

Protocols for Designated Crisis Responders (DCRs)

2020 Update

RCW 71.05.214

Washington State Health Care Authority

Division of Behavioral Health and Recovery

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Executive Summary

The 2020 update of the Protocols for Designated Crisis Responders (DCRs) is provided by the Washington State Health Care Authority (HCA), as mandated by RCW 71.05.214.

HCA is required to develop statewide protocols to be utilized by professionals and designated crisis responders in the administration of chapters 10.77, 71.05, and 71.34 RCW. The protocols shall be updated at least every three years. The protocols shall provide uniform development and application of criteria in evaluation and commitment recommendations, of individuals who have, or are alleged to have, behavioral health disorders and are subject to RCW 71.05.

In compliance with the legislative mandate, the Department of Social and Health Services (DSHS) submitted the initial protocols to the Governor and the Legislature in 1999, and updated them in 2002, 2005, 2008, 2011, 2014, and 2017. Responsibility for updating these protocols transferred to HCA in 2018 with the passage of 2ESHB 1388 (Chapter 201, Laws of 2018).

It is the intent of the 2020 Protocol Workgroup that the protocols help support and clarify the work of DCRs in the face of new legislative changes. Changes to RCW 71.05, 71.34, and 10.77 are incorporated into these updated protocols and the document itself has been restructured and updated to better recognize and address populations with specific needs in the Involuntary Treatment Act (ITA) process – minors, American Indian and Alaskan Natives (AI/AN), and individuals with substance use disorder. The workgroup believes that these changes better clarify ITA process for DCRs and stakeholders and provide progressive guidance for use of the statutes.

Guided by the 2019 Addendum to the DCR Protocols, substance use disorder has been fully integrated into the involuntary treatment process, a continuation of the work that began in the 2017 protocols. This is represented by changes to language, incorporation of substance use disorder professionals and treatment facilities into the involuntary treatment process, and the utilization of the DSM-5 diagnostic criteria for substance use disorder as a framework for considering presentation and risk. The Protocol Workgroup focused on giving substance use and mental health equal consideration when accepting referrals, conducting investigations, and completing detentions.

The items identified for inclusion in the 2019 Addendum are also incorporated into this document, with one exception. The 2019 Addendum states that petitions for detention must be for mental health or substance use disorder; however, the process has changed since the 2019 Addendum's submission, and petitions may indicate both mental health and substance use disorder depending on court guidelines and practice.

RCW 71.34 concerning behavioral health services for minors has been brought more into alignment with RCW 71.05 by recent legislation, to include standardization of language and incorporation of the Joel's Law process for minors. To reflect this alignment, these protocols have included statutory references for both RCW 71.05 and 71.34 where appropriate.

Legislative updates addressing the needs of AI/AN individuals in the involuntary treatment process have been incorporated throughout the protocols, including definitions for Tribal DCRs, Tribal Crisis Coordination Protocols, and culturally competent care and assessments. Updates to the statute requiring DCR consultation with tribal entities, expanding and defining tribal jurisdiction in the civil commitment

process, and adding tribes to the list of petitioners for Joel's Law process have also been integrated into these protocols.

Legislation passed in the 2020 legislative session allows for the use of video technology for ITA assessment by DCRs. Guidance was developed by HCA in consultation with community stakeholders. The HCA guidance has been incorporated into this document. Legislation passed in 2021 clarified that the use of video technology for ITA assessment is also available for the assessment of minors.

Effective July 2019, legislation provided for additional control regarding firearm rights, adding a process for 180-day suspension of firearm rights when an individual is detained due to likelihood of serious harm. Further legislation in 2020 provided additional reporting requirements for DCRs related to suspension of firearm rights beginning January 1, 2021. This process is outlined within these protocols.

2E2SSB 5720 (2020) made changes to the definitions of "gravely disabled" and "likelihood of serious harm" for adults and minors that are not currently in effect but have been included in this protocol document due to the impact they will have on the ITA system when they do come into effect. These changes to detention criteria are contingent on specific conditions in the civil commitment system (numbers of single bed certifications for adults, and average wait time for a Children's Long-term Inpatient Program [CLIP] bed for minors), so an effective date is unknown at this time.

As of January 1, 2020, all behavioral health organizations (BHOs) have converted to integrated managed care, with Medicaid funding overseen by managed care organizations (MCOs). Non-Medicaid services are managed by behavioral health administrative service organizations (BH-ASOs).

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

The 2020 Protocol Workgroup included staff from HCA, with active collaboration from a broad stakeholder group. A list of participants and their affiliations can be found in Appendix A.

Conventions used in this report

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

Within the document are definitions of a number of important words or phrases. When the definition is taken from Washington State statute, a Revised Code of Washington (RCW) citation follows. When no citation is noted, the definition has been developed for this document and should be read as part of the guidelines and without specific statutory authority.

The reader should be aware that RCW citations that appear at the end of many sections are included as references only. They can provide direction to the statute for further information but should not be taken as direct sources for all 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 (LRA) to involuntary detention” (as in Section 230) and “less restrictive alternative court orders” (as in Sections 400 – 430).

The 2020 protocols also have limitations. It is beyond the scope of the protocols to address the myriad clinical skills and practices required of DCRs or the role of the DCRs in providing crisis response and resolution as a mental health professional. In addition, some of the practices followed by DCRs are influenced by the rulings of local courts. These rulings have resulted in procedural differences across the state, which are beyond the authority of the protocols to remedy. The workgroup recognizes that there are significant variations among counties with respect to geography, population, resources, and socioeconomic and political factors. Notwithstanding these issues, the 2020 Protocol Workgroup is satisfied that these protocols will continue to move DCR practices toward greater uniformity in implementation of applicable statutes across the state.

The 2020 Protocol Workgroup wishes to emphasize that regardless of differences in court rulings, local procedures, or inpatient psychiatric bed capacity, it is imperative to the integrity of the system and those we serve that DCRs make their decisions based on clinical presentation, collateral information, and the rules implementing RCWs 71.05, 71.34, and 10.77.

Legislative intent and purpose

Legislation passed in 2020 added clarification to the intent of the adult statute RCW 71.05 that it applies to individuals who are 18 years of age or older. Portions of the intent section from RCW 71.05.010 were added to the purpose section of the minor statute RCW 71.34, bringing them more into alignment.

RCW 71.05.010 Intent (Adult Statute)

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

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

(b) To prevent inappropriate, indefinite commitment of persons living with behavioral health disorders and to eliminate legal disabilities that arise from such commitment;

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

(d) To safeguard individual rights;

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

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

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

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

RCW 71.34.010 Purpose (Minor Statute)

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

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

participate in the treatment decisions for their minor children. The behavioral health care and treatment providers shall, to the extent possible, offer services that involve minors' parents or family.

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

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

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

*(4) It is also the purpose of this chapter to protect the health and safety of minors suffering from behavioral health disorders and to protect public safety through use of the *parens patriae* and police powers of the state. Accordingly, when construing the requirements of this chapter the court must focus on the merits of the petition, except where requirements have been totally disregarded, as provided in *In re C.W.*, 147 Wn.2d 259, 281 (2002). A presumption in favor of deciding petitions on their merits furthers both public and private interests because the mental and physical well-being of minors as well as public safety may be implicated by the decision to release a minor and discontinue his or her treatment.*

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

Recent legislation involving RCW 71.05 and RCW 71.34

SSB 6124 passed during the 2018 legislative session. Relating to involuntary treatment act hearings by video, it allows for court hearings under the involuntary commitment act to be conducted by video.

ESSB 6491 passed during the 2018 legislative session. Assisted outpatient mental health treatment is expanded to include a need for treatment related to a substance use disorder and renamed assisted outpatient behavioral health treatment (AOBHT). Eligibility requirements for AOBHT regarding safe behavior and previous commitments are reduced. The time for a DCR to complete an initial AOBHT investigation is extended to 48 hours; the AOBHT petition may be filed solely by the DCR; the time for superior court review of the AOBHT petition is extended to within five judicial days of filing the petition; and the DCR must provide the individual with specified legal paperwork.

Requirements for LRA providers are expanded to include notification to the care coordinator if specific conditions exist. Under Joel's Law, RCW 71.05.201, the options for court orders include a request to order the DCR to file a petition for AOBHT. Medication management is changed to an optional LRA treatment

service. A DCR may be appointed by the county, an entity appointed by the county, or the behavioral health organization.

2SHB 1907 passed during the 2019 legislative session. References to "secure detoxification facility" are changed to "secure withdrawal management and stabilization facility" in the ITA statute. The Department of Health is required to develop a process by which a provider of behavioral health services may become dually licensed as both an evaluation and treatment (E&T) facility and a secure withdrawal management and stabilization (SWMS) facility. The Health Care Authority is required to develop an addendum to the designated crisis responder statewide protocols to address implementation of the integration of mental health and substance use disorder treatment systems, to include the applicability of commitment criteria and general processes for referrals and investigations of individuals with substance use disorders. (Note this addendum was completed and has now been incorporated into this version of the protocols.)

