Report to the Legislature

Protocols

Designated Mental Health Professionals

RCW 71.05.214

December 2011

Department of Social & Health Services
Aging and Disability Services Administration
Division of Behavioral Health and Recovery
P.O. Box 45330
Olympia, WA 98504-5330
(360) 725-3700
Fax: (360) 725-2280

For a copy of this document in an alternative format, or for a hard copy contact David Kludt at:
Department of Social & Health Services, Aging and Disability Services Administration
Division of Behavioral Health and Recovery
P.O. Box 45330, Olympia, WA 98504-5330
Phone (360) 725-3700 Fax-725-2280

Protocols: Designated Mental Health Professionals

December 2011

TABLE OF CONTENTS

PREFACE

The 2011 update of the Protocols for Designated Mental Health Professionals (DMHP's) 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, the department submitted the initial protocols to the Governor and the Legislature in September 1999, and updated in 2002, and in December 2005, and updated in 2008.

The 2011 Protocol Update was written with the understanding that as of September 2005 the Regional Support Networks (RSNs) must incorporate the Protocols for Designated Mental Health Professionals into the practice of Designated Mental Health Professionals. It is the intent of the 2011 Protocol Work Group that the Protocols help support and clarify the work of the DMHPs in the face of new legislative changes and limited resources.

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.

The 2011 Protocol Work Group included staff from DSHS Division of Behavioral Health and Recovery, with active collaboration from a broad stakeholder group. A list of participants and their affiliations can be found in Appendix A:

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

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 immediately 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.

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.

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) and "less restrictive alternative ***court orders*** (as in Sections 400 – 430).

The 2011 Protocols also 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 work group recognized that there are significant variations between counties with respect to geography, population, resources, socioeconomic, and political factors. Notwithstanding these issues, the 2011 Protocol Work Group is satisfied that these protocols will continue to move DMHP practices toward greater uniformity across the state.

The 2011 Protocol Work Group wishes to acknowledge that the shortage of inpatient beds in the State of Washington continues to have a significant impact on individuals who at times find themselves involuntarily detained to community hospital emergency departments. This shortage also impacts the work of the DMHPs. To address the impact the 2011 Protocol Update tries to clarify the procedures regarding detaining individuals to non-ITA certified facilities. In addition to this critical issue there are other important issues which impact DMHPs, requiring statutory change. The members of the 2011 Protocol Work Group have agreed to continue to work together to address these concerns.

The 2011 Protocol Work Group also wish 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 Designated Mental Health Professionals make their decisions based on the clinical presentation, and the rules governing RCW 71.05 and RCW 71.34.

Recent Legislation involving RCW 71.05 and RCW 71.34

SHB 2131 passed during the 2011 Special Session and signed into law by the Governor is an important piece of legislation to the practice of DMHPs. This legislation which went into effect on January 1, 2012 requires:

1. When conducting an evaluation under this chapter that; consideration shall include all reasonably available information from credible witnesses and records regarding:
   a.) Prior commitments for evaluation of the need for civil commitments when the recommendation is made pursuant to an evaluation conducted under chapter 10.77 RCW
   b.) History of one or more violent acts
   c.) Prior determination 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 DMHP 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 DMHP or prosecutor shall provide notice of the date, time, and location of the probable cause hearing to such a witness.
3. When conducting an evaluation for offenders identified under RCW 72.09.370 the DMHP or professional person shall consider an offenders history of judicially required or administratively ordered antipsychotic medication while in confinement.

SSB 5187 passed during the 2011 Legislative session. **Parent Initiated Treatment** RCW 71.34.600 requires facilities 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 facility is required to provide the parent notification and provide a copy in the client chart for state review.
Washington State Division of Behavioral Health and Recovery, Parent Notification form is attached to this document as Appendix N.

GLOSSARY OF TERMS

Following is a Glossary of Terms used in this document. 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 to which they will testify to 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 clerk of the court, the prosecuting and defense attorneys.

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

"Designated mental health professional" means a mental health professional designated by the appropriate Regional Support Network to perform the duties of the Involuntary Treatment Acts. RCW 71.05.020(6) and RCW 71.34.020(4). As per RCW 71.05.020 (16) "Mental health professional" means a psychiatrist, psychologist, psychiatric nurse, or social worker, and such other mental health professionals as defined by WAC 388-865-0150 "Mental Health Professional". See Appendix J - DMHP Knowledge and Education.

"**Good faith voluntary**" implies the individual expresses a sincere (i.e., without coercion, deception or deceit) willingness to abide by the procedures and treatment plan prescribed by the treatment facility and professional staff to whom the person has "in good faith volunteered." Also, the person does not have a history which belies this stated intent, or a cognitive impairment that prevents them from making this decision.

- For a minor, the good faith commitment by the minor's parents or legal guardians is considered.
- When the investigation concerns a cognitively impaired person who is unable to provide good faith informed consent to less restrictive treatment options, the DMHP determines whether the person's health care decision maker listed under RCW 7.70.065 can and will consent to the less restrictive treatment on behalf of the person.

Reference: Detention of Chorney, (1992), See Appendix K.
Reference: Detention of Kirby, (1992), See Appendix K.

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

- 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(14)(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(14) (b).

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 K.

"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.

"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 related to mental health services" means 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 health service provider. This may include documents of legal proceedings under this chapter or RCW 71.34 or RCW 10.77, or somatic health care information. RCW 71.05.445(1) (a) and RCW 71.34.225(1) (a).

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

- There is evidence that a referred person may suffer from a mental disorder; and
- 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 refuses to seek appropriate, treatment options. RCW 71.05.150 (1) (a) 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:

- 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;
- 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).

"**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).

"**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 and
- family at the time of referral and investigation, and/or
- other information that is immediately accessible
- other information which may be available and include an individual's crisis plan or other available treatment record, evaluations of incompetency or insanity under RCW 10.77, criminal history records, risk assessments, and discharge summaries from DOC, historical behavior including a history of one or more violent acts, and records from prior civil commitments.

"**Reliability**" 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.

"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 certified under WAC 388-865-0500 when:

- An involuntarily treated adult requires services not available in an E&T, a state hospital; or
- An involuntarily treated adult on a ninety or one hundred eighty day involuntary commitment 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; or
- For involuntarily treated children, The facility - 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). WAC 388-865-0526

"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.

"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.

"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:*

- *There is evidence that a referred person may suffer from a mental disorder; and*
- *There is evidence that the person, as a result of a mental disorder, presents a likelihood of serious harm to him or herself, other persons or other's property, or*
- *may be gravely disabled; and*
- *The person refuses to voluntarily accept appropriate, available, less-restrictive treatment options.*

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

Assessment of urgency:

- As quickly as possible, the DMHP assesses the degree of urgency and resources available to resolve or contain the crisis, including whether it is appropriate to involve law enforcement. This may include making a request to take the person into custody under RCW 71.05.
- If the DMHP assesses the person, or others, are in immediate physical danger, the DMHP calls 911 to respond, or asks the referring person to call 911.

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
- If a minor, the name of the parent or legal guardian
- Date and time of the referral call
- 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, and potential sources of support to resolve the crisis
- Contact information of the referent
- Names and contact information for potential witnesses, which may include family members, landlords, neighbors or 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 there is one.

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

- Further investigation is warranted.
    - If so, the DMHP determines the need for a second individual to accompany the DMHP during the outreach, to ensure safety needs are met.
- Community Support Service emergency crisis intervention services or other community services are more appropriate; or if

- No further service or investigation is indicated.

Availability of a resource 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 or 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 71.05.390, RCW 71.34.200 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 inpatient evaluation and treatment facility. However, a DMHP may issue an oral or written custody authorization without an in-person evaluation when:

- A potentially dangerous situation exists; and
- 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. Persons 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.

