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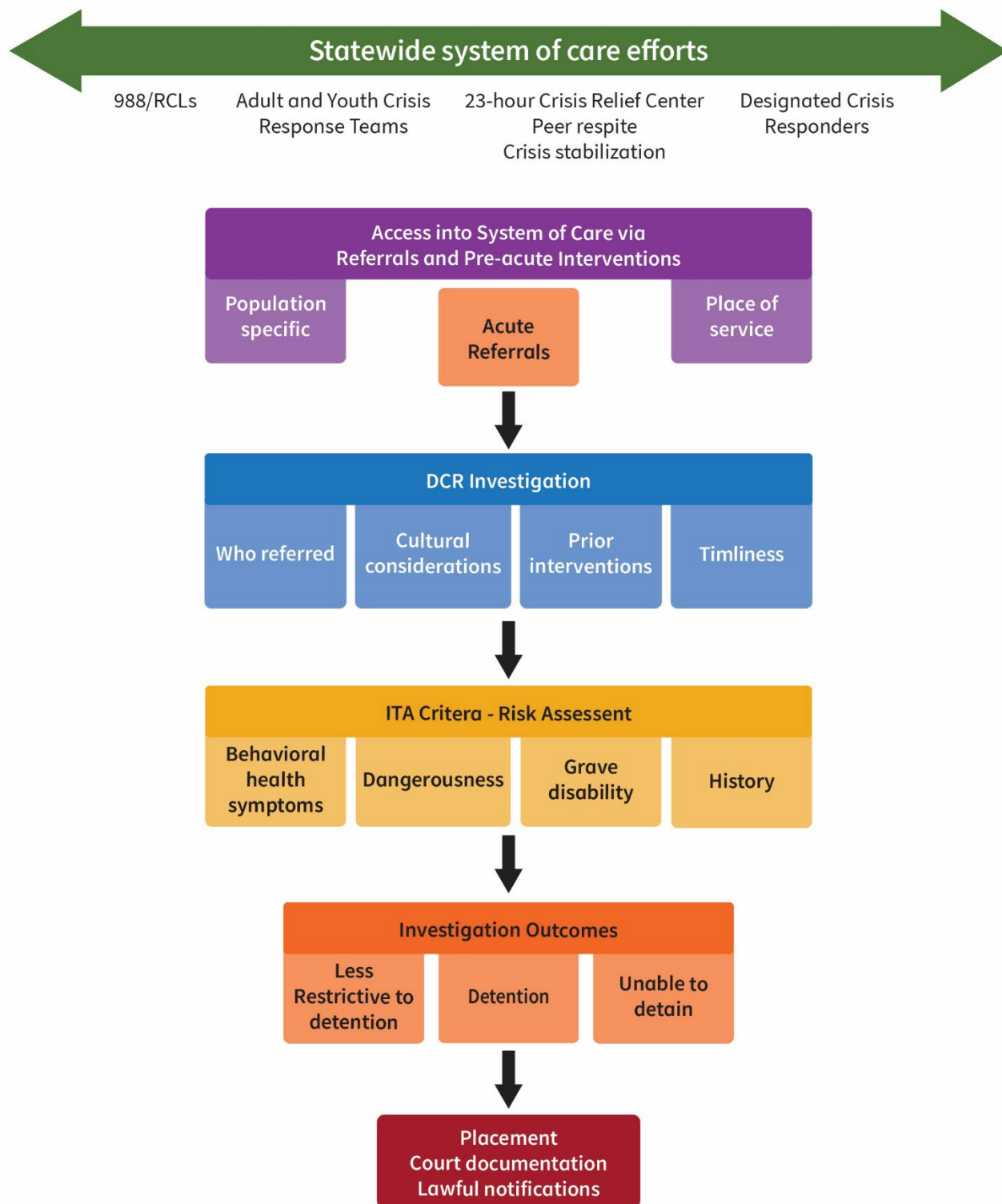
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Washington Crisis System Approach Protocols for DCRs

Goal is to promote awareness of unique needs and pre-acute intervention options



Executive Summary

The 2026 update of the Protocols for Designated Crisis Responders (DCRs) is provided by the Washington State Health Care Authority (HCA), as mandated by the Revised Code of Washington (RCW) [71.05.214](#).

RCW 71.05.214 Protocols—Development—Submission to governor and legislature.

The authority shall develop statewide protocols to be utilized by professional persons and designated crisis responders in administration of this chapter and chapters [10.77](#) and [71.34](#) 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, behavioral health disorders and are subject to this chapter.

The initial protocols shall be developed not later than September 1, 1999. The authority shall develop and update the protocols in consultation with representatives of designated crisis responders, the department of social and health services, Tribal government, local government, law enforcement, county and city prosecutors, public defenders, and groups concerned with behavioral health disorders. The protocols shall be submitted to the governor and legislature upon adoption by the authority.

The Washington Department of Social and Health Services (DSHS) published the initial protocols in September 1999. Between 1999 and 2019, DSHS published the following six revisions:

- [Protocols, County Designated Mental Health Professional, September 1, 2002](#)
- [Protocols, Designated Mental Health Professional, December 2005](#)
- [Protocols, Designated Mental Health Professional, December 2008](#)
- [Protocols, Designated Mental Health Professional, December 2011](#)
- [Protocols, Designated Mental Health Professional September 2014](#)
- [Protocols, Designated Mental Health Professional September 2017](#)

On July 1, 2018, enacted 2nd Engrossed Substitute House Bill 1388 transferred the powers, duties, and functions of the Department of Social and Health Services pertaining to the behavioral health system and purchasing function of the behavioral health administration, except for oversight and management of state-run mental health institutions and licensing and certification activities, to Washington State Health Care Authority (HCA). The transfer ensured the alignment of behavioral health services with physical health, aiming for a “whole person” approach to managed care. Since 2018, HCA has maintained publishing of the protocols. Additional revisions to the protocols include:

- 2019 Addendum to the Designated Crisis Responder (DCR) Statewide Protocols
- [Protocols for Designated Crisis Responders \(DCRs\), 2020 Update](#), published in November 2021¹

Development of this protocol update has included consultation among programs within the HCA related to the provision of behavioral health and forensic diversion services, along with collaboration with additional state services that establish the continuum of care. Further consultation in the protocol development to address cultural, systemic, and trauma-focused concerns included consultation with advocacy groups in recovery support behavioral health. *(A list of participants and their affiliations can be found in [Appendix H](#).)*

¹ This document was submitted after the original statute guideline due to operational disruptions and staffing shortages associated with the COVID-19 pandemic. Update of the Protocols for Designated Crisis Responders will resume the original triennial update schedule per RCW 71.05.214.

Conventions used in this report

The reader should be aware of several conventions used in this update of the protocols: In the development of this update, partners voiced a desire for a more effective and useful tool.

This report is intended to support Designated Crisis Responders in their processes and protocols as well as to provide clarification and insight to the general public regarding these processes and protocols and why they exist

While it may be assumed that this document will be used primarily by those who work in fields related to crisis response and management, the reader/user should be aware of the conventions used in the update of these protocols. This update was developed in direct response to the need for a more effective and useful tool for all who may use it, including but not limited to:

- Professionals handling referrals due to acuity
- Designated crisis responders (DCRs)
- Inpatient facilities providing Involuntary Treatment Act (ITA) in the State of Washington
- Healthcare workers needing guidance in system of care regarding acuity
- Educational institutions teaching or researching crisis response in health, legal, or social work fields or who are otherwise seeking information on acuity and crisis management
- Families affected by or engaged in ITA or crisis situations
- Media professionals seeking information on acuity and crisis management in the State of Washington
- General public gathering information on systems of care

To this end, these protocols have been updated to reflect the most current legislative mandates, best practices, and present effective procedures that may be applied regionally and that consider the disparate audiences for whom this report was prepared. Common definitions are provided at the beginning of this document. The reader is encouraged to reach out to [HCA DCR Protocols](#) should any relevant definition be overlooked or found incomplete.

The Washington State Health Care Authority (HCA) strives to support holistic, evidence-based, person-centered care addressing both physical and behavioral health conditions. Resources and references throughout the document are built in to encourage the continuous application in professional practice of self-reflection and self-critique, learning from patients, and partnership-building, with an awareness of each person's limited ability to fully understand another individual's worldview, culture(s), and communities.

Links to statutes, legislative bills, and judicial determinations are provided for reference and continued understanding. To encourage better understanding of cultural humility (especially where trauma-informed approaches exist), legislative bills that have family member testimony and judicial cases that have individuals' personal histories attached are included.

Additionally, throughout the referral section, there are population-specific considerations with resources for culturally appropriate care considerations to help staff achieve higher levels of continuing education for their occupations.

General guidance

The following terminology broadly applies to the entirety of the Involuntary Treatment Act and is utilized throughout this document.²

Behavioral health disorder: Either a mental disorder as defined in this section, a substance use disorder as defined in this section, or a co-occurring mental disorder and substance use disorder [RCW

² The definitions of these terms are current and accurate as of August 2026

[71.05.020\(7\)](#), [71.34.020\(9\)](#)].

Behavioral health treatment: Inclusive of mental health treatment, substance use disorder treatment, and co-occurring treatment.

Designated Crisis Responder (DCR): A mental health professional appointed by the county, by an entity appointed by the county, or by the authority in consultation with a Tribe or after meeting and conferring with an Indian health care provider, to perform the duties specified in this chapter [\[RCW 71.05.020\(17\)\]](#).

Evaluation and treatment facility: Any facility that may provide directly, or by direct arrangement with other public or private agencies, emergency evaluation and treatment, outpatient care, and timely and appropriate inpatient care to persons suffering from a mental disorder, and which is licensed or certified as such by the department. The authority may certify single beds as temporary evaluation and treatment beds under [RCW 71.05.745](#). A physically separate and separately operated portion of a state hospital may be designated as an evaluation and treatment facility. A facility which is part of, or operated by, the department of social and health services or any federal agency will not require certification. No correctional institution or facility, or jail, shall be an evaluation and treatment facility within the meaning of this chapter [\[RCW 71.05.020\(24\)\]](#).

Gravely disabled: A condition in which a person, as a result of a behavioral health disorder: (a) is in danger of serious physical harm resulting from a failure to provide for their 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 their actions and is not receiving such care as is essential for their health or safety [\[RCW 71.05.020\(24\)\]](#). (See [Appendix A](#) for a contingent effective definition)

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\(28\)\]](#).

Investigation and evaluation: 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 behavioral health disorder; and
- b) There is evidence that the person, as a result of a behavioral health disorder presents a likelihood of serious harm to themselves, other persons, other's property, or the referred person may be gravely disabled, and
- c) The referred person refuses to seek appropriate treatment options [\[RCW 71.05.150\(1\)](#), [RCW 71.05.153\(1\)](#) and [RCW 71.34.710](#)].

Likelihood of serious harm: (a) A substantial risk that: (i) physical harm will be inflicted by a person upon their own person, as evidenced by threats or attempts to commit suicide or inflict physical harm on oneself; (ii) physical harm will be inflicted by a person 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 (iii) physical harm will be inflicted by a person upon the property of others, as evidenced by behavior which has caused substantial loss or damage to the property of others; or (b) the person has threatened the physical safety of another and has a history of one or more violent acts [\[RCW 71.05.020\(36\)\]](#). (See [Appendix A](#) for a contingent effective definition)

Mental disorder: Any organic, mental, or emotional impairment which has substantial adverse effects on a person's cognitive or volitional functions [\[RCW 71.05.020\(38\)\]](#)

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\(43\)](#).

Mental health advance directive or directive: A written document in which the principal makes a

declaration of instructions or preferences or appoints an agent to make decisions on behalf of the principal regarding the principal's mental health treatment, or both, and that is consistent with the provisions of this chapter [RCW 71.32.020(12)].

Secure withdrawal management and stabilization facility: A facility operated by either a public or private agency or by the program of an agency which provides care to voluntary individuals and individuals involuntarily detained and committed under this chapter for whom there is a likelihood of serious harm or who are gravely disabled due to the presence of a substance use disorder. Secure withdrawal management and stabilization facilities must

- a) Provide the following services:
 - i. Assessment and treatment, provided by certified substance use disorder professionals or co-occurring disorder specialists;
 - ii. Clinical stabilization services;
 - iii. Acute or subacute detoxification services for intoxicated individuals; and
 - iv. Discharge assistance provided by certified substance use disorder professionals or co-occurring disorder specialists, including facilitating transitions to appropriate voluntary or involuntary inpatient services or to less restrictive alternatives as appropriate for the individual;
- b) Include security measures sufficient to protect the patients, staff, and community; and
- c) Be licensed or certified as such by the department of health [RCW 71.05.020(52)].

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 [RCW 71.05.020(53)].

Use of references

Within the document there are definitions of additional important words or phrases. Terminology is linked closely to the subject matter. Definitions are taken from Washington State statute when able and an RCW citation follows. When no citation is noted, the definition is a general, common utilization from Merriam-Webster and should be read as part of the guidelines and without specific statutory authority. A glossary of all terminology is at the conclusion of this document.

Citations that appear are included as references only. They provide directions to the statutes for further information but should not be taken as direct sources for all the content of the section. Links to the RCW citations allow for DCRs and others to explore the session laws and the bill reports that provide the background and summary as to purpose for the statute.

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 (LRA) to involuntary detention” and “less restrictive alternative court orders”

Caveat of limitation

The 2026 protocols also have limitations. It is beyond the scope of the protocols to address the myriad clinical skills and practices required of DCRs or the role of the DCRs in providing crisis response and resolution as a mental health professional. In addition, some of the practices followed by DCRs are influenced by the rulings of local courts.

These rulings have resulted in procedural differences across the state that are beyond the authority of the protocols to remedy. There are significant variations among counties with respect to geography, population, resources, and socioeconomic and political factors.

After the 2020 update, published in 2021, the next comprehensive update of the Protocols was not initiated until

early 2024 due to the public health emergency as a result of the COVID-19 pandemic. This unprecedented event saw too many extenuating factors in the healthcare arena, particularly among crisis response settings, that went largely unmitigated as not enough evidence-backed data, expertise, or guidance existed at that time. Further, the concern that the Protocols would reflect only outlying scenarios unique only to the pandemic halted further, meaningful updating that reflected expert consensus and best practices. It is for this reason, as well as the need to incorporate current, relevant data and language, that these Protocols are now updated as comprehensively and completely as possible, and will resume the original update schedule of at least every three (3) years per RCW [71.05.214](#).

The purpose of these protocols is to continue to move DCR practices toward greater uniformity in implementation of applicable statutes across the state and to emphasize that regardless of differences in court rulings, local procedures, or inpatient psychiatric bed capacity, it is imperative to the integrity of the system, and those we serve, that DCRs make their decisions based on clinical presentation, collateral information, and the rules implementing RCWs 71.05, 71.34, and 10.77.

Legislative intent and purpose

Civil involuntary treatment in Washington State is primarily regulated through two chapters of the Revised Code of Washington (RCW): **Chapter 71.05** for adults and **Chapter 71.34** for minors.

Chapter **71.05 RCW Behavioral Health Disorders**, often referred to as the Involuntary Treatment Act (ITA), provides the statutory framework for civil investigation, evaluation, detention, and commitment of individuals experiencing a mental disorder or a substance use disorder whose symptoms are so acute that the individual may need to be treated on an involuntary basis for outpatient least restrictive alternative treatment, or inpatient treatment in an Evaluation and Treatment facility (E&T) or Secure Withdrawal Management and Stabilization facility (SWMS).

Designated Crisis Responders (DCR) conduct evaluations under this statute balancing the individual's needs, their civil rights, and public safety to ensure the least restrictive treatment options are considered, understanding the two different statutes governing their conduct regarding adults (RCW 71.05 et. al.) or minors (RCW 71.34 et.al.) and the nuanced provisions therein.

RCW 71.05.010 Intent (Adult Statute)

(1) The provisions of this chapter apply to persons who are eighteen years of age or older and are intended by the legislature:

- (a) To protect the health and safety of persons suffering from behavioral health 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 persons living with behavioral health disorders and to eliminate legal disabilities that arise from such commitment;
- (c) To provide prompt evaluation and timely and appropriate treatment of persons with serious behavioral health disorders;
- (d) To safeguard individual rights;
- (e) To provide continuity of care for persons with serious behavioral health 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 their treatment.

In contrast to RCW 71.05, the **Behavioral Health Services for Minors** statute **RCW 71.34** addresses the continuum of services for minors while including guidance and alignment of intent on the provision of involuntary treatment for adolescents, ages 13 to 17.

RCW 71.34.010 Purpose (Minor Statute)

(1) It is the purpose of this chapter to assure that minors in need of behavioral health care and treatment receive an appropriate continuum of culturally relevant care and treatment, including prevention and early intervention, self-directed care, parent-directed care, and involuntary treatment. To facilitate the continuum of care and treatment to minors in out-of-home placements, all divisions of the authority and the department that provide behavioral health services to minors shall jointly plan and deliver those services.

(2) It is also the purpose of this chapter to protect the rights of adolescents to confidentiality and to independently seek services for behavioral health disorders. Mental health and substance use disorder professionals shall guard against needless hospitalization and deprivations of liberty, enable treatment decisions to be made in response to clinical needs in accordance with sound professional judgment, and encourage the use of voluntary services. Mental health and substance use disorder professionals shall, whenever clinically appropriate, **offer less restrictive alternatives to inpatient treatment**. Additionally, all behavioral health care and treatment providers shall assure that minors' parents are given an opportunity to participate in the treatment decisions for their minor children. The behavioral health care and treatment providers shall, to the extent possible, offer services that involve minors' parents or family.

(3)(a) It is the intent of the legislature to enhance continuity of care for minors with serious behavioral health disorders that can be controlled or stabilized in a less restrictive alternative commitment. Within the guidelines stated in [In re LaBelle, 107 Wn.2d 196 \(1986\)](#)³, the legislature intends to encourage appropriate interventions at a point when there is the best opportunity to restore the minor to or maintain satisfactory functioning.

(b) For minors with a prior history or pattern of repeated hospitalizations or law enforcement interventions due to decompensation, the consideration of prior behavioral health history is particularly relevant in determining whether the minor would receive, if released, such care as is essential for their health or safety.

(c) Therefore, the legislature finds that for minors who are currently under a commitment order, a prior history of decompensation leading to repeated hospitalizations or law enforcement interventions should be given great weight in determining whether a new less restrictive alternative commitment should be ordered. The court must also consider any school behavioral issues, the impact on the family, the safety of other children in the household, and the developmental age of the minor.

(4) It is also the purpose of this chapter to protect the health and safety of minors suffering from behavioral health disorders and to protect public safety through use of the parens patriae and police powers of the state. Accordingly, 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 minors as well as public safety may be implicated by the decision to release a minor and discontinue their treatment.

(5) It is also the purpose of this chapter to assure the ability of parents to exercise reasonable, compassionate care and control of their minor children when there is a medical necessity for treatment and without the requirement of filing a petition under this chapter, including the ability to request and receive medically necessary treatment for their adolescent children without the consent of the adolescent.

³ [In re LaBelle :: 1986 :: Washington Supreme Court Decisions :: Washington Case Law :: Washington Law :: U.S. Law :: Justia](#)

Overview of legislative changes

Legislative changes to statutes relevant to involuntary treatment between 2021 and 2026

Various bills and legislation are cited, using standard abbreviations and acronyms for such throughout. A more exhaustive list defining each type of bill may be found on The State of Washington's website: leg.wa.gov.

ESHB: Engrossed Substitute House Bill

HB: House Bill

E2SHB: Engrossed Second Substitute House Bill

SHB: Substitute House Bill

ESSSB: Engrossed Substitute Senate Bill

SSB: Substitute Senate Bill

E2SSB: Engrossed Second Substitute Senate Bill

Legislation passed in 2021

Veteran diversion from involuntary commitment: SHB 1314

- A DCR must attempt to ascertain whether a person under investigation is a veteran or is eligible for veteran's status, and if amenable to treatment by the Veteran's Health Administration (VHA). If amenable, the DCR must first refer the person to the VHA for behavioral health treatment at a facility that meets the person's needs.

Civil commitment – Transition teams – Less restrictive alternative treatment: ESSSB 5071

- Creates transition teams and enhances behavioral health services to support release of persons found not guilty by reason of insanity (NGRI), and certain persons who have been civilly committed following violent felony based on incompetence to stand trial from the state hospitals. Imposes requirements on the Health Care Authority and behavioral health administrative organizations related to less restrictive alternative treatment orders. Pertains to Conditional Releases for 10.77 RCW or 71.05 RCW LRA,

Involuntary commitment: SSB 5073

- Permitted DCR ITA Investigation for minor by video if MHP present with minor
- A DCR must attempt to ascertain whether a person under investigation has executed a mental health advanced directive
- Following the initial detention a facility may transfer a detained patient for involuntary treatment to a more appropriate treatment between an E&T or SWMS
- A DCR must provide notification to the Tribe and the Indian health care provider when the DCR investigates an individual known to be an American Indian/Alaskan Native (AI/AN) who receive medical or behavioral services from a Tribe
- A federally recognized Indian Tribe may file a Joel's Law petition based on behalf of a Tribal member
- HCA must establish written guidelines for conducting culturally appropriate involuntary commitment evaluations of an AI/AN by June 30, 2022
- Identified a court may conduct periodic review of the progress of a person on a Least restrictive alternative or conditional release order, modify the terms of the order and take certain actions
- The definition of less restriction alternative (LRA) for an adolescent is altered to explicitly include residential treatment outside an inpatient hospital setting
- Terminology changed from written orders of apprehension to warrants
- Terminology changed from drug abuse, substance abuse and alcoholism to substance abuse disorder

Legislation passed in 2022

Assisted outpatient treatment: SHB 1773

- Establishes a new procedure for designated persons to directly file a petition in superior court for up to 18 months of assisted outpatient treatment (AOT) and establishes requirements and procedures for the petition process
- Provides that less restrictive alternative (LRA) treatment may include a requirement to participate in partial hospitalization or intensive outpatient treatment
- Allows for revocation of an LRA order based on a person being in need of AOT on the same grounds as for other LRA orders
- Amends behavioral health treatment for minors to allow AOT for adolescents aged 13 to 17

Increasing access to behavioral health services for minors: HB1800

- Behavioral Health Services for Minors chapter expanded with requirement for Authority to dedicate at least one full-time employee dedicated to connecting families, behavioral health providers, educators, and other stakeholders with current information about law and policy related to behavioral health services for minors

Legislation passed in 2023

988 Behavioral health crisis response and suicide prevention system: E2SHB 1134

- Endorsement for mobile rapid response crisis teams
- HCA and BHASOs must develop recommendations for creating a crisis workforce
- Directs DOH to expand marketing of 988
- Establishes liability protections for several entities related to the dispatching

Court files and records exemptions for firearm background checks: HB 1599

- Permits access to ITA files and records of court proceedings to the Washington state patrol firearms background division to conduct background checks

Behavioral health workforce: SSHB 1724

- Expanded definition of mental health professional to include certified or licensed agency affiliated counselor

23-hour Crisis relief centers: 2SSB 5120

- Establishes 23-hour crisis relief centers as a new BH facility type
- Established staffing requirements, who can be brought to a 23-hour facility (must accept any client who arrives voluntarily), when to engage a DCR if the person does not want to remain voluntarily, etc.
- Eliminates triage facilities as a facility type

Competency evaluations: E2SSB 5440

- Requires a court to determine if there is genuine doubt as to competency before ordering an evaluation
- Requires courts to dismiss nonfelony charges and refer defendant to services when recommended by a forensic navigator

Legislation passed in 2024

Behavioral health – Coordination and recognition with Indian behavioral health system: SSHB 1877

- Providing Tribe with notice and a limited right to intervene in involuntary treatment proceedings
- Designated crisis responders (DCRs) must collaborate with Tribal law enforcement

- The Health Care Authority (HCA) is required to develop guidelines for culturally appropriate evaluations of American Indians and Alaska Natives
- Tribe can seek reimbursement for judicial costs related to civil commitment proceedings
- Behavioral health service providers shall accept tribal court orders from tribes located within the state on the same basis as state court orders issued under this chapter

Physician Assistant Collaborative Practice: ESHB 2041

- Redacted supervising for psychiatrist and redefined as consistent with RCW 18.71A.010

Behavioral Health Providers: ESSHB 2247

- Created a new credential for Licensed Psychological Associate and added this to the definition of mental health professional for purposes of the community behavioral health system scope of practice

23-Hour Crisis Relief Centers – Minors: ESSB 5853

- Terminology adding the crisis relief center for behavioral health crisis services for minors as a facility type

Legislation passed in 2025

Removing Obsolete Language: SHB 1281 pursuant to RCW 1.08.025

- Changed a reference to “the developmentally disabled” to “individuals with developmental disabilities”
- Changed the term “advanced registered nurse practitioner” to “advanced practice registered nurse” in accordance with 2024 legislation

Involuntary Treatment – Legal Representation: ESSB 5745

- The county where a person is detained shall administer appointed counsel services under the ITA, either directly or by contraction for that representation
- State Hospital is standardized to mean Western State Hospital, Eastern State Hospital, and the Child Study and Treatment Center
- State Facility replaces the term state institution and defines the facilities as the Center for Behavioral Health and Learning located on the University of Washington northwest medical campus, and facilities owned or operated by Department of Social and Human Services (DSHS) that are not state hospitals that provide inpatient services to individuals under the ITA

Legislation passed in 2026

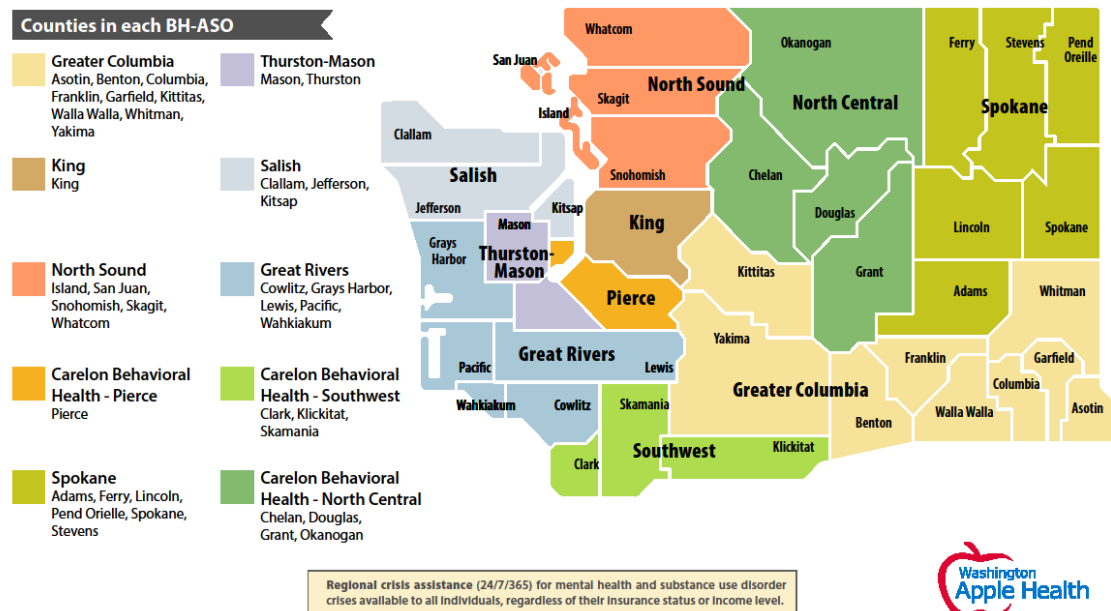
Concerning the reprocurement of medical assistance services, including the realignment of behavioral health crisis services for Medicaid enrollees: E2SHB 1813

- Requires the Health Care Authority (Authority) to adjust Medicaid rates to reflect increases and decreases in service facilities and capacity
- Requires the Authority's preparations for the reprocurement of Medicaid managed care contracts to consider methodologies for measuring network access and adequacy and contract amendments to reduce administrative burdens for health care providers
- Requires the Authority to direct managed care organizations to establish, continue, or expand delegation arrangements with behavioral health administrative services organizations (BHASOs) for crisis services
- Requires the Authority to develop a plan for a statewide BHASO that serves American Indians and Alaska Natives

Washington crisis services system of care

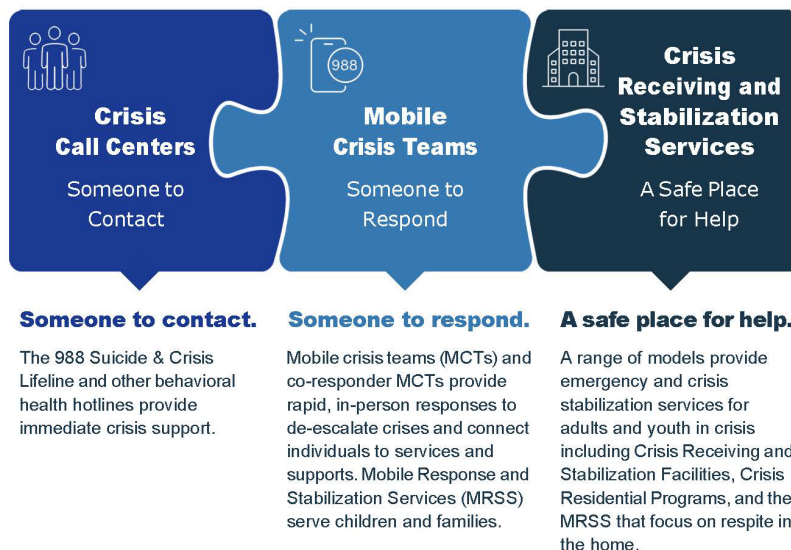
Washington Health Care Authority (HCA) contracts with regional Behavioral Health Administrative Services Organizations (BH-ASO) to provide crisis and Involuntary Treatment Act (ITA) services throughout the state.

Behavioral Health-Administrative Services Organizations (BH-ASO)



BH-ASOs contract with Behavioral Health Agencies (BHA) to provide 24-hour crisis response and DCR services. Crisis services may be provided regionally or within a specific county. The continuum of crisis services may include warm lines for telephone support, regional crisis lines for resources, referrals, and follow-up care, adult and youth mobile crisis teams, 23-hour crisis relief, peer services, crisis stabilization, and Designated Crisis Responder providers. Each county has a Designated Crisis Responder (DCR) service provider and may also have Tribal Designated Crisis Responders authorized by the Tribe.

SAMHSA Landscape of Crisis Care



988 and Regional Crisis Lines triage crisis referrals to identify service response that considers all least restrictive alternatives in the community. Least restrictive services may include utilization of mobile outreach or referral to emergency services for voluntary admission.

Regional crisis lines

Region	Phone
Great Rivers	1-800-803-8833
Greater Columbia	1-888-544-9986
King	1-866-427-4747
North Central	1-800-852-2923
North Sound	1-800-584-3578
Pierce	1-800-576-7764
Salish	1-888-910-0416
Southwest	1-800-626-8137
Spokane	1-877-266-1818
Thurston/Mason	1-800-270-0041



Mobile crisis response

A behavioral health crisis can be devastating, and even traumatic, for individuals, families, and our communities. Although we cannot know when a crisis may occur, we can create a system that is agile and responsive when the need arises. We strive for a crisis system in Washington State that minimizes delays, reduces the use of law enforcement and emergency departments, and only looks to the most restrictive responses when no other safe solution can be found. Whenever possible, the crisis system should explore all least restrictive alternatives before referral for a DCR evaluation is considered.

A key component of our state's crisis system is the utilization of rapidly deployed mobile crisis response to the location of the crisis and provide crisis assessment and stabilization services to anyone, anywhere, and at any time.

Mobile crisis response can include

- Mobile Crisis Response (MCR) teams
- Mobile Rapid Response Crisis Teams (MRRCT)
- Endorsed Mobile Rapid Response Crisis Teams (EMRRCT)
- Endorsed Community-Based Crisis Teams (ECBCT)

When a situation appears to be primarily related to a behavioral health crisis and there is no medical emergency acuity, call response workers are encouraged to consider contacting mobile crisis response or other behavioral health crisis resources before activating 911 or sending someone to the emergency department. If appropriate, mobile crisis response can arrange in-home stabilization supports to help individuals remain safely in their homes while receiving care. Utilizing these services can help ensure people receive compassionate, specialized support while reducing unnecessary emergency system involvement. Click the links below to see regional mobile crisis response services:

[2026 Mobile Crisis Response Endorsement Program Map](#)

[Mobile Response and Stabilization Services – Youth Teams](#)

Designated Crisis Responder services

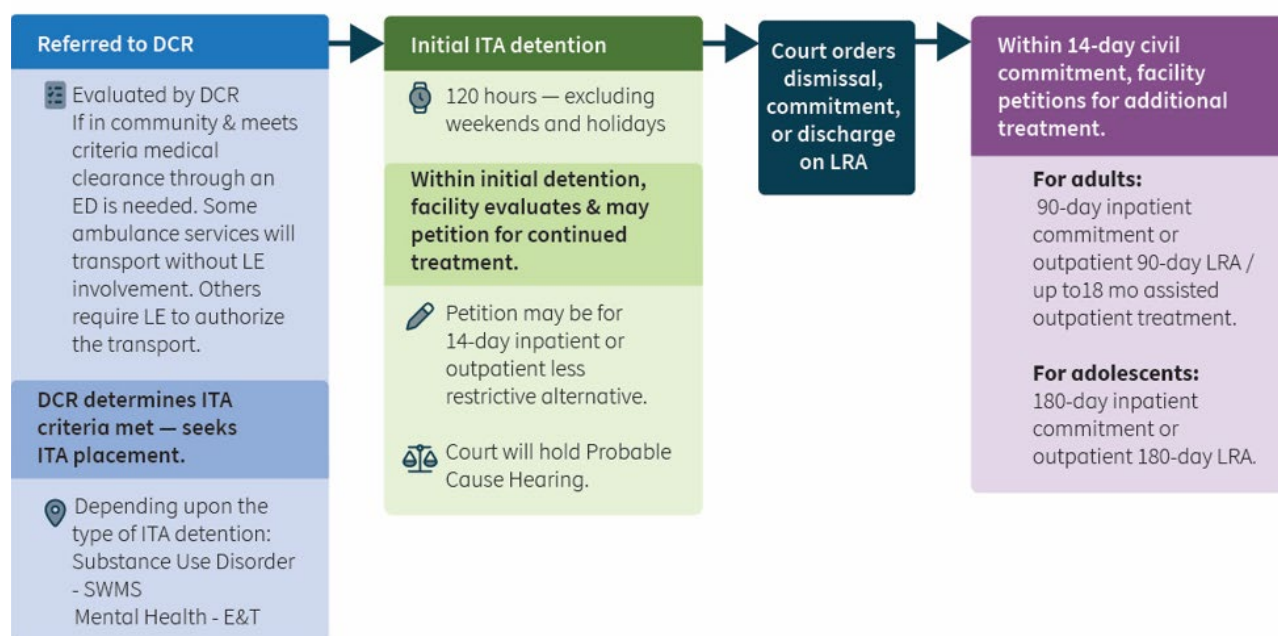
If a crisis is unable to be triaged or served by less restrictive to acute level response, a referral to a designated crisis responder may be in order. **DCRs conduct an evaluation and determine if an individual meets criteria for inpatient admission under involuntary treatment statutes.** Involuntary treatment may occur at an evaluation and treatment facility (E&T) while involuntary substance abuse treatment services are at a secure withdrawal management and stabilization facility (SWMS).

Some inpatient facilities are licensed for both E&T and SWMS services. To ensure the rights of the individual, continued involuntary inpatient treatment may only occur once the facility has assessed the individual, determined the necessity for treatment and petitioned the court.

Although the DCR is determining criteria is met for an initial detention and securing involuntary placement, the treatment facility determines the course of inpatient care. Initial detention is for up to 120 hours excluding weekends and holidays. A facility may decide to drop the initial detention and release the individual or based upon their treatment providers assessment, the facility will file a petition for future involuntary inpatient treatment.

It is beneficial that DCRs assist an individual's supports with understanding the ITA process and encourage engagement with National Alliance on Mental Illness (NAMI)⁴, which can provide additional resources around behavioral health treatment and recovery.

ITA Process flowchart



Educational resources

[2025 National Guidelines for a Behavioral Health Coordinated System of Crisis Care](#), SAMHSA, January 15, 2025

⁴ [National Alliance on Mental Illness \(NAMI\)](#), an alliance of more than 650 local affiliates and 49 state organizations, in operation since 1979

[Model Definitions for Behavioral Health Emergency, Crisis, and Crisis-Related Services](#), SAMHSA, January 15, 2025

[Prenatal, child, youth, and young adult behavioral health | Washington State Health Care Authority](#)

Washington Behavioral Health Crisis Response and Suicide Prevention System: Crisis Response Improvement Strategy Steering Committee Final Report, HCA CRIS Committee, December 31, 2024

DRAFT

Tribal/Indian Behavioral Health System

Overview

Washington is home to **29 federally recognized Tribes**, which exercise sovereignty over their respective Tribal lands. Health care on Tribal lands is provided through an Indian health care delivery system that is supported by the federal Indian Health Service and provides care in urban and rural areas. Behavioral health services are provided by Indian Health Care, Tribal providers and Urban Indian Health Programs, and includes outpatient mental health, outpatient substance use disorder, and inpatient substance use disorder programs. Awareness of the Tribal Behavioral Health System and the statewide crisis system connection is vital for appropriate coordination of care for tribal members.

