

Washington State
**Department of Social
& Health Services**

Report to the Legislature

Protocols

Designated Mental Health Professionals

RCW 71.05.214

December 2008

Department of Social & Health Services
Health and Rehabilitative Services
Mental Health Division
P.O. Box 45320
Olympia, WA 98504-5320
(360) 902-8070
Fax: (360) 902-0809

For a copy of this document in an alternative format, or for a hard copy contact David Kludt or Lois Thadei at:
Department of Social & Health Services, Health and Rehabilitative Services Administration
Mental Health Division
P.O. Box 45320, Olympia, WA. 98504-5320
Phone (360) 902- 0786 or 360-902-7857
Fax (360) - 902-0809

Protocols: Designated Mental Health Professionals

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PREFACE

The 2008 update of the Protocols for Designated Mental Health Professionals (DMHPs) is provided by the Department of Social and Health Services (DSHS), Mental Health Division (MHD), as mandated by RCW 71.05.214.

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

In compliance with the legislative mandate, the department submitted the initial protocols to the Governor and the Legislature in September, 1999, and updates in 2002, and 2005.

The 2008 Protocol Update was written with the understanding that as of September 2005, the Regional Support Networks (RSNs) “must incorporate the statewide protocols for County Designated Mental Health Professionals (CDMHPs) or its successor into the practice of Designated Mental Health Professionals.”

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

The 2008 Protocol Work Group included staff from DSHS Mental Health Division with active collaboration from a broad stakeholder group. A list of participants and their affiliations can be found in Appendix A.

The reader should be aware of several conventions used in this update of the protocols: Within the document are definitions of a number of important words or phrases. When the definition is taken from Washington State law, a Revised Code of Washington (RCW) citation immediately follows. When no citation is noted, the definition has been developed for this document and should be read as part of the guidelines and without specific statutory authority.

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

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

The 2008 Protocols also have limitations. It is beyond the scope of the protocols to address the myriad of clinical skills and practices required of DMHPs or the role of the DMHP in providing crisis response and resolution as a mental health professional. In addition, some of the practices followed by DMHPs are influenced by the rulings of local courts. These rulings have resulted in

procedural differences across the state which are beyond the authority of the protocols to remedy. The work group recognized that there are significant variations between counties with respect to geography, population, resources, socioeconomic, and political factors. Notwithstanding these issues, the 2008 Protocol Work Group is satisfied that these protocols will continue to move DMHP practices toward greater uniformity across the state.

The 2008 Protocol Work Group wishes to acknowledge that the shortage of inpatient beds in the State of Washington continues to have a significant impact on DMHPs and their practices. This shortage also has significant impact on consumers who at times find themselves involuntarily detained to community hospital emergency departments. In addition to this critical issue there are other important issues which impact DMHPs, requiring statutory change. Members of the 2008 Protocol Work Group have agreed to continue to work together to address these concerns.

Mental Health Workers Safety

The 2008 Protocol Work Group gave considerable thought and discussion to the issue of workers safety. The protocols contain numerous references to SHB 1456 also known as the Marty Smith Bill in memory of Marty Smith a DMHP who was murdered while conducting an ITA investigation.

Designated Crisis Responders

The Omnibus Treatment of Mental and Substance Abuse Disorders Act of 2005 (2005 E2SSB 5763) authorized two Integrated Crisis Response and Involuntary Treatment Pilot Projects, established an integrated Mental Health and Chemical Dependency ITA law and authorized Designated Crisis Responders. The Legislature directed DSHS to select two pilot sites, one rural and one urban. Pierce County was selected to represent an urban setting, and North Sound RSN, which serves Skagit, Whatcom, Island, Snohomish and San Juan counties, was the rural selection.

The Pierce County and North Sound secure detoxification facilities began operations in April 2006 and May 2006, respectively. In the pilot counties Designated Crisis Responders investigate and have the authority to detain individuals who are determined to be “gravely disabled or presenting a likelihood of serious harm” due to mental illness, substance abuse, or both for 72 hours to secure detoxification facilities under a new statute created for the pilots, RCW 70.96B. Designated Crisis Responders may exercise the powers and duties of a Designated Mental Health Professional following 40 hours of chemical dependency training.

The 2008 protocols do not address the specific role and practice of DCRs. The Protocol Work Group does endorse the concept of DCRs if appropriate resources are provided.

GLOSSARY OF TERMS

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

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

“Credibility” means the state of being believable or trustworthy.

“Designated mental health professional” means a mental health professional designated by the appropriate Regional Support Network to perform the duties of the Involuntary Treatment Acts. RCW 71.05.020(11) and RCW 71.34.020(4). As per RCW 71.05.020 (25) "Mental health professional" means a psychiatrist, psychologist, psychiatric nurse, or social worker, and such other mental health professionals as defined by WAC 388-865-0150 “Mental Health Professional”. See Appendix J - DMHP Knowledge and Education.

“Good faith” implies the individual expresses a sincere (i.e., without coercion, deception or deceit) willingness to abide by the procedures and treatment plan prescribed by the treatment facility and professional staff to whom the person has “in good faith volunteered.” Also, the person does not have a history which belies this stated intent, nor a cognitive impairment that prevents him or her from making this decision.

- For a minor, the good faith commitment by the minor’s parent or legal guardian is considered when the investigation concerns a cognitively impaired person who is unable to provide good faith informed consent to less-restrictive treatment options.
- The DMHP determines whether the person’s healthcare decision maker listed under RCW 7.70.065 can and will consent to the less-restrictive alternative treatment on behalf of the person.

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

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

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

However, persons cannot be detained on the basis of a severe deterioration in routine functioning unless the detention is shown to be essential for their health or safety. In re: Labelle, 107 Wn.2d 196, 728 P.2d 138 (1986), See Appendix K.

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

"Information related to mental health services" means all information and records compiled, obtained, or maintained in the course of providing services to either voluntary or involuntary recipients of services by a mental health service provider. This may include documents of legal proceedings under this chapter or RCW 71.34 or RCW 10.77, or somatic health care information. RCW 71.05.445(1)(a) and RCW 71.34.345(1)(a).

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

- There is evidence that a referred person may suffer from a mental disorder; and
- There is evidence that the person, as a result of a mental disorder, presents a likelihood of serious harm to him or herself, other persons, other's property, or
- The referred person may be gravely disabled and refuses to seek appropriate treatment options. RCW 71.05.150 (1) and RCW 71.34.710(1)

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

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

- Physical harm will be inflicted by an individual upon their own person, as evidenced by their threats or attempts to commit suicide or inflict physical harm on themselves;
- Physical harm will be inflicted by an individual upon another, as evidenced by behavior which has caused such harm or which places another person or persons in reasonable fear of sustaining such harm; or
- Physical harm will be inflicted by an individual upon the property of others, as evidenced by behavior which has caused substantial loss or damage to the property of others; or
- The individual has threatened the physical safety of another and has a history of one or more violent acts." RCW 71.05.020(23).

"Mental disorder" means any organic, mental or emotional impairment which has substantial adverse effects on an individual's cognitive or volitional functions." RCW 71.05.020(24). For a minor, the presence of alcohol abuse, drug abuse, juvenile criminal history, antisocial behavior or mental retardation alone is insufficient to justify a finding of "mental disorder" within the meaning of RCW 71.34.020(13). Likewise, an adult cannot be detained for evaluation and treatment or judicially committed solely by reason of a developmental disability, impairment by chronic alcoholism or drug abuse, or dementia, nor is he or she ineligible for detention or commitment based on the condition alone if the person otherwise meets the criteria for detention or judicial commitment. RCW 71.05.040.

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

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

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

- referral sources,
- risk assessments from the Department of Corrections (DOC),
- law enforcement,
- treatment providers and
- family at the time of referral and investigation, and/or
- other information that is immediately accessible.
- Other information may include an individual consumer’s crisis plan or other available treatment record, forensic evaluation reports (per RCW 10.77), criminal history records, risk assessments, and records from prior civil commitments.

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

“Single Bed Certification” refers to the process or result of a MHD designee request for a one-time waiver that allows involuntary treatment to occur in a facility that isn’t certified under WAC 388-865-0500 when:

- An involuntarily treated adult requires services not available in an E&T, a state hospital; or
- An involuntarily treated adult is expected to be ready for discharge from inpatient services within the next thirty days and being at a community facility would facilitate continuity of care, consistent with the consumer's individual treatment needs; or
- For involuntarily treated children, a hospital may request an exception to allow treatment in a facility not certified under WAC 388-865-0500 until the child's discharge from that setting to the community, or until the child transfers to a bed in a children's long-term inpatient program (CLIP). WAC 388-865-0526

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

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

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

REFERRALS FOR ITA INVESTIGATION

100–Referrals for an ITA investigation.

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

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

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

Assessment of urgency:

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

The DMHP accepts, screens and documents all referrals for an ITA investigation.

Documentation includes the:

- Name of the individual referred for an ITA investigation
- Name of caller and relationship to person being referred
- If a minor, the name of the parent or legal guardian
- Date and time of the referral call
- Facts alleged by the caller
- Available personal information about the person to be investigated, including, age, ethnicity, language, whether an advance directive may exist, whatever history may be available, and potential sources of support to resolve the crisis
- Contact information of the referent
- Names and contact information for potential witnesses
- The name of the person’s guardian or other healthcare decision-maker, if there is one.

