence p. 203.
Grave Disability - passive behavior. p.204.
Danger to self and others - active behavior. p. 204. Explanation of RCW 71.05.020(1)(a). pp. 204, 06. Explanation of RCW 71.05.020(1)(b). pp. 205-08.
Analysis of fact pattern in four gravely disabled cases. pp. 209-225. In Re Meistrell, 47 Wn. App. 100, 733 P.2d 1004 (1987).

Recent past mental history. pp. 108-09.
Substantial evidence. p. 109.
In Re Pugh, 68 Wn. App. 687, 845 P.2d 1034 (1993), review denied, 122 Wn.2d 1018, 863 P.2d 1352 (1993).

Likelihood of serious harm. Recent overt acts.
In Re Quesnell, 83 Wn.2d 224, 517 P.2d. 568 (1973).

Constitutional guarantees and due process. p. 230.
Base elements of procedural due process. p. 231.
Attorney's duty to investigate before hearing. p. 238. Waiver of substantial rights. p. 239.
Presumption of competency. p. 239.
Absent knowing consent by Respondent to waiver. p. 240. Role of jury in civil commitment. p. 240.
Duties of private attorney. p.243.

In Re R., 97 Wn.2d 182, 641 P.2d 704 (1982).
Physician-patient privilege and physician testimony at ITA hearings. pp. 186-99.

In Re Schuoler, 106 Wn.2d 500, 723 P.2d 1103. (1986).
Compares guardianship and involuntary commitment. pp 504-05. Right to refuse medication. p. 506.
Court makes "substituted judgement." p.507.
Procedural due process at hearing. pp. 509-10.
Statutory and constitutional right to refuse ECT. p.512.

In Re Swanson, 115 Wn.2d 21, 793 P.2d 962. (1990). Time 72 hour period ends. p.31.
Time 72 hour period begins. P.33.

Marriage of True, 104 Wn.App. 953, P2. .(2001).
Note. This is not an involuntary treatment case but it has a good discussion of discovery of records created during mental health counseling. p.296.

Sherwin v. Arveson, 96 Wn.2d 77, 633 P.2d 1335 (1981).
Jurisdiction. pp. 80-82.
Venue. p. 82.
Right to a jury trial. p. 83.

State v. Lowrimore, 67 Wn. App. 949, 841 P.2d 779. (1992). Non Emergency Petition. pp. 955-56.

State v. M. R. C., 98 Wn. App. 52, ____P.2d____. (1999). Corpus delicti rule. p. 55.
History of corpus delicti rule. p. 56.
Disinguishes involuntary commitment hearings and criminal trials. p. 57.
Waiver of right and corpus delecti rule. p. 58.

State v. Walker, 93 Wn. App. 382,_____P.2d____.
(1998).
Discussion of the terms "committed" and "detained." p. 388. Notice Requirements in a petition. p. 390.

Recommended Resources Available from State Library: Books

Aguilera, D.C. (1990). Crisis intervention: Theory and methodology (6th ed.). St. Louis, MO: The C.V. Mosbey Company.

Allen, M. (Ed.) . (1995). *The Growth and Specialization of Emergency Psychiatry*. Jossey Bass, San Francisco, CA.

American Psychiatric Association (APA)(DSM-IV, 1994a). Diagnostic and Statistical Manual of Mental Disorders (4th ed.). Washington, DC: Author.

American Psychiatric Association. (1994b). Forced into treatment: The role of coercion in clinical practice. Washington, DC: Author.

Barton, G., & Friedman, R. (Eds.). (1986). *Handbook of Emergency Psychiatry for Clinical Administrators.* The Haworth Press, NY.

Beck, J. (1985). The Potentially Violent patient and the Tarasoff Decision in Psychiatric Practice. American Psychiatric Press, Washington, DC.

Bellak, L, & Siegel, H. (1983). *Handbook of Intensive Brief and Emergency Psychotherapy.* C.P.S., Inc., Larchmont, NY.

