Washington State
Department of Social
& Health Services

Report to the Legislature

Protocols

County Designated Mental Health Professionals

RCW 71.05.214

September 1, 2002

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

Protocols: County Designated Mental Health Professionals

September 1, 2002
Table of Contents

PREFACE

The 2002 Update of the Protocols for County Designated Mental Health Professionals (CDMHPs) is provided by the Department of Social and Health Services, Mental Health Division, 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 of Social and Health Services, Mental Health Division submitted to the Governor and the Legislature the initial Protocols in September 1999. The 2002 Protocol Update was developed by the 2002 Protocol Update Work Group, which included staff from the Department of Social and Health Services, Mental Health Division, in partnership with the Washington Association of County Designated Mental Health Professionals, and with the active collaboration of a broad stakeholder group. A list of participants and their affiliations can be found in Appendix A. Public input on the final draft was solicited and comments were incorporated before the 2002 Protocol Update was finalized.

The review and update of the 2002 Protocol Update attempted to address the following:

- ❖ Organizational and language changes to improve clarity;
- ❖ Statutory changes made after the initial 1999 publication;

- ❖ Enhancements related to:
  - Children and minors;
  - American Indians on tribal reservations;
  - Elderly persons, including persons with dementia;
  - Persons in jails and prisons;
  - Persons with substance abuse;
  - Foreign nationals;
  - Access to reasonably available history;
  - Less restrictive court orders;
  - Mandatory reporting requirements; and
  - Confidentiality.

The 2002 Protocol Update is intended to provide guidelines to County Designated Mental Health Professionals on the process of administration of the involuntary treatment acts for adults (Chapter 71.05 RCW) and minors (Chapter 71.34 RCW) and in their role in the implementation of the criminal insanity statute (Chapter 10.77 RCW). It is also intended to assist consumers, advocates, allied systems, courts and other interested persons to better understand the role of the County Designated Mental Health Professional in implementing these laws. This Protocol Update also includes a significantly expanded Appendix, provided as resource material in the spirit of promoting best practice.

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 phases. 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 be not 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 2002 Protocol Update also has limitations. It is beyond the scope of the protocols to address the myriad of clinical skills and practices required of CDMHPs or the role of the CDMHP in providing crisis response and resolution as a mental health professional. The document also does not include statutory or rule changes made after the published date, and it does not include changes as a result of the Health Insurance Portability and Accountability Act (HIPAA). In addition, some of the practices followed by County Designated Mental Health Professionals are influenced by the rulings of local courts. These rulings have resulted in procedural differences across the state that are beyond the authority of the Protocols to remedy. 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 2002 Protocol Update Work Group is satisfied that these protocols will continue to move County Designated Mental Health Professional practices toward greater uniformity across the state. The Protocols are a work in progress, and it is the sincere hope of the Work Group that attention will continue to be focused on these important concerns.

The completed 2002 Protocol Update will be made available to any interested person through the Mental Health Division web site at http://www.wa.gov/dshs/mentalhealth. Notice of this availability will be widely distributed.

If you have comments or questions, would like to request printed copies of this 2002 Protocol Update, or are interested in training on this subject, please contact David Weston, Mental Health Program Administrator at (360) 902-0782.

The Department of Social and Health Services, Mental Health Division would like to extend its appreciation and thanks to all of the persons that worked so thoughtfully and diligently on the development of this Protocol Update. The active participation of representatives from many different stakeholder groups, both from within the public mental health system as well as allied care systems, greatly enriched the quality of the Protocol Update. We would particularly like to thank the Washington Association of County Designated Mental Health Professionals for partnering with us in the organization and facilitation of the Protocol review process.

Karl R. Brimner, M. Ed.
Director
Mental Health Division
Department of Social and Health Services

September 1, 2002

PURPOSE AND AUTHORITY

Protocols for County Designated Mental Health Professionals (CDMHPs) are provided by the Department of Social and Health Services, Mental Health Division, 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."*

The purpose of these protocols is to provide County Designated Mental Health Professionals (CDMHPs) with statewide criteria that they can use to:

(1) Increase assurance that statewide, uniforms decisions will be made regarding the treatment of individuals and the protection of the public;
(2) More effectively administer chapter 71.05 RCW (Mental Illness) and chapter 10.77 RCW (Criminally Insane--Procedures); and
(3) More effectively administer chapter 71.34 RCW (Mental Health Services for Minors).

The professional judgment of CDMHPs is fundamental to the Involuntary Treatment Act process. These protocols are designed to provide guidance and direction to CDMHPs and assist with the complex processes and procedures of the Act.

REFERRALS FOR ITA INVESTIGATION

100–Referrals for an ITA investigation.

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

(1) Assessment of urgency:
   (a) As quickly as possible, the CDMHP assesses the degree of urgency and resources available to resolve or contain the crisis.
   (b) If the CDMHP assesses that the person or others are in immediate physical danger, the CDMHP calls 911 to respond, or asks the referring person to call 911.
   (c) The CDMHP determines whether it is appropriate to involve law enforcement. This may include making a request to take the person into protective custody under RCW 71.05.

(2) The CDMHP accepts, screens and documents all referrals for an Involuntary Treatment Act (ITA) investigation. Documentation includes the:
   (a) Name of the individual referred for an ITA investigation;
   (b) Name of caller and relationship to person being referred;
   (c) If a minor, the name of the parent or legal guardian;
   (d) Date and time of the referral call;
   (e) Facts alleged by the caller;
   (f) 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;
   (g) Contact information of the referent;
   (h) Names and contact information for potential witnesses;
   (i) The name of the person's guardian or other healthcare decision-maker, if there is one.

(3) The CDMHP decides and documents, for each person referred, whether:
   (a) An investigation is warranted; or
   (b) Community Support Service emergency crisis intervention services or other community services are more appropriate; or
   (c) No service or investigation is required.

(4) At the time of the referral, the CDMHP provides information to the referent about CDMHP procedures and protocols as they relate to the referral. This may include informing the referent whether a face-to-face interview can be expected or what further information is needed for a face-to-face interview. The CDMHP 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.

(5) The CDMHP 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 or emergency room. However, a CDMHP may issue a custody authorization without an in-person evaluation when:

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

105–CDMHP requirement to report abuse or neglect.