(1) For children, notify Child Protective Services at 1-866-END-HARM (1-866-363-4276[1]).
(2) For adults in a Residential Care Facility and DDD contracted Supportive Living Facilities notify the Residential Care Services Complaint Resolution Unit Hotline at 1-800-562-6078 [2];
(3) Adult Family Homes website to report abuse is http://www.adsa.dshs.wa.gov/APS/reportabuse.htm [3]. Complaints should be called into the Complaint Resolution Unit: www.adsa.dshs.wa.gov/APS
(4) For adults not in either a Residential Care Facility (#2 above) or an Adult Family Home (#3 above), reports are to be made to the following regional offices:

[1] Telephone number verified 12/31/2011
[2] Telephone number verified 12/31/2011
[3] Website verified 12/31/2011

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*	*1-800-459-0421 TTY: 509-568-3086*
2	*King, Snohomish, Skagit, Island, San Juan, Whatcom*	*1-866-221-4909 TTY 1-800-977-5456*
3	*Pierce, Kitsap, Thurston, Mason, Lewis, Clallam, Jefferson, Grays Harbor, Pacific, Wahkiakum, Cowlitz, Skamania, Clark*	*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; 1-800-533-6828
  DOH FSL Fax Number: 360-236-2901
  In-home Services (home care, home health, hospice agency) licensed by DOH:
  DOH FSL Hotline: 1-800-633-6828
  DOH FSL Fax number: 360-236-2901
- **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), RCW 74.34.035, RCW 74.34.050, and RCW 73.34.053; RCW 26.44.020(3) and RCW 26.44.030(1) (a).

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)

The DMHP may not detain any minor under the age of 13. RCW 71.34.700

The DMHP responds to all referrals for involuntary inpatient 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.

To the extent possible, the DMHP contacts the minor's parent or legal guardian upon receipt of a referral for involuntary inpatient treatment in accordance with 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

Reference: RCW 71.34.020

Note: Parent Initiated Treatment
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 with a child/adolescent inpatient psychiatric unit and request that a mental health evaluation be provided. 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 parent initiated inpatient treatment at the facility providing the evaluation. See Appendix N.

Reference: RCW 71.34.600

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 give close attention to the identification of possible appropriate less restrictive alternative placements.

Reference: RCW 71.05.040.

Reference: 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, boarding homes (many are called assisted living facilities), adult family homes, and residential treatment facilities.

Unlike the general community, licensed residential care facilities are required to provide individualized services and supports and may be considered a less restrictive alternative to involuntary detention. Residents' rights, law and admission, transfer and discharge requirements are explained in further detail in Appendix C: . This information may be helpful to DMHPs when assessing a request from a facility to involuntarily detain a resident.

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 can 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.

- Adult Family Homes website to report abuse is http:www.adsa.dshs.wa.gov/APS

Reference: 42 CFR 488.3 Subpart A; RCW 18.20.185; RCW 18.51.190; RCW 70.129.110; RCW 74.39A.060; RCW 74.42.450(7).

125–Referrals from a hospital emergency department.

It is expected that a medical screening be conducted and that the individual is able to be medically discharged from ED prior to referral to a DMHP.

Adults: The DMHP will initiate an ITA investigation within six hours of being referred by the facility. If a peace officer caused the person to be delivered to a crisis stabilization unit, triage facility, an evaluation and treatment facility, or the emergency department of a local hospital pursuant to the officer's authority under the ITA, a mental health professional (as defined by 388-865-0150) examines 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.
Minors: The DMHP will evaluate the child at the ER/ED and make a determination whether the child meets criteria for detention within 12 hours of the referral.

RCW 71.05.050; RCW 71.05.153(2); and RCW 71.34.700

130–Referrals of a person using alcohol and/or drugs.

Note: 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. The DMHP initiates a referral to the Designated Chemical Dependency Specialist as clinically indicated.

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.

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: <u>Only persons who are eligible for release from the jail or prison can be detained to a treatment facility.</u>**

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

(2) 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.

(3) If contacted, the DMHP will evaluate the defendant or offender(s), who are 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 71.05.385, RCW 71.05.390 and RCW 71.34.200.
- Discusses arrangements for transportation to an emergency department for medical clearance and for transportation of the inmate to the evaluation and treatment facility, along with information about the person.

If an investigation is requested for an incarcerated person who has undergone competency evaluation under RCW 10.77 (Mentally Ill Offender), and the evaluator expresses the opinion that the person is a substantial danger to other persons, and should be kept under further control, an evaluation shall be conducted of such person under chapter 71.05 RCW. RCW 10.77.060(3) (f). To the extent possible, the DMHP 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(2) (c)

<u>Offender Re-entry Community Support Program (ORCSP):</u> 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 71.24.470, or
- is enrolled with DSHS Division of Developmental Disabilities (DDD) under RCW 71.24.470

The investigation shall occur not more than ten days, nor less than five days, prior to the actual release of the Designated ORCSP participant. A DMHP must conduct a second investigation on the day of release if requested by the ORCSP Committee. When conducting an evaluation of an ORCSP 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 ORCSP participant does not change the commitment criteria under RCW 71.05. An ORCSP participant may be detained because he or she is gravely disabled as well as because he or she presents a likelihood of serious harm.

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 on school facilities for possible involuntary detention under RCW 71.05 or RCW 71.34. Note: For purposes of this section only, "Minor" is defined as a person 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)

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, and that any statement made may be used against them;

Inform the individual being investigated that they may speak immediately with an attorney (DMHP suspends the interview of the individual). However, the DMHP is not obligated to stop the investigation while the individual who is being investigated attempts to consult with an attorney.
Additional Considerations:

- If the individual chooses to remain silent or requests an attorney, the DMHP is obligated to stop the interview. The individual may choose to resume the interview at anytime.
- 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 an interpreter, if available during the investigation. The DMHP reads the rights to the individual in their entirety if requested by the individual being investigated.
- Under RCW 11.92.043(5) and RCW 11.94.010(3) neither a guardian nor any other healthcare decision-maker can consent to involuntary treatment, observation or evaluation on behalf of the individual.

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 consult with mental health specialists or medical specialists as needed when conducting an investigation of a child, an older adult, an ethnic minority or an individual with a medical condition.

The DMHP determines whether the individual has a health care decision-maker listed under RCW 7.70.065 or a mental health care decision-maker under RCW 71.32, or the parent or legal guardian in the case of a minor, when the individual appears to be cognitively impaired. The DMHP proceeds with investigation if the healthcare decision-maker is not available.

As soon as reasonably possible, the DMHP attempts 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.

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

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

207–Availability of resource.

Availability of a detention bed will not be a factor in determination of detention.

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

- Pursue resources (detention beds) in counties within close proximity, or
- Elsewhere within the state, or
- Utilize a Single Bed Certification

When a person is detained to a non E&T bed in a hospital due to lack of available ITA beds in the state the DMHP will follow all applicable Washington State laws for the ITA or LRA process including:

1. The DMHP will make the decision to detain (or not) the person within the legally required time frames.
2. The person will be served the ITA or LRA Revocation paperwork
3. The DMHP will request a single bed certification from the State Hospitals in their catchment area and deliver a copy of it to the hospital where the person is held.
4. The DMHP will file the ITA or LRA Revocation paperwork with the Superior court of the county the person is physically present (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
5. The DMHP does not have the 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

"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 certified under WAC 388-865-0500 when:

- An involuntarily detained individual requires services not available in an E&T, a state hospital; or
- An involuntarily detained individual 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 individual's treatment needs; or

- 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).

Reference: WAC 388-865-0526

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

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 person'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) However, persons cannot be detained on the basis of a severe deterioration in routine functioning unless the detention is shown to be essential for the individual's health or safety. (In re: Labelle (1986), 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 there exists, as a result of the mental disorder, a danger to the person, to others, the property of others, or grave disability and if so, if it is imminent. The DMHP makes this assessment:

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

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

Note: RCW 71.05 is silent on this provision but it is consistent with current practice.

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 record, 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 prior to meeting the individual to be investigated. Possible sources of information can be found in Appendix G.

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 (ORCSP), 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.

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 DMHPs need to compile reasonably available history is always to be considered in light of the intent of chapter 71.05 RCW 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, whether successful or not.

Reference: RCW 71.05.212 and RCW 71.05.245

225–Interviewing witnesses as part of an investigation.

It may be appropriate and necessary for a DMHP to use information provided from witnesses to establish evidence of mental disorder. For a minor, obtaining information from the parent, legal guardian, care providers, school, juvenile justice and other involved systems may be used to further the investigation. For individuals currently receiving mental health services, attempts will be made to interview service providers to provide the most current information/evidence related to the investigation.

A DMHP:

- Interviews potential credible witnesses who may have pertinent information and/or evidence. Credible witnesses may include family members, landlords, neighbors or others with significant contact or history of involvement with the individual.
- Assesses the specific facts alleged and the reliability and credibility of any individual providing information that will be used to determine whether to initiate detention.
- Inform the prosecuting attorney of the contact information for credible witnesses.

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

*"**Reliability**" 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.*

The DMHP exercises 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

A DMHP informs 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 affiant of the date, time and location of the probable cause hearing. If unknown, the DMHP will provide any affiant 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 client 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 client and community. The DMHP also considers the individual's developmental age in relationship to his or her chronological age.