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

- An investigation is warranted.
 - If so, the DMHP determines the need for a second person accompany the DMHP during the outreach, to ensure safety needs are met.
- Community Support Service emergency crisis intervention services or other community services are more appropriate; or if
- No service or investigation is required.

Availability of a resource shall not be the criteria for refusing to initiate an ITA investigation.

At the time of the referral, the DMHP provides information to the referent about DMHP procedures and protocols as it relates to the referral. This may include informing the referent whether a face-to-face interview can be expected or what further information is needed for a face-to-face interview. The DMHP discloses to the referring party additional information about an investigation only as authorized by law, including RCW 71.05.390, RCW 71.34.200 and RCW 70.02.050.

The DMHP always attempts to conduct a face-to-face evaluation prior to authorizing police or ambulance personnel to take a person to an inpatient evaluation and treatment facility. However, a DMHP may issue a custody authorization without an in-person evaluation when:

- A potentially dangerous situation exists; and
- Failure to take the person into custody as quickly as possible poses a threat to the person and/or others.

105–DMHP requirement to report suspected abuse or neglect.

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

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

- (1) For children, notify Child Protective Services at 1-866-END-HARM (1-866-363-4276¹).
- (2) For adults in a Residential Care Facility and DDD contracted Supportive Living Facilities notify the Residential Care Services Complaint Resolution Unit Hotline at 1-800-562-6078²;
- (3) Adult Family Homes website to report abuse is <http://www.adsa.dshs.wa.gov/APS/reportabuse.htm>³. Complaints should be called into the Complaint Resolution Unit: www.adsa.dshs.wa.gov/APS
- (4) For adults not in either a Residential Care Facility (#2 above) or an Adult Family Home (#3 above), reports are to be made to the following regional offices:

¹ Telephone number verified 10/13/2008 12:05 PM

² Telephone number verified 10/13/2008 12:06 PM

³ Website verified 11/4/2008 2:17 PM

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

DSHS Region	Counties in Region	APS Phone Number	APS TTY Number
Region 1	Spokane, Grant, Okanogan, Adams, Chelan, Douglas, Lincoln, Ferry, Stevens, Whitman, Pend Oreille	1-800-459-0421	1-509-568-3086 1-888-300-1273
Region 2	Yakima, Kittitas, Benton, Franklin, Walla Walla, Columbia, Garfield, Asotin	1-877-389-3013	1-800-973-5456
Region 3	Snohomish, Skagit, Island, San Juan, Whatcom	1-800-487-0416	1-800-843-8058
Region 4	King	1-866-221-4909	1-800-977-5456
Region 5	Pierce	1-800-442-5129	1-800-688-1165
	Kitsap	1-888-833-4925	1-800-688-1169
Region 6	Thurston, Mason, Lewis, Clallam, Jefferson, Grays Harbor, Pacific, Wahkiakum, Cowlitz, Skamania, Klickitat, Clark	1-877-734-6277	1-800-672-7091

The Department of Health reporting numbers are:

- **Facility & Services Licensing:** Concerns involving care or service to patient/resident in a setting licensed by DOH:
 - Hospitals, clinics, residential treatment facilities, etc:
DOH FSL Hotline; 1-800-533-6828
DOH FSL Fax Number Fax number: 360-236-2901
 - In-home Services (home care, home health, hospice agency) licensed by DOH:
DOH FSL Hotline: 1-800-633-6828
DOH FSL Fax number: 360-236-2901
- **Health Professionals Quality Assurance office general reporting numbers - concerns about licensed professionals:**
 - Phone: 360-236-4700
 - Fax: 360-236-4626

Reference: RCW 74.34.020(8), RCW 74.34.035, RCW 74.34.050, and RCW 74.34.053; RCW 26.44.020(3) and RCW 26.44.030(1)(a).

110–Referrals of a minor.

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

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

The DMHP may not detain any minor under the age of 13. RCW 71.34.700 and .710

The DMHP responds to all referrals for involuntary inpatient treatment, including but not limited to referrals of minors living in foster care, licensed residential care, hospitals, or juvenile correctional facilities;

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

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

Reference: RCW 71.34.020

115–Referrals of a person with dementia or a developmental disability.

The DMHP does not rule out a referral for investigation solely because of the presence of dementia, chronic alcoholism or drug abuse, or a developmental disability. RCW 71.05.040. A person with dementia, a developmental disability or another cognitive disorder may have a mental disorder as defined in RCW 71.05.020(24) if the person's impairment has substantial adverse effects on his or her cognitive or volitional functions.

Reference: RCW 71.05.020 (24)

120–Referrals of an adult from a licensed residential care facility.

The three broad categories of licensed care facilities are nursing homes, boarding homes (many are called assisted living facilities), and adult family homes.

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

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

restrictive alternative if the needs of the resident can be met and the safety of other residents can be protected through reasonable changes in the facility's practices or the provision of additional services. However, if the facility cannot protect the resident and the health and safety of all residents, the facility may not be an appropriate less restrictive alternative.

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

The following considerations inform the response of the DMHP:

- Whenever possible, the DMHP evaluates the person at the licensed residential care facility rather than an emergency room so that situational, staffing, and other factors can be observed.
- The DMHP confers with and obtains information from the facility on the reason for the referral, the level of safety threat to residents, and alternatives that may have been considered to maintain the individual at the facility. Alternatives could include changes in care approaches, consultations with mental health professionals/specialists and/or clinical specialists, reduction of environmental or situational stressors, and medical evaluations of treatable conditions that could cause aggression or significant decline in functioning.
- When appropriate, available, and consistent with confidentiality provisions, the DMHP obtains information from a variety of sources such as the resident, family members of the resident, guardians, facility staff, attending physician, the resident's file, the resident's caseworker or mental health provider, and/or the ombudsperson. All collateral contacts are documented, including the name, phone number, and substance of information obtained.
- If the investigation does not result in detention but the resident has remaining mental health care needs, the DMHP may also provide further recommendations and resources to the facility staff and others, including recommendations for possible follow-up services.
- If the resident is being evaluated in an emergency department and the investigation does not result in detention, the resident may have re-admission rights to the long-term care facility. If the DMHP has concerns about facility refusal to re-admit the resident, the DMHP notifies the Residential Care Services Complaint Resolution Unit (CRU) Hotline at 1-800-562-6078, TTY 1-800-737-7931.
- If during the course of the investigation the DMHP has concerns about mental health or other services provided by the facility, the DMHP notifies the Residential Care Services Complaint Resolution Unit (CRU) Hotline for follow-up at 1-800-562-6078.
- Adult Family Homes website to report abuse is <http://www.adsa.dshs.wa.gov/APS>

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

125–Referrals from a hospital emergency department.

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

Adults: The DMHP will initiate an ITA investigation within six hours of being referred by the facility. If a peace officer caused the person to be delivered to a crisis stabilization unit, an evaluation and treatment facility, or the emergency department of a local hospital pursuant to the officer's authority under the ITA, the DMHP must examine the person within three hours of his or her arrival, and determine whether he or she meets detention criteria within 12 hours of being referred by the facility.

Minors: The DMHP will make a face to face contact for the purposes of an ITA investigation within 12 hours of being referred by the facility.

RCW 71.05.050; RCW 71.05.153; and RCW 71.34.700

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

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

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

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

The DMHP evaluates the person to determine the presence of a mental disorder when it is clinically appropriate to do so or when the individual is no longer intoxicated by alcohol and/or drugs. If the person presents a likelihood of serious harm or is gravely disabled and the DMHP cannot establish that this is as a result of a mental disorder, the DMHP initiates a referral to the Designated Chemical Dependency Specialist. A referral to other appropriate treatment resources may also be considered in order to protect the person or others who are at risk of harm.

If the person is not at imminent risk of harm to themselves or others or is not gravely disabled, the DMHP refers the case to an appropriate treatment resource in the community.

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

135–Referrals of American Indians on tribal reservations.

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

140--Referrals of a person incarcerated in a jail or prison.

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

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

- (1) The DMHP maintains any information received in consumer clinical records including but not limited to, competency evaluations, court orders for commitment or involuntary treatment while in custody, mental health evaluations by jail staff, criminal history, and arrest reports.
- (2) The DMHP obtains information from the facility making the referral regarding: the person's criminal charges status (felony or misdemeanor); release date; jail hold (if any); and the correctional facility's policy. Prior to determining if detention is possible, the DMHP:
 - Identifies and explores issues that may impede commitment;
 - Suggests ways of resolving those issues. Note: Only persons who are eligible for release from the correctional facility can be detained to a treatment facility. The detention can be affected through emergency procedures or through the issuance of an Order to Appear.

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

- Coordinates the process with law enforcement personnel, County Department of Corrections (DOC) representatives, representatives of the legal system and other appropriate persons to the extent permitted by applicable law, including RCW 71.05.390.
- Discusses arrangements for transportation of the inmate to the evaluation and treatment facility along with information about the person. Note: The jail or prison may only release the inmate to a state hospital or to a consenting evaluation and treatment facility.