E2SSB 5432 passed during the 2019 legislative session. It removes behavioral health organizations from law and establishes managed care organizations and behavioral health administrative services organizations (BH-ASOs) to manage the community behavioral health system. It also establishes a workgroup led by the Health Care Authority to determine how to manage access to long-term, involuntary commitment resources in the community and state hospitals until the risk may be fully integrated into managed care.

2E2SSB 5720 passed during the 2020 legislative session. The period of initial detention under the ITA is increased from 72 hours to 120 hours. Definitions of "likelihood of serious harm" and "gravely disabled" are broadened contingent on single-bed certifications and CLIP bed wait times. The use of video is allowed for DCR evaluation and interpreters in hearings. Notification requirements regarding the six-month suspension of firearm rights are increased. A court must issue an order of dismissal when an individual is not detained or committed. A court may authorize involuntary medication as part of an LRA order if the individual was provided with involuntary medication during the involuntary commitment period. A court order for a peace officer to detain an individual for involuntary treatment must be entered into the Washington Crime Information Center database as a written order of apprehension. References to mental disorders and substance use disorders are changed to behavioral health disorders. The definition of violent act is expanded to include behavior that results in injury, or substantial loss or damage to property. The examination required at three hours must be performed by a mental health professional or a chemical dependency professional. When an individual is detained for treatment in a different county from where the individual was initially detained, the facility may file the petition and proof of service. A facility may deny a minor's access to an attorney during the initial detention period only if there is an immediate risk of harm to the minor or others. The time frame to file a 180-day petition for additional treatment of a minor is shortened to three days.

Multiple provisions from adult ITA are imported into minor ITA and applied to individuals under 18 years of age: Joel's Law; strong consideration of prior behavioral health history; consideration of information from all credible witnesses; and the instruction to courts to focus on the merits of involuntary commitment petitions. References are added regarding *parens patrie* and police powers of the state; the statement that dismissal is not the appropriate remedy for violations of certain timeliness requirements; mandatory components of LRA treatment; authorization for a peace officer to take an individual into custody and deliver them to an appropriate facility; authorization for a peace officer to detain an individual who has been arrested for up to eight hours at an appropriate facility; the right to an inventory

of possessions upon entry into detention; duty to warn; and authorization to allow an individual who is detained to leave a facility for temporary periods.

The rights of detained individuals are harmonized between the adult and minor ITA chapters, including clarifying the right to treatment by spiritual means. Language is stricken regarding the Rules of Evidence not applying during a minor's probable cause hearing. The venue for the detention or revocation hearing of a minor must be in the county where treatment is being provided.

An Involuntary Treatment Workgroup is established with up to 18 members to be appointed by the Governor. The workgroup must evaluate the implementation of this act and must provide two reports containing recommendations to the Legislature by January 1, 2021, and June 30, 2022.

SSB 6259 passed during the 2020 legislative session. DCRs may be appointed by HCA in consultation with Indian Health Care Providers (IHCP) or tribes. A tribe must have exclusive jurisdiction over the involuntary commitment of an AI/AN individual to an E&T located within the boundaries of the tribe. The tribe may consent to concurrent state jurisdiction or expressly decline to exercise exclusive jurisdiction. Involuntary commitment orders by tribal court must be recognized and enforced by Washington courts. The DCR must notify the tribe or IHCP regarding whether a petition for initial detention or involuntary outpatient treatment will be filed for an individual who is AI/AN and receives medical or behavioral health services. Notification must be to the tribal contact listed in HCA's Tribal Crisis Coordination Plan as soon as possible and within three hours.

State health information privacy laws are amended to explicitly include IHCPs among qualified professional individuals who may share information and records related to mental health services and civil commitment services, to include tribal courts and to allow mental health information sharing by IHCPs for the purpose of care coordination.

A federally recognized Indian tribe may file a petition for initial detention with the superior court under Joel's Law when a DCR decides not to detain an individual for evaluation and treatment who is a member of that tribe.

The Indian Health Advisory Council must draft recommended legislation to address Indian health improvement needs, including crisis coordination between Indian health care providers and the state's behavioral health system.

A definition is provided in the Community Behavioral Health Services Act for "historical trauma," meaning situations where a community experienced traumatic events, the events generated high levels of collective distress, and the events were perpetuated by outsiders with a destructive or genocidal intent.

HCA must establish written guidelines for conducting culturally appropriate civil commitment evaluations in consultation with IHCPs and the American Indian Health Commission by June 30, 2021.

SHB 1314 passed during the 2021 legislative session. During the 12-hour period in which an individual may be held in a facility pending evaluation by a DCR, the facility must inquire into the individual's veteran status or eligibility for veteran's benefits. If the person identifies as a veteran or is eligible for veteran's status, the facility must ask the person whether he or she is amenable to treatment from the Veteran's Health Administration (VHA). The DCR must receive the information and refer the person to a VA facility for treatment as appropriate.

SSB 5073 passed during the 2021 legislative session. A DCR may conduct the assessment portion of an involuntary treatment evaluation for a minor by video, provided that a health professional who can adequately assist the minor is present at the time of the assessment.

A DCR must attempt to ascertain whether an individual under investigation for civil commitment has executed a mental health advance directive.

The ability for a federally recognized Indian Tribe to file a Joel's Law petition on behalf of an individual who is a member of that Tribe is added to RCW 71.34, making this process available for minors as well as adults. All requirements of the Joel's Law process now include federally recognized Tribes.

Glossary

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

Declaration: A sworn statement by a witness, also defined as the “declarant”

Assisted Outpatient Behavioral Health Treatment (AOBHT): A type of commitment order or specific type of less restrictive alternative treatment order, which is appropriate for individuals who meet specific criteria, can be initiated prior to involuntary inpatient treatment or at any point during a period of commitment, and cannot be revoked but can be enforced or modified

Mental health advance directive: An advance directive entered under Ch. 71.32 RCW.

Behavioral health disorder: Either a mental disorder as defined in this section, a substance use disorder as defined in this section, or a co-occurring mental disorder and substance use disorder [RCW 71.05.020(7), 71.34.020(9)]

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

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

Cognitive functions: The capacity to accurately know or perceive reality, and to understand the fundamental consequences of one’s actions

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

No person may be presumed incompetent as a consequence of receiving evaluation or treatment for a behavioral health disorder. Competency may not be determined or withdrawn except under the provisions of chapter 10.77 or 11.88 RCW [RCW 71.05.217(3)]

Credible: The state of being believable or trustworthy

Cultural humility: The continuous application in professional practice of self-reflection and self-critique, learning from patients, and partnership-building, with an awareness of the limited ability to understand the individual’s worldview, culture(s), and communities

Culturally appropriate care: Health care services provided with cultural humility and an understanding of the individual’s culture and community, and informed by historical trauma and the resulting cycles of Adverse Childhood Experiences (ACEs)

Designated Crisis Responder (DCR): *A mental health professional appointed by the county, by an entity appointed by the county, or by the authority in consultation with a federally recognized Indian tribe or after*

meeting and conferring with an Indian health care provider, to perform the duties specified in this chapter.
[RCW 71.05.020(16)]

Detention vs. commitment: A detention is a 120-hour period of further involuntary evaluation and treatment initiated by a DCR under RCW 71.05 or 71.34; a commitment is a court order issued by the judge or commissioner in response to a petition

Good faith voluntary: The DCR must assess for the ability of an individual to provide informed consent to proposed voluntary treatment; failure to be a “good faith voluntary” patient is not grounds for initial detention under RCW 71.05.150 or RCW 71.05.153; whether or not a respondent is a “good faith volunteer” is considered under RCW 71.05.230 when a petition for treatment beyond the 72-hour evaluation and treatment period is filed

Gravely disabled: *A condition in which a person, as a result of a behavioral health disorder: (a) is in danger of serious physical harm resulting from a failure to provide for his or her essential human needs of health or safety, or (b) manifests severe deterioration in routine functioning evidenced by repeated and escalating loss of cognitive or volitional control over his or her actions and is not receiving such care as is essential for his or her health or safety [RCW 71.05.020(24)]*

Note: The following definitions of “gravely disabled” and “severe deterioration from safe behavior” (changes underlined) will become effective for adults only when monthly single bed certifications fall below 200 reports for three consecutive months, and for minors only when the average wait time for children’s long-term inpatient placement admission is 30 days or less for two consecutive quarters.

“Gravely disabled” means a condition in which a person, as a result of a behavioral health disorder: (a) Is in danger of serious physical harm resulting from a failure to provide for his or her essential human needs of health or safety; or (b) manifests severe deterioration from safe behavior evidenced by repeated and escalating loss of cognitive or volitional control over his or her actions and is not receiving such care as is essential for his or her health or safety;

“Severe deterioration from safe behavior” means that a person will, if not treated, suffer or continue to suffer severe and abnormal mental, emotional, or physical distress, and this distress is associated with significant impairment of judgment, reason, or behavior.

However, individuals cannot be detained on the basis of a severe deterioration in routine functioning unless the detention is shown to be essential for their health or safety. In re: Labelle (1986), see Appendix M.

