Washington State Department of Social and Health Services

Transforming Lives

REPORT TO THE LEGISLATURE

Community Services Regional Support Networks
2017 Designated Mental Health Protocols

RCW 71.05.214

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EXECUTIVE SUMMARY

The 2017 update of the Protocols for Designated Mental Health Professionals (DMHPs) is provided by the Department of Social and Health Services (DSHS), Division of Behavioral Health and Recovery (DBHR), as mandated by RCW 71.05.214.

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

In compliance with the legislative mandate, the Department submitted the initial protocols to the Governor and the Legislature in 1999, and updated in 2002, 2005, 2008, 2011 and 2014.

It is the intent of the 2017 Protocol Workgroup that the Protocols help support and clarify the work of the DMHPs in the face of new legislative changes and limited resources. As of April 1, 2016, all Regional Support Networks converted to Behavioral Health Organizations, with the exception of the Full Integration Region: Southwest Washington, comprised of Clark and Skamania counties, which is now overseen by Managed Care Organizations and Administrative Service Organizations.

Current provisions for the use of Single Bed Certification and the Unavailable Detention Facilities Report (hereafter referred to as the No-Bed Report) can be found in 71.05.745, 71.05.750, 71.05.755, and WAC 388-865-0526.

DSHS and their community partners are working to develop appropriate treatment and diversion resources to address the needs of individuals in need of inpatient psychiatric services.

These protocols are also intended to assist consumers, advocates, allied systems, courts, and other interested persons to better understand the role of the DMHP in implementing the civil commitment laws.

The 2017 Protocol Workgroup 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 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).

Throughout this document, all references to DMHP will appear as DMHP/DCR, pending changes effective April 1, 2018. Aspects of the Protocols related specifically to SUD ITA will be noted as effective April 1, 2018.

The 2017 Protocols also have limitations. It is beyond the scope of the protocols to address the myriad of clinical skills and practices required of DMHPs/DCRs or the role of the DMHP/DCRs in providing crisis response and resolution as a mental health professional. In addition, some of the practices followed by DMHPs/DCRs are influenced by the rulings of local courts. These rulings have resulted in procedural differences across the state, which are beyond the authority of the protocols to remedy. The workgroup recognizes that there are significant variations between counties with respect to geography, population, resources, and socioeconomic and political factors. Notwithstanding these issues, the 2017 Protocol Workgroup is satisfied that these protocols will continue to move DMHP/DCR practices toward greater uniformity in implementation of applicable statutes across the state.

The 2017 Protocol Work Group wishes to emphasize that regardless of differences in court rulings, local procedures, or the shortage of inpatient psychiatric beds, it is imperative to the integrity of the system and those we serve, that Designated Mental Health Professionals/Designated Crisis Responders make their decisions based on clinical presentation, collateral information and the rules implementing RCW 71.05, RCW 71.34, and RCW 10.77.

Legislative Intent 71.05.010 (amended to specifically define the authority of the DMHPs/DCRs in the 2015 Legislative session – section 1(a))

(1) The provisions of this chapter are intended by the legislature:

(a) To protect the health and safety of persons suffering from mental disorders and to protect public safety through use of the parens patriae and police powers of the state;

(b) To prevent inappropriate, indefinite commitment of mentally disordered persons and to eliminate legal disabilities that arise from such commitment;

(c) To provide prompt evaluation and timely and appropriate treatment of persons with serious mental disorders;

(d) To safeguard individual rights;

(e) To provide continuity of care for persons with serious mental disorders;

(f) To encourage the full use of all existing agencies, professional personnel, and public funds to prevent duplication of services and unnecessary expenditures; and

(g) To encourage, whenever appropriate, that services be provided within the community.

(2) When construing the requirements of this chapter the court must focus on the merits of the petition, except where requirements have been totally disregarded, as provided in In re C.W., 147 Wn.2d 259, 281 (2002). A presumption in favor of deciding petitions on their merits furthers both public and private interests because the mental and physical well-being of individuals as well as public safety may be implicated by the decision to release an individual and discontinue his or her treatment.

Recent Legislation involving RCW 71.05 and RCW 71.34

E2SSB 5269 passed during the 2015 Legislative session. Relating to court review of detention decisions under the Involuntary Treatment Act. Authorizes an immediate family member, guardian, or conservator to appeal a DMHP's decision to not detain a person under the ITA. Act is named Joel's Law.

E2SSB 5649 passed during the 2015 Legislative session. Relating to the involuntary treatment act. Requires RSNs to provide an adequate network of E&T services to ensure access to treatment. Requires DMHPs to report to DSHS within 24 hours when the DMHP cannot find a bed for a person who meets ITA detention criteria; DSHS must take corrective action to ensure adequate treatment beds. Allows DSHS to authorize single bed certifications if facility is willing and able to provide timely and appropriate mental health treatment. Modifies time limits for initial detention. WSIPP must study nonemergency detention and LRA orders. (Incorporates 5644 and 5645/1401.)

E2SHB 1450 passed during the 2015 Legislative session. Relating to involuntary outpatient mental health treatment. Allows a DMHP to seek an LRA order on basis that person is in need of assisted outpatient mental health treatment if person has been committed for inpatient treatment twice within the last 36 months and meets other conditions. Minimum requirements are established for LRA treatment orders, and new procedures for LRA enforcement, modification, and revocation. (Incorporates 1287.)

SSB 6445 passed during the 2016 Legislative session. Relating to clarifying the role of physician assistants in the delivery of mental health services. Expands use of physician assistants in behavioral health care, including involuntary treatment.

2SHB 1448 passed during the 2016 Legislative session. Relating to procedures for responding to reports of threatened or attempted suicide. Requires WASPC to adopt a model policy relating to referral of a person to a mental health agency by law enforcement following a report of threatened or attempted suicide and for all general authority law enforcement agencies to adopt a policy by 7/01/17. Requires DMHPs to arrange for an MHP to contact a person within 24 hours after receiving a referral from law enforcement.

E3SHB 1713 passed during the 2016 Legislative session. Relating to integrating the treatment systems for mental health and chemical dependency. Requires integration of mental health and chemical dependency involuntary treatment systems under a single crisis responder by 4/01/18. Requires DSHS and HCA to convene a task force to align behavioral health regulations with primary care and reduce administrative burdens.

SHB 2541 passed during the 2016 Legislative session. Relating to less restrictive involuntary treatment orders. Allows a facility petitioning for an LRA to recommend conditions without submitting a treatment plan.

HB 2808 passed during the 2016 Legislative session. Relating to amending the process for a person's immediate family member, guardian, or conservator to petition the court for the person's initial detention under the involuntary treatment act. Requires a petition under Joel's Law to be filed in the county where the DMHP evaluation occurred or was requested to occur.

GLOSSARY OF TERMINOLOGY

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

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

Declaration: a sworn statement by a witness, also defined as the "declarant"

Assisted Outpatient Treatment (AOT): a specific type of Less Restrictive Alternative order which is appropriate for individuals who meet specific criteria, can be initiated prior to involuntary inpatient treatment or at any point during a period of commitment, and cannot be revoked but can be enforced or modified

Behavioral Health Treatment: inclusive of mental health treatment, substance use disorder treatment, and co-occurring treatment

Capacity: a medical determination defined as the mental or cognitive ability to understand the nature and effects of one's acts. It is a fluid state and can change based on circumstances, e.g. a person with an infection experiencing delirium or someone who is unconscious; this is a determination made by a medical professional, not a DMHP/DCR

Cognitive Functions: the capacity to accurately know or perceive reality, and to understand the fundamental consequences of one's actions

Competency: a legal determination defined as the ability to understand information relevant to their legal situation and to appreciate the reasonably foreseeable consequences of a decision or lack of decision; this is a determination made by the court, not a DMHP/DCR

No person shall be presumed incompetent as a consequence of receiving an evaluation or voluntary or involuntary treatment for a mental disorder, under this chapter or any prior laws of this state dealing with mental illness. Competency shall not be determined or withdrawn except under the provisions of chapter 10.77 or 11.88 RCW [RCW 71.05.360(1)(b)]

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

Credible: the state of being believable or trustworthy

Designated Crisis Responder (DCR): a mental health professional appointed by the county or other authority authorized in rule to perform the duties specified in RCW 71.05 beginning April 1, 2018, and who has received chemical dependency training as determined by the department (E3SB 1713 Sec 201) RCW 71.05.760

Designated Mental Health Professional (DMHP): a mental health professional designated by one or more counties or other authority authorized in rule to perform the duties specified in this

chapter, such as the applicable Behavioral Health Organization or Fully Integrated Region [RCW 71.05.020(11), RCW 71.34.020(4) and RCW 10.77.010(6)]

Detention vs Commitment: a detention is a 72 hour period of further involuntary evaluation and treatment initiated by a DMHP/DCR under 71.05 or 71.34; a commitment is a court order issued by the judge or commissioner in response to a petition

Dismiss & Detain: a court order dismissing charges and referring the individual to a DMHP/DCR for assessment; this assessment is for a period of 72 hours of evaluation and treatment [RCW 10.77.065]

Dismiss & Refer: a court order dismissing charges and ordering an individual who has been determined to be violent to be evaluated for involuntary treatment in an inpatient psychiatric facility; this evaluation is for a period of 90 days of treatment [RCW 10.77.060]

Good Faith Voluntary: the DMHP/DCR must assess for the ability of an individual to provide informed consent to proposed voluntary treatment; failure to be a "good faith voluntary" patient is not grounds for initial detention under RCW 71.05.150 or RCW 71.05.153; whether or not a Respondent is a "good faith volunteer" is considered under RCW 71.05.230 when a petition for treatment beyond the seventy-two hour evaluation and treatment period is filed

Gravely Disabled: *a condition resulting from a mental disorder in which a person (a) is in danger of serious physical harm resulting from their failure to provide for their own essential human needs of health or safety, or (b) manifests severe deterioration in routine functioning evidenced by repeated and escalating loss of cognitive or volitional control over his or her actions, and is not receiving such care as is essential for his or her health or safety [RCW 71.05.020(17)]*

However, individuals 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 M

Grave disability for extending a 90/180 day less restrictive alternative court order: 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; under these circumstances grave disability does not require that the person be at imminent risk of serious physical harm

History of one or more violent acts: the period of time ten years prior to the filing of a petition under this chapter, excluding any time spent, but not any violent acts committed, in a mental health facility, a long-term alcoholism or drug treatment facility [effective April 1, 2018] or in confinement as a result of a criminal conviction [RCW 71.05.020(19)]

Whenever a DMHP/DCR or professional person is conducting an evaluation under this chapter, consideration shall include all reasonably available information from credible witnesses and records regarding:

• Prior recommendations for evaluation of the need for civil commitments when the recommendation is made pursuant to an evaluation conducted under chapter 10.77 RCW

• Historical behavior, including history of one or more violent acts ("Violent act" means behavior that resulted in homicide, attempted suicide, nonfatal injuries, or substantial damage to property) [RCW 71.05.020(19)]

• Prior determinations of incompetency or insanity under chapter 10.77 RCW

• Prior commitments under this chapter

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

• Such symptoms or behavior are closely associated with symptoms or behavior which preceded and led to a past incident of involuntary hospitalization, severe deterioration, or one or more violent acts

• These symptoms or behavior represent a marked and concerning change in the baseline behavior of the respondent

• Without treatment, the continued deterioration of the respondent is probable

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

Specifically when considering history for assisted outpatient treatment, review of a history of violent acts is only for “recent history”, defined as 3 years [RCW 71.05.245(3)(a)]

Imminent: *the state or condition of being likely to occur at any moment or near at hand, rather than distant or remote [RCW 71.05.020(20)]*

Information and Records Related to Mental Health Services: health care information that relates to all information and records compiled, obtained, or maintained in the course of providing services by a mental health service agency or mental health professional to persons who are receiving or have received services for mental illness.

The term includes mental health information contained in a medical bill, registration records, as defined in RCW 71.05.020, and all other records regarding the person maintained by the department, by regional support networks and their staff, and by treatment facilities. The term further includes documents of legal proceedings under chapter 71.05, 71.34, or 10.77 RCW, or somatic health care information.

For health care information maintained by a hospital as defined in RCW 70.41.020 or a health care facility or health care provider that participates with a hospital in an organized health care arrangement defined under federal law, "information and records related to mental health services" is limited to information and records of services provided by a mental health professional or information and records of services created by a hospital-operated community

mental health program as defined in RCW 71.24.025(6). The term does not include psychotherapy notes [RCW 70.02.010(21)]. Please note, Part 2 CFR 42 may result in differential access to records for SUD treatment.

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

A. a description, in language the patient could reasonably be expected to understand, of:

i. the nature and character of the proposed treatment;

ii. the anticipated results of the proposed treatment;

iii. the recognized possible alternative forms of treatment; and

iv. the recognized serious possible risks, complications, and anticipated benefits involved in the treatment and in the recognized possible alternative forms of treatment, including no treatment;

B. or, as an alternative, a statement that the patient elects not to be informed of the elements set forth in (a) of this subsection [RCW 7.70.060]

Investigation: the act or process of systematically searching for relevant, credible and timely information to determine if: There is evidence that a referred individual may suffer from a mental disorder or substance use disorder (effective April 1, 2018); and

(a) there is evidence that the individual, as a result of a mental disorder or substance use disorder (effective April 1, 2018), presents a likelihood of serious harm to themselves, other individuals, other's property, or the referred individual may be gravely disabled, and

(b) the referred individual refuses to seek appropriate treatment options

[RCW 71.05.150 (1), RCW 71.05.153(1) and RCW 71.34.050]

Joel's Law: also E2SSB 5269, passed during the 2015 Legislative session, allowing for an immediate family member (defined as spouse, domestic partner, child, stepchild, parent, stepparent, grandparent, or sibling), guardian or conservator to petition the court for an individual's immediate detention if the individual was assessed and the DMHP/DCR made the decision not to detain, or, 48 hours have elapsed since the request for investigation and the DMHP/DCR has not taken action to have the person detained. [RCW 71.05.201]

Joel's Law was amended by HB 2808 during the 2016 legislative session, requiring that the petition must be filed in the county in which the DMHP investigation occurred or was requested to occur. [RCW 71.05.201]

Law enforcement officer: 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, park rangers, border

patrol officers, immigration and customs enforcement, tribal police, or a fish and wildlife officer or ex officio fish and wildlife officer as defined in RCW 77.08.010.