Berman, A. L., & Jobes, D. A. (1991). Adolescent suicide: Assessment and intervention. Washington DC: American Psychological Press.

Bongar, B. (Ed). (1992). Suicide: Guidelines for assessment, management, and treatment. Oxford; Oxford University Press.

Cohen, N. (Ed.). (1991). *Psychiatric Outreach to the Mentally Ill.* Jossey Bass, San Francisco, CA.

Cohen, N. L. (1990). Psychiatry takes to the streets; Outreach and crisis intervention for the mentally ill. New York: The Guilford Press.

Cohen, R., & Ahearn, F. (1980). *Handbook for Mental Health Care of Disaster Victims.* The John Hopkins University Press, Baltimore, MD.

Dennis, D. L., & Monahan, J. (Eds.), Coercion and aggressive community treatment: A new frontier in mental health law, New York: Plenum Press.

Ellis, T. E., & Newman, C. F. (1996). Choosing to Live: How to defeat suicide through Cognitive Therapy. Oakland, CA: New harbinger Publications.

Golan, N. (1978). Treatment in Crisis Situations. Free Press, NY.

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Recommended Resources: Internet Websites [8]

Mental Illness, Title 71 RCW: http://apps.leg.wa.gov/rcw/default.aspx?Cite=71

Developmental Disabilities, Title 71.a RCW:
http://apps.leg.wa.gov/rcw/default.aspx?Cite=71A State Institutions Title, 72 RCW:
http://apps.leg.wa.gov/rcw/default.aspx?Cite=72
Criminally Insane, Title 10.77 RCW: http://apps.leg.wa.gov/RCW/default.aspx?cite=10.77

Alcoholism, Intoxication, and Drug Addiction, Title 70.96A
http://apps.leg.wa.gov/RCW/default.aspx?cite=70.96A

Fire Arms and Dangerous Weapons, Title 9.41: http://apps.leg.wa.gov/RCW/default.aspx?cite=9.41
Guardianship, Title 11.88 RCW: http://apps.leg.wa.gov/RCW/default.aspx?cite=11.88

[8] All hyperlinks in following paragraph are functioning as of 10-31-08.

Appendix M: WAC 388-865-0600 through 0640

388-865-0600
Purpose.

In order to enhance and facilitate the department of corrections' ability to carry out its responsibility of planning and ensuring community protection, mental health records and information, as defined in this section, that are otherwise confidential shall be released by any mental health service provider to the department of corrections personnel for whom the information is necessary to carry out the responsibilities of their office as authorized in RCW 71.05.445 and 71.34.225. Department of corrections personnel must use records only for the stated purpose and must assure that records remain confidential and subject to the limitations on disclosure outlined in chapter 71.05 RCW, except as provided in RCW 72.09.585.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c),71.34.800 , 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0600, filed 5/31/01, effective 7/1/01.]

388-865-0610
Definitions.

Relevant records and reports includes written documents obtained from other agencies or sources, often referred to as third-party documents, as well as documents produced by the agency receiving the request. Relevant records and reports do not include the documents restricted by either federal law or federal regulation related to treatment for alcoholism or drug dependency or the Health Insurance Portability and Accountability Act or state law related to sexually transmitted diseases, as outlined in RCW 71.05.445 and 71.34.225.

(1) **"Relevant records and reports"** means:

(a)) Records and reports of inpatient treatment:

(i) Inpatient psychosocial assessment - Any initial, interval, or interim assessment usually completed by a person with a master's degree in social work (or equivalent) or equivalent document as established by the holders of the records and reports;

(ii)) Inpatient intake assessment - The first assessment completed for an admission, usually completed by a psychiatrist or other physician or equivalent document as established by the holders of the records and reports;

(iii) Inpatient psychiatric assessment - Any initial, interim, or interval assessment usually completed by a psychiatrist (or professional determined to be equivalent) or equivalent document as established by the holders of the records and reports;

(iv) Inpatient discharge/release summary - Summary of a hospital stay usually completed by a psychiatrist (or professional determined to be equivalent) or equivalent document as established by the holders of the records and reports;

(v) Inpatient treatment plan - A document designed to guide multidisciplinary inpatient treatment or equivalent document as established by the holders of the records and reports;

(vi) Inpatient discharge and aftercare plan data base - A document designed to establish a plan of treatment and support following discharge from the inpatient setting or equivalent document as established by the holders of the records and reports.