At the HCA the Office of Tribal Affairs (OTA) works to ensure Washington state recognizes and protects the interests, rights and sovereignty of Tribal Nations. OTA exists to support and honor our state's government-to-government relationship and unique partnership with Tribe, including expanding Tribal crisis behavioral health services [[RCW 43.376](#)].

Important terminology

American Indian or Alaska Native: Any individual who is a member of a federally recognized Tribe, or eligible for the Indian health service [[RCW 43.71B.010\(3\)](#)].

Federally recognized Indian Tribe: Any Indian Tribe, band, nation, or other organized group or community, including any Alaska Native village or group or regional or village corporation as defined in or established pursuant to the Alaska Native claims settlement act ([43 U.S.C. Sec. 1601 et seq.](#)) which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians [WA Indian Health Improvement Act RCW 43.71B.010]

Indian Health Care Provider (IHCP): A health care program operated by the Indian health service or by a Tribe, Tribal organization, or urban Indian organization as those terms are defined in 25 U.S.C. Sec. 1603 [[RCW 43.71B.010\(11\)](#)].

Tribal Crisis Coordination Protocol: A government-to-government agreement between HCA and the Indian Nation or Indian Nation regional plan that establishes protocols for the coordination of crisis services (including involuntary treatment), care coordination, and discharge planning. These protocols outline how the DCR will engage with an individual Tribal member or non-Tribal member on Tribal lands. Protocols are developed in coordination with Tribal and non-Tribal regional crisis entities.

Tribal DCR: A mental health professional appointed by the authority in consultation with a Tribe or after meeting and conferring with an Indian Health Care Provider (IHCP), to perform the duties specified in RCW 71.05 [[WAC 182-125-0100](#)].

Tribal Land: Any territory within the state of Washington over which a Tribe has legal jurisdiction, including any land held in trust for the Tribe by the federal government.

Tribally operated facility: A health care facility operated by one or more Tribe or Tribal organizations to provide specialty services, including but not limited to evaluation and treatment services, secure detox services, inpatient psychiatric services, nursing home services, and residential substance use disorder services [[RCW 43.71B.010\(17\)](#)].

Tribal sovereignty: Tribes possess the right to form their own governments; to make and enforce laws, both civil and criminal; to tax; to establish and determine membership (i.e., Tribal citizenship); to license and regulate activities within their jurisdiction; to zone; and to exclude persons from Tribal lands.

Tribe: A federally recognized Indian Tribe [[RCW 71.24.025\(55\)](#)].

Legislative Expansion of Indian Behavioral Health with RCW 71.05

In 2020, Senate Bill 6259, the Indian Behavioral Health Act was passed which established the collaboration the HCA and Tribes for the designation of Tribal DCRs.

Additionally, this bill

- Required notification to Tribes of ITA proceedings for a Tribal member/citizen
- Amended the Joel's Law statute to recognize Tribe's ability to petition in the state courts for an ITA
- Required notification of IHCP of ITA proceeds for Tribal member/citizen
- Tasked HCA to work with the AIHC to develop a statewide Tribal Crisis and Care Coordination Hub
Establishing guidelines for culturally appropriate evaluations of American Indians and Alaska Natives

During the 2023-2024 legislative session, House Bill 1877 was passed. This bill is intended to further improve the expansion of the Indian behavioral health system within the Washington State behavioral health system, improving recognition for collaborative acute care services.

This improvement further calls for

- Directing the administrative office of the courts to develop court forms for use by Tribal designated crisis responders
- Requiring behavioral health service providers to accept Tribal court orders on the same basis as state court orders
- Allowing Tribal attorneys to intervene in court proceedings under the Involuntary Treatment Act involving a Tribal member, with the right to attend proceedings, speak in court, request copies of



- orders, submit information, and petition the court
- Requiring behavioral health administrative services organizations to collaborate with Tribe and Indian health care providers on crisis coordination, care coordination, and discharge and transition planning

Tribal Care Coordination: What BH-ASOs and DCRs need to know

The Tribal Crisis Coordination Protocols are a government-to-government cross-system resource used by Tribal and Indian Health Care Providers (IHCP), regional Behavioral Health Administrative Service Organizations, Behavioral Health Agencies, and various crisis service entities to establish procedures for the ways non-Tribal crisis care organizations can coordinate and provide services on Tribal reservation lands and for when a help-seeker identifies as Native, Indigenous, or American Indian or Alaska Native (AI/AN) yet is not on reservation land.

Each Tribe develops their own version of a Tribal Crisis Coordination Protocol with assistance from the HCA Office of Tribal Affairs and Department of Health [[RCW 43.376](#)].

- Final plans are provided to the agencies identified in the Protocols development including Regional BHASOs, BHAs, Regional DCR Offices, and other crisis providers.
- With permission from the Tribe, a Tribal Crisis Coordination Protocol will be saved on the [VOA Tribal Services Webpage](#).

As part of the HB 1877 expansion efforts, the HCA Office of Tribal Affairs has developed documents to assist in the provision of acute behavioral health services for AI/AN people and member of Washington State Tribes. BH-ASOs and DCR offices should ensure awareness of these documents and actively participate in continuing education opportunities pertaining to Tribal Sovereignty and the Indian Health Care System.

HCA Office of Tribal Affairs documents include

- Guidelines for how to navigate a crisis without a Tribal Crisis Coordination Protocol
- Guidelines for culturally appropriate evaluations of American Indians and Alaska Natives
- [Tribal Crisis Services](#)
- [Tribal Designated Crisis Responder \(DCR\) FAQ](#)

Best practices for DCR engagement on Tribal land

As identified in the DCR knowledge and training, DCRs should be familiar with the cultural and political dimensions of Tribal sovereignty and understand government-to-government relationships prior to conducting ITA investigation and evaluations on Tribal land.

There is possibility that ITA investigations on Tribal land will require coordination with Tribal law enforcement rather than city, county, or state law enforcement.

1. If there is a Tribal Crisis Coordination Protocol, the DCR will follow that protocol, established by the Tribe, HCA/DOH, BH-ASO, and regional crisis services, to the best of their ability.
2. If the Tribal referral is from a Tribal behavioral health provider, the DCR office will make contact and determine if the provider can be the second (2nd) for safety and if the ITA evaluation can be conducted on Tribal land.
3. As not all Tribes have their own Tribal law enforcement, DCRs should attempt to coordinate with the referral source to determine the appropriate law enforcement entity prior to accessing Tribal land. If the referral source is not a Tribal behavioral health provider, law enforcement will need to be the 2nd for safety on the outreach.
4. If a 2nd for safety cannot be established either via a behavioral health agency, a law enforcement officer, or other first responder, the DCR needs to consider utilization of a Custody Authorization if

warranted or coordinated with law enforcement for their determination of authorization of transport to an emergency department for further ITA investigation and evaluation in a safe environment per RCW 71.05.

Ways to make contact:

1. Review Tribal Profile on the Native Resources Hub: **Tribal Services | VOAWW**
Example - **Port Gamble S'Klallam Tribe, Tribal Services Profile**

If there is a Tribal Crisis Coordination Protocol, the DCR will comply with those protocols.

2. Call the VOAWW Contact and ask for Indian Health Care Provider
During Normal Business Hours 1-866-491-1683

After hours #988 Option 4, Native and Strong Lifeline Staff

If there is no Indian Health Care Provider, the DCR will consult a Tribal Council representative to identify provider contact information and contact information for notification of their investigation decision.

Additional supports

The Tribes of Washington – Map of Tribe, Tribal land, and links to Tribal information

<https://www.washingtonTribe.org/the-Tribe-of-washington/>

Indian Health Services, The Federal Health Program for American Indians and Alaska Natives

<https://www.ihs.gov/findhealthcare/>

Washington State Department of Social and Health Services, Services for American Indians and Alaska Natives, list of Washington Tribe and links to their Tribal webpages

<https://www.dshs.wa.gov/bha/services-american-indians-and-alaska-natives>

American Indian Health Commission (AIHC)

AIHC – We are resilient. Our ways are resilient. (aihc-wa.com)

Health Care Authority (HCA) Office of Tribal Affairs (OTA)

Contact us | Washington State Health Care Authority

Northwest Portland Area Indian Health Board WA Tribe

Member Tribe | NPAIHB

List of Washington State Tribal Courts from the Governor's Office of Indian Affairs:

Washington State Tribal Courts | GOIA

Educational resources

Diversity Goals for Evaluation and Treatment of American Indians and Alaska Natives by B. Jabbari National Institutes of Health (NIH)

Diversity Goals for Evaluation and Treatment of American Indians and Alaska Natives - StatPearls - NCBI Bookshelf (nih.gov)

Emerging Tribal Models for the Civil Commitment of American Indians by Spero M. Manson Et al.
American Indian and Alaska Native Mental Health Research

Centers for American Indian and Alaska Native Health
Colorado School of Public Health/University of Colorado Anschutz Medical Campus (www.ucdenver.edu/caianh)
[1_1_1987_9_manson.pdf \(cuanschutz.edu\)](#)

Federal and State Laws for Sharing Health Information with Indian Health Care Providers, An Overview for Health Care Providers in Washington State. Last Updated 11-19-25. American Indian Health Commission.
<https://aihc-wa.com/wp-content/uploads/sites/49/2026/04/Sharing-Protected-Health-Information-with-Indian-Health-Care-Providers-11-19-25.pdf>

Indian Health Manual, Chapter 14 – Mental Health Program, Part 3 – Professional Services
The Indian Health Manual (IHM) is the reference for IHS employees regarding IHS-specific policy and procedural instructions
[Chapter 14 - Mental Health Program | Part 3 \(ihs.gov\)](#)

In Search of Cultural Competence in Evaluation Chapter 3: Culturally Competent Evaluation in Indian Country by Joan LaFrance
<https://www.betterevaluation.org/sites/default/files/2022-04/CCevalinidancountry.pdf>

Steps for Conducting Research and Evaluation in Native Communities
NACE, Native American Center for Excellence, Substance Abuse Prevention
[Best \(and worst\) practice: Conducting program evaluations in Indian country \(samhsa.gov\)](#)

[Tribal Sovereignty and the Indian Health Care System Webinar Series](#), Center for Community-Engaged Drug Education, Epidemiology and Research (CEDEER), University of Washington Addictions, Drug and Alcohol Institute (ADAI), 2023

Designated Crisis Responder (DCR)

In the State of Washington, Designated Crisis Responders (DCR) are the only people with the authority to involuntarily detain a person into a facility for longer than twelve hours for involuntary treatment.

DCRs are licensed or credentialed mental health professionals and provide evaluations under the Involuntary Treatment Act for adults (RCW 71.05) and for adolescents age thirteen to seventeen (RCW 71.34).

No designated crisis responder shall be civilly or criminally liable for performing duties pursuant to the decision of whether to detain a person: PROVIDED, that such duties were performed in good faith and without gross negligence [RCW 71.05.120(1)].

Appendix B includes Washington State Case Law that provides synopsis and summary of performing duties in good faith, identifying criteria, ensuring applicable standards of care, and determinations regarding negligence. DCRs are encouraged to review case law.

Statutory requirements

Designated Crisis Responder (DCR) [RCW 71.05.020(17)]

A mental health professional appointed by the county, by an entity appointed by the county, or by the authority in consultation with a Tribe or after meeting and conferring with an Indian health care provider, to perform the duties specified in this chapter.

Duty to warn [RCW 71.05.120(3)]

The exemptions from liability statute does not relieve a person from the duty to warn or to take reasonable precautions to provide protection from violent behavior where the patient has communicated an actual threat of physical violence against a reasonably identified victim or victims. The duty to warn or to take reasonable precautions to provide protection from violent behavior is discharged if reasonable efforts are made to communicate the threat to the victim or victims and to law enforcement personnel.⁵

Designated crisis responders—Training—Qualifications [RCW 71.05.760]

- (1)(a) The authority or its designee shall provide training to the designated crisis responders.
- (b)(i) To qualify as a designated crisis responder, a person must have received substance use disorder training as determined by the authority and be a:
 - (b)(i)(A) Mental health professional with an advanced degree.
 - (b)(ii) Training must include training specific to the duties of a designated crisis responder, including diagnosis of substance abuse and dependence and assessment of risk associated with substance use.

Mental health professional [RCW 71.05.020(40)]

An individual practicing within the mental health professional's statutory scope of practice who is:

- (a) A psychiatrist, psychologist, physician assistant working with a supervising psychiatrist, psychiatric advanced registered nurse practitioner, psychiatric nurse, or social worker, as defined in this chapter and chapter 71.34 RCW;
- (b) A mental health counselor, mental health counselor associate, marriage and family therapist, or marriage and family therapist associate, as defined in chapter 18.225 RCW;
- (c) A certified or licensed agency affiliated counselor, as defined in chapter 18.19 RCW; or
- (d) A licensed psychological associate as described in chapter 18.83 RCW.

Tribal DCRs [WAC 182-125-0100]

A Tribal organization may, in consultation or conference with HCA, designate professionals as Tribal DCRs, to perform the duties outlined in RCW 71.05 and 71.34. As outlined in the protocols developed by the

⁵ Volk v. DeMeerleer :: 2016 :: Washington Supreme Court Decisions :: Washington Case Law :: Washington Law :: U.S. Law :: Justia

Tribal organization, Tribal DCRs will have the same authority as DCRs and within the Superior Court system for Tribal and non-Tribal members.

Knowledge base: What DCRs need to know

Applicable statutes

- [RCW 71.05](#) Behavioral Health Disorders
- [RCW 71.34](#) Behavioral Health Services for Minors
- [RCW 71.24](#) Community Behavioral Health
- [RCW 70.02](#) Medical Records – Health Care Information Access and Disclosure
- [RCW 71.32](#) Mental Health Advance Directive
- [RCW 7.70.065](#) Informed consent
- [RCW 10.77](#) Criminally Insane
- [RCW 37.12](#) Indian Lands Jurisdiction
- [RCW 9.41](#) Firearms and Dangerous Weapons
- [RCW 11.88](#) Guardianship
- [WAC 246-341](#) Behavioral Health Agency Licensing and Certification Requirements

Education/Training

- Professional ethics and knowledge of consumer rights
- Psychopathology and psychopharmacology
- 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 71.34.385](#)
- Knowledge of individual and family dynamics, life span development, psychotherapy and family crisis intervention
- Crisis intervention and assessment of risk associated with both mental health disorders and substance use disorders, including suicide risk assessment and assessment of danger to others
- Assessment of grave disability, health and safety, cognitive and volitional functions
- Competency with special populations: co-occurring disorders, developmental and intellectual disabilities, ethnic minorities, children and adolescents, older individuals, and LGBTQ individuals
- Tribal sovereignty and government-to-government relationships
- Guidelines for culturally appropriate evaluations of American Indians and Alaska Natives
- HCA Washington State's Virtual Crisis Academy eLearning opportunities
 - Mobile Response and Stabilization Services (MRSS)
 - Mobile Crisis Response (MCR)
 - Trauma Informed Approach (TIA) for DCRs
 - Family Initiated Treatment (FIT)
- Knowledge of local/regional mental health and substance use disorder treatment resources
- Petition writing: factors, elements, and content
- Continuing education: Clinical and legal education related to DCR processes
- Washington ITA Court Case History – See [Appendix B](#) for case listing

Educational resources

[Addressing Firearm Safety with Patients at Risk of Suicide](#), St. Charles Health System, March 1, 2024

[SAMHSA Advisory, Model Standards Crisis Care Workers](#), February 2026

[Tribal Sovereignty and the Indian Health Care System Webinar Series](#), Center for Community-Engaged Drug Education, Epidemiology and Research (CEDEER), University of Washington Addictions, Drug and Alcohol Institute (ADAI), 2023

WADCR Association DCR Code of Ethics

Enacted January 31, 1996; Updated October 31, 2024

There is no more sensitive area in the law than the contemplation of commitment for one suffering from a mental disorder. On the one hand, the statutory safeguards accorded the individual are imperative to assure due process. On the other hand, there is the grave responsibility of surveillance of an individual who is in danger to self, others, or property, or is gravely disabled. The mental health professional, in assuming such onerous duties, is an indispensable instrumentality in the administration of justice.

Howard A. Patrick
Judge of the Superior Court
Island-San Juan Counties

An individual who is designated by County Authority in the State of Washington as a Mental Health Professional, hereinafter referred as a Designated Crisis Responder (DCR), is credentialed to perform a specific task in the implementation of the adult and juvenile Involuntary Treatment Acts. The DCR believes in the dignity and worth of the individual and, based upon a uniform criteria of knowledge and skill development, makes every possible effort to protect the welfare of the individual and society.

Therefore, confidentiality, competency, and empathy are inherent qualities to which the DCR aspires. The DCR makes every responsible effort to ensure the highest quality care of persons referred while safeguarding their constitutional rights. In pursuit of this ideal, the DCR subscribes to the following principles.

Responsibility: The credentialed DCR places high value on the objectivity, integrity, and skills development and maintains the highest standards in service offered.

- a) As a **practitioner**, the credentialed DCR understands the potential consequences of decisions made while performing duties, and therefore judiciously weighs facts in critical decision making.
- b) As an **educator**, the credentialed DCR understands that families, relative, referral sources, and the community may desire information regarding services rendered.

Competency: The DCR aspires to high standards of scholarship and skill development in the interest of the public and professional identity of the DCR.

- a) A credentialed DCR discourages unqualified persons from practicing and assists the public in identifying competent DCRs. When a credentialed DCR becomes aware of questionable practices of credentialed or non-credentialed DCRs, attempts shall be made to resolve this issue informally. When that is not possible, attention from the appropriate governing entities shall be sought for a formal resolution.
- b) A credentialed DCR recognizes when it is appropriate to refer persons to specialists for situations falling outside their expertise.
- c) A credentialed DCR knows personal limitations in regard to sound professional practice and seeks professional assistance and consultation when it is needed.

Public statements: The credentialed DCR will use discretion when making statements to the public, mindful of the need for clarity and honest representation of the facts.

Moral and legal standards: The credentialed DCR is sensitive to social codes and moral standards of the

community in which they work, recognizing that insensitivity involving clients, the public or colleagues impugns the DCR and their professional reputation.

Legal versus clinical issues

- The credentialed DCR will be called upon to decide if an individual's constitutional rights are to be denied in the interest of clinical care and/or community safety. The credentialed DCR recognizes the sensitive balance therein and resists special interest pressure to involuntarily detain mentally ill individuals
- The credentialed DCR supports the principle that an individual who is mentally ill, intoxicated by alcohol or other substances, or is a behavior management problem by reason of age or infirmity, does not in itself constitute reason for Involuntary Civil Commitment
- The credentialed DCR shall, where indicated, make reasonable efforts to have law enforcement personnel at hand to ensure their own safety, the safety of the community and the safety of persons being evaluated

Confidentiality: The credentialed DCR will not breach confidentiality, yet will assist family, relatives and the community in providing pertinent facts regarding evaluations of clients referred. The credentialed DCR will follow the general provision of as identified in [RCW 10.77](#), [70.02](#), [71.05](#), [71.24](#), and [71.34](#), along with [42 CFR Part 2](#) for substance use records.

Misrepresentation: The credentialed DCR will not distort, misconstrue, or misrepresent professional qualifications, associations or affiliations. A credentialed DCR will not use affiliation with the WADCR for purposes that are not consistent with stated objectives of the association.

Unprofessional conduct: The following constitute unprofessional conduct for a DCR:

1. Unprofessional conduct as defined in the uniform discipline act, [RCW 18.130.180](#)
2. Impaired ability to practice as described in [RCW 18.130.170](#)
3. Failure to report information required by law
4. Failure to refer clients to appropriate health care professionals, if services needed are beyond the expertise of the DCR

The private activities of individuals shall not furnish grounds for disciplinary action unless the actions affect the performance of DCR duties.

The credentialed DCR may subscribe to the Code of Ethics of their particular discipline, i.e., N.A.S.W., A.P.A., without conflicting with the WADCR Code of Ethics.

Sources

1. [RCW 18.83.120](#) (Law relating to Psychologists)
2. [Substance Abuse Treatment Workers Code of Ethics](#)
3. By-laws of WMHCA Article II. (Section 1 (b))
4. Substitute House Bill # 470 (an act relating to counselors, social workers, mental health counselors, and marriage and family counselors).

Rights of an individual being investigated

Detain: To hold or keep in or as if in custody, such as a police station, a prison or a hospital, and prevent them from leaving.

In the community or in a facility, professionals may seek to hold an individual for a DCR evaluation to occur. Under the ITA law there are several statutes which specifically provide for the assurance of constitutional rights of individuals being held.

These statutes allow for timeframes that the individual may be legally kept such that a DCR may conduct an ITA investigation and evaluation to determine if involuntary treatment is warranted. DCRs are tasked with assuring that individuals are notified of their individual rights at the time of their involuntary evaluation.

Treatment of the mentally ill is one of the most significant problems facing the public today. We hesitate to frustrate professionals' efforts to treat mentally ill individuals as quickly and efficiently as possible... Nevertheless, we cannot forget the statutory and constitutional rights of individuals afflicted with...mental illness.

In Re Schuoler, (1986)⁶

Best practices for DCR conducting ITA investigations

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

Per **RCW 71.05.217(5)**, whenever any person is detained under this chapter, the person must be advised that unless the person is released or voluntarily admits himself or herself for treatment within 120 hours of the initial detention, a judicial hearing must be held in a superior court within 120 hours to determine whether there is probable cause to detain the person for up to an additional 14 days based on an allegation that because of a behavioral health disorder the person presents a likelihood of serious harm or is gravely disabled, and that at the probable cause hearing the person has the following rights:

- (a) To communicate immediately with an attorney; to have an attorney appointed if the person is indigent; and to be told the name and address of the attorney that has been designated
- (b) To remain silent, and to know that any statement the person makes may be used against them

The DCR should consider this an opportunity to explain:

- The ITA detention process simply and clearly
- A description of the DCR's role and responsibilities
- The purpose of inpatient facilities
- A brief explanation of timelines and court process

If the individual chooses to remain silent or requests an attorney, the DCR is obligated to stop the interview. However, the DCR is not obligated to stop the investigation. The individual may choose to resume the interview at any time.

Rights should be provided in writing in a language that the individual is able to understand or be read by a

⁶ In Re Schuoler :: 1986 :: Washington Supreme Court Decisions :: Washington Case Law :: Washington Law :: U.S. Law :: Justia, <https://law.justia.com/cases/washington/supreme-cours/1986/51133-1-1.html>

certified interpreter. If requested by the individual being investigated, the DCR should read the rights to the individual in their entirety.

Notification of Rights calls for the DCR to

- 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
 - Any statement made may be used against them
 - they may speak immediately with an attorney
 - If they are detained as likelihood of serious harm, their right to possess a firearm will be suspended for six months (for adults)
- Inform the individual that additional rights regarding treatment are posted in facilities pursuant to [RCW 71.05.217](#) for adults and [RCW 71.34.355](#) for minors.

Suspension of firearm rights: What DCRs need to know

When the DCR provides notification of rights, they will include notification of the possibility of suspension of firearm rights. [RCW 71.05.182\(1\)](#) specifies that an individual who presents a likelihood of serious harm may not have in their possession or control any firearm for a period of six months after the date the individual is detained for the initial 120-hour detention. Firearm rights will be automatically restored at the end of six months. The individual can petition for restoration under [RCW 9.41.047\(3\)](#) if they are seeking restoration before the end of six months.

Procedurally DCRs will tend to have a verbal notification of the possible suspension of firearm rights at the beginning of the investigation then if the individual is detained for dangerousness, the completion of the notification will be part of the service conclusion.

See [page 106](#) for instructions on ITA Investigation Notification Requirements.

Informed consent: What DCRs need to know

DCRs should familiarize themselves with the concept of informed consent, especially as it applies to health care decisions and capacity. Although consent is not required for involuntary treatment, health care decision makers, guardians, and parents may be helpful individuals to interview and may be required to be notified once investigation and evaluation determinations are made. Additionally, informed consent may be necessary for voluntary treatment referrals.

Information specific to behavioral health treatment for minors is found in the referral section on page 47.

Informed consent: (1) If a patient who has capacity to make health a care [a health care] decision, or their representative if they do not have the capacity to make a health care decision, signs a consent form which sets forth the following, the signed consent form shall constitute prima facie evidence that the patient gave their informed consent to the treatment administered and the patient has the burden of rebutting this by a preponderance of the evidence:

- (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
 - (iv) the recognized serious possible risks, complications, and anticipated benefits involved in the treatment and in the recognized possible alternative forms of treatment, including non-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. [\[RCW 7.70.060\]](#)

Crisis System and DCR Referrals

Referrals for a Designated Crisis Responder Investigation typically are coordinated through a 988 Suicide and Crisis Lifeline crisis center or designated contact hub which strive to ensure less restrictive crisis services are explored prior to utilization of acute involuntary treatment.

988/Crisis Call Center Hubs and Regional Crisis Lines

The National Suicide Hotline Designation Act of 2020 established a national, 3-digit easy to remember number to call, 988, for people to connect directly to National Suicide Prevention Lifeline services. In response to this legislation, the Washington legislature passed HB 1477 ([E2SHB 1477](#)), the Crisis Call Center Hubs and Crisis Services Act, in 2021 to enhance and expand behavioral health crisis response and suicide prevention services for all people in Washington state.

In accordance with [RCW 71.24.045](#), regional crisis lines (RCLs), have operated under the administration of BH-ASOs as a core service and primary access point for a region's behavioral health crisis system. Before the passage of E2SHB 1477 (2021) and the national implementation of 988 as the established three-digit number to replace the NSPL ten-digit number, the NSPL crisis centers operated independently with minimal integration to the rest of the crisis system. They would refer to the RCLs for any in-person behavioral health response. E2SHB 1477 envisions coordinated and enhanced crisis services by building out a comprehensive crisis system with the 988 Suicide & Crisis Lifeline as the main entry point for someone in crisis. The comprehensive system will be supported by the creation of a new technology infrastructure, as well as the expansion of existing services and creation of new crisis services and supports.

Using the 988 Suicide & Crisis Lifeline as a single point of entry for someone in crisis simplifies access and reduces the barriers to receiving services.



General referral considerations

Any individual can request a DCR investigation, including family members, concerned citizens, landlords, treatment providers, service professionals, police, fire fighters, and paramedics. The ITA statute does not require the referent to have a specific credential. As the crisis system strives to increase less restrictive options to involuntary treatment, there are regional differences in how referrals and dispatch of DCRs are managed.

The following information is typically gathered for referrals which may result in a DCR being dispatched.

1. Screening includes documentation of:
 - Date and time of the referral
 - Name of caller and relationship to individual being referred
 - Name of the individual referred for an ITA investigation
 - Name and telephone number of the individual's guardian or other health care decision-maker, if applicable
 - Tribal affiliation [RCW 71.05.150(5)]
 - Veteran status or eligibility [RCW 71.05.153(4)]
 - Facts alleged by the referent
 - Available personal information about the individual to be investigated including:
 - Demographic information
 - Language spoken
 - If the individual has a health care decision-maker and if they are available [RCW 7.70.065]
 - If a minor, the name of the parent or legal guardian
 - Whether the individual has an executed mental health advance directive [RCW 71.32]
 - Whatever history may be available
 - Potential sources of support to resolve the crisis
 - 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)
2. As quickly as possible, staff assesses the degree of urgency and resources available to resolve or contain the crisis, including:
 - If staff need to call 911 for immediate physical danger or safety concerns
 - Whether the referent needs to contact 911
 - If immediate medical concerns are indicated, the ability for the referent to assist with medical transport to a hospital or contact 911

Safety - General considerations: What referents and DCRs need to know

Upon contact for a DCR dispatch or determination by a DCR office of a dispatch, safety must be ensured.

This includes

- Consultation with resources for AI/AN, including review of the Tribal Crisis Coordination Protocol
- Review of any historical information to determine whether it is appropriate to involve law enforcement
- The presence of a second individual to accompany the DCR during community outreach to ensure safety needs are met [RCW 71.05.700]
 - If a **community treatment provider**, verify they will remain present during the ITA investigation and are trained in Safety and Violence Prevention
 - If **law enforcement**, verify they will remain present and willing to coordinate transport of individual for emergency custody under [RCW 71.05.153](#)

Community dispatch may be limited due to safety concerns, lack of available translation services, or referral collaboration needs. Based upon review or referral information and supplemental considerations, such as location or specific characteristics of the referred individual, the DCR will inform the referent whether a face-to-face interview can be expected and estimated time of the DCR investigation. DCR Investigations should occur in a timely and reasonable manner in accordance with BH-ASO, Tribal contract and ITA statutes.

Case study: Example and findings

On November 4, 2005, Marty Smith, a designated mental health professional, was murdered while responding to a residential call in Poulsbo, Wash. In 2007, the Washington state legislature passed the Marty Smith Bill, requiring all community mental health agency workers in direct contact with consumers to receive annual training in safety and violence prevention. Other important provisions allowed for two-person outreaches and required employers to provide use of communication devices during any community outreach.⁷

Findings: 2007 c 360

"The legislature finds that designated mental health professionals go out into the community to evaluate people for potential detention under the state's involuntary treatment act. Also, designated mental health professionals and other mental health workers do crisis intervention work intended to stabilize a person in crisis and provide immediate treatment and intervention in communities throughout Washington state. In many cases, the presence of a second trained individual on outreach to a person's private home or other private location will enhance safety for consumers, families, and mental health professionals and will advance the legislature's interest in quality mental health care services." [RCW 71.05.700]

Referents should be notified by a DCR or representative of the DCR office if dispatch for ITA investigation cannot occur due to the required ITA safety statutes. Referents should be advised by the DCR if dispatch may be scheduled in a reasonable time, potentially the next day, or if situation warrants immediate need, utilization of a Crisis Respite Center, Crisis Stabilization Unit, or Emergency Department. For a person presenting in the community, no medical clearance is required prior to investigation by a designated crisis responder [RCW 71.05.020(38)]

Limited resource awareness: What DCRs need to know

An awareness of the lack of ITA inpatient placements shall not be the determining factor for refusing to conduct an ITA investigation. A DCR must conduct an ITA investigation and follow all procedures for seeking placement and coordination of care.

DCRs can find additional considerations for service referrals in the ITA investigation and outcomes section on [page 92](#).

⁷ Crisis System of Care: Safety First: Out of Tragedy Comes a Program to Protect Outreach Workers. (2016). https://www.neomed.edu/wp-content/uploads/CJCCOE_NatConMag2016-Crisis-to-Recovery.pdf. Retrieved April 30, 2024, from https://www.neomed.edu/wp-content/uploads/CJCCOE_NatConMag2016-Crisis-to-Recovery.pdf, p. 22 - 23

Specialized referral considerations

Specialized referral considerations include **population-specific** identifiers and **place of service**.

Referents and DCRs should be aware of service considerations for these populations and locations, as there may be opportunities for the use of the crisis care continuum, including least restrictive options to involuntary treatment, and the assurance of person-specific and location-specific timeliness and safety responses.

Place of service referral considerations can be found on [page 48](#).

Population-specific referrals

Population specific referrals are focused on unique needs, characteristics or demographics of a particular group of individuals. Awareness of these populations allows for targeted care considerations and interventions, reducing health disparities and bridging the gap in healthcare quality. For some populations there are Washington state laws that mandate access to behavioral health services and least restrictive treatment. Referents and DCRs are to be mindful of these considerations.

Common population-specific referrals include

- **Active Military/Veteran**
- **American Indian/Alaskan Native People**
- Designation of Special Finding Violent Felony
- **Diagnosis of Dementia**
- Elderly
- Foreign Nationals
- **Individuals with Developmental/Intellectual Disability**
- Minors
- Persons who have fled from state of origin

In conjunction with the population-specific considerations, awareness for the cultural considerations such as ethnicity, gender diversity, language, nationality, and sexual orientation is vital for crisis resolution. Referents should ensure that when making a referral for a DCR ITA investigation cultural consideration and population-specific identification to presented. If not collected during the initial referral, the DCR should gather this information before dispatching.

Cultural considerations: What referents and DCRs need to know

Ethnicity: DCRs should review appropriate cultural consideration resources prior to dispatching. DCRs should collaborate with other MHPs to establish cultural competency awareness and utilize peer supervision and consultation. Awareness of the interconnection between ethnicity and nationality, especially for individuals visiting the United States, someone for whom English is a second language, or potentially has experienced trauma due to ethnic cleansing or war, is essential for ensuring individuals receive trauma informed care.

Utilization of American Indian/Alaskan Native (AI/AN) as a term may be both as a distinct cultural ethnicity and/or a sovereign nationality.

***Page 16** provides an overview of the Tribal/Indian behavioral health system including resources for ensuring cultural considerations.*

Gender Diversity: All major medical associations in the U.S. recognize that gender affirming care is an essential health equity and lifesaving practice.⁸ Due to experiencing more severe psychological distress and being at higher risk for suicide compared to non-gender diverse individuals, referents and DCRs need to be prepared for culturally appropriate evaluation of gender diverse individuals.

In crisis care it is crucial that referents and DCRs respect and support an individual's gender identity. This can be provided by

- Using the individual's chosen name and pronouns
- Center the intervention on the situation, not the identity
- Be open to learning and normalizing gender-diversity
- Pursuing training in gender diverse cultural competency

Language: Family members and friends should not be used as interpreters. Their English language proficiency may not be sufficient, and they may not understand behavioral health or involuntary treatment related terminology. There is potential that the person being interviewed will withhold pertinent information due to discomfort sharing this with their friend or relative. DCRs need to ensure that any evaluation includes the ability to access appropriate language line interpretation services if an interpreter is not available.

Nationality: The Vienna Convention and related bilateral agreements require consular notification when detaining an individual who is a citizen of a foreign country known as a foreign national. Prior to evaluation, a DCR should be aware of the procedure to follow if outcome is to detain.

Specific information pertaining to this requirement is contained later in the section related to detaining a Foreign National on page 40.

Sexual Orientation: Research has continued to indicate sexual minority individuals experience sharply elevated suicide risk, especially for young adults.⁹ Due to stigma, prejudice, and discrimination, members of sexual minorities have a higher risk of mental health problems, such as depression, eating disorders, anxiety, and substance use disorders.¹⁰ Referents and DCRs need to ensure awareness of risks, appropriate evaluation considerations, and appropriate safety planning to reduce stressors and risks.

Sexual orientation refers to how an individual is attracted romantically and sexually to other people. Referents and DCRs need to ensure identification of this cultural component as it may have a significant impact on the crisis situation.

There are different kinds of sexual orientation to be aware of; for example, a person may be:

- Heterosexual: Attracted only or almost only to the other binary (male/female) gender. "Binary" is the idea that there are only two genders, male and female
- Gay: Attracted only or almost only to those of the same gender
- Bisexual: Attracted both to people of their own binary gender and to those of the other binary gender
- Pansexual: Attracted to those of any gender
- Asexual: Not sexually attracted to any gender; this is different from deciding not to have sex with anyone (abstinence or celibacy)

⁸ Medical Association Statements in Support of Health Care for Transgender People and Youth, June 24, 2026, <https://glaad.org/medical-association-statements-supporting-trans-youth-healthcare-and-against-discriminatory>

⁹ **Cost of exclusion: LGBTQ+ young adults are at dramatically higher suicide risk** | University of Michigan News, January 13, 2026

¹⁰ **Mental Health and Suicidal Behavior: The Role of Sexual Orientation - Henrique Pereira, 2021**, Journal of Psychosexual Health, August 18, 2021

Referents and DCRs should be aware of nationwide resources which can provide vital support, intervention, advocacy and networking. [The National Council on Family Relations](#) recommends the following key organizations: [The Trevor Project](#) (crisis support for youth), [PFLAG](#) (support for families), [The Trevor Project](#) (LGBTQ+ National Help Center), [Trans Lifeline](#) (trans-specific crisis support), and [Lambda Legal](#) (legal aid).

Educational resources

[A Question of Color](#), a one-hour documentary film by Kathe Sandler, Full Transcript, 1992

[Advancing Health Equity through Cultural Humility](#), Area Health Education Center for Western Washington at Whatcom Community College

MHA's 2026 BIPOC Mental Health Toolkit, [BIPOC Mental Health Month | Mental Health America](#)

Cultural Responsivity and Implicit Bias, [Provider training and education | PacificSource](#)

[Improving Cultural Competency for Behavioral Health Professionals](#), Think Cultural Health, HHS.gov

[Racism, Bias, and Other Determinants of Health: Issues and Actions](#), Region IV Public Health Training Center

[Suicidal Ideation Disparities Among Transgender and Gender Diverse Compared to Cisgender Community Health Patients - PMC](#), January 17, 2023

[Transgender, Gender Diverse or Intersex Cultural Competency Training](#), Inland Empire Health Plan

Active military and veterans

All referring providers should ensure that an attempt to ascertain a person's possible military or veteran status has been made as this helps with service coordination. In 2021, Washington Legislature passed the Veteran Diversion from Involuntary Commitment bill to ensure that treatment by the Veterans Health Administration would be pursued if individuals were amenable and that option is available.¹¹

RCW 71.05.153(4) requires that when an emergency department requests a DCR evaluation for an individual, the facility where the patient is located must inquire as to the person's veteran status or eligibility for veterans benefits and, if the person appears to be potentially eligible for these benefits, inquire whether the person would be amenable to treatment by the Veterans Health Administration compared to other treatment options.