Grave disability for extending a 90/180-day less restrictive alternative court order: Applies when, without continued involuntary treatment and based on the individual'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 their health or safety; under these circumstances, grave disability does not require that the individual be at imminent risk of serious physical harm.

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

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

[RCW 71.05.212] Whenever a DCR or professional person is conducting an evaluation under this chapter, consideration shall include all reasonably available information from credible witnesses and records regarding:

- Prior recommendations for evaluation of the need for civil commitments when the recommendation is made pursuant to an evaluation conducted under chapter 10.77 RCW
- Historical behavior, including history of one or more violent acts ("Violent act" means behavior that resulted in homicide, attempted suicide, nonfatal injuries, or substantial damage to property) [RCW 71.05.020]
- Prior determinations of incompetency or insanity under chapter 10.77 RCW
- Prior commitments under this chapter

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

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

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

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

Indian Health Care Provider (IHCP): Health care program operated by the Indian health service or by a tribe, tribal organization, or urban Indian organization as those terms are defined in 25 U.S.C. Sec. 1603

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

A.

- the nature and character of the proposed treatment;*
- the anticipated results of the proposed treatment;*
- the recognized possible alternative forms of treatment; and*
- the recognized serious possible risks, complications, and anticipated benefits involved in the treatment and in the recognized possible alternative forms of treatment, including non-treatment.*

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

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

- a) there is evidence that a referred individual may suffer from a behavioral health disorder and
- b) there is evidence that the individual, as a result of a behavioral health disorder, presents a likelihood of serious harm to themselves, other individuals, other's property, or the referred individual may be gravely disabled, and
- c) the referred individual refuses to seek appropriate treatment options [RCW 71.05.150 (1), RCW 71.05.153(1) and RCW 71.34.710

Joel's Law: E2SSB 5269 (2015). Joel's Law allows for an immediate family member, guardian, or conservator, or a federally recognized Indian tribe if the adult individual is a member of such tribe, to petition the court for an individual's immediate detention if the individual was assessed and the DCR made the decision not to detain, or, if 48 hours have elapsed since the request for investigation and the DCR has not taken action to have the individual detained. The petition must be filed in the county in which the investigation occurred or was requested to occur. "Immediate family member" is defined as a spouse, domestic partner, child, stepchild, parent, stepparent, grandparent, or sibling. [RCW 71.05.201]

Law enforcement officer: A member of the state patrol, a sheriff or deputy sheriff, or a member of the police force of a city, town, university, state college, or port district, park rangers, border patrol officers, immigration and customs enforcement, tribal police, or a fish and wildlife officer or ex officio fish and wildlife officer as defined in RCW 77.08.010.

Less restrictive alternative treatment (LRA): means a program of individualized treatment in a less restrictive setting than inpatient treatment. The program is outlined in a court order for outpatient treatment which include services to be provided and conditions that the individual must adhere to. An LRA order may be enforced, modified or revoked as appropriate. [RCW 71.05.575 – 71.05.595]

Conditional release (CR): means a revocable modification of a commitment, which may be revoked upon violation of any of its terms. Often utilized in a similar way to an LRA.

Likelihood of serious harm: (a) *A substantial risk that:*

- i. *physical harm will be inflicted by a person upon his or her own person, as evidenced by threats or attempts to commit suicide or inflict physical harm on oneself;*
- ii. *physical harm will be inflicted by a person upon another, as evidenced by behavior which has caused such harm, or which places another person or persons in reasonable fear of sustaining such harm; or*
- iii. *physical harm will be inflicted by a person upon the property of others, as evidenced by behavior which has caused substantial loss or damage to the property of others; or*

(b) the person has threatened the physical safety of another and has a history of one or more violent acts [RCW 71.05.020(36)]

Note: The following definition of "likelihood of serious harm" (changes underlined) will become effective for adults only when monthly single bed certifications fall below 200 reports for three consecutive

months, and for minors only when the average wait time for children's long-term inpatient placement admission is 30 days or less for two consecutive quarters.

"Likelihood of serious harm" means:

- a) A substantial risk that: (i) Physical harm will be inflicted by a person upon his or her own person, as evidenced by threats or attempts to commit suicide or inflict physical harm on oneself; (ii) physical harm will be inflicted by a person upon another, as evidenced by behavior which has caused harm, substantial pain, or which places another person or persons in reasonable fear of harm to themselves or others; or (iii) physical harm will be inflicted by a person upon the property of others, as evidenced by behavior which has caused substantial loss or damage to the property of others; or
- b) The person has threatened the physical safety of another and has a history of one or more violent acts

Medical clearance: *A physician or other health care provider has determined that a person is medically stable and ready for referral to the designated crisis responder. [RCW 71.05.020(37)]*

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

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

For a minor, the presence of alcohol abuse, drug abuse, juvenile criminal history, antisocial behavior, or intellectual disabilities alone is insufficient to justify a finding of "mental disorder" within the meaning of RCW 71.34.020(42).

Mental health professional (MHP): *A psychiatrist, psychologist, physician assistant working with a supervising psychiatrist, psychiatric advanced registered nurse practitioner, psychiatric nurse, or social worker, and such other mental health professionals as may be defined by rules adopted by the secretary of DOH pursuant to this chapter [RCW 71.05.020(39)]*

"Mental health professional" or "MHP" means a designation given by DOH to an agency staff member or an attestation by the licensed behavioral health agency that the person meets the following:

- a) *A psychiatrist, psychologist, physician assistant working with a supervising psychiatrist, psychiatric advanced registered nurse practitioner (ARNP), psychiatric nurse, or social worker as defined in chapters 71.05 and 71.34 RCW;*
- b) *A person who is licensed by DOH as a mental health counselor or mental health counselor associate, marriage and family therapist, or marriage and family therapist associate;*
- c) *A person with a master's degree or further advanced degree in counseling or one of the social sciences from an accredited college or university who has at least two years of experience in direct treatment of persons with mental illness or emotional disturbance, experience that was gained under the supervision of a mental health professional recognized by DOH or attested to by the licensed behavioral health agency;*
- d) *A person who meets the waiver criteria of RCW 71.24.260, and the waiver was granted prior to 1986; or*

- e) *A person who had an approved waiver to perform the duties of a mental health professional (MHP), that was requested by the behavioral health organization (BHO) and granted by the mental health division prior to July 1, 2001. [WAC 246-341-0515]*

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

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

No-bed Report (also Unavailable Detention Facilities Report): When a DCR determines an individual meets criteria for involuntary inpatient treatment but is unable to detain them due to the lack of an available bed at an evaluation and treatment (E&T) facility or secure withdrawal management and stabilization (SWMS) facility, and the individual cannot be served by the use of a Single Bed Certification, the DCR is required to make a report to HCA within 24 hours.

Parent: *An individual who has established a parent-child relationship under RCW 26.26A.100, including either parent if custody is shared under a joint custody agreement, or a person or agency judicially appointed as legal guardian or custodian of the child [RCW 71.34.020(46)]*

Peace Officer: An officer as defined by RCW 71.05.020(40). (See also, law enforcement officer.)

Reasonably available information: To be considered by the DCR [RCW 71.05.212]:

- Credible witnesses
- Risk assessments and/or discharge summaries from the Department of Corrections (DOC)
- Law enforcement
- Treatment providers, including IHCPs
- Family

Other information which may be available and include:

- Crisis plan
- Mental health advance directives
- Other available treatment records
- Forensic evaluations under RCW 10.77
- Criminal history records
- Risk assessments
- Any information regarding a history of one or more violent acts (see definition)
- Prior civil commitments

Re-entry Community Services Program (RCSP): A category of persons who have been determined by a multi-agency committee to be at a high risk of violence and also have a mental health disorder

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

Secure withdrawal management and stabilization facility (SWMS): *A facility operated by either a public or private agency or by the program of an agency which provides care to voluntary individuals and individuals involuntarily detained and committed under this chapter for whom there is a likelihood of serious*

harm or who are gravely disabled due to the presence of a substance use disorder. Secure withdrawal management and stabilization facilities must:

(a) Provide the following services:

(i) Assessment and treatment, provided by certified substance use disorder professionals or co-occurring disorder specialists;

(ii) Clinical stabilization services;

(iii) Acute or subacute detoxification services for intoxicated individuals; and

(iv) Discharge assistance provided by certified substance use disorder professionals or co-occurring disorder specialists, including facilitating transitions to appropriate voluntary or involuntary inpatient services or to less restrictive alternatives as appropriate for the individual;

(b) Include security measures sufficient to protect the patients, staff, and community; and

(c) Be licensed or certified as such by the department of health; [RCW 71.05.020(51)]

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

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

Single bed certification: The process for requesting an exception to be granted to allow a facility that is willing and able but is not certified under WAC 182-300 to provide timely and appropriate, involuntary inpatient mental health treatment to an adult on a 120-hour initial detention or detention pending a revocation proceeding, a 14-day commitment, or for a maximum of 30 days to allow a community facility to provide treatment to an adult on a 90- or 180-day inpatient involuntary commitment order [RCW 71.05.745, WAC 182-300]

For involuntarily detained or committed children, this exception may be granted to allow timely and appropriate treatment in a facility not certified, until the child's discharge from that setting to the community, or until they transfer to a bed in a CLIP [WAC 182-300].