If an investigation is requested for an incarcerated person who has undergone competency evaluation under RCW 10.77 (Mentally Ill Offender), and the evaluator expresses the opinion that the person is a substantial danger to other persons, and should be kept under further control, an evaluation shall be conducted of such person under chapter 71.05 RCW. RCW 10.77.060(3)(f). To the extent possible, the DMHP will conduct the investigation shortly before the person's scheduled release date or when the correctional facility has the authority to release the person if the detention criteria are met. RCW 10.77.065(2) (c)

Dangerous Mentally Ill Offender (DMIO): The Washington State Department of Corrections (DOC) may request an investigation for a dangerous mentally ill offender incarcerated in a DOC facility. In order to qualify under RCW 72.09.370, the offender has been:

- designated by the DOC through the DMIO Statewide Review Committee as meeting criterion for dangerousness AND has either
- been diagnosed with a mental disorder under RCW 71.05.020(24), or

- is enrolled with the DSHS Division of Developmental Disabilities (DDD) under RCW 71A.16.020.

The investigation shall occur not more than ten days, nor less than five days, prior to the actual release of the Designated DMIO. A DMHP must conduct a second investigation on the day of release if requested by the DMIO Committee. When conducting an evaluation of a DMIO person, the DMHP shall consider the offender's criminal history, his or her history of judicially required or administratively ordered antipsychotic medication while in confinement, and any known history of involuntary civil commitment. RCW 72.09.370(3). The fact that an offender is identified as a DMIO does not change the commitment criteria under RCW 71.05. A DMIO may be committed because he or she is gravely disabled as well as because he or she presents a likelihood of serious harm.

When the DMHP recommends taking an incarcerated person into custody pursuant to RCW 71.05 or RCW 72.09.370 because the incarcerated person represents a danger to others, the DMHP must specifically document that the recommendation is based on an opinion that the incarcerated person represents a danger to others.

145–Referrals of a minor charged with possessing firearms on school facilities.

The DMHP examines and evaluates minors referred by law enforcement after being charged with the illegal possession of firearms on school facilities for possible involuntary detention under RCW 71.05 or RCW 71.34. Note: For purposes of this section only, “Minor” is defined as a person between the ages of 12 and 21.

- The evaluation shall occur at the facility in which the minor is detained or confined.
- When practicable, and as allowed by applicable privacy laws such as the Family Educational Rights and Privacy Act (FERPA)(20 U.S.C. § 1232g; 34 CFR Part 99), the DMHP should request from the school facility and school district all prior risk assessments and weapons or violence incident reports concerning the minor which are in the possession of the school facility or school district.
- The DMHP may refer the minor to the County Designated Chemical Dependency Specialist for examination and evaluation under the chemical dependency commitment statute, RCW 70.96A.
- The DMHP provides the result of the examination to the charging criminal court for use in the criminal disposition.
- The DMHP, to the extent permitted by law, notifies a parent or guardian of the minor being examined of the fact of the examination and the result.
- The DMHP, if appropriate, may refer the minor to the local RSN, DSHS or other community providers for other services to the minor or family.
- When clinically appropriate, the DMHP should request the following, 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.

INVESTIGATION PROCESS

200–Rights of a person being investigated.

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

When a DMHP investigates a person for possible involuntary detention the DMHP shall:

- Identify themselves by name and position;
- Inform the person of the purpose and possible consequences of the investigation;
- Inform the individual that he or she has the right to remain silent, and that any statement made may be used against him or her;
- Inform the person being investigated that he or she may speak immediately with an attorney. However, the DMHP is not obligated to stop the investigation while the individual who is being investigated attempts to consult with an attorney if a likelihood of serious harm is imminent.
- For individuals who are not proficient in English, rights should be provided in writing in a language that the individual is able to understand or read by an interpreter, if available during the investigation. The DMHP reads the rights to the individual in their entirety if requested by the person being investigated.
- Under RCW 11.92.043(5) and RCW 11.94.010(3) neither a guardian nor any other healthcare decision-maker can consent to involuntary treatment, observation or evaluation on behalf of the individual.

205–Process for conducting an ITA investigation.

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

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

As soon as reasonably possible, the DMHP attempts to contact any known individuals with the power to make health care decisions to inform them of the investigation and rights of the person being investigated.

Note: A health care decision-maker's powers depend on the authorization in the legal instrument. If the healthcare decision-maker is authorized to care for and maintain the person in a setting least

restrictive to the person's freedom, the health care decision-maker could consent to additional treatment or placement in a less restrictive setting appropriate to his/her personal care needs

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

207–Availability of resource.

“Single Bed Certification” refers to the process or result of a MHD designee request for a one-time waiver that allows involuntary treatment to occur in a facility that isn't certified under WAC 388-865-0500 when:

- An involuntarily treated adult requires services not available in an E&T, a state hospital; or
- An involuntarily treated adult is expected to be ready for discharge from inpatient services within the next thirty days and being at a community facility would facilitate continuity of care, consistent with the consumer's individual treatment needs; or
- For involuntarily treated children, a hospital may request an exception to allow treatment in a facility not certified under WAC 388-865-0500 until the child's discharge from that setting to the community, or until they transfer to a bed in a children's long-term inpatient program (CLIP).

Reference: WAC 388-865-0526

Availability of a detention bed will not be a factor in determination of detention. The priority is always to locate a bed in the client's county of residence. If the client meets the criteria the DMHP can explore the following options after exploring local resources.

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

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

210–Evaluation to determine the presence of a mental disorder.

“Mental disorder” means any organic, mental or emotional impairment which has substantial adverse effects on an individual's cognitive or volitional functions.” RCW 71.05.020(24) For a minor, the presence of alcohol abuse, drug abuse, juvenile criminal history, antisocial behavior or mental retardation alone is insufficient to justify a finding of “mental disorder” within the meaning of RCW 71.34.020(13).

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

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

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

A formal diagnosis of a mental illness is not required to establish a mental, emotional or organic impairment as defined in RCW 71.05.020(24) or RCW 71.34.020(13), but only that the disorder has a substantial adverse effect on cognitive or volitional functioning.

Note: A person who has a chronic condition such as developmental disability, impairment caused by chronic alcoholism or drug abuse, or dementia cannot be detained merely because of the existence of the condition. However, if the condition causes a person to be gravely disabled or to present a likelihood of serious harm, the person may be detained if there are no less restrictive alternatives available.

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

In the case of a minor, the DMHP also considers the individual's developmental age in relationship to his or her chronological age.

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

215—Assessment to determine presence of dangerousness or grave disability.

"Likelihood of serious harm" as defined in RCW 71.05.020 (23) means a substantial risk that

- *Physical harm will be inflicted by an individual upon his or her own person, as evidenced by threats or attempts to commit suicide or inflict physical harm on oneself;*
- *Physical harm will be inflicted by an individual upon another, as evidenced by behavior which has caused such harm or which places another person or persons in reasonable fear of sustaining such harm; or*
- *Physical harm will be inflicted by an individual upon the property of others, as evidenced by behavior which has caused substantial loss or damage to the property of others; or*
- *The individual has threatened the physical safety of another and has a history of one or more violent acts." RCW 71.05.020(23). Note: This provision applies only to adults, as there is no similar criterion for minors in RCW 71.34.*

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

- *Is in danger of serious physical harm resulting from a failure to provide for his or her essential human needs of health or safety RCW 71.05.020(17)(a); or*
- *Manifests severe deterioration in routine functioning evidenced by repeated and escalating loss of cognitive or volitional control over his or her actions and is not receiving such care as is essential for his or her health or safety." RCW 71.05.020(17)(b) However, persons cannot be detained on the basis of a severe deterioration in routine functioning unless the detention is shown to be essential for the individual's health or safety. (In re: Labelle (1986), See Appendix K.)*

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

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

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

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

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

220–Use of reasonably available history.

“Reasonably Available History” means history which is made available to the DMHP by

- referral sources,
- risk assessments from the Department of Corrections (DOC),
- law enforcement,
- treatment providers and
- family at the time of referral and investigation, and/or
- other information that is immediately accessible.

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

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

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

- Advance directives previously prepared by the referred person. When the DMHP becomes aware of an advance directive, he or she shall access and respect the criteria as it is stated in the document;
- Prior recommendations for evaluation of the need for civil commitment when the recommendation is made pursuant to an evaluation conducted under chapter 10.77 RCW;
- Violent acts, which means homicide, attempted suicide, nonfatal injuries, or substantial damage to property. RCW 71.05.020(39) History of violent acts refers to the period of ten years prior to the filing of a petition, not including time spent in a mental health facility or in confinement as a result of a criminal conviction, but including any violent acts committed in such settings. RCW 71.05.020(19);
- Prior determinations of incompetency or insanity under RCW 10.77;
- Prior commitments made under RCW 71.05; and
- For Dangerous Mentally Ill Offender (DMIO) consumers, criminal history and a history of involuntary medication orders. RCW 72.09.370(3).

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

The DMHPs need to compile reasonably available history is always to be considered in light of the intent of chapter 71.05 RCW to provide prompt evaluation and timely and appropriate treatment.

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

DMHP efforts to obtain reasonably available history, whether successful or not, should be documented.

Reference: RCW 71.05.212 and RCW 71.05.245

225–Interviewing witnesses as part of an investigation.

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

A DMHP:

- Interviews available witnesses who may have pertinent information and/or evidence; and
- Assesses the specific facts alleged and the reliability and credibility of any individual providing information that will be used to determine whether to initiate detention.