Considering all reasonably available information, the DCR may refer the person to the VHA for mental health or substance use disorder treatment at a facility capable of meeting the needs of the person. This includes, but is not limited to, the involuntary treatment options available at the Seattle division of the VA Puget Sound health care system or any VA Hospitals identified in the future.

DCRs may need to assist facilities with VHA referrals as referring providers may be unaware of the statute requirements for placement consideration. It is additionally important that DCRs are aware of the cultural considerations that are critical and impact active military and veterans, including higher risk of suicide.

Active military: What DCRs need to know

The Department of Defense (DOD), in an effort to provide for the behavioral health needs of military service members, established instructions for command-directed evaluations. These instructions are outlined in the **Department of Defense Instructions document Number 6490.04**.

In case of contact with an active military member, a commanding officer, or request for referral at a military base or community office, DCRs should be familiar with this DOD guidance. Although the DOD instructional guidance only addresses mental health, a DCR evaluation for involuntary substance use detention is permitted in Washington. A DCR may need to explain the SUD ITA criteria and detention procedures to active military and commanding officers.

DCRs should be familiar with military locations, including:

- **Washington National Guard locations**
- **Washington Military Installations** (Air Force, Air National Guard, Marine Corps, Navy, and US Army)
- **United States Coast Guard – Pacific Area**

Best practices for DCR engagement with active military and veterans

1. During the referral ask the referent if the individual identifies as active in the military or as a veteran.
2. If unknown, ensure that during investigation, the individual is asked if they identify as active military or a veteran
3. If the individual is active in the military, ask if they would like their commanding officer contacted.
 - Commanding officers may be contacted without permission as the DCR shall include all reasonably available information from credible witnesses when conducting an evaluation (**RCW 71.05.212(1)**).
4. If the individual is active military or a veteran, ask if they would be amenable to treatment by the Veterans Health Administration, Seattle division of the VA Puget Sound health care system, or any VA

¹¹ Senate Bill Report SHB 1314, Washington State Legislature, <https://lawfilesext.leg.wa.gov/biennium/2021-22/Pdf/Bill%20Reports/Senate/1314-S%20SBA%20BH%2021.pdf?q=20240624233200>

Hospitals identified in the future.

5. For active military, if a commanding officer is a credible witness, the DCR shall provide notice of the initial detention placement and contact information to ensure awareness of potential hearing. ([RCW 71.05.212\(2\)](#)).

Educational resources

Annual Report on Suicide in the Military (DoD), [Annual Report on Suicide in the Military](#)

Guidelines for Psychological Practice with Military Service Members, Veterans, and Their Families (APA), [Guidelines for Psychological Practice With Military Service Members, Veterans, and Their Families](#)

Exemplary Practices for Military Populations (ACA), [Exemplary Practices for Military Populations](#)

The State of Veteran Suicide (Mission Roll Call), [The State of Veteran Suicide \(2025 Update\) - Mission Roll Call](#)

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American Indian/Alaska Natives (AI/AN) people

All referring providers should ensure that an attempt to determine if an individual is AI/AN or is receiving services from a Tribe as this helps with service and care coordination. This is vitally important for Washington Tribal members. In 2018 and 2024, Washington Legislature passed two bills that specifically promote improvement across the behavioral health system for American Indian/Alaskan Native individuals. Ensuring identification of AI/AN is statutorily required under RCW 71.05 and 71.34.

All referring providers should have utilized less restrictive alternative resources to involuntary treatment including attempts to coordinate with Tribal services and consult Tribal Crisis Coordination Protocols. If a Tribal Crisis Coordination Protocol is not in place, follow the guidance provided in [Navigating a Crisis without a Tribal Crisis Coordination Protocol](#).

Ways to make contact:

1. Review Tribal Profile on the Native Resources Hub: [Tribal Services | VOAWW](#)
Example - [Port Gamble S'Klallam Tribe, Tribal Services Profile](#)
2. Call the VOAWW, Native Resources Hub Contact and ask for Indian Health Care Provider: During Normal Business Hours **1-866-491-1683**
After hours #988 Option 4, Native and Strong Lifeline Staff

DCRs may need to assist facilities with AI/AN referrals and access to less restrictive coordination services. It is important that DCRs are aware of the cultural considerations that are critical and have an impact on this population. DCRs should know how to contact the VOAWW, what the Tribal Profiles appear like on the Native Resource Hub, and finding information on the Tribal Crisis Coordination Protocols. The section on Tribal/Indian Behavioral Health System at the front of the protocols includes educational resources for DCRs on cultural considerations.

Best practices for DCR engagement with AI/AN individuals

As identified in the DCR knowledge and training, DCRs should be familiar with the cultural and political dimensions of Tribal sovereignty and understand government-to-government relationships prior to conducting ITA investigation and evaluations.

1. Ensure during referral that the individual or the referent is asked if the individual identifies as AI/AN and if the individual has any Tribal affiliation in Washington.
 - If unknown, consider the following for determining potential Tribal affiliation:
 - ensure that during investigation, the individual is asked if they identify as AI/AN and determine Tribal affiliation
 - determine if the individual's place of residence is on Tribal land
 - whether the individual was referred for investigation by an Indian Health Care Provider
 - if witnesses or other documentation indicates a Tribal affiliation
2. Identify if there is a Tribal Crisis Coordination Protocol for their Tribal affiliation by checking the following:
 - Your DCR Office resources
 - Native Resources Hub webpage [Tribal Services | VOAWW](#)
 - Local BH-ASO resources, DCR agency, or BH-ASO where the individual resides
 - HCA Office of Tribal Affairs
3. If a Tribal Crisis Coordination Protocol is not in place, follow the guidance provided in the [Navigating a Crisis without a Tribal Crisis Coordination Protocol](#).

4. Notify the Tribal contact of the investigation outcome as soon as possible, but no later than three hours from the time the decision is made [RCW 71.05.150(5)]. Refer to guidance in the ITA investigation and notification requirements section for a member of a Tribe (page 107).
5. For questions or concerns, consult your DCR Office Supervisor.

Additional supports and educational resources are included in the Indian/Tribal Behavioral Health section on [page 16](#).

DRAFT

Designation of Special Finding Violent Felony

Special Finding Violent Felony (SFVF) is a designation for individuals who have been civilly committed following a finding of incompetence to stand trial for a felony classified as violent under [RCW 9.94A.030](#). People who have been determined to have committed a violent felony offense may be civilly committed under additional grounds pursuant to [RCW 71.05.280](#). Individuals identified as SFVF have been determined by the court to present a likelihood of serious harm, or substantial likelihood of repeating similar acts of violence that led to their initial commitment.

In 2021, in an effort to increase less restrictive alternative treatment for individuals civilly committed following dismissal of a violent felony charge based on incompetency to stand trial, the legislature established a multidisciplinary transition team¹². The multidisciplinary transition team consists of a representative of the community behavioral health agency, a representative of DSHS, and a specially trained community corrections officer.

A transition team must monitor the person's progress in treatment, compliance with court ordered conditions, and problem solve around extra support the person may need or circumstances that may arise that threaten the safety of the person and the community. Although the transition team includes a community corrections officer, the individual is not on parole or probation and cannot be lodged at a jail unless arrested for a new crime.

Best practices for DCR engagement with Multidisciplinary team

DCRs who have contact or are made aware of an individual who is part of a multidisciplinary transition team for individuals designated as SFVF shall ensure appropriate coordination with members of the team, including notification of any ITA investigation outcomes or placement for initial detention or revocation.

Due to concerns about the safety of the person and the community, DCRs should collaborate with the multidisciplinary transition team to determine the appropriate outcome. Individuals with the SFVF designation will have specific and detailed less restrictive alternative orders. These orders specify that when the individual fails to adhere to the treatment conditions or shows functional deterioration, the multidisciplinary team is to quickly ensure the individual is evaluated for inpatient care. DCRs need to coordinate with the multidisciplinary team to ensure appropriate planning for evaluation outcomes.

¹² [E2SSB 5071 Final Bill Report 2021](#), Creating transition teams to assist specified persons under civil commitment, Washington State Legislature

Diagnosis of dementia

Dementia: *a condition characterized by progressive or persistent loss of intellectual functioning, especially with impairment of memory and abstract thinking, and often with personality change, resulting from organic disease of the brain.*

The age of onset for dementia varies depending on the specific type of dementia. Early-onset dementia can affect individuals as young as their 30s or 40s. Persons with symptoms of or diagnosed with dementia cannot be detained to an evaluation and treatment facility or judicially civilly committed solely by reason of that condition unless such condition causes the individual to be gravely disabled or to present a likelihood of serious harm.

The DCR may not rule out a referral for investigation because of the sole presence of dementia.

Persons with developmental disabilities, impaired by substance use disorder, or **suffering from dementia** shall not be detained for evaluation and treatment or judicially committed solely by reason of that condition unless such condition causes a person to be gravely disabled or to present a likelihood of serious harm.

However, persons with developmental disabilities, impaired by substance use disorder, or suffering from dementia and who otherwise meet the criteria for detention or judicial commitment are not ineligible for detention or commitment based on this condition alone. [\[RCW 71.05.040\]](#)

In cases where the subject of the investigation has a diagnosis of dementia, the DCR should explore and document all available less restrictive alternatives before pursuing detention. These may include returning the individual to their residence with additional supports, enhanced caregiving arrangements, community-based services, hospice, adult family home placement, memory care, or other appropriate interventions.

DCRs should recognize that access to some less restrictive services may require coordination that may not be immediately available at the time of the evaluation. The evaluation outcome should therefore consider both the appropriateness and the practical availability of less restrictive alternatives to safely meet the individual's needs.

Best practices for DCR engagement with individuals with symptoms of dementia

1. Familiarize yourself with Dementia presentations and manner by which to approach individual for evaluation.
 - i. Ensure an identified consult resource for second opinion if needed.
2. Ensure any health care decision makers for the individual have been consulted.
3. Follow guidance under [Interviewing Witnesses as Part of an Investigation](#)
4. Review medical clearance/stability related to assessing grave disability.
5. Historical information and current behavioral health treatment will be important to review.
6. Follow guidance under [Use of Reasonable Available History](#)
7. Collaborate with referral sources to establish appropriate less restrictive alternatives to involuntary detention that ensures the safety of the individual.

Educational resources

University of Tasmania, Wicking Dementia Research and Education Centre, [About Wicking Dementia Centre - Wicking Dementia Research and Education Centre | University of Tasmania](#)

Assessment of Dementia in the ED (RCEM Learning), <https://www.rcemlearning.co.uk/reference/assessment-of-dementia-in-the-ed/>

The use of involuntary treatment among older adults with cognitive impairment receiving nursing care at home:
A cross-sectional study (International Journal of Nursing Study),
<https://www.sciencedirect.com/science/article/abs/pii/S0020748918302128>

DRAFT

Elderly

Elderly: *Of, relating to, or characteristic of later life or elderly persons.*

Senior citizen: *Per the U.S. government, those individuals aged 65 and older.*

Referrals for individuals over the age of 65 pose a unique challenge as various social, medical, cognitive, and psychological factors may affect functioning and require specific individualized initial intervention. There is potential an individual may initially require medical treatment prior to psychiatric treatment. On occasion medical treatment can help to resolve some psychological symptoms, for example,

Assessing for and treating delirium is crucial in the care of hospitalized older adults. Delirium is an acute condition marked by a disturbance in orientation, cognition (specifically attention), and perception.¹³

Elderly populations: What DCRs need to know

People ages 85 and older increasingly have the highest rates of suicide.¹⁴ DCRs need to familiarize themselves with the constellations of biopsychosocial factors that converge among older adults that increase their risk for suicide which are known as the 5 D's of suicide risk: depression, disability, (physical) disease, (social) disconnection, and (access) to deadly means.

Interventions with older adults must be grounded in respect and awareness of ageism and stigmatization. For example, the use of communication that is characterized as having a slower rate, exaggerated intonation, elevated pitch/volume, simpler vocabulary and grammar may be perceived as using “baby talk” when unnecessary and inappropriate.

DCRs need to be mindful to avoid communication styles that may create or reflect an unconscious bias and treat adults as incompetent or child-like, including:

- Pet names or diminutives (sweetie, Honey, Grandma, etc.)
- Inappropriate use of the plural “we”
- Insinuations that the older adults’ preferences are incorrect (“Wouldn’t you rather...”)
- Use of slowed rate of speech, increased volume, or baby-talk

Evaluation and Treatment Facilities licensed by the Department of Health as Residential Treatment Facilities may have limited ability to meet the mobility or self-care tasks for certain individuals. DCRs should be aware that during the clinical presentation for ITA detention, providing an accurate indication of functioning is essential for appropriate placement.

Best practices for DCR engagement with elderly individuals

1. Ensure awareness of guardianship, conservator, or power of attorney and engage in process of investigation
2. Review medical information and rule out medical conditions concerns including delirium
3. Identify if the individual has had a geriatric consult, especially if they are currently in the emergency department or on a medical floor. In 2013, the American College of Emergency Physicians, The American Geriatrics Society, Emergency Nurses Association, and the Society for Academic Emergency Medicine

¹³ Clinical Toolbox, [Hospital – GeroCentral](#)

¹⁴ [Suicide Data and Statistics | Suicide Prevention | CDC](#)

established [Geriatric Emergency Department Guidelines](#) to assist with the utilization of less expensive outpatient treatment rather than expensive inpatient modalities. Appropriate geriatric consultation can improve appropriate diagnosis and treatment referrals.

4. Ensure investigation includes interviewing additional witnesses to identify previous level of functioning and polypharmacy concerns with prescribed medications, over-the-counter supplements and medications, along with potential substance use.
5. Always take into consideration whether elder abuse, neglect, or self-neglect may have created the need for the evaluation.
6. If the ITA evaluation does not result in detention, DCRs are to assist referral sources with establishing beneficial transitional less restrictive appropriate services to meet the individual's needs.

Educational resources

Abeles, N. (2014, May). *What mental health providers should know about working with older adults*. American Psychological Association. <https://www.apa.org/pi/aging/resources/guides/practitioners-should-know>

Foundational Competencies in Older Adult Mental Health Certificate Program – E4 Center

GeroCentral, Epidemiology, Characteristics of Older Adults Who Die By Suicide, [Suicide – GeroCentral](#)

Mobile Crisis Responder Resource Guide, Helping Aging, Older Adults, <https://soundgenerations.org/mobile-crisis-responder-guide/>

Screening for Delirium: What Clinicians Should Know, Center to Advance Palliative Care, Mairan, D. (2023, April). <https://www.capc.org/blog/screening-for-delirium-what-clinicians-should-know/>

Foreign Nationals and the Vienna Convention on Consular Relations

Detention of foreign nationals is subject to the requirements of the Vienna Convention. This applies both to citizens of other countries and diplomatic personnel of other countries.

Foreign National: *Anyone who is not a citizen of the United States (U.S.).*

Dual citizenship: *A person with citizenship in the U.S. and a foreign country. An individual with dual citizenship is not a foreign national.*

The U.S. Department of State provides the following overview¹⁵

In the United States, foreign governments have **embassies** (a foreign government's headquarters) in Washington, DC and consulates (branch offices) in other cities. Both embassies and consulates provide assistance to that country's citizens in the United States.

When foreign nationals are arrested or detained, they must be advised of the option to have the closest consulate or the embassy notified. For 58 countries, the closest consulate or the embassy must be notified, regardless of the foreign nationals wishes. This is **consular notification**.

Foreign government officials are entitled to communicate with their nationals in U.S. jails and prisons to check on their welfare and provide consular assistance. They may contact family, ensure legal representation and medical care, or provide reading materials. This is **consular access**.

Consular notification and access are mutual obligations based in treaties between the U.S. government and foreign governments.

The prompt, courteous offer to the foreign national of the possibility of consular assistance, and the prompt, courteous notification to the foreign national's nearest consulate or the embassy so that they can provide consular services helps us model how we want U.S. citizens treated in a similar situation overseas. By providing appropriate consular notification and consular access to foreign governments, we help ensure that U.S. citizens have the same protections if arrested or detained abroad.

Involuntary detention and civil commitment are a form of detention subject to consular notification. Facilities and DCRs should follow the advisements similar to that provided law enforcement holds or detains an individual.

If an individual states that they are a foreign national, claims to be a diplomat, or have consular immunity, this information needs to be directly relayed during the referral process. **The Vienna Convention on Consular Relations** identifies that all foreign service personnel shall be treated with respect and courtesy, regardless of the level of established immunity.

As the United States is a party to several bilateral agreements, facilities and DCRs are obligated to notify the consulate upon the person's detention, regardless of whether the detained person(s) request that their consulate be notified.

Diplomatic agents: *Ambassadors and United Nations representatives who are exempt from arrest or detention and are immune from all criminal (and most civil) prosecution by the state. The family members of diplomatic agents are additionally afforded this exemption.*

¹⁵ U.S. Department of State, **Consular Notification and Access** <https://travel.state.gov/content/travel/en/consularnotification.html>

Consular officers: Members of consular posts who perform various formal functions on behalf of their own governments.

Honorary consuls: Part-time employees of the country they represent and are either permanent residents of the U.S. or U.S. nationals.

An individual who claims diplomatic or consular immunity shall not be physically restrained unless restraint is necessary for the protection of the individual or others.¹⁶

All diplomatic and consular personnel who are entitled to exemptions from arrest and being detained are registered with the Department of State and are issued distinctive identification cards by the Department of State Protocol Office. These cards are the best means of identifying Foreign Service personnel and family members. Issuance of these identification cards does not always occur promptly, and verification of status should be attempted.

Verify the individual's claims of diplomatic immunity by telephone with the Department of State any time there is a possibility of the individual being held for a DCR Investigation. Referents or DCRs should use the following numbers in order of preference:

**Office of Foreign Missions
San Francisco, CA**

(415) 744-2910, Ext. 22 or 23
(415) 744-2913 FAX (0800-1700 PST)

Diplomatic Security Service

915 Second Avenue, Room 3410
Seattle, WA 98174
(206) 220-7721 (206) 220-7723 FAX

**Office of Foreign Missions
Diplomatic Motor Vehicle Office
Washington D.C.**

(202) 895-3521 (Driver License Verification) or
(202) 895-3532 (Registration Verification)
(202) 895-3533 FAX (0815-1700 EST)

**Department of State
Diplomatic Security Service
Command Center Washington D.C.**

(202) 647-7277
(202) 647-1512 (Available 24 hours)
(202) 647-0122 FAX

Additional resources on consular notification and access process:

- [Contact Info for Foreign Embassies and Consulates](#)
- [Consular Notification and Access Manual](#)

Consular notification tools are provided by the U.S. Department of State and included in [Appendix C](#).

Best practices for DCR engagement with foreign nationals

These practices are followed when an individual indicates they are a foreign national. DCRs are not required by statute to inquire if an individual is a foreign national.

1. Attempt to verify the individual's country of citizenship. Check for a passport or other travel documents if the individual is unable to provide information.
2. Utilize the Consular Notification Pocket Reference Card or Consular Notification Process Flow Chart to determine if consular notification is mandatory (i.e., is the person a citizen of one of the 58 countries where notification is mandatory), or optional based on the person's wishes.
3. If the individual claims diplomatic immunity, verify the individual's status by contacting the

¹⁶ 22 U.S. Code § 254d: [22 U.S. Code § 254d - Dismissal on motion of action against individual entitled to immunity | U.S. Code | US Law | LII / Legal Information Institute](#)

Department of State (process identified above)

4. For diplomatic personnel, once status is verified, advise the individual of the right to contact their consular officials.
 - If the individual requests, help facilitate contact with the consular officials.
 - If the individual lacks capacity to provide consent, the DCR shall without delay, inform the consular officials.
5. The DCR will follow all other ITA investigation procedures and notification requirements.
 - There is a **Foreign National Notification form** on the DCR webpage that may be used for providing notification; this form is generally optional but recommended.

DRAFT

Individuals with developmental/intellectual disability (DD/ID)

Centers for Medicare and Medicaid Services states, “Dignity of risk is the idea that self-determination and the right to take reasonable risks are essential for dignity and self-esteem, therefore should not be impeded by caregivers, concerned about their responsibility to ensure health and welfare.”¹⁷

Dignity of risk: *The right of every person, including those with a disability, to make informed choices and take reasonable risks to learn, grow, and have better quality of life. An aspect of dignity of risk is the importance that when people’s rights may be limited that supports have considered less restrictive options that are not overly restrictive and provide for as much independence as possible. Least restrictive should always be considered before moving into highly restrictive procedures.*

RCW 71.05.040 specifies that persons with developmental disabilities shall not be detained for evaluation and treatment solely by reason of that condition unless such condition causes a person to be gravely disabled or to present a likelihood of serious harm.

However, people with developmental disabilities who otherwise meet the criteria for detention are not ineligible for detention or commitment based on this condition alone. For an exploration into the consideration, DCRs could read **Matter of Detention of Rs** in which the court reviews RCW 71.05.040, criteria for civil commitment and a person’s developmental disability.

As with any individual, providers and other support should seek to assist in helping to find services that are provided in the less restrictive alternative to detention as feasible. Crisis services and DCRs may need to assist referral sources with exploring less restrictive alternative options.

Ways to make contact: <https://www.dshs.wa.gov/dda/find-dda-office>

If the individual has a diagnosis of a developmental or intellectual disability, call the regional Developmental Disabilities Administration (DDA) field services contact to explore all less restrictive treatment options.

During daytime hours, the Regional Clinical Team can verify enrollment with the DDA, provide additional contacts and possibly assist with additional service planning

For referrals to DCRs for ITA investigation and evaluation, it is important that the contact names for any provider supports are shared including immediate caregivers, health care decision makers, case managers, and DSHS Developmental Disabilities Administration (DDA) contact.

Best practices for DCR engagement with individual developmental disabilities

1. Ensure contact with DDA to rule out any less restrictive alternatives.
 - Request a copy of the cross-system crisis plan if one exists.
2. Ensure accurate awareness of individual’s level of functioning.
 - Behaviors may communicate distress (physical vs. verbal)
 - Evidence may be more related to observation and witness statements

¹⁷ Centers for Medicare and Medicaid Services, Balancing Choice and Risk, August 14, 2019, https://www.medicaid.gov/medicaid/home-community-based-services/downloads/balancing-risk-choice_0.pdf

3. Evaluate for safety, determining management of safety for distressing behavior if present, and risk in environment if escalation if recurrence is continual.
4. Maintain communication with health care decision makers throughout evaluation process.

Educational resources

The Guidebook: Meeting the mental health needs of people with intellectual disabilities, **The Guidebook: Meeting the mental health needs of people with intellectual disabilities**

Initial Management of Behavioral Crises in Adults with Intellectual and Developmental Disabilities Health Care for Adults with Intellectual and Developmental Disabilities

<https://iddtoolkit.vkcsites.org/behavioral-and-mental-health-issues/management-beh-crises/>

HELP with Emotional and Behavioral Concerns in Adults with Intellectual and Developmental Disabilities Health Care for Adults with Intellectual and Developmental Disabilities, https://vkc.vumc.org/assets/files/idd/4-1_HELP_Emotional_Behavioural_Concerns.pdf

Suicide Prevention for Individuals with Intellectual and Developmental Disabilities, **Suicide Prevention for Individuals with Intellectual and Developmental Disabilities**

Minors

Referrals to DCR Offices for minors can involve evaluation for inpatient treatment but will often involve consultations with care coordinators around several less restrictive alternative crisis care options.

Adolescent: *A minor thirteen years of age or older. [RCW 71.34.020(3)]*¹⁸

Minor: *Any person under the age of eighteen years. [RCW 71.34.020(44)]*

Only an “adolescent” (above the age of 13) is subject to involuntary detention proceedings (RCW 71.34.700-.710). Minors under that age may be admitted for treatment with parental consent. Persons become subject to RCW 71.05 when they turn 18 years of age (RCW 71.34.360).

Prevention intervention focus

The legislature has emphasized the need for continuity of care and appropriate interventions, within parental control, before inpatient treatment is pursued. It is the intent of the legislature to enhance continuity of care for minors with serious behavioral health disorders that can be controlled or stabilized in a less restrictive alternative commitment. Within the guidelines stated in [In re LaBelle, 107 Wn.2d 196 \(1986\)](#), the legislature intends to encourage appropriate interventions at a point when there is the best opportunity to restore the minor to or maintain satisfactory functioning.

And,

It is also the purpose of this chapter to assure the ability of parents to exercise reasonable, compassionate care and control of their minor children when there is a medical necessity for treatment and without the requirement of filing a petition under this chapter, including the ability to request and receive medically necessary treatment for their adolescent children without the consent of the adolescent [RCW 71.34.010(3), (5)].

Again, **referrals to DCR Offices for minors will often also involve consultations with care coordinators around several less restrictive alternative crisis care options.** These crisis care options may include Wraparound with Intensive Services (WiSe) outpatient treatment, Mobile Response and Stabilization Services – Youth Teams, and Family Initiated Treatment. These services may be coordinated and provided with or without a DCR ITA evaluation.

Brief information about less restrictive alternative crisis services for minors is below and additional information can be found either through local county Crisis Services, Regional BH-ASO, or the HCA website.

Wraparound with Intensive Services (WiSe)

WiSe helps individuals and their families receive intensive behavioral health support at home and in the community. WiSe is a voluntary service built around your family's unique needs and goals. A team of professionals and natural supports work together with the family to create a plan that makes sense for the youth.

Mobile Response and Stabilization Services – Youth Teams

The Mobile Response and Stabilization Services (MRSS) model is a crisis intervention approach designed to address the immediate needs of children, youth, young adults, and their caregivers. It emphasizes rapid

¹⁸ The definition for adolescent and age of consent for treatment is 13 years old as of the publishing of this document. See RCW 71.34 for any legislative changes.

response and intervention to stabilize families experiencing behavioral health challenges and prevent further escalation or harm. Overall, MRSS plays a role in providing timely and effective support to families facing behavioral health challenges, helping to prevent crises from escalating and promoting the overall health and stability of children and their families.

Family Initiated Treatment (FIT)

FIT is the process by which a parent or guardian requests treatment on behalf of an adolescent over the age of 13. The adolescent does not have to agree to treatment to be placed in an inpatient facility. Admission to an inpatient facility via FIT is not an ITA detention and is not part of the ITA process. FIT may be considered by a facility either before or after a referral for DCR assessment, and the availability and appropriateness of FIT may be a factor in the DCR's consideration regarding detention.

RCW 71.34.020(46)(a) "Parent" has the same meaning as defined in **RCW 26.26A.010**, including either parent if custody is shared under a joint custody agreement, or a person or agency judicially appointed as legal guardian or custodian of the child. (b) For purposes of family-initiated treatment under **RCW 71.34.600** through **71.34.670**, "parent" also includes a person to whom a parent defined in (a) of this subsection has given a signed authorization to make health care decisions for the adolescent, a stepparent who is involved in caring for the adolescent, a kinship caregiver who is involved in caring for the adolescent, or another relative who is responsible for the health care of the adolescent, who may be required to provide a declaration under penalty of perjury stating that he or she is a relative responsible for the health care of the adolescent pursuant to chapter 5.50 RCW. If a dispute arises between individuals authorized to act as a parent for the purpose of RCW 71.34.600 through 71.34.670, the disagreement must be resolved according to the priority established under RCW 7.70.065(2)(a).

To request treatment, the parent/guardian brings the adolescent to a behavioral health facility or hospital emergency department. Facility or hospital staff are required to provide information to parents/guardians regarding all services available in RCW 71.34.

The adolescent is evaluated by an appropriately trained professional person within 24 hours to determine if they have a behavioral health disorder and if there is medical necessity for inpatient treatment. A provider is not obligated to provide treatment. The adolescent cannot be refused admission to an inpatient facility because they have not consented to treatment [RCW 71.34.600].

Once an adolescent is admitted to a facility under FIT, they may not be discharged only because they request it. They will be assessed for ongoing medical necessity during their treatment. The adolescent has access to a petition process to request release, reviewed by the superior court [RCW 71.34.620].

Youth and minor populations: What DCRs need to know

DCRs are responsible for being aware of the rules of chapter 71.34 RCW Behavioral Health Services for Minors. The purpose of this statute is to assure that minors receive treatment that is culturally relevant and appropriate across the continuum of services including prevention, early intervention, self-directed, parent-directed, voluntary, and involuntary treatment.

1. RCW 71.34.010(2) specifies that all behavioral health care and treatment providers shall assure that minors' parents are given an opportunity to participate in the treatment decisions for their minor children.
2. The definition for adolescent and age of consent for treatment is 13 years old as of the publishing of this document. While this age may change based on legislative ruling, the procedures and process regarding consent, ITA detention and notifications do not. DCRs must maintain awareness of the definition of adolescent, age of consent for treatment, and legal authority for detaining adolescents. [**RCW 71.34.020(3)**, **71.34.430**, **71.34.500(1)**, **71.34.700**, and **71.34.710**].

Consent and notification

The Behavioral Health Services for Minors statute does not provide a DCR with authority to detain an adolescent under the age of thirteen [RCW 71.34.710]. For a minor under the age of thirteen, consent for care is provided by the minor's parents or legal guardians.

An adolescent 13 years of age and older may admit themselves voluntarily for outpatient or inpatient treatment, without parental consent, if the professional person in charge of the facility agrees with the need for treatment. (RCW 71.34.500, .530). In the event of any minor 13 years of age or older (and/or their parent) refuses admission, the minor may be evaluated and detained by a DCR in accordance with RCW 71.34.710.

Community outpatient providers and facilities may refer an adolescent, 13 years of age and older, for a DCR evaluation. To the extent possible, the minor's parent or legal guardian should be informed of the referral for evaluation. For a minor who is a state dependent, the minor's Washington State Department of Children, Youth, and Families (DCYF) case worker, or the DCYF 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].

Additional supports for parents, caregivers, and guardians

1580 Children in Crisis FAQ - referrals made when there is a system barrier

Kids Mental Health Washington, Supporting the behavioral health needs of Washington kids, youth and families. <https://kidsmentalhealthwa.org>

Parent's guide to Family Initiated Treatment <https://www.hca.wa.gov/assets/free-or-low-cost/82-0227-parents-guide-to-family-initiated-treatment.pdf>

The Center of Parent Excellence (COPE) project | Washington State Health Care Authority - support for parents navigating the BH system <https://www.hca.wa.gov/about-hca/programs-and-initiatives/behavioral-health-and-recovery/center-parent-excellence-cope-project>

WISe: Information for Families <https://www.hca.wa.gov/assets/free-or-low-cost/82-0154-522-wise-family-fact-sheet.pdf>

Wraparound with Intensive Services (WISe) | Washington State Health Care Authority <https://www.hca.wa.gov/free-or-low-cost-health-care/i-need-behavioral-health-support/wraparound-intensive-services-wise>

Educational resources

Family initiated treatment (FIT) | Washington State Health Care Authority <https://www.hca.wa.gov/free-or-low-cost-health-care/i-need-behavioral-health-support/family-initiated-treatment-fit>

[FIT Washington](#) (training modules), self-paced online eLearning <https://fitwashington.com/>

Persons who have fled from state of origin

RCW 71.05.195 concerns the return individuals who are found as not guilty by reason of insanity and fled from detention, commitment, or conditional release in a state or Tribe other than in Washington.

During a referral or while conducting an ITA investigation, a DCR may learn that an individual has fled from another state or Tribe. The DCR should complete the evaluation and identify if criteria under RCW 71.05 are met for initial ITA detention and seek placement. The DCR will orally and in writing document all known information and ensure this is provided to the facility where initial detention is to occur. The E&T/SWMS facility may then coordinate with the local County Prosecuting Attorney to determine if the individual's status falls under the criteria identified in **RCW 71.05.195**.

The DCR Office may receive a request to initiate a civil commitment on an individual who has been identified as having been found not guilty by reason of insanity, detained, committed, or conditionally released and having fled from another state or Tribe. **In such a situation, it is imperative that RCW 71.05.195 is reviewed and the local County Prosecuting Attorney is consulted to ensure the required documentation is collected.**

DCR staff are to be aware that the focus is the person's safe transfer to the custody or care of the requesting state or Tribe without undue risk to the safety of the person or others is the primary endeavor.

Educational resources

House Bill Report, SHB 2533, Title: An act relating to adopting the interstate compact on mental health, **2533-S SBR HSC 10.pdf**

Lawmaker pushing bill to allow extradition of criminally insane https://www.goskagit.com/news/lawmaker-pushing-bill-to-allow-extradition-of-criminally-insane/article_dfe3cec3-3f12-5eff-b1b5-f9ff94482b53.html

Place of service referrals

Place of service referrals are locations where a DCR may be dispatched to initiate an investigation for involuntary detention. These locations include a variety of settings which range from secure facilities to personal residences. Referents should be aware of least restrictive options along the crisis care continuum and considerations pertaining to involuntary treatment based upon the place of service.

The following sections on place of service referrals describe **considerations for both referents and DCRs to be knowledgeable about**. Referrals for a DCR ITA investigation may come from the following place of service:

- **Emergency department or hospital medical floors**
- Acute inpatient behavioral health treatment facilities, such as Psych units and E&T/SMWS
- **Crisis relief centers and residential treatment facilities**
 - 23-hour Crisis relief centers
 - Residential treatment facilities
 - Crisis Stabilization Unit
 - SUD withdrawal
 - SUD residential treatment
- **Carceral settings**
 - Juvenile Detention
 - City or County Jail
 - State Prison
- **Community outreach**
 - First Responder/Law Enforcement Diversion
 - Professional service providers
 - Outpatient behavioral health agencies
 - Social services
 - Human services
 - Community corrections offices (non-jail)
 - Intensive behavioral health treatment facilities (IBHTF)
 - Licensed residential care facilities
 - adult family homes
 - nursing homes
 - assisted living facilities
 - enhanced secure facilities (ECS)
 - Residences or non-professional community sites

Emergency department or hospital medical floors

Medical clearance means a physician or other health care provider, including an Indian health care provider, has determined that a person is medically stable and ready for referral to the designated crisis responder or facility. For a person presenting in the community, no medical clearance is required prior to investigation by a designated crisis responder [\[RCW 71.05.020\(38\)\]](#).

Medical clearance/stability - BH-ASO coordination

BH-ASOs and DCR Office Managers should coordinate with local emergency departments (ED) regularly to establish procedures for ITA referrals and determination regarding medical clearance.

As various inpatient facilities have required medical testing standards and considerations for medical stability

and medical clearance may vary from facility to facility, ensuring an understanding of medical stability for facility transfer is vital.

An ED physician may be unaware of the various types of involuntary facilities in the state of Washington (Acute Care Hospitals, Private Psychiatric and Alcoholism Hospitals, and Residential Treatment Facilities) and the access to care standards for each facility.

ED Coordination – SUD ITA evaluation and “Ricky’s Law”

Current intoxication, history of intoxication, and/or other substance use should be considered in the assessment of risk for dangerousness and potential involuntary treatment. **An individual does not have to “sober up” prior to being referred to a DCR for evaluation for involuntary treatment.** The goal of involuntary treatment for substance use is to allow for those who are at-risk due to immediate substance use, dangerousness and/or grave disability receive the necessary care imminently. Individuals do need medical stability and clearance for referral to the designated crisis responder or treatment facilities. Single bed certifications cannot be utilized for substance use involuntary treatment when secure withdrawal management and stabilization facilities are unable to admit due to medical acuity.

Timeliness requirements: What ED/hospitals need to know

Emergency departments and hospital medical floors need to ensure awareness of the RCW 71.05 and 71.34 statutory guidelines for timeliness requirements.

See [page 78](#) for *Timeliness Requirements*.

RCW 71.05.153(4) specifies that persons delivered to emergency department by peace officer must be examined by a mental health professional or substance use disorder professional within three hours after arrival, not counting time periods prior to medical clearance. If a facility does not have social workers (SW), mental health professionals (MHP), or substance use professionals (SUDP), for conducting required assessments, agreements with BH-ASOs should be developed to comply with statutory requirements. In some areas of the state, if the ED physician has evaluated the individual, identified concerns for the possibility of dangerousness and/or grave disability, and requests DCR ITA investigation and evaluation, the DCR functions as the MHP.

RCW 71.05.050(3) identifies a person brought to the emergency room (non-police officer) who presents with a likelihood of harm, or concern of grave disability, and refuses voluntary admission, the facility may detain for no more than six hours from the time the professional staff notify the DCR of need for evaluation, not counting time periods prior to medical clearance.

RCW 71.05.050(2) states if the professional staff of a hospital regards a person voluntarily admitted who requests discharge as presenting with a likelihood of harm, or concern of grave disability, the facility may detain such person for notification of need for evaluation, which shall in ordinary circumstances be no later than the next judicial day.

Medical clearance: What DCRs need to know

Emergency departments will perform appropriate medical testing as indicated based on individual presentation. As not all ED physicians are aware of the various E&T/SWMS facility types, there is potential that not all lab work will be completed. DCRs need to be mindful that medical stability determinations can vary from hospital to hospital setting or opinions of attending physicians. The DCR office is to verify that the health care provider has documented the patient as medically stable and appropriate for transfer of treatment.