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

Substance use disorder (SUD): *A cluster of cognitive, behavioral, and physiological symptoms indicating that an individual continues using the substance despite significant substance-related problems; the diagnosis of a substance use disorder is based on a pathological pattern of behaviors related to the use of the substances [RCW 71.05.020(53)]*

Substance use disorder professional (SUDP): *A person certified as a substance use disorder professional by DOH under chapter 18.205 RCW [RCW 71.05.020(54)]*

Sufficient environmental controls: An individual is receiving, or is likely to receive, such care from responsible individuals as is essential to their health, safety, and the safety of others; this description does not apply to jails, as they are not a less restrictive treatment option

Timelines:

Emergency Department

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

An adult taken to a crisis stabilization unit, E&T, emergency department of a local hospital, triage facility, secure withdrawal and stabilization facility, approved, or approved substance use disorder treatment program by a peace officer may be held for **up to 12 hours**, not counting time periods prior to medical clearance [RCW 71.05.153(3)].

Within **3 hours, not counting time for medical clearance**, the individual must be assessed by a mental health professional or substance use disorder professional; **within 12 hours of the notice of need for evaluation**, the DCR must determine if the individual meets criteria for detention [RCW 71.05.153(4)].

A minor, 13 years or older, brought to an evaluation and treatment facility, hospital emergency department, secure withdrawal management and stabilization facility with available space, or an approved substance use disorder treatment program with available space, (the professional person in charge of the facility will evaluate the minor's condition and may arrange for the detention of the minor for **up to 12 hours** to enable a DCR to evaluate the minor [(RCW 71.34.700(2)].

Inpatient Unit

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

A minor, 13 years or older, admitted voluntarily to an evaluation and treatment facility or approved substance use disorder treatment program may give notice of intent to leave at any time. The professional person shall discharge the minor by the second judicial day [RCW 71.34.520].

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

Tribal DCR: A mental health professional appointed by the authority in consultation with a federally recognized Indian tribe, or after meeting and conferring with an Indian Health Care Provider (IHCP), to perform the duties specified in this chapter

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

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

Video: Unless the context clearly indicates otherwise, the delivery of behavioral health services through the use of interactive audio and video technology, permitting real-time communication between an individual and a designated crisis responder, for the purpose of evaluation. "Video" does not include the use of audio-only telephone, facsimile, email, or store and forward technology. "Store and forward technology" means use of an asynchronous transmission of an individual's medical information from a mental health service provider to the designated crisis responder which results in medical diagnosis, consultation, or treatment. [RCW 71.05.020(58)].

Violent act: Behavior that results in homicide, attempted suicide, injury, or substantial loss or damage to property. [RCW 71.05.020(59)]

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

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

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

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

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

Nothing in this chapter shall be construed to limit the right of any person to apply voluntarily to any public or private agency or practitioner for treatment of a behavioral health disorder, either by direct application or by referral. Any person voluntarily admitted for inpatient treatment to any public or private agency shall be released immediately upon his or her request. [RCW 71.05.050(1)]

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

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

Witness: Any individual who provides information to the DCR in the course of an investigation

Potential credible witnesses may include family members, landlords, neighbors, and others with significant contact and history of involvement with the individual to include tribal authorities and Indian Health Care Providers.

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

Referral and investigation

100 – Referrals for an ITA Investigation

The ITA process begins when the DCR receives a referral. Even when a referral is not taken by the DCR who conducts the investigation, it is the beginning of the investigation. Legal timelines begin at the time of referral when the referral originates in a hospital, and any information collected at the time of referral is evidence regarding the DCR's detention decision.

Anyone can make a referral to a DCR. Regional differences in resources and process may create expectations regarding referents, but the statute does not require any credential or procedure prior to making a referral to a DCR.

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

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

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

- Whether it is appropriate to involve law enforcement
- Making a request to take the individual into custody under RCW 71.05 or RCW 71.34

Calling 911 or asking the referring individual to call 911, if the DCR assesses immediate physical danger or safety concerns. The DCR accepts, screens, and documents all referrals for an ITA investigation.

Documentation includes the:

- Name of the individual referred for an ITA investigation
- Name and telephone number of the individual's guardian or other health care decision-maker, if applicable
- Tribal affiliation, if applicable
- Name of caller and relationship to individual being referred
- Date and time of the referral
- Facts alleged by the referent
- Available personal information about the individual to be investigated including:
 - Demographic information
 - Language spoken
 - Whether the individual has an executed mental health advance directive [RCW 71.05.150, 71.05.153]
 - Tribal Crisis Coordination Plan
 - Whatever history may be available

- Potential sources of support to resolve the crisis
- If a minor, the name of the parent or legal guardian
- Contact information of the referent
- Names and contact information for potential witnesses, which may include law enforcement, outpatient providers, and anyone meeting the definition of a potential credible witness (see definition of witness)

The DCR determines if:

- Further investigation is indicated
- There is a need for a second individual to accompany the DCR during the outreach to ensure safety needs are met [RCW 71.05.700]
- Crisis behavioral health services or other community services are more appropriate (and any recommendations).

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

At the time of the referral, the DCR provides information to the referent about DCR procedures and protocols as they relate to the referral. This may include informing the referent whether a face-to-face interview can be expected and what further information is needed for a face-to-face interview. The DCR discloses to the referring party additional information about an investigation only as authorized by law [RCW 70.02.050, .230, .240, .250 and .320. and].

The DCR attempts to conduct a face-to-face evaluation prior to authorizing police or ambulance personnel to take an individual to an evaluation and treatment facility, the emergency department of a local hospital, or other authorized involuntary treatment facility [RCW 71.05.153(1)]. There are two types of situations in which a custody authorization may be issued before an assessment:

First, when a potentially dangerous situation exists and failure to take the individual into custody as quickly as possible poses a threat to the individual or others, the DCR may issue an oral or written custody authorization to law enforcement. The DCR will follow up with a face-to-face assessment after transport to safety has occurred, and the investigation can proceed [RCW 71.05.153(2)].

Second, it is not the intention of the statute to use this process routinely, but in situations where the immediate setting is unsafe and there is ample evidence from collateral sources of information and observation of the individual's presentation, an individual can be detained on an emergent detention without an attempted face-to-face assessment. The DCR will follow up to notify and serve the individual face to face as soon as the individual is in a safe setting.

105 – Timelines for Response

The DCR conducts an ITA investigation and makes a determination regarding detention regardless of statutory timelines.

For Adults

- If an individual was brought to an emergency department voluntarily, the DCR must determine whether the individual meets detention criteria within 6 hours of the emergency department staff determining that a referral to the DCR is needed, not counting time periods prior to medical clearance [RCW 71.05.050].
- If an individual was taken to the emergency department by peace officers, a MHP or SUDP must examine the individual within 3 hours of their arrival, not counting time periods prior to medical clearance, and the DCR must determine whether the individual meets detention criteria within 12 hours of receiving the referral, not counting time periods prior to medical clearance [RCW 71.05.153(4)].
- If an individual was voluntarily admitted for inpatient treatment and requests discharge but presents as a risk of harm or gravely disabled, the DCR must determine whether the individual meets detention criteria no later than end of the next judicial day [RCW 71.05.050].

For Minors

- The DCR will evaluate the minor at the emergency department and commence proceedings to determine whether the minor meets criteria for detention. The minor may be held for twelve hours pending ITA evaluation. [71.34.700(2)]
- A minor, 13 years or older, voluntarily admitted to an evaluation and treatment facility or approved substance use disorder treatment program may give notice of intent to leave at any time. The professional person shall discharge the minor by the second judicial day. [RCW 71.34.520]

110 – Rights of an Individual Being Investigated

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

The DCR shall advise the individual that they have the rights specified in RCW 71.05.217 or, in the case of a minor, rights specified in RCW 71.34.355.

- Identify self by name and position
- Inform the individual of the purpose and possible consequences of the investigation
- Inform the individual that they have the right to remain silent
- Inform the individual that any statement made may be used against them
- Inform the individual being investigated that they may speak immediately with an attorney
- Inform the individual that if they are detained as harm to self, others or property, their right to possess a firearm will be suspended for six months (for adults)
- Reference further rights regarding treatment posted in facilities [RCW 71.05.217, RCW 71.34.355]

The DCR should also consider:

- This is an opportunity for the DCR to explain the legal process simply and clearly, to include a description of the DCR's role and responsibilities, inpatient facilities, and a brief explanation of timelines and court process.
- If the individual chooses to remain silent or requests an attorney, the DCR is obligated to stop the interview. However, the DCR is not obligated to stop the investigation. The individual may choose

to resume the interview at any time. Rights should be provided in writing in a language that the individual is able to understand or read by a certified interpreter. If requested by the individual being investigated, the DCR should read the rights to the individual in their entirety.