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

(a) physical harm will be inflicted by an individual upon their own person, as evidenced by their threats or attempts to commit suicide or inflict physical harm on themselves; or

(b) physical harm will be inflicted by an individual upon another, as evidenced by behavior which has caused such harm or which places another individual or individuals in reasonable fear of sustaining such harm; or

(c) physical harm will be inflicted by an individual upon the property of others, as evidenced by behavior which has caused substantial loss or damage to the property of others; or

(d) the individual has threatened the physical safety of another and has a history of one or more violent acts [RCW 71.05.020(27)]

Medical clearance: *a physician or other health care provider has determined that a person is medically stable and ready for referral to the designated mental health professional. [RCW 71.05.020(28)]*

Mental disorder: *any organic, mental or emotional impairment, which has substantial adverse effects on an individual's cognitive or volitional functions [RCW 71.05.020(29)]*

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

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

Mental Health Professional (MHP): *a psychiatrist, psychologist, physician's assistant working with a supervising psychiatrist, psychiatric advanced registered nurse practitioner, psychiatric nurse, or social worker, and such other mental health professionals as may be defined by rules pursuant to this chapter [RCW 71.05.020(30)]*

Mental health professional (MHP) means a designation given by the department to an agency staff member who is:

(1) A psychiatrist, psychologist, psychiatric advanced registered nurse practitioner (ARNP), or social worker as defined in chapters 71.05 and 71.34 RCW;

(2) A person who is licensed by the department of health as a mental health counselor or mental health counselor associate, marriage and family therapist, or marriage and family therapist associate;

(3) A person with a master's degree or further advanced degree in counseling or one of the social sciences from an accredited college or university who has at least two years of experience in direct treatment of persons with mental illness or emotional disturbance, that was gained under the supervision of a mental health professional and is recognized by the department;

(4) A person who meets the waiver criteria of RCW 71.24.260, which was granted prior to 1986;

(5) A person who had an approved waiver to perform the duties of a mental health professional (MHP), that was requested by the behavioral health organization (BHO) and granted by the mental health division prior to July 1, 2001; or

(6) A person who has been granted a time-limited exception of the minimum requirements of a mental health professional by the division of behavioral health and recovery (DBHR) [WAC 388-877-0200]

Minor: any person under the age of 18 [RCW 71.34.020(15)]

For the purposes of the ITA evaluation, the DMHP/DCR may petition for the involuntary detention of a minor aged 13-17 [RCW 71.34.710]

ORCS Offender Re-entry Community Safety: a category of offenders who have been determined by a multi-agency committee to be at a high risk of violence and also have a mental health disorder

No-Bed Report (also Unavailable Detention Facilities Report): when a DMHP/DCR determines a person meets criteria for involuntary inpatient treatment, but is unable to detain the person at risk due to the lack of an available bed at an Evaluation and Treatment facility or the person cannot be served by the use of a Single Bed Certification, the DMHP/DCR is required to make a report to the Department within 24 hours

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

Reasonably available information: to be considered by the DMHP/DCR [RCW 71.05.212]:

• credible witnesses

• risk assessments and/or discharge summaries from the Department of Corrections (DOC)

• law enforcement

• treatment providers

• family

Other information which may be available and include:

• crisis plan

• mental health advance directive

• other available treatment records

• forensic evaluations under RCW 10.77

• criminal history records

• risk assessments

• any information regarding a history of one or more violent acts (see definition)

• prior civil commitments

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

Secure Detoxification Facility: *a facility operated by either a public or private agency, and certified by the department, that provides evaluation and assessment, acute and subacute detoxification services, and discharge planning by a chemical dependency professional, as well as security measures sufficient to protect the patients, staff, and community for intoxicated persons [RCW 71.05.020(49), 71.05.760(2)(a)] (effective April 1, 2018)*

Approved substance use disorder treatment program: *a program for persons with a substance use disorder provided by a treatment program certified by the department as meeting standards adopted under chapter 71.24 RCW [RCW 71.05.020(4)]*

Secure Detox (pilot project): *a facility operated by either a public or private agency or by the program of an agency that serves the purpose of providing evaluation and assessment, and acute and/or subacute detoxification services for intoxicated persons and includes security measures sufficient to protect the patients, staff, and community [RCW 70.96B.010(39)] (expires April 1, 2018)*

Sheena's Law 2SHB 1448: bill passed by legislature in 2016, requiring that local law enforcement develop a policy, following specific criteria, for referrals to the local DMHP/DCR office, when they are concerned for an individual who has a history of threatening or attempting suicide but does not meet criteria to be taken into custody at that time

Single bed certification: the process for requesting an exception to be granted to allow a facility that is willing and able but is not certified under WAC 388-865-0500 to provide timely and appropriate, involuntary inpatient mental health treatment to an adult on a seventy-two hour detention or fourteen-day commitment or for a maximum of thirty days to allow a community facility to provide treatment to an adult on a ninety- or one hundred eighty-day inpatient involuntary commitment order [RCW 71.05.745, WAC 388-865-0526]

For involuntarily detained or committed children, this exception may be granted to allow timely and appropriate treatment in a facility not certified, 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]

Single bed certification will not be available for individuals detained due to substance use disorder until July 1, 2026

Substance use disorder (SUD): *a cluster of cognitive, behavioral, and physiological symptoms indicating that an individual continues using the substance despite significant substance-related problems; the diagnosis of a substance use disorder is based on a pathological pattern of behaviors related to the use of the substances [71.05.020(52)] (effective April 1, 2018)*

Sufficient environmental controls: an individual 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; this description does not apply to jails, as they are not a less restrictive treatment option

Timeframes:

Individuals presenting voluntarily to a public or private agency for inpatient treatment, who staff feel are at risk of imminent likelihood of serious harm upon request for release, may be held in further custody pending the DMHP/DCR's assessment, no later than **the next judicial day** [RCW 71.05.050(2)]

Individuals brought to an emergency room for observation or treatment, and refusing voluntary treatment, may be held in further custody pending the DMHP/DCR's assessment, **no more than 6 hours**, not counting time periods prior to medical clearance [RCW 71.05.050 (3)]

Individuals taken to a crisis stabilization unit, E&T, emergency department of a local hospital, triage facility, secure detoxification facility, or approved substance use disorder treatment program (effective April 1, 2018) by a peace officer may be held for **up to 12 hours**, not counting time periods prior to medical clearance [RCW 71.05.153 (4)]

Within **3 hours**, the individual must be assessed by a mental health professional; **within 12 hours of the notice of need for evaluation**, the DMHP/DCR must determine if the individual meets criteria for detention [RCW 71.05.153(5)]

A minor, 13 years or older, brought to an evaluation and treatment facility, hospital emergency room, or secure detoxification facility with available space (effective April 1, 2018); the professional person in charge of the facility will evaluate the minor's condition and may arrange for the detention of the minor for **up to 12 hours** to enable a DMHP/DCR to evaluate the minor [(RCW 71.34.700(3)]

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

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

A minor 13 years of age and older may admit himself or herself to an E&T or approved substance use disorder treatment program (effective April 1, 2018) for voluntary inpatient treatment without parental consent, if the professional person in charge of the facility agrees with the need for inpatient treatment [RCW 71.34.500]

The treatment facility will provide notice to the minor's parents within 24 hours of admission [RCW 71.34.510]

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

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

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

Detention of Chorney, (1992), See Appendix M.

Detention of Kirby, (1992), See Appendix M.

Witness: any individual who provides information to the DMHP/DCR in the course of an investigation

Potential credible witnesses may include:

• Family members

• Landlords

• Neighbors

• Others with significant contact and history of involvement with the person

If the DMHP/DCR relies upon information from a credible witness in reaching a decision to detain the individual, contact information for any such witness must be provided to the prosecutor; the DMHP/DCR or prosecutor shall provide notice of the date, time, and location of the probable cause hearing to such a witness [RCW 71.05.212(2)]

REFERRALS

100–Referrals for an ITA Investigation

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

(a) There is evidence that a referred person may suffer from a mental disorder or substance use disorder (effective April 1, 2018); and

(b) There is evidence that the person, as a result of a mental disorder or substance use disorder (effective April 1, 2018), presents a likelihood of serious harm to themselves, other persons, other's property, or the referred person may be gravely disabled, and

(c) The referred person refuses to seek appropriate treatment options.

[RCW 71.05.150 (1), RCW 71.05.153(1) and RCW 71.34.050]

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

As quickly as possible, the DMHP/DCR assesses the degree of urgency and resources available to resolve or contain the crisis, including:

- Whether it is appropriate to involve law enforcement
- Making a request to take the person into custody under RCW 71.05 or RCW 71.34
- Calling 911 or asking the referring person to call 911, if the DMHP/DCR assesses immediate physical danger or safety concerns.
- The DMHP/DCR accepts, screens, and documents all referrals for an ITA investigation.
- Documentation includes the:
- Name of the individual referred for an ITA investigation;
- Name and telephone number of the individual's guardian or other healthcare decision-maker, if applicable.
- Name of caller and relationship to individual being referred;
- Date and time of the referral;
- Facts alleged by the caller
- Available personal information about the individual to be investigated including:
- Demographic information
- Language
- Whether an advance directive may exist (for individuals who may have only received SUD treatment, an advance directive may not be available)
- Whatever history may be available
- Potential sources of support to resolve the crisis
- If a minor, the name of the parent or legal guardian
- Contact information of the referent,
- Names and contact information for potential witnesses, which may include law enforcement, outpatient providers, and anyone meeting the definition of a potential credible witness (see definition of witness)

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

a) Further investigation is indicated
b) There is a need for a second individual to accompany the DMHP/DCR during the outreach to ensure safety needs are met [RCW 71.05.700]
c) crisis behavioral health services or other community services are more appropriate

d) No further service or investigation is indicated

Lack of resources shall not be the criteria for refusing to initiate an ITA investigation. If resources are unavailable, the DMHP/DCR is advised to document actions taken and recommendations for treatment thoroughly, and follow the recommendations of their BHO/ASO/MCO regarding resource utilization and follow-up on treatment recommendations, particularly for Single Bed Certification and No-Bed Report use.

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

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

However, a DMHP/DCR 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 or others [RCW 71.05.153(2)]. It is considered best practice to follow up with a face-to-face assessment afterwards whenever practicable.

105–DMHP/DCR Requirement to Report Suspected Abuse or Neglect
DMHPs/DCRs are "mandatory reporters" of suspected abuse or neglect. Individuals filing reports in good faith are immune from liability. Knowing failure to make a mandatory report, or intentionally filing a false report, is a crime.

If a DMHP/DCR has reasonable cause to believe that abuse, neglect, financial exploitation or abandonment of an individual has occurred, the DMHP/DCR 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/DCR must also immediately make a report to the appropriate law enforcement agency as well as to DSHS.

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

For adults in a Residential Care Facility, Adult Family Homes, and DDA contracted Supportive Living, facilities notify the Residential Care Services Complaint Resolution Unit Hotline at **1-800-562-6078**; or submitted electronically at http://www.adsa.dshs.wa.gov/APS/reportabuse.htm.

For adults not in either a Residential Care Facility or an Adult Family Home reports are to be made to the following regional offices:

Adult Protective Services (APS) Abuse & Neglect Complaint Intake Lines:

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

Department of Health (DOH) Reporting Lines:

Facility and Services Licensing	
Hospitals, clinics, residential facilities	DOH FSL Hotline:1-800-633-6828 DOH FSL Fax Number: 360-236-2626
In-Home Services	
Home care, home health, hospice agency licensed by DOH	DOH FSL Hotline: 1-800-633-6828 DOH FSL Fax Number: 360-236-2626
Health Professionals Quality Assurance Office	
Concerns about licensed professionals	Phone: 360-236-4700 Fax: 360-236-4626

[RCW 74.34.020(8), RCW 74.34.035, RCW 74.34.050, RCW 73.34.053, RCW 26.44.020(3), and RCW 26.44.030(1)(a)]

110–Referrals of a Minor

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

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

Parent Initiated Treatment (PIT) is applicable if the child is under the age of 18, and the parent/guardian/authorized individual brings the child to a mental health facility or a hospital and

requests that a mental health evaluation be provided. If it is determined the child has a mental disorder, and there is a medical need for inpatient treatment, the parent/guardian may request that the child be held for parent initiated inpatient treatment at the evaluation and treatment facility or inpatient facility licensed under statute providing the evaluation. PIT is considered to be a less restrictive alternative to ITA and should be considered prior to an ITA investigation [RCW 71.34.600].

Any evaluation and treatment facility, hospital emergency room, inpatient facility licensed under statute, secure detoxification facility, or other approved substance use disorder treatment program (effective April 1, 2018) to which a parent or guardian brings their minor child requesting mental health or substance use disorder treatment (effective April 1, 2018), must promptly provide written and verbal notice of all available treatment options under statute [RCW 71.34.375].

See Appendix P

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

For a minor who is a state dependent, the DMHP/DCR 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].

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

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

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

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

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

The DMHP/DCR may refer the minor to the County Designated Chemical Dependency Specialist for investigation and evaluation under the chemical dependency commitment statute, RCW 70.96A. (expires 4/1/18)

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

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

[RCW 9.41.280(2) and RCW 9.41.010(9)]

115–Referrals of a Person with Dementia or a Developmental Disability
The DMHP/DCR may not rule out a referral for investigation because of the sole presence of dementia, 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. In cases where the subject of the investigation has a diagnosis of dementia, the DMHP/DCR should explore all less restrictive treatment options including returning to a nursing home (Appendix C) or other residence, increased supports, or empowering and encouraging family to assist in treatment decisions. In cases where the subject of the investigation has a diagnosis of intellectual disability, and may receive services from the Developmental Disability Administration (DDA), the DMHP/DCR should explore all less restrictive treatment options including any resources that may be available through DDA. [RCW 71.05.040]

Please see Appendix E for a list of Regional DDA contacts

120–Referrals of an Adult from a Licensed Residential Care Facility
The four broad categories of licensed care facilities are nursing homes, assisted living facilities, adult family homes, and residential treatment facilities.

Licensed residential care facilities are required to provide individualized services and support and may be considered a less restrictive alternative to involuntary detention. Information that may be helpful to DMHPs when assessing a referral from a facility (i.e.: a summary of residents' rights and a facility's transfer and discharge requirements) is included in Appendix C.

If there is sufficient evidence to indicate that the person, as a result of a mental disorder, is a danger to self or others or other's property, or is gravely disabled, then the DMHP/DCR assesses whether the facility is a less restrictive treatment option. The facility may be considered a potential less restrictive treatment option 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 treatment option.

The checklists in Appendix D may help the DMHP/DCR 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/DCR:

- Whenever possible, it's best if the DMHP/DCR 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/DCR 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/DCR 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/DCR 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/DCR has concerns about facility refusal to re-admit the resident, the DMHP/DCR can notify 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/DCR has concerns about mental health or other services provided by the facility, the DMHP/DCR notifies the Residential Care Services Complaint Resolution Unit (CRU) Hotline for follow-up at 1-800-562-6078. The website to report Adult Family Home abuse is: www.adsa.dshs.wa.gov/APS

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

125–Referrals from a Medical Hospital/Emergency Department
Medical clearance and referral

It is best practice that a medical screening be conducted and that the individual is able to be medically discharged from the medical hospital and/or emergency department prior to referral to a DMHP/DCR. Medical assessment and clearance is the determination of the treating physician and includes multiple factors, of which intoxication is one.

When investigating an individual for detention due to mental health disorder or substance use disorder, the DMHP/DCR should not rule out evaluation of an intoxicated individual. Current intoxication and history of intoxication and substance use should be considered in the assessment of risk, not used as a rule out for assessment or detention. (effective April 1, 2018)

We recognize that there are individuals who do not require hospital level medical care and are medically cleared, but whose medical care needs are more than can be handled by an E&T or psychiatric hospital. These situations may be handled with the use of a single bed certification, if available, or may require further discussion and collaboration with the hospital staff.

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

• Deliver non-emergent medical care to an incompetent patient; or

• Appoint a legal guardian who can make medical decisions on behalf of the patient

[RCW 7.70.050(4), RCW 7.70.065, RCW 11.88.010(1)(e)]

Consultation with an emergency room physician

A DMHP/DCR conducting an evaluation of a person under RCW 71.05.150 or 71.05.153 must consult with any examining emergency room physician regarding the physician's observations and opinions relating to the person's condition, and whether, in the view of the physician, detention is appropriate. The DMHP/DCR shall take serious consideration of observations and opinions by examining emergency room physicians in determining whether detention under this chapter is appropriate. The designated mental health professional must document the consultation with an examining emergency room physician, including the physician's observations or opinions regarding whether detention of the person is appropriate [RCW 71.05.154].

An Appeals Court decision filed August 2016 (In re the Detention of K.R.) highlights the language requiring consultation with "any examining emergency room physician" without regard for the time or location of the investigation. DMHPs/DCRs are advised to document clearly, both in their clinical note and their petitions, their consultation (or lack of consultation and why).

Timelines

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

For Adults:

• If an individual was brought to an emergency department voluntarily, the DMHP/DCR must determine whether the individual meets detention criteria within 6 hours of the emergency department staff determining that a referral to the DMHP/DCR is needed, not counting time periods prior to medical clearance [RCW 71.05.050].

• If an individual was taken to the emergency department by peace officers, a MHP must examine the person within 3 hours of his or her arrival, not counting time periods prior to medical clearance, and the DMHP/DCR must determine whether the person meets detention criteria within 12 hours of receiving the referral, not counting time periods prior to medical clearance [RCW 71.05.153(4)].

• If an individual was voluntarily admitted for inpatient psychiatric treatment and requests discharge, but presents as a risk of harm or gravely disabled the DMHP/DCR must determine whether the individual meets detention criteria no later than end of the next judicial day [RCW 71.05.050].

For Minors:

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

• The DMHP/DCR will evaluate the child at the emergency department and commence proceedings to determine whether the child meets criteria for detention within 12 hours of the referral.

130–Referrals of a Person Using Alcohol and/or Drugs (until April 1, 2018)
DMHPs/DCRs 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.140.

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/DCR conducts an ITA investigation under RCW 71.05 or RCW 71.34.

The DMHP/DCR evaluates the person to determine the presence of a mental disorder when it is clinically appropriate to do so or when the individual is no longer intoxicated by alcohol and/or drugs. If the person does not meet criteria for detention under RCW 71.05 or RCW 71.34, the DMHP/DCR refers the case to an appropriate treatment resource in the community, including petitioning for an AOT evaluation, or initiates a referral to the Designated Chemical Dependency Specialist as clinically indicated.

[RCW 70.96A.120, RCW 70.96A.140 and RCW 70.96A.148]

135–Referrals of American Indians on Tribal Reservations
DMHPs/DCRs should consult with the Tribal government and the county prosecuting attorney regarding any interlocal agreements between the BHO, MCO, or ASO and the Tribal government. Tribal governments may also develop a protocol for Tribal DMHP/DCR staff in collaboration with the BHO, MCO, or ASO in their region.