(vii) Forensic discharge review - A report completed by a state hospital for individuals admitted for evaluation or treatment who have transferred from a correctional facility or is or has been under the supervision of the department of corrections.

(b)) Records and reports of outpatient treatment:

(i) Outpatient intake evaluation - Any initial or intake evaluation or summary done by any mental health practitioner or case manager the purpose of which is to provide an initial clinical assessment in order to guide outpatient service delivery or equivalent document as established by the holders of the records and reports;

(ii)) Outpatient periodic review - Any periodic update, summary, or review of treatment done by any mental health practitioner or case manager. This includes, but is not limited to: Documents indicating diagnostic change or update; annual or periodic psychiatric assessment, evaluation, update, summary, or review; annual or periodic treatment summary; concurrent review; individual service plan as required by WAC 388-865-0425 through 388-865-0430, or equivalent document as established by the holders of the records and reports;

(iii)) Outpatient crisis plan - A document designed to guide intervention during a mental health crisis or decompensation or equivalent document as established by the holders of the records and reports;

(iv) Outpatient discharge or release summary - Summary of outpatient treatment completed by a mental health professional or case manager at the time of termination of outpatient services or equivalent document as established by the holders of the records and reports;

(v)) Outpatient treatment plan - A document designed to guide multidisciplinary outpatient treatment and support or equivalent document as established by the holders of the records and reports.

(c)) Records and reports regarding providers and medications:

(i) Current medications and adverse reactions - A list of all known current medications prescribed by the licensed practitioner to the individual and a list of any known adverse reactions or allergies to medications or to environmental agents;

(ii)) Name, address and telephone number of the case manager or primary clinician.

(d)) Records and reports of other relevant treatment and evaluation:

(i) Psychological evaluation - A formal report, assessment, or evaluation based on psychological tests conducted by a psychologist;

(ii)) Neuropsychological evaluation - A formal neuropsychological report, assessment, or evaluation based on neuropsychological tests conducted by a psychologist;

(iii) Educational assessment - A formal report, assessment, or evaluation of educational needs or equivalent document as established by the holders of the records and reports;

(iv) Functional assessment - A formal report, assessment, or evaluation of degree of functional independence. This may include but is not limited to: Occupational therapy evaluations, rehabilitative services data base activities assessment, residential level of care screening, problem severity scale, instruments used for functional assessment or equivalent document as established by the holders of the records and reports;

(v) Forensic evaluation - An evaluation or report conducted pursuant to chapter 10.77 RCW;

(vi)) Offender/violence alert - A any documents pertaining to statutory obligations regarding dangerous or criminal behavior or to dangerous or criminal propensities. This includes, but is not limited to, formal documents specifically designed to track the need to provide or past provision of: Duty to warn, duty to report child/elder abuse, victim/witness notification, violent offender notification, and sexual/kidnaping offender notification per RCW 4.24.550, 10.77.205, 13.40.215, 13.40.217, 26.44.330, 71.05.120, 71.05.330, 71.05.340, 71.05.425, 71.09.140, and 74.34.035;

(vii)) Risk assessment - Any tests or formal evaluations including department of corrections risk assessments administered or conducted as part of a formal violence or criminal risk assessment process that is not specifically addressed in any psychological evaluation or neuropsychological evaluation.