CDMHPs are "mandatory reporters" of possible 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 CDMHP has reasonable cause to believe that abuse, neglect, financial exploitation or abandonment of an individual has occurred, the CDMHP must immediately report it directly to DSHS. If there is reason to suspect that sexual or physical assault has occurred, the CDMHP 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 1-800-562-5624 or 1-866-END-HARM (1-866-363-4276).
(2) For adults in a residential care facility, notify the Residential Care Services Complaint Resolution Unit Hotline at 1-800-562-6078;
(3) For adults not in a residential care facility, reports are to be made to the following regional offices:

Region 1: 1-800-459-0421 Spokane, Grant, Okanogan, Adams, Chelan, Douglas, Lincoln. Ferry, Stevens, Whitman, Pend Oreille	Region 4: 1-866-221-4909 King
Region 2: 1-877-389-3013 Yakima, Kittitas, Benton, Franklin, Walla Walla, Columbia, Garfield, Asotin	Region 5: (Two numbers) Pierce Co: 1-800-442-5129; Kitsap Co: 1-888-833-4925
Region 3: 1-800-487-0416 Snohomish, Skagit, Island, San Juan, Whatcom	Region 6: 1-877-734-6277 Thurston, Mason, Lewis, Clallam, Jefferson, Grays Harbor, Pacific, Wahkiakum, Cowlitz, Skamania, Klickitat, Clark

Reference: RCW 74.34.020(8), RCW 74.34.035, RCW 74.34.050, and RCW 73.34.053; RCW 26.44.020(3) and RCW 26.44.030(1)(a).

110–Referrals of a minor.

- "**Minor**" means any person under the age of eighteen. 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)

(1) The CDMHP may not detain any minor under the age of 13. RCW 71.34.040
(2) The CDMHP 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;
(3) To the extent possible, the CDMHP 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 CDMHP contacts the minor's DSHS social worker, 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

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

The CDMHP does not rule out a referral for investigation solely because of the presence of dementia or a developmental disability. A person with dementia, a developmental disability or another cognitive disorder may have a mental disorder as defined in RCW 71.05.020(20) if the person's impairment has substantial adverse effects on his/her cognitive or volitional functions.

RCW 71.05.020(20)

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

The CDMHP responds to a referral from a licensed residential care facility as quickly as a referral from other community entities. 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 CDMHPs 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 CDMHP 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

CDMHP 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 CDMHP's response:

(1) Whenever possible, the CDMHP evaluates the person at the licensed residential care facility rather than an emergency room so that situational, staffing, and other factors can be observed;
(2) The CDMHP 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.
(3) When appropriate, available, and consistent with confidentiality provisions, the CDMHP obtains information from a variety of sources such as the resident, family members of the resident, 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.
(4) If the investigation does not result in detention but the resident has remaining mental health care needs, the CDMHP may also provide further recommendations to the facility staff and others, including recommendations for possible follow-up services.
(5) 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 CDMHP has concerns about facility refusal to re-admit the resident, the CDMHP notifies the Residential Care Services Complaint Resolution Unit (CRU) Hotline at 1-800-562-6078.
(6) If during the course of the investigation the CDMHP has concerns about mental health or other services provided by the facility, the CDMHP notifies the Residential Care Services Complaint Resolution Unit (CRU) Hotline for follow-up at 1-800-562-6078.

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.

Note: A case is currently pending before the Washington State Supreme Court regarding how long a person may be held in an emergency room prior to the facility making a referral to the CDMHP.
Adults: The CDMHP must complete an ITA investigation and if appropriate, detain the person within **6 hours** of being notified by the facility. RCW 71.05.050

Minors: The CDMHP must complete an ITA investigation and if appropriate, detain the minor within **12 hours** of being notified by the facility. RCW 71.34.040

Reference: RCW 71.05.050 and RCW 71.71.34.040

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

Note: CDMHPs 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.

(1) The CDMHP does not rule out any referral for investigation solely because the person is under the influence of alcohol and/or drugs.
(2) 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 CDMHP conducts an ITA investigation under RCW 71.05 or RCW 71.34.
(3) The CDMHP assesses 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 CDMHP cannot establish that this is as a result of a mental disorder, the CDMHP initiates a referral to the County Designated Chemical Dependency Specialist or to other appropriate treatment resources in order to protect the person or others who are at risk of harm.
(4) If the person is not at imminent risk of harm to themselves or others or is not gravely disabled, the CDMHP 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.

CDMHPs should consult with the county prosecuting attorney regarding any interlocal agreements between the Regional Support Network and tribal governments. Tribal governments have authority over activities on federally recognized tribal reservations. Individual Regional Support Networks are currently in the process of developing interlocal agreements with tribal governments on the conditions and procedures for conducting ITA investigations and detaining American Indians on tribal reservations. Appendix D contains a map of Federally Recognized Tribes in the state of Washington.

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

The CDMHP 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 CDMHP maintains in consumer clinical records any information received, 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 CDMHP obtains information on the person's criminal charges status (felony or misdemeanor); release date; jail hold (if any); and the correctional facility's policy with the person making the referral. Prior to determining if detention is possible, the CDMHP:
   (a) Identifies and explores issues that may impede commitment;
   (b) 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 effected through emergency procedures or through the issuance of an Order to Appear.

(3) If the CDMHP decides that a detention under RCW 71.05 or RCW 71.34 is necessary, the CDMHP:
   (a) Coordinates the process with law enforcement personnel, County Department of Corrections representatives, representatives of the legal system and other appropriate persons to the extent permitted by applicable law, including RCW 71.05.155, RCW 71.05.390 and RCW 71.34.200.
   (b) 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.

(4) If an investigation is requested for an incarcerated person who has undergone a 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 CDMHP 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)

(5) Dangerous Mentally Ill Offender (DMIO): If an investigation is requested for a person incarcerated in a Washington State Department of Corrections prison identified by the DMIO Statewide Review Committee as a Dangerous Mentally Ill Offender (DMIO) under RCW 72.09.370, the investigation shall occur not more than ten days, nor less than five days, prior to release. A second investigation by a CDMHP must occur on the day of release if requested by the DMIO Committee. When conducting an evaluation of a DMIO person, the CDMHP shall consider the offender's history of judicially required or administratively ordered antipsychotic medication while in confinement. The fact that an offender is identified as a DMIO does not change the commitment criteria under RCW 71.05 and 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 CDMHP 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 CDMHP must specifically document that the recommendation is based on an opinion that the incarcerated person represents a danger to others. If the CDMHP believes that less restrictive alternative treatment is appropriate upon release, he/she shall seek an Order to Appear, pursuant to the provisions of RCW 71.05, to require the inmate to appear at an evaluation and treatment facility. If an Order to Appear is issued, the inmate shall remain within the jail or prison until completion of his or her term of confinement and be transported, by corrections personnel on the day of completion, directly to the identified evaluation and treatment facility.

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

The CDMHP 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.

(1) The evaluation shall occur at the facility in which the minor is detained or confined.
(2) The CDMHP may refer the minor to the County Designated Chemical Dependency Specialist for examination and evaluation under the chemical dependency commitment statute, RCW 70.96A.
(3) The CDMHP provides the result of the examination to the charging criminal court for use in the criminal disposition.
(4) The CDMHP, 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.
(5) The CDMHP, if appropriate, may refer the minor to the local Regional Support Network, DSHS or other community providers for other services to the minor or family.