Appendix F contains a map of Federally Recognized Tribes within the BHOs 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/DCR does not rule out any referral for investigation solely because the individual is incarcerated. Individuals 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 criteria for detention are met. Procedures may vary by region and will depend on agreements developed between the BHO/MCO/ASO, the DMHP/DCR office, the jail, and the court, as well as available resources.

Eligible for Release or Temporary Release Order
The DMHP/DCR obtains information from the facility making the referral regarding:

- the individual's criminal charges status - felony or misdemeanor
- release date, if eligible for release
- the jail policy regarding release – temporary release order, charges dropped once an opinion is provided, etc.
- if there is a Dismiss & Detain or Dismiss & Refer order
    - for Dismiss & Detain orders, the threshold of evidence for evaluation is a preponderance of evidence
    - for Dismiss & Refer orders, the threshold of evidence for evaluation is clear, cogent, and convincing

The DMHP/DCR 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
- Arrest reports

Discharge Review
If contacted, the DMHP/DCR will evaluate the defendant or offender, who is currently incarcerated and the subject of a discharge review, for involuntary mental health treatment within 72 hours prior to release from confinement. This 72 hour period is interpreted by the Department of Corrections to not include weekends and holidays.

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

• Coordinates the process with law enforcement personnel, County Department of Corrections (DOC) representatives, representatives of the legal system and other appropriate persons to the extent permitted by applicable law, including RCW 71.05.153, RCW 70.02, RCW 70.02.230 and RCW 70.02.240, RCW 70.02.250 and RCW 70.02.320.

• Discusses arrangements for transportation to an emergency department for medical clearance and for transportation of the inmate to the evaluation and treatment facility.

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

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

• Been diagnosed with a mental disorder under RCW 71.05.020(26); or

• Is enrolled with DSHS Developmental Disabilities Administration (DDA)

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

143-Referrals from Law Enforcement in the Community
2SHB 1448 (Sheena's Law) passed during the 2016 legislative session, calls for the development of a model policy directing referrals from law enforcement to DMHP/DCR agencies in specific situations when the subject of the referral is not in crisis or at a likelihood of serious harm. Following is a model policy for use by DMHP/DCR agencies in developing their own policies and procedures for receiving and handling these referrals from local law enforcement agencies [RCW 71.05.458]

Please note: These suggested procedures are not an intended substitute for high acuity crisis situations when more immediate outreach or intervention is required.

Define appropriate referrals:

- Adults who are the subject of a report of threatened or attempted suicide
- The responding officer believes that the individual could benefit from mental health treatment
- The individual is safe enough to be left in the community (not in crisis) but may accept treatment from further contact with a mental health professional

This does not apply to:

- Involuntary commitments
- Involuntary transports to an ER or crisis facility
- Voluntary transports to an ER or crisis facility
- Transports to a jail
- Notification from local law enforcement agency

The DMHP/DCR office will coordinate with the local law enforcement agency to develop an agreed upon method for transmitting referrals. The referral should be in writing and include enough information for the DMHP/DCR office to understand the situation. The written referral can be supplemented by a phone call, which should be documented by the DMHP/DCR office as well.

The DMHP/DCR office must facilitate contact (or an attempt to contact) the individual within 24 hours (not including weekends or holidays) of receipt of the written referral.

Documentation in DMHP/DCR office:

- Document receipt of written referral (and phone call if received), including time and date received.
- Document contact (or attempt to contact). If the contact is delegated to a mental health professional outside the DMHP/DCR office, the report back should include information about the need for additional mental health intervention (DMHP/DCR evaluation), and may include other information as determined by the office.
- Documentation should be consistent with your agency's policy for crisis referral documentation and contractual requirements.

Triage:

The DMHP/DCR office will develop a procedure for receipt and triage of referrals and will determine the staff designated to accept, review, and document the referrals. Based on available staff and resources, as well as referral relationships in the community, the DMHP/DCR office will determine the mental health professional who will be assigned to contact (or attempt to contact) the individual.

Contact:

Contact, or attempt to contact, must occur within 24 hours of receipt of the written referral from law enforcement to the DMHP/DCR office. This includes any delegation of the referral to the individual's assigned case manager, the crisis team, or any other mental health professional.

Method of contact (phone, face-to-face) is not defined in statute and must be determined by clinical review in the DMHP/DCR office.

- DMHP/DCR office must define 'good faith effort' in attempting to contact the individual.
- Number of attempts to contact
- Time frame for attempting contacts beyond the 24 hour period
- Procedure if no contact within the 24 hour period
- Contact must include a determination about additional intervention required.

INVESTIGATION PROCESS

200–Rights of an Individual Being Investigated

The DMHP/DCR will advise the individual of their legal rights before beginning an interview to evaluate the person for possible involuntary detention. When a DMHP/DCR investigates an individual for possible involuntary detention the DMHP/DCR shall:

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

The DMHP/DCR should also consider:

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

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

205–Process for Conducting an ITA Investigation

The DMHP/DCR performs or attempts to perform a face-to-face evaluation as part of the investigation before a petition for detention is filed. Regardless of local judicial support, when conducting an investigation for an emergent detention, the DMHP/DCR must also consider criteria for non-emergent detention and AOT. [RCW 71.05.156]

The DMHP/DCR evaluates the facts relating to the individual being referred for investigation based on statute and applicable case law. The DMHP/DCR is advised to seek consultation as needed when conducting an investigation of a child, an older adult, an ethnic minority, or an individual with a medical condition or a disability.

The DMHP/DCR will attempt to determine whether there is a Mental Health Advance Directive (which may not be available for individuals enrolled in SUD treatment) for the individual being investigated. The DMHP/DCR will also attempt to contact any known individuals with the power to make health care decisions to inform them of the investigation and rights of the individual being investigated [RCW 71.32].

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

[RCW 71.05.150 (1) (a) and RCW 71.34.050]

206-Assisted Outpatient Treatment
When conducting an assessment for Assisted Outpatient Treatment (AOT), address the following criteria:

"In need of assisted outpatient mental health treatment" means that a person, as a result of a mental disorder:

(a) Has been committed by a court to detention for involuntary mental health treatment at least twice during the preceding thirty-six months, or, if the person is currently committed for involuntary mental health treatment, the person has been committed to detention for involuntary mental health treatment at least once during the thirty-six months preceding the date of initial detention of the current commitment cycle;

(b) is unlikely to voluntarily participate in outpatient treatment without an order for less restrictive alternative treatment, in view of the person's treatment history or current behavior;

(c) is unlikely to survive safely in the community without supervision;

(d) is likely to benefit from less restrictive alternative treatment; and

(e) requires less restrictive alternative treatment to prevent a relapse, decompensation, or deterioration that is likely to result in the person presenting a likelihood of serious harm or the person becoming gravely disabled within a reasonably short period of time.

For purposes of (a) of this subsection, time spent in a mental health facility or in confinement as a result of a criminal conviction is excluded from the thirty-six month calculation

[RCW 71.05.020(21)]

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

Until July 1, 2026, availability of resources will be a factor for detentions to a Secure Detox Facility. Individuals who meet criteria due to a primary substance use disorder presentation, rather than a primary mental health disorder presentation, will not be eligible for treatment in a facility on a Single Bed Certification (effective April 1, 2018). If no resources are available the DMHP/DCR will follow BHO, MCO, or county practices, and will complete a No-Bed Report.

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

1. Pursue certified E&T beds or certified Secure Detox beds (effective April 1, 2018) in counties within close proximity
2. Locate and secure certified E&T beds or certified Secure Detox beds (effective April 1, 2018) elsewhere within the state
3. Request a Single Bed Certification according to WAC 388-865-0526 (if pursuing an E&T bed only until July 1, 2026)
4. Complete a No-Bed Report according to RCW 71.05.755

E&T or Secure Detox not available

When conducting an ITA investigation in circumstances which suggest an E&T or Secure Detox (effective April 1, 2018) bed may not be readily available to meet the treatment needs of an individual, the DMHP/DCR will proceed as follows:

1. The DMHP/DCR determines whether or not the person meets detention criteria, observing legally required time frames, following all applicable Washington State laws for the ITA or LRA process.
2. If the detention investigation occurs in a hospital or hospital emergency department, the DMHP/DCR will notify treating hospital medical staff of their findings.
3. When the DMHP/DCR determines that the individual meets emergent detention criteria, the DMHP/DCR either:
    a. locates an E&T or Secure Detox (effective April 1, 2018) bed and secures provisional acceptance from that facility or;
    b. makes a determination that the individual's treatment needs can be met with a Single Bed Certification (for mental health detention only until July 1, 2026) and secures provisional acceptance from that facility

Single Bed Certification

1. If an E&T bed is required and no E&T bed can be located, the BHO/MCO/ASO or its designee, responsible for the region in which the DMHP/DCR is designated should locate an appropriate bed capable of providing individualized treatment and request single bed certification from the State Hospital which serves their BHO/MCO/ASO.
2. The Single Bed Certification Form requires that the BHO/MCO/ASO or its designee, by signing the form, documents that the facility confirmed it is willing and able to provide adequate treatment services and that the facility will provisionally accept placement upon receipt of the approved Single Bed Certification.
    a. The State Hospitals will only process requests submitted on the most current form (found here https://www.dshs.wa.gov/bha/division-behavioral-health-and-recovery/designated-mental-health-professionals).
    b. If the request is for a minor, the facility must submit the written request [WAC 388-865-0526 (1)].
    c. 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).

3. The State Hospital will process the request within two hours and fax the approved request back to the representative of the BHO/MCO/ASO.
4. Upon receipt of the state hospital approved Single Bed Certification Form, the person may be served the ITA or LRA Revocation paperwork.
5. The DMHP/DCR will provide a copy of the approved Single Bed Certification Form to the facility where the person is held.
6. The DMHP/DCR will file or attempt to file the ITA or LRA Revocation paperwork with the Superior court of the county where the person is physically present (It is suggested that DMHP/DCR get a court certified copy of the legally filed paperwork to send with the client if an E&T bed is found in another county). [RCW 71.05.160, RCW 71.05.340 and RCW 71.34.710, RCW 71.34.780]

No-Bed Report (Unavailable Detention Facilities Report Form)
If the DMHP/DCR cannot find a hospital which is willing to accept a Single Bed Certification, or there is no Secure Detox bed available (until July 1, 2026), the DMHP/DCR will follow the procedural guidelines developed by his or her BHO/MCO/ASO:

1. The individual cannot be detained unless there is a bed to detain to them – either E&T, Secure Detox, or Single Bed Cert in a facility willing and able to provide services.
2. The ITA investigation is concluded when a determination is reached. If the determination is that the individual meets criteria for detention, but there is no available bed, the investigation is still concluded.
3. If the individual is not detained because there is no available bed, a new referral can be accepted if the individual continues to present as meeting criteria for detention.
4. When an individual meets criteria for detention but cannot be detained due to no available bed, follow the procedure determined by the BHO/MCO/ASO. These procedures may vary by region based on available resources and may include:
    a. Assessment and search for an available bed every 24 hours
    b. Coordination with a hospital emergency room to provide care under their authority and maintain physical safety until a bed can be located.
    c. Follow-up in the community by crisis services to re-assess for safety if the individual is released.

The DMHP/DCR does not have legal authority to dismiss or "drop" the ITA or LRA hold. This must be done by the treating physician or person in charge of the facility [RCW 71.05.210 and RCW 71.34.770].

210–Evaluation to Determine the Presence of a Mental Disorder
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 this section [RCW 71.34.020(13)].

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/DCR assesses an individual's behavior, judgment, orientation, general intellectual functioning, specific cognitive deficits or abnormalities, memory, thought process, affect, and impulse control.

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

215–Assessment to Determine Presence of Dangerousness or Grave Disability
"Likelihood of serious harm" 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(27)].

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

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

Is in danger of serious physical harm resulting from a failure to provide for his or her essential human needs of health or safety RCW 71.05.020(17)(a); or

Manifests severe deterioration in routine functioning evidenced by repeated and escalating loss of cognitive or volitional control over his or her actions and is not receiving such care as is essential for his or her health or safety [RCW 71.05.020(17)(b)].

See Appendix K.

"Imminent" means the state or condition of being likely to occur at any moment; near at hand, rather than distant or remote [RCW 71.05.020(20)].

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

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

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

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

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

A DMHP/DCR who conducts an evaluation for imminent likelihood of serious harm or imminent danger because of being gravely disabled under RCW 71.05.153 must also evaluate the individual under RCW 71.05.150 for likelihood of serious harm or grave disability that does not meet the imminent standard for emergency detention, and to determine if the individual is in need of assisted outpatient treatment [RCW 71.05.156].

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

220–Use of Reasonably Available History
Information to be considered by the DMHP/DCR [RCW 71.05.212]:

- credible witnesses
- risk assessments and/or discharge summaries from the Department of Corrections (DOC)
- law enforcement
- treatment providers
- family

Other information which may be available and include:

- crisis plan
- mental health advance directive
- other available treatment records
- forensic evaluations under RCW 10.77
- criminal history records
- risk assessments
- any information regarding a history of one or more violent acts (see definition)
- prior civil commitments

The DMHP/DCR searches reasonably available records and/or databases in order to obtain the individual's background and history, including the Developmental Disabilities Administration if appropriate. Possible sources of information can be found in Appendix H.

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

The DMHP/DCR's pursuit of reasonably available history is always considered in light of the statute's intent to provide prompt evaluation and timely and appropriate treatment.

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

DMHP/DCR documents efforts to obtain reasonably available history.
[RCW 71.05.212 and RCW 71.05.245]

225–Interviewing Witnesses as Part of an Investigation

Credible means the state of being believable or trustworthy

Reliable means the state of being accurate in providing facts; a reliable person provides factual information and can be expected to report the same facts on different occasions; a reliable witness is typically expected to be available if needed to consult with attorneys, treatment team members, or to testify in court
The DMHP/DCR must consider information provided from credible witnesses [RCW 71.05.212]. For minors, the DMHP/DCR shall investigate the specific allegations and the credibility of the witnesses [RCW 71.34.710]. Information obtained from the parent, legal guardian, care providers, school, juvenile justice and other involved systems may be used to further the investigation. For minors currently receiving mental health services, attempts will be made to interview the service providers for the most current information/evidence related to the investigation.

A DMHP/DCR shall:

- Interview potentially credible witnesses who may have pertinent information. Credible witnesses may include family members, landlords, neighbors or others with significant

contact or history of involvement with the individual, including persons identified by the individual being investigated.

- Assess the specific facts alleged and the reliability and credibility of any individual providing information that will be used to determine whether to initiate detention;
- Inform the prosecuting attorney of the contact information for credible witnesses;
- Exercise reasonable professional judgment regarding which witnesses to contact before deciding if an individual should be detained. This may include whether the witness's story is consistent, plausible, free from bias or personal interest and able to be corroborated by other individuals or physical evidence
- Inform witnesses that they may be required to testify in court under oath and may be cross-examined by an attorney. If known, the DMHP/DCR will inform any possible witness of the date, time and location of the probable cause hearing. If unknown, the DMHP/DCR will provide any possible witness with the telephone number of the prosecuting attorney.
- A DMHP/DCR must consult with any examining emergency room physician when conducting an evaluation for emergent, non-emergent, or the need for assisted outpatient treatment, and give serious consideration to the observations and opinions of the examining emergency room physician [RCW 71.05.154]. The DMHP/DCR must document this consultation, or the reason for lack of consultation, both in the petition and in case documentation.

230–Consideration of Less Restrictive Alternatives to Involuntary Detention

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

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

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

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

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

- 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
- Either renews or facilitates contact with the individual when requested
- Completes a No-Bed Report if the decision not to detain is due to lack of an available bed (see 207-Availability of Resources)
- Also determines if the individual is in need of Assisted Outpatient Treatment

236 – Joel's Law
If a DMHP/DCR makes the determination not to detain an individual for emergent or non-emergent detention, or 48 hours have elapsed since the DMHP/DCR office received a request for an ITA investigation and have not taken steps to detain the individual; an immediate family member, guardian, or conservator may file a petition with the superior court of the county in which the investigation occurred or was requested to occur, for the individual's initial detention [RCW 71.05.201].

When accepting referrals for initial detention investigations, the DMHP/DCR must inquire if the referral comes from an immediate family member, guardian, or conservator. If so, and the individual is not detained, or the referral is not acted upon within 48 hours; the DMHP/DCR must inform the referent regarding the process to petition for court review [RCW 71.05.203].

The decision not to detain, or to not act on a referral, can be for any reason (doesn't meet criteria, agreeable to voluntary hospitalization, meets criteria but no bed available, current jail hold that cannot be dropped, individual cannot be located etc.), and does not affect the ability of the immediate family member, guardian, or conservator to file a petition for initial detention.