If during the ITA evaluation process an individual is determined to be no longer medically stable and appropriate for transfer of treatment the DCR should discuss considerations for stopping the ITA evaluation process, dropping an ITA hold, or detaining on a Single Bed Certification.

Referrals from medical floors may require additional consultation with care coordinators, social services, and treating physicians. Individuals on medical floors may be receiving medical treatment which certain E&T facilities may not have the capacity to provide. DCRs may need to explain facility transfer limitations and ITA detention options including Single Bed Certifications.

At times, a DCR's role will be to provide education about the system of care, navigating the ITA referral, and engaging additional system wide supports through the BH-ASO, DSHS, and Home and Community Services.

Best practices for DCR engagement with ED/Medical floor

1. Determine timeliness requirement, communicate awareness, and time of response. (See [page 78](#) for *timeliness requirements*)
2. Ensure population specific identifiers per statute (AI/AN, Military, Veteran) are recorded.
3. Ensure health care decision makers are identified and make contact as necessary.
4. Provide notification of rights.
5. If the individual has not been determined to be medically clear/stable, identify necessary medical information, consult with treating physician, and stop evaluation pending medical clearance.
 - Keep a record of the time when the evaluation has stopped pending medical clearance.
 - i. Depending upon medical condition and stability considerations, the DCR will determine appropriate course of action for ITA evaluation attempt.
 - ii. If medical clearance/stability can be determined in a timely manner, the DCR shall plan to complete the ITA investigation, record time evaluation restarts ensuring that ITA evaluation time does not exceed statute provisions.
 - If the evaluation was for an individual who came from a Licensed Care Facility, the resident may have re-admission rights. The DCR may need to assist the hospital in reporting Abuse/Neglect if the facility refuses to readmit. *Review the section for Community Outreach - Licensed residential care facilities on [page 74](#) for additional information and education.*
6. If a patient on a medical floor does not meet criteria or an ITA detention placement cannot be secured by either a facility transfer or a Single Bed Certification, the DCR will need to discuss interventions with hospital staff and inform them of the completion of a No Bed Report.

ED/Medical floor interventions: Behavior management best practices

Not all dangerous or concerning behaviors may be due to a behavioral health disorder. Factors such as an individual's physical health may contribute to behaviors considered to be acting out. Health conditions such as urinary tract infection, constipation, respiratory disorders, medication interactions, or environmental stressors may impact an individual's routines, functioning, and behavior.

Intervention practices:

- Monitor medical or medication concerns.
 - Assess for utilization of a PRN medication
- Ensure current lab work has been completed to rule out additional medical issues.
- Maintain continuous assessment of pain levels and implementation or change of pain management plan
- Review of medications – any recent changes, medication refusal. Implementing plan if medication change correlates to change in behavior.
- Identify plan-of-care methods for specifically deescalating the individual. Examples may be
 - Moving patient away from excessive auditory and visual stimuli, striving to provide a calm, quiet, peaceful space.
 - Use a calm, quiet voice, no matter what the patient's voice tone or level is.

- Allow time for the patient to vent before trying to intervene, unless danger to self or others is involved.
- Ensure behavior changes are documented including interventions attempted and outcomes. Note duration, intensity and frequency.
 - Redirect the patient toward a new interest, rather than away from the object, individual or topic involved in the behavior. Reorient the patient without disagreeing with him/her.
- Review admission documentation for behavioral health diagnosis, consult with behavioral health treatment provider, identify method for outpatient assessment of current symptom functioning, and implement plan for increased outpatient behavioral health services
 - Provide support, such as empathetic reflections, regarding emotions and distress related to delusional thought content. Being mindful to not confront or collude with delusional beliefs.
 - Offer time for the patient to communicate their concerns, even if they are irrelevant or delusional.
- Assess whether behavior escalation is potentially a trauma response or related to a lack of cultural awareness. Implement individualized and program specific services to address individual needs and promote services awareness

Acute inpatient behavioral health treatment facilities

Acute inpatient behavioral health treatment facilities provide twenty-four-hour continuous monitoring and supervision. These facilities provide multidisciplinary professional intervention to stabilize severe acute behavioral health symptoms. Services are provided for in a hospital environment. These facilities provide short term and long-term civil commitment treatment.

The Department of Health (DOH) licenses facilities that provide for brief forms of acute treatment including

- Voluntary and/or involuntary psychiatric units at Acute Care Hospitals (HAC) [RCW 70.41]
- Voluntary and/or involuntary private psychiatric and alcoholism hospitals (HPSY) [RCW 71.12]
- Residential Treatment Facilities licensed as Behavioral Health Agencies for E&T & SWMS [RCW 71.12]

State hospitals and state facilities which provide forensic competency treatment, civil conversion, and lengthier civil commitment are operated by the Department of Social and Health Services (DSHS).

State Hospitals¹⁹

- The Child Study and Treatment Center (Lakewood)
- Eastern State Hospital (Medical Lake)
- Western State Hospital (Lakewood)

State Facilities

- Olympic Heritage Behavioral Health (Tukwila)
- Behavioral Health and Treatment Center – Maple Lane Campus (Centralia)
- Behavioral Health and Treatment Center – Steilacoom Unit (Lakewood)
- Special Commitment Center (McNeil Island)

Treatment and intervention practices at acute inpatient facilities

Current federal and/or state law requires acute inpatient behavioral health treatment facilities to conduct assessments, provide individualized treatment, and provide for services as reasonably possible to meet the individual's needs. Depending upon the type of state licensure, some facilities may not have the ability to ensure

¹⁹ Current as of September 2026

ambulatory, or ADL needs are provided.

Individual with certain medical conditions may require treatment at specific licensed facilities and are unable to receive treatment at other facilities. The requirements to provide individualized services and supports means **these facilities may be considered a less restrictive alternative to involuntary treatment if the individual is assessed, been advised of the need for voluntary treatment and the professional staff of the facility has evidence that the individual has in good faith volunteered admission and the facility can provide for the individual safety and treatment.**

- Staff at these facilities are to be trained in behavior management, including safety and violence prevention
- Facilities should attempt appropriate less restrictive interventions prior to considering involuntary treatment
- The availability and capacity of staff resources to offer additional services in response to emergent medical needs varies by facility license
- In certain circumstances, individuals may also have a right to have their bed held during a temporary medical admission

Not all dangerous or concerning behaviors may be due to a behavioral health disorder. Factors such as an individual's physical health may contribute to behaviors considered to be acting out. Health conditions such as urinary tract infection, constipation, respiratory disorders, medication interactions, or environmental stressors may impact an individual's functioning and behavior. Acute inpatient facilities need to ensure that preventative and early intervention methods are attempted as less restrictive options prior to immediate referrals for involuntary detention evaluation.

Intervention practices

- Consultation with facility nurse or individual's treating provider to identify possible medical or medication concerns. *Examples of concern: constipation, dehydration, GI distress, ear infections, and/or O2 deficiency*
 - Assess for utilization of a PRN medication
- Ensuring current lab work has been completed to rule out medical issues. *Examples of lab work: urine analysis, electrolyte levels, thyroid level, B12, folic acid, and/or medication levels*
- Assessment of pain levels and implementation or change of pain management plan.
- Review of medications: Any recent changes, medication refusal. Implementing plan if medication change correlates to change in behavior. Determine if PRN may need to be ordered as a routine medication.
- Ensuring routine plan of care identifies methods for specifically deescalating the individual. Examples may be quiet time, visit from family or other supports, 1:1 with a staff member, or soothing activities like listening to music. Ensure these have been attempted and attempts documented.
 - Remove the patient from excessive auditory and visual stimuli. Provide a calm, quiet, peaceful space for the patient to regroup.
 - Use a calm, quiet voice, no matter what the patient's voice tone or level is.
 - Allow time for the patient to vent before trying to intervene, unless danger to self or others is involved.
 - Let the patient tell you what will help and work with the family or support system to find creative ways to make it happen.
- Attempting to provide consistent structure in the patient's daily routine.
- Ensuring behavior changes are documented including interventions attempted and outcomes. Note duration, intensity and frequency.

- Redirect the patient toward a new interest, rather than away from the object, individual or topic involved in the behavior. Reorient the patient without disagreeing with him/her.
- Assess whether behavior escalation is potentially a trauma response or related to a lack of cultural awareness. Implement individualized and program specific services to address individual needs and promote services awareness.
- If interventions are not improving the patient's presentation and the patient is seeking discharge, a facility provider shall assess for potential involuntary treatment. The facility needs to follow the DOH guidance for release of voluntary individuals.

Release of voluntary individuals: What facilities and DCRs need to know

In April 2021, DOH released an interpretive statement, titled [Release of Voluntary Individuals from Inpatient Behavioral Health Settings](#)²⁰. Acute inpatient facilities need to ensure an understanding of this interpretive statement. The statement indicates that all inpatient behavioral health settings including all hospitals and residential treatment facilities are required to release 'immediately' voluntarily admitted individuals who request release ([RCW 71.05.050](#)).

"The only exception is when the individual, at the time of the request for release, is exhibiting behaviors that could qualify the individual for involuntary detention."²¹

To meet the immediacy requirement of RCW 71.05.050(1):

- The facility should direct that any professional staff (as defined by [RCW 71.05.020 \(42\)](#)) available at the time of the individual's request to be released immediately conduct any prerelease assessment for the limited purpose of determining whether a more comprehensive assessment by a DCR is needed.
- A DCR should not be contacted unless the facility has documented reasonable grounds to believe that the individual may meet the criteria for a limited involuntary detention.
- The process from the point of the individual's initial request to their release or referral to a DCR should take a matter of hours.
- Facilities are to consult with DCR, promptly and without undue delay, regardless of the time of day or day of the week.
- An adolescent who is voluntarily admitted and gives notice of intent to leave shall be released by the second judicial day after notice is received ([RCW 71.34.520](#)).

Best practices for DCR engagement with acute inpatient facilities

1. Determine timeliness requirement, communicate awareness, and time of response. (See [page 78](#) for *Timeliness Requirements*)
2. Consult with facility staff to determine methods of facility intervention utilized to document rule out of

²⁰ Read this full statement in [Appendix G](#)

²¹ [RCW 71.05.050](#)

less restrictive alternatives.

3. Ensure population specific identifiers per statute (AI/AN, Military, Veteran) are recorded.
4. Ensure health care decision makers are identified and make contact as necessary.
5. If individual is not determined to be medically clear/stable, identify necessary medical information, consult with treating physician, stop evaluation pending medical clearance. DCRs need to keep record of time evaluation has stopped pending medical clearance. When notified of medical clearance, record the time that the evaluation restarts and monitor that the ITA evaluation timeframe does not exceed statutory time limit.

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Crisis relief centers and residential treatment facilities

Within the crisis continuum of behavioral health services are comprehensive supports aiming to stabilize and maintain care for individuals either during a crisis or post-crisis to prevent unnecessary hospitalizations. These services include:

- **23-hour crisis relief center (CRC):** A community-based facility or portion of a facility which is licensed or certified by the department of health and open 24 hours a day, seven days a week, offering access to mental health and substance use care for no more than 23 hours and 59 minutes at a time per patient, and which accepts all behavioral health crisis walk-ins drop-offs from first responders, and individuals referred through the 988 system regardless of behavioral health acuity, and meets the requirements under [RCW 71.24.916](#) [[RCW 71.05.020\(1\)](#); [RCW 71.24.025\(1\)](#)].
- **Crisis stabilization unit (CSU):** A short-term **licensed** facility, which has been designed to assess, diagnose, and treat individuals experiencing an acute crisis without the use of long-term hospitalization, or to determine the need for involuntary commitment of an individual [[RCW 71.05.020\(14\)](#)].
- **Substance use disorder withdrawal management services:** Twenty-four-hour medically managed or medically monitored detoxification and assessment and treatment referral for adults or adolescents withdrawing from alcohol or drugs, which may include induction on medications for addiction recovery [[RCW 71.24.618\(8\)](#)].
- **Residential substance use disorder treatment:** A protocol that provides individualized, concentrated program services at a residential facility. Individuals often no longer require round-the-clock medical monitoring. These programs offer structure, support, and evidenced based therapies in a live-in setting. The length of stay varies and is dependent on initial and ongoing assessments using ASAM criteria and progress toward treatment goals.

Crisis relief centers (CRCs) are designed to be a no-wrong door, no barrier method to access crisis stabilization services. These facilities are a brief landing place that use multidisciplinary teams to address immediate needs and connect individuals to the appropriate next steps in their care plan.

CRCs are *not* designed for stays of more than 23 hours and 59 minutes, so they are not classified as residential treatment facilities. However, special exceptions, such as waiting for an evaluation by a designated crisis responder (DCR) or waiting to transition to another setting as a part of their care plan, may allow an individual to stay at the facility for up to 36 hours.

Residential treatment facilities (RTFs) are a facility **licensed by the Department of Health (DOH)** in which twenty-four-hour on-site care is provided for the evaluation, stabilization, or treatment of residents for substance use, mental health, co-occurring disorders, or for drug exposed infants. **Facilities providing behavioral health treatment are dually licensed as behavioral health agencies (BHAs) under WAC 246-341.** RTFs provide low barrier behavioral health care for urgent and emergent needs that can be met without an admission to acute inpatient care.

Services licensed by DOH as both an RTF and BHA²²:

- Crisis Stabilization Unit (CSU)
- Substance use disorder withdrawal management (detox)
- Residential substance use disorder treatment

CRCs and CSUs may hold an individual for DCR ITA investigation if the professional staff regards an individual admitted and requesting discharge as presenting as a result of a behavioral health disorder, an imminent

²² As of September 2026

likelihood of serious harm, or gravely disabled. (See [page 78](#) for *Timeliness Requirements*.)

Substance use disorder withdrawal management and residential substance use disorder treatment are provided in RTFs as a voluntary residential form of service. These treatment services are provided for in the licensed residential treatment facility and must comply with DOH WACs under chapters [246-337](#) and [246-341](#). Treatment providers should be aware of behavioral interventions for de-escalating individuals receiving treatment.

Although substance use disorder withdrawal management (detox) and residential substance use disorder treatment facilities do not have authority under RCW 71.05 for holding an individual for DCR investigation, professional staff should follow standards identified in the release of voluntary individuals and consult with crisis services for crisis care considerations. See section below regarding release of voluntary individuals.

Treatment and intervention practices for CRCs and RTFs

Not all dangerous or concerning behaviors may be due to a behavioral health disorder. Factors such as an individual's health may contribute to behaviors considered to be acting out. Health conditions such as urinary tract infection, constipation, respiratory disorders, medication interactions, or environmental stressors may impact an individual's functioning and behavior. CRCs and RTFs need to ensure that preventative and early intervention methods are attempted as less restrictive options prior to immediate referrals for acute inpatient consideration.

Intervention practices include

- Consultation with facility nurse or medical provider to identify possible medical or medication concerns. *Examples of concern: constipation, dehydration, GI distress, ear infections, and/or O2 deficiency*
 - Assess for utilization of a PRN medication
- Ensuring current lab work has been completed to rule out medical issues. *Examples of lab work: urine analysis, electrolyte levels, thyroid level, B12, folic acid, and/or medication levels*
- Assessment of pain levels and implementation or change of pain management plan, if feasible
- Review of medications – any recent changes, medication refusal. Implementing plan if medication change correlates to change in behavior. Determine if PRN may need to be ordered as a routine medication
- Ensuring routine plan of care identifies methods for specifically deescalating the individual. *Examples may be quiet time, visit from family or other supports, 1:1 with a staff member, or soothing activities like listening to music.* Ensure these have been attempted and attempts documented.
 - Remove the individual from excessive auditory and visual stimuli. Provide a calm, quiet, peaceful space for the individual to regroup.
 - Use a calm, quiet voice, no matter what the individual's voice tone or level is.
 - Allow time for the individual to vent before trying to intervene, unless danger to self or others is involved.
 - Let the individual tell you what will help and work with the family or support system to find creative ways to make it happen.
- Assessment for changes in environment or social setting including potential stressors, life changes, loneliness factors.
 - Voice observed environmental changes and ask the individual what change could help
 - Change the surroundings, the individual's room assignment or roommate
- Ensure behavior changes are documented including interventions attempted and outcomes. Note duration, intensity and frequency.
 - Redirect the individual toward a new interest, rather than away from the object, individual or topic involved in the behavior. Reorient the individual without disagreeing with him/her.
 - Assign the individual tasks that meet their strength and history. Short, repetitive tasks are often

best.

- Review admission documentation for behavioral health diagnosis, consult with behavioral health treatment provider, identify method for further assessment of current symptom functioning, and implement plan for increased behavioral health services
 - Provide support, such as empathetic reflections, regarding emotions and distress related to delusional thought content. Being mindful to not confront or collude with delusional beliefs.
 - Offer time for the individual to communicate their concerns, even if they are irrelevant or delusional.
- Assess whether behavior escalation is potentially a trauma response or related to a lack of cultural awareness. Implement individualized and program specific services to address individual needs and promote services awareness

Release of voluntary individuals: What facilities and DCRs need to know

In April 2021, DOH released an interpretive statement: [Release of Voluntary Individuals from Inpatient Behavioral Health Settings](#)²³. Residential treatment facilities need to ensure an understanding of this interpretive statement. The statement indicates that all inpatient behavioral health settings including all hospitals and residential treatment facilities are required to release ‘immediately’ voluntarily admitted individuals who request release (**RCW 71.05.050**).

“The only exception is when the individual, at the time of the request for release, is exhibiting behaviors that could qualify the individual for involuntary detention.”

To meet the immediacy requirement of **RCW 71.05.050(1)**

- Direct that any professional staff (as defined by **RCW 71.05.020 (42)**) available at the time of the individual’s request to be released immediately conduct any prerelease assessment for the limited purpose of determining whether a more comprehensive assessment by a DCR is needed.
- A DCR should not be contacted unless the facility has documented reasonable grounds to believe that the individual may meet the criteria for a limited involuntary detention.
- The process from the point of the individual’s initial request to their release or referral to a DCR should take a matter of hours.
- Facilities are to consult with DCR, promptly and without undue delay, regardless of the time of day or day of the week.

Best practices for DCR engagement with CRCs and RTFs

1. Ensure any residential treatment facility is aware of the DOH interpretive statement [Release of Voluntary Individuals from Inpatient Behavioral Health Settings](#) and has documented necessary requirements.
2. Determine timeliness requirement, communicate awareness, and time of response. (See [page 78 for Timeliness Requirements](#))
3. Consult with facility staff to determine methods of facility intervention utilized to document rule out of less restrictive alternatives.

²³ Find this full statement in [Appendix G](#)

4. Ensure population specific identifiers per statute (AI/AN, Military, Veteran) are recorded.
5. Ensure health care decision makers are identified and make contact as necessary.
6. If individual is not determined to be medically clear/stable, identify necessary medical information, consult with treating physician, stop evaluation pending medical clearance. Keep record of time evaluation has stopped pending medical clearance. When notified of medical clearance, record time evaluation restarts ensuring that ITA evaluation time does not exceed statute provisions.

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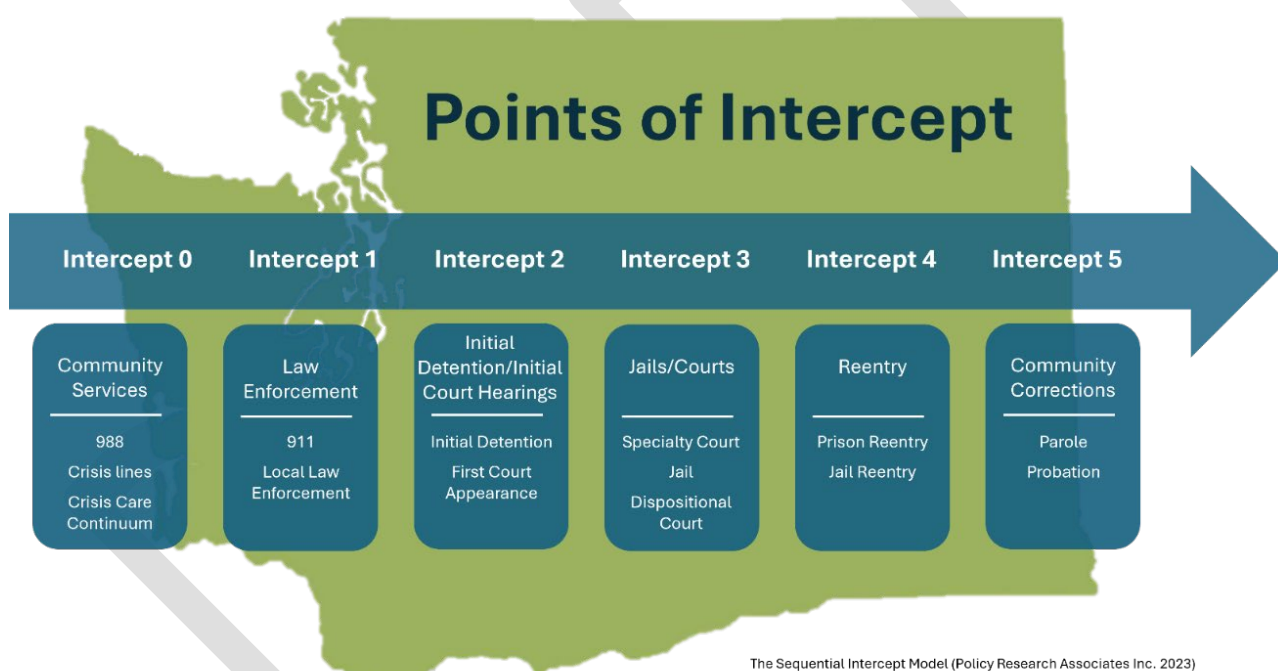
Carceral settings: Detention centers, jails, and prisons

The Sequential Intercept Model²⁴ is a framework designed to promote early screening and assessment for diversion of individuals into treatment programs to enable a reduction in criminal charges or conviction.

The Sequential Intercept Model (Munetz & Griffin, 2006) provides a framework for conceptualizing the interface between the criminal court and behavioral health systems. Washington, in an effort to reduce the criminalization of individuals with mental illness and substance use, is increasingly utilizing the SIM as a conceptual framework to guide diversion programs²⁵.

The sequential intercept model has several key objectives:

- Preventing initial involvement with the criminal court system
- Decreasing admissions to jail
- Engaging people in treatment as soon as possible
- Minimizing time moving through the criminal court system
- Connecting people to community treatment options
- Decreasing the rate of return to the criminal court system



ITA referrals - What carceral settings need to know

Carceral settings making the referral should provide the following relevant referral information regarding:

²⁴ Adapted from Abreu, D., Parker, T. W., Noether, C. D., Steadman, H. J., & Case, B. (2017). Revising the paradigm for jail diversion for people with mental and substance use disorders: Intercept 0. *Behavioral Sciences & the Law*, 35(5-6), 380–395. <https://doi.org/10.1002/bsl.2300> and Munetz, M. R., & Griffin, P. A. (2006). Use of the Sequential Intercept Model as an approach to decriminalization of people with serious mental illness. *Psychiatric Services*, 57(4), 544–549. <https://doi.org/10.1176/ps.2006.57.4.544>

²⁵ <https://www.dshs.wa.gov/sites/default/files/BHSIA/FMHS/Best-Practices-for-Behavioral-Health-Services-in-Jail-Settings-Final-2025.pdf>

- 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.

Referents should be prepared for the DCR to review the following, including but not limited to:

- Competency evaluations
- Court orders for commitment or involuntary treatment while in custody
- Behavioral health evaluations by facility staff
- Criminal history
- Arrest reports

Individuals in detention, jail or prison who have a behavioral health disorder can be detained to an involuntary inpatient 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 BH-ASO, the DCR office, the carceral settings, and the court, as well as available resources.

Referrals from a Tribal jail will follow the appropriate MOU, BH-ASO agreement, or Tribal Crisis Coordination Protocols.

Carceral settings need to be aware that direct admissions from the facility to an involuntary inpatient facility may require the dismissal of criminal charges.

- Inpatient admission criteria are established by each inpatient facility
- Unless otherwise established, inpatient facilities require medical assessment and clearance with current laboratory results
- Inpatient placement is approved on a case-by-case basis to facilities with the first available bed.
- DCRs will not typically know bed availability at the time of an ITA investigation
- Individuals transferred to emergency department for medical clearance may not be held by the hospital beyond 12 hours while the DCR seeks placement ([RCW 71.05.153.\(3\)](#), [71.34.700\(2\)](#))
- If placement for an ITA detention cannot be identified and the hospital will not permit a Single Bed Certification, the DCR is required to complete a No Bed Report. The hospital will determine the next course of treatment considerations, including referrals to outpatient services.

Carceral settings: What DCRs need to know

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 DCR does not rule out any referral for investigation solely because the individual is incarcerated.

DCRs need to ensure awareness of the specific statutory criteria for referral and legal clearance or eligibility for release from custody. Consultation with the referring facility may determine that utilization of mobile outreach is an appropriate less restrictive.

Carceral setting referrals may include:

- Post-arrest diversion from juvenile detention and community jail
- Persons charged with possessing firearms or dangerous weapons on school facilities
- Persons that are pre-discharge pending release from a juvenile detention, community jail, or correctional facility
- Incarcerated individuals who have undergone competency evaluation and are set to be released
- Washington State Department of Corrections inmates designated to participate in Re-entry Community Services Program (RCSP)
- Individuals who were previously under a discharge review at WSH or ESH and are currently incarcerated

A DCR shall consult with referral source on current criminal charge status and eligibility for release. Identifying considerations for next steps once an ITA investigation opinion is provided are essential for any carceral setting evaluation.

Post-arrest diversion from juvenile detention and community jail

Post-arrest diversion is utilized to seek alternatives to incarceration for individuals identified to have behavioral health needs. Many of the post-arrest diversion referrals are for specialized programs including specialized courts (drug, mental health, and veterans' courts), prosecutorial diversion/deflection programs, navigator programs for outpatient competency restoration, and connections directly with outpatient behavioral health agencies.

There will, however, be occasions when individuals are brought directly to juvenile detention or jail while experiencing severe behavioral health symptoms or the individual may decompensate while in custody. For individuals experiencing severe behavioral health symptoms and concern for their health and safety is evident, carceral settings will identify if referral for evaluation by a DCR is legally possible.

As there are regional limitations on direct ITA admissions from carceral settings to inpatient facilities, DCRs should ensure that referents are aware a release from incarceration and an opinion by the DCR for ITA detention does not guarantee ITA placement.

Person charged with possessing firearms or dangerous weapons on school facilities

The DCR investigates and evaluates persons referred by law enforcement after being arrested for the illegal possession of firearms, as defined in [RCW 9.41.010\(11\)](#), or dangerous weapons on school facilities for possible detention under RCW 71.05 or RCW 71.34. [RCW 9.41.280\(2\)](#).

For purposes of this section only, “person” is defined as an individual between the ages of 12 and 21.

The evaluation shall occur at the facility in which the person is detained or confined. The DCR shall notify the parent or guardian.

When practicable, and as allowed by applicable privacy laws such as the Family Educational Rights and Privacy Act (FERPA)²⁶, the DCR 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 DCR provides the result of the evaluation to the charging criminal court for use in the criminal disposition. The 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 DCR, if appropriate, may refer the person to local behavioral health administrative services organization for follow-up services or other community providers for other services to the family and person [[RCW 9.41.280\(2\)](#)].

Pending release – County Jail

A county jail may request an ITA evaluation for an individual who has had a preliminary court appearance and the individual's release is pending the evaluation. If the court did not find, or previously found, probable cause, the individual in custody at the jail is to be released without conditions, unless the court identifies a delay of release cause.

Washington State Courts, Superior Court Criminal Rules (CrR), 3.2 Release of Accused, identifies, “the court may delay release of a person in the following circumstances: (2) If the person's mental condition is such that the

²⁶ 34 CFR Part 99: Refer to [FERPA | Protecting Student Privacy](#) for more information

court believes the person should be interviewed by a mental health professional for possible commitment to a mental treatment facility pursuant to RCW 71.05, the court may delay release of the person.”²⁷

CrR 3.2 further identifies that the jail must release the individual no later than 24 hours after the individual’s preliminary court appearance unless other ground exists for the jail to continue their incarceration.

Referrals for DCR Investigation based upon a delay of release should ensure coordination with county jail on access to available historical records, court release order, and access for transfer or release. The DCR coordinating the investigation response needs to be mindful about the time of day and the timeframe of the release delay.

Although the individual is in a secure location, the county jail has a limited duration of time that the facility can lawfully maintain custody of the individual for a DCR investigation. Additionally, DCRs need to be aware that if the individual does not meet criteria for being detained, depending upon regional area certain services and resources may not be available after hours limiting less restrictive alternative options.

Pending release – Prison

Prison health services re-entry staff may request a DCR evaluation prior to an individual’s release, based on a pending planned release date. The request for the evaluation is made **five (5) days prior to the date of pending release** as the Department of Corrections will need to plan for the DCR entry into the closed facility.

If at the time of the evaluation the individual meets criteria for detention, transport to an emergency department for medical clearance then subsequent ITA placement is arranged.

If the individual does not meet criteria at the time of the evaluation, the individual will remain at the facility pending release. The facility may re-request an evaluation if the individual’s presentation worsens.

Additionally, many prisons have jail type settings known as ‘violator units’ that house individuals who have been accused of violating conditions of their supervision with DOC. An individual may be sanctioned to this setting on a violation for up to 30 days.

Prison health services reentry staff may need to coordinate with DCR staff to determine appropriate response times for ITA evaluations based upon various factors including sanction release dates, a hearing date, or pending discharge. The facility may need to maintain the five-day procedural request for clearing a DCR staff member for performing the evaluation.

Competency considerations and restoration

In order to have a fair trial, a person charged with a crime must understand the charges against them and be able to assist their attorney in their own defense.

If either or both of these abilities seems to be lacking and it appears that the person has a mental health condition, a judge may order a competency evaluation to inform the court about the person’s abilities to stand trial.

Incompetency: *A person lacks the capacity to understand the nature of the proceedings against them or to assist in their own defense as a result of mental disease or defect.*

Often, the defense or prosecuting attorney raises the question about a person’s competency and whether they have a mental health condition. **RCW 10.77** provides the statutory authority for competency restoration and engagement with DCRs for evaluation when identified.

²⁷ Washington State Courts, Superior Court Criminal Rules, 3.2 Release of Accused

If a defendant is charged with a **nonfelony crime which is not a serious offense** and found by the court to be not competent, the court may stay or dismiss the proceedings, holding the individual to allow for a DCR to evaluate and consider an initial detention. **RCW 71.05.235 specifies that the DCR shall examine the individual within 48 hours.** The court is to be presented immediately with the outcome of the DCR evaluation as determination for whether to enter an order for ITA placement must be determined.

If the judge orders a competency evaluation, a trained evaluator will conduct an assessment. The majority of these competency evaluations are done by a Department of Social and Health Services employee known as a Forensic Evaluator. The Forensic Evaluator's role is to assess and inform the court about the person's abilities to understand their charges, the court process, and/or if the person has the ability to assist in their trial defense as a result of living with a mental health condition. A judge makes the final decision about whether the person meets the legal criteria for competency to stand trial. The legal definition of competency to stand trial is found in the Revised Code of Washington **10.77.010(15), (19)**. This work is overseen by the DSHS Behavioral Health Administration's Office of Forensic Mental Health Services.

If a judge determines that a person does not understand their charges, the court process, and/or lacks the ability to assist in their defense because of a mental health condition, competency restoration services may be ordered. For clarification, people in competency restoration programs have not been convicted of a crime. Therefore, they are considered pre-trial detainees. If found competent, they may stand trial on their current charge(s) that brought them into the legal system.

Competency restoration programs

Competency restoration can be provided in two settings:

- **Inpatient restoration** is provided in state hospitals or residential treatment facilities.
- **Outpatient restoration** is provided in the community by contracted behavioral health providers.

The outpatient competency restoration programs (OCRP) are currently available in:

- The Spokane County region, including Spokane, Pend Oreille, Stevens, Ferry, Adams, and Lincoln counties
- The Southwest region, including Clark, Skamania, and Klickitat counties
- The Salish region, including Jefferson, Clallam, and Kitsap counties, and
- Pierce County, King County, Thurston County, and Mason County

A person can be ordered into OCRP for up to 90 days for a misdemeanor order and for up to one year for felony orders. OCRP uses the Breaking Barriers Competency Restoration Program²⁸ to assist individuals in becoming competent. The program facilitates medication management, individual and group psychoeducational and psychosocial therapies, and connects people to Forensic Housing and Assistance²⁹ through Peer Services (FHARPS) if unstably housed, Forensic Projects for Assistance in Transition from Homelessness (FPATH) if eligible, outpatient mental health treatment, and outpatient substance use disorder treatment, among other community-based services as needed. Individuals in OCRP spend approximately 10 hours per week in restoration programming.

Each OCRP provides, at a minimum, one Breaking Barriers master instructor (licensed mental health professional), one Breaking Barriers subject matter expert (non-licensed mental health professional), one certified peer counselor and a part-time prescriber. These staff work closely with the DSHS forensic navigators

²⁸ **Competency Restoration, A guide to competency evaluation and restoration**

²⁹ **FHARPS and FPATH teams** are located in community behavioral health agencies that have Certified Peer Support Specialists who work with people experiencing homelessness and are supported by Forensic Navigators and OCRP

and other service providers to ensure coordinated transition and service planning for people in the program.

If a defendant is charged with a **nonfelony crime which is a serious offense** and found by the court to not be competent, the court shall consider all available and appropriate alternatives to inpatient competency restoration, including outpatient competency restoration. Individuals on OCRP receive services monitored by a DSHS contracted outpatient competency restoration program.

To be eligible for an order for outpatient competency restoration, a defendant must be willing to

- Adhere to medications or receive prescribed intramuscular medication
- Abstain from alcohol and unprescribed drugs
- Comply with urinalysis or breathalyzer monitoring if needed

If a defendant fails to comply with the restrictions of the outpatient competency restoration program, placement into an appropriate inpatient competency program shall be coordinated thus revoking the individual's conditional release. The court orders for outpatient competency restoration (CROROP) cannot be revoked by a DCR.

RCW 10.77.400 identifies whenever a defendant has pleaded not guilty by reason of insanity, a qualified expert or professional person is appointed to evaluate and report upon the mental condition of the defendant. The report of the evaluation shall include the opinion as to whether the defendant should be evaluated by a DCR.

To the extent possible, the DCR, upon request of the correctional facility, will conduct the investigation shortly before the individual's scheduled release date or when the correctional facility has the authority to release the individual if the detention criteria are met [**RCW 10.77.405**].

Individuals in the Re-entry Community Services Program (RCSP)

The Reentry Community Services Program (RCSP) provides support services for adults leaving prison who have complex mental illness and who pose a danger to themselves or to others.³⁰ Individuals are eligible to receive mental health services and housing assistance up to 60 months excluding periods of confinement or program disengagement. RCSP serves a narrow segment of individuals at high risk of re-entry struggle and potential return to incarceration.

Incarcerated individuals are referred to the program by The Washington State Department of Corrections (DOC), family members, or professional providers. HCA, RCSP, and DOC screen referrals for eligibility. While still incarcerated, RCSP will start engagement with the individual to establish rapport and develop transition plan for re-entry.

As the eligibility criteria for RCSP is an identification of complex mental illness and posing a danger to themselves or to others, DOC may request a DCR investigation for a DOC inmate referred to be an RCSP participant.

To qualify under **RCW 72.09.370**, the individual has been designated by DOC through the RCS Statewide Review Committee as meeting criteria for dangerousness and has either:

- Been diagnosed with a behavioral health disorder under **RCW 71.05.020(7)** or
- Is enrolled with DSHS Developmental Disabilities Administration (DDA)

The investigation shall occur not more than 10 days, but not less than five days, prior to the actual release of the designated RCSP participant. When conducting an evaluation of an RCSP participant, the DCR shall consider the person's history of judicially required or administratively ordered antipsychotic medication while in

³⁰ **Engrossed Second Substitute Bill 5304, Chapter 243, Laws of 2021**

confinement.

The fact that a person is identified as an RCSP participant does not change the commitment criteria under RCW 71.05. As the individual is pending discharge from the correctional facility to the community, remaining at the facility may not be identified as a less restrictive when the individual meets other elements of criteria for involuntary treatment.

If an RCSP participant is determined to meet criteria for ITA detention, DOC will coordinate with WSH/ESH for the transfer of the individual for ITA treatment. The DCR may need to assist DOC with making the arrangements for this transfer of care.

If the DCR evaluates an RCSP participant and identifies the individual does not meet criteria for detention, the RCSP Committee may request a second investigation to occur near the day of release for the individual. Coordinating this second investigation is dependent upon the DCR ability to access the DOC facility.