"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 a person, 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 whether it is necessary to re-contact the individual if he/she does not follow through with recommended treatment;
- Advises the service provider to contact the DMHP if the individual refuses to participate in treatment, if the decision not to detain the individual was based on the individual accepting less-restrictive treatment;
- Either renews or facilitates contact with the individual when it is clinically necessary based on consultation with the service provider.

Note: For minors, a parent may request court review of the DMHP's decision not to detain that minor. RCW 71.34.710

DETENTIONS

300–Rights of a person 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. The DMHP reads the rights to the individual in their entirety if requested by the individual being detained.

- 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.

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

305–Detention in the absence of imminent danger.

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

Imminent danger is not required for the emergency detention of minors.

Reference: 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.
- A DMHP may arrange the transportation of an individual from a licensed residential care facility.

315–Detention to a facility in another county.

When a DMHP in one county detains an individual in an inpatient evaluation and treatment facility (not including the state hospitals) in another county, the detaining DMHP must agree to send the original paperwork, to the admitting facility within the statutory time limit.

The detaining DMHP must also agree to testify, if necessary, at any court hearings, and should inform any affiants needed for the court hearings that they will need to be available to testify at the hearings. The detaining DMHP should also contact the Office of the Prosecuting Attorney or the DMHP Court Liaison, for that county as soon as practicable, in order to coordinate affiants and to become familiar with the procedures that will be used in the hearing (e.g., whether testimony by telephone 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 or supplemental petition for initial detention, proof of service of notice and a copy of the notice of detention with the court and serve the individual's designated attorney a copy of these documents.

For 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 person is developmentally disabled.

If an individual who is either known or thought to be a client of the Division of Developmental Disabilities (DDD) is involuntarily detained, the DMHP notifies, by the next judicial day following the initial detention, a designated representative of DDD of this action. Attached Appendix E.

Reference: RCW 71.05.630(2) (g)

330–DMHP responsibilities if detained person is a foreign national.

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

- 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 H.
- 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 a record of 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/law/consular/consular_745.html[4]

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. It is suggested they consult their prosecuting attorneys for procedures.

LESS RESTRICTIVE ALTERNATIVE COURT ORDERS

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

400–Rights of a person 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 person being detained. In addition, the DMHP informs the person, in writing or, if possible orally in a language understood by the person, that:

- He/she will be released within five days unless a judicial hearing is held. RCW 71.05.340 (3) (c); and
- 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.
- Minors will be released within seven days unless a judicial hearing is held. RCW 71.34.780(3)

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

405–Advising certified mental health outpatient treatment providers in documenting compliance with CR/LRA Court Orders.

[4] Functioning hyperlink as of 2/10/2012

The office of the DMHP advises certified mental health outpatient providers by documenting 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 as per WAC 388.865.0466.
- 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) 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: WAC 388-865-0466

410–Criteria for extending CR/LRA Court Orders for adults.

The following criteria apply for extending LRA Court Orders for adults:

- During the current period of court ordered treatment the person has threatened, attempted, or inflicted physical harm to self or 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;
- Was taken into custody as a result of conduct in which he or she attempted or inflicted serious physical harm to self or upon the person of another, and continues to present, as a result of mental disorder a likelihood of serious harm;
- 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
- Continues to be gravely disabled while on a CR/LRA Court Order
- Persons 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

*"**Grave disability**", when being considered for extending a CR/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.*

Reference: RCW 71.05.320(3)

415–Petitions for extending a CR/LRA Court Order for adults.

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 and must also consider the cognitive and volitional functioning of the individual prior to court ordered treatment.
- The DMHP 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 treatment. The DMHP 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 or an examining physician and an examining mental health professional. RCW 71.05.410 (3).

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

- The person 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
- The person 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 CR/LRA Court Order, the DMHP gives great weight to evidence of prior history or pattern of decompensation and discontinuation of treatment resulting in:

- Repeated hospitalization;
- Repeated police intervention resulting in juvenile offenses, criminal charges, diversion programs or jail admissions. RCW 71.05.285

NOTE: The DMHP can only file petitions for the extension of CR/LRAs if the County Superior Court accepts and agrees to adjudicate the petition.

Reference: RCW 71.05.280, RCW 71.05.285 and RCW 71.05.320(3)

420–Criteria for revoking CR/LRA court order for adults.

Note: This section does not apply to Conditional Release orders under RCW 10.77, Criminally Insane – Procedures.

Note RE: Ability to file a new case rather than revoke: If a person meets criteria for revocation but is also gravely disabled or presents a likelihood of serious harm, 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.

The DMHP may file a petition to revoke the CR/LRA order of an individual on such an order, apprehending and taking 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:

- The person fails to comply with the terms and conditions of his/her CR/LRA Court Order;
- The person experiences substantial deterioration in his/her condition,
- There is evidence of substantial decompensation with a reasonable probability that the decompensation can be reversed by further inpatient treatment; or
- The person poses a likelihood of serious harm.
- In some cases, 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 has 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 may file a revocation petition and order the person apprehended and temporarily detained 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.

Note: If the revoked individual is placed in an E&T in a county, where the patient does not live or does not receive treatment, that county's court may not be able to obtain jurisdiction to preside over the revocation proceedings. The DMHP should contact the Office of the Prosecuting Attorney or designated mental health court liaison when out-of-county placement occurs to determine if this is an issue.

425–Procedures for revoking a CR/LRA Court Order for adults.

Note: This section applies only to RCW 71.05 and Conditional Release orders under RCW 10.77, Criminally Insane – Procedures.

The DMHP files a petition for revocation of a CR/LRA Court Order;

- When detaining an individual under criteria RCW 71.05.340 (3) (a), the DMHP documents the facts used to make the determination to detain, including names and contact information for all witnesses;
- When detaining an individual under criteria RCW 71.05.340 (3) (b), based on information from the outpatient treatment provider, the DMHP 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.
- The DMHP serves the individual copies of their legal paperwork and takes them into custody.
- The DMHP 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.

  The DMHP 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. RCW 71.05.212 (2).

430–Less Restrictive Alternative court orders for minors.

Revocations: 71.34.780 Minor's failure to adhere to outpatient conditions-Deterioration of minor's functioning-Transport to inpatient facility-Order of apprehension and detention-Revocation of alternative treatment or conditional release-Hearings

1. If the professional person in charge of an outpatient treatment program, a DMHP, 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, the DMHP, or the secretary may order that the minor be taken into custody and transported to an inpatient evaluation and treatment facility.

2. The DMHP 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. At the time of service, the minor shall be informed of the right to a hearing and to representation by an attorney. The DMHP or the secretary may modify or rescind the order of apprehension and detention at any time prior to the hearing.
3. The hearing must be set within seven calendar days from the time of detention.

Reference: RCW 71.34.780

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 71.05.155; RCW 71.05.390, RCW 71.05.445, RCW 71.05.610 through 630; RCW 10.77.065 and RCW 10.77.210; and in the case of minors, RCW 71.34.200 through 225.

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.

Referrants may be advised that the investigation has been completed.

505–Sharing information with parents, responsible family members, other legal representatives.

If possible, the DMHP must inform a responsible member of the individual's immediate family, guardian, and/or healthcare decision-maker when an individual is detained for evaluation and treatment. For 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.

Reference: RCW 71.05.360 (5) and RCW 71.34.710

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 71.05.390(11).
- 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 71.05.390(10).
- 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 71.05.390(7) (a).
- 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 71.05.390(7) (b) (iii).
- 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 71.05.390(7) (b).
- 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 71.05.390(17).

515–Sharing Information with Department of Corrections personnel.

Information must be shared with the Department of Corrections (DOC), including Community Corrections Officers, regarding the following persons:

1. 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 their address, and a statement as to whether the individual is or is not being treated. If a written request for information is made, all "relevant records and reports" necessary for DOC personnel to carry out their duties may be disclosed. RCW 71.05.445 (1)(b)
2. Other individuals subject to DOC reports or supervision. At DOC's written request, for the purposes of either completing presentence investigations or risk assessments, general assessing of an offender's risk to the community, supervising an offender (either in prison or in the

community), or planning of or provisioning of the supervision of an offender, a DMHP shall release "information related to mental health services." RCW 71.05.445 (2)(a); RCW 71.34.345(2)

Information related to mental health services includes "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." This may include documents of legal proceedings under RCW 71.05, 71.34 or 10.77, or "somatic health care information." It includes all "relevant records and reports."