For the purposes of 71.05.201 and 71.05.203 only, immediate family member is defined as: spouse, domestic partner, child, stepchild, parent, stepparent, grandparent, or sibling.

The immediate family member, guardian or conservator may file a petition for initial detention at any time after the determination not to detain, or the 48 hour period following a request for detention.

Once filed, the court has one day to review the petition, and five days to make a determination regarding the order. Once the order is issued, the DMHP/DCR office must find, apprehend, and arrange for placement in a treatment bed without delay. The order is good for 180 days.

DETENTIONS

300–Rights of an Individual Being Detained
When assessing an individual for detention, the DMHP/DCR must inform the individual of his/her rights, as follows:

• At the beginning of the interview, 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 wants to consult with an attorney, the DMHP/DCR will stop the interview while continuing on with the evaluation and detention process.

• Inform the individual of their rights in detention, either orally or in writing. For individuals who are not proficient in English, rights should be provided in writing in a language that the individual is able to understand or read by a certified interpreter, if that person is available. If requested by the individual being detained, the DMHP/DCR reads the rights to the individual in their entirety.

• As soon as possible following the detention, the DMHP/DCR 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/DCR 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/DCR proceeds with detention if the healthcare decision-maker is not available.

• As soon as is reasonably possible, the DMHP/DCR attempts to contact any known individuals with the power to make health care decisions to inform them of the detention and rights of the person being detained.

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

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

305–Detention in the Absence of Imminent Harm
Imminent: 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)]

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

If an adult meets the criteria for detention, but the likelihood of serious harm presented is not imminent, then the DMHP/DCR may initiate a non-emergency detention. The DMHP/DCR petitions the Superior Court for an order directing the DMHP/DCR to detain the adult to an evaluation and treatment facility or Secure Detox facility if a bed is available (effective April 1, 2018 – July 1, 2026).

A DMHP/DCR who conducts an evaluation for imminent likelihood of serious harm or imminent danger because of being gravely disabled under RCW 71.05.153 must also evaluate the person under RCW 71.05.150 for likelihood of serious harm or grave disability that does not meet the imminent standard for emergency detention and for the need for assisted outpatient mental health treatment [RCW 71.05.156].

A history of violent acts (see definition) may support a non-emergent detention, even without current, immediate risk, if the individual's pattern of behavior indicates they may decompensate and become violent again without intervention.

Establishing imminent harm is not required for the emergency detention of minors.

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/DCR requests that the facility staff 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.
- The DMHP/DCR may arrange the transportation of an individual from a licensed residential care facility.

315–Detention to a Facility in another County
When a DMHP/DCR detains an individual to an inpatient evaluation and treatment facility in another county, the detaining DMHP/DCR must:

- Send the documentation of Petition for Initial Detention, to the admitting facility within the statutory time limit
- Agree to testify, if necessary, at any court hearings
- Inform any potential witness needed for the court hearings that they may need to be available to testify at the hearings
- Make a copy of legal paperwork for office records

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/DCR must file a copy of the petition for initial detention, proof of service of notice, and a copy of the notice of rights and notice of detention with the court and serve the individual's designated attorney a copy of these documents.

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

[RCW 71.05.160 and RCW 71.34.710(2)]

325–Notification if Detained Individual has a Developmental Disability
If an individual who is known to be a client of the Developmental Disabilities Administration (DDA) is involuntarily detained, the DMHP/DCR notifies, by the next judicial day following the initial detention, a designated representative of DDA of this action [RCW 70.02.230(2)(r)].

See Appendix E.

330–DMHP Responsibilities if Detained Individual is a Foreign National
The Vienna Convention and related bilateral agreements place additional requirements on DMHPs/DCRs when detaining an individual who is a citizen of a foreign country (foreign national). Specific information pertaining to this requirement is contained in Appendix I.

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

In all cases, the DMHP/DCR documents:

• The date and time the foreign national was informed of his/her consular rights;

• The date and time any notification was sent to the relevant consular officer; and

• Any actual contact between the foreign national and the consular officer.

Additional contact information for foreign consular offices is located at the following link:

https://travel.state.gov/content/travel/en/consularnotification.html

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

LESS RESTRICTIVE ALTERNATIVE COURT ORDERS

400–Rights of an Individual Evaluated and Detained for a Revocation Hearing

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

• A revocation hearing to determine whether he/she will be detained for up to the balance of his/her commitment must be held **within five days** following the date of the petition to revoke the CR/LRA Court Order RCW [71.05.590(4)(b)]. Consult with prosecutor of local jurisdiction for clarification regarding judicial versus calendar days.

• For minors, a revocation hearing must be held **within seven calendar days** following the date of petition to revoke the CR/LRA Court Order [RCW 71.34.780(3)].

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

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

• Closely monitoring CR/LRA Court orders by documenting in the individual's clinical record the need for revocation

• Providing the DMHP/DCR with information needed to support petitions for further court-ordered less restrictive treatment

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

[RCW 71.05.320 and WAC 388-877A-0195]

410–Criteria for Extending CR/LRA Court Orders for Adults

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

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

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

a. During the current period of court ordered treatment the individual has threatened, attempted, or inflicted physical harm upon the person of another, or substantial damage upon the property of another, and as a result of mental disorder presents a likelihood of serious harm; or

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

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

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

e. The individual was previously committed by a court detention for involuntary treatment in the previous 36 months (exclusive of hospitalization or incarceration time) that preceded the individual's 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].

Maximum time period for extension is 180 days, even for initial orders of 365 days.

415–Petitions for Extending a LRA Court Order for Adults
Prior to expiration of a CR a new LRA petition may be filed under RCW 71.05.320(3) or (4). 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 LRA.

The following are the procedures to follow when evaluating an adult for extending a LRA Court Order:

- Evaluate the individual's current condition
- Consider the cognitive and volitional functioning of the individual prior to court ordered treatment
- Assess 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; and
- Consider the individual's history as well as their pattern of decompensation

If the petitioning DMHP/DCR 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/DCR is not providing a declaration, the case manager is to include either declarations from:

- Two physicians
- A physician and a mental health professional
- A physician assistant and a mental health professional
- A psychiatric advanced nurse practitioner and a mental health professional

The declarants must have examined the individual.

[RCW 71.05.290(2)]

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

a. The individual is in danger of serious physical harm resulting from a failure to provide for his/her essential human needs of health or safety, or for a minor, is not receiving such care as is essential to his/her health and safety from a responsible adult; or

b. The individual manifests severe deterioration in routine functioning evidenced by repeated and escalating loss of cognitive or volitional control over his/her actions and is not receiving such care as is essential to his/her self and safety.

When extending a LRA Court Order, the DMHP/DCR gives great weight to evidence of prior history or pattern of decompensation and discontinuation of treatment resulting in:

- Repeated hospitalizations
- Repeated police intervention resulting in juvenile offenses, criminal charges, diversion programs or jail admissions

[RCW 71.05.285]

420–Procedure and Criteria for Modifying, Enforcing, or Revoking a CR/LRA Court Order for Adults
Revocation (for CR/LRA Orders)

If the DMHP/DCR finds that the individual meets criteria for revocation, they may cause the person to be taken into custody and placed into inpatient treatment. In the process of taking the referral for revocation assessment, the DMHP/DCR must ensure that the treatment provider making the referral has explored all appropriate options for modification and enforcement prior to considering revocation.

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

- Complete and file the Petition for Revocation and accompanying paperwork, and attaches a copy of the CR/LRA Court Order
- Serve the individual a copy of the paperwork
- Inform the outpatient treatment provider or 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/DCR informs the potential witnesses of the date, time and place of the hearing and telephone number of the prosecutor's office.
- The DMHP/DCR may modify or rescind the order at any time prior to the hearing.
- Venue for revocation proceedings is in the county in which the petition is filed.

Criteria for revocation:

a) That a flexible range of responses appropriate to the circumstances have been considered and attempted, and

b) The individual fails to comply with the terms and conditions of his/her CR/LRA Court Order;

c) The individual experiences substantial deterioration in his/her condition;

d) There is evidence of substantial decompensation with a reasonable probability that the decompensation can be reversed by further inpatient treatment; or

e) The individual poses a likelihood of serious harm

Modification & Enforcement (for CR/LRA and AOT orders)

If the DMHP/DCR finds that the individual's needs are best met by modification or enforcement of the order, other than revocation, or the order is for AOT, they may utilize one of the following responses:

- The DMHP/DCR may counsel, advise, or admonish the person as to their rights and responsibilities under the court order
- May offer incentives to motivate compliance
- May increase the intensity of outpatient services
- May request a court hearing for review and modification of the court order (The request must be made to the court with jurisdiction over the order and specify why the modification is necessary. The county prosecutor shall assist in requesting this hearing and issuing a summons)
- May cause the person to be transported to a facility providing services, triage facility, crisis stabilization unit, emergency department, or E&T and held for up to 12 hours for the purpose of further evaluation

[RCW 71.05.590]

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

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

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

- determines 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;
- and may order that the minor be taken into custody and transported to an inpatient evaluation and treatment facility;
- 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
- inform the minor at the time of service of the right to a hearing and to representation by an attorney;
- may modify or rescind the order of apprehension and detention at any time prior to the hearing.

The DMHP/DCR files the revocation petition in the county in which the less restrictive alternative treatment is ordered. A petition for revocation of conditional release may be filed with the court in the county ordering inpatient treatment or the county where the minor on conditional release is residing.

[RCW 71.34.780]

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

CONFIDENTIALITY

500–General Provisions on Confidentiality

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

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

Referents may be advised that the investigation has been completed.

Code of Federal Regulations (CFR) 42 § 2.51 Medical emergencies.

(a) General Rule. Under the procedures required by paragraph (c) of this section, patient identifying information may be disclosed to medical personnel who have a need for information about a patient for the purpose of treating a condition which poses an immediate threat to the health of any individual and which requires immediate medical intervention.

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

Whenever any person is detained for evaluation and treatment pursuant to this chapter, both the person and, if possible, a responsible member of his or her immediate family, personal representative, guardian, or conservator, if any, shall be advised as soon as possible in writing or orally, by the officer or person taking him or her into custody or by personnel of the evaluation and treatment facility where the person is detained unless the person is released or voluntarily

admits himself or herself for treatment within seventy-two hours of the initial detention. [RCW 71.05.360(5)]

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

510–Sharing Information with Law Enforcement
Information may be shared with law enforcement in the following situations:

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

515–Sharing Information with Department of Corrections Personnel
Information must be shared with the Department of Corrections (DOC), including Community Corrections Officers, regarding individuals supervised by DOC who have failed to report or who are involved in an emergent situation that poses significant risk to the public or the offender.

At DOC's oral request for information, the DMHP/DCR shall provide information regarding:

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

At DOC's written request for information within 24 hours, DMHPs/DCRs shall release "information related to mental health services" for DOC personnel to carry out their duties. This includes all "relevant records and reports" (i.e. all information and records compiled, obtained, or maintained in the course of providing services to either voluntary or involuntary recipients of services by a mental service provider." RCW 70.02.250 and WAC 388-865-0610.

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

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

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

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

• Department of Corrections that he or she is treating the offender;

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

520–Sharing Information to Protect Identified Persons

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

• Call the individual/victim who has been threatened or harassed;

• Release information as is pertinent to the threat or harassment and date of detention if applicable;

• Inform the accepting facility of the threat and the identified victim's contact information;

• Document the notifications in the case write up;

• Make sure that the fact of release is noted in the case; and

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

RCW 70.02.230(2)(h)(i) and RCW 70.02.240]

See Appendix O.

APPENDICES

Appendix A: 2016 Designated Mental Health Professionals Protocol Workgroup Members

Staci Cornwell	Frontier Behavioral Health
S. Brandon Foister	Compass Health
Misty Barganski	Compass Health
Sandy Whitcutt	North Sound BHO
Richard VanCleave	Salish BHO
Kathy Robertson	Salish BHO
Gregory Robinson	Washington Council for Behavioral Health
Joan Miller	Washington Council for Behavioral Health
Adelina Dana	Thurston-Mason BHO
Loni Greninger	Division of Behavioral Health and Recovery
Diane Swanberg	King County Crisis and Commitment Services
Jeff Hite	Clark County Department of Community Services
Tonya Stern	Spokane County Regional BHO
Brian Austin	Snohomish County Human Services
Karie Rainer	Department of Corrections
Lisa Westlund	Clark County Department of Community Services
Tera Stickley	Cascade Mental Health
B. Tenzin Denison	Okanogan Behavioral Healthcare
Eric Skansgaard	Catholic Family and Child Services
Lara Toney	Thurston-Mason BHO

Kevin Black	Senior Counsel for Senate Human Services, Mental Health & Housing Committee
Carola Schmid	Snohomish County Human Services
Thomas Fuchs	Division of Behavioral Health and Recovery
Nate Hinrichs	MultiCare Good Samaritan Behavioral Health
Brittney Jensen	Peninsula Behavioral Health
Drew McDaniel	Columbia Wellness
Tiffany Buchanan	Behavioral Health Resources
Ian Harrel	Behavioral Health Resources
Chrisann Christensen	Blue Mountain Counseling
Anne Mizuta	King County Prosecuting Attorney
Renee Morrison	Pend Oreille County Mental Health Services
Amanda Zepeda	Adams County Integrated Health Care Services

Appendix B: County Prosecutor's Office Phone List

County	Prosecuting Attorney	Telephone/Fax	Email Address
Adams	Randy J. Flyckt	509-659-3219 (t) 509-659-3224 (f)	randyf@co.adams.wa.us
Asotin	Benjamin C. Nichols	509-243-2061 (t) 509-243-2090 (f)	bnichols@co.asotin.wa.us
Benton	Andrew K. Miller	509-735-3591 (t) 509-736-3066 (f)	andy.miller@co.benton.wa.us
Chelan	Douglas Shae	509-667-6202 (t) 509-667-6490 (f)	douglas.shae@co.chelan.wa.us
Clallam	Mark B. Nichols	360-417-2301 (t)	prosecutor@co.clallam.wa.us
Clark	Anthony F. Golik	360-397-2261 (t) 360-397-2230 (f)	tony.golik@clark.wa.gov
Columbia	Rea Culwell	509-382-1197 (t) 509-382-1191 (f)	rculwell@waprosecutors.org
Cowlitz	Ryan Jurvakainen	360-577-3080 (t) 360-414-9121 (f)	
Douglas	Steven M. Clem	509-745-8535 (t) 509-745-8670 (f)	sclem@co.douglas.wa.us

Ferry	Kathryn I. Burke	509-775-5206 (t) 509-775-5212 (f)	
Franklin	Shawn P. Sant	509-545-3543 (t) 509-545-2135 (f)	ssant@co.franklin.wa.us
Garfield	Matthew Newberg	509-843-3082 (t) 509-843-2337 (f)	mnewberg@co.garfiled.wa.us
Grant	Garth Dano	509-754-2011 (t) 509-754-6574 (f)	
Grays Harbor	Gerald Fuller	360-249-3951 (t) 360-249-6064 (f)	gfuller@co.grays-harbor.wa.us
Island	Gregory M. Banks	360-679-7363 (t) 360-240-5566 (f)	gregb@co.island.wa.us
Jefferson	Michael Haas	360-385-9180 (t) 360-385-9186 (f)	
King	Dan Satterberg	206-296-9067 (t) 206-296-9013 (f)	dan.satterberg@kingcounty.gov
Kitsap	Tina R. Robinson	360-337-7174 (t) 360-337-4949 (f)	
Kittitas	Gregory L. Zempel	509-962-7520 (t) 509-962-7022 (f)	gregz@co.kittitas.wa.us
Klickitat	David R. Quesnel	509-773-5838 (t) 509-773-6696 (f)	davidq@kilckitatcounty.org
Lewis	Jonathan L. Meyer	360-740-1240 (t) 360-740-1497 (f)	jonathan.meyer@lewiscountywa.gov
Lincoln	Jeffrey S. Barkdull	509-725-4040 (t) 509-725-3478 (f)	jbarkdull@co.lincoln.wa.us
Mason	Michael Dorcy	360-427-9670 x417(t) 360-427-7754 (f)	micheaD@co.mason.wa.us
Okanogan	Karl F. Sloan	509-422-7280 (t) 509-422-7290 (f)	ksolan@co.okanogan.wa.us
Pacific	Mark McClain	360-875-9361 (t) 360-875-9362 (f)	
Pend Oreille	Dolly N. Hunt	509-447-4414 (t) 509-447-0235 (f)	
Pierce	Mark Lindquist	253-798-7400 (t) 253-798-6636 (f)	mlindqu@co.pierce.wa.us
San Juan	Randall K. Gaylord	360-378-4101 (t) 360-378-3180 (f)	randyg@sanjuanco.com
Skagit	Richard Weyrich	360-336-9460 (t) 360-336-9347 (f)	richardw@co.skagit.wa.us
Skamania	Adam N. Kick	509-427-3790 (t) 509-427-3798 (f)	kick@co.skamania.wa.us
Snohomish	Mark K. Roe	425-388-6330 (t) 425-388-7172 (f)	mroe@snoco.org

Spokane	Larry H. Haskell	509-477-3662 (t) 509-477-3409 (f)	
Stevens	Timothy D. Rasmussen	509-684-7500 (t) 509-684-8310 (f)	trasmussen@co.stevens.wa.us
Thurston	Jon Tunheim	360-786-5540 (t) 360-754-3358 (f)	tunheij@co.thurston.wa.us
Wahkiakum	Daniel H. Bigelow	360-795-3652 (t) 360-795-6506 (f)	dbigelow@wapa-sep.wa.gov
Walla Walla	James L. Nagel	509-524-5445 (t) 509-524-5485 (f)	jnagle@co.walla-walla.wa.us
Whatcom	David S. McEachran	360-676-6784 (t) 360-738-2532 (f)	dmceachr@co.whatcom.wa.us
Whitman	Denis P. Tracy	509-397-6250 (t) 509-397-5659 (f)	denist@co.whitman.wa.us
Yakima	Joseph A. Brusic	509-574-1210 (t) 509-574-1211 (f)	joseph.brusic@co.yakima.wa.us

Appendix C: Requirements of Licensed Residential Care Facilities

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

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

Licensed residential care facilities that serve residents with dementia, mental illness, or a developmental disability are required to receive training to provide individualized services to

these populations. However, the availability and capacity of staff resources to offer additional services in response to emergent needs varies in residential environments and is relevant when the DMHP/DCR is considering if the services and treatment needed by the resident can be provided by the facility as a less-restrictive alternative.