The DCR determines whether the individual 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 DCR proceeds with detention if the health care decision-maker is not available. Neither a guardian nor any other health care decision-maker can consent to involuntary behavioral health treatment, observation, or evaluation on behalf of the individual, with the exception of Family Initiated Treatment for minors [RCW 11.92.043(1)(f) effective until 1/1/2022, and RCW 71.34.600].

115 – Process for Conducting an ITA Investigation

The DCR performs or attempts to perform a face-to-face evaluation as part of the investigation before a petition for detention is filed. There may be exceptions where a potentially dangerous situation exists and failure to take the individual into custody as quickly as possible poses a threat to the individual or others and a custody authorization may be issued by a DCR. Regardless of local judicial support, when conducting an investigation for an emergent detention, the DCR must also consider criteria for non-emergent detention and AOBHT, and document as such, regardless of availability of judicial process for non-emergent detention or AOBHT. [RCW 71.05.156]

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

For American Indian/Alaskan Natives, resources for consultation are available from the Tribal Crisis Coordination Hub.

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

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

Health care decision makers include the tribe for tribal members or investigations requested on tribal land – in these circumstances, the Tribal Crisis Coordination Plan and/or the BH-ASO's agreements with the tribe will guide the consultation process regarding the individual's health care decision maker.

120 – Video Assessment

Note: Individual DCR offices may need to modify some of these guidelines based on their local court practices and their work processes with local hospitals and emergency facilities. Examples of regional variation would include timing of completing and serving paperwork, timing of securing collateral information, method of providing the individual with their rights and steps in serving the individual with their detention paperwork.

The Designated Crisis Responder office will work with facilities to incorporate video assessment into regional practice and develop protocols for each facility that address all the elements of the assessment to include paperwork, communication, collection of collateral information, and coordination of treatment for the client.

- 1. Prosecutor coordination:** HCA advises coordinating with local prosecutors to facilitate smooth implementation of the ITA evaluations conducted by video.
- 2. Determining when to conduct video ITA evaluations:** Video ITA evaluations may be conducted for adults for both emergent and non-emergent detentions.
- 3. Coordinating out of region detentions:** When detaining to an E&T or SWMS facility outside of your region, verify with the destination facility which party will file the petition.
- 4. The licensed health care professional:** The presence of a licensed health care professional or professional person is mandatory for video ITA evaluations. "Professional person" is defined under 71.05.020 as a mental health professional, substance use disorder professional, a physician, physician assistant, psychiatric advanced registered nurse practitioner, registered nurse, and such others as may be defined by rules adopted by the secretary pursuant to the provisions of this chapter;

Licensed Health Care Professional is not defined in law. It includes but is not limited to the professionals identified under the "professional person" definition. This includes professions under the mental health professional and substance use disorder professional definitions, as well as the following DOH licensure types:

- Licensed mental health counselors, marriage and family therapists, and social workers
 - Health care assistants
 - Medical assistants
 - Licensed practical nurses
 - Nursing assistants
 - Osteopaths
 - Osteopathic physicians' assistants
 - Licensed psychologists
 - Emergency medical services and trauma care workers
- 5. Role of the licensed health care professional or professional person:** This individual would be responsible for:
 - Remaining with the client when the DCR is conducting the evaluation
 - Facilitating the use of technology, namely verifying that the DCR is clearly visible and audible, and that the audio/video communication is functioning correctly
 - Providing a phone if the client wishes to call an attorney
 - Serving physical copies of the paperwork, as directed by the DCR
 - Providing instructions to the ambulance crew, as directed by the DCR
 - 6. Settings for conducting video ITA evaluations:** Video ITA evaluations may be conducted in any setting in which a professional person is available to assist and facilitate the evaluation. Examples may include:
 - Acute care hospital, including emergency department
 - Evaluation and treatment Facility

- Secure withdrawal management and stabilization facility
 - Crisis stabilization facility
 - Crisis triage facility
 - Jail/correctional facility
 - Detention centers
 - Community setting
 - Any tribal facility with permission from and coordination with the tribe as outlined in the Tribe/HCA Protocols for Crisis Coordination
- 7. Extenuating circumstances:** Prior to initiating the evaluation the DCR should consult with facility staff to verify that there are no extenuating circumstances which would preclude the use of video assessment. If there are extenuating circumstances, consult with facility staff to determine if those obstacles can be mitigated. Examples:
- Need for interpretive services
 - Client has visual limitations and cannot see the screen
 - Client's presentation and symptoms are specifically related to technology, causing them fear and discomfort beyond distress resulting from a crisis situation
- 8. Physical space and connectivity:** The location of the DCR when conducting video evaluations may vary. However, all locations should be situated so that the evaluation is as secure and confidential as possible. The DCR may be located in an office in the hospital or facility, the DCR office, or other type office. If the DCR conducts the evaluation from home, the network connection must be secure and encrypted and the DCR should attest to the fact that no other individuals can observe or potentially interrupt the evaluation.
- 9. Collateral information:** Prior to commencing the evaluation, DCRs should gather as much collateral information as possible. This will include history, recent events, and current presentation. Information from facility staff will be especially important as the DCR will not be physically present for the evaluation.
- 10. Conducting the evaluation/investigation:**
- a. The DCR shall introduce themselves and read the client rights as usual.
 - b. The DCR shall include in the documentation/petition that it is a video assessment and identify the assisting staff present with the client document the time rights were read and that a copy of the rights was provided to the client by the assisting staff, per usual practice.
 - c. Proceed with the ITA evaluation. During the evaluation take into consideration the novelty and/or concerns of the individual experiencing this type of evaluation.
 - d. Consultation with the ED medical professional, if required, regarding your decision to detain or not detain will need to happen over the phone or video. Document the conversation and any concerns voiced by the ER medical professional.
- 11. Locating an E&T or SWMS bed:** If the DCR has made the decision to detain, the DCR should begin calling facilities, per usual practice. DCRs may request that the assisting staff fax the DCR the labs and any medical documentation/information that would be provided in the normal course of placing a detained individual so that the DCR can send the information to potential facilities for screening. Keep the assisting staff apprised of progress in finding a facility willing to accept the client.
- 12. Final steps:**

- a. If detaining the individual, complete your paperwork, sign, date and finalize. Fax it to the facility so the assisting staff can physically serve the client. Ensure that the documentation clearly states the circumstances and details of the video assessment, including identifying the facility professional who assisted.
 - i. Coordinate with the assisting staff to facilitate a second, brief video session to virtually serve the client.
 - ii. If detaining due to risk of harm to self/others/property, the DCR reads the client the DCR Notification of Suspension of Firearm Rights over video.
- b. If not detaining the individual, coordinate with the assisting staff to let them know the outcome of the decision and develop a plan to hand-off the client for an appropriate less restrictive alternative, crisis follow-up service, return to family, etc.

Guidance for DCR coordination with assisting facility staff

- a) The DCR is responsible for assisting facility staff so that the facility staff can understand paperwork and documentation requirements according to the outcome of the evaluation. If a client is being detained the client will need to be served a copy of the detention paperwork. There may be additional facility requirements depending on location of placement and it is the responsibility of the DCR to work with facility staff to ensure that all involved get the needed paperwork. This may include instructing facility staff to provide copies of paperwork to secure transport providers and preparing copies for the destination facility.
- b) If the client is being recommended for voluntary hospitalization, the hospital and DCR will follow their regular procedures.
- c) If the client does not meet criteria for detention and the DCR recommends less restrictive options in the community or in another setting, the hospital and DCR will follow their regular procedure for such cases.
- d) If the client meets criteria for detention, and they are staying at the hospital on a Single Bed Certification, the DCR (or hospital staff) will complete the form as usual, fax to the state hospital, then a copy will be included along with the detention paperwork.
- e) If the client meets criteria for detention but there is no bed available, consult with the attending physician by phone to discuss risk factors and a plan. The DCR will complete the No Bed Report as usual.

125 – Determining the Presence of a Behavioral Health Disorder

"Behavioral health disorder" means either a mental disorder as defined in this section, a substance use disorder as defined in this section, or a co-occurring mental disorder and substance use disorder [RCW 71.05.020(7), RCW 71.34.020(9)]

A formal diagnosis of a behavioral health disorder is not required to establish a mental, emotional or organic impairment, but only that the disorder has a substantial adverse effect on cognitive or volitional functioning.

Individuals with co-occurring mental disorder and substance use disorder may present with different symptoms and different risk factors depending on their specific situation at the time of assessment - if

they are intoxicated, withdrawing, have not been taking their psychiatric medications, or any number of factors.

To evaluate the presence of a mental disorder or substance use disorder, a DCR assesses an individual's behavior, presentation, judgment, orientation, memory, thought process, affect, and impulse control.

The DCR also takes into consideration the individual's age; developmental and cognitive functioning; culture and ethnicity; language spoken and communication; history of diagnosis, treatment, and periods of recovery; the duration, frequency and intensity of any behavioral health symptom; and any medical conditions or diagnoses.