RCW 71.05.445 (1) (a); RCW 71.05.445 (4); RCW 71.05.345(1) (a); RCW 71.34.345(3).

Relevant records and reports is further defined extensively and explicitly in WAC 388-865-0610.

Additionally;

- What DOC must include in a written request is found in WAC 388-865-0640.
- Direction as to how old of records must be released is found in WAC 388-865-0620.
- Timelines for reporting the requested information are found in WAC 388-865-0630

Reference: WAC 388-865-0600 through -0640 is found in Appendix L.

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 individual. Whenever a DMHP investigates someone who has made threats to, or repeatedly harassed another individual, the DMHP must:

- Call the individual 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.
- Call appropriate law enforcement agencies (both the law enforcement agencies of the victim and of the suspect).

Reference: RCW 71.05.390 (10) and RCW 71.34.200 (12), RCW 71.34.340 see Appendix M.

525–Sharing information with adult/child protective services.

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, whether an investigation will be performed, the fact, place, and date of the investigation, and whether the person was detained. Information disclosed by Adult Protective Services (RCW 74.34.095) and Child Protective Services (RCW 26.44.030) are confidential.

Reference: RCW 71.05.390(1)

APPENDICES

Appendix A: 2011 Designated Mental Health Professionals Protocol Workgroup Members

Washington Association of Designated Mental Health Professionals:
Robby Pellett – President WADMHP, DMHP King County
Luke Waggoner – Treasurer WADMHP, Clinical Manager, Walla Walla County Human Services
Ian Harrel – President Emeritus WADMHP, Emergency Services Director, Behavioral Health Resources

Regional Support Networks:
Sandy Whitcutt – North Sound Mental Health Administration, Quality Specialist
Richard VanCleave – Peninsula Regional Support Network, Clinical Services Manager

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

Department of Social and Health Services:
Dan Peterson – ADSA/Division of Developmental Disabilities, Mental Health Resource Manager
Michael Walls – Department of Corrections, Director Mental Health
Anthony O'Leary – ADSA/Home and Community Services, Roads to Community Living
Carol Sloan – ADSA/Home and Community Services, Program Manager
Pete Marburger – ADSA/Division of Behavioral Health and Recovery, Community Monitor Lead
Monica Jordan – ADSA/Division of Behavioral Health and Recovery, Program Administrator
Holly Borso – ADSA/Division of Behavioral Health and Recovery, Program Administrator
Ruth Leonard – ADSA/Division of Behavioral Health and Recovery, Regional Treatment Manager
Mark Nelson – ADSA/Division of Behavioral Health and Recovery, CLIP Program Administrator
Wanda Johns – ADSA/Division of Behavioral Health and Recovery, Secretary Senior
David Kludt – ADSA/Division of Behavioral Health and Recovery, Program Administrator

Other Stakeholders:
Jim Bloss – NAMI Washington
Jan Dobbs – Spokane Mental Health, Director of Emergency Services
JoEllen Watson – Coordinator King County Crisis and Commitment Services
Pam Hutchinson – Compass Health, Skagit County Mental Health Outreach Crisis Services Manager
Marlene Burrows – Clark County, Director of Crisis Services
Bea Dixon – Recovery Innovations, Recovery Services Administrator
Ethan Rogers – King County Prosecutor's Office, Senior Deputy Prosecuting Attorney (ITA Division)
Christopher Jennings – Pierce County Office of Assigned Counsel

Appendix B: County Prosecutor's Office Phone List

CIVIL COMMITMENT DPAs IN WASHINGTON STATE

COUNTY	*ADDRESS/PHONE*	*DPA(S)*
AG's Office	*7141 Cleanwater Dr. SW* *P.O. Box 40124* *Olympia, WA 98504-0124* *(360) 586-6542* *Dorothy Seaborne-Taylor, Paralegal*	*Sara Coates* *Steven Ssemaala* *Wendy Lux* *Katy Hatfield* *Amber Leaders*
Adams	*210 W. Broadway* *Ritzville, WA 99169* *(509) 659-3219*	
Asotin	*135 2nd St.* *P.O. Box 220* *Asotin, WA 99402* *(509) 243-2061*	
Benton	*7122 W. Okanogan Place, Bldg. A* *Kennewick, WA 99336* *(509) 735-3591*	*Christine Bennett* *Reid Hay* *Ryan Brown* *Stephen Hallstrom* *Ryan Lukson*
Chelan	*401 Washington St., 5TH Level* *Wenatchee, WA 98807* *(509) 667-6202*	
Clallam	*223 E. 4th St., Ste. 11* *Port Angeles, WA 98362* *(360) 417-2301*	
Clark	*604 W. Evergreen* *P.O. Box 5000* *Vancouver, WA 98666-5000* *(360) 397-2478*	*Lori Volkman*
Columbia	*116 N. 3rd St.* *Dayton, WA 99328* *(509) 382-1197*	
Cowlitz	*312 S.W. 1st Ave.* *Kelso, WA 98626* *(360) 577-3080*	
Franklin	*1016 - N. 4th Ave, Rms. 328 & 317* *Pasco, WA 99301* *(509) 545-3543*	*Ryan Verhulp* *Kim Kremer* *Janet Taylor*
Garfield	*809 Columbia St.* *P.O. Box 820* *Pomeroy, WA 99347* *(509) 843-3082*	
Grant	*P.O. Box 37* *Ephrata, WA 98823* *(509) 754-2011*	

Grays Harbor	***102 W. Broadway*** ***Rm. 102*** ***Montesano, WA 98563***	***Jennifer Wieland***
Island	***101 NE 6th St.*** ***P.O. Box 5000*** ***Coupeville, WA 98239*** ***(360) 679-7363***	
Jefferson	***1820 Jefferson St.*** ***P.O. Box 1220*** ***Port Townsend, WA 98368*** ***(360) 385-9180***	***David Alvarez***
King	***908 - Jefferson St., 2nd Fl.*** ***Seattle, WA 98104*** ***(206) 296-8936*** ***Marsha Luiz, Paralegal***	***Anne Mizuta*** ***Ali Keller***
Kitsap	***614 Division St., MS 35*** ***Port Orchard, WA 98366*** ***(360) 337-7174***	***Chad Enright***
Kittitas	***205 W. 5th Ave., #213*** ***Ellensburg, WA 98926*** ***(509) 962-7520***	
Klickitat	***205 S. Columbus Ave.*** ***MS-CH-18 Room 106*** ***Goldendale, WA 98620*** ***(509) 773-5838***	
Lewis	***345 W. Main St.*** ***Chehalis, WA 98532*** ***(360) 740-1240***	***Glenn Carter***
Lincoln	***450 Logan St.*** ***Davenport, WA 99122*** ***(509) 725-4040***	
Mason	***521 N. 4th St. #B*** ***Shelton, WA 98584*** ***(360) 427-9670 x417***	
Okanogan	***237 Fourth Ave. N.*** ***Okanogan, WA 98840*** ***(509) 422-7280***	
Pacific	***300 Memorial Dr.*** ***P.O. Box 45*** ***South Bend, WA 98586*** ***(360) 875-9361***	***David Burke***
Pend Orielle	***229 S. Garden Ave.*** ***P.O. Box 5070*** ***Newport, WA 99156*** ***(509) 447-4414***	
Pierce	***1305 - Tacoma Ave. S., Ste 104*** ***Tacoma, WA 98402*** ***(253) 798-4348***	***Ken Nichols***

	Deb, Legal Assistant ***(253) 798-4342***	
San Juan	***350 Court St.*** ***P.O. Box 760*** ***Friday Harbor, WA 98250*** ***(360) 378-4101***	
Skagit	***605 S. Third St.*** ***Courthouse Annex*** ***Mount Vernon, WA 98273*** ***(360) 336-9460*** ***Debbie Nicholson, Legal Asst.*** ***360-419-3452 (Direct line)***	***Rotating***
Skamania	***240 NW Vancouver Ave.*** ***Stevenson, WA 98468*** ***(509) 427-3790***	
Snohomish	***3000 Rockefeller Ave*** ***MS 305*** ***Everett, WA 98201*** ***(425) 388-6330***	***Michael Held*** ***(425) 388-6357*** ***Rotating DPAs***
Spokane	***1115 - W. Broadway Ave.*** ***Spokane, WA 99260*** ***Karen Bond, Paralegal*** ***(509) 477-2848***	***Jim Kaufman,*** ***(509) 477-3612*** ***Kristen O'Sullivan,*** ***(509) 477-2848***
Stevens	***215 S. Oak St.*** ***Colville, WA 99114*** ***(509) 684-7500***	
Thurston	***926 - 24th Way SW*** ***Olympia, WA 98502*** ***(360) 786-5270*** ***Jena Nagala, Legal Assistant***	***Joseph Wheeler***
Wahkiakum	***64 Main St.*** ***P.O. Box 397*** ***Cathlamet, WA 98612*** ***(360) 795-3652***	
Walla Walla	***240 W. Alder, Ste. 201*** ***Walla Walla, WA 99362-2807*** ***(509) 524-5445***	
Whatcom	***County Courthouse, Ste. 201*** ***311 Grand Avenue*** ***Bellingham, WA 98225-4079*** ***(360) 676-6784***	***Karen Frakes***
Whitman	***400 N. Main St.*** ***P.O. Box 30*** ***Colfax, WA 99111*** ***(509) 397-6250***	
Yakima	***128 - N. 2nd St., Room 329*** ***Yakima, WA 98901*** ***(509) 574-1210***	***Susan Arb***