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

Adult Family Homes http://www.adsa.dshs.wa.gov/professional/afh.htm

Assisted Living Facilities http://www.adsa.dshs.wa.gov/Professional/bh.htm

Skilled Nursing Facilities http://www.adsa.dshs.wa.gov/professional/nh.htm

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

Resident rights provisions in statute: http://apps.leg.wa.gov/RCW/default.aspx?cite=70.129

Adult Family Home Professionals: http://www.adsa.dshs.wa.gov/professional/afh.htm

Assisted Living Facilities Professionals: http://www.adsa.dshs.wa.gov/professional/bh.htm

Skilled Nursing Facility Professionals: http://www.adsa.dshs.wa.gov/professional/nh.htm

Appendix D: DMHP/DCR Intervention Checklist

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

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

TREATMENT SUGGESTIONS

1. Has the facility nurse or resident's treating physician been consulted regarding the resident's needs? What recommendations were provided? How has the resident responded? If recommendations have not been implemented, what is the reason?
2. What lab work, if any, has been done to rule out medical issues? Example: UA, electrolytes, TSH, B12, diagnosis, folic acid, medication levels.
3. Has a pain assessment been completed?
4. Is there any possibility of constipation, dehydration, GI distress or 02 deficiency?
5. What medications does the resident receive? Have there been any medication changes recently? If so, do they correlate in any way to the behavioral changes?

6. Has the resident experienced any environmental or social changes recently? For example, any recent losses, change of residence?
7. Are PRN medications being used as ordered? Are they effective? If so, has the treating physician considered ordering as routine medications?
8. Are behavior changes documented? What interventions have been attempted and what is the documented outcome? Does documentation address duration, intensity and frequency of the behaviors as necessary to assess effectiveness of current interventions? For an individual in a skilled nursing facility, has the individual been identified as having indicators of mental illness on the Pre-Admission Screening Resident Review (PASSR) evaluation?
9. What specifically deescalates the behaviors? Example: staff or family attention or presence, being left alone, removal from/of visual or auditory stimuli. Have all alternatives utilizing these options been explored?
10. Has the family, as appropriate, been notified of the problem and involved in interventions or response plans?
11. Have hospice services been considered as a resource to assist in end-of-life concerns?

BEHAVIORAL INTERVENTION SUGGESTIONS

1. Remove the resident from excessive auditory and visual stimuli. Provide a calm, quiet, peaceful space for the resident to regroup.
2. Use a calm, quiet voice, no matter what the resident's voice tone or level is.
    a. Allow time for the resident to vent before trying to intervene, unless danger to self or others is involved.
    b. Offer time for the resident to communicate his/her concerns, even if they are irrelevant or delusional.
3. Increase consistent structure in the resident's daily routine.
4. Redirect the resident toward a new interest, rather than away from the object, person or topic involved in the behavior. Reorient the resident without disagreeing with him/her.
5. Offer rest and position change. Change the surrounding, the resident's room assignment or roommate.
6. Assign the resident tasks that meet their strength and history. Short, repetitive tasks are often best.
7. Go along with, or accommodate a fixed delusion or perseverative thought rather than fight it.
8. Let the resident tell you what will help and work with the family or support system to find creative ways to make it happen. Example: "I want to go home"—allow the family to recreate as much as possible the one room or space in the house that resident found the most comfortable.
9. Utilize PRN medications as ordered.

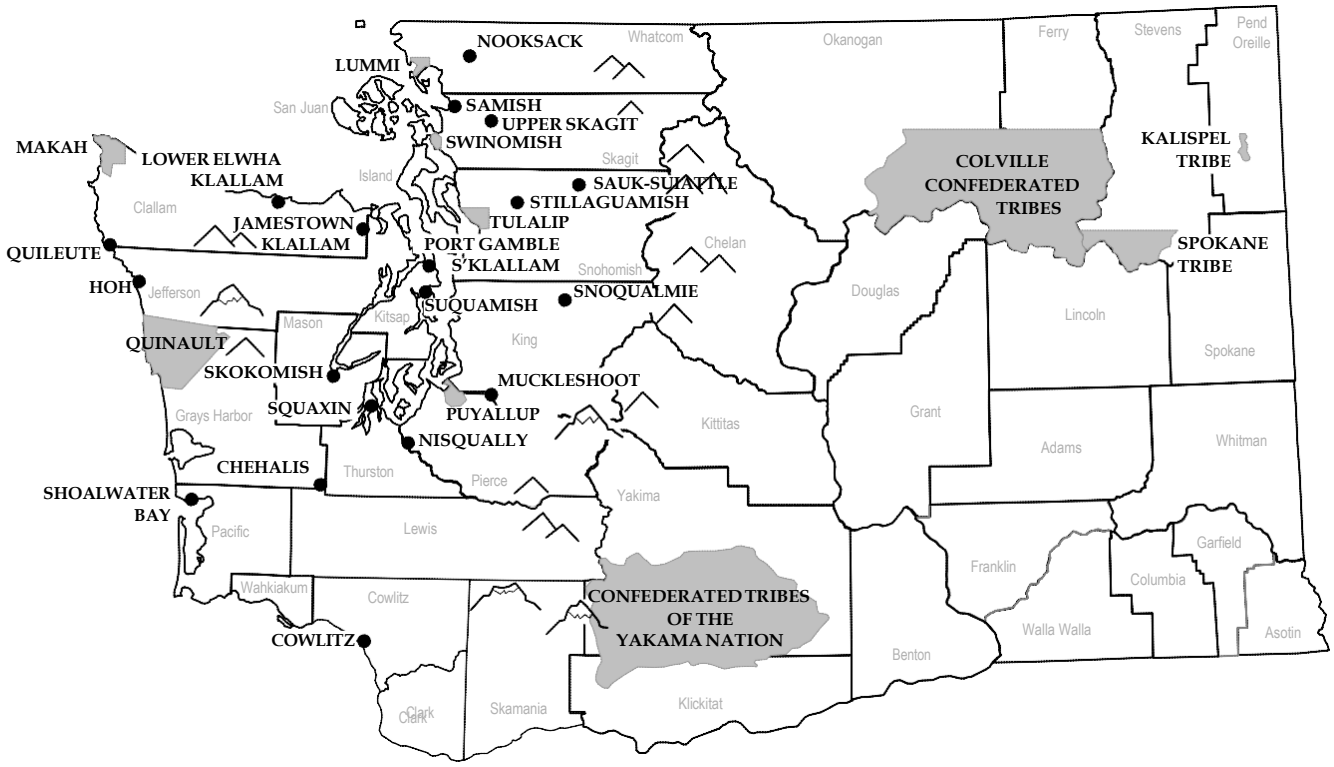
Appendix E: DDA Contacts Listed by BHO/FIR and County - for DMHPs/DCRs

BHO	DDA Staff Contacts	DDA Fax/Cell numbers
Chelan-Douglas	Risa Salters 509-665-5296 Tory Fiedler 509-225-4626	509-374-7103 (f) 509-308-1228 (c)
Grays Harbor	Jeff Green 360-725-4305 Amee Kile 360-725-4282	360-568-6502 (f)
Greater Columbia	509-734-2111	509-734-7103 (f)
Tri-Cities/Walla Walla	Nikki Reed 509-374-2122 Tory Fielder 509-225-4626	509-574-5607 (f) 509-728-4203 (c)
Asotin/Pullman	Tory Fielder 509-225-4626	509-574-5607 (f) 509-969-9049 (c)
Yakima/Ellensburg	Itza Reyes 509-225-4636 Tory Fielder 509-225-4626	509-574-5607 (f) 509-840-4472 (c)
King	Dan Peterson 206-568-5670 Gene McConnachie 206-568-5718	206-720-3038 (f)
North Sound	Sue Halle 425-339-4887 Kristin Ihrig 425-339-4828	425-339-4856 (f)
Pierce	Katie Kimball 253-404-5594 Amee Kile 360-725-4282	253-593-2053 (f)
Peninsula	Jeff Green 360-725-4305	360-568-6502 (f)

	Amee Kile 360-725-4282	
Except Kitsap	Katie Kimball 253-404-5594 Amee Kile 360-725-4282	253-593-2052 (f)
Spokane	Karen Lantz 509-329-2956 Tory Fielder 509-225-4626	360-568-6502 (f)
Except Okanagan/Grant	Risa Salters 509-665-5296 Tory Fiedler 509-225-4626	509-374-7103 (f) 509-308-1228 (c)
Southwest WA Behavioral Health	Jeff Green 360-725-4305 Amee Kile 360-725-4282	360-568-6502 (f)
Thurston-Mason	Jeff Green 360-725-4305 Amee Kile 360-725-4282	360-568-6502 (f)
Timberlands	Jeff Green 360-725-4305 Amee Kile 360-725-4282	360-568-6502 (f)

Appendix F: Federally Recognized Tribes of Washington State

FEDERALLY RECOGNIZED TRIBES OF WASHINGTON STATE



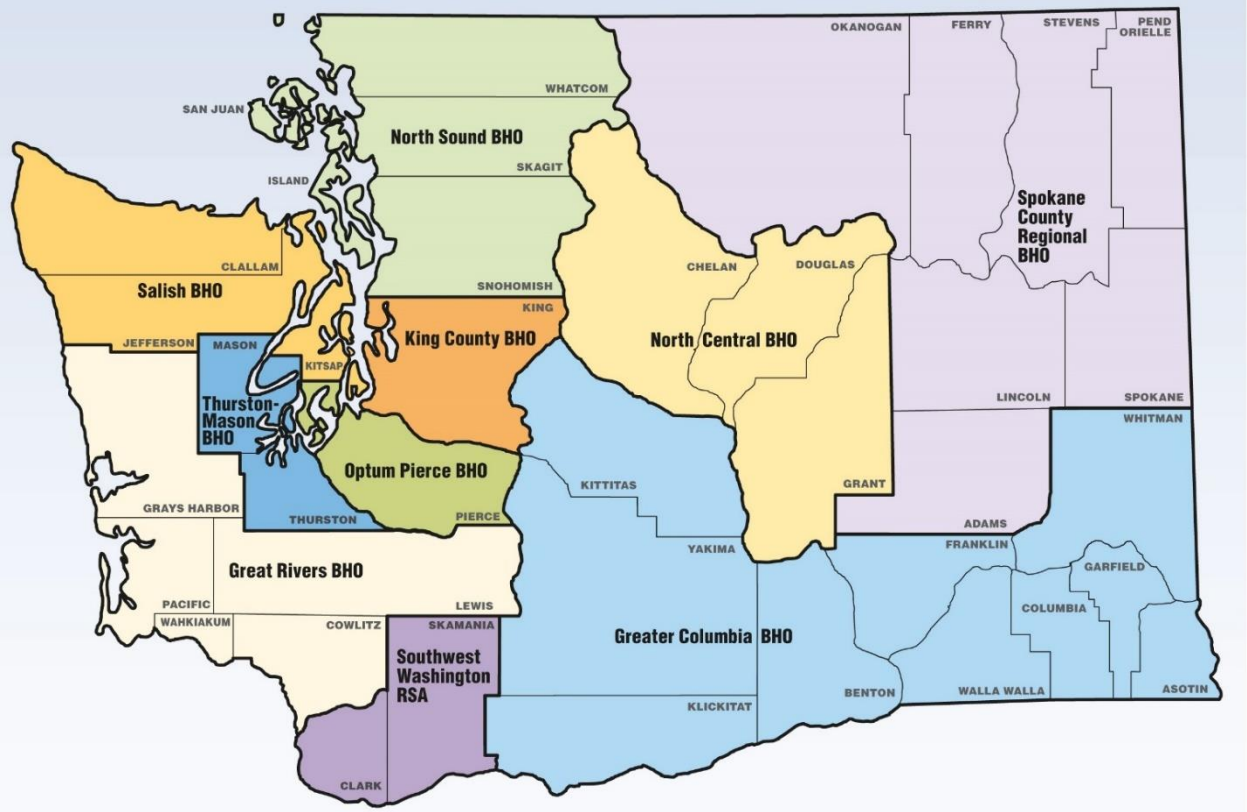
Appendix G: Tribal Behavioral Health Clinics

Chehalis Tsapowum BH Program 420 Howanut Drive Oakville, WA 98568	**Colville Tribal Alcohol/Drug Program** Post Office Box 150 Nespelem, WA 99155	**Cowlitz Tribal Treatment** Post Office Box 2429 Longview, WA 98632 306.575.3316

360.709.1733		
Cowlitz Tribal Treatment 770 NE 26th Ave Vancouver, WA 98665 360.397.8228	**Cowlitz Tribal Treatment (Seattle)** 15455 65th Ave South Tukwila, WA 98188 206.721.5179	**Hoh Indian Tribe*** 2261 Lower Hoh Road Forks, WA 98331 360.374.6582
Jamestown S'Klallam Social Services 808 North 5h Ave Sequim, WA 98382 360.681.4625	**Klallam Counseling Services** 933 East First Street Port Angeles, WA 98362 360.452.4432	**Lummi CARE Counseling Services** 2616 Kwina Road Bellingham, WA 98226 360.312.2420
Kalispel Tribe Camas Path Health – South Office 934 South Garfield Road Airway Heights, WA 99001 509.789.7630	**Kalispel Tribe Camas Path Health – North Office** 72 Camas Flat Road Cusick, WA 99119 509.445.0646	**Muckleshoot Behavioral Health** 17500 SE 392nd Street Auburn, WA 98092 253.804.8752 866.427.3737 (after hours)
Makah Tribe Wellness Center 100 Wellness Way Neah Bay, WA 98404 360.645.2075	**Nooksack Tribal Alcoholism Program** 6750 Mission Rd Everson, WA 98247 360.966.7778	**Nooksack Tribal Mental Health Program** 2510 Sulwhanon Dr Everson, WA 98247 360.966.2376
Puyallup Tribal Treatment Center 2209 East 32nd Street Tacoma, WA 98404 253.593.0232	**Nisqually Tribe Substance Abuse Program** 4816 She-Nah-Num Drive SE Olympia, WA 98513 360.412.2727	**Port Gamble S'Klallam Wellness Program** 7550 Little Boston Road NE Kingston, WA 98346 360.297.6326
Samish Indian Nation Health Clinic 1809 Commercial Avenue Anacortes, WA 98404 360.899.5454	**Squaxin Island Tribe Behavioral Health** 100 SE Whitener Road Shelton, WA 98584 360.426.1582	**Northwest Indian Treatment Center (Squaxin Island Tribe)** 308 East Young Elma, WA 98541 360.482.2674
Quinault Nation Health Center 1505 Kla Ook Wa Drive Taholah, WA 98587 360.276.8211 ext. 454	**Shoalwater Bay Indian Tribe** 2373 Tokeland Road Tokeland, WA 98590 360.267.0119	**Quileute Counseling and Recovery (SUD)** 191 Ocean Drive LaPush, WA 98350 360.374.4320
Quileute Tribal Health Clinic 560 Quileute Heights Loop LaPush, WA 98350 360.374.9035	**Snoqualmie Tribal Mental Health** 9450 Ethan Wade Way SE Snoqualmie, WA 98065 425.888.6551 ext. 6302	**Sauk-Suiattle Tribe Community Clinic** 5318 Chief Brown Lane Darrington, WA 98241 360.436.0131
Skokomish HOPE Behavioral Health	**Suquamish Tribe Wellness Center**	**Stillaguamish Tribe Health Center**

80 North Tribal Center Road Skokomish Nation, WA 98584 360.877.2008 ext. 2605	18490 Suquamish Way NE #107 Suquamish, WA 98392 360.394.8558	17014 59th Ave NE Arlington, WA 98223 360.435.3985
Island Crossing Counseling Services (OST Program – Stillaguamish Tribe) 21123 Smokey Point Blvd Arlington, WA 98223 360.652.9640	**Spokane Tribal Health Clinic** 6228 E. Old School Road Wellpinit, WA 99040 509.258.7502	**Swinomish Counseling Services (Mental Health)** 17400 Reservation Road LaConner, WA 98257 360.466.7265
Tulalip Behavioral Health Services 2821 Mission Hill Road Marysville, WA 98270 360.716.3284	**Tulalip Youth Treatment Services** 2821 Mission Hill Road Marysville, WA 98270 360.716.4400	**Upper Skagit Tribe CD Program (Substance Use Disorders)** 25959 Community Plaza Way Sedro Woolley, WA 98284 360.854.7070
Yakima Nation Behavioral Health Program (MH) 16 West 1st Avenue Toppenish, WA 98948 509.865.5121 ext. 6200	** Asterisk indicates that tribe does not have a behavioral health clinic.*	

Appendix H: Behavioral Health Organizations and Full Integration Region



Appendix I: List of Resources for "Available History"

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

Possible resources include:

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

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

The following information is from the U.S. Department of State website. For more detailed information, contact information for foreign consular offices, and fax sheets for notification, see the website: https://travel.state.gov/content/travel/en/consularnotification.html

It is best practice to follow these steps regardless of the individual's immigration status.