Reference: RCW 9.41.280 (2)

INVESTIGATION PROCESS

200–Rights of a person being investigated.

A CDMHP informs the person being investigated for involuntary detention of his/her legal rights as soon as is reasonably and safely possible.

(1) The CDMHP identifies him/herself by name and position;
(2) The CDMHP informs the person of the purpose and possible consequences of the investigation;
(3) The CDMHP informs the individual that he/she has the right to remain silent, and that any statement made may be used against him or her;
(4) The CDMHP informs the person being investigated that he/she may speak immediately with an attorney. However, the CDMHP is not obligated to stop the investigation while the individual being investigated attempts to consult with an attorney if a likelihood of serious harm is imminent.
(5) The CDMHP informs the person of his/her rights 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 available during the investigation. The CDMHP reads the rights to the individual in their entirety if requested by the person being investigated.
(6) When the individual appears to be cognitively impaired, the CDMHP 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 CDMHP proceeds with investigation if the healthcare decision-maker is not available. As soon as is reasonably possible, the CDMHP 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. 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 CDMHP performs or attempts to perform a face to face evaluation as part of the investigation before a petition for detention is filed. The CDMHP evaluates the facts relating to the person being referred for investigation based on the mental health statutes and applicable case law. The CDMHP 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 CDMHP's investigation focuses upon the following criteria, based upon independent investigation and professional judgment.

- ""**Investigation**": means the act or process of systematically searching for relevant, credible and timely information to determine if:
    (a) There is evidence that a referred person may suffer from a mental disorder; and
    (b) There is evidence that the person, as a result of a mental disorder,
        (i) presents a likelihood of serious harm to him or herself, other persons or other's property, or
        (ii) may be gravely disabled; and
    (c) The person will voluntarily accept appropriate, available, less-restrictive treatment options.

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

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

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(20) or RCW 71.34.020(13), but only that the disorder has a substantial adverse effect on cognitive or volitional functioning.

Note: An individual with severe and chronic conditions may have baseline functioning which at all times meets the definition of mental disorder. In some cases, the impairment resulting from a mental disorder may become "substantial" if the individual demonstrates a decline in baseline functioning.

To evaluate the presence of a mental disorder, a CDMHP assesses:

(1) 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 CDMHP also considers the individual's developmental age in relationship to his or her chronological age. The CDMHP also takes into consideration the person's age, ethnicity, culture and linguistic abilities; and
(2) The duration, frequency and intensity of any psychiatric symptoms.

- "**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(20) 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.

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

The CDMHP 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 CDMHP makes this assessment:

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

- "**Likelihood of serious harm"** as defined in RCW 71.05.020 (19) means:
  (a) A substantial risk that:
    (iii) 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;
    (iv) 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
    (v) 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
  (b) The individual has threatened the physical safety of another and has a history of one or more violent acts." RCW 71.05.020(19). Note: This provision applies only to adults, as there is no similar criterion for minors in RCW 71.34.
- **"Gravely disabled"** means: a condition in which a person, as a result of a mental disorder:
  (a) Is in danger of serious physical harm resulting from a failure to provide for his or her essential human needs of health or safety RCW 71.05.020(14)(a); or
  (b) Manifests severe deterioration in routine functioning evidenced by repeated and escalating loss of cognitive or volitional control over his or her actions and is not receiving such care as is essential for his or her health or safety." RCW 71.05.020(14)(b) However, persons cannot be detained on the basis of a severe deterioration in routine functioning unless the detention is shown to be essential for the individual's health or safety. In Re LaBelle (1986), See Appendix I.

- "**Imminence**" means "the state or condition of being likely to occur at any moment; near, at hand, rather than distant or remote." A CDMHP may take a person into emergency custody only 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)

220–Use of reasonably available history.

The CDMHP 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 F.

- **"Reasonably Available History"** means history which is made available to the CDMHP by referral sources, 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, and records from prior civil commitments.

(1) When making decisions regarding referred persons, a CDMHP considers reasonably available history regarding:
   (a) 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;
   (b) Violent acts, which means homicide, attempted suicide, nonfatal injuries, or substantial damage to property. RCW 71.05.020(32). 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(16)
   (c) Prior determinations of incompetency or insanity under RCW 10.77;
   (d) Prior commitments made under RCW 71.05; and
   (e) For Dangerous Mentally Ill Offender (DMIO) consumers, a history of involuntary medications. RCW 72.09.370

(2) While a CDMHP 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.

(3) The CDMHP's 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.

(4) The CDMHP reviews historical information to determine its reliability, credibility and relevance.

(5) CDMHP 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 CDMHP 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.

(1) A CDMHP interviews available witnesses who may have pertinent information and/or evidence;
(2) A CDMHP 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.

(3) The CDMHP 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
(4) A CDMHP 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 CDMHP 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 CDMHP also considers the individual's developmental age in relationship to his or her chronological age.

- "**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.

(a) For a minor, the good faith commitment by the minor's parent or legal guardian is considered.
(b) When the investigation concerns a cognitively impaired person who is unable to provide good faith informed consent to less-restrictive treatment options, the CDMHP 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, (1992), See Appendix I.

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 CDMHP:

(1) 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;
(2) Advises the service provider to contact the CDMHP 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;
(3) Either renews or facilitates contact with the person when it is clinically necessary based on consultation with the service provider.
(4) Note: For minors, a parent may request court review of the CDMHP's decision not to detain that minor. In this circumstance, the parent has the right to access the CDMHP's report or notes to present in evidence at the court hearing. RCW 71.34.050 (1).

DETENTIONS

300–Rights of a person being detained.

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

(1) The CDMHP must advise the individual being detained that he/she has the rights specified in RCW 71.05.200 or, in the case of a minor, rights specified in RCW 71.34.050.
(2) The CDMHP is not obligated to stop the detention process while the individual being detained attempts to consult with an attorney.
(3) The CDMHP informs the person of his/her rights 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 CDMHP reads the rights to the individual in their entirety if requested by the person being detained.
(4) As soon as possible following the detention, the CDMHP 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 7.70.065.
(5) The CDMHP must take reasonable precautions to safeguard the consumer's property, including locking the consumer's home or other property as soon as possible after the person has been detained. WAC 388-865-0245(3).
(6) When the individual appears to be cognitively impaired, the CDMHP 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 CDMHP proceeds with detention if the healthcare decision-maker is not available. As soon as is reasonably possible, the CDMHP 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.