(e)) Records and reports of legal status - Legal documents are documents filed with the court or produced by the court indicating current legal status or legal obligations including, but not limited to:

(i) Legal documents pertaining to chapter 71.05 RCW;

(ii) Legal documents pertaining to chapter 71.34 RCW;

(iii) Legal documents containing court findings pertaining to chapter 10.77 RCW;

(iv) Legal documents regarding guardianship of the person;

(v) Legal documents regarding durable power of attorney;

(vi) Legal or official documents regarding a protective payee;

(vii) Mental health advance directive.

"Relevant information" means descriptions of a consumer's participation in, and response to, mental health treatment and services not available in a relevant record or report, including all statutorily mandated reporting or duty to warn notifications as identified in WAC 388-865-610 (1)(d)(vi), Offender/Violence alert, and all requests for evaluations for involuntary civil commitments under chapter 71.05

RCW. The information may be provided in verbal or written form at the discretion of the mental health service provider.

[Statutory Authority: RCW 71.05.445 and 71.05.390 as amended by 2004 c 166. 05-14-082, § 388-865-0610, filed 6/30/05, effective 7/31/05. Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and43.20B.335 . 01-12-047, § 388-865-0610, filed 5/31/01, effective 7/1/01.]

388-865-0620
Scope.

Many records and reports are updated on a regular or as needed basis. The scope of the records and reports to be released to the department of corrections are dependent upon the reason for the request.

(1) For the purpose of a presentence investigation release only the most recently completed or received records of those completed or received within the twenty-four-month period prior to the date of the request; or

(2) For all other purposes including risk assessments release all versions of records and reports that were completed or received within the ten year period prior to the date of the request that are still available.

[Statutory Authority: RCW 71.05.445 and 71.05.390 as amended by 2004 c 166. 05-14-082, § 388-865-0620, filed 6/30/05, effective 7/31/05. Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and43.20B.335 . 01-12-047, § 388-865-0620, filed 5/31/01, effective 7/1/01.]

388-865-0630
Time frame.

The mental health service provider shall provide the requested relevant records, reports and information to the authorized department of corrections person in a timely manner, according to the purpose of the request:

(1) Presentence investigation - within seven calendar days of the receipt of the request. If some or all of the requested relevant records, reports and information are not available within that time period the mental health service provider shall notify the authorized department of corrections person prior to the end of the seven-day-period and provide the requested relevant records, reports or information within a mutually agreed to time period; or

(2) All other purposes - within thirty calendar days of the receipt of the request. If some or all of the requested relevant records, reports and information are not available within that time period the mental health service provider shall notify the authorized department of corrections person prior to the end of the thirty-day period and provide the requested relevant records, reports or information within a mutually agreed to time period; or

(3)) Emergent situation requests - When an offender subject has failed to report for department of corrections supervision or in an emergent situation that poses a significant risk to the public, the mental health provider shall upon request, release information related to mental health services delivered to the offender and, if known, information regarding the whereabouts of the offender. Requests if oral must be subsequently confirmed in writing the next working day, which includes email or facsimile so long as the requesting person at the department of corrections is clearly defined. The request must specify the information being requested. Disclosure of the information requested does not require the consent of consumer.

(a) Information that can be released is limited to:

(i) A statement as to whether the offender is or is not being treated by the mental health services provider; and

(ii) Address or information about the location or whereabouts of the offender.

[Statutory Authority: RCW 71.05.445 and 71.05.390 as amended by 2004 c 166. 05-14-082, § 388-865-0630, filed 6/30/05, effective 7/31/05. Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c), 71.34.800, 9.41.047, 43.20B.020, and43.20B.335 . 01-12-047, § 388-865-0630, filed 5/31/01, effective 7/1/01.]

388-865-0640

Written requests.

The written request for relevant records, reports and information shall include:

(1) Verification that the person for whom records, reports and information are being requested is under the authority of the department of corrections, per chapter 9.94A RCW, and the expiration date of that authority.

(2) Sufficient information to identify the person for whom records, reports and information are being requested including name and other identifying data.

(3) Specification as to which records and reports are being requested and the purpose for the request.