Department of Corrections facilities with Reentry Center locations³¹

Bellingham Reentry Center, Bellingham
Olympia Corrections Center, Olympia
Helen B. Ratcliff Reentry Center, Seattle
Reynolds Reentry Center, Seattle
Brownstone Reentry Center, Spokane

Eleanor Chase House, Spokane
Longview Reentry Center, Spokane
Tacoma Community Justice Center, Tacoma
Wenatchee Valley Reentry Center, Wenatchee

Incarcerated individuals previously the subject of Discharge Review at WSH or ESH

RCW 71.05.157(1) specifies that when a DCR is notified of a defendant or offender who was subject to a discharge review under **RCW 71.05.232** is to be released to the community, **the designated crisis responder shall evaluate the person within seventy-two hours of release.**

Discharge reviews under RCW 71.05.232 occur when a state hospital admits a person for evaluation or treatment who has a history of one or more violent acts and has been transferred from a correctional facility to WSH/ESH or has been under the department of corrections or the indeterminate sentence review board.

When contacted by the jail or prison, the DCR will evaluate the individual for ITA detention within 72 hours prior to release. This 72-hour period is interpreted by the Department of Corrections (DOC) to not include weekends and holidays.

Educational resources

Best Practices for Behavioral Health Services in Jail Settings – DSHS, Behavioral Health and Habilitation Administration (2025) <https://www.dshs.wa.gov/sites/default/files/BHSIA/FMHS/Best-Practices-for-Behavioral-Health-Services-in-Jail-Settings-Final-2025.pdf>

Joplin Consulting (2016). Jail diversion for people with mental illness in Washington state [https://www.ofm.wa.gov/sites/default/files/public/legacy/report s/Jail%20Diversi%20for%20People%20with%20Mental%20Illness%20in%20Washington%20State%20Study.pdf](https://www.ofm.wa.gov/sites/default/files/public/legacy/report%20Jail%20Diversi%20for%20People%20with%20Mental%20Illness%20in%20Washington%20State%20Study.pdf)

The Sequential Intercept Model - Policy Research Associates (2023) <https://www.prainc.com/sim/>

Diversion Navigators work to identify people in jail, who may be eligible and willing to engage in services, for diversion programs pursuant to RCW 10.77. <https://www.dshs.wa.gov/sites/default/files/BHSIA/Diversion-Navigator-One-Page-2024.pdf>

³¹ As of September 2026. Refer to [DOC Reentry Centers](#) for more information

Community outreach referent locations

Crisis services and DCR investigations can be provided in a multitude of community locations. Those working in the crisis system should be knowledgeable of these locations and safety considerations. Referents at these sites can assist crisis services with their efforts to provide person-centered, less restrictive treatment by sharing any intervention efforts that have been utilized.

Community outreach locations can include

- First responder or law enforcement pre-arrest diversion
- Professional service providers
- Intensive behavioral health treatment facilities
- Licensed residential care facilities
- Residences or non-professional service sites

First responder or law enforcement pre-arrest diversion

Overview

Increasingly, law enforcement and emergency services personnel are striving to develop and utilize community-based alternatives to criminal justice involvement and incarceration of people with behavioral health presentations. For many people in crisis, law enforcement officers may be the initial point of contact. Accessing behavioral health services or a lack of awareness of available resources may create challenges for law enforcement.

The development of Crisis Intervention Teams (CIT), police-mental health co-responder teams, and emergency services-mental health co-response teams have increasingly been utilized to bridge the gap and link individuals with behavioral health needs into pre-arrest diversion.

The aim of these diversion services is to ensure recognition and response to symptoms of behavioral health crisis, de-escalation of situations, avoiding use of force, and when able to connect people to alternatives to arrest.

Pre-arrest diversion efforts are emphasized in the framework for [The Sequential Intercept Model](#). This model emphasizes key points where community-based crisis care may reduce criminal charges and conviction. The Washington state legislature has additionally emphasized the establishment of pre-booking diversion such as [ESB 5476](#) in 2021 which established the Recovery Navigator Program (RNP) for simple drug possession, or the Law Enforcement Assisted Diversion (LEAD) program established through [ESSSB 5536](#) in 2023.

Law enforcement diversion: What peace officers need to know

[RCW 10.31.110](#) allows for arrest diversion for any criminal charges when the person is known to have a behavioral health condition. It also requires local prosecutors and law enforcement to develop guidelines with the input of defense counsel and disability rights advocates on how best to use this arrest discretion.

Arrest diversion may include:

- Delivery of individuals to a crisis stabilization unit
 - Individual may be held up to 12 hours
 - Individual must be examined by MHP or SUDP within 3 hours of arrival
- Delivery of individuals to a 23-hour crisis relief center
 - Individual may be held up to 12 hours
 - Individual must be examined by MHP or SUDP within 3 hours of arrival
- Referral to a DCR for ITA investigation
- Referral for mobile crisis response services
- Referral to the regional entity handling legal system diversion, including RNP and (LEAD)

RCW 71.05.153(2) allows for a peace officer to take or cause such a person to be taken into custody and immediately delivered to the emergency department when they have reasonable cause to believe that such person is suffering from a behavioral health disorder and present an imminent likelihood of serious harm or is in imminent danger because of being gravely disabled.

The individual must be examined by an MHP or SUDP within 3 hours of arrival and if the need for ITA evaluation is requested, the DCR must determine if the individual meets detention criteria, within twelve hours of admission, not counting time periods prior to medical clearance.

Best practices for DCR engagement with law enforcement

1. For emergent crisis referrals, DCRs should follow their BH-ASO contract timeliness requirements.
2. DCRs should coordinate with law enforcement to ensure safety for the person, self, and others.
 - Law enforcement and emergency services personnel may be utilized as a second for safety if they are aware of required direct observation and agree to remain for outreach under **RCW 71.05.700**.
3. Maintaining an awareness of the various pre-arrest diversion services is essential.

Educational resources

[The Sequential Intercept Model - Policy Research Associates](https://www.prainc.com/sim/#toc_History_and_Impact_of_the_SIM)

https://www.prainc.com/sim/#toc_History_and_Impact_of_the_SIM

Pre Booking Diversion Options

<https://www.hca.wa.gov/assets/program/prebooking-diversion-options-for-waspc.pdf>

Final Bill Report, Engrossed Senate Bill 5476, Responding to the State v. Blake decision by addressing justice system responses and behavioral health prevention, treatment, and related services.

[https://lawfilesext.leg.wa.gov/biennium/2021-](https://lawfilesext.leg.wa.gov/biennium/2021-22/Pdf/Bill%20Reports/Senate/5476.E%20SBR%20FBR%202021.pdf)

[22/Pdf/Bill%20Reports/Senate/5476.E%20SBR%20FBR%202021.pdf](https://lawfilesext.leg.wa.gov/biennium/2021-22/Pdf/Bill%20Reports/Senate/5476.E%20SBR%20FBR%202021.pdf)

Professional service providers

Professional service providers include any location that is not identified as being a publicly owned location or an individual's private residence.

Professional service providers include

- Outpatient behavioral health agencies (BHAs)
- Social services including offices operated by DCYF or DSHS
- Human services, including homeless shelters, food banks, youth centers
- Community corrections (non-jail)

Professional service providers should be trained in working with individuals exhibiting behavioral health symptoms and knowledgeable about the crisis system continuum. As identified in the General referral considerations section (*page 27*), contact with the crisis system may initially result in utilization of other crisis system services such as mobile outreach.

Professional services providers should be aware of behavioral interventions for managing the situation to allow for crisis response.

Intervention: What professional service providers need to know

Not all dangerous or concerning behaviors may be due to a behavioral health disorder. Factors such as an

individual's physical health or situational stress may contribute to behaviors considered to be acting out. Professional service providers need to ensure that preventative and early intervention methods are attempted to maintain stability while awaiting crisis response.

Intervention practices

- Assess whether behavior escalation is potentially a trauma response or related to a lack of cultural awareness. Attempt to address individual needs.
- Check if routine plan of service identifies methods for specifically deescalating the individual.
 - Remove the individual from excessive auditory and visual stimuli. Provide a calm, quiet, peaceful space for the individual to regroup.
 - Use a calm, quiet voice, no matter what the individual's voice tone or level is.
 - Allow time for the individual to vent before trying to intervene, unless danger to self or others is involved.
 - Let the individual tell you what will help and work with the family or support system to find creative ways to make it happen.
- Inquire about pain levels and ask how to non-medically make the individual comfortable, if feasible.
- Redirect the individual toward a new interest, rather than away from the object, individual or topic involved in the behavior. Reorient the individual without disagreeing with him/her.
 - Provide support, such as empathetic reflections, regarding emotions and distress related to delusional thought content. Being mindful to not confront or collude with delusional beliefs.
 - Offer time for the individual to communicate their concerns, even if they are irrelevant or delusional.

Limited resource awareness: What Professional service providers need to know

- Referents need to be aware that coordination for crisis services includes **ensuring management of safety and violence prevention** for the individual, the professional service provider, and other individuals.
- **If immediate safety for anyone present is required, referents need to contact local emergency services.**
- If the referral identifies a DCR may be dispatched for ITA investigation
 - Referents at professional service provider locations need to ensure that staff are available to monitor the DCR ITA investigation continuously to ensure safety. (See [page 28](#) for *Safety - General dispatch considerations*)
 - For community dispatch there may be limitations to immediacy of custody authorization for an individual to be transport to a hospital. (See [page 80](#) for *additional information regarding Custody Authorizations*)
 - **Referents and DCRs will need to be prepared for establishing alternative plans of care if transport cannot be arranged.**

Intensive Behavioral Health Treatment Facilities (IBHTFs)

Intensive behavioral health treatment facility (IBHTF): A community-based specialized residential treatment facility for individuals with behavioral health conditions, including individuals discharging from or being diverted from state and local hospitals, whose impairment or behaviors do not meet, or no longer meet, criteria for involuntary inpatient commitment under chapter 71.05 RCW, but whose care needs cannot be met

in other community-based placement settings. [RCW 71.24.025(36)]

IBHTFs: What crisis continuum professionals and DCRs need to know

IBHTFs provide treatment and support in a residential setting to individuals who no longer require involuntary inpatient psychiatric services. These facilities serve as an important “step down” and help these individuals to fully and successfully integrate into their community. All IBHTFs will have a DOH residential treatment facility and behavioral health agency licensure. Many individuals transitioning from involuntary inpatient psychiatric services into an IBHTF will have a court order for less restrictive alternative treatment.

IBHTFs use a person-centered treatment planning philosophy that incorporates person-first, strengths-based, recovery-oriented, and trauma-informed principles. These facilities each have up to 16 beds for live-in care that prioritizes the person’s needs. They provide onsite behavioral health interventions, psychosocial rehabilitation, and skill building to help people reintegrate back into their community.

Each IBHTF will have a team of specially trained staff who will provide 24/7 coverage. Each IBHTF treatment team consists of:

- Psychiatric care provider
- Mental health professional
- Registered nurse
- Mental health care provider
- Certified peer counselor
- Substance use disorder professional
- Program support staff

Treatment and intervention: What IBHTFs need to know

IBHTFs as an intensive level service provider and step down from hospitalization are to strive to continue the treatment provision of prevention in an effort to reduce utilization of hospitalization. IBHTFs should be familiar with the less restrictive considerations as identified in the section for Community Outreach: Licensed Residential Care Facilities on page 69. DCRs will explore the level of treatment and utilization individuals receive and if increased services within the IBHTFs may allow for a less restrictive alternative to hospitalization can be identified.

Not all dangerous or concerning behaviors may be due to a behavioral health disorder. Factors such as an individual’s physical health may contribute to behaviors considered to be acting out. Health conditions such as urinary tract infection, constipation, respiratory disorders, medication interactions, or environmental stressors may impact an individual’s functioning and behavior. IBHTFs need to ensure that preventative and early intervention methods are attempted as less restrictive options prior to immediate referrals for acute inpatient consideration.

Intervention practices include

- Consultation with facility nurse or medical provider to identify possible medical or medication concerns. *Examples of concern: constipation, dehydration, GI distress, ear infections, and/or O2 deficiency*
 - Assess for utilization of a PRN medication
- Ensuring current lab work has been completed to rule out medical issues. *Examples of lab work: urine analysis, electrolyte levels, thyroid level, B12, folic acid, and/or medication levels*
- Assessment of pain levels and implementation or change of pain management plan, if feasible.

- Review of medications: Any recent changes, medication refusal. Implementing plan if medication change correlates to change in behavior. Determine if PRN may need to be ordered as a routine medication.
- Ensure routine plan of care identifies methods for specifically deescalating the individual. *Examples may be quiet time, visit from family or other supports, 1:1 with a staff member, or soothing activities like listening to music.* Ensure these have been attempted and attempts documented.
 - Remove the individual from excessive auditory and visual stimuli. Provide a calm, quiet, peaceful space for the individual to regroup.
 - Use a calm, quiet voice, no matter what the individual's voice tone or level is.
 - Allow time for the individual to vent before trying to intervene, unless danger to self or others is involved.
 - Let the individual tell you what will help and work with the family or support system to find creative ways to make it happen.
- Assessment for changes in environment or social setting including potential stressors, life changes, loneliness factors.
 - Voice observed environmental changes and ask the individual what change could help
 - Change the surroundings, the individual's room assignment or roommate
- Ensure behavior changes are documented including interventions attempted and outcomes. Note duration, intensity and frequency.
 - Redirect the individual toward a new interest, rather than away from the object, individual or topic involved in the behavior. Reorient the individual without disagreeing with him/her.
 - Assign the individual tasks that meet their strength and history. Short, repetitive tasks are often best.
- Review admission documentation for behavioral health diagnosis, consult with behavioral health treatment provider, identify method for further assessment of current symptom functioning, and implement plan for increased behavioral health services.
 - Provide support, such as empathetic reflections, regarding emotions and distress related to delusional thought content. Being mindful to not confront or collude with delusional beliefs.
 - Offer time for the individual to communicate their concerns, even if they are irrelevant or delusional.
- Assess whether behavior escalation is potentially a trauma response or related to a lack of cultural awareness. Implement individualized and program specific services to address individual needs and promote services awareness.

Best practices for DCR engagement with IBHTFs

1. If the IBHTF is a residential treatment facility, ensure the facility is aware of the DOH interpretive statement [Release of Voluntary Individuals from Inpatient Behavioral Health Settings](#) and has documented necessary requirements.
2. Determine timeliness requirement, communicate awareness, and time of response. (See [page 78](#) for *Timeliness Requirements*)
3. Consult with facility staff to determine methods of facility intervention utilized to document rule out of less restrictive alternatives.
4. Ensure population specific identifiers per statute (AI/AN, Military, Veteran) are recorded.
5. Ensure health care decision makers are identified and make contact as necessary.
6. If individual is not determined to be medically clear/stable, identify necessary medical information,

consult with treating physician, stop evaluation pending medical clearance. Keep record of time evaluation has stopped pending medical clearance. When notified of medical clearance, record time evaluation restarts ensuring that ITA evaluation time does not exceed statute provisions.

Licensed residential care facilities

Overview of functions and limitations

Licensed residential care facilities are a type of social service licensed by Department of Social Health and Services (DSHS). These facilities provide housing, meals, personal care assistance, and help connect individuals with additional resources to maintain housing and care.

The four types of licensed residential care facilities:

- Adult family homes (AFH)
- Nursing homes
- Assisted living facilities (ALF)
- Enhanced services facilities (ESF)

Licensed residential care facilities are not Department of Health (DOH) residential treatment facilities (RTFs). Some enhanced services facilities (ESF) have a DOH license for providing behavioral health treatment as a behavioral health agency (BHA). The ESF provides outpatient behavioral health treatment within the facility in an effort to improve behavioral health stabilization.

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.

- Staff at these facilities should be trained in behavior management including safety and violence prevention.
- DCR staff should coordinate with the facility for having a staff member available to monitor the ITA evaluation for ensuring DCR safety.
- DCR staff must maintain appropriate awareness of situational safety.

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 DCR considers if the services and treatment needed by the resident can be provided by the facility as a less restrictive alternative.

Current federal and/or state law

- Requires licensed residential care facilities to conduct assessments and provide or arrange for services if reasonably possible to meet residents' needs
- Indicates facilities may be considered a less restrictive alternative to involuntary treatment if the facility can provide for the individual safety and treatment

The facility is not permitted to transfer or discharge the resident as residents have a legal right to remain at licensed residential care facilities if their needs can be met. If the individual's health or safety can be adequately managed 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 may be considered a less restrictive alternative.

If there is sufficient evidence to indicate that the individual, as a result of a behavioral health disorder, is a danger to self, others, or others' property, or is gravely disabled, then the DCR assesses whether the facility is a less restrictive treatment option.

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. In certain circumstances, residents may also have a right to have their bed held during a temporary hospitalization.

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)].

Intervention: What facilities need to know

Not all dangerous or concerning behaviors may be due to a behavioral health disorder. Factors such as an individual's health may contribute to behaviors considered to be acting out. Health conditions such as urinary tract infection, constipation, respiratory disorders, medication interactions, or environmental stressors may impact an individual's routines, functioning, and behavior. Licensed residential care facilities need to ensure that preventative and early intervention methods are attempted as less restrictive options prior to immediate referrals for acute inpatient consideration.

Intervention practices

- Consultation with facility nurse or individual's treating physician to identify possible medical or medication concerns. *Examples of concern: constipation, dehydration, GI distress, ear infections, and/or O2 deficiency*
 - Assess for utilization of a PRN medication
- Ensure current lab work has been completed to rule out medical issues. *Examples of lab work: urine analysis, electrolyte levels, thyroid level, B12, folic acid, and/or medication levels*
- Assessment of pain levels and implementation or change of pain management plan
- Review of medications: Any recent changes, medication refusal, medication dosage, etc. Implementing plan if medication change correlates to change in behavior.
 - Determine if PRN may need to be ordered as a routine medication
- Ensure routine plan of care identifies methods for specifically deescalating the individual. *Examples may be quiet time, visit from family or other supports, 1:1 with a staff member, or soothing activities like listening to music.* Ensure these have been attempted and attempts documented.
 - Remove the resident from excessive auditory and visual stimuli. Provide a calm, quiet, peaceful space for the resident to regroup.
 - Use a calm, quiet voice, no matter what the resident's voice tone or level is.
 - Allow time for the resident to vent before trying to intervene, unless danger to self or others is involved.
 - Let the resident tell you what will help and work with the family or support system to find creative ways to make it happen. Allow the family to recreate as much as possible the one room or space in the house that resident found the most comfortable. *Example: "I want to go home."*
- Assessment of changes in environment or social setting such as potential stressors, life changes, loneliness factors.
 - Increase consistent structure in the resident's daily routine.
 - Change the surroundings, the resident's room assignment or roommate.
- Ensure behavior changes are documented including interventions attempted and outcomes. Note duration, intensity and frequency.
 - Redirect the resident toward a new interest, rather than away from the object, individual or topic involved in the behavior. Reorient the resident without disagreeing with him/her.
 - Assign the resident tasks that meet their strength and history. Short, repetitive tasks are often best.
- Review admission documentation for behavioral health diagnosis, consult with behavioral health

treatment provider, identify method for outpatient assessment of current symptom functioning, and implement plan for increased outpatient behavioral health services.

- Provide support, such as empathetic reflections, regarding emotions and distress related to delusional thought content. Being mindful to not confront or collude with delusional beliefs.
- Offer time for the resident to communicate their concerns, even if they are irrelevant or delusional.
- Assess whether behavior escalation is potentially a trauma response or related to a lack of cultural awareness. Implement individualized and program specific services to address individual needs and promote services awareness.

Licensed residential care facilities: What DCRs need to know

1. Enhanced secure facilities (ESF) may additionally be licensed as behavioral health agencies (BHA) providers
2. DCR staff should coordinate with the facility for having a staff member available to monitor the ITA evaluation for ensuring DCR and resident safety. DCR staff must maintain appropriate awareness of environmental and situational safety throughout investigations
 - If there is sufficient evidence to indicate that the individual, as a result of a behavioral health disorder, is a danger to self, others, or others' property, or is gravely disabled, then the DCR is to assesses whether the facility is appropriately a less restrictive treatment option.
3. The facility may be considered a potentially 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.
 - a. 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.

Best Practices for DCR engagement with licensed residential care facilities

A DCR should evaluate the individual at the licensed residential care facility rather than an emergency department so that situational, staffing, and other factors can be observed, including the individual treatment records, medication logs, and related documentation.

1. The DCR confers with and obtains information from the facility on:
 - The reason for the referral,
 - The level of safety threat to residents, and
 - Interventions that may have been considered to maintain the individual at the facility
2. When appropriate, available, and consistent with confidentiality provisions, the DCR obtains information from collateral sources. All collateral contacts are documented, including the name, phone number, and substance of information obtained.
 - a. Collateral sources include:
 - Family members of the resident
 - Guardians,
 - Facility staff
 - Attending physician and/or Indian Health Care Provider
 - The resident's caseworker or mental health provider
 - any Office of Behavioral Health Advocacy representatives
3. If the investigation does not result in detention but the resident has remaining behavioral health care

needs, the DCR may also provide further recommendations and resources to the facility staff and others, including recommendations for possible follow-up services.

Additional resources

The following links lead to websites with information on laws and regulations for licensed residential care facilities.

Topic	Website
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

Residences or non-professional service sites

Referents should be aware that utilization of less restrictive alternatives for responses to individuals experiencing a behavioral health crisis has become a priority for Washington. The development of Mobile Rapid Response Crisis Teams (MRRCT) provides an alternative to traditional emergency responses and allows in-home stabilization supports. The utilization of MRRCT can help ensure people receive compassionate, specialized support which reduces unnecessary emergency system involvement.

988 and regional crisis lines will work to identify use of the MRRCT who will then utilize acuity guides to determine final response decisions. When identified efforts will be made to engage MRRCT as a community crisis response. MRRCT will engage with DCRs as needed to determine appropriate crisis response options.

Best Practices for DCR response to residences or non-social service sites

Community outreach to residences or non-social services sites for an ITA investigation may occur if a second individual trained in safety and violence prevention is able to accompany the DCR. Second-for-safety individuals include Mobile Crisis Team members, law enforcement, or BHA staff members trained in safety and violence prevention [RCW 71.05.700].

At no time during a community outreach should the DCR be without a trained second-for-safety individual present. Even if the situation appears calm and safe, two individuals trained in safety and violence prevention are to be present.

If law enforcement or other emergency service personnel are being utilized as a second for safety, their presence and direct observation are required. The DCR shall not continue an investigation without a second for safety. The DCR shall disengage from an ITA investigation if a second for safety is not present, establish safety, and coordinate either custody authorization to a safe location or arrange a future community outreach.

Timeliness requirements

Dismissal of a commitment petition is not the appropriate remedy for a violation of the timeliness requirements of this section based on the intent of this chapter under 71.05.010 except in the few cases where the facility staff or designated crisis responder has totally disregarded the requirements of this section. [RCW 71.05.050(5)]

RCW 71.05 and 71.34 provide statutory authority for professionals to briefly hold individuals against their will to enable sufficient time for an Involuntary Treatment evaluation. **It is important that the community, professionals, and DCRs recognize that individuals are afforded rights to not be held beyond these timeframes without official proceedings.** Due to timeliness requirements of the ITA statute, there are some ITA referrals that require priority of response.

The ITA statute identifies that the DCR conducts an investigation and evaluation and makes a determination regarding if the individual meets criteria for detention. DCRs are expected to arrange detention placement as promptly as reasonably possible, balancing individual due process rights and safety. The DCR conducts an ITA investigation and makes a determination regarding detention regardless of statutory timelines.

As a court may rule at the 14-day probable cause hearing that the statutory timeframes were “totally disregarded” (which results in the dismissal of petitions for continued treatment and order that the individual be released), BH-ASOs, DCR Offices, and Tribes should have procedural guidelines that address timeliness requirements for ITA referrals, investigation and evaluations, and completion of any required outcome documentation.

Procedural guidelines may identify consultation considerations with supervisors and discussions with local prosecuting attorneys on negotiating timeframe challenges, especially for out of county initial detentions. DCRs are to follow their agency policy and procedures.

For adults

Within six hours

Within six (6) hours: If an individual has been brought to or comes to an **emergency department voluntarily or has been receiving treatment at the hospital voluntarily**, and staff determine a referral for ITA is needed, the DCR must determine whether the individual meets detention criteria within six (6) hours not counting time periods prior to medical clearance [RCW 71.05.050(3)].

Within 12 hours

Within 12 hours: If an individual brought to or accepted at a **23-hour crisis relief center** and thereafter refuses to stay voluntarily, the facility may not hold the individual no more than 12 hours from the time the staff notify the DCR of the need for ITA evaluation. [RCW 71.05.050(4)].

Within 12 hours:

- Persons delivered to a crisis stabilization unit, 23-hour crisis relief center, evaluation and treatment facility, emergency department of a local hospital, secure withdrawal management and stabilization facility, or approved substance use disorder treatment program **by peace officers** pursuant to subsection (2) of this section may be held by the facility for a period of up to twelve hours, not counting time periods prior to medical clearance [RCW 71.05.153(3)].
- An individual brought to the **emergency department by law enforcement order** must be examined by an MHP or SUDP within three (3) hours of their arrival to determine if a referral for ITA

evaluation is warranted. The hospital may not hold the individual for more than 12 hours from the time the staff notify the DCR of the need for ITA evaluation, and the DCR must determine whether the individual meets detention criteria. Evaluation periods do not count time periods prior to medical clearance. [RCW 71.05.153(4)].

Within next Judicial Day

Next Judicial Day: If an individual was **voluntarily admitted for inpatient treatment*** and requests discharge but presents as a risk of harm or gravely disabled, the DCR must determine whether the individual meets detention criteria no later than end of the next judicial day [RCW 71.05.050(2)].

**Includes admission to a crisis stabilization unit, E&T, SWMS, or other voluntary inpatient facilities.*

Within 48 hours

Within 48 hours: If a defendant has been found not competent*, the court may order a DCR to examine the individual within 48 hours [RCW 71.05.235 and RCW 10.77.650(6)(a)].

**DCR needs access to the forensic competency evaluation report.*

Within 72 hours

Within 72 hours: If an offender who was subject to a discharge review* under RCW 71.05.232 is to be released to the community from the jail, the DCR shall evaluate the person within 72 hours of release [RCW 71.05.157].

**DCR needs access to the state hospital and department of correction or indeterminate sentence review board discharge review determination.*

For adolescents (ages 13 to 17)

Within 12 hours

Within 12 hours: At facilities* where the adolescent is unwilling to consent to voluntary admission, professional staff should evaluate the adolescent's condition, determine whether adolescent suffers from a behavioral health disorder, and in need of immediate inpatient treatment.

The facility may hold the adolescent for up to 12 hours, not including time periods prior to medical clearance, in order to enable a DCR to evaluate for initial detention [RCW 71.34.700(2)].

**Includes E&Ts, SWMS, Hospitals, 23-hour crisis relief center*

Within next Judicial Day

Next Judicial Day: A voluntarily admitted adolescent at an **evaluation and treatment facility or approved substance use disorder treatment program** may give notice of **intent to leave** at any time. The professional person shall discharge the minor by the second judicial day [RCW 71.34.520].

Best practices for facilities handling Intent to Leave notifications

1. Document notification and timeliness
2. Evaluate adolescent to assess risk considerations
3. Conduct care coordination to assess less restrictive alternative options per RCW 71.34.010(2)
4. Determine if utilize of Family Initiate Treatment is an option
5. If clinically warranted, make referral to DCR Office for ITA evaluation and provide timeliness requirement

Utilization of custody authorization order

The DCR evaluates the facts relating to the individual being referred for investigation based on statute and applicable case law. The DCR is advised to seek consultation as needed when conducting an investigation. DCRs are to perform or attempt to perform face-to-face evaluation prior to issuing custody authorization orders or petitions for detention.

There may be exceptions where a potentially dangerous situation exists and the individual poses a threat to the safety to self and others. Coordination with emergency services for utilization of custody authorization orders of law enforcement custody for further ability to evaluate in a safe environment will need to be established.

RCW 71.05.153(1) provides DCRs with the authority to “cause by oral or written order” that an individual to be taken into emergency custody to an emergency department when the DCR has received information alleging that a person, as a result of a behavioral health disorder, presents an imminent likelihood of serious harm or is in imminent danger because of being gravely disabled.

The utilization of custody authorization necessitates collaboration among the judicial, law enforcement and emergency services. It is vital that BH-ASO, Tribe, and DCR Office Managers actively establish procedures and ongoing networking to review these processes. Ensuring the safety of professionals, the public, and individuals is of utmost concern.

The establishment of a written Superior Court Custody Authorization Orders may vary depending on regional resources and court determinations. Not all counties or DCR Offices will utilize Custody Authorization Orders. In such situations, DCRs may consult with law enforcement as **RCW 71.05.153(2)(a)** provides authority for law enforcement to take or cause a person to be taken into custody and transported to an emergency department.

Best practices for DCR utilization of custody authorization

1. Attempt to conduct a face-to-face evaluation.
 - If during evaluation the situation becomes unsafe:
 - Stop evaluation
 - Ensure safety
 - Contact emergency services
 - Coordinate law enforcement response due to dangerous situation
 - Issue custody authorization order
2. If during referral it is determined that a potentially dangerous situation exists and failure to take the individual into custody as quickly as possible poses a threat to the individual or others, coordination with emergency services is vital.
 - Contact emergency services and coordinate for law enforcement response due to the potentially dangerous situation.
 - If your Superior Court has a written Custody Authorization order, fax this order to the local law enforcement office if able.
 - If your county does not have a written Custody Authorization order, follow established behavioral health 911/EMS policy and procedures as established by your BH-ASO, Tribe, and law enforcement.

ITA Investigations and Evaluations

Overview

Throughout the ITA investigation and evaluation process the DCR will use their professional judgement, follow statutory and legally set criteria and not abuse the established authority granted by the RCW.

Depending upon regional systems of care and established judicial systems, based upon the findings of the ITA investigation and evaluation, DCRs have the authority to file petitions under

- **RCW 71.05.148 Assisted Outpatient Treatment**
- **RCW 71.05.150 Initial Detention – Absence of Imminent Harm (Adult)/Non-Emergent**
- **RCW 71.05.153 Initial Detention – Emergency Detention**
- **RCW 71.05.590 Enforcement, modification, or revocation of LRA/CR orders**
- **RCW 71.34.710 Adolescent – Petition for initial detention**
- **RCW 71.34.780 Adolescent – Revocation of alternative treatment**

Adolescents: What facilities and DCRs need to know

If the referent or DCR determine that an adolescent (ages 13 through 17) is a dependent of the state, the adolescent's Washington State Department of Children, Youth, and Families (DCYF) case worker is considered the "parent" as the agency is judicially appointed as the legal guardian or custodian of the child [RCW 71.34.020(47)]. In such situations, the DCR must coordinate with the facility to notify the DCYF case worker or the DCYF case worker's supervisor, if known and available, as soon as possible in accordance with RCW 71.34.710(2)(b)

RCW 71.34.010(2) provides that all behavioral health care and treatment providers shall assure that minors' parents or the identified DCYF case worker are given an opportunity to participate in the treatment decisions for minor children. The behavioral health care and treatment providers shall, to the extent possible, offer services that involve minors' parents, family, or DCYF case worker.

- DCRs shall determine the age of the individual referred for evaluation and identify if parents, family, or DCYF case worker are aware of the referral request.
- If the minor's parents, family, or DCYF case worker are unaware, the DCR will make notification.

RCW 71.34.010(5) indicates it is also the purpose of this chapter to ensure the ability of parents to exercise reasonable, compassionate care and control of their minor children when there is a medical necessity for treatment and without the requirement of filing a petition under this chapter, including the ability to request and receive medically necessary treatment for their adolescent children without the consent of the adolescent.

- DCRs should not rule out an ITA investigation on an adolescent strictly due to the parents' ability to consent under Family Initiated Treatment (FIT).
- Depending upon the level of acuity an initial detention may be required for inpatient admission.
 - Adolescents may only be admitted to Children's Long Term Inpatient Program (CLIP) treatment as voluntary or under an ITA commitment. They cannot be admitted to CLIP under FIT.

A DCR may conduct an ITA investigation and decide for initial detention without a parent, family member, or DCYF case worker present, however, attempts for inclusion should be documented. (See [page 96](#) for petition completion requirements.)

Foreign nationals: What facilities and DCRs need to know

Facilities and DCRs that utilize RCW 71.05/71.34 to hold an individual for ITA investigation are "detaining" the

individual. Detaining used in this sense means to not allow the person to leave freely and as such facilities and DCRs need to follow the U.S. Department of State guidance for Detained Foreign Nationals. (See [page 40](#) for information on determining foreign nationals' status, rights, and responsibilities.)

Consular notification tools are provided by the U.S. Department of State and included in [Appendix C](#); these include [Consular Notification Process Flow Chart](#) and [Consular Notification Pocket Reference Card](#)

Best practices for DCR to conduct an ITA investigation

1. At time of referral, determine if crisis plan for individual exists.
2. Ensure safety concerns are identified and all procedures and statutes followed.
3. Prior to dispatch, vital information pertaining to population specifics is verified as able, including:
 - Age of the individual; contact parents to extent possible
 - Active Military/Veteran status
 - American Indian/Alaska Native status; if possible consult with Tribal Crisis Coordination Hub
 - Foreign National status
 - Health Care Decision Makers; contact as necessary
3. At time of face-to-face, evaluate safety of situation and individuals involved. Maintain awareness of safety protocols throughout evaluation.
4. Notify individual of ITA rights
5. Inquire about Mental Health Advanced Directive
6. Assess the individual for the presence of a behavioral health disorder
7. Assess for dangerousness
8. Assess for grave disability
9. Review and take under consideration reasonably available history [[RCW 71.05.212](#)]
10. Conduct interviews
11. Consider less restrictive alternative to involuntary detention, the individual's good faith, and consult with population specific resources as necessary.
12. Determine ITA evaluation outcome
13. Complete DCR ITA Investigation and Evaluation documentation and notifications per behavioral health agency policy and procedures.

Determining the presence of a behavioral health disorder

Behavioral health disorder: *Either a mental disorder as defined in this section, a substance use disorder as defined in this section, or a co-occurring mental disorder and substance use disorder [RCW 71.05.020(8), RCW 71.34.020(10)]*

Historical trauma: *Situations where a community experienced traumatic events, the events generated high levels of collective distress, and the events were perpetuated by outsiders with a destructive or genocidal intent*

Trauma-Informed care: *A strengths-based framework grounded in an understanding of and responsiveness to the impact of trauma, and emphasizes the physical, psychological, and emotional safety for both providers and survivors, and creates opportunities for survivors to build a sense of control and empowerment.*

Designated Crisis Responders are master-level clinical staff with training and education in behavioral health including assessment and diagnosis of behavioral health disorders. **A DCR, however, does not need to provide a formal diagnosis of a behavioral health disorder to lawfully detain an individual.**

During the evaluation, the DCR determines if mental, emotional, or organic impairment are present and cause a substantial adverse effect on the individual's cognitive or volitional functioning.

Individuals with co-occurring mental and substance use disorder may present with different symptoms and different risk factors depending on their specific situation at the time of investigation – if they are intoxicated, withdrawing, have not been taking their psychiatric medications, or any number of factors. To evaluate the presence of a mental disorder or substance use disorder, a DCR evaluates an individual's behavior, presentation, judgment, orientation, memory, thought process, affect, and impulse control.

The DCR also takes into consideration the following factors:

- Age
- Developmental and cognitive functioning
- Culture and ethnicity
- Language spoken and communication
- History of diagnosis, treatment, and periods of recovery
- The duration, frequency and intensity of any behavioral health symptom
- Any medical conditions or diagnoses.

The DCR is aware of and practices trauma-informed care, recognizing signs and symptoms that may indicate trauma (coping and survival skills), acknowledging that the experience of trauma is widespread, and actively avoiding re-traumatization as much as can be done within the context of a crisis and an involuntary treatment assessment.

For members of minority cultural groups, including AI/AN individuals, trauma and historical trauma are particularly significant, and must be addressed by conducting culturally appropriate evaluations.

An adult cannot be detained for evaluation and treatment solely by reason of the presence of a developmental disability, substance use disorder, or dementia alone, but may be detained for evaluation and treatment on the basis of such a sole condition if that sole condition causes the individual to be gravely disabled, or to present a likelihood of serious harm [RCW 71.05.040].

Determining dangerousness

Imminent: *The state or condition of being likely to occur at any moment; near at hand, rather than distant or remote* [RCW 71.05.020(28)].

Under Washington's Involuntary Treatment Act³², dangerousness is legally defined as a "likelihood of serious harm". There are three separate categories for serious harm: danger to self, danger to others, and danger to property.

In determining criteria for involuntary treatment, the DCR must establish a connection between the information supporting existence between a behavioral health disorder (mental health, substance use, or co-occurring) and the resulting indications or evidence of dangerousness.

Likelihood of serious harm: *A strong possibility exists of*

(a) A substantial risk that:

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

(ii) physical harm will be inflicted by a person 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 (iii) physical harm will be inflicted by a person upon the property of others, as evidenced by behavior which has caused substantial loss or damage to the property of others;

or

(b) The person has threatened the physical safety of another and has a history of one or more violent acts; [RCW 71.05.020(37)]

History of one or more violent acts: *The period 10 years prior to the filing of a petition under this chapter, excluding any time spent, but not any violent acts committed, in a behavioral health facility or in confinement as a result of a criminal conviction* [RCW 71.05.020(27)]

Probable cause and history considerations

Probable cause to believe that an individual is imminently a danger as a result of a behavioral health disorder may be based on actions that are likely; it is not necessary that the individual have actually harmed self or others.