(1) If the person does meet criteria for detention, but no imminent danger exists, then the CDMHP may initiate a non-emergency detention by petitioning the superior court for an order directing the referred person to appear at an inpatient evaluation and treatment facility or outpatient treatment provider within 24 hours after the order is served. RCW 71.05.150(1)
Note: Imminent danger is not required for the emergency detention of minors.
(2) The CDMHP may proceed with emergency detention if the non-emergency detention process would cause a delay that would reasonably increase the likelihood of danger to the point that the likelihood of danger would be imminent. Note: RCW 71.05 is silent on this provision but it is consistent with current practice.

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:

(1) The CDMHP requests the facility staff to provide the appropriate documentation, including medications currently used, durable medical equipment used by the person, and relevant medical information to the psychiatric staff at the inpatient evaluation and treatment facility.
(2) Before a CDMHP arranges the transportation of a person from a licensed residential care facility, the CDMHP requests the facility to provide the person with the transfer/discharge notice required of the facility under its licensing laws.

315–Detention to a facility in another county.

When a CDMHP in one county detains an individual in an inpatient evaluation and treatment facility (not including the state hospitals) in another county, the detaining CDMHP must agree to send the original paperwork to the admitting facility within the statutory time limit. The detaining CDMHP must also agree to testify in person, if necessary, at any court hearings and arrange for any witnesses needed for the court hearing to be available to testify at court hearings.

320–Documentation of petition for initial detention.

On the next judicial day following the initial detention, the CDMHP 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 emergency detention with the court and serve the individual's

designated attorney a copy of these documents. For minors, the CDMHP 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 CDMHP notifies, by the next judicial day following the initial detention, a designated representative of DDD of this action.

Reference: RCW 71.05.630(2)(g)

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

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

(1) If a person who has been detained is a foreign national, the CDMHP 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)
(2) If the person who has been detained is a foreign national and is legally not competent such that the appointment of a guardian or trustee appears to be in the persons interests, the CDMHP must inform the consular official from that country without delay, whether or not the detained person wants the consular official notified. (Vienna Convention)
(3) If the person who has been detained is a citizen of any of the nations with Bilateral Agreements, the CDMHP 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 F.
(4) In all cases, the CDMHP 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.state.gov/www/global/legal_affairs/ca_notification/ca_prelim.html

LESS RESTRICTIVE ALTERNATIVE COURT ORDERS

Refer to Appendix G for sample forms that may be used in the Less Restrictive Alternative (LRA) Court Order process.

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

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

(1) He/she will be released within 5 days unless a judicial hearing is held RCW 71.05.340 (3) (c); and
(2) A revocation hearing to determine whether he/she will be detained for up to the balance of his/her commitment must be held within 5 days following the date of the petition to revoke the LRA Court Order.
(3) Minors will be released within 7 days unless a judicial hearing is held. RCW 71.34.110(3)

405–Coordinating with service providers in monitoring LRA Court Orders.

(1) The CDMHP coordinates with service providers in monitoring the person's compliance with his/her LRA Court Order and stresses the importance of:
    (a)Closely monitoring LRA Court Orders, including assessing the need for revocation based on likelihood of serious harm, failing to adhere to conditions, or substantial deterioration in functioning; and/or substantial decompensation with a reasonable probability that the decompensation can be reversed by further treatment; RCW 71.05.340(3)(b) and
    (b) Providing CDMHPs with information needed to support petitions for further court-ordered less restrictive treatment.
(2) The CDMHP maintains a system which tracks LRA Court Orders as they are approaching expiration, and encourages a careful review of the need to petition for extension of the court ordered less restrictive alternative. Petitioning to extend the 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 LRA Court Order. This investigation may involve consultation with the treatment provider(s) to determine if further involuntary treatment by extending the LRA Court Order is warranted.
(3) It is important that the outpatient treatment provider is fully educated and aware of the ability to continue a LRA Court Order, even when the individual's circumstances do not warrant hospitalization or meet acute care

criteria. 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 LRA Court Orders for adults.

The following criteria apply for extending Less Restrictive Alternative Court Orders for adults:

(1) 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 or developmental disability presents a likelihood of serious harm; or
(2) Was taken into custody as a result of conduct in which he or she attempted or inflicted serious physical harm upon the person of another, and continues to present, as a result of mental disorder or developmental disability a likelihood of serious harm;
(3) Is in custody pursuant to RCW 71.05.280(3) and as a result of mental disorder or developmental disability presents a substantial likelihood of repeating similar acts considering the charged criminal behavior, life history, progress in treatment, and the public safety; or
(4) Continues to be gravely disabled while on a LRA Court Order.

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

Reference: RCW 71.05.320(2)

415–Procedures for extending a LRA Court Order for adults.

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

(1) The CDMHP evaluates the individual's current condition and must also consider the cognitive and volitional functioning of the individual prior to court ordered treatment.
(2) The CDMHP 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 CDMHP considers the individual's history or pattern of decompensation.

(3) If the petitioner CDMHP is to provide a declaration as an examining mental health professional, the case manager shall include a declaration by an examining physician. If the petitioner CDMHP is not providing a declaration, the case manager is to include either declarations from two examining physicians or an examining physician and an examining mental health professional. RCW 71.05.410 (3).
(4) The CDMHP files a petition for extending a LRA Court Order on the grounds of grave disability if:
    (a) 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
    (b) 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.
(5) For extending a LRA Court Order, the CDMHP gives great weight to evidence of prior history or pattern of decompensation and discontinuation of treatment resulting in:
    (a) Repeated hospitalization;
    (b) 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(2)

420–Criteria for revoking LRA Court Order for adults.

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

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

(1) RCW 71.05.340 (3)(a): A CDMHP may apprehend and take into custody and temporarily detain in an evaluation and treatment facility in or near the county, the person receiving the outpatient treatment **if the CDMHP determines:**
    (a) The person fails to comply with the terms and conditions of his/her LRA Court Order;
    (b) The person experiences substantial deterioration in his/her condition,
    (c) There is evidence of substantial decompensation with a reasonable probability that the decompensation can be reversed by further inpatient treatment; or
    (d) The person poses a likelihood of serious harm.
(2) RCW 71.05.340(3)(b): The CDMHP is required to order the person apprehended and temporarily detained in an inpatient evaluation and

treatment facility in or near the county, **when the outpatient treatment provider determines:**

(a) The person fails to comply with the terms and conditions of his/her LRA Court Order; or
(b) The person experiences substantial deterioration in his/her condition; and
(c) As a result, of either (a) or (b), the person presents an increased likelihood of serious harm.

(3) 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 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.

(4) 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 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 CDMHP serves the witnesses with a subpoena in time to be present for the hearing.

(5) In some cases, it is appropriate for the CDMHP 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 LRA Court Order or substantial deterioration has occurred as documented in the outpatient treatment provider's written statement, affidavit or declaration.