1. Determine the foreign national's country of nationality. In the absence of other information, assume this is the country on whose passport or other travel document the foreign national is traveling.
2. If the foreign national's country is **NOT** on the list of "mandatory notification" countries and jurisdictions:
    a. Use Statement 1 (see below) to inform the national, without delay, that he or she may have his or her consular officers notified and may communicate with them.
    b. If the foreign national requests that his or her consular officers be notified, notify the nearest embassy or consulate of the foreign national's country without delay.
    c. Forward any communication from the foreign national to his or her consular officers without delay.
3. If the foreign national's country is on the list of "mandatory notification" countries:
    a. Notify that country's nearest embassy or consulate, without delay, of the arrest or detention.
    b. Use Statement 2 (see below) to tell the national, without delay, that you are making this notification and that he or she may communicate with the consulate.
    c. Forward any communication from the foreign national to his or her consular officers without delay.
4. Keep a written record of:
    a. What information you provided to the foreign national and when.
    b. The foreign national's requests, if any.
    c. Whether you notified consular officers and, if so, the date and time and the means used to notify them. If you used fax or email to notify the consular officers, you should keep the fax confirmation sheet or sent email in your records.
    d. Any other relevant actions taken.

Countries and Jurisdictions with Mandatory Notifications

Albania
Algeria
Antigua & Barbuda
Armenia
Azerbaijan
Bahamas
Barbados
Belarus
Belize
Brunei
Bulgaria
China (including Macao & Hong Kong)
Costa Rica
Cyprus
Czech Republic
Dominica
Fiji
Gambia
Georgia
Ghana
Grenada
Guyana
Hungary
Jamaica
Kazakhstan
Kiribati
Kuwait
Kyrgyzstan
Malaysia
Malta
Mauritius
Moldova
Mongolia
Nigeria
Philippines
Poland
Romania
Russia
Saint Kitts & Nevis
Saint Lucia
Saint Vincent & the Grenadines
Seychelles
Sierra Leone
Singapore
Slovakia
Tajikistan
Tanzania
Tonga
Trinidad & Tobago
Tunisia
Turkmenistan
Tuvalu
Ukraine
United Kingdom
Uzbekistan
Zambia
Zimbabwe

Statement 1 – For all foreign nationals except those from "mandatory notification" countries

As a non-U.S. citizen who is being arrested or detained, you may request that we notify your country's consular officers here in the United States of your situation. You may also communicate with your consular officers. A consular officer may be able to help you obtain legal representation, and may contact your family and visit you in detention, among other things. If you want us to notify your consular officers, you can request this notification now, or at any time in the future. Do you want us to notify your consular officers at this time?

Statement 2 – For foreign nationals from "mandatory notification" countries

Because of your nationality, we are required to notify your country's consular officers here in the United States that you have been arrested or detained. We will do this as soon as possible. In addition, you may communicate with your consular officers. You are not required to accept their assistance, but your consular officers may be able to help you obtain legal representation, and may contact your family and visit you in detention, among other things. Please sign to show that you have received this information.

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

NOTICE NOT TO EXTEND LESS RESTRICTIVE ALTERNATIVE (LRA)

COUNTY INVOLUNTARY TREATMENT

PHONE: _____
FAX: _____

Case Manager: _____
Agency:
_____
Phone Number: _____

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

Client: _____
Address: _____
_____
DOB: _____ SS#: _____
LRA Expiration Date: _____

Circle One:
90- 180- day

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

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

_____
_____
_____
_____

Case Manager: _____ Date: _____
Case Manager Supervisor: _____ Date: _____

LESS RESTRICTIVE ALTERNATIVE (LRA) EXTENSION REQUEST

COUNTY INVOLUNTARY TREATMENT

PHONE: _____

FAX: _____

DMHP Assigned: _____

CLIENT NAME: _____

Address: _____

_____

Telephone: _____

DOB: _____

Case Manager: _____

Agency Name: _____ Phone: _____

Attached is the Petition and Co-Affidavit/Declaration to extend the current LRA for:

Circle One:

90- 180- days

Current 90- 180- day LRA will expire: _____

General Questions:

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

_____
_____
_____
_____
_____

Additional Information:

_____
_____
_____
_____
_____

LESS RESTRICTIVE ALTERNATIVE (LRA)
EXTENSION REQUEST

_____COUNTY INVOLUNTARY TREATMENT

PHONE: _____

FAX: _____

Case Manager:
_____

Agency: _____ Phone:
_____

Requests an Extension for an additional _____ (90 or 180) days involuntary treatment for:

Client:
_____
_

Address:
_____
_____
_____

DOB: _____ SS#:
_____

CIRCLE ONE:

90- 180- day current

LRA Current Expiration Date: _____

THIS FORM MUST BE SUBMITTED FOUR (4) WEEKS

PRIOR TO THE EXPIRATION DATE

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

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

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

_____
_____
_____
_____

3. Threatened, attempted to inflict 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 spend (but not excluding any violent acts committed) incarcerated or in a mental health facility.

_____
_____
_____
_____

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

_____
_____
_____
_____

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

_____
_____
_____
_____

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

_____
_____
_____
_____

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

_____
_____
_____
_____

9. Please specify all proposed conditions for the future LRA.
   _____
   _____
   _____
10. The physician and the mental health professional evaluates the consumer face-to-face prior to completing the co-affidavit/declaration. The co-affidavit/declaration is to be signed by physician and mental health professional and provided to the DMHP prior to evaluation of consumer by DMHP.

Case Manager: _____ Date: _____

OFFICE: _____

FAX: _____

Date: _____

To: _____

Telephone: _____

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

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

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

If you have any questions, please contact a Designated Mental Health Professional at _____ or your case manager.

Sincerely,

Designated Mental Health Professional

cc: Office of Public Defense: _____

Case Manager: _____

Enclosures

Appendix L: DMHP/DCR Knowledge and Education

Qualifications as defined in statute:

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

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

RCW 71.05.020 (13) "Designated Crisis Responder" means a mental health professional appointed by the behavioral health organization to perform the duties specified in this chapter (effective April 1, 2018)

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/DCR function/knowledge base

Appendix M: References and Resources

1. Current Diagnostic and Statistical Manual
2. Washington State DMHP/DCR Protocols, updated September 2017
3. Washington Administrative Code: WAC 388-865 "Community Mental Health and Involuntary Treatment Programs" and WAC 388-877 Behavioral Health Services
4. Revised Code of Washington
    a. Medical Records – Healthcare Information Access and Disclosure – RCW 70.02
    b. Adult Involuntary Treatment – Chapter 71.05 RCW Mental Health Services for Minors – Chapter 71.34 RCW Criminally Insane – Chapter 10.77 RCW
    c. Treatment for Alcoholism, Intoxication and Drug Addiction – Chapter 70.96A RCW Interstate Compact on Mental Illness – Chapter 72.27 RCW
    d. Indian Lands Jurisdiction – Chapter 37.12 RCW Developmental Disabilities – Chapter 71a RCW
    e. Fire Arms and Dangerous Weapons – Chapter 9.41 RCW Guardianship – Chapter 11.88 RCW
5. Washington Court Rules - State Rules
    a. Superior Court Mental Proceeding Rules (MPR)
    b. Includes approved forms for petitions.
    c. found at pages 479-492 of 2007 version of Washington Court Rules

6. Washington State Case Law - Index to Cases

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

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

- Detention of C.K., 108 Wn.App. 65, P.2d (2001).
  Legislative intent pp. 73-74, 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 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.2 (1998)
  File petition three days before the end of the prior period for 90 and 180 day 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. 956-957
- 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 alternative 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 pp. 222-226
  Jury instructions pp. 223-224
  Gravely disabled pp. 224-226
- 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. 216-217
- 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. 799-801
  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. 770-771, 776
- Detention of R.W., 98 Wn. App. P.2d (1999)
  Comment on the evidence pp. 141, 144-145
  Role of the jury pp. 144
- Detention of V. B., 104 Wn. App. 953, P.2d (2001)
  Peace officer testimony pp. 963-964
  Adequacy of due process procedures p. 953
  State interest in use of officer p. 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. 844-845
  Burden of proof pp. 845-846
  Right to remain silent pp. 846-847
  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. 282-284
  Standard of dangerousness p. 284
  Recent overt act pp. 284-285
  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, 206
  Explanation of RCW 71.05.020(1)(b) pp. 205-208
  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. 108-109
  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. 186-199
- In Re Schouler, 106 Wn.2d 500, 723 P.2d 1103 (1986)
  Compares guardianship and involuntary commitment pp. 504-505
  Right to refuse medication p. 506
  Court makes "substituted judgement" p. 507
  Procedural due process at hearing pp. 509-510
  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. 955-956
- State v. M.R.C., 98 Wn App. 52 P.2d (1999)
  Corpus delicti rule p. 55
  History of corpus delicti rule p. 56
  Distinguishes involuntary commitment hearings and criminal trials p. 57
  Waiver of right and corpus delicti rule p. 58

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Recommended Resources: Internet Websites

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

All hyperlinks are functioning as of 04-04-2017.

Appendix N: WAC 388-865-0600 through 0640

WAC 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. WSR 01-12-047, § 388-865-0600, filed 5/31/01, effective 7/1/01.]

WAC 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 database - 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 database 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. WSR 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, and 43.20B.335. WSR 01-12-047, § 388-865-0610, filed 5/31/01, effective 7/1/01.]

WAC 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. WSR 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, and 43.20B.335. WSR 01-12-047, § 388-865-0620, filed 5/31/01, effective 7/1/01.]

WAC 388-865-0630

Time frame.

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

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

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

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

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

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

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

[Statutory Authority: RCW 71.05.445 and 71.05.390 as amended by 2004 c 166. WSR 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, and 43.20B.335. WSR 01-12-047, § 388-865-0630, filed 5/31/01, effective 7/1/01.]

WAC 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. WSR 01-12-047, § 388-865-0640, filed 5/31/01, effective 7/1/01.]

Appendix O: RCW 70.02.230

Mental health services, confidentiality of records—Permitted disclosures. (*Effective until April 1, 2018.*)

(1) Except as provided in this section, RCW 70.02.050, 71.05.445, * 70.96A.150, 74.09.295, 70.02.210, 70.02.240, 70.02.250, and 70.02.260, or pursuant to a valid authorization under RCW 70.02.030, the fact of admission to a provider for mental health services and all information and records compiled, obtained, or maintained in the course of providing mental health services to either voluntary or involuntary recipients of services at public or private agencies must be confidential.

(2) Information and records related to mental health services, other than those obtained through treatment under chapter 71.34 RCW, may be disclosed only:

(a) In communications between qualified professional persons to meet the requirements of chapter 71.05 RCW, in the provision of services or appropriate referrals, or in the course of guardianship proceedings if provided to a professional person:

(i) Employed by the facility;

(ii) Who has medical responsibility for the patient's care;

(iii) Who is a designated mental health professional;

(iv) Who is providing services under chapter 71.24 RCW;

(v) Who is employed by a state or local correctional facility where the person is confined or supervised; or

(vi) Who is providing evaluation, treatment, or follow-up services under chapter 10.77 RCW;

(b) When the communications regard the special needs of a patient and the necessary circumstances giving rise to such needs and the disclosure is made by a facility providing services to the operator of a facility in which the patient resides or will reside;

(c)(i) When the person receiving services, or his or her guardian, designates persons to whom information or records may be released, or if the person is a minor, when his or her parents make such a designation;

(ii) A public or private agency shall release to a person's next of kin, attorney, personal representative, guardian, or conservator, if any:

(A) The information that the person is presently a patient in the facility or that the person is seriously physically ill;

(B) A statement evaluating the mental and physical condition of the patient, and a statement of the probable duration of the patient's confinement, if such information is requested by the next of kin, attorney, personal representative, guardian, or conservator; and

(iii) Other information requested by the next of kin or attorney as may be necessary to decide whether or not proceedings should be instituted to appoint a guardian or conservator;

(d)(i) To the courts as necessary to the administration of chapter 71.05 RCW or to a court ordering an evaluation or treatment under chapter 10.77 RCW solely for the purpose of preventing the entry of any evaluation or treatment order that is inconsistent with any order entered under chapter 71.05 RCW.

(ii) To a court or its designee in which a motion under chapter 10.77 RCW has been made for involuntary medication of a defendant for the purpose of competency restoration.

(iii) Disclosure under this subsection is mandatory for the purpose of the federal health insurance portability and accountability act;

(e)(i) When a mental health professional is requested by a representative of a law enforcement or corrections agency, including a police officer, sheriff, community corrections officer, a municipal attorney, or prosecuting attorney to undertake an investigation or provide

treatment under RCW 71.05.150, 10.31.110, or 71.05.153, the mental health professional shall, if requested to do so, advise the representative in writing of the results of the investigation including a statement of reasons for the decision to detain or release the person investigated. The written report must be submitted within seventy-two hours of the completion of the investigation or the request from the law enforcement or corrections representative, whichever occurs later.

(ii) Disclosure under this subsection is mandatory for the purposes of the federal health insurance portability and accountability act;

(f) To the attorney of the detained person;

(g) To the prosecuting attorney as necessary to carry out the responsibilities of the office under RCW 71.05.330(2), 71.05.340(1)(b), and 71.05.335. The prosecutor must be provided access to records regarding the committed person's treatment and prognosis, medication, behavior problems, and other records relevant to the issue of whether treatment less restrictive than inpatient treatment is in the best interest of the committed person or others. Information must be disclosed only after giving notice to the committed person and the person's counsel;

(h)(i) 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 must be made by the professional person in charge of the public or private agency or his or her designee and must include the dates of commitment, admission, discharge, or release, authorized or unauthorized absence from the agency's facility, and only any other information that is pertinent to the threat or harassment. The agency or its employees are not civilly liable for the decision to disclose or not, so long as the decision was reached in good faith and without gross negligence.

(ii) Disclosure under this subsection is mandatory for the purposes of the federal health insurance portability and accountability act;

(i)(i) To appropriate corrections and law enforcement agencies 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 mental health service agency or its employees are not civilly liable for the decision to disclose or not so long as the decision was reached in good faith and without gross negligence.