(4) Specification as to what relevant information is requested and the purpose for the request.

(5) Identification of the department of corrections person to whom the records, reports and information shall be sent, including the person's name, title and address.

(6)) Name, title and signature of the requestor and date of the request.

[Statutory Authority: RCW 71.05.560, 71.24.035 (5)(c),71.34.800 , 9.41.047, 43.20B.020, and 43.20B.335. 01-12-047, § 388-865-0640, filed 5/31/01, effective 7/1/01.]

Appendix N: RCW 70.02.230
Patient Authorization of Disclosure

(1) A patient may authorize a health care provider or health care facility to disclose the patient's health care information. A health care provider or health care facility shall honor an authorization and, if requested, provide a copy of the recorded health care information unless the health care provider or health care facility denies the patient access to health care information under RCW 70.02.090.

(2) A health care provider or health care facility may charge a reasonable fee for providing the health care information and is not required to honor an authorization until the fee is paid.

(3) To be valid, a disclosure authorization to a health care provider or health care facility shall:
   a. Be in writing, dated, and signed by the patient;
   b. Identify the nature of the information to be disclosed;
   c. Identify the name and institutional affiliation of the person or class of persons to whom the information is to be disclosed;
   d. Identify the provider or class of providers who are to make the disclosure;
   e. Identify the patient; and
   f. Contain an expiration date or an expiration event that relates to the patient or the purpose of the use or disclosure.

(4) Unless disclosure without authorization is otherwise permitted under RCW 70.02.050 or the federal health insurance portability and accountability act of 1996 and its implementing regulations, an authorization may permit the disclosure of health care information to a class of persons that includes:
   a. Researchers if the health care provider or health care facility obtains the informed consent for the use of the patient's health care information for research purposes; or
   b. Third-party payors if the information is only disclosed for payment purposes.

(5) Except as provided by this chapter, the signing of an authorization by a patient is not a waiver of any rights a patient has under other statutes, the rules of evidence, or common law.

(6) When an authorization permits the disclosure of health care information to a financial institution or an employer of the patient for purposes other than payment, the authorization as it pertains to those disclosures shall expire one year after the signing of the authorization, unless the authorization is renewed by the patient.

(7) A health care provider or health care facility shall retain the original or a copy of each authorization or revocation in conjunction with any health care information from which disclosures are made.

(8) Where the patient is under the supervision of the department of corrections, an authorization signed pursuant to this section for health care information related to mental health or drug or alcohol treatment expires at the end of the term of supervision, unless the patient is part of a treatment program that requires the continued exchange of information until the end of the period of treatment.

[2014 c 220 § 15; 2005 c 468 § 3; 2004 c 166 § 19; 1994 sp.s. c 9 § 741; 1993 c 448 § 3; 1991 c 335 § 202.]

Notes:

Effective date -- 2014 c 220: See note following RCW 70.02.290.

Severability -- Effective dates -- 2004 c 166: See notes following RCW 71.05.040.

Severability -- Headings and captions not law -- Effective date -- 1994 sp.s. c 9: See RCW 18.79.900 through 18.79.902.

Effective date -- 1993 c 448: See note following RCW 70.02.010.

Appendix O: RCW 70.02.240
Patient's Revocation of Authorization for Disclosure

A patient may revoke in writing a disclosure authorization to a health care provider at any time unless disclosure is required to effectuate payments for health care that has been provided or other substantial action has been taken in reliance on the authorization. A patient may not maintain an action against the health care provider for disclosures made in good-faith reliance on an authorization if the health care provider had no actual notice of the revocation of the authorization.

[1991 c 335 § 203.]

Appendix P: **Mental Health Treatment Options for Minor Children**

Parents or guardians seeking a mental health evaluation or treatment for a child must be notified of all legally available treatment options. These include minor-initiated treatment, parent-initiated treatment, and involuntary commitment.