***“Credibility”** means the state of being believable or trustworthy.*

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

The DMHP exercises reasonable professional judgment regarding which witnesses to contact before deciding if a person should be detained. This may include whether the witness's story is consistent, plausible, free from bias or personal interest and able to be corroborated by other individuals or physical evidence; and

A DMHP informs witnesses that they may be required to testify in court under oath and may be cross-examined by an attorney.

230–Consideration of less restrictive alternatives to involuntary detention.

When considering whether to utilize less restrictive alternatives to involuntary detention, the DMHP assesses whether the client, in good faith, will accept those services and whether sufficient environmental controls and supports are in place that reasonably ensure safety of the client and community. In the case of a minor, the DMHP also considers the individual's developmental age in relationship to his or her chronological age.

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

“**Good faith**” implies the individual expresses a sincere (i.e., without coercion, deception or deceit) willingness to abide by the procedures and treatment plan prescribed by the treatment facility and professional staff to whom the person has “in good faith volunteered.” Also, the individual does not have a history which belies this stated intent, nor a cognitive impairment that prevents him or her from making this decision.

- For a minor, the good faith commitment by the minor’s parent or legal guardian is considered when the investigation concerns a cognitively impaired person who is unable to provide good faith informed consent to less-restrictive treatment options.
- The DMHP determines whether the person’s healthcare decision maker listed under RCW 7.70.065 can and will consent to the less-restrictive alternative treatment on behalf of the person.

“**Sufficient environmental controls are in place**” means that a person is receiving, or is likely to receive such care from responsible persons as is essential to his/her health and safety and the safety of others.

Reference: Detention of Chorney, 64 Wn. App. 469, 477, 825 P.2d 330 (1992), See Appendix K.

235–Referring a person for services when the decision is not to detain.

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

- Determines whether a direct referral to community support services, emergency crisis intervention services or other community services is appropriate in order to assure continuity of care and whether it is necessary to re-contact the person if he/she does not follow through with recommended treatment;
- Advises the service provider to contact the DMHP if the individual refuses to participate in treatment, if the decision not to detain the individual was based on the individual accepting less-restrictive treatment;
- Either renews or facilitates contact with the person when it is clinically necessary based on consultation with the service provider.

Note: For minors, a parent may request court review of the DMHP’s decision not to detain that minor. In this circumstance, the parent has the right to access the DMHP’s report or notes to present in evidence at the court hearing. RCW 71.34.

DETENTIONS

300–Rights of a person being detained.

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

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

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

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

305–Detention in the absence of imminent danger.

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

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

RCW 71.05.150(1).

310–Detention of an adult from a licensed residential care facility.

The following process applies to an individual being detained from a licensed residential care facility to an inpatient evaluation and treatment facility:

- The DMHP requests the facility staff to provide the appropriate documentation, including current medication(s) and last dosage, durable medical equipment used by the person, and relevant medical information to the psychiatric staff at the inpatient evaluation and treatment facility.
- A DMHP may arrange the transportation of a person from a licensed residential care facility.

315–Detention to a facility in another county.

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

The detaining DMHP must also agree to testify, if necessary, at any court hearings, and may arrange for any witnesses needed for the court hearing to be available to testify at the hearings. Along with direct contact with the facility, the detaining DMHP should also contact the Office of the Prosecuting Attorney or the DMHP Court Liaison, for that county as soon as practicable, in order to coordinate witnesses and to become familiar with the procedures that will be used in the hearing (e.g., whether testimony by telephone is available).

A phone list of each county's Prosecuting Attorney Office, including those with separate ITA units, is attached as Appendix B.

320–Documentation of petition for initial detention.

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

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

Reference: RCW 71.05.160 and RCW 71.34.050(2)

325–Notification if detained person is developmentally disabled.

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

Reference: RCW 71.05.630(2)(g)

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

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

- If a person who has been detained is a foreign national, the DMHP must advise the individual of his/her rights to contact consular officials from his/her home country and helps facilitate that contact if the person being detained desires it. (Vienna Convention)
- If the person who has been detained is a foreign national and is legally not competent the DMHP must inform the consular official from that country without delay, whether or not the detained person wants the consular official notified. (Vienna Convention)
- If the person who has been detained is a citizen of any of the nations with Bilateral Agreements, the DMHP must inform the consular official from that country without delay, whether or not the detained person wants the consular official notified. Nations with Bilateral Agreements, and consular contacts, are listed in Appendix H.
- In all cases, the DMHP documents the date and time the foreign national was informed of his/her consular rights, the date and time any notification was sent to the relevant consular officer, and a record of any actual contact between the foreign national and the consular officer.

Additional information on the Vienna Convention and related bilateral agreements can be found at the U.S. State Department web site: <http://www.travel.state.gov/law/notify.html>.⁴

⁴ Functioning hyperlink as of 10/31/08 10:32 AM

LESS RESTRICTIVE ALTERNATIVE COURT ORDERS

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

400–Rights of a person being detained for a revocation hearing.

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

- He/she will be released within five days unless a judicial hearing is held. RCW 71.05.340(3)(c); and
- A revocation hearing to determine whether he/she will be detained for up to the balance of his/her commitment must be held within five days following the date of the petition to revoke the CR/LRA Court Order.
- Minors will be released within seven days unless a judicial hearing is held. RCW 71.34.710(3)

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

The office of the DMHP advises certified mental health outpatient providers by documenting the person's compliance with his/her CR/LRA Court Order and stresses the importance of:

- Closely monitoring CR/LRA Court orders by documenting in the consumers' clinical record the need for revocation as per WAC 388-865-0466.
- Providing DMHPs with information needed to support petitions for further court-ordered less restrictive treatment.

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

Reference: WAC 388-865-0466

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

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

- During the current period of court ordered treatment the person has threatened, attempted, or inflicted physical harm upon the person of another, or substantial damage upon the property of another, and as a result of mental disorder presents a likelihood of serious harm;
- Was taken into custody as a result of conduct in which he or she attempted or inflicted serious physical harm upon the person of another, and continues to present, as a result of mental disorder a likelihood of serious harm;
- Is in custody pursuant to RCW 71.05.280(3) and as a result of mental disorder presents a substantial likelihood of repeating similar acts considering the charged criminal behavior, life history, progress in treatment, and the public safety; or
- Continues to be gravely disabled while on a CR/LRA Court Order.

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

Reference: RCW 71.05.320(3)

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

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

- The DMHP evaluates the individual’s current condition and must also consider the cognitive and volitional functioning of the individual prior to court ordered treatment.
- The DMHP assesses if the individual would accept treatment, or take medication if not on a court order and whether the individual has a history of rapid decompensation when not in treatment. The DMHP considers the individual’s history as well as their pattern of decompensation.
- If the petitioning DMHP is to provide a declaration as an examining mental health professional, the case manager shall include a declaration by an examining physician. If the petitioning DMHP is not providing a declaration, the case manager is to include either declarations from two examining physicians or an examining physician and an examining mental health professional. RCW 71.05.
- The DMHP may file a petition for extending a CR/LRA Court Order on the grounds of grave disability if:

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

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

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

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

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

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

Note RE: Ability to file a new case rather than revoke: If a person meets criteria for revocation but is also gravely disabled or presents a likelihood of serious harm, a DMHP has the option of initiating a new 72 hour detention rather than revoking a CR/LRA court order. Superior Court Rule MPR 4.4.

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

- RCW 71.05.340 (3)(b): A DMHP may apprehend and take into custody and temporarily detain in an evaluation and treatment facility, in or near the county in which the individual is receiving outpatient treatment,
- if the DMHP determines:
 - The person fails to comply with the terms and conditions of his/her CR/LRA Court Order;
 - The person experiences substantial deterioration in his/her condition,
 - There is evidence of substantial decompensation with a reasonable probability that the decompensation can be reversed by further inpatient treatment; or
 - The person poses a likelihood of serious harm.
- In this circumstance, the DMHP must file the revocation petition, and may rely solely on the determination made by the outpatient treatment provider.
- The written declaration from the treatment provider should include the date and time the treatment provider last personally evaluated the patient, the specific conditions of the

CR/LRA Court Order that have been violated, specific behaviors that demonstrate substantial deterioration, and “lesser restrictive” actions taken by the case manager to avoid revocation and re-hospitalization, such as a different treatment approach or outreach by the case manager.

- If a subsequent revocation hearing is required, the outpatient treatment provider is expected to testify at the hearing regarding the person's lack of compliance with the conditions of the CR/LRA Court Order and/or the person's substantial deterioration which has resulted in increased likelihood of serious harm to self or others. If the county where the hearing is to occur requires in-person testimony, the DMHP serves the witnesses with a subpoena in time to be present for the hearing.
- In some cases, it is appropriate for the DMHP to file the revocation petition, and to rely solely on the determination made by the outpatient treatment provider. This occurs when in the opinion of the treatment provider, the person presents an increased risk of harm, which has resulted from the person's lack of compliance with the conditions of the CR/LRA Court Order or substantial deterioration has occurred as documented in the outpatient treatment provider's written statement, affidavit or declaration.