The DCR is aware of and practices trauma informed care, recognizing signs and symptoms that may indicate trauma (coping and survival skills), acknowledging that the experience of trauma is widespread, and actively avoiding re-traumatization as much as can be done within the context of a crisis and an involuntary treatment assessment. For members of minority cultural groups, including AI/AN individuals, trauma and historical trauma are particularly significant, and must be addressed by conducting culturally appropriate evaluations. [Guidelines for culturally appropriate evaluations of American Indian or Alaska Natives will be developed.]

The DCR may, in addition to evaluating presentation and symptomology, also review the DSM-5 framework for substance use disorder. This framework does not indicate detention criteria on its own but does indicate the presence of a substance use disorder and may provide guidelines for evaluating risk holistically in the individual's life. When evaluating an individual for detention, history and patterns of behavior become even more important, due to the variation in symptoms and risk based on the individual's current state – intoxication, withdrawal, in recovery, in treatment, etc.

The DCR will use this framework and criteria to establish the presence of a substance use disorder for the purposes of the petition for detention but is not required to establish a formal diagnosis.

DSM-5 Diagnostic Criteria for Other (or Unknown) Substance Use Disorder

1. The substance is taken in larger amounts, or over a longer period than was intended.
2. There is a persistent desire or unsuccessful attempts to cut down or control use of the substance.
3. A great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects.
4. Craving, or a strong desire or urge to use the substance.
5. Recurrent use of the substance despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of its use.
6. Important social, occupational, or recreational activities are given up or reduced because of use of the substance.
7. Recurrent use of the substance in situations in which it is physically hazardous.
8. Use of the substance is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.
9. Tolerance as defined by either of the following,
 - a. A need for markedly increased amounts of the substance to achieve intoxication or desired effect
 - b. A markedly diminished effect with continued use of the same amount of the substance

10. Withdrawal as manifested by either of the following:
 - a. The characteristic withdrawal syndrome for other (or unknown) substance (refer to criteria A and B of the criteria sets for other [or unknown] substance withdrawal, pg. 583),
 - b. The substance (or a very closely related substance) is taken to relieve or avoid withdrawal symptoms

130 – Determining Dangerousness and/or Grave Disability

Danger to Self or Others

“Likelihood of serious harm” means a substantial risk that:

Physical harm will be inflicted by an individual upon his or her own person, as evidenced by threats or attempts to commit suicide or inflict physical harm on oneself;

Physical harm will be inflicted by an individual upon another, as evidenced by behavior which has caused such harm or which places another person or persons in reasonable fear of sustaining such harm; or

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

The individual has threatened the physical safety of another and has a history of one or more violent acts [RCW 71.05.020(36)].

Grave Disability

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

Is in danger of serious physical harm resulting from a failure to provide for his or her essential human needs of health or safety RCW 71.05.020(24)(a); or

Manifests severe deterioration in routine functioning evidenced by repeated and escalating loss of cognitive or volitional control over his or her actions and is not receiving such care as is essential for his or her health or safety [RCW 71.05.020(24)(b)].

See Appendix L.

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

The following definitions of “gravely disabled,” “severe deterioration from safe behavior” and “likelihood of serious harm” will become effective for adults when monthly single bed certifications fall below 200 reports for three consecutive months, and for minors when the average wait time for children’s long-term inpatient placement admission is 30 days or less for two consecutive quarters.

“Gravely disabled” means a condition in which a person, as a result of a behavioral health disorder: (a) Is in danger of serious physical harm resulting from a failure to provide for his or her essential human needs of health or safety; or (b) manifests severe deterioration from safe behavior evidenced by repeated and escalating loss of cognitive or volitional control over his or her actions and is not receiving such care as is essential for his or her health or safety;

"Severe deterioration from safe behavior" means that a person will, if not treated, suffer or continue to suffer severe and abnormal mental, emotional, or physical distress, and this distress is associated with significant impairment of judgment, reason, or behavior

A substantial risk that: (i) Physical harm will be inflicted by a person upon his or her own person, as evidenced by threats or attempts to commit suicide or inflict physical harm on oneself; (ii) physical harm will be inflicted by a person upon another, as evidenced by behavior which has caused harm, substantial pain, or which places another person or persons in reasonable fear of harm to themselves or others; or (iii) physical harm will be inflicted by a person upon the property of others, as evidenced by behavior which has caused substantial loss or damage to the property of others; or (b) The person has threatened the physical safety of another and has a history of one or more violent acts.

A DCR may take an individual, or cause by oral or written authorization to be taken into emergency custody, when the individual presents an imminent likelihood of serious harm or is in imminent danger because they are gravely disabled as a result of a behavioral health disorder [RCW 71.05.153(1)].

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

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

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

Symptoms and behavior of the respondent which standing alone would not justify civil commitment may support a finding of grave disability or likelihood of serious harm, or a finding that the person is in need of assisted outpatient behavioral health treatment, when:

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

(b) These symptoms or behavior represent a marked and concerning change in the baseline behavior of the respondent; and

(c) Without treatment, the continued deterioration of the respondent is probable.

[RCW 71.05.212(3)]

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

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

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

135 – Use of Reasonably Available History

Information to be considered by the DCR [RCW 71.05.212]:

- Prior recommendations for evaluation of the need for civil commitments when the recommendation is made pursuant to an evaluation conducted under chapter 10.77 RCW
- Historical behavior, including history of one or more violent acts
- Prior determinations of incompetency or insanity under chapter 10.77 RCW
- Prior commitments under this chapter
- Risk assessments and/or discharge summaries from the Department of Corrections (DOC)
- Information from:
 - Credible witnesses
 - Law enforcement (to include tribal law enforcement, see full definition of law enforcement in the Glossary)
 - Treatment providers and other behavioral health providers (including Indian Health Care Providers (IHCPs))
 - Family

Other information which may be available and include:

- Crisis plan
- Mental health advance directive
- Other available treatment records (for both mental health and substance use treatment)
- Forensic evaluations under RCW 10.77
- Criminal history records
- Risk assessments
- Any information regarding a history of one or more violent acts (see definition)
- Prior civil commitments
- Medical records or emergency department information
- Any information collected in a prior evaluations documenting cultural considerations

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

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

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

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

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

140 – Interviewing Witnesses as Part of an Investigation

Credible means the state of being believable or trustworthy.

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

The DCR must consider information provided from credible witnesses [RCW 71.05.212]. For minors, the DCR shall investigate the specific allegations and the credibility of the witnesses [RCW 71.34.710]. Information obtained from the parent, legal guardian, care providers, school, juvenile justice and other involved systems may be used to further the investigation. For minors currently receiving mental health services, attempts will be made to interview the service providers for the most current information/evidence related to the investigation.

A DCR shall:

- Interview reasonably available, potentially credible witnesses who may have pertinent information. Credible witnesses may include family members, landlords, neighbors or others with significant contact or history of involvement with the individual, including individuals identified by the individual being investigated.
- Interview professionals and other treatment providers, including tribal providers and IHCPs.
- Assess the specific facts alleged and the reliability and credibility of any individual providing information that will be used to determine whether to initiate detention.
- Inform the prosecuting attorney of the contact information for credible witnesses.
- Exercise reasonable professional judgment regarding which witnesses to contact before deciding if an individual should be detained. This may include whether the witness's story is consistent, plausible, free from bias or personal interest and able to be corroborated by other individuals or physical evidence.
- Inform witnesses (to include family and providers) that they may be required to testify in court under oath and may be cross-examined by an attorney. If known, the DCR will inform any possible witness of the date, time and location of the probable cause hearing. If unknown, the DCR will provide any possible witness with the telephone number of the prosecuting attorney.
- Request declarations/affidavits from witnesses and collateral sources of information (including tribal providers) to be filed with detention paperwork.
- A DCR must consult with any examining emergency department physician, advanced registered nurse practitioner, or physician assistant when conducting an evaluation for emergent, non-emergent, or the need for assisted outpatient treatment, and give serious consideration to the observations and opinions of the examining emergency department staff [RCW 71.05]. The DCR must document this consultation, or the reason for lack of consultation, both in the petition and in case documentation.

143 – Investigation Outcomes Other Than Detention

Non-Emergent Detention – Detention in the Absence of Imminent Harm

A DCR may take an individual into emergency custody when the individual presents an imminent likelihood of serious harm or is in imminent danger because they are gravely disabled as a result of a behavioral health disorder [RCW 71.05.153(1)].

If an adult meets the criteria for detention but the likelihood of serious harm presented is not imminent, then the DCR may initiate a non-emergency detention. [RCW 71.05.150(1)]. The DCR petitions the Superior Court for an order directing the DCR to detain the adult to an involuntary treatment facility.

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

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

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

Evaluation to Determine Need for Assisted Outpatient Behavioral Health Treatment

When conducting an assessment for AOBHT, address the following criteria.