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, boarding homes, and nursing homes. 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 licensed residential care facilities:

Key laws and regulations for:

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

- Descriptions of Adult Family Homes, Boarding Homes and Nursing Homes: 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
- Boarding Home Professionals: http://www.adsa.dshs.wa.gov/professional/bh.htm
- Nursing Home 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 a person 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 a person in a nursing home, has the person 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.

    a. 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.

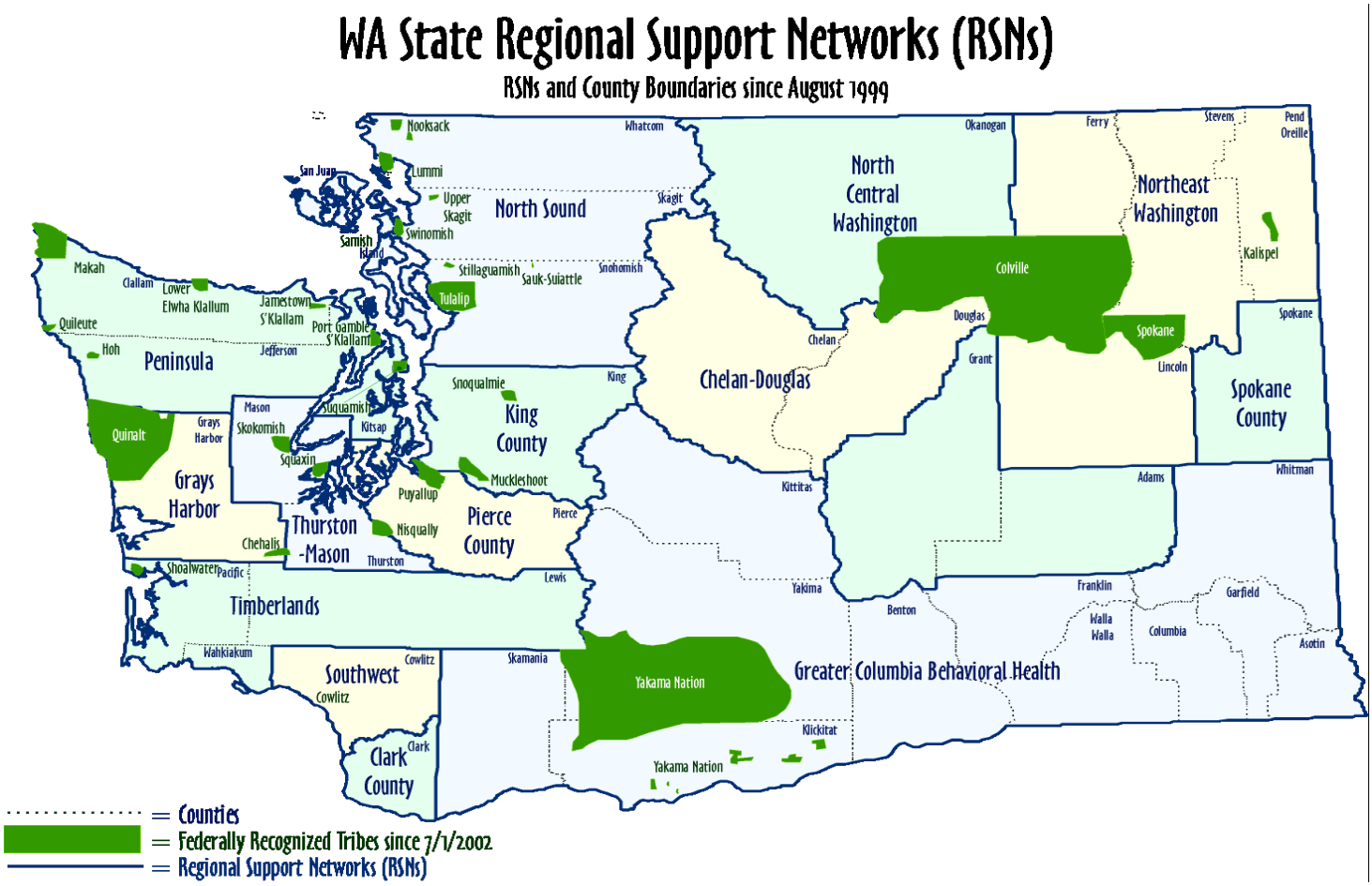
8. Let the resident tell you what will help and work with the family or support system to find creative ways to make it happen. Example: "I want to go home"—allow the family to recreate as much as possible the one room or space in the house that resident found the most comfortable.

Utilize PRN medications as ordered.

Appendix E: DDD Contacts Listed by RSN and County - for DMHPs

RSN	DDD Staff Contacts	DDD Fax
Chelan-Douglas	Todd Vercoe – 509-329-2921 or Tory Fiedler – 509-225-4626	509-568-3037
Clark	Jeff Green – 360-725-4305 or Amee Kile – 360-725-4282	360-568-6502
Grays Harbor	Jeff Green – 360-725-4305 or Amee Kile – 360-725-4282	360-568-6502
Greater Columbia	Joe Hall – 509-374-2122 or Tory Fiedler – 509-225-4626 Skamania call Jeff Green – 360-725-4305	509-574-5607 except in Skamania County Fax 360-568-6502
King	Dan Peterson – 206-568-5670 or Dr. Gene Mcconnachie – 206-568-5718	206-720-3038
North Central	Todd Vercoe – 509-329-2921 or Tory Fiedler – 509-225-4626	509-568-3037
North Sound	Mary Norris – 425-339-4887 or Dr. Kristin Ihrig – 425-339-4828	425-339-4856
Pierce	Ann Miklusis 253-404-6526 or Denise Pech – 253-404-6540	253-597-4368
Peninsula	Jeff Green – 360-725-4305 or Amee Kile – 360-725-4282 Kitsap call Ann Miklusis 253-404-6526	360-568-6502 Except in Kitsap fax 253-597-4368
Spokane	Todd Vercoe – 509-329-2921 or Tory Fiedler – 509-225-4626	509-568-3037
Southwest	Jeff Green – 360-725-4305 or Amee Kile – 360-725-4282	360-568-6502
Timberlands	Jeff Green – 360-725-4305 or Amee Kile – 360-725-4282	360-568-6502

Appendix F: Federally Recognized Tribes of Washington State



Date: 7/1/02

Appendix G: List of Resources for "Available History" [5]

Accessing potentially relevant information and records, including information and records that, if reasonably available, must be considered (RCW 71.05.212) is often extremely difficult. 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. Regional Support Network Administrators may want to consider developing interagency agreements with county or local law enforcement officials.

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.

[5] Phone numbers and web sites verified 2/3/2012

Appendix H: 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 [6]

Determine the foreign national's country. In the absence of other information, assume this is the country on whose passport or other travel document 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 [7]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 e-mail addresses for foreign embassies and consulates in the United States, see http://www.state.gov/www/global/legal_affairs/ca_notification/part1.html#statements of the web site. The web site includes hyperlinks to the embassies and consulates. Each consulate or embassy web site 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 in http://www.state.gov/www/global/legal_affairs/ca_notification/part1.html and further information at http://www.state.gov/www/global/legal_affairs/ca_notification/part1.html#statements, which contains a suggested fax sheet, you may for making the notification.
- Tell the foreign national that you are making this notification. A suggested statement to the foreign national is found at http://www.state.gov/www/global/legal_affairs/ca_notification/part1.html#statements , and translations into selected languages are in Part Four.