Note: MPR 5.2 provides that, “The notice of apprehension and detention and the petition for hearing required in RCW 71.05.340, shall be filed in the county ordering the commitment from which the person was conditionally released.” The court may, if it finds good cause, order the revocation proceedings “transferred to the court in the county in which the person was receiving outpatient care or the county of the person's residence.” Therefore, if the revoked individual is placed in an E&T in a county where the CR/LRA order did not originate, or where the patient does not live or does not receive treatment, that county's court may not be able to obtain venue to preside over the revocation proceedings. MPR 5.2. The DMHP should contact the Office of the Prosecuting Attorney or designated mental health court liaison when out-of-county placement occurs to determine if this is an issue.

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

Note: This section applies only to Conditional or Less Restrictive Alternative Release orders under RCW 71.05, and NOT Conditional Release Orders under RCW 10.77, Criminally Insane – Procedures.

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

- When detaining a person under criteria RCW 71.05.340 (3) (a), the DMHP documents the facts used to make the determination to detain, including names and contact information for all witnesses;
- When detaining a person under criteria RCW 71.05.340 (3) (b), based on information from the outpatient treatment provider, the DMHP attaches the facts demonstrating that the individual presents an increased likelihood of serious harm to self or others, and attaches the supporting documents or declaration of the treatment provider, including the names and contact information for all witnesses.
- The DMHP serves the papers and takes the person into custody;

- The DMHP completes and files the Petition for Revocation and accompanying paperwork indicating which grounds are being relied upon for revocation, and attaches a copy of the CR/LRA Court Order.
- The DMHP informs the outpatient treatment provider that their court testimony may be required at a subsequent revocation hearing. If the county where the hearing is to occur requires in-person testimony, the DMHP serves the witnesses with a subpoena in time to be present for the hearing.

430–Less Restrictive Alternative court orders for minors.

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

1. If the professional person in charge of an outpatient treatment program, a DMHP, or the secretary determined that a minor is failing to adhere to the conditions of the court order for less restrictive alternative treatment or the conditions for the conditional release, or that substantial deterioration in the minor’s functioning has occurred, the DMHP, or the secretary may order that the minor be taken into custody and transported to an inpatient evaluation and treatment facility.
2. The DMHP or the secretary shall file the order of apprehension and detention and serve it upon the minor and notify the minor’s parent and the minor’s attorney, if any, of the detention within two days of return. At the time of service the minor shall be informed of the right to a hearing and to representation by an attorney. The DMHP or the secretary may modify or rescind the order of apprehension and detention at any time prior to the hearing.
3. Similar to adults. Seven days are called out.
4. The person is in danger of serious physical harm resulting from a failure to provide for his/her essential human needs of health or safety, or for a minor, is not receiving such care as is essential to his/her health and safety from a responsible adult; or
 - The person manifests severe deterioration in routine functioning evidenced by repeated and escalating loss of cognitive or volitional control over his/her actions and is not receiving such care as is essential to his/her self and safety.

Note: RCW 71.34.780 provides very little guidance on Less Restrictive Court Orders for minors.

- The DMHP may file a petition for revocation of a minor if: The minor is failing to adhere to the conditions of the CR/LRA Court Order; or
- Substantial deterioration in the minor’s routine functioning has occurred.

Reference: RCW 71.34.780

CONFIDENTIALITY

500–General provisions on confidentiality.

Information gathered by DMHPs is confidential under Washington State law and may not be disclosed to anyone unless specifically permitted by law, by a signed release, or by a court order signed by a judge. Statutory provisions related to confidentiality of mental health information and records can be found in multiple locations including, but not limited to RCW 71.05.155; RCW 71.05.390, RCW 71.05.445, RCW 71.05.610 through 630; RCW 10.77.065 and RCW 10.77.210; and in the case of minors, RCW 71.34.340.

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

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

Referrants may be advised that the investigation has been completed.

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

Whenever possible, the DMHP must inform a responsible member of the individual's family, guardian, and/or healthcare decision-maker when an individual is detained for evaluation and treatment. For minors, the parent(s) or legal guardian of the minor must be notified of the fact of detention. Notice must include information regarding the patient's rights and the court process.

Reference: RCW 71.05.360 (5) and RCW 71.34.340(13)

510–Sharing information with law enforcement.

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

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

- If there is a crisis or emergent situation that poses a significant and imminent risk to the public. In this case, any information considered relevant to the situation or necessary for its resolution may be shared with corrections or law enforcement. RCW 71.05.390(11).
- If a person being evaluated has threatened the health and safety of another, or has repeatedly harassed another. In this case, the date of commitment, admission, discharge, or release may be disclosed, as well as any absence from a facility (authorized or unauthorized), may be shared with the appropriate law enforcement agency, as well as with the person threatened and/or harassed. Any information that is pertinent to the threat or harassment may also be disclosed. RCW 71.05.390(10).
- If law enforcement made the referral, and they make a request to find out the results of the investigation. In this case, the results must be disclosed in writing, including a statement of the reasons why the person was or was not detained. This written disclosure must occur within 72 hours of the later of the completion of the investigation or the request for the results. RCW 71.05.390(7)(a).
- If a person escapes from custody. In this case, as much information may be disclosed as is necessary for law enforcement to carry out their duties in returning the patient. RCW 71.05.390(7)(b)(iii).
- If law enforcement requests information to help them carry out their duties. The fact, place, and date of involuntary commitment may be disclosed, as may the date of discharge or release and last known address. Additional information may be disclosed if notice is given to the person and his or her attorney, and a showing is made by clear, cogent, and convincing evidence that the information is necessary for law enforcement to carry out their duties and that law enforcement will maintain appropriate safeguards for strict confidentiality. RCW 71.05.390(7)(b).
- If law enforcement requests information as part of an investigation of an Unlawful Possession of a Firearm case (RCW 9.41.040(2)(a)(ii)). In this case, the only items that may be disclosed are the fact, place, and date of involuntary commitment; an official copy of the commitment orders; and an official copy of any notice (written or oral) given to the person that he or she is now ineligible to possess a firearm. RCW 71.05.390(17).

515–Sharing Information with Department of Corrections personnel.

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

1. Persons supervised by DOC who have failed to report or who are involved in an emergent situation that poses significant risk to the public or the offender. At DOC's oral request for information, the DMHP shall provide information regarding where the person may be found, including his or her address, and a statement as to whether the person is or is not being treated. If a written request for information is made, all "relevant records and reports" necessary for DOC personnel to carry out their duties may be disclosed. RCW 71.05.445 (2)(b)
2. Other persons subject to DOC reports or supervision. At DOC's written request, for the purposes of either completing presentence investigations or risk assessments, general assessing of an offender's risk to the community, supervising an offender (either in prison or in the community),

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

Information related to mental health services includes "all information and records compiled, obtained, or maintained in the course of providing services to either voluntary or involuntary recipients of services by a mental service provider." This may include documents of legal proceedings under RCW 71.05, 71.34 or 10.77, or "somatic health care information." It includes all "relevant records and reports."

RCW 71.05.445 (1)(a); RCW 71.05.445 (4).

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

Additionally;

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

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

520–Sharing information to protect identified persons.

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

- Call the person who has been threatened or harassed. Release information as is pertinent to the threat or harassment, date of detention, date of discharge, and date of authorized or unauthorized absence from the detention facility.
- Document the notification in the case write up. Make sure that the fact of release is noted in the case.
- Call appropriate law enforcement agencies (both the law enforcement agencies of the victim and of the suspect).

Reference: RCW 71.05.390 (10) and see Appendix M.

525–Sharing information with adult/child protective services.

To the extent permitted or required by applicable law, the DMHP should notify the Adult Protective Service, Residential Care Services Complaint Resolution, or Child Protective Services worker making the referral whether an investigation will be performed, of the fact, place, and date of the investigation and whether the person was detained. Information disclosed by Adult Protective Services/Child Protective Services is confidential and protected under RCW 74.34.095 and chapter 13.50 RCW.

Reference: RCW 71.05.390(general confidentiality statute pertaining to mental health records)

APPENDICES

Appendix A: Lists of 2008 Protocol Update Workgroup Members

Washington Association of Designated Mental Health Professionals

Ian Harrel WACDMHP
Robby Pellett WACDMHP

Regional Support Networks

Sandy Whitcutt North Sound Mental Health Administration
Jo Ellen Watson King County Crisis & Commitment
Marlene Burrows Clark County RSN

Observers with Comments:

Kevin Black Staff Counsel, Senate Human Services and Corrections Committee
Bernie Ryan Senior Counsel for Senate Democratic Caucus

Department of Social and Health Services:

David Kludd HRSA/Mental Health Division
Anthony O'Leary HRSA/Mental Health Division
Paul Bigelow HRSA/Mental Health Division
Lois Thadei HRSA/Mental Health Division
Gregory Twiddy HRSA/Mental Health Division
Dan Peterson ADSA/Division of Developmental Disabilities
Carol Sloan ADSA/Home and Community Services
Victoria Roberts HRSA/Division of Alcohol & Substance Abuse
Phyllis Coolen DSHS/HRSA
Merja Kehl DSHS/Children's Administration

Other Stakeholders:

Jan Dobbs Spokane Mental Health/Emergency Services
Judy Snow Pierce County Human Services/Emergency Services
David Asia Skagit County Human Services
Michael Walls DSHS/Department of Corrections
Robbie MacMannus Compass Health/Emergency Services
Pam Hutchinson Compass Health/Emergency Services
Eason Henderson Snohomish County ITA
Yolanda Reyes Grant County Mental Health/Emergency Services
Ethan Rogers King County Prosecuting Attorney's Office
Chris Jennings Pierce County Division of Assigned Counsel