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

- a) *Has been committed by a court to detention for involuntary behavioral health treatment during the preceding thirty-six months;*
- b) *is unlikely to voluntarily participate in outpatient treatment without an order for less restrictive alternative treatment, based on a history of nonadherence with treatment or in view of the person's current behavior;*
- c) *is likely to benefit from less restrictive alternative treatment; and*
- d) *requires less restrictive alternative treatment to prevent a relapse, decompensation, or deterioration that is likely to result in the person presenting a likelihood of serious harm or the person becoming gravely disabled within a reasonably short period of time; [RCW 71.05.020(29)]*

Consideration of Alternatives to Detention

When considering whether to utilize alternatives to emergent detention, the DCR assesses whether those alternatives are reasonably available, and if voluntary, if the individual is willing and able to accept those services and if sufficient environmental controls and supports are in place to reasonably ensure the safety of the individual and community.

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

Referring an Individual for Services when the Decision is not to Detain

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

- Determines whether a direct referral to community support services, emergency crisis intervention services or other community services is appropriate in order to assure continuity of care
- Either renews or facilitates contact with the individual when requested
- *RCW 71.05.150(6) In any investigation and evaluation of an individual under RCW 71.05.150 or 71.05.153 in which the designated crisis responder knows, or has reason to know, that the individual is an American Indian or Alaska Native who receives medical or behavioral health services from a tribe within this state, the designated crisis responder shall notify the tribe or Indian health care provider regarding whether or not a petition for initial detention or involuntary outpatient treatment will be filed. Notification shall be made in person or by telephonic or electronic communication to the tribal contact listed in the authority's tribal crisis coordination plan as soon as possible but no later than three hours subject to the requirements in RCW 70.02.230 (2)(ee) and (3). A designated crisis responder may restrict the release of information as necessary to comply with 42 C.F.R. Part 2.*

145 – Availability of Resources – Single Bed Certification and No-Bed Reports

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

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

Immediate availability of a certified bed in an evaluation and treatment facility or a secure withdrawal management and stabilization facility will not be a factor in determining whether or not to conduct an investigation. Nor shall it influence the determination if an individual meets detention criteria.

An individual can only be detained on an SBC if they are able to be detained under ITA for Mental Disorder. An individual cannot be detained on an SBC if they only meet criteria for detention under ITA for a Substance Use Disorder. If the DCR is unsuccessful in locating an available bed in an E&T or SWMS, and the hospital is unwilling to accept an SBC for the individual, the DCR will complete a No-Bed Report, and will continue providing any further appropriate services to the individual per these protocols and the applicable MCO, BH-ASO, tribe or HCA practices.

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

- Pursue certified E&T beds or certified SWMS beds in counties within close proximity
- Locate and secure certified E&T beds or certified SWMS beds elsewhere within the state
- Request a Single Bed Certification in accordance with WAC 182-300-0100 (if pursuing an E&T bed only until July 1, 2026)
- Complete a No-Bed Report in accordance with RCW 71.05.750

Single Bed Certification

1. If an E&T bed is required and no E&T bed can be located, the MCO/BH-ASO or its designee responsible for the region in which the DCR is designated should locate an appropriate bed capable of providing individualized treatment and request single bed certification from the State Hospital that serves their region.
2. The Single Bed Certification Form requires that the MCO/BH-ASO or its designee, by signing the form, documents that the facility confirmed it is willing and able to provide adequate treatment services and that the facility will provisionally accept placement upon receipt of the approved Single Bed Certification.
 - a. The State Hospitals will only process requests submitted on the most current form (found here: <https://www.hca.wa.gov/billers-providers-partners/behavioral-health-recovery/designated-crisis-responders-dcr>).
 - b. For involuntarily detained minors, a hospital may request an exception to allow treatment in a facility not certified under WAC 246-341 until the minor's discharge from that setting to the community, or until they transfer to a bed in a CLIP.
3. The State Hospital will process the request in a timely manner and fax the approved request back to the representative of the MCO/BH-ASO.
4. Upon receipt of the state hospital approved Single Bed Certification Form, the individual may be served the ITA or LRA Revocation paperwork.

A designated crisis responder who submits an application for a single bed certification for treatment at a facility that is willing and able to provide timely and appropriate mental health treatment in good faith belief that the single bed certification is appropriate may presume that the single bed certification will be approved for the purpose of completing the detention process and responding to other emergency calls. [RCW 71.05.745(3)]

5. The DCR will provide a copy of the approved Single Bed Certification Form to the facility where the individual is held and keep a copy for their own office records.
6. The DCR will file or attempt to file the ITA or LRA Revocation paperwork with the Superior Court of the county where the individual is physically present. (If required by the facility, it is suggested that the DCR get a court certified copy of the legally filed paperwork to send with the individual if an E&T is found in another county.) [RCW 71.05.160, RCW 71.05.340 and RCW 71.34.710, RCW 71.34.780]

E&T or SWMS not available

When conducting an ITA investigation in circumstances which suggest an E&T or SWMS bed is not readily available to meet the treatment needs of an individual, the DCR will proceed as follows:

1. The DCR determines if the individual meets detention criteria, observing legally required time frames, following all applicable Washington State laws for the ITA or LRA process.
2. If the detention investigation occurs in a hospital or hospital emergency department, the DCR will notify treating hospital medical staff of their findings.
3. When the DCR determines that the individual meets emergent detention criteria, the DCR either:
 - a. Locates an E&T or SWMS bed and secures provisional acceptance from that facility or;

- b. Makes a determination that the individual's treatment needs can be met with a Single Bed Certification (for detention to an E&T only until July 1, 2026) and secures provisional acceptance from that facility.
4. If the DCR is unsuccessful in locating an E&T or SWMS, and an SBC is not appropriate for the individual, the DCR will complete an Unavailable Detention Facility Report (No-Bed Report) and will continue providing any further appropriate services to the individual per these protocols and the applicable MCO, BH-ASO, Tribe or HCA practices. The individual must be released unless there is a bed to detain them to.

No-Bed Report (Unavailable Detention Facilities Report Form)

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

1. The individual cannot be detained unless there is a bed to detain them to – either E&T, SWMS, or Single Bed Certification in a facility willing and able to provide services.
2. The ITA investigation is concluded when a determination is reached. If the determination is that the individual meets criteria for detention but there is no available bed, the investigation is still concluded.
3. A face-to-face reassessment is conducted each day by the DCR or mental health professional (MHP) employed by the crisis provider to verify that the individual continues to require involuntary treatment.
4. Every time an individual meets criteria for detention but cannot be detained due to no available bed, follow the procedure determined by the DCR's BH-ASO, tribe or HCA. These procedures may vary by region based on available resources and may include:
 - a. A face-to-face reassessment is conducted each day by the DCR or mental health professional (MHP) employed by the crisis provider to verify that the individual continues to require involuntary treatment. If a bed is still not available, the DCR sends a new Unavailable Detention Facilities Report (No Bed Report) to HCA and the DCR or MHP works to develop a safety plan to help the individual meet their health and safety needs. The DCR continues to work to find an involuntary treatment bed and explore less restrictive alternatives.
 - b. Coordination with a hospital emergency department to provide care under their authority and maintain physical safety until a bed can be located; and/or,
 - c. Follow-up in the community by crisis services to reassess the individual for safety if the individual is released.

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

155 – Considerations for Specific Populations and Locations;

155.1 – Minors

The DCR may not detain any minor under the age of 13 [RCW 71.34.500(1)]. Authorization from an individual who may consent on behalf of a minor is required for inpatient treatment of a minor under the age of 13 [RCW 7.70.065(2)].

Notification

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

For a minor who is a state dependent, the DCR contacts the minor's Washington State Department of Children, Youth, and Families (DCYF) case worker, or the DCYF case worker's supervisor if known and available, as soon as possible, and prior to contacting the minor's parent [RCW 13.34.320 and RCW 13.34.330].

Family Initiated Treatment (FIT)

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

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

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

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

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

Referrals of a Person Charged with Possessing Firearms or Dangerous Weapons on School Facilities

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

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

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

When practicable, and as allowed by applicable privacy laws such as the Family Educational Rights and Privacy Act (FERPA), the DCR should request from the school facility and school district all prior risk assessments and weapons or violence incident reports concerning the minor, which are in the possession of the school facility or school district. The DCR provides the result of the evaluation to the charging criminal court for use in the criminal disposition. The DCR, to the extent permitted by law, notifies a parent or guardian of the minor being examined of the fact of the investigation and the result.

The DCR, if appropriate, may refer the person to local behavioral health administrative services organization for follow-up services or other community providers for other services to the family and person. [RCW 9.41.280(2)]

155.2 – American Indian/Alaska Natives (AI/AN)

Referrals of Members of a Federally Recognized Tribe

DCRs will provide culturally appropriate available resources to members of federally recognized Tribes by coordinating with the Tribal government or IHCP as follows:

- If there is a Tribal Crisis Coordination Plan, the DCR will comply with those protocols.
- If there is not a Tribal Crisis Coordination Plan, the DCR will consult the Indian Health Care Provider to identify provider contact information and contact information for notification of their detention decision.
- If there is no Indian Health Care Provider, the DCR will consult a Tribal Council representative to identify provider contact information and contact information for notification of their detention decision.