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

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

(1) The CDMHP responds to referrals for revocation of a LRA Court Order;

(2) When detaining a person under criteria RCW 71.05.340 (3) (a), the CDMHP documents the facts used to make the determination to detain, including names and contact information for all witnesses;

(3) When detaining a person under criteria RCW 71.05.340 (3) (b), based on information from the outpatient treatment provider, the CDMHP documents the facts demonstrating that the individual presents an increased likelihood of serious harm to self or others, and attaches the supporting affidavit or declaration of the treatment provider;

(4) The CDMHP serves the papers and takes the person into custody;

(5) The CDMHP completes and files the Petition for Revocation and accompanying paperwork and attaches a copy of the LRA Court Order and indicates which grounds are being relied upon for revocation.

(6) The CDMHP 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 CDMHP serves the witnesses with a subpoena in time to be present for the hearing.

430–Less Restrictive Alternative court orders for minors.

Note: RCW 71.34 provides very little guidance on Less Restrictive Court Orders for minors.

The following criteria apply for revoking Less Restrictive Alternative Court Orders for minors:

1) The minor is failing to adhere to the conditions of the LRA Court Order; or
2) Substantial deterioration in the minor's routine functioning has occurred.

The court shall review the CDMHP's petition to revoke the LRA Court Order, and pursuant to the determination of the court the minor shall be returned to less restrictive alternative treatment on the same or modified conditions, or shall be returned to inpatient treatment.

Reference: RCW 71.34.110(1) and 71.34.110(3)

CONFIDENTIALITY

500–General provisions on confidentiality.

Information gathered by CDMHPs is confidential under Washington State law and may not be disclosed to anyone unless specifically permitted by law, by a signed release, or by a court order signed by a judge. Statutory provisions related to confidentiality of mental health information and records can be found in multiple locations including, but not limited to RCW 71.05.155; RCW 71.05.390, RCW 71.05.445, RCW 71.05.610 through 630; RCW 10.77.065 and RCW 10.77.210; and in the case of minors, RCW 71.34.200 through 225.

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

Because individuals who have referred a case for investigation already know that the case was under investigation, they may be told that the investigation has been completed.

505–Sharing information with parents and legal representatives.

Whenever possible, the CDMHP must inform a responsible member of the individual's family, guardian, and/or healthcare decision-maker whenever 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.

RCW 71.05.200 and RCW 71.34.050

510–Sharing information with law enforcement.

(1) RCW 71.05.390(7), (10) and (11) permit the CDMHP to divulge information when requested by law enforcement agencies. This is limited to the fact, place, and date of involuntary admission; the fact and date of discharge; and

the last known address. In the event of a crisis or emergent situation posing imminent risk to the public, all necessary and relevant information may be disclosed to law enforcement.

(2) CDMHPs may release information regarding the results of an investigation when the investigation is requested by a representative of a law enforcement agency, including a police officer, corrections officer, sheriff, a municipal attorney, or prosecuting attorney. If requested the CDMHP must submit the results of the investigation in writing within 72-hours of the completion of the investigation. RCW 71.05.155

515–Sharing information with Department of Corrections personnel.

Upon request, information related to mental health services must be shared with Washington State Department of Corrections (DOC) personnel when:

(1) The request is made in writing by a DOC staff with regard to a person under the supervision of DOC; and

(2) The request specifies that the information or records are to be used for one of the four authorized purposes – completing pre-sentence investigations, supervision of an incarcerated person, planning for and provision of supervision of a person, or assessment of a person's risk to the community.

- **"Information related to mental health services"** means all information and records compiled, obtained, or maintained in the course of providing services to either voluntary or involuntary recipients of services by a mental health service provider. This may include documents of legal proceedings under this chapter or RCW 71.34 or RCW 10.77, or somatic health care information. RCW 71.05.445(1)(a) and RCW 71.34.225(1)(a).

Additional detail regarding the process, scope and limitation of sharing information with Department of Corrections under this statute can be found in WAC 388-865-0600 through 388-865-0640.

Reference: RCW 71.05.445, RCW 71.34.225 and WAC 388-865-0600 through 388-865-0640

520–Sharing information to protect identified persons.

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

(1) Call the person who has been threatened or harassed. Release only such information as is pertinent to the threat or harassment, such as date of detention, date of discharge, and date of authorized or unauthorized absence from the detention facility.

(2) Document the notification in the case write up. Make sure that the fact of release is noted in the case.
(3) Call appropriate law enforcement agencies (both the law enforcement agencies of the victim and of the suspect).

RCW 71.05.390 (10) and RCW 71.34.200 (12).
Also see In Re Tarasoff, Appendix I.

525–Sharing information with Adult/Child Protective Services.

To the extent permitted or required by applicable law, the CDMHP should inform the Adult Protective Service or Child Protective Service worker making the referral 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.

Reference: RCW 71.05.390(1)

APPENDICES

Appendix A: List of 2002 Protocol Update Workgroup Members

Washington Association of County Designated Mental Health Professionals:

Gary Carter	Kitsap Mental Health Services
Jan Dobbs	Spokane Mental Health
Jim Jones	Pierce County Involuntary Commitment Services
Jeffery Weist	Kitsap Mental Health Services
Tim Justice	Whatcom Counseling & Psychiatric Clinic
Vicki Bringman	Okanogan County Counseling Services

Department of Social and Health Services

David Weston	Mental Health Division
Kathy Burns Peterson	Mental Health Division
Sabine Whipple	Mental Health Division
Mary Sarno	Mental Health Division
Andy Pascua	Mental Health Division Advisory Board
Bob Howenstine	Division of Developmental Disabilities
Marrianne Backous	Aging and Adult Services, Home & Community Services
Jake Romo	Aging and Adult Services, Home & Community Services
Rosemary Biggins	Aging and Adult Services, Residential Care Services
Emilio Vela	Division of Alcohol and Substance Abuse
Mark Soelling	Western State Hospital
Dinah Martin	Children's Administration

Regional Support Networks

Amnon Shoenfeld	King RSN
Dave Stewart	Pierce RSN
Preston Hess	North Sound RSN
Gary Rose	Timberlands RSN
Vic Roberts	Greater Columbia Behavioral Health
Anita Langston	Thurston-Mason Ombudsman
Cheri Hall	Thurston-Mason Ombuds Asst.
Barbara Qualley	NEWRSN Ombudsman
Sherry Storms	Mental Health Ombudsman of King County

Other Stakeholders

Kathy Crane	Children's Long Term Inpatient Programs
Larry Smith	King County Adult and Juvenile Detention
Annette Squetimkin-Anquoe	Puyallup Tribal Health Authority
Isaac Jack	Nisqually Tribe Mental Health
Lois Granger	Quileute Tribe
Chuck Wagner	Suquamish Tribe