Appendix B: County Prosecutors Office Phone List

CIVIL COMMITMENT DPAs IN WASHINGTON STATE

<u>COUNTY</u>	<u>PROSECUTING ATTORNEY/ADDRESS/PHONE</u>
Attorney General's Office	Dorothy Seaborne-Taylor, Paralegal 7141 Cleanwater Dr. SW P.O. Box 40124 Olympia, WA 98504-0124 (360) 586-6538 (360) 586-6658 (fax) (updated 10/08)
Adams County	210 W. Broadway Ritzville, WA 99169 (509) 659-3219
Asotin County	135 2 nd St. P.O. Box 220 Asotin, WA 99402 (509) 243-2061
Benton County	Shannon Slaght 7122 W. Okanogan Place, Bldg. A Kennewick, WA 99336 (509) 735-3591 (509) 222-3705 (fax) (updated 10/08)
Chelan County	401 Washington St. P.O. Box 2596 Wenatchee, WA 98807 (509) 667-6202
Clallam County	223 E. 4 th St., Ste. 11 Port Angeles, WA 98362 (360) 417-2301
Clark County	Bernard Veljacic, DPA 604 W. Evergreen P.O. Box 5000 Vancouver, WA 98666-5000 (360) 397-2478 (updated 10/08)
Columbia County	116 N. 3 rd St. P.O. Box 270

	Dayton, WA 99328 (509) 382-1197 (updated 10/08)
Cowlitz County	312 S.W. 1st Street Kelso, WA 98626 (360) 577-3074 (updated 10/08)
Franklin County	Andrea Salinas, DPA / Ryan Verhulp, DPA P.O. Box 1160 Pasco, WA 99301-1160 (509) 545-3543 For COV call: Debbie (updated 10/08)
Garfield County	809 Columbia St. P.O. Box 820 Pomeroy, WA 99347 (509) 843-3082
Grant County	35 "C" St. NW P.O. Box 37 Ephrata, WA 98823 (509) 754-2011 x455
Grays Harbor County	Jennifer Wieland, DPA P.O. Box 550 Montesano, WA 98683 (360) 249-3951 (updated 10/08)
Island County	101 NE 6 th St. P.O. Box 5000 Coupeville, WA 98239 (360) 679-7363
Jefferson County	David Alvarez dalvarez@co.jefferson.wa.us 1820 Jefferson St. P.O. Box 1220 Port Townsend, WA 98368 (360) 385-9219
King County	Ethan Rogers, DPA Claire Gilchrist, DPA Anne Beardsley, DPA HMC Box 359967 325 - 9 th Avenue

	Seattle, WA 98104 (206) 296-8936 Marsha Luiz, Paralegal
Kitsap County	Phil Bacus, DPA 614 Division St., MS 35 Port Orchard, WA 98366 (360) 337-7271 direct (updated 10/08)
Kittitas County	205 W. 5 th Ave., #213 Ellensburg, WA 98926 (509) 962-7520
Klickitat County	Craig Juris, DPA 205 S. Columbus Ave. MS-CH-18 Goldendale, WA 98620 (509) 773-5838 (updated 5/08)
Lewis County	Glen Carter, DPA Civil Division 345 W. Main St. Chehalis, WA 98532 (360) 740-1240 (360) 740-1497 (fax) (updated 10/08)
Lincoln County	450 Logan St. P.O. Box 874 Davenport, WA 99122 (509) 725-4040
Mason County	521 N. 4 th St. P.O. Box 639 Shelton, WA 98584 (360) 427-9670 x417
Okanogan County	237 Fourth Ave. N. P.O. Box 1130 Okanogan, WA 98840 (509) 422-7280
Pacific County	David Burke, DPA Brandy Hooper, Paralegal 300 Memorial Dr. P.O. Box 45 South Bend, WA 98586

(360) 875-9361
(360) 875-9362 (fax)
(updated 10/08)

Pend Oreille County S. 229 Garden Ave.
P.O. Box 5070
Newport, WA 99156
(509) 447-4414

Pierce County Ken Nichols, DPA
946 County-City Building
Tacoma, WA 98402
(253) 798-4348
Janine McSparren, Legal Assistant
(253) 798-4342
(253) 798-4544 (fax)
(October 2008)

San Juan County 350 Court St.
P.O. Box 760
Friday Harbor, WA 98250
(360) 378-4101

Skagit County Melinda Miller, DPA
Debbie Nicholson, Legal Asst.
360-419-3452 (direct line)
605 S. Third St.
Courthouse Annex
Mount Vernon, WA 98273
(360) 336-9460
(360) 336-9497 (fax)
Court Tues and Thurs only
As of 8/08 - For COV call: (360) 336-9460 x3351
(updated 4/08)

Skamania County Christopher Lanz, DPA
P.O. Box 790
240 NW Vancouver Ave.
Stevenson, WA 98468
(509) 427-3796
(updated 4/08)

Snohomish County Michelle Gehlsen
(425) 388-3747
(425) 273-5373 (cell)
Kathy, Secretary (425) 388-6350
(425) 388-7172 (fax)
For COV call:
Cassie or Tony

(425) 388-7215
(425) 388-7216 (fax)
3000 Rockefeller Ave
MS 305
Everett, WA 98201
(updated 10/08)

Spokane County
Neil Korbas, DPA
Donna, Secretary
W. 1115 Broadway Ave.
Spokane, WA 99260
(509) 477-2879
(509) 477-3987 (fax)
(October 2008)

Stevens County
215 S. Oak St. #114
Colville, WA 99114
(509) 684-7500

Thurston County
Donald R. Peters, Jr., DPA
2000 Lakeridge Dr. SW, Bldg. 2
Olympia, WA 98502
(360) 709-3230
(360) 754-3358 (fax)
(updated 10/08)

Wahkiakum County
64 Main St.
P.O. Box 397
Cathlamet, WA 98612
(360) 795-3652

Walla Walla County
240 W. Alder, Ste. 201
Walla Walla, WA 99362-2807
(509) 524-5445

Whatcom County
County Courthouse, Second Floor
311 Grand Avenue
Bellingham, WA 98225-4079
(360) 676-6784 x50709
Terri Zemel, Paralegal
(360) 738-2532 (fax)
(updated 10/08)

Whitman County
400 N. Main St.
P.O. Box 30
Colfax, WA 99111
(509) 397-6250

Yakima County
Dan Polage, DPA

Dan.polage@co.yakima.wa.us
128 - N. 2nd St., Room 329
Yakima, WA 98901
(509) 574-1200
(updated 10/08)

Appendix C: Requirements of Licensed Residential Care Facilities

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

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

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

Following hyper-links lead to websites with information on licensed residential care facilities:

Key laws and regulations for:

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

- Descriptions of Adult Family Homes, Boarding Homes and Nursing Homes: <http://www.adsa.dshs.wa.gov/pubinfo/housing/other>

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

Appendix D: DMHP Intervention Checklist

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

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

1. Has the facility nurse or resident's treating physician been consulted regarding the resident's needs? What recommendations were provided? How has the resident responded? If recommendations have not been implemented, what is the reason?
2. What lab work, if any, has been done to rule out medical issues? Example: UA, electrolytes, TSH, B12, diagnosis, folic acid, medication levels.
3. Has a pain assessment been completed?
4. Is there any possibility of constipation, dehydration, GI distress or O₂ deficiency?
5. What medications does the resident receive? Have there been any medication changes recently? If so, do they correlate in any way to the behavioral changes?
6. Has the resident experienced any environmental or social changes recently? For example, any recent losses, change of residence?
7. Are PRN medications being used as ordered? Are they effective? If so, has the treating physician considered ordering as routine medications?
8. Are behavior changes documented? What interventions have been attempted and what is the documented outcome? Does documentation address duration, intensity and frequency of the behaviors as necessary to assess effectiveness of current interventions? For a person in a nursing home, has the person been identified as having indicators of mental illness on the Pre-Admission Screening Resident Review (PASSR) evaluation?
9. What specifically deescalates the behaviors? Example: staff or family attention or presence, being left alone, removal from/of visual or auditory stimuli. Have all alternatives utilizing these options been explored?
10. Has the family, as appropriate, been notified of the problem and involved in interventions or response plans?
11. Have hospice services been considered as a resource to assist in end-of-life concerns?

BEHAVIORAL INTERVENTION SUGGESTIONS

1. Remove the resident from excessive auditory and visual stimuli. Provide a calm, quiet, peaceful space for the resident to regroup.
2. Use a calm, quiet voice, no matter what the resident's voice tone or level is.
 - a. Allow time for the resident to vent before trying to intervene, unless danger to self or others is involved.

- b. Offer time for the resident to communicate his/her concerns, even if he or she is irrelevant or delusional.
3. Increase consistent structure in the resident's daily routine.
4. Redirect the resident toward a new interest, rather than away from the object, person or topic involved in the behavior.
 - a. Reorient the resident without disagreeing with him/her.
5. Offer rest and position change. Change the surrounding, the resident's room assignment or roommate.
6. Assign the resident tasks that meet their strength and history. Short, repetitive tasks are often best.
7. Go along with, or accommodate, a fixed delusion or preservative thought rather than fight it.
8. Let the resident tell you what will help and work with the family or support system to find creative ways to make it happen. Example: "I want to go home"—allow the family to recreate as much as possible the one room or space in the house that resident found the most comfortable.