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

[6] All hyperlinks functioning this section as of 10/31/2008 3:01 PM
[7] Functioning hyperlink as of 4/4/2006 10:42 AM

Mandatory Notification Countries and Jurisdictions

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 I: Sample Forms for Less Restrictive Alternative Process
(See Section 400)

NOTICE NOT TO EXTEND CONDITIONAL RELEASE/LESS RESTRICTIVE ALTERNATIVE (CR/LRA)

COUNTY INVOLUNTARY TREATMENT

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

Case Manager:
_____

Agency: _____ Phone Number: _____

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

Client:
_____

Address:
_____

DOB: _____ SS # _____

CR / LRA Expiration Date
_____

Circle One: 90- 180- day

THIS FORM MUST BE SUBMITTED FOUR (4) WEEKS PRIOR TO THE EXPIRATION DATE OF THE CR/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 (CR/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 CR/LRA for (Circle one) 90- 180- days.

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

GENERAL QUESTIONS:

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

Additional information:

LESS RESTRICTIVE ALTERNATIVE (CR/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 CR/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 CR/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 in good faith? What documentation would support "poor faith" status? If the person is cognitively impaired, is the healthcare decision-maker willing to consent to less restrictive treatment on behalf of this person?

Appendix I, Continued

9. Please specify all proposed conditions for the future CR/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 J: DMHP Knowledge and Education

Qualifications as defined in statute:

"Designated mental health professional" means a mental health professional designated by the appropriate Regional Support Network to perform the duties of the Involuntary Treatment Acts. RCW 71.05.020(6) and RCW 71.34.020(4)

RCW 71.05.020 (16) "Mental health professional" means a psychiatrist, psychologist, psychiatric nurse, or social worker, and such other mental health professionals as defined by WAC 388-865-0150 “Mental Health Professional”.

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 K: References and Resources

1. Diagnostic and Statistical Manual IV

2. Washington State DMHP Protocols, updated September 2002

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

6. Revised Code of Washington

   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 898, ___ P.2d. ___ (1999).
   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, ___ P.2d_ ___.(2001).
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.

Hodson, J. D. (1983). The ethics of legal coercion. Boston, MA: D. Reidel.

Jacobson, G. (Ed.). (1980). *Crisis Intervention in the1980's.* Jossey Bass, San Francisco, CA.

Kittrie, N. N. (1971). The right to be different: Deviance and enforced therapy. Baltimore, MD: The Johns Hopkins Press.

Meloy, R., Haroun, A., & Schiller, E. (1990). *Clinical Guidelines for Involuntary Outpatient Treatment.* Professional Resource Exchange, Inc., Sarasota, FL.

Monahan, J., & Steadman, H. (Eds.). (1994). Violence and mental disorder: Developments in risk assessment. Chicago: University of Chicago Press.

Perlin, M. (1994). *Law and Mental Disability*. The Michie Company, Charlottesville, VA.

Phelan, M., Strathdee, G., & Thornicroft, G. (Eds.). (1995). Emergency mental health services in the community. Cambridge: University Press.

Roberts, A. (1991). Conceptualizing Crisis Theory and the Crisis Intervention Model. In Roberts, A. (Ed.), Contemporary perspectives on crisis intervention and prevention, pp. 3-17. Englewood Cliffs, NJ: Prentice Hall.

Rooney, R. (1992). *Strategies for Work with Involuntary Clients*. Columbia University Press, Durham, NC.

Sales, B. D., & Shah, S. A. (Eds.). (1996). Mental health and law: research, policy and services. Durham, NC: Carolina Academic Press.

Sales, B. D., & Shuman, D. W. (Eds.). (1996). Law, mental health, and mental disorder. Pacific Grove, CA: Brooks/Cole Publishing Company.

Slaby, A., Leib, J., & Tancredi, L. (1981). *Handbook of Psychiatric Emergencies.* Medical Examination Publishing Co., Garden City, NY.

Slaikeu, K. A. (1990). 2nd Ed. Crisis intervention: A handbook for practice and research. Boston, MA: Allyn and Bacon, Inc.

Stein, L.I., & Santos, A.B. (1998). Assertive Community Treatment of persons with severe mental illness. New York: Norton.

Tardiff, K. (1984). *The psychiatric Uses of Seclusion and Restraint.*. American Psychiatric Press, Washington, DC.

Winick, B. (1997). *The Right to Refuse Mental Health Treatment*. American Psychological Association, Washington, DC.

Recommended Resources Available from State Library: Journal Articles

Applebaum, P. S. (1985). Special section on APA's Model Commitment Law. Hospital and Community psychiatry, 36(9), 966-968.

Appelbaum, P. (1992). Forensic psychiatry: The need for self-regulation. Bulletin of the American Academy of Psychiatry and the Law, 20(2), 153-162.

Appelbaum, P. (1996). Civil mental health law: Its history and its future. Mental & Physical Disability Law Reporter, 20(5), 599-604.

Austin, B. S. (1986). Legal standards for civil commitment: The impact of deinstitutionalization on the non-dangerous mentally ill patient in need of treatment. Seattle, WA: University of Washington.

Bachrach, L. (1980). Overview: Model programs for chronic mental patients. American Journal of Psychiatry, 137, 1023-1031.

Bachrach, L. (Ed.). (1983). Deinstitutionalization. San Francisco, CA: Jossey Bass.

Bachrach, L. (1988). Defining chronic mental illness; A concept paper. Hospital and Community Psychiatry, 39(4), 383-387.

Ballus, C. (1997). Effects of antipsychotics on the clinical and psychosocial behavior of patients with schizophrenia. Schizophrenia Research, 28(2-3), 247-255.

Berg, J. W., Bonnie, R. J. (1996). When push comes to shove: Aggressive community treatment and the law. In, Dennis, D., & Monahan, J. Coercion and aggressive community treatment: A new frontier in mental health law. New York: Plenum Press, 172-193.

Bloom, J. D., & Williams, M. H. (1994). Oregon's civil commitment law: 140 years of change. Hospital and Community Psychiatry, 45(5), 466-470.

Bond, G. R., McDonel, E.C., Miller, L. D., & Pensee, M. (1991). Assertive community treatment and reference groups: An evaluation of their effectiveness for young adults with serious mental illness and substance abuse. Psychosocial Rehabilitation Journal, 15(2), 31-43.

Borland, A., McRea, J., & Lycan., C. (1989). Outcomes of five years of continuous intensive case management. Hospital and Community Psychiatry, 40(4), 369-376.

Brooks, A. D. (1994). The civil commitment of pathologically violent sex offenders. Administration and Policy in Mental Health, 21(5), 417-429.

Browne, E. W. (1975). The right to treatment under civil commitment. Reno, NV: National Council of Juvenile Court Judges.

Canetto, S. S. (1997). Gender and suicidal behavior: Theories and evidence. In, Mari, Silverman, & Canetto (Eds). Review of suicidology, pp. 138-167, New York: Guilford Press.

Convit, A.,Jeager, J., Lin, S. P., Meisner, M., & Volavka, J. (1988). Predicting assaultiveness in psychiatric inpatients: A pilot study. Hospital and Community Psychiatry, 39(4), 429-434.

Cope, S., Smith, J., & Smith, R. (1995). The crisis team as a part of comprehensive local services. Psychiatric Bulletin, 19(10), 616-619.

Deci, P. A., Santos, A. B., Hiott, D. W., Schoenwald, S., & Dias, J. K. (1995). Dissemination of Assertive Community Treatment Programs. Psychiatric Services, 46(7), 676-678.

Diamond, R. J. (1996). Coercion and tenacious treatment in the community: Applications to the real world. In Dennis, D. L., & Monahan, J. (Eds.), Coercion and aggressive community treatment: A new frontier in mental health law, pp. 51-72. New York: Plenum Press.

Drake, R. E. (1998). Brief history, current status, and future place of Assertive Community Treatment. American Journal of Orthopsychiatry, 68(2), 172-175.

Drake, R. E., & Burns, B. J. (1995). Special section on Assertive Community Treatment: An introduction. Psychiatric Services, 46(7), 667-668.

Durham, M. L. (1996). Civil commitment of the mentally ill: research, policy and practice. In Sales, B. D., & Shah, S. A. (Eds.), Mental health and the law: Research, policy, and services, pp. 17-40. Durham, NC: Carolina Academic Press.

Durham, M. L., Carr, H. D., & Pierce, G. L. (1984). Police involvement and influence in involuntary commitment. Hospital and Community Psychiatry, 35(6), 580-584.