During the evaluation, a DCR will conduct an investigation to gather information that may include, but is not limited to:

- Intentional acts of self-harm, or harm to others
- Statements of intent or plan for self-harm, or harm others
- Behaviors that place a person in harm's way, or are dangerous to others
- Symptoms that increase the likelihood of self-harm
- Reports of property damage

A history of violence towards others may be considered in determining dangerousness. The more recent the dangerous behavior, the greater the consideration given. There must be a connection between the dangerousness and a behavioral health disorder.

While a 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.

Behaviors that threaten or damage property alone do not necessarily equate to dangerousness and meet the

³² Washington HCA ITA Fact Sheet

criteria standards. Again, there must be a connection between the dangerousness and a behavioral health disorder.

In 2020, Washington legislature passed Senate Bill 5720³³ which will redefine likelihood of serious harm. See [Appendix A](#) for an explanation of this contingency definition.

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³³ Updated in 2026 legislative session: [5720-S.PL.pdf](#)

Determining grave disability

Grave disability or gravely disabled criteria is a legal standard utilized to define an individual's inability to provide for basic needs, as a result of a behavioral health disorder.

In Washington, **grave disability** has two alternative prongs, dictating that the individual either

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

During a DCR evaluation, information is gathered to determine if an individual has the help of responsible family, friends, or others who are willing and able to help provide for a person's basic needs. Individuals who can survive safely with help from others are likely not to meet criteria.

An individual may be considered gravely disabled if as a result of a behavioral disorder, is unable to use the elements of life which are essential to health, safety and development, including food, clothing, and shelter even though provided by others. 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.

Best practice for DCRs in determining grave disability

It is important that DCRs familiarize themselves with the Washington Supreme Court's case [*In re: LaBelle*, 07 Wn.2d 196 \(1986\)](#) to ensure that utilization of the grave disability criteria is properly construed and standards of proof sufficiently satisfy due process requirements. This decision serves as a pivotal reference point utilized in present day legal proceedings determinations.

As involuntary commitment is a significant deprivation of liberty, the due process of law must ensure an individual's behavioral health condition "render[s] him unable to make a rational choice with respect to his ability to care for his essential needs".³⁴ When petitions are filed for initial detention, determinations of grave disability must have written evidence that can permit a meaningful review.

DCRs must bear in mind that using standardized or boilerplate language and check boxes without sufficient written explanation increases the likelihood that the case may not survive judicial review.³⁵

To justify commitment, such care must be shown to be essential to an individual's health or safety and the evidence should indicate the harmful consequences likely to follow if involuntary treatment is not ordered. Moreover, the person must be unable, because of severe deterioration of functioning, to make a rational decision with respect to their need for treatment.

The DCR needs to incorporate into the petition how the individual is unable to make a rational decision. For a good case example, check out the [*Detention of H.T.* \(2026\)](#), which was a detention on the basis of prong b, grave disability and explores the significance of the petitioning aspects.

In conducting evaluations for grave disability, DCRs need to take into consideration an individual's ability to provide for their essential needs including food, clothing, and shelter. In making a determination of criteria, it is not necessary that an individual be unable to provide for all the required elements.

³⁴ LaBelle, 107 Wn.2d at 210, [In Re LaBelle :: 1986 :: Washington Supreme Court Decisions :: Washington Case Law :: Washington Law :: U.S. Law :: Justia](#),

³⁵ In Re M.G.-M :: 2024 :: Washington Court of Appeals :: Washington Courts, https://www.courts.wa.gov/opinions/pdf/395316_unp.pdf

The following table was created by Live Well San Diego³⁶ in California to assist community behavioral health staff with understanding the various considerations pertaining to grave disability.

Necessity	Not gravely disabled	Potentially gravely disabled
Food	Adequate knowledge of nutritional needs. Appears adequately nourished. Able to explain the manner by which they obtain food – i.e., prepare own meals or prepared by third party.	Unable to distinguish between food and non-food items. No food available or food is spoiled. Appears inadequately nourished. Denies / unaware of the need for food. Unable to explain how they obtain food.
Clothing	Manner of dress is appropriate to the season, temperature, physical limitations, culture and/or religion.	Public nudity or inadvertent exhibitionism. Uses non-clothing items to clothe self. Destroying, giving away or discarding clothing without recall of or reason for doing so and / or resulting in an inability to clothe self appropriately.
Shelter	Able to describe current shelter situation and / or plan for safely utilizing, maintaining or obtaining shelter. If evicted, eviction is not due to behavior which indicates an inability to utilize shelter properly. If chronically homeless, they aware of shelter options, or able to describe how shelter needs are met.	Repeatedly unable to properly utilize resources for shelter. Refusal to utilize available housing due to unsubstantiated concerns / fears: i.e., someone tampering with electricity, FBI or CIA wiretaps, etc. Inability to formulate a plan for shelter is not due to developmental, cultural or social factors. Maintains a household in a manner that is clearly dangerous to health and safety (filth, fire hazard, etc.)

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. DCRs must be familiar with the *LaBelle* case as this will help to further explain considerations related to grave disability and likelihood criteria.³⁷

Note: In 2020, the Washington legislature passed Senate Bill 5720 which will redefine "prong b" of grave disability if the statewide number of single bed certifications drops to a certain level. See [Appendix A](#) for an explanation of this contingency definition.

Educational resources

Defining "Gravely Disabled": Washington Supreme Court's 1986 Ruling on Involuntary Mental Health Commitment **Defining "Gravely Disabled": Washington Supreme Court's 1986 Ruling on Involuntary Mental Health Commitment: Wash. | CaseMine**

[LaBelle, In re LaBelle, In re \(LaBelle, In re, 728 P.2d 138, 107 Wn.2d 196 \(Wash. 1986\)\) - vLex United States](#)

³⁶ [Live Well San Diego | Home](#)

³⁷ [LaBelle, In re LaBelle, In re \(LaBelle, In re, 728 P.2d 138, 107 Wn.2d 196 \(Wash. 1986\)\) - vLex United States](#)

Use of reasonably available history

Per **RCW 71.05.212** and **71.05.245** the DCR is to **document efforts to obtain reasonably available history**. The DCR searches reasonably available records and/or databases in order to obtain the individual's background and history. The DCR reviews historical information to determine its reliability, credibility, and relevance. The 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.

A history of violent acts 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.

In addition, when considering continued commitment under less restrictive alternative commitment "evidence of repeated hospitalization or law enforcement intervention related to the person's mental illness should be given great weight" **[RCW 71.05.012]**. Courts must also give "great weight" to a recent or prior history of one or more violent acts, repeated hospitalizations, law enforcement interventions, and involuntary medication orders when considering petitions for continued treatment. **[RCW 71.05.245, .285, .575]**

Evaluation shall include all reasonably available information from credible witnesses and records including:

- Emergency room/hospital visit and admission records
- Information and records from crisis outreach providers, outpatient behavioral health providers (both mental health and substance use treatment) and other services, to include Tribal government, Indian Health Care Providers, DCYF, and DDA
- 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 (<https://watch.wsp.wa.gov/public/watch>)
- DCR office records. In addition to information regarding prior investigations and detentions under RCW 71.05, these records may include additional relevant information
- Forensic evaluation reports conducted under RCW 10.77 are sent to the DCR office in the county where the criminal offense occurred. These reports contain recommendations regarding civil commitment and history
- State psychiatric hospital records. The state psychiatric hospitals (Western State Hospital and Eastern State Hospital) maintain records of individuals who 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 a day:

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

If a DCR is evaluating an individual from a Licensed Residential Care Facility, the DCR ensures that there are copies of recent medication(s) logs, durable medication equipment used by the individual, and history of medical and psychiatric treatment.

- If the evaluation is conducted in the community a copy of this historical information needs transported with the individual to better assist with coordination of care at the hospital.

Consultation with ED medical professional

During an ITA evaluation, *at an emergency department*, the DCR shall take serious consideration of observations and opinions by the examining emergency department physician, advanced registered nurse practitioner, or physician's assistant in determining whether detention under this chapter is appropriate ([RCW 71.05.154](#)).

If the medical professional is not available for consultation, the DCR can review the professional's written observations and opinions. The DCR must document the consultation with the medical professional, or review of their written observations and opinions [RCW 71.05.154].

In some regions and communities, DCRs may conduct an outreach evaluation and detain to places other than hospital emergency rooms. For an ITA evaluation conducted in the field and a detention commenced when there is no examining emergency room physician, the DCR should indicate these specific details in their petition documentation.³⁸

Acquiring confidential information in crisis situations

DCRs are afforded the ability to gather protected health information in crisis or emergency situations under two provisions of federal law. Both federal laws should be reviewed for documentation requirements related to any types of requests. These laws are useful in the gathering of credible and reliable investigation facts.

DCRs may need to reference these laws when speaking with other behavioral health or medical providers to gather relevant historical information to support an ITA petition.

The first rule is the **Health Insurance Portability and Accountability Act (HIPAA)**³⁹. [45 CFR 164.512\(j\)](#), which identifies the **uses permitted to avert a serious threat to health or safety**.

(1) Permitted disclosures. A covered entity may, consistent with applicable law and standards of ethical conduct, use or disclose protected health information, if the covered entity, in good faith, believes the use or disclosure: (i),

(A) Is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public; and

(B) Is to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Section 164.512(j)(4) also provides identifies that the disclosure is presumed to have been made in good faith.

A covered entity that uses or discloses protected health information pursuant to **paragraph (j)(1)** of this section is presumed to have acted in good faith with regard to a belief described in **paragraph (j)(1)(i)**, if the belief is based upon the covered entity's actual knowledge or in reliance on a credible representation by a person with apparent knowledge or authority.

The second federal law that permits for a DCR to gather patient identifying information is the rule for Confidentiality of Substance Use Disorder Patient Records, commonly referred to as **42 CFR Part 2**. [42 CFR 2.51](#) provides:

(a) General rule. Under the procedures required by [paragraph \(c\)](#) of this section, patient identifying information *may be disclosed to medical personnel* to the extent necessary to:

(1) Meet a bona fide medical emergency in which the patient's prior written consent cannot be obtained

A frequent question surrounding 42 CFR Part 2 relates to "bona fide medical emergency". The DCR may either

³⁸ [IN RE: the DETENTION OF C.A.C. \(2018\) | FindLaw](#), C.A.C. contested detention as procedurally improper without an emergency room physician consultation.

³⁹ [Health Information Privacy | HHS.gov](#)

have difficulty gathering information from substance use treatment providers or there may be uncertainty about the extent of information that may be disclosed. 42 CFR Part 2 has been updated to address the definition of “bona fide medical emergency” as it pertains to involuntary treatment.

Regarding involuntary commitment, *patient identifying information may be disclosed to medical personnel* to the extent necessary to meet a bona fide medical emergency in which the patient's prior informed consent cannot be obtained. This may include situations in which the patient is not regarded as being legally competent under the laws of their jurisdiction. Such circumstances may apply when a patient is subject to an involuntary commitment (*i.e.*, formally committed for behavioral health treatment by a court, board, commission, or other lawful authority). Consistent with § 2.51, during the period of time a patient is not regarded as being legally competent, any previously established, unrevoked, or unmodified general designation remains valid for their current treating providers until such time as the individual's competency is restored. The treating provider(s) would, in such circumstances, be expected to follow provisions of this rule pursuant to medical emergencies, including all documentation requirements. Importantly, at any time when a patient is legally competent, they may modify their general designation consistent with the provisions of this final rule.⁴⁰

Subpart B – General Provisions § 2.11 Definitions

Program (3): *Medical personnel or other staff in a general medical facility whose primary function is the provision of substance use disorder diagnosis, treatment, or referral for treatment and who are identified as such providers.*

⁴⁰ “Confidentiality of Substance Use Disorder Patient Records,” Federal Register:: The Daily Journal of the United States Government, January 18, 2017, <https://www.federalregister.gov/d/2017-00719/p-637>

Interviewing witnesses as part of an investigation

Credible: *The state of being believable or trustworthy.*

Reliable: *The state of being accurate in providing facts; a reliable individual 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 DCR must consider information provided from credible witnesses [RCW 71.05.212].

For adolescents, the 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 adolescents 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 DCR shall:

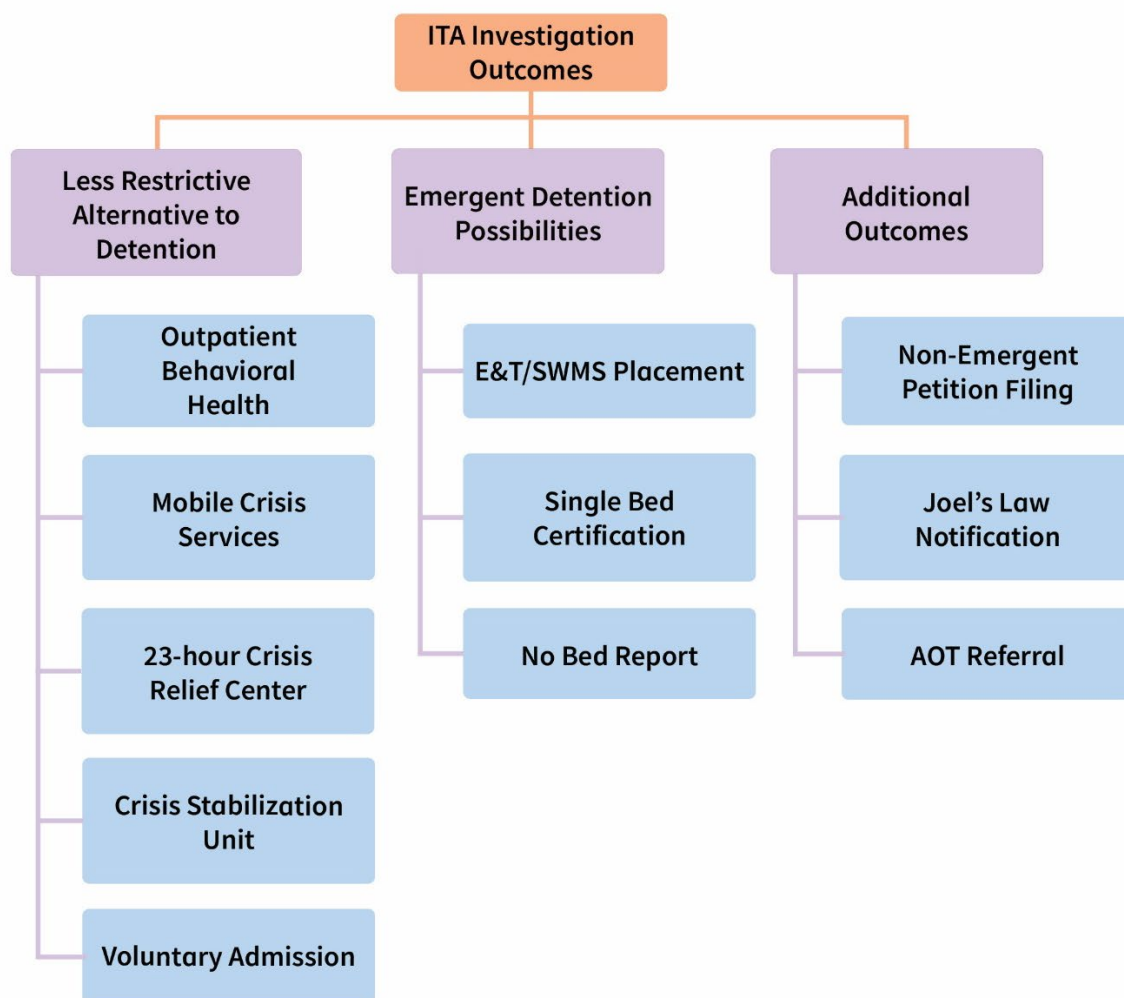
- Interview reasonably available, potentially credible witnesses who may have pertinent information. Credible witnesses may include family members, landlords, neighbors or others with significant contact or history of involvement with the individual, including individuals identified by the individual being investigated.
- Interview professionals and other treatment providers, including Tribal providers and IHCPs.
- 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 (including family and providers) that they may be required to testify in court under oath and may be cross-examined by an attorney. If known, the DCR will inform any possible witness of the date, time and location of the probable cause hearing. If unknown, the DCR will provide any possible witness with the telephone number of the prosecuting attorney.
- Request declarations/affidavits from witnesses and collateral sources of information (including Tribal providers) to be filed with detention paperwork.
- A DCR must consult with any examining emergency department physician, advanced registered nurse practitioner, or physician assistant 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 department staff [RCW 71.05]. The DCR must document this consultation, or the reason for lack of consultation, both in the petition and in case documentation.

ITA investigation and evaluation outcomes

The Involuntary Treatment Act provides a statutory framework for evaluation and possible detention for individuals experiencing acute mental and/or substance use disorder symptoms. DCRs are to investigate and evaluate an individual's symptoms, assessing risk, monitoring individual's safety, while considering aspects of individual rights and due process, yet also determining that no other less restrictive alternatives to involuntary inpatient treatment options are available to address the identified needs of the individual.

Referrals for ITA investigations and evaluations may have several different outcomes depending upon an individual's good faith to consent to treatment, available resources at the time of the evaluation, program services in the community, support systems in the individual's network, or unexpected inability to access services. Collaboration and communication with referral sources, community providers, and social services will be vital during the outcome process.

Outcome considerations



Less restrictive alternatives to detention: Referring to behavioral health services

When an investigation results in a decision not to detain an individual, the DCR will determine the appropriate service referral. This may include considerations across the spectrum from more intensive to less intensive options.

The individual may possibly meet medical necessity for a voluntary inpatient admission and consent to this level of service, or the utilization of crisis stabilization may be a beneficial community supportive option. Other options such as 23-hour Crisis Relief Center service followed by a transition into Crisis Stabilization, may also be considered.

In addition, for some individuals, assistance with referrals back into services with their outpatient behavioral treatment providers with mobile crisis support can be of benefit. As with any voluntary treatment service referral, **the DCR will discuss informed consent with the individual and complete release of information documentation for the current crisis episode. This is a provision of ensuring the individual's good faith ability to actively and voluntarily engage in treatment.**

Best practice for DCRs when making less restrictive referrals

The DCR will assist in this referral process depending upon where the individual is located at the time of the evaluation outcome.

1. If the evaluation of the individual's dangerousness for actual and potential lethality is identified to be low to moderate and the individual consents to safety planning, the DCR considers a referral to outpatient behavioral health options.
 - a. The DCR ensures the safety of the individual by establishing a proactive plan and completes appropriate releases of information for supports to enable wrap-around approach and crisis follow-up.
2. If the evaluation of the individual's dangerousness for actual and potential lethality is identified to be moderate and/or there is potential for grave disability without direct support, the DCR considers a referral for more intensive supportive behavioral health services such as Mobile Crisis, 23-Hour Crisis Respite, or a Crisis Stabilization Unit.
3. If the evaluation of the individual's dangerousness for actual and potential lethality is identified to be high and/or there is identified grave disability, yet the individual is able to consent to voluntary inpatient treatment, the DCR will consult with a medical treating provider for an inpatient facility referral.

Emergent detention possibilities

Once a DCR has completed an ITA investigation and evaluation and determines that criteria has been met to detain an individual on the grounds specified in RCW 71.05 or 71.34, the DCR must secure placement in an Evaluation and Treatment (E&T) facility for mental health treatment or a Secure Withdrawal Management and Stabilization (SWMS) facility for substance use treatment.

As the ITA placement referral process varies from region to region depending upon system of care services and resources, DCRs are to follow their agency policies and procedures for ITA detention placement.

In general, a DCR will explore the following options after determining the availability of local resources:

1. Pursue certified E&T beds or certified SWMS beds in counties within close proximity
2. Locate and secure certified E&T beds or certified SWMS beds elsewhere within the state
3. Request a Single Bed Certification* for a mental health ITA at the facility where the individual is located

**Single Bed Certification may not be utilized for Substance Use Disorder ITA SWMS detentions*

4. Complete a No-Bed Report in accordance with [RCW 71.05.750](#)

E&T/SWMS placement

A DCR will seek ITA placement within close proximity to the supports and services the individual currently utilizes. For individuals with supports and primary or recent services in other regional areas, placement in those locations will be considered more appropriate.

Seeking ITA placement varies by region and is dependent on BH-ASO and Tribal contracts. DCRs will coordinate with the facility where the individual is located to ensure that all appropriate individual ITA evaluation clinical information and medical records are presented to facilities for consideration of acceptance.

For mental health ITA placements, if E&T placement cannot be located the DCR will discuss single bed certification options then no-bed report procedures with the Emergency Department or Medical facility.

For substance use ITA placements, if SWMS placement cannot be located the DCR will discuss no-bed report procedures as SBCs cannot be used for SUD ITAs.

Emergency Room/Medical Facility awareness regarding Single Bed Certification and No-Bed Report

Single Bed Certification (SBC): A procedure granting an exception to allow timely and appropriate treatment in a facility that is not certified to provide involuntary inpatient treatment to an individual on an initial detention or revocation, or a 14-day commitment. SBCs for a maximum of 30 days may also be granted to allow a community facility to provide treatment to an individual on a 90- or 180-day commitment [[RCW 71.05.745](#), [WAC 182-300-0100](#)].

For Single Bed Certification, a facility must be willing and able to provide timely and appropriate mental health treatment including:

Daily contact with a mental health professional for the purposes of

- Observation and evaluation
- Assessing whether the person is appropriate for release from involuntary commitment to accept treatment on a voluntary basis
- Maintaining standards for administration and monitoring of medication, including psychiatry medications

As the approval for the single bed certification can be extended depending on the period of inpatient treatment the individual is committed to receive, it is important that the facility monitors the date of submission and approval period.

Notice of Unavailable Detention Facilities (No-Bed Report): A form filed by the DCR with HCA according to procedure when an available bed cannot be located in an E&T or SWMS facility [[RCW 71.05.750](#)].

If the hospital is unwilling to accept a Single Bed Certification, or there is no SWMS bed available, the DCR will follow the procedural guidelines developed by their BH-ASO or Tribe for completion of the no-bed report:

- The individual remains a patient at the medical facility were evaluated.
- The medical facility may have legal EMTALA obligation to stabilize and treat. Facilities should be aware

- of this possibility and have procedures in place for occurrence.
- BH-ASOs, MCOs, and DCR Offices may work in collaboration with medical facilities to provide continued care.

Best practices for DCR offices completing single bed certification

1. If an E&T bed is required and no E&T bed can be located, the BH-ASO or its designee responsible for the region in which the DCR is designated should locate an appropriate bed capable of providing individualized treatment and request single bed certification from the State Hospital that serves their region.
2. The Single Bed Certification Form requires that the BH-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**⁴¹. DCRs need to ensure they complete the correct form for their region.
 - **Western State Hospital**
 - **Eastern State Hospital**
 - b. For involuntarily detained adolescents, a hospital may request an exception to allow treatment in a facility not certified under WAC 246-341 until the adolescent's discharge from that setting to the community, or until they transfer to a facility providing CLIP treatment.
3. The State Hospital will process the request in a timely manner and fax the approved request back to the representative of the BH-ASO.

A designated crisis responder who submits an application for a single bed certification for treatment at a facility that is willing and able to provide timely and appropriate mental health treatment in good faith belief that the single bed certification is appropriate may presume that the single bed certification will be approved for the purpose of completing the detention process and responding to other emergency calls [RCW 71.05.745(3)].
4. The DCR office will provide a copy of the approved Single Bed Certification Form to the facility where the individual is held and keep a copy for their own office records.

Best practices for DCR offices completing no-bed report

1. If an ITA detention bed cannot be secured, the DCR will ensure the medical facility where the individual is located is fully aware a no-bed report is being submitted to the HCA and BH-ASO.
 - The DCR office is responsible for submitting an **Unavailable Detention Facility Report (No Bed Report)** to the HCA and BH-ASO within twenty-four (24) hours
2. The DCR will coordinate with the facility to reassess the individual on a daily basis to determine if criteria for detention is met and detention placement can be secured.
3. ITA investigation and no-bed reporting will continue unless ITA placement is secured or a less restrictive alternative to detention is determined. Throughout the process the DCR office will maintain communication with the facility, the BH-ASO and the MCO is involved.

⁴¹ <https://www.hca.wa.gov/billers-providers-partners/program-information-providers/designated-crisis-responders-dcr>

Additional outcomes

Not all DCR ITA evaluations will have immediate treatment referrals. During some community outreach situations, DCRs may not be able to secure transport of an individual or the individual's current presentation may not meet current detention criteria. In these situations, the ITA statute provides for additional considerations and less restrictive considerations. These may be situations in which the DCR completes a petition for a non-emergent detention, a Joel's Law Notification, or an Assisted Outpatient Treatment Referral.

Non-emergent detention – Detention in the absence of imminent harm

Per [RCW 71.05.150](#), the Superior Court and system of care have established in some regions a non-emergent petitioning process for DCRs to utilize for petitioning the court to detain an adult when the individual's presentation indicates an absence of imminent harm.

In these regions, when the DCR conducts a community outreach and determines an individual is not imminently at risk yet presents with a likelihood of serious harm or grave disability, the DCR can review additional history and the DCR petitions the superior court for an order of apprehension directing for collaboration between law enforcement and the DCR office to detain the individual to a hospital for placement into an ITA facility).

Note: RCW 71.34 does not contain provisions for the use of non-emergent detentions for adolescents.

At any time after the DCR has performed the outreach, if the situation warrants, the referent may contact crisis or emergency services. The referent will also be informed of any Joel's Law notification (see below).

Best practices for DCR when completing non-emergent petitions

1. At the conclusion of the ITA investigation and evaluation, collaborate with the referent to establish a safety plan that addresses concerns and provides awareness of the court timeframes.
 - a. Unlike an Emergent Detention ([RCW 71.05.153](#)), where an individual is held by the DCR and meets the criteria of being imminently at risk, non-emergent detentions do not allow for the individual to be held before a court issues its "pick-up" order. Therefore, while the DCR is working to complete the non-emergent petition process, the DCR should notify any identified supports or services are aware and take care that safety plans are followed.
2. Complete required ITA petition documentation and submit to Superior Court following established DCR Office procedures.
3. If/when the court issues the order for the detention, ensure that apprehension, notification of rights, and service of the initial detention documentation occurs in a timely and appropriate manner.
4. The DCR will comply with all required statutory notifications for ITA detention.

“Joel’s Law” - Petition for initial detention when DCR does not detain

Note: If you have new information about someone that would support detention, that was not available, known, or shared at the time of the initial referral or investigation, you are encouraged to re-refer the person for investigation.

Background

In July 2013, Joel Reuter, a 28-year-old software engineer who was diagnosed with bipolar disorder, was fatally shot by Seattle police during what his parents stated was a psychotic episode.⁴² Joel’s parents championed legislation that came to be known as Joel’s law, that enables the petitioning of the court for involuntary commitment if a DCR declines to detain. This law went into effect in 2015.

Joel’s law petitioning may be done for adolescents and adults.

Petitions may be submitted by an immediate family member, guardian, conservator, or a Tribe, if the individual is a member of such a tribe.

The decision not to detain, or to not act on a referral, can be made for many reasons. For example, the person may not meet criteria, may agree to voluntary hospitalization, may have met criteria for detention but there was no inpatient bed available, or may have been on a jail hold that could not be dropped.

The filing of a Joel’s law petition is with the superior court of the county in which the DCR investigation occurred or was requested to occur, for the individual’s initiation detention.

This occurs in one of two circumstances:

- When a DCR makes the determination not to detain an individual (adult or minor) for emergent or non-emergent detention
- 48 hours have elapsed since the DCR office received a request for an ITA investigation and have not taken steps to detain the individual

In addition, if more than ten (10) days have elapsed since the investigation, or the request for the investigation, the entity seeking a Joel’s Law petition may request a new investigation.

Under [RCW 71.05.201](#) and [RCW 71.05.203](#) only, “immediate family member” means spouse, domestic partner, child, stepchild, parent, stepparent, grandparent, or sibling. A “parent” can include the DCYF case worker of an adolescent if the adolescent is dependent and the

Joel’s Law petition process

If DCR receives an ITA investigation request and does not evaluate within 48 hours, or evaluates and does not detain, then:

Immediate family member, guardian, or conservator files petition with court for review of initial detention.

Judge or court commissioner reviews petition.

⌚ Must review within 1 judicial day

Petition is sent to DCR office. DCR gives sworn statement of their actions and records.

⌚ Must review within 1 judicial day

Judge or court commissioner issues final decision on petition.

⌚ No later than 5 judicial days from the day the petition was filed

If judge issues order for initial detention*, DCR office coordinates with law enforcement to execute order.

⌚ Order is valid for 180 days

Individual is transported to ER for medical clearance. Once individual is medically clear, DCR will seek inpatient placement.

* Judge may issue order for initial detention if there is probable cause and the individual refused to voluntarily accept treatment.

⁴² Senate Bill Report, SB 5269, An act relating to court review of detention decisions under the involuntary treatment act. [5269 SBA HSMH 15.pdf](#)

DCYF is the guardian [RCW 71.34.020(47)].

Immediate family members, guardians, conservators, or a Tribe may download the [Joel's Law Petition for Initial Detention by Family, Guardian, or Conservator](#). This packet includes the petition, declaration, and user guide. It is directly from the Washington Courts website.

Once filed, the court has one day to review the petition, and five days to decide regarding the order. The court should ask the DCR office for records pertaining to the initial request for ITA investigation or ITA investigation before deciding.

An order of apprehension is issued to the DCR office and law enforcement. The DCR office will coordinate with law enforcement, and others to arrange for the individual to be taken to a hospital for placement into a treatment bed without delay. The order is in effect for 180 days.

Best practices for DCRs regarding Joel's Law notification

1. DCRs should be aware of the process for accessing the Joel's Law Guide and consumer advocacy agencies that can assist family members, guardians, conservators, or a Tribe with the process as referral sources may specifically seek guidance directly from evaluating DCRs and DCR offices.
2. **Although**, RCW 71.05.203 specifies the DCR or DCR agency must, **upon request**, disclose the date of a DCR investigation to an immediate family member, guardian, or conservator, or a federally recognized Indian tribe if the person is a member of such a Tribe, of a person to assist in the preparation of a petition under RCW 71.05.201, **providing the referent with the option of filing a Joel's Law petition is effective consumer advocacy**.
3. If there are ITA Investigation referrals that the DCR Agency does not acted upon within 48 hours, the DCR office needs to document the reason for the referral was not investigated and the referents need advised under RCW 71.05.203 of filing options.

Assisted Outpatient Treatment [RCW 71.05.148]

Assisted Outpatient Treatment (AOT) is an involuntary process encompassed within Washington's Involuntary Treatment Act. AOT is based on Kendra's Law, an assisted outpatient treatment law passed in 1999 in New York State. The purpose of AOT is to support individuals who are at risk of rehospitalization and have a history of difficulty adhering to their behavioral health treatment plan in a less restrictive setting.

Through AOT, community-based behavioral health treatment is available under civil commitment. The aim is to better motivate an individual who struggles with voluntary treatment adherence to engage fully with their treatment plan. Further, providers offer focused attention to treatment and work diligently to keep an individual engaged.

Essential elements of Assisted Outpatient Treatment (AOT)

Courts, BH-ASOs and BHAs work together to support successful AOT Implementation.

Courts

- Dedicate a court docket to AOT as a quasi-therapeutic court
- The judge, prosecutor, and defense work collaboratively for the benefit of the participant
- Work collaboratively with the treatment team holding them accountable to the treatment plan
- Develop how they will accept participants whose AOT order was filed in the county of the hospital discharging

Behavioral Health Administrative Service Organizations (BH-ASOs)

- Gain support of all stakeholders in the community
- Contract with BHA to assess, and assist petitioning process, and provide treatment
- The BH-ASO establishes a referral system that allows all parties to identify those in need of AOT

Behavioral Health Agencies (BHAs)

- Assess potential participants
- Assist in petitioning process including psychiatric assessment
- Well trained in evidence-based practices for treating people with lack of insight
- Support individuals in court
- Work collaboratively with the courts
- Work actively to transition to appropriate treatment upon graduation from AOT

The AOT methodology embraces the idea that **with earlier intervention, a significant impact can be made on the lives of individuals struggling with behavioral health conditions**. By connecting participants to the treatment they need, AOT is especially helpful to those facing the social and economic consequences of living with an untreated mental health or substance use disorder.

AOT may be ordered by the civil court, if legal criteria are met, as a form of less restrictive alternative treatment to involuntary inpatient treatment, or it may be ordered as one type of less restrictive alternative treatment upon discharge from an involuntary inpatient commitment.

An AOT order may be for up to 18-months. A court may supervise an individual on an AOT order, requiring appearance in court for periodic reviews. A court may modify the order after considering input from the agency or facility designated to provide or facilitate services.

An individual is eligible for AOT if the court finds that the legal criteria are met. Legal criteria includes that the individual has been diagnosed with a behavioral health disorder based upon clinical determination and **at least one of the following** is true:

- The individual is unlikely to survive safely in the community without supervision and the individual's condition is substantially deteriorating

- The individual needs assisted outpatient treatment to prevent a relapse or deterioration that would be likely to result in grave disability or a likelihood of serious harm to themselves or to others
- The individual has a history of showing lack of compliance with treatment for their behavioral health disorder that has at least twice within the 36 months prior to the filing of the petition been a significant factor in necessitating emergency medical care or hospitalization for behavioral health-related medical conditions

Best practice for DCRs when making AOT referrals

If in the course of an investigation, the DCR identifies an individual does not currently meet criteria for ITA detention yet has a history of medical or psychiatric hospitalization due to lack of compliance with behavioral health treatment, the DCR should consult with the BH-ASO AOT Coordinator to determine if a referral for Assisted Outpatient Treatment can be made.

DCRs should ensure awareness of AOT program developments and consider opportunities for collaboration on the utilization of this less restrictive treatment to acute hospitalization.

Additional information is available on [HCA's AOT webpage](#).

ITA detention placement search, petition completion, and serving

Seeking ITA placement: What DCRs and facility staff should know

Once a DCR has conducted an ITA investigation and determined an individual meets criteria for an initial detention or revocation, the DCR will seek provisional acceptance at the nearest treatment facility providing 120-hour evaluation and treatment or secure withdrawal management and stabilization [RCW 71.05.170].

The DCR will utilize facility contact information for case presentation and assist with the sharing of clinical and medical information.

- The DCR will provide medical staff at the emergency department or medical floor with information about placement procedures
- Copies of clinical and medical information will be provided to the potential placement facility as requested
- DCRs will maintain open communication throughout the coordination, and explain to medical staff the limitations of certain facilities and reason for additional medical clearance requests;
- DCRs are to assist the facility, as requested, so that the placement presentation process occurs in a timely manner
- DCRs may need to assist facility staff with arranging for secure transport to an accepting inpatient facility
- Behavioral health service providers shall accept tribal court orders from tribes located within the state on the same basis as state court orders issued under this chapter [RCW 71.05.337(2)]

Court documentation for Initial Detention

The case *In re Swanson* (1990) identifies the time parameters and calculation determinations for initial detentions under the ITA statute. Although initial detention duration changed to 120 hours, excluding weekends and holidays, the court clarification in the case remains valid.

The start of an initial detention is the time of provisional acceptance by an evaluation and treatment facility or secure withdrawal management and stabilization facility.⁴³

For every investigation resulting in detention with provisional acceptance, including SBCs, the DCR will complete a petition identifying the criteria and facts which legally support the initial detention.

The petition must clearly indicate

- Substantial evidence to prove an indication of a behavioral health disorder
- Presentation of dangerousness and/or grave disability
- The reason why less restrictive alternatives to detention are insufficient

The DCR will serve the individual with a copy of the legal paperwork once detention/revocation placement has been identified. For adolescents, the DCR or the admitting facility, at the request of the DCR, may serve the adolescent and the adolescent's parent [RCW 71.34.710(2)(b)].

The ITA detention packet includes the following court templates:

- The notice of rights with indication of time informed
- The petition

⁴³ In re Swanson, 115 Wn.2d 21, 804 P.2d 1 (1990) <https://www.casemine.com/judgement/us/5914c021add7b049347b1f9f>

- The notice of firearm suspension (for dangerousness only)
- The proof of service of notice with indication of time served

ITA investigation notification requirements for other individuals and entities are covered on [page 98](#).

Completion of suspension of firearm rights

As previously identified in the section describing rights of an individual being investigated ([page 24](#)), the DCR will advise the individual being investigated for involuntary detention of their rights pursuant to RCW 71.05.217(5) and including [RCW 71.05.182](#) pertaining to the suspension of firearm rights for an individual who presents a likelihood of serious harm and is placed for treatment under the initial detention.

When the DCR has received provisional acceptance, ITA initial detention court documentation including the Superior Court Notice by DCR of Suspension of Firearm Rights for any individual detained under the criteria of serious harm is to be completed. RCW 71.05.182 only pertains to the suspension of right to possess firearms for individuals who present as at risk of serious harm as a result of a behavioral health disorder, substance use disorder, or both. The firearms suspension does not apply to individuals detained as only gravely disabled unless the petition also alleges a risk of serious harm.