Utilize PRN medications as ordered.

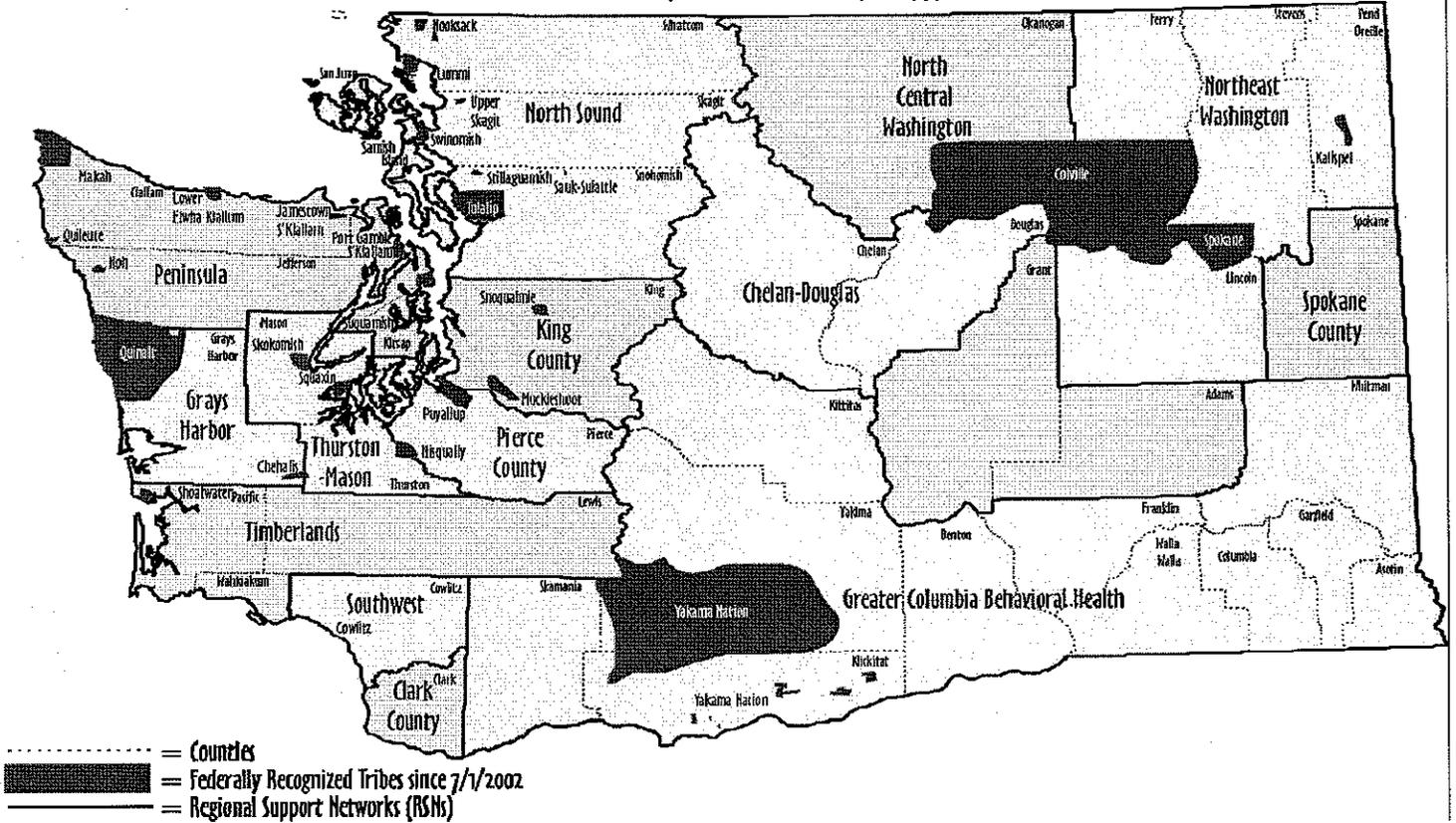
Appendix E: DDD Contacts Listed by RSN and County - for DMHPs

RSN	County	DDD Contact/Phone
Chelan-Douglas	Chelan	Todd Vercoe 509-329-2921
	Douglas	Karen Lantz 509-329-2956
Clark	Clark	Peggy Shinn 360-725-4273 Amee Kile 360-725-4282
Grays Harbor	Grays Harbor	
Greater Columbia	Asotin	Tory Fiedler 509-225-4626 or Joe Hall 509-374-2122
	Benton	
	Columbia	
	Franklin	
	Garfield	
	Kittitas	
	Klickitat	
	Skamania	Peggy Shinn 360-725-4273 Amee Kile 360-725-4282
Whitman	Whitman	Todd Vercoe 509-329-2921 Karen Lantz 509-329-2956
	Yakima	Tory Fiedler 509-225-4626 or Joe Hall 509-374-2122
King	King	Dan Peterson or Dr. Gene Mcconnachie 206-568-5670
North Central	Adams	Todd Vercoe 509-329-2921 Karen Lantz 509-329-2956
	Ferry	
	Grant	
	Lincoln	
	Okanogan	
	Pend Oreille	
	Stevens	
North Sound	Island	Mary Norris 425-339-4887 Kristin Ihrig 425-339-4828
	San Juan Island	
	Skagit	
	Snohomish	
	Whatcom	
Peninsula	Clallam	Peggy Shinn 360-725-4273 Amee Kile 360-725-4282
	Jefferson	
	Kitsap	Ann Mikluis 253-404-6526 253-278-0305 Denise Pech 253-404-6540
Pierce	Pierce	
Spokane	Spokane	Todd Vercoe 509-329-2921 Karen Lantz 509-329-2956
Southwest	Cowlitz	
Thurston-Mason	Mason	Peggy Shinn 360-725-4273 Amee Kile 360-725-4282
	Thurston	
Timberlands	Lewis	
	Pacific	
	Wahkiakum	

Appendix F: Federally Recognized Tribes of Washington State

WA State Regional Support Networks (RSNs)

RSNs and County Boundaries since August 1999



Date: 7/1/02

Appendix G: List of Resources for “Available History”⁵

Accessing potentially relevant information and records, including information and records that, if reasonably available, must be considered (RCW 71.05.212) is often extremely difficult. Possible resources include:

- County or local law enforcement records. Some local law enforcement offices, jails and juvenile detention authorities may be able to share criminal history information. Regional Support Network Administrators may want to consider developing interagency agreements with county or local law enforcement officials.
- Washington State Patrol (WSP) information. The WSP provides criminal history information via the Internet through the Washington Access To Criminal History (WATCH) Program. A \$10 fee is charged for each criminal history search. For additional information contact the WSP Identification and Criminal History Section by telephone at (360) 705-5100 or by Internet at www.wa.gov/wsp/crime/crimhist.htm
- DMHP office records. In addition to information regarding prior investigations and detentions under RCW 71.05 these records may include additional relevant information. Since 1998 copies of evaluation reports conducted under RCW 10.77 have been sent to the DMHP office in the county where the criminal offense occurred. These reports contain recommendations regarding civil commitment.
- Case Manager Locator database. This may identify current or prior outpatient treatment providers who may have relevant information.
- State psychiatric hospital records. The state psychiatric hospitals (Western State Hospital and Eastern State Hospital) maintain records of persons that have been committed to the hospital under civil (RCW 71.05) and criminal (RCW 10.77) statutes. Staff (Medical Records Office, Admitting Nurse or other Admissions personnel) are available 24 hours each day at:
 - Western State Hospital: (253) 582-8900
 - Eastern State Hospital: (509) 299-3121
- Community support service provider, residential facility, or treating physician clinical records may contain relevant information.

⁵ Phone numbers and web sites verified 11/4/2008 2:41 PM

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

This information is from the U.S. State Department web site. Additional information on the Vienna Convention and related bilateral agreements can also be found at the U.S. State Department web site: http://www.state.gov/www/global/legal_affairs/ca_notification/ca_prelim.html ⁶

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

If the foreign national's country is **not** on the mandatory notification list:

- Offer, without delay, to notify the foreign national's consular officials of the arrest/detention. For a suggested statement to the foreign national, see **Statement 1** on the web site's Part 1 Basic Instructions at: http://www.state.gov/www/global/legal_affairs/ca_notification/part1.html ⁷Translations of the statement into selected foreign languages are in Part Four of this publication.
- If the foreign national asks that consular notification be given, notify the nearest consular officials of the foreign national's country without delay. For phone and fax numbers and e-mail addresses for foreign embassies and consulates in the United States, see http://www.state.gov/www/global/legal_affairs/ca_notification/part1.html#statements of the web site. The web site includes hyperlinks to the embassies and consulates. Each consulate or embassy web site contains a "Contact Us" hyperlink which produces further contact information.

If the foreign national's country **is** on the list of mandatory notification countries:

- Notify that country's nearest consular officials, without delay, of the arrest/detention. Phone and fax numbers are in http://www.state.gov/www/global/legal_affairs/ca_notification/part1.html and further information at http://www.state.gov/www/global/legal_affairs/ca_notification/part1.html#statements which contains a suggested fax sheet you may use for making the notification.
- Tell the foreign national that you are making this notification. A suggested statement to the foreign national is found at http://www.state.gov/www/global/legal_affairs/ca_notification/part1.html#statements, and translations into selected languages are in Part Four.