Durham, M. L., & Carr, H. D. (1985). Use of summons in involuntary civil commitment. Bulletin of American Academy of Psychiatry and Law, 13(3), 243-251].

Durham, M. L. & La Fond, J. Q. (1985). The empirical consequences and policy implications of broadening the statutory criteria for civil commitment. Yale Law & Policy Review, 3(2), 395-446.

Edelsohn, G., & Hiday, V. (1990). Civil commitment: A range of patient attitudes. Bulletin of the American Academy of Psychiatry & the Law, 18(1), 65-77.

Eddy, D., Wolpert, R., & Rosenberg, M. (1987). Estimating the effectiveness of interventions to prevent youth suicide. Medical Care, 25(12), 57-65.

Essock, S.M., & Kontos, N. J. (1995). Implementing Assertive Community Treatment Teams. Psychiatric Services, 46(7), 679-683.

Essock, S. M., Frishman, L. K., & Kontos, N. J. (1998). Cost-effectiveness of Assertive Community Treatment Teams. American Journal of Orthopsychiatry , 68(2), 179-190.
Fernandez, G., & Nygard, S. (1990). Impact of outpatient involuntary commitment on the revolving door-syndrome in North Carolina. Hospital and Community Psychiatry, 40, 1001-1004.

Fischer, W. H., Pierce, G. L., & Applebaum, P. S. (1988). How flexible are our civil commitment statutes? Hospital and Community Psychiatry, 39(7), 711-712.

Garbarino, J., and Guttmann, E. (1986). Characteristics of High Risk Families: Parental and Adolescent Perspectives. In Garbarino, J., Schellenbach, C., and Sebes, J. (Ed.), Troubled Youth, Troubled Families, pp. 121-148. New York: Aldine

Gaskins, R., & Wasow, M. (1979). Vicious circles of civil commitment. Social work, 24(2), 127-131.

Geller, J. L. (1990). Clinical guidelines for the use of involuntary outpatient treatment. Hospital and Community Psychiatry, 41(7), 749-755.

Geller, J. L., Fisher, W. H., & McDermeit, M. (1995). A national survey of mobile crisis services and their evaluation. Psychiatric services, 46(9), 893-897.

Gillig, P. M. (1995). The spectrum of mobile outreach and its role in emergency service. New Directions for mental health Services, 67, 13-21.

Gutheil, T. G. (1980). In search of true freedom: Drug refusal, involuntary medication, and "rotting with your rights on". American Journal of Psychiatry, 137, 327-328.

Gutheil, T. G., Applebaum, P. S., Wexler, D. B. (1983). The inappropriateness of "least restrictive alternative" analysis for involuntary procedures with the institutionalized mentally ill. Journal of Psychiatry and Law, 11(1), 7-17.

Hiday, V., & Goodman, R. (1982). The least restrictive alternative to involuntary hospitalization, outpatient commitment: Its use and effectiveness. Journal of Psychiatry and Law, 10, 81-96.

Hiday, V. A. (1992). Coercion in civil commitment: Process, preference, and outcome. International Journal of Law and Psychiatry, 15(4), 359-377.

Hiday, V. (1996). Outpatient commitment: Official coercion in the community. In Dennis, D. L., & Monahan, J. (Eds.), Coercion and aggressive community treatment: A new frontier in mental health law, pp. 51-72. New York: Plenum Press.

Holinger, P., & Offer, D. (1981). Perspectives on adolescent suicide. Research in Community and Mental Health, 2, 139-157.

Hornblow, A. R. (1886). The evolution and effectiveness of telephone counseling services. Hospital and Community Psychiatry, 37(7), 731-733.

Hughes, D. H. (1996). Implications of recent court rulings for crisis and psychiatric emergency services. Psychiatric Services, 47(12), 1332-1333.

La Fond, J. Q. (1981). An examination of the purposes of involuntary civil commitment. Buffalo Law Review, 30, 499-535.

La Fond, J. Q. (1996). The impact of law on the delivery of involuntary mental health services. In Sales, B. D., & Shuman, D. W. (Eds.), Law, mental health, and mental disorder, pp. 219-239. Pacific Grove, CA: Brooks/Cole Publishing Company.

La Fond, J. Q., & Durham, M. L. (1994). Cognitive dissonance: have insanity defense and civil commitment reforms made a difference? Villanova Law Review, 39(1), 71-122.

Lamb, H. R., & Shaner, R. (1995). Outcomes for psychiatric emergency patients seen by outreach police-mental health teams. Psychiatric Services, 46(12), 1267-1271.

Leukefeld, C. G., & Tims, F. M. (1990). Compulsory treatment for drug abuse. International Journal of Addiction, 25(6), 621-640.

Lindsay, K. P., Paul, G. L., & Mariotto, M. J. (1989). Urban psychiatric commitments: Disability and dangerous behavior of black and white recent admissions. Hospital and Community Psychiatry, 40(3), 286-294.
Lidz, C., Mulvey, E., Hoge, S., Kirsch, B., Monahan, J., Eisenberg, M., Gardner, W., & Roth, L. (1995). Perceived coercion in mental hospital admission: Pressures and process. Archives of General psychiatry, 52, 1034-1039.

Maier, G. J. (1989). The tyranny of irresponsible freedom. Hospital and Community Psychiatry, 40(5), 453.

Maloy, K. A. (1996). Does involuntary outpatient commitment work? In Sales, B. D., & Shah, S. A. (Eds.), Mental health and the law: Research, policy, and services, pp. 41-74. Durham, NC: Carolina Academic Press.

McGrew, J. H., Bond, G. R., Dietzen, L., McKasson, M. A., & Miller, L. D. (1995). A multi-site study of client outcomes, in Assertive Community treatment. Psychiatric Services, 46(7), 696-701.

McHugo, G. J., Hargreaves, W., Drake, R E., Clark, R.E., Xie, H., Bond, G R., & Burns, B. J. (1998). Methodological issues in assertive community treatment studies. American Journal of Orthopsychiatry, 68(2), 246-259.

McNiel, D. E., & Binder, R. L. (1987). Predictive validity of judgements of dangerousness in emergency civil commitment. American Journal if psychiatry, 144(2), 197-200.

Megargee, E. I. (1976). The prediction of dangerous behavior. Criminal justice and behavior, 3(1), 3-21.

Meloy, J. R., Haroun, A., & Schiller, E. F. (1990). Clinical guidelines for involuntary outpatient treatment. Sarasota, FL: Professional Resource Exchange, Inc.

Mental Health Weekly. (1997). Court decision on sexual predators threatens MH agencies. Mental Health Weekly, 7, (27), 1-5.

Modlin, H. (1990). Post Traumatic Stress Disorder: Differential Diagnosis. In Meek, C. (Ed.), Post Traumatic Disorder: Assessment Differential Diagnosis and Forensic Evaluation, pp. 63-72. Sarasota, Florida: Professional Resource Exchange, Inc.

Monahan, J., & Steadman, H. (Eds.). (1994). Violence and mental disorder: Developments in risk assessment. Chicago: University of Chicago Press.

Monahan, J., Hoge, S., Lidz, C., Eisenberg, M., Bennett, N., Gardener, W., Mulvey, E., & Roth, L. (1996). Coercion to inpatient treatment: Initial results and implication for assertive treatment in the community. In Dennis, D., & Monahan, J. (Eds.), Coercion and aggressive community treatment: A new frontier in mental health law, pp. 13-28. New York: Plenum press.

Mulvey, E. P., Geller, J. L., & Roth, L. H. (1987). The promise and peril of involuntary outpatient commitment. American Psychologist, 42, 571.

Munetz, M. R., Grande, T., Kleist, J., & Peterson, G. A. (1996). The effectiveness of outpatient civil commitment. Psychiatric Services, 47(11), 1251-1253.

Nicholson, R. A. (1988). Characteristics associated with change in the legal status of involuntary psychiatric patients. Hospital and community psychiatry, 39(4), 424-429.

O'Connor v. Donaldson. (1975). 422, U.S. 563.

O'Hare, T. (1996). Court-ordered versus voluntary clients: Problem differences and readiness for change. Social Work, 41(4), 417-422.

Polcin, D. L. (1990). Ethical issues in the Deinstitutionalization of clients with mental disorders. Journal of Mental Health Counseling, 12(4), 446-457.

Rachlin, S. (1983). The influence of law on Deinstitutionalization. In Bachrach, L. (Ed.), Deinstitutionalization, pp. 41-54. San Francisco, CA: Jossey Bass.