When following notification requirements for family, guardians, conservators, and/or Tribes, the DCR should clearly identify if the detention of the individual includes a likelihood of risk of serious harm and that notification of suspension of firearm rights has occurred. **If the initial detention is solely for grave disability, the provisions under RCW 71.05.182 for suspension of firearm rights does not apply.**

Best Practice for a DCR in completing the court documentation notice

The DCR will complete the DCR Suspension of Firearm Rights to the best of their ability including

1. For a second time, advise the individual of the firearm suspension and that this can be discussed with their legal representation;
2. Inform the individual of their right to sign the notification. Signing is not required. If the individual declines or is unable to sign the notice due to symptom presentation, mark the appropriate box on the form;
3. Page two (2) should include as much known information as possible. Spell the individual's name as clearly as possible and list any aliases if known. It is beneficial to provide a copy of the individual's identification if it is available;
4. Only submit this court form with the ITA detention petition and court documents. **Do not submit this court document directly to Department of Licensing(DOL) or Washington Patrol (WSP).** The court clerk where the court documentation is filed provides notification to DOL and WSP for purposes of firearm restriction checks; and
5. Mark on the Proof/Return of service court documentation that the Notice of Suspension of firearm rights is included.

Notification of the firearm suspension for sheriff or chief of police is discussed under the ITA Investigation notification requirements beginning on [page 105](#).

Out-of-county ITA placement

When a DCR receives provisional acceptance to detain an individual to an E&T/SWMS in another county, the detaining DCR must:

- Request from the facility the Defense attorney contact information to be included on the ITA detention petition documentation.
- Make a copy of legal paperwork for office records

- Serve the individual with their copy of the ITA petition
- Arrange for the court documentation packet for Initial Detention to be delivered to the admitting facility within the statutory time limit
- Agree to testify, if necessary, at any court hearings
- Inform any potential witnesses that they may need to be available to testify in court at the probable cause hearing.

For out of county ITA placements, [RCW 71.05.160\(2\)\(b\)](#) provides that the DCR can request that the accepting program or facility file appropriate papers with the court and serve the designated attorney of the detained person.

DRAFT

Joel's Law 'order of initial detention' and 'warrant'

As identified on page 90, utilization of Joel's Law petitioning allows for family, guardian, conservator, or a Tribe to file a petition for an order of initial detention when a DCR has investigated and not detained or an individual was not evaluated by a DCR within 48 hours of a referral.

This petition will be reviewed by the superior court and the petitioner will be notified of the court's decision. If the court orders an initial detention under [RCW 71.05.201\(8\)](#), then a copy of the order will be provided to the petitioner, the DCR agency and law enforcement.

Best practices for DCR Office coordination for Joel's Law orders

1. The DCR Office will review the order, and confirm that petitioner is aware of the order. DCR should alert the petitioner to apprehension and ITA placement process.
2. DCR Office will coordinate with law enforcement for appropriate apprehension of the respondent.
 - Unless otherwise arranged apprehension is to an emergency department for medical clearance and ITA placement
3. DCR will provide respondent with notification of rights and copy of the ITA initial detention court order.
4. The DCR will seek inpatient ITA admission, informing facilities the respondent is on a Joel's Law order.
5. If ITA provisional acceptance cannot be determined, the DCR will explore additional considerations that may include a temporary SBC for mental health to explore additional treatment placement during the initial detention
6. If ITA placement cannot be determined, the DCR will complete and submit a No Bed Report. See [page 90](#) for instructions on completion of a no bed report.
7. The DCR will notify the petitioner of continued placement attempts.
8. If the hospital is unable to provide an SBC and there is not immediate cause to warrant holding the respondent after the completion of the no bed report, the emergency department may make decision to discharge the respondent.
 - The DCR office should ensure that the petitioner is advised of any potential for discharge
 - The DCR office will continue to make attempts to apprehend and place the respondent into inpatient involuntary treatment.
9. A Joel's Law order of initial detention is valid for 180 days.

ITA Investigation Notification Requirements

Notification of initial detention: What DCRs needs to know

As soon as reasonably possible, the DCR will make notification of the initial detention or revocation, subject to any federal or state laws, for the following:

- County sheriff or chief of police for firearm suspension due to dangerousness ([RCW 71.05.182](#))
- Parents or guardians of an adolescent ([RCW 71.34.710\(2\)\(a\)](#))
- DCYF case worker if an adolescent is a dependent of the state ([RCW 13.34.315](#))
- Individual with developmental or intellectual disability in services with DSHS
 - By the next judicial day ([RCW 70.02.230\(2\)\(s\)](#))
- Member of a Tribe(s) and/or receives health care from an IHCP
 - Within three hours from time of detention ([RCW 71.05.150\(5\)](#))
- Credible witnesses interviewed ([RCW 71.05.212\(2\)](#))
- Foreign National consular notification, as applicable
- Department of corrections/Community corrections ([RCW 71.05.157](#))
- Guardian, conservator, and health-care decision makers ([RCW 71.05.150\(3\)](#))

Notification to sheriff or chief of police for six-month firearm suspension

In conjunction with the completion of ITA initial detention court documentation related to initial detention firearm suspension for initial detention based on likelihood of serious harm (*as identified on page 98*), the DCR is responsible for the completion of the [HCA form Six-month suspension of right to possess firearm*](#) for any individual that the court notification⁴⁴ has been completed. The DCR is only releasing notice of dangerousness determination and no other clinical information.

The DCR will

1. Provide as much identifying information and a copy of identification if possible.
2. Submit both pages of the notification to the sheriff of the county or the chief of police of the municipality in which the individual resides. If residence is unknown, submit documentation to the county and municipality where the individual was investigated and detained.

*For some county courts or regional areas, the ITA petition court documents have been specifically designed to include both the Washington State Patrol Firearms Division and Department of Licensing court clerk notification along with verifiable information of the DCR notification to the appropriate sheriff or chief of police. The DCR Supervisor at your agency will inform you of the appropriate documents for you to complete for this required notification procedure.

Notifications related to adolescents

As identified in the section of ITA investigations and evaluations (*page 86*), RCW 71.34.010(2) identifies that all behavioral health care and treatment providers shall assure that minor's parents are given an opportunity to participate in the treatment decisions for their minor children. The behavioral health care and treatment

⁴⁴ This form can be found at <https://www.hca.wa.gov/assets/program/notice-six-month-suspension-firearm-rights-dcr.pdf>

providers shall, to the extent possible, offer services that involve minor's parents or family.

For detentions involving an adolescent, the DCR must also provide the adolescent's parent or legal guardian with the ITA detention documentation as soon as possible. [RCW 71.34.710(2)]

If an adolescent (ages 13 to 17) is a dependent of the state, the adolescent's Washington State Department of Children, Youth, and Families (DCYF) case worker, or the DCYF case worker's supervisor, if known and available, is to be notified of the detention and provided with the ITA detention documentation as soon as possible [RCW 13.34.315].

Notifications related to individuals with developmental or intellectual disability

RCW 70.02.230(2)(s) specifies that mental health services and records for adults may be disclosed as necessary to coordinate treatment for mental illness, developmental disabilities, or substance use disorder for persons who are under the supervision of DSHS. **For adult ITA detentions involving an individual identified to be in services for DD/IDD, the DCR is required to provide notification by the next judicial day.** The DCR is only releasing notice of the fact, place, and date of a mental health involuntary commitment.

Notification for a member of a Tribe(s) and/or receiving health care from an IHCP

Initial investigations and revocations [RCW 71.05.150(5), 71.05.153, 71.05.590(7)]

If the DCR knows, or has reason to know, that the individual is an American Indian or Alaska Native who receives medical or behavioral health services from a Tribe with this state, the DCR **shall** notify the Tribe and Indian health care provider **whether or not a petition for initial detention or involuntary outpatient treatment will be filed** as soon as possible, but no later than three hours from the time the decision is made.

If a petition for initial detention or involuntary outpatient treatment is filed, the designated crisis responder **must** provide the tribe and Indian health care provider with a copy of the petition, together with any orders issued by the court and a notice of the tribe's right to intervene as soon as possible, but before the hearing, and no later than 24 hours from the time the petition is served upon the person and the person's guardian. **Notification under this section is subject to any federal and state laws and regulations** including the requirements in RCW 70.02.230 (2)(ee) and (3) and **shall** be made in person or by telephonic or electronic communication to the tribal contact listed in the authority's tribal crisis coordination plan.

The court clerk shall provide copies of any court orders necessary for the DCR to provide notice to the Tribe or Indian health care provider.

Assisted Outpatient Treatment petitions [RCW 71.05.148(7)]

If the DCR or the BH-ASO knows, or has reason to know, is an American Indian or Alaska Native who receives medical or behavioral health services from a tribe within this state, the DCR or BH-ASO **shall** notify the tribe and Indian health care provider.

- Notification shall be made in person or by telephonic or electronic communication to the tribal contact listed in the authority's tribal crisis coordination plan as soon as possible, but before the hearing and no later than 24 hours from the time the petition is served upon the person and the person's guardian.
- The notice to the Tribe or Indian health care provider **must include a copy of the petition**, together with any orders issued by the court and a notice of the tribe's right to intervene. The

court clerk shall provide copies of any court orders necessary for the DCR or the BH-ASO to provide notice to the Tribe or Indian health care provider under this section.

For additional information pertaining to notification to Tribe(s) and Indian health care providers, DCRs should review the [Tribal Involuntary Treatment Notification Requirements, Patient Privacy document](#). For Tribes that do not have a Tribal crisis coordination plan in place, DCRs shall follow the guidance provided in the [Navigating a Crisis without a Tribal Crisis Coordination Protocol](#).

Best practices for DCR notification to Tribes

1. Ensure during referral that the individual or the referent is asked if the individual identifies as AI/AN or is receiving medical or behavioral health services from a Tribe within this state.
 - If unknown, ensure that during investigation, the individual is asked if they identify as AI/AN and determine Tribal affiliation.
2. Identify if there is a Tribal Crisis Coordination Protocol for their Tribal affiliation by checking the following:
 - Your DCR Office resources
 - Native Resources Hub webpage [Tribal Services | VOAWW](#)
 - Local BH-ASO resources, DCR agency, or BH-ASO where the individual resides
3. Notify the Tribal contact of the investigation outcome as soon as possible, but
 - a. no later than three hours from the time the decision is made for initial detention or revocation [[RCW 71.05.150\(5\)](#), [RCW 71.05.590\(7\)](#)].
 - b. no later than 24 hours from the time petition is served for Assisted Outpatient Treatment [[RCW 71.05.148\(7\)](#)]
4. For questions or concerns, consult your DCR Office Supervisor.

Ways to make contact:

1. Review Tribal Profile on the Native Resources Hub: [Tribal Services | VOAWW](#)
Example - [Port Gamble S'Klallam Tribe, Tribal Services Profile](#)

If there is a Tribal Crisis Coordination Protocol, the DCR will comply with those protocols.

2. Call the VOAWW Contact and ask for Indian Health Care Provider
During Normal Business Hours 1-866-491-1683

After hours #988 Option 4, Native and Strong Lifeline Staff

If there is no Indian Health Care Provider, the DCR will consult a Tribal Council representative to identify provider contact information and contact information for notification of their investigation decision.

Notification for a foreign national

If during the referral or ITA evaluation the DCR identified the individual who is being detained is a citizen of any of the nations with Bilateral Agreements requiring mandatory notification, the DCR must inform the consular official from that country without delay, whether or not the detained individual wants the consular official notified.

Any detention of a foreign national is subject to the requirements of the Vienna Convention and DCRs must follow federal U.S. Department of State notification requirements.

- The U.S. Department of State maintains a listing for contact information for foreign embassies and consulates under **Consular Notifications and Access** listed here:
<https://travel.state.gov/content/travel/en/consularnotification/ConsularNotificationandAccess.html>
- The HCA maintains a **Foreign National Notification form** that can be utilized to indicate the involuntary treatment initial detention

In all cases, the DCR documents:

- The date and time the foreign national was informed of their consular rights
- The date and time any notification was sent to the relevant consular officer
- Any actual contact between the foreign national and the consular officer

Initial detention release of information requests: What DCRs need to know

DCRs should be familiar with information access and disclosure for health care medical records chapter **RCW 70.02**. Specifically, **RCW 70.02.230** and **.240** provide for the permissive disclosure of information for adults and minors, respectively.

In addition, the DCR may have disclosure obligations to law enforcement and correctional facilities if the DCR is employed by a “mental health service agency,” as defined in RCW 70.02.010. A mental health service agency shall release to the persons authorized upon request including the fact, place, and date of an involuntary commitment (**RCW 70.02.260(1)(a)(i)**).

The information subject to release under **RCW 70.02.260** must be released, when such information is requested during the course of business and for the purpose of carrying out the responsibilities of the requesting person's office, to any or all of the following:

- Law enforcement officers
- City or county prosecuting attorneys
- Personnel of a county, city, or tribal jail or tribal detention or holding facility
- Designated mental health professionals or designated crisis responders, as appropriate
- Public health officers
- Therapeutic court personnel as defined in **RCW 71.05.020**
- Personnel of the department of corrections, including the indeterminate sentence review board (ISRB) and personnel assigned to perform board-related duties

*Note: **RCW 70.02.260(2)** provides immunity from liability for disclosures made pursuant to provisions of the statute.*

Less Restrictive Alternative Court Orders

A less restrictive alternative (LRA) court order is an involuntary order for outpatient treatment services to be provided to an individual who meets specific criteria under RCW 71.05/71.34.

If the court finds that the individual meets this criteria, the court releases the individual under the order subject to conditions set by the court. This is an ‘alternative’ to the involuntary inpatient treatment or a ‘condition’ of release from inpatient care.

‘**Less restrictive alternative court orders**’ is an umbrella term that includes and covers assisted outpatient treatment orders, less restrictive alternative orders, and conditional release orders.

Behavioral health service provider means a public or private agency that provides mental health, substance use disorder, or co-occurring disorder services to persons with behavioral health disorders as defined under this section and receives funding from public sources.

This includes, but is not limited to:

- Hospitals licensed under chapter [70.41](#) RCW
- Evaluation and treatment facilities as defined in this section
- Community mental health service delivery systems or community behavioral health programs as defined in [RCW 71.24.025](#)
- Licensed or certified behavioral health agencies under [RCW 71.24.037](#)
- An entity with a Tribal attestation confirming it meets minimum standards or a licensed or certified behavioral health agency as defined in [RCW 71.24.025](#)
- Facilities conducting competency evaluations and restoration under [RCW 10.77](#)
- Approved substance use disorder treatment programs as defined in this section
- Secure withdrawal management and stabilization facilities as defined in this section
- Correctional facilities operated by state, local, and tribal governments

Care coordinator pertaining to less restrictive alternative treatment means a clinical practitioner who coordinates the activities of less restrictive alternative treatment. The care coordinator coordinates activities with the designated crisis responders that are necessary for enforcement and continuation of less restrictive alternative orders and is responsible for coordinating service activities with other agencies and establishing and maintaining a therapeutic relationship with the individual on a continuing basis [[RCW 71.05.585\(7\)](#)].

Conditional release (CR) means a revocable modification of a commitment, which may be revoked upon violation of any of its terms. Often utilized in a similar way to an LRA. Conditional releases are issued by the facility and filed with the court, but do not require court approval and are connected to the original inpatient court order.

Less restrictive alternative treatment means a program of individualized treatment in a less restrictive setting



than inpatient treatment. The program is outlined in a court order for outpatient treatment which includes services to be provided and conditions that the individual must adhere to. Any court order may be enforced, modified or revoked as appropriate [RCWs 71.05.575-71.05.595].

This term includes:

- Treatment that can be ordered near the completion of the 120-hour initial detention under RCW 71.05.240 including:
 - 90-day LRA, or
 - Up to 18-months AOT order
- Treatment that can be ordered near the conclusion of the 90-day civil commitment under RCW 71.05.320 including:
 - 180-day LRA, or
 - 365-day LRA, if previously on an 180-day commitment in a state hospital.
- Some individuals who may be discharged from their civil commitment early under conditional release who must continue follow-up care requirements for the rest of their civil commitment period under RCW 71.05.340 including:
 - 90-day CR, or
 - 180-day CR
- And Assisted Outpatient Treatment under RCW 71.05.148 up to 18-months may be ordered as an alternative to involuntary inpatient treatment.

LRA Court Order Criteria and BHA Responsibility

For the court to place an individual on an LRA court order, the court must have evidence that the person has a behavioral health disorder and presents a likelihood of serious harm and/or gravely disabled, and that treatment in a less restrictive setting is in the **best interest of the individual**.

The order must have a **behavioral health service provider** that is certified or licensed to provide or coordinate the full scope of services required under the less restrictive alternative order and has agreed to this responsibility [\[RCW 71.05.585\]](#).

This provider is responsible for:

- Assigning a **care coordinator**, [RCW 71.05.585\(7\)](#)
- Conducting an intake evaluation with the provider of the LRA treatment
- Performing a psychiatric evaluation, a substance use disorder evaluation, or both
- Scheduling regular contacts for treatment services for the duration of the order
- A transition plan addressing access to continued services at the expiration of the order
- An individual crisis plan
- Consultation about the formation of a mental health advanced directive under chapter 71.32 RCW
- Notification to the care coordinator assigned in (a) of this subsection if reasonable efforts to engage the client fail to produce substantial compliance with court-ordered treatment conditions

LRA treatment is provided at a **licensed or certified behavioral health agency** and includes treatment services identified under [WAC 246-341-0805](#). These services include psychiatric, substance use disorder treatment, and medical components of community support services.

The behavioral health agency ensures the individual on the LRA court order is provided treatment and has periodic evaluation to determine rationale for requesting a petition for additional period of less restrictive treatment or allowing less restrictive to expire.

An outpatient treatment services provider can report to the DCR if an individual is failing to adhere to the conditions along with deterioration in functioning. The DCR will assess for possible readmission to inpatient treatment. The DCR may then file a petition with the court for revocation of less restrictive alternative treatment court order.

Best practices for behavioral health agencies

Throughout the period of court ordered treatment the behavioral health treatment provider should be evaluating the individual's functioning and engagement in treatment. The provider should determine if the individual needs additional court ordered treatment.

Additionally, consider that the goal is to stop the revolving door and “encourage appropriate interventions at a point when there is the best opportunity to restore the person to or maintain satisfactory functioning” in an outpatient rather than inpatient setting.

If the individual has a history of repeated hospitalizations or law enforcement interventions, immediate discussion regarding care coordination and transition planning for conclusion of order should be discussed with MCO for Medicaid members and BH-ASO for any non-Medicaid individuals. Considerations for additional commitment orders including options for AOT should be explored.

Less Restrictive Alternative Treatment Court Orders: What DCRs need to know

RCW 71.05.012 indicates “...the legislature finds that for persons who are currently under a commitment order, a prior history of decompensation leading to repeated hospitalizations or law enforcement interventions should be given great weight in determining whether a new less restrictive alternative commitment should be ordered.”

Regarding less restrictive alternative treatment court orders, DCRs shall:

- Collaborate with medical providers to petition for Assisted Outpatient Treatment
- Conduct ITA investigation and file for revocation of the various LRA treatment court orders
- File petitions for modification or additional treatment for various LRA treatment court orders

For all ITA evaluations, investigations, and petitions (including LRA orders, revocations, and modifications), DCRs are required to maintain best practices in investigative procedures, court documentation, and legal notifications.

- Guidelines for best practices for DCR to conduct an ITA investigation begin on page 98.
- Revocation placement searches are regionally dependent, yet the Seeking ITA placement section can assist with additional guidelines. Placement considerations can be found on page **.
- DCRs must ensure compliance with all Federal and state notifications, especially for any individual identified to be on any form of a court order, ITA investigation Notification Requirements can be found on page 99.

Petitioning for Assisted Outpatient Treatment: What DCRs need to know

AOT referral was previously discussed as a less restrictive alternative to detention outcome in the ITA investigation and evaluation section on *page 98*. As DCRs are among several of the professionals that have the ability to petition for AOT treatment, DCR Offices should be aware and able to assist with the AOT petitioning process.

An individual is eligible for AOT if the court finds that the legal criteria are met.

Legal criteria includes that the individual has been diagnosed with a behavioral health disorder based upon

clinical determination and at least one of the following is true:

- The individual is unlikely to survive safely in the community without supervision and the individual's condition is substantially deteriorating
- The individual needs assisted outpatient treatment to prevent a relapse or deterioration that would be likely to result in grave disability or a likelihood of serious harm to themselves or to others
- The individual has a history of showing lack of compliance with treatment for their behavioral health disorder that has at least twice within the 36 months prior to the filing of the petition been a significant factor in necessitating emergency medical care or hospitalization for behavioral health-related medical conditions
- All less restrictive alternative orders require identification of a licensed or certified BHA willing to provide court ordered treatment services. Before initiating a petition for AOT, a DCR should be aware of the AOT service providers and collaborate on care coordination for the court order.

Best Practices for a DCR when performing AOT petitioning

1. Prior to evaluation, familiarize yourself with RCWs [71.05.012](#) and [71.05.148](#)
2. Evaluate the individual's current behavioral health condition
3. Assess the cognitive and volitional functioning of the individual
4. Assess whether the individual would accept treatment, take medication, if 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
5. Complete the AOT petition and file with the county clerk
 - a. DCR will provide a declaration as the examining mental health professional
 - b. A medical professional is needed to examine the individual and provide a declaration. Indian Health Care Providers are medical professionals.
 - c. The medical professional may include:
 - A physician
 - A physician assistant
 - A psychiatric advanced nurse practitioner
6. Await notification from court for scheduled hearing
 - Per [RCW 71.05.148\(7\)](#), if the AOT petition is for an AI/AN individual who receives medical or behavioral health services from a Tribe within this state, the DCR will ensure the Tribe receives a copy of the petition and notice of hearing when this has been served upon them in the same manner as a summons
 - Notice shall be before the hearing and no later than 24 hours from the time the petition is served upon the person
 - Notice to the Tribe must include a copy of the petition and notice of rights

Revocation considerations for AOT, CR, or LRA/O

When a DCR office receives a referral for revocation evaluation, the DCR needs to ensure:

- Awareness of type of LRA treatment court order (AOT, CR, or LRA/O),
- Knowledge of the court order start and end date,
- Prior history of repeated hospitalization,
- History of law enforcement interventions, and
- Consultation with the BHA care coordinator or treatment provider to verify status of individual's engagement in services and opportunity for modification of the order.

When a DCR conducts an evaluation for revocation, the DCR will ensure the individual is advised of ITA rights and

follow the best practices for conducting ITA investigation.

Individuals on LRA treatment court orders are to additionally be advised in writing or, if possible, orally in a language understood by the individual, that:

- A revocation hearing must be held within five days following the date of the petition for revocation [RCW 71.05.590(5)(b)].
 - **For minors**, the hearing must be held within seven calendar days following the date of petition for revocation [RCW 71.34.780(3)]
- If the individual is on an LRA treatment court order issued by a tribal court, consult the tribal prosecutor for the correct procedure.

The plain language of RCW 71.05.590(1), (2), and (5) demonstrates that a DCR's decision to revoke a less restrictive court order is conditioned only on the determination that one of four events has occurred:

- The respondent has failed to adhere to the LRO
- The respondent's functioning has substantially deteriorated
- The respondent has experienced a substantial decompensation that could be reversed by further treatment
- The respondent poses a likelihood of serious harm

Once a DCR determines that one of these events has occurred, the DCR may consider alternatives to revocation and offer a range of intervention options, that is “appropriate to the circumstances and consistent with the interests of the individual and the public in personal autonomy, safety, recovery, and compliance” [RCW 71.05.590(2)].

“There is nothing in this statute to demonstrate an intent to mandate a specific process for deciding which action is the most appropriate or an intent to make compliance with such a process a precondition to taking any of the authorized actions. Nothing in this language supports the contention that the DCR was required to engage in a specific process or that the court was required to evaluate and make findings regarding the adequacy of a DCR's prepetition decision-making process.”⁴⁵

If an individual meets criteria for revocation and also meets criteria for a new initial detention, a DCR has the option of initiating a new 120-hour detention rather than revoking an LRA treatment court order. The DCR may take this into consideration if the existing court order ends shortly.

Best practice for DCRs determining revocation criteria and placement

DCRs must utilize the ITA investigation and evaluation to determine:

- That a flexible range of responses appropriate to the circumstances have been considered and attempted
- That the individual has failed to comply with the terms and conditions of the LRA treatment court order
- If there is substantial deterioration in the person's functioning
- There is evidence of substantial decompensation with a reasonable probability that the decompensation can be reversed by further inpatient treatment
- The individual poses a likelihood of serious harm

⁴⁵ IN RE: the DETENTION OF: B.M. (2021) | FindLaw, B.M. challenges the trial court's order revoking her less restrictive treatment under the ITA.

Petitions for revocation should include a copy of any court orders for less restrictive alternative treatment. DCRs should seek placement at a facility within the individual's community to ensure a flexible range of considerations for care coordination.

The DCR needs to ensure that the outpatient treatment provider is aware of the revocation and ITA placement. [\[RCW 71.05.590\(1\); 71.05.590\(2\); RCW 71.34.780\]](#).

Additional Commitment Orders – Considerations for Extension

RCW 71.05.012 indicates "...the legislature finds that for persons who are currently under a commitment order, a prior history of decompensation leading to repeated hospitalizations or law enforcement interventions should be given great weight in determining whether a new less restrictive alternative commitment should be ordered."

If requested by the outpatient provider (including IHCPs), the DCR may review behavioral health agency information and evaluation of an individual to petition to seek additional treatment under outpatient involuntary treatment. This should occur whenever 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 outpatient treatment court order.

This investigation may involve consultation with the treatment provider(s) and other possible witnesses to determine if further outpatient involuntary treatment is warranted. An individual's history of decompensation without continued involuntary outpatient treatment is important to consider when determining if the criteria for grave disability can be met. [RCW 71.05.320\(4\)](#) outlines the provisions for seeking additional treatment under outpatient involuntary treatment.

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

A good case to review for a better understanding of utilization of successive less restrictive alternative court orders is [IN RE: the DETENTION OF C.K. \(2001\)](#) as it provides both the facts of clinical presentation, RCW review, and reference to LaBelle and the intent for LRA treatment.

Extension of LRA: What DCRs need to know

The following criteria apply when considering additional outpatient involuntary treatment for adults.

1. 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
2. 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
3. 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
4. Continues to be gravely disabled while on a LRA Court Order.
5. For those on AOT, 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 outpatient 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 71.05.020(26)).

Petitions for additional outpatient involuntary treatment may be completed as an 180-day LRA/LRO or as an up to 18-month Assisted Outpatient Treatment. Outpatient treatment providers seeking an extension may need to be informed of the two differences between these orders.

Individuals previously on conditional release will require petitions filed for either the 180-day LRA/LRO or for an AOT. Individuals on AOT orders do not require the filing of petitions only by DCRs. AOT treatment providers may file for extensions on AOT orders.

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Appendix A: Grave Disability and Likelihood of serious harm contingent definition⁴⁶

For Adult:

If and when the Health Care Authority (HCA) provides written notice to the Office of the Code Reviser, Senate, and House of Representatives that monthly reported single-bed certifications have fallen below 200 reports for three consecutive months, the definitions of likelihood of serious harm and gravely disabled that apply to adults are expanded to include a risk of physical harm evidenced by harm, substantial pain, or which places a person in reasonable fear of harm to themselves or others and modified to change "manifests severe deterioration in routine functioning" to "manifests severe deterioration from safe behavior." Severe deterioration from safe behavior would be defined to mean that the person will, if not treated, suffer or continue to suffer severe and abnormal mental, emotional, or physical distress associated with significant impairment of judgment, reason, or behavior.

(25) "Gravely disabled" means a condition in which a person, as a result of a behavioral health disorder: (a) Is in danger of serious physical harm resulting from a failure to provide for their essential human needs of health or safety; or (b) manifests severe deterioration from safe behavior evidenced by repeated and escalating loss of cognitive or volitional control over their actions and is not receiving such care as is essential for their health or safety;

(37) "Likelihood of serious harm" means:

(a) A substantial risk that: (i) Physical harm will be inflicted by a person upon their own person, as evidenced by threats or attempts to commit suicide or inflict physical harm on oneself; (ii) physical harm will be inflicted by a person upon another, as evidenced by behavior which has caused harm, substantial pain, or which places another person or persons in reasonable fear of harm to themselves or others; or (iii) physical harm will be inflicted by a person upon the property of others, as evidenced by behavior which has caused substantial loss or damage to the property of others; or

(b) The person has threatened the physical safety of another and has a history of one or more violent acts;

For Minor:

If and when HCA provides written notice to the Office of the Code Reviser, Senate, and House of Representatives that the average wait time for children's long-term inpatient placement admission is 30 days or less for two consecutive quarters, the definitions of likelihood of serious harm and gravely disabled that apply to adolescents are expanded to include a risk of physical harm evidenced by harm, substantial pain, or which places a person in reasonable fear of harm to themselves or others, and modified to change "manifests severe deterioration in routine functioning" to "manifests severe deterioration from safe behavior." Severe deterioration from safe behavior would be defined to mean that the person will, if not treated, suffer or continue to suffer severe and abnormal mental, emotional, or physical distress associated with significant impairment of judgment, reason, or behavior.

(27) "Gravely disabled minor" means a minor who, as a result of a behavioral health disorder, (a) is in danger of serious physical harm resulting from a failure to provide for their essential human needs of health or safety, or (b) manifests severe deterioration from safe behavior evidenced by repeated and escalating loss of cognitive or volitional control over their actions and is not receiving such care as is essential for their health or safety.

⁴⁶ Final Bill Report, 2E2SSB 5720, Brief Description: Concerning the involuntary treatment act. [5720-S2.E2 SBR FBR 20.pdf](#)

(39) "Likelihood of serious harm" means:

(a) A substantial risk that: (i) Physical harm will be inflicted by a minor upon his or her own person, as evidenced by threats or attempts to commit suicide or inflict physical harm on oneself; (ii) physical harm will be inflicted by a minor upon another individual, as evidenced by behavior which has caused harm, substantial pain, or which places another person or persons in reasonable fear of harm to themselves or others; or (iii) physical harm will be inflicted by a minor upon the property of others, as evidenced by behavior which has caused substantial loss or damage to the property of others; or

(b) The minor has threatened the physical safety of another and has a history of one or more violent acts.

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Appendix B: Washington State Case Law

Dalen v. St. John Medical Center, 8 Wash.App.2d 49 436 P.3d 877 (2019)

Question of gross negligence for detaining patient

Detention of A.C., 3d 731 533 P.3d 81 (2023)

Failure to release upon expiration of civil commitment order – subsequent petitions filed

Detention of A.S., 138 Wn.2dP.2d (1999) at 898

Defective Petitions

Expert Witness

Gravely Disabled

Detention of B.M., 17 Wn.App.2d 914 492 P.3d (2021)

Less restrictive treatment order criteria regarding violations

Detention of C.A.C., 6 Wn.App.2d 231 430 P.3d (2018)

Community outreach initial detention – subsequent civil commitment without ER physician consult (RCW 71.05.154)

Detention of Chorney, 64 Wn.App. 469, 825 P.2d 330 (1992)

Good Faith Volunteer

Burden of proof to show good faith volunteer

Detention of C.K., 108 Wn.App. 65, P.2d (2001).

Less restrictive alternative – utilization of additional treatment (extension)

Legislative intent of RCW 71.05

Great weight given to prior history or pattern of decompensation

Grave disability

Detention of C.W., 147 Wn.2d 259, 281 (2002)

Rights vs. public interest – dismissal will not usually be appropriate remedy

RCW 71.05.050 – *time limitation does not commence until the professional staff determine that the patient meets the requirements of the statute that referral to ... is necessary*

Detention of D.H., 1 Wash.3d 764 533 P.3d 97 (2023)

Expiration of initial detention, holding without authority, initiating subsequent ITA investigations without release or discharge

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

Detention of E.S., 22 Wash. App. 2d 161 509 P.3d 871 (2022)

Inpatient facility filed successive 14-day petitions

Detention of H.T., Docket Number: 87418-7 (2026)

Grave disability, prong b – no prior mental health history

Detention of Kirby, 65 Wn. App. 862, 829 P.2d 1139 (1992)

Exploration into good faith volunteer supporting evidence

Detention of M.K., (2012)

Grave Disability – insufficient evidence example

Detention of N.G. And C.M., Docket Number: 54362-1 (2022)

Considerations for ITA court case dismissals – lack of dismissal and subsequent ITA investigation with detention

RCW 71.05.320(8) *No person committed under this section may be detained unless a valid order of commitment is in effect.*

Detention of R.H., (2019)

Grave disability determination

Less restrictive alternative -scribe error, incomplete document completion

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

Burden of proof to show conflict of interest in revocations

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

Detention of R.W., 98 Wn. App. P.2d (1999)
Comment on the evidence
Role of the jury

Detention of T.S., 14 Wn.App.2d 36 469 P.3d 315 (2020)
RCW 71.05.590(4)(d) Less restrictive treatment order revocation and determination of inpatient commitment order

Detention of W., 70 Wn.App.279, P.2d (1993)
Commitment to non-certified facility (pre-SBC)
Medical complexity

Detention of W.S., 22 Wn.App.2d 275 510 P.3d (2022)
Utilization of jury trial is not applicable to 14-day probable cause hearing (RCW 71.05.180)

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

In Re LaBelle, 107 Wn.2d 196, 728 P.2d 138 (1986)
Imminence
Grave disability – passive behavior
Danger to self and others – active behavior
Explanation of RCW 71.05.020(1)(a)
Explanation of RCW 71.05.020(1)(b)
Analysis of fact pattern in four gravely disabled cases

In Re Meistrell, 47 Wn. App. 100, 733 P.2d 1004 (1987)
Case law frequently cited – holds that recent past mental history is relevant in determining present and immediate future mental behavior

In Re Swanson, 115 Wn.2d 21, 793 P.2d 962 (1990)
The Supreme Court suggested that “in determining whether a case is to be dismissed, courts should focus on the merits of the petition, the intent of the statute, and whether the State ‘totally disregarded the requirements of the statute.’ ”
Emergency detention period ... authorized by RCW 71.05.150 *et seq.* begins upon an evaluation and treatment facility's immediate provisional acceptance of a petition and person for detention.

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

Peterhans v. University of Washington, 34 Wash.App.2d 745 571 P.3d 322 (2025)
State and university that managed hospital were not liable for patient's suicide attempt injuries following his discharge from involuntary treatment.
Gross negligence considerations

Stevens County v. Stevens County Sheriff's Department, 20 Wash.App.2d 34 499 P.3d 917 (2021)
Challenge to RCW 71.05.182 six month firearm restriction for dangerousness

Volk v. DeMeerleer, 187 Wash.2d 241 386 P.3d 254 (2016)
Likelihood of serious harm
Duty to warn

Appendix C: Consular Notification

The following flow chart would be utilized in the same manner for ITA detentions.

ARRESTING A NON-U.S. CITIZEN Consular Notification Process



Q: Are you a U.S. citizen?

A. "YES, I am a U.S. citizen. "

(No further action required.)



A. "NO, I am not a U.S. citizen. "



Q: Are you a national of one of these countries?

Albania
Algeria
Antigua and Barbuda
Armenia
Azerbaijan
Bahamas
Barbados
Belarus
Belize
Brunei
Bulgaria
China¹

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
Poland²

Romania
Russia
St. Kitts and Nevis
St. Lucia
St. Vincent and
the Grenadines
Seychelles
Sierra Leone
Singapore
Slovakia
Tajikistan
Tanzania

Tonga
Trinidad and Tobago
Tunisia
Turkmenistan
Tuvalu
Ukraine
United Kingdom³
Uzbekistan
Zambia
Zimbabwe

1. Includes Hong Kong and Macao. For consular notification purposes, does not include Taiwan (a Taiwan passport may bear the name "Republic of China").

2. Mandatory only for non-permanent residents in the United States (i.e., those not holding a "green card"); for green card holders, notification is upon request.

3. UK includes Anguilla, British Virgin Islands, Bermuda, Montserrat, and the Turks and Caicos Islands. Residents' passports bear the name of their territory and may also bear the name "United Kingdom." Whether or not the passport bears the name "United Kingdom," consular services for these persons are provided by UK consulates.

A. "YES"

STEP 1. Inform detainee that they may communicate with embassy/consulate, and that you must notify the embassy/consulate of arrest/detention.

STEP 2. Notify nearest embassy/consulate without delay.

STEP 3. Make record of notification in case file. Where email or fax is sent, keep confirmation.

STEP 4. Allow consular officers access to detainee if they subsequently request access.

(No further action required.)



A. "NO"

Inform detainee, without delay, that they may have the embassy/consulate notified of arrest/detention.



Q: Do you want your embassy/consulate notified of your arrest/detention?

A. "YES"

STEP 1. Make note in case file.

STEP 2. Notify nearest embassy/consulate without delay.

STEP 3. Make record of notification in case file. Where email or fax is sent, keep confirmation.

STEP 4. Allow consular officers access to detainee if they subsequently request access.

(No further action required.)