Minor-Initiated Treatment (RCW 71.34.500-530)

A minor child, 13 to 18 years old, of age or older may request an evaluation for outpatient or inpatient mental health treatment without parental consent. If the facility agrees with the need for mental health treatment, the child may be offered mental health services. For a child under the age of 13, either parental consent or consent from an approved guardian is required for inpatient treatment.

Parent-Initiated Treatment (RCW 71.34.600-660)

If the child is under the age of 18, the parent, guardian or authorized individual may bring the child to any mental health facility or hospital and request that a mental health evaluation be provided. This evaluation cannot take longer than 72 hours. Consent of the child is not required for either an outpatient or inpatient evaluation, or recommended inpatient treatment.

If it is determined the child has a mental disorder, and there is medical need for inpatient treatment, the parent or guardian may request that the child be held for treatment. If the inpatient program believes the child needs treatment for more than 7 days, the state (DSHS) must then review the need for treatment. The child has the right to petition the Superior Court for release from the facility after the 7 days.

After the state review, if the state determines that the child no longer needs inpatient treatment, the parent or guardian must be immediately notified, and the child will be released within 24 hours. In this case, if the parent or guardian and facility both believe it is a medically necessary for the child to remain in inpatient treatment, the facility will hold the child until the 2nd judicial day following the state review. This will allow the parent or guardian time to file an at-risk youth petition (RCW 13.32A.191) by calling the Department of Child and Family Services Intake Line or by going to their local Juvenile Court.

For information about possible out-of-home placement of the child, call the Department of Child and Family Services and request a family assessment per RCW 13.32A.150. Family Reconciliation Services (RCW 13.32A.040) may also be provided through this Department. Children admitted to inpatient facilities under minor initiated or parent initiated treatment procedures must be released from the facility immediately upon the written request of the parent.

Please note:

A provider is not obligated to provide treatment to a minor under the provisions of Parent-Initiated Treatment. However, no provider may refuse to treat a minor under these provisions solely on the basis the minor has not consented to the treatment.

If the child is admitted to an inpatient mental health facility, he/she will be seen by a mental health specialist and medical staff within 24 hours. If it is determined that your child would be better served by a chemical dependency treatment facility he/she will be referred to an approved treatment program defined under RCW 70.96A.020. **Involuntary Treatment (RCW 71.34.700-795)**

If the facility believes the child is in need of immediate inpatient mental health treatment and the child refuses to consent to a voluntary admission, the child may be held for up to 12 hours to enable a Designed Mental Health Professional (DMHP) to evaluate the child for possible involuntary commitment.

If no voluntary or less restrictive alternatives are available, and the DMHP determines that the child presents as a likelihood of serious harm or grave disability, as a result of a mental disorder, the child may be held at a facility. The child can be held for treatment up to 72 hours, excluding weekends and holidays. During this time, the facility may petition the court to have the child committed for an additional fourteen days if they believe further treatment is necessary. At the end of the 14 days, the facility may file a petition for up to one hundred eighty days of additional treatment. If the facility does not file a petition for an additional 14 or 180 days, the parent or guardian may seek review of the decision by filing notice with the court and providing a copy of the facility's report. To obtain a copy of the report, a Release of Information form must be completed and submitted to the records department of the inpatient facility.

If the DMHP does not hold the child, the parent or guardian may seek review of that decision by filing notice with the court and providing a copy of the DMHP's report or notes. To obtain a copy of the report or notes, a Release of Information form must be completed and submitted to the records department of the DMHP agency.

If the child is released from hospitalization on a conditional release or a court order for a less restrictive alternative and is not following the conditions of that order or has substantially deteriorated in his/her functioning the child may be taken into custody by a DMHP and transported to an inpatient evaluation and treatment facility. For further assistance or questions, call the local mental health crisis line and request to speak with a DMHP.

____ Please initial here to indicate you have been provided with written and verbal notice of the available treatment options for the child.

Parent/Guardian Signature Date

Facility Representative Signature Date