Harry Kramer	Washington Community Mental Health Council
Katie Cameron	South Sound Alzheimer's Council
Bill Weiss	Washington Association of Sheriffs and Police Chiefs
Virginia Rockwood	Washington State District and Municipal Court Judges Association
Carolyn Williamson	Pierce County Prosecutor's Office
Allison Stanhope	Office of the Attorney General
Paul Weisser	Office of the Attorney General
Dennis Dyck	WIMIRT – East
Beverly Miller	WIMIRT – West
Nancy Braswell	WIMIRT – West
Rick Lichtenstadter	King County Public Defenders
Katharine Wilcox	King County Prosecutor's Office
Mike Finkle	Washington State Association of Municipal Attorneys
Jeff Crollard	State Long Term Care Ombudsman Program attorney
Kary Hyre	State Long Term Care Ombudsman

Appendix B: Glossary of Terms

Following is a glossary of terms used in this document with a reference to the section containing the definition. 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"** (Section 210): means the capacity to accurately know or perceive reality, and to understand the fundamental consequences of one's actions.

- "**Credibility**" (Section 225): means the state of being believable or trustworthy.

- "**Good faith**" (Section 230): 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 has a history, which does not belie this stated intent, or a cognitive impairment that prevents him or her from making this decision.
    (a) For a minor, the good faith commitment by the minor's parent or legal guardian is considered.
    (b) When the investigation concerns a cognitively impaired person who is unable to provide good faith informed consent to less-restrictive treatment options, the CDMHP 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"** (Section 410): When being considered for extending a less restrictive alternative court order, grave disability 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.

- **"Gravely disabled"** (Section 215): means a condition in which a person, as a result of a mental disorder:
    (a) Is in danger of serious physical harm resulting from a failure to provide for his or her essential human needs of health or safety RCW 71.05.020(14)(a); or
    (b) Manifests severe deterioration in routine functioning evidenced by repeated and escalating loss of cognitive or volitional control over his or her actions and is not receiving such care as is essential for his or her health or safety. RCW 71.05.020(14)(b). However, persons cannot be detained on the basis of a severe deterioration in routine

functioning unless the detention is shown to be essential for the individual's health or safety. In Re LaBelle (1986), See Appendix I.

- **Imminence**" (Section 215): means "the state or condition of being likely to occur at any moment; near, at hand, rather than distant or remote."

- **"Information related to mental health services"** (Section 515): means all information and records compiled, obtained, or maintained in the course of providing services to either voluntary or involuntary recipients of services by a mental health service provider. This may include documents of legal proceedings under this chapter or RCW 71.34 or RCW 10.77, or somatic health care information. RCW 71.05.445(1)(a) and RCW 71.34.225(1)(a).

- "**Investigation**" (Section 205): means the act or process of systematically searching for relevant, credible and timely information to determine if:
  - (a) There is evidence that a referred person may suffer from a mental disorder; and
  - (b) There is evidence that the person, as a result of a mental disorder,
  - (i) presents a likelihood of serious harm to him or herself, other persons or other's property, or
  - (ii) may be gravely disabled; and
  - (c) The person will voluntarily accept appropriate, available, less-restrictive treatment options. RCW 71.05.150 (1)(a) and RCW 71.34.050.

- "**Likelihood of serious harm"** (Section 215): means:
  - (a) A substantial risk that:
  - (i) 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;
  - (ii) 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
  - (iii) 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
  - (b) The individual has threatened the physical safety of another and has a history of one or more violent acts." RCW 71.05.020(19).

- "**Mental disorder"** (Section 210): means any organic, mental or emotional impairment which has substantial adverse effects on an individual's cognitive or volitional functions." RCW 71.05.020(20). 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).

- "**Minor**" (Section 110): means any person under the age of eighteen. RCW 71.34.020 (15)

- "**Parent**" (Section 110): 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"** (Section 220): means history which is made available to CDMHP's by referral sources, 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, and records from prior civil commitments.

- "**Reliability**" (Section 225): 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.

- **"Substantial adverse effects"** (Section 210): means significant and considerable negative impact on an individual.

- **"Sufficient environmental controls are in place"** (Section 230): 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.

- **"Volitional functions"** (Section 210): 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.

Appendix C: Licensed residential care facilities' requirements

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 or adjust care techniques 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 CDMHP is considering if the services and treatment needed by the resident can be provided by the facility as a less-restrictive alternative.

Following are links to websites with information on licensed residential care facilities:

http://www.aasa.dshs.wa.gov/professional/lawsandregs.htm

(A link to the key laws and regulations for Adult Family Homes, Boarding Homes & Nursing Homes)

http://www.aasa.dshs.wa.gov/topics/rescare.htm
(A link to descriptions of Adult Family Homes, Boarding Homes and Nursing Homes)

http://www.leg.wa.gov/RCW/index.cfm?fuseaction=section&section=70.129.110
(A link to resident rights provisions in statute)

RESIDENTIAL SERVICES - CDMHP INTERVENTION CHECKLIST

Following are guidelines and questions that may be helpful to CDMHP's in evaluating a person in a licensed residential care facility. For example, the dangerous behavior may not be due not to a mental disorder but to other factors, such as an infection (e.g., UTI's in residents with dementia), constipation, respiratory disorders, medication interactions, or environmental stressors. Note: Speed of access to medical resources, e.g. lab work, can vary by facility type.

1. Has the facility nurse or resident's treating physician been consulted regarding the resident's needs? What recommendations were provided? How has the resident responded? If recommendations have not been implemented, what is the reason?

2. What lab work, if any, has been done to rule out medical issues? Example: UA, electrolytes, TSH, B12, diagnosis, folic acid, medication levels.

3. Has a pain assessment been completed?

4. Is there any possibility of constipation, dehydration, GI distress or 02 deficiency?

5. What medications does the resident receive? Have there been any medication changes recently? If so, do they correlate in any way to the behavioral changes?

6. Has the resident experienced any environmental or social changes recently? For example, any recent losses, change of residence?

7. Are PRN medications being used as ordered? Are they effective? If so, has the treating physician considered ordering as routine medications?

8. Are behavior changes documented? What interventions have been attempted and what is the documented outcome? Does documentation address duration, intensity and frequency of the behaviors as necessary to assess effectiveness of current interventions? For a person in a nursing home, has the person been identified as having indicators of mental illness on the Pre-Admission Screening Resident Review (PASSR) evaluation?

9. What specifically deescalates the behaviors? Example: staff or family attention or presence, being left alone, removal from/of visual or auditory stimuli. Have all alternatives utilizing these options been explored?

10. Has the family, as appropriate, been notified of the problem and involved in interventions or response plans?

11. Have hospice services been considered as a resource to assist in end-of-life concerns?

RESIDENTIAL SERVICES - 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.