A. "NO"

STEP 1. Make note in case file.

STEP 2. Do not inform the embassy/consulate.

(No further action required.)



IN ALL CASES:

Do not inform embassy/consulate about detainee's refugee or asylum status.

Detainee may communicate with consular officer and may request consular access at any time (whether previously declined or not).

Contact Us:
U.S. Department of State
Consular Notification & Access
ConsNot@state.gov
Diplomatic Security
After Hours
(571) 345-3146

Scan for more info



For more information visit: travel.state.gov/CNA

STEPS TO FOLLOW WHEN A FOREIGN NATIONAL IS ARRESTED OR DETAINED¹

- 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.
- If the foreign national's country is **NOT** on the list of "mandatory notification" ("list") countries and jurisdictions:
 - Use Statement 1 on the back of this card to inform the national, without delay, that he or she may have his or her consular officers notified and may communicate with them.
 - 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.
 - Forward any communication from the foreign national to his or her consular officers without delay.
- If the foreign national's country is on the list of "mandatory notification" ("list") countries:
 - Notify that country's nearest embassy or consulate, without delay, of the arrest or detention.
 - Use Statement 2 on the back of this card to tell the national, without delay, that you are making this notification and that he or she may communicate with the consulate.
 - Forward any communication from the foreign national to his or her consular officers without delay.
- Keep a written record of:
 - What information you provided to the foreign national and when.
 - The foreign national's requests, if any.
 - Whether you notified consular officers and, if so, the date and time and the means used to notify them (e.g., fax, email or phone.) If you used fax or email to notify the consular officers, you should keep the fax confirmation sheet or sent email in your records.
 - Any other relevant actions taken.

¹These steps should be followed for all foreign nationals, regardless of their immigration status.



SUGGESTED STATEMENTS TO ARRESTED OR DETAINED FOREIGN NATIONALS

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.

U.S. DEPARTMENT of STATE
Bureau of Consular Affairs

MANDATORY NOTIFICATION "LIST" COUNTRIES

Albania	Malta
Algeria	Mauritius
Antigua and Barbuda	Moldova
Armenia	Mongolia
Azerbaijan	Nigeria
Bahamas	Philippines
Barbados	Poland ²
Belarus	Romania
Belize	Russia
Brunel	Saint Kitts and Nevis
Bulgaria	Saint Lucia
China (including Macao and Hong Kong) ¹	Saint Vincent and the Grenadines
Costa Rica	Seychelles
Cyprus	Sierra Leone
Czech Republic	Singapore
Dominica	Slovakia
Fiji	Tajikistan
Gambia	Tanzania
Georgia	Tonga
Ghana	Trinidad and Tobago
Grenada	Tunisia
Guyana	Turkmenistan
Hungary	Tuvalu
Jamaica	Ukraine
Kazakhstan	United Kingdom ³
Kiribati	Uzbekistan
Kuwait	Zambia
Kyrgyzstan	Zimbabwe
Malaysia	

¹Does not include Republic of China (Taiwan) passport holders.

²Mandatory for non-permanent only.

³U.K. includes Anguilla, Bermuda, the British Virgin Islands, the Cayman Islands, Montserrat, and the Turks and Caicos Islands. Residents' passports bear the name of their territory and may also bear the name "United Kingdom."



CONSULAR NOTIFICATION AND ACCESS REFERENCE CARD

Instructions for Arrests and Detentions
of Foreign Nationals

This card summarizes for law enforcement officials the basic consular notification procedures to follow upon the arrest or detention of a foreign national. For more detailed instructions and legal material, see the Department of State publication Consular Notification and Access. The complete publication is available at travel.state.gov/CNA.

QUESTIONS MAY ALSO BE ADDRESSED TO:
U.S. DEPARTMENT of STATE
CA/P, SA-17, 12th Floor
Washington, DC 20522-1712

Telephone: (571) 345-3146 – Diplomatic Security After Hours
Contact Email: consnot@state.gov

Appendix D: Video Assessment

Note: Individual DCR offices may need to modify some of these guidelines based on their local court practices and their work processes with local hospitals and emergency facilities. Examples of regional variation would include timing of completing and serving paperwork, timing of securing collateral information, method of providing the individual with their rights and steps in serving the individual with their detention paperwork. The Designated Crisis Responder office will work with facilities to incorporate video assessment into regional practice and develop protocols for each facility that address all the elements of the assessment to include paperwork, communication, collection of collateral information, and coordination of treatment for the client.

1. **Prosecutor coordination:** HCA advises coordinating with local prosecutors to facilitate smooth implementation of the ITA evaluations conducted by video.
2. **Determining when to conduct video ITA evaluations:** Video ITA evaluations may be conducted for adults for both emergent and non-emergent detentions.
3. **Coordinating out of region detentions:** When detaining to an E&T or SWMS facility outside of your region, verify with the destination facility which party will file the petition.
4. **The licensed health care professional:** The presence of a licensed health care professional or professional person is mandatory for video ITA evaluations. “Professional person” is defined under [71.05.020](#) as a mental health professional, substance use disorder professional, a physician, physician assistant, psychiatric advanced registered nurse practitioner, registered nurse, and such others as may be defined by rules adopted by the secretary pursuant to the provisions of this chapter;

Licensed Health Care Professional is not defined in law. It includes but is not limited to the professionals identified under the “professional person” definition. This includes professions under the mental health professional and substance use disorder professional definitions, as well as the following DOH licensure types:

- Licensed mental health counselors, marriage and family therapists, and social workers
 - Health care assistants
 - Medical assistants
 - Licensed practical nurses
 - Nursing assistants
 - Osteopaths
 - Osteopathic physicians’ assistants
 - Licensed psychologists
 - Emergency medical services and trauma care workers
5. **Role of the licensed health care professional or professional person:** This individual would be responsible for:
 - Remaining with the client when the DCR is conducting the evaluation
 - Facilitating the use of technology, namely verifying that the DCR is clearly visible and audible, and that the audio/video communication is functioning correctly
 - Providing a phone if the client wishes to call an attorney
 - Serving physical copies of the paperwork, as directed by the DCR
 - Providing instructions to the ambulance crew, as directed by the DCR
 6. **Settings for conducting video ITA evaluations:** Video ITA evaluations may be conducted in any setting in which a professional person is available to assist and facilitate the evaluation. Examples may include:
 - Acute care hospital, including emergency department
 - Evaluation and treatment Facility

- Secure withdrawal management and stabilization facility
 - Crisis stabilization facility
 - Crisis triage facility
 - Jail/correctional facility
 - Detention centers
 - Community setting
 - Any Tribal facility with permission from and coordination with the Tribe as outlined in the Tribe/HCA Protocols for Crisis Coordination
7. **Extenuating circumstances:** Prior to initiating the evaluation the DCR should consult with facility staff to verify that there are no extenuating circumstances which would preclude the use of video assessment. If there are extenuating circumstances, consult with facility staff to determine if those obstacles can be mitigated. Examples:
- Need for interpretive services
 - Client has visual limitations and cannot see the screen
 - Client's presentation and symptoms are specifically related to technology, causing them fear and discomfort beyond distress resulting from a crisis situation
8. **Physical space and connectivity:** The location of the DCR when conducting video evaluations may vary. However, all locations should be situated so that the evaluation is as secure and confidential as possible. The DCR may be located in an office in the hospital or facility, the DCR office, or other type office. If the DCR conducts the evaluation from home, the network connection must be secure and encrypted and the DCR should attest to the fact that no other individuals can observe or potentially interrupt the evaluation.
9. **Collateral information:** Prior to commencing the evaluation, DCRs should gather as much collateral information as possible. This will include history, recent events, and current presentation. Information from facility staff will be especially important as the DCR will not be physically present for the evaluation.
10. **Conducting the evaluation/investigation:**
- a. The DCR shall introduce themselves and read the client rights as usual.
 - b. The DCR shall include in the documentation/petition that it is a video assessment and identify the assisting staff present with the client document the time rights were read and that a copy of the rights was provided to the client by the assisting staff, per usual practice.
 - c. Proceed with the ITA evaluation. During the evaluation take into consideration the novelty and/or concerns of the individual experiencing this type of evaluation.
 - d. Consultation with the ED medical professional, if required, regarding your decision to detain or not detain will need to happen over the phone or video. Document the conversation and any concerns voiced by the ER medical professional.
11. **Locating an E&T or SWMS bed:** If the DCR has made the decision to detain, the DCR should begin calling facilities, per usual practice. DCRs may request that the assisting staff fax the DCR the labs and any medical documentation/information that would be provided in the normal course of placing a detained individual so that the DCR can send the information to potential facilities for screening. Keep the assisting staff apprised of progress in finding a facility willing to accept the client.
12. **Final steps:**
- a. If detaining the individual, complete your paperwork, sign, date and finalize. Fax it to the facility so the assisting staff can physically serve the client. Ensure that the documentation clearly states the circumstances and details of the video assessment, including identifying the facility professional who assisted.
 - b. Coordinate with the assisting staff to facilitate a second, brief video session to virtually serve the client.

- c. If detaining due to risk of harm to self/others/property, the DCR reads the client the DCR Notification of Suspension of Firearm Rights over video.
- d. If not detaining the individual, coordinate with the assisting staff to let them know the outcome of the decision and develop a plan to hand-off the client for an appropriate less restrictive alternative, crisis follow-up service, return to family, etc.

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Appendix E: F.A.Q Civil Commitment

1. Is an SBC required if a patient is sent to the ED for medical intervention?

- If patient is only being sent for brief medical treatment and not admission to a medical floor, then intention is that patient will be return to the ITA placement at the existing E&T/SWMS facility. This means that an SBC is not necessary at the ED where the patient is receiving the medical intervention.
- RCW 71.05.270 Temporary release. Nothing in this chapter shall prohibit the professional person in charge of a treatment facility, or his or her professional designee, from permitting a person detained for intensive treatment to leave the facility for prescribed periods during the term of the person's detention, under such conditions as may be appropriate.

2. Is an SBC required when a patient is ordered to 90- or 180-day civil commitment and remains at the E&T/SWMS facility they had been initially detained to?

- HCA finds that a facility licensed by DOH for ITA services does not require an SBC to provide treatment under a 90- or 180-day civil commitment order.
- The first and third sentences of the SBC rule, WAC 182-300-0100, state that SBCs may be granted for facilities “not certified under chapter 246-341 WAC.” Facilities licensed under WAC 246-341-1133 are explicitly allowed to provide treatment for individuals “held for 120-hour detention or on 14-day, 90-day, or 180-day civil commitment orders according to chapters 71.05 and 71.34 RCW.” This includes all facilities and beds that are licensed by DOH to provide adult or youth Evaluation and Treatment services. WAC 246-341-1133(4) explicitly allows for short term ITA facilities treating youth to provide treatment under a “180-day inpatient involuntary commitment order only until the child is discharged from the order to the community, or until a bed is available for that child in a CLIP facility.” Under these circumstances, no SBC is required for an Evaluation and Treatment facility to provide these ITA treatment services.

3. Out of County Revocation placement/transfer – Attorney representation (December 2025)

HCA was recently informed that the King County prosecuting attorney’s office will no longer provide representation for LRA/LRO revocations when an adult is detained by a DCR in another county and transferred to a King County E&T/SWMS facility for the revocation hearing. This representation should be provided by the prosecutors in the county where the DCR detained the individual. The reason for this decision is that the adult statute requires the revocation petition to be filed promptly by the DCR, venue lies in the county where the petition is filed, and the prosecutor of the county where the petition is filed must represent the case. See [RCW 71.05.590\(5\)\(a\)](#), (c); [RCW 71.05.130](#).

DCR Offices should consider:

- King County E&T/SWMS facilities will continue to accept initial detentions. DCRs may determine if the individual meets criteria for an initial detention in a new matter rather than a revocation of an existing LRA/LRO.
- Coordinating with their county jurisdictions to file the revocation petition in their county where the person was detained and determine if the Superior Court of that county will hold the revocation hearing even if the individual has been transported to a facility in King County. Alternatively, a motion for change of venue to King County can be filed along with the revocation petition in the county where the individual was detained.

It is important for DCR offices to review the revocation statute, [RCW 71.05.590](#), and related statutes, as it may impact provisional acceptance and transportation considerations.

- A person may be detained for up to 12 hours for evaluation to determine whether a revocation petition will be filed;
- Revocation petitions must be filed by the DCR (not the facility) within 24 hours of detention;
- A revocation hearing must be held within 5 days;

- The venue for proceedings is the county where the petition is filed; and
- The prosecuting attorney of the county in which the petition is filed is responsible for representing the revocation, even if the patient has been transferred to a facility that is out of county, unless a change of venue has been filed and granted by the court. Change of venue must be granted in a timely manner to ensure the facility and the court where the person is detained can meet statutory timelines for the revocation hearing.

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Appendix F: Law Enforcement agencies by county

ADAMS

Adams County SO
Othello PD
Ritzville PD

ASOTIN

Asotin County SO
Asotin PD
Clarkston PD

BENTON

Benton County SO
Kennewick PD
Prosser PD
Richland PD
West Richland PD

CHELAN

Chelan County SO
Wenatchee PD

CLALLAM

Clallam County SO
Forks PD
Hoh Tribal PD
La Push Tribal PD
Lower Elwha Tribal PD
Makah Tribal PD
Port Angeles PD
Sequim PD

CLARK

Clark County SO
Battle Ground PD
Camas PD
Cowlitz Tribal PD
La Center PD
Ridgefield PD
Vancouver PD
Washougal PD
WSU PD-Vancouver

COLUMBIA

Columbia County SO

COWLITZ

Cowlitz County SO
Castle Rock PD
Kalama PD
Kelso PD
Longview PD
Woodland PD

DOUGLAS

Douglas County SO
East Wenatchee PD

FERRY

Ferry County SO
Republic PD

FRANKLIN

Franklin County SO
Connell PD
Pasco PD
Port of Pasco PD

GARFIELD

Garfield County SO

GRANT

Grant County SO
Coulee City PD
Ephrata PD
Grand Coulee PD
Mattawa PD
Moses Lake PD
Quincy PD
Royal City PD
Soap Lake PD
Warden PD

GRAYS HARBOR

Grays Harbor County SO
Aberdeen PD
Chehalis Tribal PD
Cosmopolis PD
Elma PD
Hoquiam PD
McCleary PD
Montesano PD
Oakville PD
Ocean Shores PD
Quinault Tribal PD
Westport PD

ISLAND

Island County SO
Coupeville PD
Langley PD
Oak Harbor PD

JEFFERSON

Jefferson County SO
Port Townsend PD

KING

King County SO
Auburn PD
Algona PD
Beaux Arts PD
Bellevue PD
Black Diamond PD
Bothell PD
Burien PD
Carnation PD
Clyde Hill PD
Covington PD
Des Moines PD
Duvall PD
Enumclaw PD
Federal Way PD
Issaquah PD
Kenmore PD
Kent PD
Kirkland PD
Lake Forest Park PD
Maple Valley PD
Medina PD
Mercer Island PD
Muckleshoot Tribal PD
Newcastle PD
Normandy Park PD
North Bend PD
Pacific PD
Port of Seattle PD
Redmond PD
Renton PD
Sammamish PD
SeaTac PD
Seattle PD
Shoreline PD
Skykomish PD
Snoqualmie PD
Snoqualmie Tribal PD
Tukwila PD
University of WA PD
Woodinville PD
Yarrow Point PD

KITSAP

Kitsap County SO
Bainbridge Island PD
Bremerton PD
Port Gamble S'Klallam Tribal PD
Port Orchard PD
Poulsbo PD
Suquamish Tribal PD

KITTITAS

Kittitas County SO
Central WA University PD
Cle Elum - Roslyn PD
Ellensburg PD
Kittitas PD

KLICKITAT

Klickitat County SO
Bingen-White Salmon PD
Goldendale PD

LEWIS

Lewis County SO
Centralia PD
Chehalis PD
Morton PD
Mossyrock PD
Napavine PD
Pe Ell PD
Toledo PD
Vader PD
Winlock PD

LINCOLN

Lincoln County SO
Odessa PD
Reardan PD
Wilbur PD
MASON
Mason County SO
Shelton PD
Skokomish Tribal PD
Squaxin Island Tribal PD

OKANOGAN

Okanogan County SO
Brewster PD
Colville Tribal PD
Coulee Dam PD
Elmer City PD
Omak PD
Oroville PD
Tonasket PD
Twisp PD
Winthrop PD

PACIFIC

Pacific County SO
Ilwaco PD
Long Beach PD
Raymond PD
Shoalwater Bay Tribal PD
South Bend PD

PEND OREILLE

Pend Oreille County SO
Kalispel Tribal PD
Newport PD

PIERCE

Pierce County SO
Bonney Lake PD
Buckley PD
DuPont PD
Eatonville PD
Edgewood PD
Fife PD
Fircrest PD
Gig Harbor PD
Lakewood PD
Milton PD
Orting PD
Puyallup PD
Puyallup Tribal PD
Roy PD
Ruston PD
Steilacoom PD
Sumner PD
Tacoma PD
University Place PD

SAN JUAN

San Juan County SO

SKAGIT

Skagit County SO
Anacortes PD
Burlington PD
Mount Vernon PD
Sedro-Woolley PD
Swinomish Tribal PD
Upper Skagit Tribal PD

SKAMANIA

Skamania County SO
SNOHOMISH
Snohomish County SO
Arlington PD
Brier PD
Darrington PD
Edmonds PD
Everett PD
Granite Falls PD
Gold Bar PD
Index PD
Lake Stevens PD
Lynnwood PD
Marysville PD
Mill Creek PD
Monroe PD
Mountlake Terrace PD

Mukilteo PD
Sauk-Suiattle Tribal PD
Snohomish Auto Theft Task Force
Snohomish PD
Stanwood PD
Stillaguamish Tribal PD
Sultan PD
Tulalip Tribal PD
Woodway PD

SPOKANE

Spokane County SO
Airway Heights PD
Cheney PD
Eastern WA University PD
Liberty Lake PD
Spokane PD
Spokane Intl Airport PD
Spokane Valley PD

STEVENS

Stevens County SO
Chewelah PD
Colville PD
Kettle Falls PD
Spokane Tribal PD
Springdale PD

THURSTON

Thurston County SO
Evergreen State College PD
Lacey PD
Nisqually Tribal PD
Olympia PD
Rainier PD
Tenino PD
Tumwater PD
Yelm PD

WAHKIAKUM

Wahkiakum County SO

WALLA WALLA

Walla Walla County SO
College Place PD
Walla Walla PD

WHATCOM

Whatcom County SO
Bellingham PD
Blaine PD
Everson-Nooksack PD
Ferndale PD
Lummi Tribal PD
Lynden PD

Nooksack Tribal PD
Sumas PD
Western WA University PD

WHITMAN

Whitman County SO
Colfax PD
Colton PD
Garfield PD
Oakesdale PD
Palouse PD
Pullman PD
Rosalia PD

Uniontown PD
WA State University PD

YAKIMA

Yakima County SO
Grandview PD
Granger PD
Mabton PD
Moxee PD
Selah PD
Sunnyside PD
Tieton PD
Toppenish PD

Union Gap PD
Wapato PD
Yakama Nation Tribal PD
Yakima PD
Zillah PD

Key

PD: Police department
SO: Sheriff's office

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Appendix G: DOH Intent to Release statement



STATE OF WASHINGTON
DEPARTMENT OF HEALTH
Olympia, Washington 98504

NOTICE OF ADOPTION INTERPRETIVE STATEMENT

Title of Interpretive Statement: Release of Voluntary Individuals from Inpatient Behavioral Health Settings | Number: OCHS-04-23-21

Issuing Entity: Department of Health, Health Systems Quality Assurance, Office of Health Systems Oversight

Subject Matter: Release of Voluntary Individuals from Inpatient Behavioral Health Settings

Effective Date: April 23, 2021

Contact Person: Dan Overton, Program Manager
Dan.overton@doh.wa.gov

OFFICE OF THE CODE REVISER
STATE OF WASHINGTON
FILED

DATE: May 03, 2021

TIME: 11:37 AM

WSR 21-10-085

Department of Health
Health Systems Quality Assurance

Interpretive Statement

Revised – 10/18/11

Title:	Release of Voluntary Individuals from Inpatient Behavioral Health Settings	Number: OCHS-04-23-21
References:	RCW 71.05.050 , RCW 71.05.020 , WAC 246-322-170	
Contact:	Dan Overton, Program Manager, Office of Community Health Systems, Health Systems Quality Assurance	
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Effective Date:	April 23, 2021	
Supersedes:	n/a	
Approved By:	Kristin Peterson, Assistant Secretary	

This interpretive statement describes how the Department of Health (department) interprets RCW [71.05.050](#) as it applies to all inpatient behavioral health settings including all hospitals and residential treatment facilities. The statement was developed by the department in consultation with partners at the Health Care Authority in an effort to help ensure that licensees providing inpatient behavioral health services are compliant with state law when responding to voluntary individuals who are seeking immediate release from inpatient care.

Background:

Voluntarily admitted individuals who request release from inpatient behavioral health services are required to be released ‘immediately’ according to [RCW 71.05.050](#). The only exception is when the individual, at the time of the request for release, is exhibiting behaviors that could qualify the individual for involuntary detention. In that case, the facility may briefly hold the individual only long enough to contact and have a designated crisis responder (DCR) respond for further evaluation in accordance with [chapter 71.05](#) RCW. Otherwise, once requested, the statute directs an individual’s release to be expedited by the facility and may not be protracted by the operational convenience or other interests of the facility. RCW [71.05.050](#) protects individual civil rights and it is critical that facilities carefully monitor their staffs’ compliance with this law. Facility policies should provide direction to staff at each step of the process for a release requested by a voluntary individual.

Standards for Policies and Procedures:

The department expects all policies, procedures, forms, and practices relating to this discharge process by any licensed facility providing inpatient behavioral health services to meet the following standards:

Timeliness:

In order to meet the immediacy requirement of RCW [71.05.050](#)(1), any policy that addresses the facility’s procedure when discharging voluntary admitted individuals who are requesting release should direct staff to complete the process, including an assessment and possible consultation

with a DCR, promptly and without undue delay, regardless of the time of day or day of the week. The process from the point of the individual's initial request to their release or referral to a DCR should take a matter of hours.

Documentation:

Policies should set clear and specific expectations for staff to timely and thoroughly document all key information at every step, especially if it is to support the facility's preliminary determination to hold the individual pending further assessment by a DCR.

- Staff should be directed to document all relevant observations such as when (time and date) and how the individual initially requested release; and how the individual presented at the time of the request, such as the individual's specific remarks, psychiatric symptoms, behaviors, any indications of cognitive impairment, change in status, etc. An assessment tool incorporated into a facility's policy is one method for a facility to ensure adequacy and consistency.
- Staff should also be directed to clearly document when and how a DCR consult was initiated and any substantive exchanges between staff and the DCR, as well as when, and if, the DCR authorized the individual be further detained for a subsequent DCR investigation.
- Finally, staff should document any reason for delay in processing a discharge requested by an individual.

Assessments:

A facility's policy should direct that any professional staff (as defined by RCW [71.05.020](#) (42)) available at the time of the individual's request to be released immediately conduct any pre-release assessment for the limited purpose of determining whether a more comprehensive assessment by a DCR is needed. A DCR should not be contacted unless the facility has documented reasonable grounds to believe that the individual may meet the criteria for a limited involuntary detention.

The policy should designate by title which staff positions may conduct a pre-release assessment. The policy should be consistent with RCW [71.05.020](#) and may not require, for example, that the assessment be performed exclusively by a 'psychiatric provider', attending physician or ARNP. The policy may require that any release requested by an individual be immediately communicated to appropriate third parties, such as an attending physician/provider, facility management, or the individual's relatives, but this cannot unduly delay the response to the release request. The policy may not require consultation or approval by such third parties as a prerequisite to release to the extent this prevents immediate release. For example, requiring a physician's consultation, assessment, or discharge order cannot serve to delay the immediate release of a voluntary individual.

The policy may not require that the scope of an assessment be so comprehensive as to supplant that of a DCR. The assessment should be timely and based on the symptoms or behaviors the individual presents at the time of their request for release. All staff should be directed by the policy to immediately bring a request for release by any voluntarily admitted individual to the attention of professional staff to efficiently facilitate an appropriate response.

Discharge Planning:

With regard to safe discharge planning requirements, such as WAC [246-322-170](#) for psychiatric hospitals, the department acknowledges inpatient behavioral health facilities have general

planning requirements at discharge, but when a voluntarily-admitted individual requests release from inpatient behavioral health services, then statutory requirements to honor these requests by facilitating an expeditious release become the imperative. More specifically, WAC [246-322-170](#) and other related rules, must be interpreted in a manner that is consistent with RCW [71.05.050](#). Consequently, a facility's policy cannot require a voluntary individual be detained against their will while staff plan for continuity of care, a suitable discharge location, or complete similar arrangements.

Engagement with individuals:

The policy may direct staff to engage in a discussion with the individual regarding early release, or seek the individual's completion of 'against medical advice (AMA)' or other 'early discharge' related paperwork, but these steps should not serve to postpone the pre-release assessment or otherwise violate the immediacy requirement under the law. The policy should direct staff at all times to engage with the individual seeking release in a way that acknowledges that individual's fundamental right to refuse further care from the facility. Staff should be trained to take care to avoid remarks or conduct that may be reasonably viewed by the individual as threatening, intimidating, coercive, or that otherwise gives the impression that the individual, once admitted, loses the right to immediately leave the facility at their request. For example, staff should not convey to the individual that a DCR must be contacted in any release requested by an individual and should avoid discussing potential financial ramifications of an 'AMA discharge', as this may not be accurate information and is a matter between the individual and their insurance provider.

Following the specific guidance in this interpretive statement and aligning policies, procedures, and practices that are enacted when an individual requests to be released will help ensure that facilities providing inpatient behavioral health services are compliant with state law and doing their utmost to protect the civil rights of individuals.

Appendix H: 2025 – 2026 Protocols acknowledgements

Protocols workgroup members, consulting bodies, legal and editorial contributors, listed in alphabetical order, and including statewide partners, HCA/Division of Health and Recovery partners, Managed Care Organization (MCO) partners, and Behavioral Health Administrative Service Organization (BH-ASO) partners

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Coordinated Care Washington

Behavioral Health Administrative Service Organizations

Greater Columbia BH-ASO

Great Rivers BH-ASO

King County BH-ASO

North Central BH-ASO

North Sound BH-ASO

Pierce BH-ASO

Salish BH-ASO

Spokane BH-ASO

Thurston-Mason BH-ASO

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Glossary

Following is a Glossary relevant to involuntary treatment act and related statutes. Each term is also included in the section(s) to which it applies. Italicized text is taken directly from the statute. 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.

Adolescent: A minor thirteen years of age or older. [RCW 71.34.020(3)]

American Indian or Alaska Native: Any individual who is: (a) A member of a federally recognized Tribe; or (b) eligible for the Indian health service [RCW 43.71B.010(3)].

Behavioral health disorder: Either a mental disorder as defined in this section, a substance use disorder as defined in this section, or a co-occurring mental disorder and substance use disorder [RCW 71.05.020(7), 71.34.020(9)]

Behavioral health service provider: A public or private agency that provides mental health, substance use disorder, or co-occurring disorder services to persons with behavioral health disorders as defined under this section and receives funding from public sources. This includes, but is not limited to: Hospitals licensed under chapter 70.41 RCW; evaluation and treatment facilities as defined in this section; community mental health service delivery systems or community behavioral health programs as defined in RCW 71.24.025; licensed or certified behavioral health agencies under RCW 71.24.037; an entity with a Tribal attestation that it meets minimum standards or a licensed or certified behavioral health agency as defined in RCW 71.24.025; facilities conducting competency evaluations and restoration under chapter 10.77 RCW; approved substance use disorder treatment programs as defined in this section; secure withdrawal management and stabilization facilities as defined in this section; and correctional facilities operated by state, local, and Tribal governments;

Behavioral health treatment: Inclusive of mental health treatment, substance use disorder treatment, and co-occurring treatment

Conditional release (CR): A revocable modification of a commitment, which may be revoked upon violation of any of its terms. Often utilized in a similar way to an LRA.

Credible: The state of being believable or trustworthy.

Decompensation: The “appearance or exacerbation of a mental disorder due to failure of defense mechanisms.” Stedman’s Medical Dictionary, 28th edition (2005).

Dementia: A condition characterized by progressive or persistent loss of intellectual functioning, especially with impairment of memory and abstract thinking, and often with personality change, resulting from organic disease of the brain.

Designated Crisis Responder (DCR): A mental health professional appointed by the county, by an entity appointed by the county, or by the authority in consultation with a Tribe or after meeting and conferring with an Indian health care provider, to perform the duties specified in this chapter [RCW 71.05.020(17)].

Detain: To hold or keep in or as if in custody, such as a police station, a prison or a hospital, and prevent them from leaving.

Dignity of risk: The right of every person, including those with a disability, to make informed choices and take reasonable risks to learn, grow, and have better quality of life. An aspect of dignity of risk is the importance that when people’s rights may be limited that supports have considered less restrictive options that are not overly restrictive and provide for as much independence as possible. Least restrictive should always be considered before moving into highly restrictive procedures.

Elderly: Of, relating to, or characteristic of later-life or elderly persons, generally aged 65 and older.

Evaluation and treatment facility: Any facility that can provide directly, or by direct arrangement with other public or private agencies, emergency evaluation and treatment, outpatient care, and timely and appropriate inpatient care to persons suffering from a mental disorder, and which is licensed or certified as such by the department. The authority may certify single beds as temporary evaluation and treatment beds under RCW 71.05.745. A physically separate and separately operated portion of a state hospital may be designated as an evaluation and treatment facility. A facility which is part of, or operated by, the department of social and health services or any federal agency will not require certification. No correctional institution or facility, or jail, shall be an evaluation and treatment facility within the meaning of this chapter; [RCW 71.05.020(24)]

Federally recognized Indian Tribe: Any Indian Tribe, band, nation, or other organized group or community, including any Alaska Native village or group or regional or village corporation as defined in or established pursuant to the Alaska Native claims settlement act (43 U.S.C. Sec. 1601 et seq.) which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians [WA Indian Health Improvement Act RCW 43.71B.010]

Gravely disabled: A condition in which a person, as a result of a behavioral health 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 [RCW 71.05.020(24)] *See Appendix A for a contingent effective definition

Historical trauma: Situations where a community experienced traumatic events, the events generated high levels of collective distress, and the events were perpetuated by outsiders with a destructive or genocidal intent

History of one or more violent acts: The period of 10 years prior to the filing of a petition under this chapter, excluding any time spent, but not any violent acts committed, in a behavioral health facility or in confinement as a result of a criminal conviction [RCW 71.05.020(27)]

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(28)]

Incompetency: A state wherein a person lacks the capacity to understand the nature of the proceedings against them or to assist in their own defense as a result of mental disease or defect.

Indian Health Care Provider (IHCP): A health care program operated by the Indian health service or by a Tribe, Tribal organization, or urban Indian organization as those terms are defined in 25 U.S.C. Sec. 1603 [RCW 43.71B.010(11)].

Informed consent: (1) If a patient who has capacity to make health a care [a health care] decision, or his or her representative if he or she does not have the capacity to make a health care decision, signs a consent form which sets forth the following, the signed consent form shall constitute prima facie evidence that the patient gave his or her informed consent to the treatment administered and the patient has the burden of rebutting this by a preponderance of the evidence:

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

[[RCW 71.05.150\(1\)](#), [RCW 71.05.153\(1\)](#) and [RCW 71.34.710](#)]

Less restrictive alternative treatment: A program of individualized treatment in a less restrictive setting than inpatient treatment. The program is outlined in a court order for outpatient treatment which includes services to be provided and conditions that the individual must adhere to. An LRA order may be enforced, modified or revoked as appropriate. [[RCWs 71.05.575](#), [.580](#), [.590](#), [.595](#)]

Likelihood of serious harm: (a) A substantial risk that: (i) physical harm will be inflicted by a person upon his or her own person, as evidenced by threats or attempts to commit suicide or inflict physical harm on oneself; (ii) physical harm will be inflicted by a person 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 (iii) physical harm will be inflicted by a person upon the property of others, as evidenced by behavior which has caused substantial loss or damage to the property of others; or (b) the person has threatened the physical safety of another and has a history of one or more violent acts [[RCW 71.05.020\(36\)](#)] See [Appendix A](#) for a contingent effective definition

Medical clearance: The state of having had a physician or other health care provider, including an Indian health care provider, determine that a person is medically stable and ready for referral to the designated crisis responder or facility. For a person presenting in the community, no medical clearance is required prior to investigation by a designated crisis responder [[RCW 71.05.020\(38\)](#)].

Mental disorder: Any organic, mental, or emotional impairment which has substantial adverse effects on a person's cognitive or volitional functions [[RCW 71.05.020\(38\)](#)]

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\(43\)](#).

Mental health advance directive or directive: A written document in which the principal makes a declaration of instructions or preferences or appoints an agent to make decisions on behalf of the principal regarding the principal's mental health treatment, or both, and that is consistent with the provisions of this chapter. [[RCW 71.32.020\(12\)](#)]

Mental health professional: An individual practicing within the mental health professional's statutory scope of practice who is (per [[RCW 71.05.020\(40\)](#)]):

- (a) A psychiatrist, psychologist, physician assistant working with a supervising psychiatrist, psychiatric advanced registered nurse practitioner, psychiatric nurse, or social worker, as defined in this chapter and chapter [71.34](#) RCW
- (b) A mental health counselor, mental health counselor associate, marriage and family therapist, or marriage and family therapist associate, as defined in chapter [18.225](#) RCW
- (c) A certified or licensed agency affiliated counselor, as defined in chapter [18.19](#) RCW
- (d) A licensed psychological associate as described in chapter [18.83](#) RCW

Minor: Any person under the age of eighteen years [[RCW 71.34.020\(44\)](#)]

Notice of Unavailable Detention Facilities (No-Bed Report): A form filed by the DCR with HCA according to procedure when an available bed cannot be located in an E&T or SWMS facility [[RCW 71.05.750](#)].

Reliable: The state of being accurate in providing facts; a reliable individual 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.

Secure withdrawal management and stabilization facility (SWMS): A facility operated by either a public or private agency or by the program of an agency which provides care to voluntary individuals and individuals involuntarily detained and committed under this chapter for whom there is a likelihood of serious harm or who are gravely disabled due to the presence of a substance use disorder.

Secure withdrawal management and stabilization facilities must:

- (a) Provide the following services:
 - (i) Assessment and treatment, provided by certified substance use disorder professionals or co-occurring disorder specialists;
 - (ii) Clinical stabilization services;
 - (iii) Acute or subacute detoxification services for intoxicated individuals; and
 - (iv) Discharge assistance provided by certified substance use disorder professionals or co-occurring disorder specialists, including facilitating transitions to appropriate voluntary or involuntary inpatient services or to less restrictive alternatives as appropriate for the individual;
- (b) Include security measures sufficient to protect the patients, staff, and community; and
- (c) Be licensed or certified as such by the department of health [\[RCW 71.05.020\(52\)\]](#)

Senior citizen: the U.S. government generally consider a senior citizen to be 65 or older.

Single Bed Certification (SBC): A procedure granting an exception to allow timely and appropriate treatment in a facility that is not certified to provide involuntary inpatient treatment to an individual on an initial detention or revocation, or a 14-day commitment. SBCs for a maximum of 30 days may also be granted to allow a community facility to provide treatment to an individual on a 90- or 180-day commitment [\[RCW 71.05.745, WAC 182-300-0100\]](#).

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 [\[RCW 71.05.020\(53\)\]](#)

Trauma-informed care: A strengths-based framework that is grounded in an understanding of and responsiveness to the impact of trauma, and emphasizes the physical, psychological, and emotional safety for both providers and survivors, and creates opportunities for survivors to build a sense of control and empowerment.

Tribal Crisis Coordination Protocol: A government-to-government agreement between HCA and the Indian Nation or Indian Nation regional plan that establishes protocols for the coordination of crisis services (including involuntary treatment), care coordination, and discharge planning. These protocols outline how the DCR will engage with an individual Tribal member or non-Tribal member on Tribal lands. Protocols are developed in coordination with Tribal and non-Tribal regional crisis entities.

Tribal DCR: A mental health professional appointed by the authority in consultation with a Tribe or after meeting and conferring with an Indian Health Care Provider (IHCP), to perform the duties specified in RCW 71.05 [\[WAC 182-125-0100\]](#).

Tribal Land: Any territory within the state of Washington over which a Tribe has legal jurisdiction, including any land held in trust for the Tribe by the federal government

Tribally operated facility: A health care facility operated by one or more Tribe or Tribal organizations to provide specialty services, including but not limited to evaluation and treatment services, secure detox services, inpatient psychiatric services, nursing home services, and residential substance use disorder services [\[RCW](#)

43.71B.010(17)].

Tribal sovereignty: Tribe possess the right to form their own governments; to make and enforce laws, both civil and criminal; to tax; to establish and determine membership (i.e., Tribal citizenship); to license and regulate activities within their jurisdiction; to zone; and to exclude persons from Tribal lands.

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Tribe: A federally recognized Indian Tribe [[RCW 71.24.025\(56\)](#)].

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