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

(j) To the persons designated in RCW 71.05.425 for the purposes described in those sections;

(k) Upon the death of a person. The person's next of kin, personal representative, guardian, or conservator, if any, must be notified. Next of kin who are of legal age and competent must be notified under this section in the following order: Spouse, parents, children, brothers and sisters, and other relatives according to the degree of relation. Access to all records and information compiled, obtained, or maintained in the course of providing services to a deceased patient are governed by RCW 70.02.140;

(l) To mark headstones or otherwise memorialize patients interred at state hospital cemeteries. The department of social and health services shall make available the name, date of birth, and date of death of patients buried in state hospital cemeteries fifty years after the death of a patient;

(m) 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:

(i) 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), must be disclosed upon request;

(ii) 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);

(iii) Disclosure under this subsection is mandatory for the purposes of the federal health insurance portability and accountability act;

(n) When a patient would otherwise be subject to the provisions of this section and disclosure is necessary for the protection of the patient or others due to his or her unauthorized disappearance from the facility, and his or her whereabouts is unknown, notice of the disappearance, along with relevant information, may be made to relatives, the department of corrections when the person is under the supervision of the department, and governmental law enforcement agencies designated by the physician or psychiatric advanced registered nurse practitioner in charge of the patient or the professional person in charge of the facility, or his or her professional designee;

(o) Pursuant to lawful order of a court;

(p) To qualified staff members of the department, to the director of behavioral health organizations, to resource management services responsible for serving a patient, or to service providers designated by resource management services as necessary to determine the progress and adequacy of treatment and to determine whether the person should be transferred to a less restrictive or more appropriate treatment modality or facility;

(q) Within the mental health service agency where the patient is receiving treatment, confidential information may be disclosed to persons employed, serving in bona fide training programs, or participating in supervised volunteer programs, at the facility when it is necessary to perform their duties;

(r) Within the department as necessary to coordinate treatment for mental illness, developmental disabilities, alcoholism, or drug abuse of persons who are under the supervision of the department;

(s) To a licensed physician or psychiatric advanced registered nurse practitioner who has determined that the life or health of the person is in danger and that treatment without the information and records related to mental health services could be injurious to the patient's health. Disclosure must be limited to the portions of the records necessary to meet the medical emergency;

(t) Consistent with the requirements of the federal health information portability and accountability act, to a licensed mental health professional or a health care professional licensed under chapter 18.71, 18.71A, 18.57, 18.57A, 18.79, or 18.36A RCW who is providing care to a person, or to whom a person has been referred for evaluation or treatment, to assure coordinated care and treatment of that person. Psychotherapy notes may not be released without authorization of the person who is the subject of the request for release of information;

(u) To administrative and office support staff designated to obtain medical records for those licensed professionals listed in (t) of this subsection;

(v) To a facility that is to receive a person who is involuntarily committed under chapter 71.05 RCW, or upon transfer of the person from one evaluation and treatment facility to another. The release of records under this subsection is limited to the information and records related to mental health services required by law, a record or summary of all somatic treatments, and a discharge summary. The discharge summary may include a statement of the patient's problem,

the treatment goals, the type of treatment which has been provided, and recommendation for future treatment, but may not include the patient's complete treatment record;

(w) To the person's counsel or guardian ad litem, without modification, at any time in order to prepare for involuntary commitment or recommitment proceedings, reexaminations, appeals, or other actions relating to detention, admission, commitment, or patient's rights under chapter 71.05 RCW;

(x) To staff members of the protection and advocacy agency or to staff members of a private, nonprofit corporation for the purpose of protecting and advocating the rights of persons with mental disorders or developmental disabilities. Resource management services may limit the release of information to the name, birthdate, and county of residence of the patient, information regarding whether the patient was voluntarily admitted, or involuntarily committed, the date and place of admission, placement, or commitment, the name and address of a guardian of the patient, and the date and place of the guardian's appointment. Any staff member who wishes to obtain additional information must notify the patient's resource management services in writing of the request and of the resource management services' right to object. The staff member shall send the notice by mail to the guardian's address. If the guardian does not object in writing within fifteen days after the notice is mailed, the staff member may obtain the additional information. If the guardian objects in writing within fifteen days after the notice is mailed, the staff member may not obtain the additional information;

(y) To all current treating providers of the patient with prescriptive authority who have written a prescription for the patient within the last twelve months. For purposes of coordinating health care, the department may release without written authorization of the patient, information acquired for billing and collection purposes as described in RCW 70.02.050(1)(d). The department shall notify the patient that billing and collection information has been released to named providers, and provide the substance of the information released and the dates of such release. The department may not release counseling, inpatient psychiatric hospitalization, or drug and alcohol treatment information without a signed written release from the client;

(z)(i) To the secretary of social and health services for either program evaluation or research, or both so long as the secretary adopts rules for the conduct of the evaluation or research, or both. Such rules must 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 persons who have received services such that the person who received such services is identifiable.

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

(ii) Nothing in this chapter may 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.

(3) Whenever federal law or federal regulations restrict the release of information contained in the information and records related to mental health services of any patient who receives treatment for chemical dependency, the department may restrict the release of the information as necessary to comply with federal law and regulations.

(4) Civil liability and immunity for the release of information about a particular person who is committed to the department of social and health services under RCW *** 71.05.280(3) and

**** 71.05.320(3)(c) after dismissal of a sex offense as defined in RCW 9.94A.030, is governed by RCW 4.24.550.

(5) The fact of admission to a provider of mental health services, as well as all records, files, evidence, findings, or orders made, prepared, collected, or maintained pursuant to chapter 71.05 RCW are not admissible as evidence in any legal proceeding outside that chapter without the written authorization of the person who was the subject of the proceeding except as provided in RCW 70.02.260, in a subsequent criminal prosecution of a person committed pursuant to RCW *** 71.05.280(3) or **** 71.05.320(3)(c) on charges that were dismissed pursuant to chapter 10.77 RCW due to incompetency to stand trial, in a civil commitment proceeding pursuant to chapter 71.09 RCW, or, in the case of a minor, a guardianship or dependency proceeding. The records and files maintained in any court proceeding pursuant to chapter 71.05 RCW must be confidential and available subsequent to such proceedings only to the person who was the subject of the proceeding or his or her attorney. In addition, the court may order the subsequent release or use of such records or files only upon good cause shown if the court finds that appropriate safeguards for strict confidentiality are and will be maintained.

(6)(a) Except as provided in RCW 4.24.550, any person may bring an action against an individual who has willfully released confidential information or records concerning him or her in violation of the provisions of this section, for the greater of the following amounts:

(i) One thousand dollars; or

(ii) Three times the amount of actual damages sustained, if any.

(b) It is not a prerequisite to recovery under this subsection that the plaintiff suffered or was threatened with special, as contrasted with general, damages.

(c) Any person may bring an action to enjoin the release of confidential information or records concerning him or her or his or her ward, in violation of the provisions of this section, and may in the same action seek damages as provided in this subsection.

(d) The court may award to the plaintiff, should he or she prevail in any action authorized by this subsection, reasonable attorney fees in addition to those otherwise provided by law.

(e) If an action is brought under this subsection, no action may be brought under RCW 70.02.170.

[2014 c 225 § 71; 2014 c 220 § 9; 2013 c 200 § 7.]

Appendix P: RCW 70.02.240

Mental health services—Minors—Permitted disclosures.

The fact of admission and all information and records related to mental health services obtained through treatment under chapter 71.34 RCW is confidential, except as authorized in RCW 70.02.050, 70.02.210, 70.02.230, 70.02.250, and 70.02.260. Such confidential information may be disclosed only:

(1) In communications between mental health professionals to meet the requirements of chapter 71.34 RCW, in the provision of services to the minor, or in making appropriate referrals;

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

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

(4) To the courts as necessary to administer chapter 71.34 RCW;

(5) 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 must be disclosed upon request;

(6) 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;

(7) To the secretary of social and health services for assistance in data collection and program evaluation or research so long as the secretary adopts rules for the conduct of such evaluation and research. The rules must 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/ . . . . . ";

(8) 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 mental health service agency or its employees are not civilly liable for the decision to disclose or not, so long as the decision was reached in good faith and without gross negligence;

(9) 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 must be made by the professional person in charge of the public or private agency or his or her designee and must include the dates of admission, discharge, authorized or unauthorized absence from the agency's facility, and only any other information that is pertinent to the threat or harassment. The agency or its employees are not civilly liable for the decision to disclose or not, so long as the decision was reached in good faith and without gross negligence;

(10) 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;

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

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

(13) 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), must 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 federal health insurance portability and accountability act;

(14) This section may 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 of the department of social and health services. The fact of admission and all information obtained pursuant to chapter 71.34 RCW are not admissible as evidence in any legal proceeding outside chapter 71.34 RCW, except guardianship or dependency, without the written consent of the minor or the minor's parent;

(15) For the purpose of a correctional facility participating in the post institutional medical assistance system supporting the expedited medical determinations and medical suspensions as provided in RCW 74.09.555 and 74.09.295;

(16) Pursuant to a lawful order of a court.

[2013 c 200 § 8.]

Appendix Q: 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)

RCW 71.34.500

Minor thirteen or older may be admitted for inpatient mental treatment or approved substance use disorder treatment program without parental consent—Professional person in charge must concur—Written renewal of consent required. (*Effective April 1, 2018.*)

(1) A minor thirteen years or older may admit himself or herself to an evaluation and treatment facility for inpatient mental health treatment or an approved substance use disorder treatment program for inpatient substance use disorder treatment without parental consent. The admission shall occur only if the professional person in charge of the facility concurs with the need for inpatient treatment. Parental authorization, or authorization from a person who may consent on behalf of the minor pursuant to RCW 7.70.065, is required for inpatient treatment of a minor under the age of thirteen.

(2) When, in the judgment of the professional person in charge of an evaluation and treatment facility or approved substance use disorder treatment program, there is reason to believe that a minor is in need of inpatient treatment because of a mental disorder or substance use disorder, and the facility provides the type of evaluation and treatment needed by the minor, and it is not feasible to treat the minor in any less restrictive setting or the minor's home, the minor may be admitted to the facility.

(3) Written renewal of voluntary consent must be obtained from the applicant no less than once every twelve months. The minor's need for continued inpatient treatments shall be reviewed and documented no less than every one hundred eighty days.

RCW 71.34.510

Notice to parents when minor admitted to inpatient treatment without parental consent.

The administrator of the treatment facility shall provide notice to the parents of a minor when the minor is voluntarily admitted to inpatient treatment under RCW 71.34.500. The notice shall be in the form most likely to reach the parent within twenty-four hours of the minor's voluntary admission and shall advise the parent: (1) That the minor has been admitted to inpatient treatment; (2) of the location and telephone number of the facility providing such treatment; (3) of the name of a professional person on the staff of the facility providing treatment who is designated to discuss the minor's need for inpatient treatment with the parent; and (4) of the medical necessity for admission.

RCW 71.34.520

Minor voluntarily admitted may give notice to leave at any time. (*Effective until April 1, 2018.*)

(1) Any minor thirteen years or older voluntarily admitted to an evaluation and treatment facility under RCW 71.34.500 may give notice of intent to leave at any time. The notice need not follow any specific form so long as it is written and the intent of the minor can be discerned.

(2) The staff member receiving the notice shall date it immediately, record its existence in the minor's clinical record, and send copies of it to the minor's attorney, if any, the *county-designated mental health professional, and the parent.

(3) The professional person shall discharge the minor, thirteen years or older, from the facility by the second judicial day following receipt of the minor's notice of intent to leave.

RCW 71.34.530
Age of consent—Outpatient treatment of minors.

Any minor thirteen years or older may request and receive outpatient treatment without the consent of the minor's parent. Parental authorization, or authorization from a person who may consent on behalf of the minor pursuant to RCW 7.70.065, is required for outpatient treatment of a minor under the age of thirteen.

Parent-Initiated Treatment (RCW 71.34.600-660)

RCW 71.34.610

Review of admission and inpatient treatment of minors—Determination of medical necessity—Department review—Minor declines necessary treatment—At-risk youth petition—Costs—Public funds.

(1) The department shall assure that, for any minor admitted to inpatient treatment under RCW 71.34.600, a review is conducted by a physician or other mental health professional who is employed by the department, or an agency under contract with the department, and who neither has a financial interest in continued inpatient treatment of the minor nor is affiliated with the facility providing the treatment. The physician or other mental health professional shall conduct the review not less than seven nor more than fourteen days following the date the minor was brought to the facility under RCW 71.34.600 to determine whether it is a medical necessity to continue the minor's treatment on an inpatient basis.

(2) In making a determination under subsection (1) of this section, the department shall consider the opinion of the treatment provider, the safety of the minor, and the likelihood the minor's mental health will deteriorate if released from inpatient treatment. The department shall consult with the parent in advance of making its determination.

(3) If, after any review conducted by the department under this section, the department determines it is no longer a medical necessity for a minor to receive inpatient treatment, the department shall immediately notify the parents and the facility. The facility shall release the minor to the parents within twenty-four hours of receiving notice. If the professional person in charge and the parent believe that it is a medical necessity for the minor to remain in inpatient treatment, the minor shall be released to the parent on the second judicial day following the department's determination in order to allow the parent time to file an at-risk youth petition under chapter 13.32A RCW. If the department determines it is a medical necessity for the minor to receive outpatient treatment and the minor declines to obtain such treatment, such refusal shall be grounds for the parent to file an at-risk youth petition.

(4) If the evaluation conducted under RCW 71.34.600 is done by the department, the reviews required by subsection (1) of this section shall be done by contract with an independent agency.

(5) The department may, subject to available funds, contract with other governmental agencies to conduct the reviews under this section. The department may seek reimbursement from the parents, their insurance, or medicaid for the expense of any review conducted by an agency under contract.

(6) In addition to the review required under this section, the department may periodically determine and re-determine the medical necessity of treatment for purposes of payment with public funds

RCW 71.34.620

Minor may petition court for release from facility.

Following the review conducted under RCW 71.34.610, a minor child may petition the superior court for his or her release from the facility. The petition may be filed not sooner than five days following the review. The court shall release the minor unless it finds, upon a preponderance of the evidence, that it is a medical necessity for the minor to remain at the facility.

RCW 71.34.630

Minor not released by petition under RCW 71.34.620—Release within thirty days—Professional may initiate proceedings to stop release. (*Effective until April 1, 2018.*)

If the minor is not released as a result of the petition filed under RCW 71.34.620, he or she shall be released not later than thirty days following the later of: (1) The date of the department's determination under RCW 71.34.610(2); or (2) the filing of a petition for judicial review under RCW 71.34.620, unless a professional person or the *county designated mental health professional initiates proceedings under this chapter.

RCW 71.34.640

Evaluation of treatment of minors.

The department shall randomly select and review the information on children who are admitted to inpatient treatment on application of the child's parent regardless of the source of payment, if any. The review shall determine whether the children reviewed were appropriately admitted into treatment based on an objective evaluation of the child's condition and the outcome of the child's treatment.

RCW 71.34.650

Parent may request determination whether minor has mental disorder requiring outpatient treatment—Consent of minor not required—Discharge of minor. (*Effective until April 1, 2018.*)

(1) A parent may bring, or authorize the bringing of, his or her minor child to a provider of outpatient mental health treatment and request that an appropriately trained professional person examine the minor to determine whether the minor has a mental disorder and is in need of outpatient treatment.

(2) The consent of the minor is not required for evaluation if the parent brings the minor to the provider.

(3) The professional person may evaluate whether the minor has a mental disorder and is in need of outpatient treatment.

(4) Any minor admitted to inpatient treatment under RCW 71.34.500 or 71.34.600 shall be discharged immediately from inpatient treatment upon written request of the parent.

RCW 71.34.660

Limitation on liability for admitting or accepting minor child. (*Effective until April 1, 2018.*)

A minor child shall have no cause of action against an evaluation and treatment facility, inpatient facility, or provider of outpatient mental health treatment for admitting or accepting the minor in good faith for evaluation or treatment under RCW 71.34.600 or 71.34.650 based solely upon the fact that the minor did not consent to evaluation or treatment if the minor's parent has consented to the evaluation or treatment.

Appendix R: Single Bed Certification Request Form for WSH & ESH

Single Bed Certification Form - WAC 388-865-0526

Fax requests to:
Western State Hospital FAX# 253-756-2873
To speak with the nurse processing the SBCs, please call 253-756-2612

Requesting BHO: □TMBHO □OPBHO □GRBHO □KCBHO □NSBHO □SaBHO □Facility □SWWASO	□Initial Request □Extension Request
Name and title of requester: (Facility name in case of a consumer under 18 years of age): □ DMHP;	
Requester Fax #:	Requester Phone #:
Date Requested:	Time Requested:
The facility that is the site of the proposed single bed certification confirms that it is willing and able to provide directly, or by direct arrangement with other public or private agencies, timely and appropriate mental health treatment to the consumer for whom the single bed certification is sought. The single bed certification will apply only to that facility.	
Facility:	City:
Accepted By:	Acceptors Phone #:
Patient Name (first, last, M.I.):	DOB:
Gender: □M □F □Other	Legal Status at the request: □72 Hour Hold □LRA Revocation □14 Day Commitment □90 Day Commitment □180 day Commitment □90 day Rev □180 Day Rev □365 Day Rev

Criteria for Request – *check appropriate box:*

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

□ The consumer can receive appropriate mental health treatment in a residential treatment facility, as defined in WAC 246-337-005.