Roesch, R., Ogloff, J., & Golding, S. (1993). Competency to stand trial: Legal and clinical issues. Applied and Preventative Psychology, 2(1), 43-51.

Santos, A. B., Henggeler, S. W., Burnes, B. J., Arana, G. W., & Meisler, N. (1995). Research on field-based services: Models for reform in the delivery of mental health care to populations with complex clinical problems. American Journal of Psychiatry, 152(8), 1111-1123.

Schwartz, H. I., Appelbaum, P. S., & Kaplan, R. D. (1984). Clinical judgements in the decision to commit; Psychiatric discretion and the law. Archives of General Psychiatry, 41, 811-815.

Schwartz, R. S. (1990). The use of ultimatums in psychiatric care. Hospital and community psychiatry, 41(11), 1242-1245.

Sebes, J. (1986). Identifying High Risk. In Garbarino, J., Schellenbach, C., and Sebes, J. (Ed.), Troubled Youth, Troubled Families, pp. 83-120. New York: Aldine Publishing.

Segal, S. P., Watson, M. A., & Nelson, L. S. (1985). Application of involuntary admission criteria to psychiatric emergency rooms. Social Work, 30(2), 160-165.

Shaffer, D. (1993). Preventing suicide in young people. Innovations in Research, 2, 1-9.

Slobogin, C. (1994). Involuntary community treatment of people who are violent and mentally ill: A legal analysis. Hospital and Community Psychiatry, 45(7), 711-713.

Staub, E. (1996). Cultural-societal roots of violence: the examples of genocidal violence and of contemporary youth violence in the United States. American Psychologist, 51(2), 117-132.

Steadman, H. J. (1981). The violent patient; predicting the probability. Roche Report: Frontiers of Psychiatry, March, 4-11.

Stein, D., & Lambert, M. (1984). Telephone counseling and crisis intervention: A review. American Journal of Community Psychology, 12(1), 101-126.

Susser, E., & Roche, B. (1996). Coercion and leverage in community outreach. In, Dennis, D., & Monahan, J. (1996). Coercion and aggressive community treatment: A new frontier in mental health law. New York: Plenum Press, 74-86.

Swanson, J. W., Swartz, M. S., George, L. K., Burns, B. K., Hiday, V. A., Borum, R., & Wagner, H. R. (1997). Interpreting the effectiveness of involuntary outpatient commitment: A conceptual model. Journal of the American Academy of Psychiatry and the Law, 25(1), 5-16.

Sweum v. Washington. 1975. Court of Appeals, State of Washington, No. 1558-II.

Teague, G. B., Bond, G. R., & Drake, R. E. (1998). Program fidelity in Assertive Community treatment: Development and use of a measure. American Journal of Orthopsychiatry, 68(2), 216-232.

Teplin, L. A., & Voit, E. S. (1996). Criminalizing the seriously mentally ill: Putting the problem in perspective. In Sales, B. D., & Shah, S. A. (Eds.), Mental health and the law: Research, policy, and services, pp. 283-318. Durham, NC: Carolina Academic Press.

Vermont Superior Court: Case No. 85-242 (1986). Vermont's outpatient commitment process challenged. Mental and Physical Disability Law Reporter, 10(4), 262.

Wanck ,B. (1984). Two decades of involuntary hospitalization legislation. American Journal of psychiatry, 141(1), 33-38.

Whanger, A. D., & Myers, A. C. (1984). Mental health assessment and therapeutic intervention with older adults. Rockville, MD: Aspen Publications.

Witheridge, T. F. (1991). The "active ingredients" of assertive outreach. New Directions for Mental Health Services, 52, 47-64.

Zwerling, I., Karasu, T., Plutchik, R., & Kellerman, S. (1975). A comparison of voluntary and involuntary patients in a state hospital. American Journal of Orthopsychiatry, 45(1), 81-87.

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 L: 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.

(2) **"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 e-mail 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 M: RCW 71.34.340

Information concerning treatment of minors confidential — Disclosure — Admissible as evidence with written consent.

The fact of admission and all information obtained through treatment under this chapter is confidential. Confidential information may be disclosed only:

(1) In communications between mental health professionals to meet the requirements of this chapter, in the provision of services to the minor, or in making appropriate referrals;

(2) In the course of guardianship or dependency proceedings;

(3) To persons with medical responsibility for the minor's care;

(4) To the minor, the minor's parent, and the minor's attorney, subject to RCW 13.50.100;

(5) When the minor or the minor's parent designates in writing the persons to whom information or records may be released;

(6) To the extent necessary to make a claim for financial aid, insurance, or medical assistance to which the minor may be entitled or for the collection of fees or costs due to providers for services rendered under this chapter;

(7) To the courts as necessary to the administration of this chapter;

(8) To law enforcement officers or public health officers as necessary to carry out the responsibilities of their office. However, only the fact and date of admission, and the date of discharge, the name and address of the treatment provider, if any, and the last known address shall be disclosed upon request;

(9) To law enforcement officers, public health officers, relatives, and other governmental law enforcement agencies, if a minor has escaped from custody, disappeared from an evaluation and treatment facility, violated conditions of a less restrictive treatment order, or failed to return from an authorized leave, and then only such information as may be necessary to provide for public safety or to assist in the apprehension of the minor. The officers are obligated to keep the information confidential in accordance with this chapter;

(10) To the secretary for assistance in data collection and program evaluation or research, provided that the secretary adopts rules for the conduct of such evaluation and research. The rules shall include, but need not be limited to, the requirement that all evaluators and researchers sign an oath of confidentiality substantially as follows:

"As a condition of conducting evaluation or research concerning persons who have received services from (fill in the facility, agency, or person) I, ..., agree not to divulge, publish, or otherwise make known to unauthorized persons or the public any information obtained in the course of such evaluation or research regarding minors who have received services in a manner such that the minor is identifiable.

I recognize that unauthorized release of confidential information may subject me to civil liability under state law.

/s/ . . . . . "

(a).

(11) To appropriate law enforcement agencies, upon request, all necessary and relevant information in the event of a crisis or emergent situation that poses a significant and imminent risk to the public. The decision to disclose or not shall not result in civil liability for the mental health service provider or its employees so long as the decision was reached in good faith and without gross negligence;

(12) To appropriate law enforcement agencies and to a person, when the identity of the person is known to the public or private agency, whose health and safety has been threatened, or who is known to have been repeatedly harassed, by the patient. The person may designate a representative to receive the disclosure. The disclosure shall be made by the professional person in charge of the public or private agency or his or her designee and shall include the dates of admission, discharge, authorized or unauthorized absence from the agency's facility, and only such other information that is pertinent to the threat or harassment. The decision to disclose or not shall not result in civil liability for the agency or its employees so long as the decision was reached in good faith and without gross negligence;

(13) To a minor's next of kin, attorney, guardian, or conservator, if any, the information that the minor is presently in the facility or that the minor is seriously physically ill and a statement evaluating the mental and physical condition of the minor as well as a statement of the probable duration of the minor's confinement;

(14) Upon the death of a minor, to the minor's next of kin;

(15) To a facility in which the minor resides or will reside;

(16) To law enforcement officers and to prosecuting attorneys as are necessary to enforce RCW 9.41.040(2)(a)(ii). The extent of information that may be released is limited as follows:

(a) Only the fact, place, and date of involuntary commitment, an official copy of any order or orders of commitment, and an official copy of any written or oral notice of ineligibility to possess a firearm that was provided to the person pursuant to RCW 9.41.047(1), shall be disclosed upon request;

(b) The law enforcement and prosecuting attorneys may only release the information obtained to the person's attorney as required by court rule and to a jury or judge, if a jury is waived, that presides over any trial at which the person is charged with violating RCW 9.41.040(2)(a)(ii);

(c) Disclosure under this subsection is mandatory for the purposes of the health insurance portability and accountability act.

This section shall not be construed to prohibit the compilation and publication of statistical data for use by government or researchers under standards, including standards to assure

maintenance of confidentiality, set forth by the secretary. The fact of admission and all information obtained pursuant to this chapter are not admissible as evidence in any legal proceeding outside this chapter, except guardianship or dependency, without the written consent of the minor or the minor's parent.

[2005 c 453 § 6; 2000 c 75 § 7; 1985 c 354 § 18. Formerly RCW 71.34.200.]

Notes: **Severability -- 2005 c 453:** See note following RCW 9.41.040.
Intent -- 2000 c 75: See note following RCW 71.05.445.

Appendix N: 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