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

⁶ All hyperlinks functioning this section as of 10/31/2008 3:01 PM

⁷ Functioning hyperlink as of 4/4/2006 10:42 AM

Mandatory Notification Countries and Jurisdictions

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

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

² Hong Kong reverted to Chinese sovereignty on July 1, 1997, and is now officially referred to as the Hong Kong Special Administrative Region, or "SAR." Under paragraph 3(f)(2) of the March 25, 1997, U.S.-China Agreement on the Maintenance of the U.S. Consulate General in the Hong Kong Special Administrative Region, U.S. officials are required to notify Chinese officials of the arrest or detention of the bearers of Hong Kong passports in the same manner as is required for bearers of Chinese passports--*i.e.*, immediately, and in any event within four days of the arrest or detention.

³ British dependencies also covered by this agreement are Anguilla, British Virgin Islands, Bermuda, Montserrat, and the Turks and Caicos Islands. Their residents carry British passports.

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

Suggested Statements to Arrested or Detained Foreign Nationals

Statement When Consular Notification is at the Foreign National's Option

(For Translations, See Part Four)

Statement 1:

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

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

Statement 2:

When Consular Notification is Mandatory

(For Translations, See Part Four)

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

Suggested Fax Sheet for Notifying Consular Officers of Arrests or Detentions

Date: _____ Time: _____

To: Embassy of _____, Washington, DC

or

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

From: Name: _____

Office: _____

Street Address: _____

City: _____

State: _____

ZIP Code: _____

Telephone: (____) _____

Fax: (____) _____

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

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

Mr./Ms. _____

Date of birth: _____

Place of birth: _____

Passport number: _____

Date of passport issuance: _____

Place of passport issuance: _____

To arrange for consular access, please call _____ between the hours of _____ and _____.

Please refer to case number _____ when you call.

Comments:

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

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

COUNTY INVOLUNTARY TREATMENT

PHONE: () -

FAX: () -

Case Manager:

Agency: _____ Phone Number: _____

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

Client:

Address:

DOB: _____ SS # _____

CR / LRA Expiration Date

Circle One: 90- 180- day

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

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

Case Manager: _____ Date _____

Case Manager Supervisor: _____ Date _____

LESS RESTRICTIVE ALTERNATIVE (CR/LRA) EXTENSION REQUEST

_____ COUNTY INVOLUNTARY TREATMENT

PHONE: () - _____

FAX: () - _____

DMHP Assigned: _____

CLIENT NAME: _____

Address: _____

Telephone #: () _____

DOB: _____

Case Manager: _____

(Name)

(Agency Name)

(Telephone #)

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

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

GENERAL QUESTIONS:

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

Additional information:

**LESS RESTRICTIVE ALTERNATIVE (CR/LRA)
EXTENSION REQUEST**

_____ COUNTY INVOLUNTARY TREATMENT

PHONE: () - _____

FAX: () - _____

Case Manager _____

Agency: _____ Phone Number: _____

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

Client: _____

Address: _____

DOB: _____ SS # _____

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

THIS FORM MUST BE SUBMITTED FOUR (4) WEEKS

PRIOR TO THE EXPIRATION DATE

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

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

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

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

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

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

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

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

8. Is the client willing to continue with outpatient treatment on a voluntary basis? Would the voluntary status be in good faith? What documentation would support "poor faith" status? If the person is cognitively impaired, is the healthcare decision-maker willing to consent to less restrictive treatment on behalf of this person?

Appendix I, Continued

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

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

Case Manager: _____ Date: _____

OFFICE ()

FAX ()

DATE: _____

TO: _____

Telephone: _____

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

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

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

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

Sincerely,

X _____
Designated Mental Health Professional

cc: Office of Public Defense: _____ ()

Case Manager: _____ ()

Enclosures

Appendix J: DMHP Knowledge and Education

Qualifications as defined in statute:

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

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

Knowledge Base:

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

Education/Training:

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

Appendix K: References and Resources

1. Diagnostic and Statistical Manual IV
2. Washington State DMHP Protocols, updated September 2002
3. Washington Administrative Code: WAC 388-865 "Community Mental Health and Involuntary Treatment Programs"
6. Revised Code of Washington
 - Adult Involuntary Treatment – Chapter 71.05 RCW
 - Mental Health Services for Minors – Chapter 71.34 RCW
 - Criminally Insane – Chapter 10.77 RCW
 - Treatment for Alcoholism, Intoxication and Drug Addiction – Chapter 70.96A RCW
 - Interstate Compact on Mental Illness – Chapter 72.27 RCW
 - Indian Lands Jurisdiction – Chapter 37.12 RCW
 - Developmental Disabilities – Chapter 71A RCW
 - Fire Arms and Dangerous Weapons – Chapter 9.41 RCW
 - Guardianship – Chapter 11.88 RCW
5. Washington Court Rules - State Rules
 - Superior Court Mental Proceeding Rules (MPR)
 - Includes approved forms for petitions.
 - found at pages 479-492 of 2007 version of Washington Court Rules
6. Recommended Resources Available from State Library: Books
 - Aguilera, D.C. (1990). Crisis intervention: Theory and methodology (6th ed.). St. Louis, MO: The C.V. Mosbey Company.
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Recommended Resources: Internet Websites ⁸

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

Developmental Disabilities, Title 71.a RCW: <http://apps.leg.wa.gov/rcw/default.aspx?Cite=71A>

State Institutions Title, 72 RCW: <http://apps.leg.wa.gov/rcw/default.aspx?Cite=72>

Criminally Insane, Title 10.77 RCW: <http://apps.leg.wa.gov/RCW/default.aspx?cite=10.77>

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

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

Guardianship, Title 11.88 RCW: <http://apps.leg.wa.gov/RCW/default.aspx?cite=11.88>

Appendix L: WAC 388-865-0600 through 0640

388-865-0600

Purpose.

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

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

388-865-0610

Definitions.

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

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

(a) Records and reports of inpatient treatment:

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

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

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

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

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

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

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

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

(b) Records and reports of outpatient treatment:

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

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

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

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

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

(c) Records and reports regarding providers and medications:

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

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

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

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

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

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

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

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

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

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

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

- (i) Legal documents pertaining to chapter 71.05 RCW;
- (ii) Legal documents pertaining to chapter 71.34 RCW;
- (iii) Legal documents containing court findings pertaining to chapter 10.77 RCW;
- (iv) Legal documents regarding guardianship of the person;
- (v) Legal documents regarding durable power of attorney;
- (vi) Legal or official documents regarding a protective payee;
- (vii) Mental health advance directive.

(2) "**Relevant information**" means descriptions of a consumer's participation in, and response to, mental health treatment and services not available in a relevant record or report, including all statutorily mandated reporting or duty to warn notifications as identified in WAC 388-865-610 (1)(d)(vi), Offender/Violence alert, and all requests for evaluations for involuntary civil commitments under chapter 71.05 RCW. The information may be provided in verbal or written form at the discretion of the mental health service provider.

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

388-865-0620

Scope.

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

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

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

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

388-865-0630

Time frame.

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

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

(2) All other purposes - within thirty calendar days of the receipt of the request. If some or all of the requested relevant records, reports and information are not available within that time period the mental health service provider shall notify the authorized

department of corrections person prior to the end of the thirty-day period and provide the requested relevant records, reports or information within a mutually agreed to time period; or

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

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

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

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

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

388-865-0640

Written requests.

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

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

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

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

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

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

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

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

Appendix M: RCW 71.34.340

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

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

- (1) In communications between mental health professionals to meet the requirements of this chapter, in the provision of services to the minor, or in making appropriate referrals;
- (2) In the course of guardianship or dependency proceedings;
- (3) To persons with medical responsibility for the minor's care;
- (4) To the minor, the minor's parent, and the minor's attorney, subject to RCW 13.50.100;
- (5) When the minor or the minor's parent designates in writing the persons to whom information or records may be released;
- (6) To the extent necessary to make a claim for financial aid, insurance, or medical assistance to which the minor may be entitled or for the collection of fees or costs due to providers for services rendered under this chapter;
- (7) To the courts as necessary to the administration of this chapter;
- (8) To law enforcement officers or public health officers as necessary to carry out the responsibilities of their office. However, only the fact and date of admission, and the date of discharge, the name and address of the treatment provider, if any, and the last known address shall be disclosed upon request;
- (9) To law enforcement officers, public health officers, relatives, and other governmental law enforcement agencies, if a minor has escaped from custody, disappeared from an evaluation and treatment facility, violated conditions of a less restrictive treatment order, or failed to return from an authorized leave, and then only such information as may be necessary to provide for public safety or to assist in the apprehension of the minor. The officers are obligated to keep the information confidential in accordance with this chapter;
- (10) To the secretary for assistance in data collection and program evaluation or research, provided that the secretary adopts rules for the conduct of such evaluation and research. The rules shall include, but need not be limited to, the requirement that all evaluators and researchers sign an oath of confidentiality substantially as follows:

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

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

/s/....."

(a).

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

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

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

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

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

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

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

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

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

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

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

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

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