The RTF is a certified E&T □Y □N

□ The consumer can receive appropriate mental health treatment at a:

- □ Hospital with a psychiatric unit
- □ Hospital that can provide timely and appropriate mental health treatment
- □ Psychiatric hospital

□ The consumer requires MEDICAL services that are not generally available at a facility certified under WAC 388-865-0526.

□ The consumer is awaiting transportation to an identified bed at a certified E&T and the Emergency Room is willing and able to provide mental health treatment in the interim.

Describe why consumer meets criteria for request. (Include medical services needed.)

If consumer is under 18 years of age, is this request for certification on an adult unit? □Y □N

(This portion of form to be completed by state hospital staff.)

Certification approved by:	Title:
Date approved:	Time approved:

THIS CERTIFICATION EXPIRES 30 DAYS FROM DATE OF APPROVAL

BHA form issued: 6/12/2017

Single Bed Certification Form - WAC 388-865-0526

Fax requests to:

Eastern State Hospital FAX# 509-565-4616

To speak with the nurse processing the SBCs, please call 509-565-4644

Requesting BHO: □GC BHO □NC BHO □SC BHO □Facility	□Initial Request □Extension Request
Name and title of requester: (Facility name in case of a consumer under 18 years of age): □ DMHP;	
Requester Fax #:	Requester Phone #:
Date Requested:	Time Requested:

The facility that is the site of the proposed single bed certification confirms that it is willing and able to provide directly, or by direct arrangement with other public or private agencies, timely and appropriate mental health treatment to the consumer for whom the single bed certification is sought. The single bed certification will apply only to that facility.

Facility:	City:
Accepted By:	Acceptors Phone #:
Patient Name (first, last, M.I.):	DOB:

Gender: □M □F □Other	Legal Status at the request: □72 Hour Hold □LRA Revocation □14 Day Commitment □90 Day Commitment □180 day Commitment □90 day Rev □180 Day Rev □365 Day Rev

Criteria for Request – *check appropriate box:*

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

□ The consumer can receive appropriate mental health treatment in a residential treatment facility, as defined in WAC 246-337-005.

The RTF is a certified E&T □Y □N

□ The consumer can receive appropriate mental health treatment at a:

- □ Hospital with a psychiatric unit
- □ Hospital that can provide timely and appropriate mental health treatment
- □ Psychiatric hospital

□ The consumer requires MEDICAL services that are not generally available at a facility certified under WAC 388-865-0526.

□ The consumer is awaiting transportation to an identified bed at a certified E&T and the Emergency Room is willing and able to provide mental health treatment in the interim.

Describe why consumer meets criteria for request. (Include medical services needed.)

If consumer is under 18 years of age, is this request for certification on an adult unit? □Y □N

(This portion of form to be completed by state hospital staff.)

Certification approved by:	Title:
Date approved:	Time approved:

THIS CERTIFICATION EXPIRES 30 DAYS FROM DATE OF APPROVAL

BHA form issued: 6/12/2017

Appendix S: Single Bed Certification Data Dictionary

Single Bed Certification Data Dictionary

Requesting BHO – Indicate the BHO which the DMHP or facility is located within. (Not the BHO of client's residence)

Initial Request – This is the first SBC for this person in this episode. Generally this is what the DMHP will use. This is also used when a person transfers facilities within the 72 hour detention. Facilities will use this for the first SBC for long term involuntary treatment if there was no previous SBC used for this episode.

Extension Request – This is for the person on a 90 or 180 order and the facility has requested a previous SBC but the person continues to need involuntary inpatient care and has not yet been admitted to the State Hospitals.

Name and Title of Requester – The DMHP's name and title (Jane Doe, DMHP) or In the case of a child, the facility's name (Sacred Heart Medical Center) who is requesting the SBC. Check the DMHP box only if you are working as a DMHP on this case.

Requester Fax #- a working fax number for the department (Western or Eastern State Hospital) to fax back the approved SBC. (Best practice is that the facility receive a copy of the approved SBC and that the DMHP keep a copy with the individual's clinical record)

Requester Phone # - a phone number that the DMHP or facility staff requesting the SBC can be reached directly. (State hospitals often have to call the requester to clarify spelling of names or other critical information in order to approve the request. If the hospital cannot reach the requester the SBC request will be denied).

Date Requested – Date the DMHP or Facility is faxing the form.

Time Requested – the time the DMHP or Facility is faxing the form. Form must be faxed to the State Hospital within an hour of Time Requested.

Facility – Name of the facility written out not just initials – (Western State Hospital not WSH) including location (Western State Hospital, Lakewood)

City – The city not the neighborhood that the facility is located within.

Accepted by – the name and title of the person who is agreeing on behalf of the facility, that the facility can meet the needs of the consumer under the single bed certification WAC 388-865-0526. For the DMHP it is generally an ER doctor or ER manager. Do not submit a SBC if the facility does not accept.

Acceptor's Phone # - a phone number that the accepting staff can be reached at if needed by the state hospital.

Patient's Name – the name of the person who is being detained or is under a court order for involuntary treatment using the - first, last, MI convention.

DOB – The Person's date of birth using the - month/day/year convention.

Gender – M is male, F is female, Other is for transgendered. Gender is based on self-report.

Legal Status at the time of the request – DMHPs will use the '72 Hour Hold' and 'LRA Revocation' boxes only, Facilities will use the '14 Day Commitment', 90 Day Commitment or 180 Day Commitment. (For those few facilities that move the detained person on a SBC from one facility to another during the 72 hours will note it under the 72 hour hold or the LRA Revocation hold). For facilities treating a person who has an order of revocation please indicate the original order ie 90 Rev or 180 Rev or 365 Rev

Criteria for Request – Only Facilities may use Box 1 as only they can make a prognosis that the consumer will be ready for discharge within 30 days and will not need to go to a State Hospital. If there is a plan to send the person to the State Hospital this is not the proper box.

The DMHP or the E&T facility may use Box 2 when an Evaluation and Treatment facility is willing to accept the Respondent on a SBC such as Kitsap Adult Inpatient Unit, Bremerton, or Foothills E&T, Spokane. This is rarely used except for long term involuntary treatment (90 -180 day orders) by the E&T

The DMHP or facility will use Box 3 when the Respondent will receive appropriate mental health treatment in one of the follow, checking the appropriate box. Facilities will use this box if they are treating the person on a 14 day or 90 day, 180 day or 365 day order.
Examples would be:
Hospital with a psychiatric unit – St Johns Peace Health Bellingham, Sacred Heart Medical Center, Spokane
Hospital that can provide timely and appropriate mental health treatment - St Clare hospital, Lakewood or Holy Family Hospital, Spokane
A psychiatric hospital – Fairfax, Kirkland or Navos, Seattle

The DMHP or Facility, may use Box 4 for the occasional person with medical treatment needs not generally available in an E&T or at the State hospitals, but to do so the DMHP or facility staff must 'adequately describe' why the person requires the medical services. Best practice is for the DMHP to consult with the ER doctor and WSH staff regarding this criteria. (Current medical concerns are such that they would generally require admission for medical treatment at a medical hospital.)

If the Respondent is waiting for more than 4 hours for transport from the ER to the E&T, but has a bed, use this last box.

Describe why box –write why the person requires a SBC at this facility – Due to impulsive behavior the respondent requires 24 hours supervision and medication management; The respondent was running in traffic due to a mental disorder; Or The respondent has not been eating consistently due to paranoid beliefs about food and requires a structured stetting to provide consistent nutrition and mental health medications; Or The respondent has been suicidal and held a gun to their head and requires the safety of 24 hour supervision and treatment for depression. Do not write it is due to the lack of beds!

If consumer is under 18 years of age, is this request for certification on an adult unit Yes/No – This is to be filled out by the facility requesting for a child under 18 years of age.

Write clearly and legibly. Incomplete or illegible forms will be denied.

Use the Fax number at the top of the form to send the form to the State Hospital.

Appendix T: Unavailable Detention Facilities Report

RCW 71.05.750 Unavailable Detention Facilities Report

DMHP BHO: ☐ GC BHO ☐ GR BHO ☐ KC BHO ☐ NC BHO ☐ NS BHO ☐ OP BHO ☐ Sa BHO ☐ SC BHO ☐ SW BH-ASO ☐ TM BHO	Investigation County:
	IP's Current Location:
Investigated Person (first, last, M.I.):	DOB:
Gender: ☐ M ☐ F ☐ Other	Criteria: ☐ Emergent ☐ Non-Emergent Danger to: ☐ Self ☐ Others ☐ Property ☐ Gravely Disabled

No E&T facility will accept per RCW 71.05.170 and person cannot be served on a Single Bed Certification or less restrictive alternative. This individual has been determined to be dangerous to self, others, property, or gravely disabled, but no Medicare participating facility with specialized capabilities or facilities and capacity to treat this patient will admit or accept a transfer.

Facility: (Y)=Youth, F=Freestanding, H=Hospital,	County	Person Issuing Refusal/Reason	Reason for Refusal				
			Capacity	Psych Acuity	Med Acuity	Other*	N/A
Bridges F E&T	Yakima		☐	☐	☐	☐	☐
Lourdes Counseling Ctr IMD E&T	Benton		☐	☐	☐	☐	☐
Two Rivers Landing (Y) F E&T	Yakima		☐	☐	☐	☐	☐
Yakima Valley Memorial H E&T	Yakima		☐	☐	☐	☐	☐
PeaceHealth St. John Med Ctr H E&T	Cowlitz		☐	☐	☐	☐	☐
Cascade Gerospych IMD H	King		☐	☐	☐	☐	☐
Cascade New Adult Unit IMD E&T	King		☐	☐	☐	☐	☐
Fairfax Hospital IMD E&T	King		☐	☐	☐	☐	☐
Multicare BH Auburn H	King		☐	☐	☐	☐	☐
Navos IMD H E&T	King		☐	☐	☐	☐	☐
Navos Inpatient Services IMD F E&T	King		☐	☐	☐	☐	☐
Seattle Childrens H (Y)	King		☐	☐	☐	☐	☐
Swedish Med Ctr Ballard H	King		☐	☐	☐	☐	☐
UW Med Harborview H E&T	King		☐	☐	☐	☐	☐
UW Med NW (Geriatric) H E&T	King		☐	☐	☐	☐	☐
Fairfax BH Everett IMD E&T	Snohomish		☐	☐	☐	☐	☐
Fairfax BH Monroe IMD E&T	Snohomish		☐	☐	☐	☐	☐
Skagit Valley Psych Svcs H E&T	Skagit		☐	☐	☐	☐	☐
Snohomish County F E&T	Snohomish		☐	☐	☐	☐	☐
Telecare E&T Sedro Wooley	Skagit		☐	☐	☐	☐	☐
St Joseph Medical Ctr H E&T	Whatcom		☐	☐	☐	☐	☐
Swedish Edmonds H E&T	Snohomish		☐	☐	☐	☐	☐
Greater Lakes F E&T	Pierce		☐	☐	☐	☐	☐
Mary Bridge Adolescent Unit (Y)	Pierce		☐	☐	☐	☐	☐
MDC F E&T	Pierce		☐	☐	☐	☐	☐
Recovery Pathways F E&T	Pierce		☐	☐	☐	☐	☐
Telecare Pierce County F E&T	Pierce		☐	☐	☐	☐	☐
Kitsap Mental Health Adults F E&T	Kitsap		☐	☐	☐	☐	☐
Kitsap Mental Health (Y) F E&T	Kitsap		☐	☐	☐	☐	☐
Eastern State Hospital	Spokane		☐	☐	☐	☐	☐
Sacred Heart ACU Adult H E&T	Spokane		☐	☐	☐	☐	☐
Sacred Heart Adolescent Beds H	Spokane		☐	☐	☐	☐	☐
Sacred Heart Adult/geriatric H E&T	Spokane		☐	☐	☐	☐	☐
Spokane MH Foothills F E&T	Spokane		☐	☐	☐	☐	☐
Spokane MH Calispel F E&T	Spokane		☐	☐	☐	☐	☐
(PeaceHealth) SW Washington Hospital H	Clark		☐	☐	☐	☐	☐
Telecare Clark County F E&T	Clark		☐	☐	☐	☐	☐
Thurston County F E&T	Thurston		☐	☐	☐	☐	☐
*** Notes:**							

DMHP Name:	Phone:
Date of Determination:	Time of Determination of Criteria Met & No Bed Available:
DMHP Signature:	

Fax Completed form to: (360) 725-3480 or send via DSHS Secure E-Mail to: BHSIABedRpt@dshs.wa.gov

BHA form issued: 11/1/2016

Appendix U: Unavailable Detention Facilities Report Data Dictionary

DMHP BHO – The Behavioral Health Organization that the DMHP is designated in, not the BHO of responsibility or residency.

GC BHO- Greater Columbia Behavioral Health Organization

NS BHP- North Sound Behavioral Health Organization

SW BH ASO- Southwest Fully Integrated Managed Care

GR BHO- Great Rivers Behavioral Health Organization

OP BHO – Optum Pierce Behavioral Health Organization

TM BHO – Thurston Mason Behavioral Health Organization

KC BHO – King County Behavioral Health Organization

Sa BHO – Salish Behavioral Health Organization

NC BHO - North Central Behavioral Health Organization

SC BHO – Spokane County Region Behavioral Health Organization

Investigation County – The County in which the involuntary detention evaluation is taking place.

IP's Current Location – Investigated Person's location; such as Othello Community Hospital Emergency Department or Bed # 425 at St Clare Hospital do not use HMC.

Investigated Person – Name of the person being evaluated by the DMHP using the 'first, last, MI' convention

DOB – The date of birth of the Investigated Person

Gender – M is male, F is female and Other is for transgender. Gender is by self-report.

Criteria – ***Emergent Box*** means imminent likelihood of serious harm or grave disability, being likely to occur at any moment or near at hand, rather than distant or remote.

Non-Emergent Box means likelihood of serious harm or grave disability and has a history of one or more violent acts (there is no time frame suggested by the term Non-Emergent such as 'distant or remote').

Danger to ***Self Box*** means the threats or acts of harm to self

Others Box means threats or acts of harm to other people

Property Box means behavior which has caused substantial loss or damage to the property of others.

Gravely Disabled Box means a condition in which a person, as a result of a mental disorder: (a) Is in danger of serious physical harm resulting from a failure to provide for his or her essential human needs of health or safety; or (b) manifests severe

deterioration in routine functioning evidenced by repeated and escalating loss of cognitive or volitional control over his or her actions and is not receiving such care as is essential for his or her health or safety.

Facilities – list of Hospitals, Evaluation and Treatment facilities who will accept an admission. Facilities in **Bold** were funded by the State and therefore accept from across the State.

County – The County where said Facility is located.

Person Issuing Refusal/Reason – This is the area for the DMHP to note the name of the person refusing acceptance of the potentially detained person.

Reason for refusal – this is the shorthand way of giving a reason for refusal.

Capacity box - means no beds available or beds closed due to insufficient staff.

Psych Acuity box – means the person's level of agitation or acuity of symptom is too much for the unit to handle at this time.

Med Acuity box – means the person's medical care needs are beyond the unit to provide. DMHP would note the medical issue of concern.

Other box – means any other reason such as sex offender status, date of court hearing, do not admit list etc… DMHP would note this in the Person issuing refusal/Reason space.

N/A box – means the unit is a Geriatric or Youth unit and your person is an adult or the unit is a voluntary unit and does not accept Single Bed Certifications.

Notes – place for DMHP to further describe obstacles to admission. It is helpful to note anything that might be an obstacle to admission.

DMHP Name –Print the name of the DMHP filling out this form in the First Last convention

Phone – Phone number for the DMHP office the DMHP is working from at the time of completing this form

Date of Determination – the date today (not initial date if this is a subsequent evaluation) when the DMHP made the determination that the investigated person met criteria for an ITA detention

Time of Determination – the time of day today (not initial time if this is a subsequent evaluation) the DMHP made the determination that the investigated person met criteria for ITA detention but there were no beds.

Signature – the DMHP signs their name.

Fax form to 360-725-3480 within 24 hours of your decision to not detain. Your BHO may require you to fax a copy to them as well.