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

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

5. Redirect the resident toward a new interest, rather than away from the object, person or topic involved in the behavior.

6. Reorient the resident without disagreeing with him/her.

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

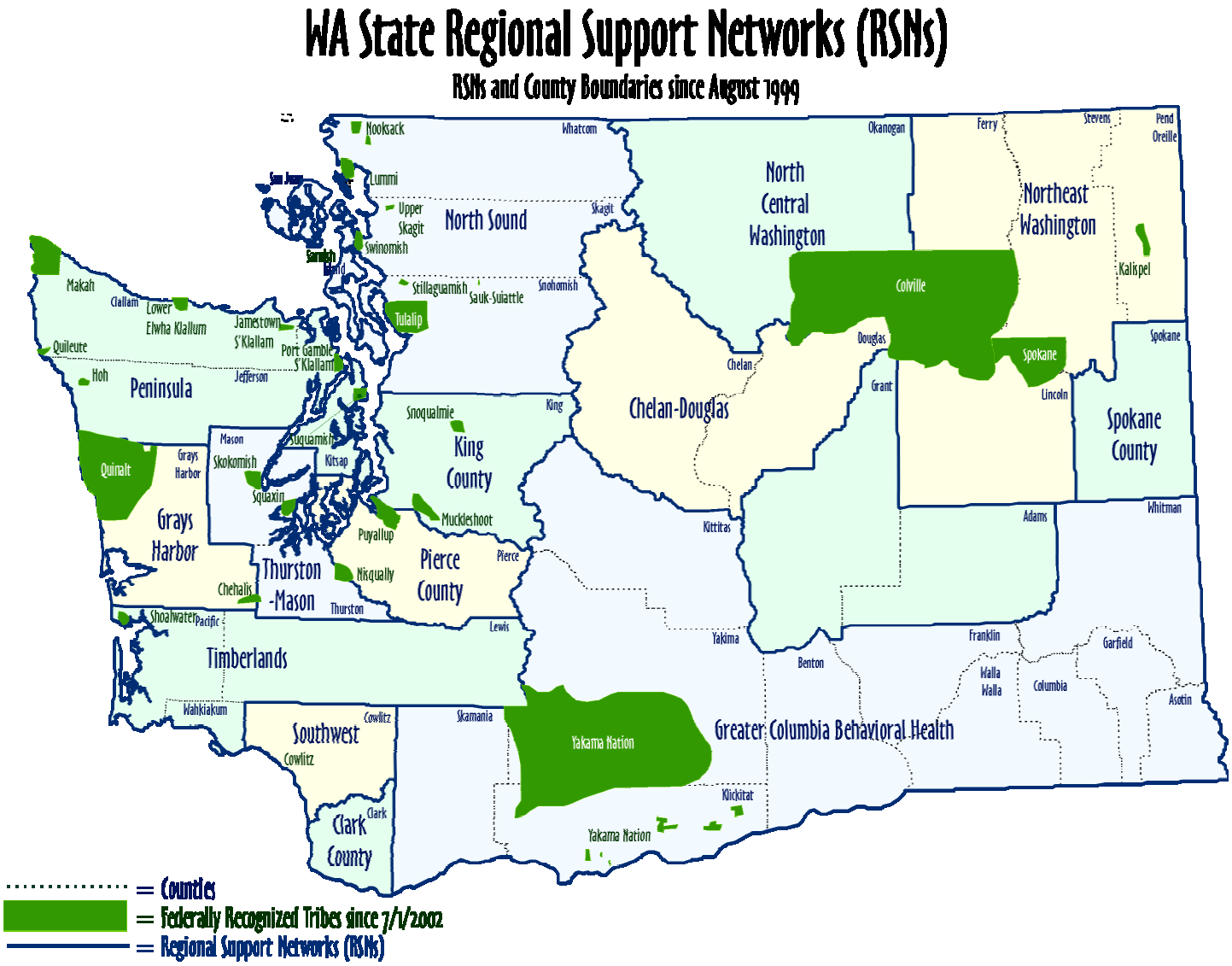
8. Assign the resident tasks that meet their strength and history. Short, repetitive tasks are often best.

9. Go along with or accommodate a fixed delusion or preservative thought rather than fight it.

10. 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.

11. Utilize PRN medications as ordered.

Appendix D: Map of Federally Recognized Tribes



Date: 7/1/02

Appendix E: List of resources for "available history"

Accessing potentially relevant information and records, including information and records that, if reasonably available, must be considered (RCW 71.05.212) 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 **W**ashington Access **T**o **C**riminal **H**istory (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.

- CDMHP 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 CDMHP 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 either 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:
    (a) Western State Hospital: (253) 582-8900.
    (b) Eastern State Hospital: (509) 299-3121.

- Community support service provider, residential facility, or treating physician clinical records may contain relevant information.

Appendix F: 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

1. 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.
2. 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**. Translations of the statement into selected foreign languages are in Part Four of this publication.
   - If the foreign national asks that consular notification be given, notify the nearest consular officials of the foreign national's country without delay. For phone and fax numbers for foreign embassies and consulates in the United States, see **Part Six** of the web site. A suggested fax sheet for making the notification is also included.
3. 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 **Part Six**, and you may use the suggested fax sheet for making the notification.
   - Tell the foreign national that you are making this notification. A suggested statement to the foreign national is found at **Statement 2**, and translations into selected languages are in Part Four.
4. Keep a written record of the provision of notification and actions taken.

~~~~~~

Mandatory Notification Countries and Jurisdictions

Antigua and Barbuda	Malta
Armenia	Mauritius
Azerbaijan	Moldova
Bahamas, The	Mongolia
Barbados	Nigeria
Belarus	Philippines
Belize	Poland (non-permanent residents only)
Brunei	Romania
Bulgaria	Russia
China[1]	Saint Kitts and Nevis
Costa Rica	Saint Lucia
Cyprus	Saint Vincent and the Grenadines
Czech Republic	Seychelles
Dominica	Sierra Leone
Fiji	Singapore
Gambia, The	Slovakia
~~~~~~

Georgia	Tajikistan
Ghana	Tanzania
Grenada	Tonga
Guyana	Trinidad and Tobago
Hong Kong[2]	Turkmenistan
Hungary	Tuvalu
Jamaica	Ukraine
Kazakhstan	United Kingdom[3]
Kiribati	U.S.S.R.[4]
Kuwait	Uzbekistan
Kyrgyzstan	Zambia
Malaysia	Zimbabwe

[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 quot;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 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 G: Sample forms for Less Restrictive Alternative process

(See Section 400)

NOTICE NOT TO EXTEND LESS RESTRICTIVE ALTERNATIVE (LRA)

_____COUNTY INVOLUNTARY TREATMENT
PHONE: ( )
FAX: ( ))

Case Manager:

Agency: Phone Number:

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

Client:

Address:

DOB: SS#:

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

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

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

_____
_____
_____
_____
_____

Case Manager: Date

Case Manager Supervisor: Date:

LESS RESTRICTIVE ALTERNATIVE (LRA) EXTENSION REQUEST

_____COUNTY INVOLUNTARY TREATMENT
PHONE: ( )
FAX: ( )

CDMHP Assigned: _____

CLIENT NAME: _____
Address: _____
_____
Telephone #: ( ) _____
DOB: _____

Case Manager: _____
(Name)
_____
(Agency Name) (Telephone #)

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

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

GENERAL QUESTIONS:

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

_____
_____
_____

Additional information:

_____

_____

_____

LESS RESTRICTIVE ALTERNATIVE (LRA) EXTENSION REQUEST

_____ COUNTY INVOLUNTARY TREATMENT
PHONE: ( )
FAX: ( )

Case Manager:

Agency: Phone Number:

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

Client:

Address:

DOB: SS#:

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

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

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

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

_____
_____
_____
_____
_____
_____

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

_____
_____
_____
_____
_____
_____

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

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

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

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

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

_____
_____
_____
_____
_____
_____
_____

8. Is the client willing to continue with outpatient treatment on a voluntary basis? Would the voluntary status be 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?

_____
_____
_____
_____
_____
_____
_____

9. Please specify <u>all</u> proposed conditions for the future LRA.

_____
_____
_____
_____
_____
_____
_____
_____

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

Case Manager: Date:

OFFICE ( )
FAX ( )

DATE: _____

TO: _____
_____

Telephone: _____

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

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

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

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

Sincerely,

County Designated Mental Health Professional

cc: Office of Public Defense: _____( )

Case Manager: _____( )

Enclosures

Appendix H: CDMHP Knowledge and Education

1. Qualifications as defined in statute:

    A. "County designated mental health professional" means a mental health professional designated by the county to perform the duties of the Involuntary Treatment Acts. RCW 71.05.020(6) and RCW 71.34.020(4)
    B. 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”.

2. Knowledge Base:

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

3. Education/Training

    A. Psychopathology and psychopharmacology.
    B. Knowledge of individual and family dynamics, life span development, psychotherapy and family crisis intervention.
    C. Crisis intervention and assessment of risk, including suicide risk assessment, assessment of danger to others and homicide risk assessment.
    D. Assessment of grave disability, health & safety, cognitive and volitional functions.
    E. Competency with special populations: Chemical dependency, co-occurring disorders, developmental disabilities, ethnic minorities, children and adolescents, older persons, and sexual minorities.
    F. 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
    G. Knowledge of local/regional mental health and chemical dependency treatment resources.
    H. Professional ethics and knowledge of consumer rights.
    I. Petition writing: Factors, elements, and content.
    J. Continuing Education: Clinical/legal/forensic education related to CDMHP function/knowledge base.

Appendix I: References and Resources

1. Diagnostic and Statistical Manual IV

2. Washington State CDMHP Protocols, updated September 2002

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

4. Revised Code of Washington

   A. Adult Involuntary Treatment – Chapter 71.05 RCW
   B. Mental Health Services for Minors – Chapter 71.34 RCW
   C. Criminally Insane – Chapter 10.77 RCW
   D. Treatment for Alcoholism, Intoxication and Drug Addiction – Chapter 70.96A RCW
   E. Interstate Compact on Mental Illness – Chapter 72.27 RCW
   F. Indian Lands Jurisdiction – Chapter 37.12 RCW
   G. Developmental Disabilities – Chapter 71a RCW
   H. Fire Arms and Dangerous Weapons – Chapter 9.41 RCW
   I. Guardianship – Chapter 11.88 RCW

5. Washington State Court Rules

   Superior Court Mental Proceeding Rules (MPR) pp 377-391. (Includes approved forms for petitions.)

6. Washington State Case Law - Index to Cases

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

In Re Meistrell, 47 Wn. App. 100, 733 P.2d 1004 (1987).
Recent past mental history. pp. 108-09.
Substantial evidence. p. 109.

In Re Pugh, 68 Wn. App. 687, 845 P.2d 1034 (1993), review denied, 122 Wn.2d 1018, 863 P.2d 1352 (1993).
Likelihood of serious harm.
Recent overt acts.

In Re Quesnell, 83 Wn.2d 224, 517 P.2d. 568 (1973).
Constitutional guarantees and due process. p. 230.
Base elements of procedural due process. p. 231.
Attorney's duty to investigate before hearing. p. 238.
Waiver of substantial rights. p. 239.
Presumption of competency. p. 239.
Absent knowing consent by Respondent to waiver. p. 240.
Role of jury in civil commitment. p. 240.
Duties of private attorney. p..243.

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

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

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

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

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

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

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

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

Recommended Resources Available from State Library: Books

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Recommended Resources Available from State Library: Journal Articles

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Essock, S. M., Frishman, L. K., & Kontos, N. J. (1998). Cost-effectiveness of Assertive Community Treatment Teams. American Journal of Orthopsychiatry , 68(2), 179-190.

Fernandez, G., & Nygard, S. (1990). Impact of outpatient involuntary commitment on the revolving door-syndrome in North Carolina. Hospital and Community Psychiatry, 40, 1001-1004.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Lindsay, K. P., Paul, G. L., & Mariotto, M. J. (1989). Urban psychiatric commitments: Disability and dangerous behavior of black and white recent admissions. Hospital and Community Psychiatry, 40(3), 286-294.

Lidz, C., Mulvey, E., Hoge, S., Kirsch, B., Monahan, J., Eisenberg, M., Gardner, W., & Roth, L. (1995). Perceived coercion in mental hospital admission: Pressures and process. Archives of General psychiatry, 52, 1034-1039.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Recommended Resources: Internet Websites

Mental Illness, Title 71 RCW:
http://www.leg.wa.gov/pub/rcw/title_71

Mental Health Washington Administrative Code
WAC 388-865-0865

Developmental Disabilities, Title 71.a RCW:
http://www.leg.wa.gov/pub/rcw/title_71a

State Institutions Title, 72 RCW:
http://www.leg.wa.gov/public/rcw/title_72

Criminally Insane, Title 10.77 RCW:
http://www.leg.wa.gov/public/rcw/title_10/chapter077/

Alcoholism, Intoxication, and Drug Addiction, Title 70.96A:
http://www.leg.wa.gov/public/rcw/title_70/chapter_096a/

Fire Arms and Dangerous Weapons, Title 9.41:
http://www.leg.wa.gov/public/rcw/title_09/chapter_041/

Guardianship, Title 11.99 RCW:
http://www.leg.wa.gov/public/rcw/title_11/chapter_088/