Referral of Members of a Federally Recognized Tribe on Tribal Land

DCRs will consult the Tribal Crisis Coordination Plan regarding conducting the ITA investigation on tribal land, to include a description of the procedures or processes for:

- 1) DCRs to access tribal lands to provide services
- 2) Providing services on tribal lands in the evening, holidays, or weekends if different than during business hours
- 3) Notifying tribal authorities when crisis services are provided on tribal land, especially on weekends or holidays or after business hours, including who is notified and timeframes for notification
- 4) How DCRs will coordinate with tribal mental health and/or SUD providers
- 5) When a DCR determines whether to detain or not for involuntary commitment, and

- 6) If ITA evaluations cannot be conducted on tribal land, how and by whom individuals will be transported to non-tribal lands for involuntary commitment assessment and detention.

Notification

Per RCW 70.02, a DCR must release information to a tribe, a tribal court, tribal law enforcement, and IHCPs on same basis as they would for a non-tribal court, provider, or law enforcement. Additionally, notification requirements regarding detention decisions specifically for AI/AN individuals are outlined below.

RCW 71.05.150(67) In any investigation and evaluation of an individual under RCW 71.05.150 or 71.05.153 in which the designated crisis responder knows, or has reason to know, that the individual is an American Indian or Alaska Native who receives medical or behavioral health services from a tribe within this state, the designated crisis responder shall notify the tribe or Indian health care provider regarding whether or not a petition for initial detention or involuntary outpatient treatment will be filed. Notification shall be made in person or by telephonic or electronic communication to the tribal contact listed in the authority's tribal crisis coordination plan as soon as possible but no later than three hours subject to the requirements in RCW 70.02.230 (2)(ee) and (3). A designated crisis responder may restrict the release of information as necessary to comply with 42 C.F.R. Part 2.

Tribal DCRs

A tribal organization may, in consultation or conference with HCA, designate professionals as Tribal DCRs, to perform the duties outlined in RCW 71.05 and RCW 71.34. As outlined in the protocols developed by the tribal organization, Tribal DCRs will have the same authority as DCRs and within the Superior Court system for tribal and non-tribal members.

Culturally Appropriate Evaluations

DCRs will conduct culturally appropriate ITA evaluations, being mindful of the tenets of culturally appropriate care that is provided with cultural humility and an understanding of the individual's culture and community, and historical and personal trauma.

HCA, in consultation with tribes and coordination with Indian Health Care Providers and the American Indian Health Commission for Washington State, shall establish written guidelines by June 30, 2021, for conducting culturally appropriate evaluations of American Indians or Alaska Natives. RCW 71.05.212(5).

155.3 – Individuals with Dementia or Developmental/Intellectual Disability (DD/ID)

Persons with developmental disabilities, impaired by substance use disorder, or suffering from dementia shall not be detained for evaluation and treatment or judicially committed solely by reason of that condition unless such condition causes a person to be gravely disabled or to present a likelihood of serious harm. However, persons with developmental disabilities, impaired by substance use disorder, or suffering from dementia and who otherwise meet the criteria for detention or judicial commitment are not ineligible for detention or commitment based on this condition alone [RCW 71.05.040].

The DCR may not rule out a referral for investigation because of the sole presence of dementia, or a developmental disability. Such an individual may be detained for evaluation and treatment on the basis of such a condition if that condition causes the individual to be gravely disabled or to present a likelihood of serious harm.

In cases where the subject of the investigation has a diagnosis of dementia, the DCR should explore all less restrictive treatment options including returning to their residential placement, possibly with increased supports, or empowering and encouraging a family to assist in treatment decisions. (See section 155.5 Referrals from a Licensed Residential Care Facility, below).

In cases where the subject of the investigation has a diagnosis of developmental or intellectual disability, and may be eligible for, or receiving services from, the DSHS Developmental Disabilities Administration (DDA), the DCR should call the regional DDA contact to explore all less restrictive treatment options including any resources that may be available through DDA, to include possible diversion options and any available treatment plans or a Cross System Crisis Plan. DDA does not provide 24-hour crisis services. If you are investigating, or have detained, someone that you believe may be involved with DDA, please contact a local office during business hours, and ask to be connected to a member of the Regional Clinical Team. They will assist you to verify enrollment with DDA and with further information, including additional contacts and possible service planning.

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

See Appendix E.

155.4 – Referrals from an Emergency Department

Medical clearance and referral

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

When investigating an individual for detention due to a behavioral health disorder, the DCR should not rule out evaluation of an intoxicated individual. Current intoxication and history of intoxication and substance use should be considered in the assessment of risk, not used as a rule out for assessment or detention.

There are individuals who do not require hospital-level medical care and are medically cleared, but whose medical care needs are more than can be handled by an involuntary inpatient facility. These situations may be handled with the use of a single bed certification, if available, or may require further discussion and collaboration with the hospital staff.

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

- Deliver non-emergent medical care to an incompetent patient; or
- Appoint a legal guardian who can make medical decisions on behalf of the patient [RCW 7.70.050(4), RCW 7.70.065, and RCW 11.88.010(1)(e) effective until 1/1/22]

Required Consultation with an Emergency Department Professional

When the individual is located in an emergency department at the time of the investigation, the DCR shall take serious consideration of observations and opinions by the examining emergency department physician, advanced registered nurse practitioner, or physician's assistant in determining whether detention under this chapter is appropriate. If the medical professional is not available for consultation, the DCR can review the professional's written observations and opinions. The designated crisis responder must document the consultation with the medical professional, or review of their written observations and opinions [RCW 71.05.154].

155.5 – Referrals from a Licensed Residential Care Facility

The five broad categories of licensed care facilities are nursing homes, assisted living facilities, adult family homes, enhanced secure facilities, and residential treatment facilities.

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

If there is sufficient evidence to indicate that the individual, as a result of a behavioral health disorder, is a danger to self, others, or others' property, or is gravely disabled, then the DCR assesses whether the facility is a less restrictive treatment option. The facility may be considered a potential less restrictive treatment option if the needs of the resident can be met and the safety of other residents can be protected through reasonable changes in the facility's practices or the provision of additional services. However, if the facility cannot protect the resident and the health and safety of all residents, the facility may not be an appropriate less restrictive treatment option.

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

The following considerations inform the response of the DCR:

- Whenever possible, the DCR should evaluate the individual at the licensed residential care facility rather than an emergency department so that situational, staffing, and other factors can be observed.
- The DCR confers with and obtains information from the facility on the reason for the referral, the level of safety threat to residents, and alternatives that may have been considered to maintain the individual at the facility. Alternatives could include changes in care approaches, consultations with mental health professionals and specialists, reduction of environmental or situational stressors, and medical evaluations of treatable conditions that could cause aggression or significant decline in functioning.
- When appropriate, available, and consistent with confidentiality provisions, the DCR obtains information from a variety of sources such as the resident, family members of the resident, guardians, facility staff, attending physician, the resident's file, the resident's caseworker or mental health provider, IHCP, and/or the ombudsperson. All collateral contacts are documented, including the name, phone number, and substance of information obtained.

- If the investigation does not result in detention but the resident has remaining behavioral health care needs, the DCR may also provide further recommendations and resources to the facility staff and others, including recommendations for possible follow-up services.

If the resident is being evaluated in an emergency department and the investigation does not result in detention, the resident may have readmission rights to the long-term care facility. If the DCR has concerns about facility refusal to readmit the resident, or the services provided to the resident, the DCR can follow the procedures outlined in section 160 – Reporting Suspected Abuse or Neglect.

155.6 – Referrals from Law Enforcement

Sheena’s Law: Referrals from Law Enforcement in the Community

The following is a model policy for use by DCR agencies in developing their own policies and procedures for receiving and handling these referrals from local law enforcement agencies [RCW 71.05.458].

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

Define appropriate referrals:

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

This does not apply to:

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

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

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

Documentation in DCR office

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

Triage

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

Contact

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

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

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

155.7 – Referrals from a Jail or Prison

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

The DCR does not rule out any referral for investigation solely because the individual is incarcerated. Individuals in a jail or prison who have a behavioral health disorder can be detained to an involuntary inpatient facility with or without a jail hold if the criteria for detention are met. Procedures may vary by region and will depend on agreements developed between the BH-ASO, the DCR office, the jail, and the court, as well as available resources. Referrals from a tribal jail will follow the appropriate MOU, BH-ASO agreement, or protocol.

The DCR obtains information from the facility making the referral regarding:

- The individual's criminal charges status - felony or misdemeanor
- Release date, if eligible for release
- The jail policy regarding release – temporary release order, charges dropped once an opinion is provided, etc.

The DCR office reviews information in clinical records, including but not limited to:

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

Discharge Review for Incarcerated Individuals

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

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

- Coordinates the process with law enforcement personnel, county DOC representatives, representatives of the legal system and other appropriate persons to the extent permitted by applicable law, including RCW 71.05.153, RCW 71.34.710, RCW 70.02, RCW 70.02.230 and RCW 70.02.240, RCW 70.02.250 and RCW 70.02.320.
- Discusses arrangements for medical clearance (transportation to an emergency department for clearance, or other locally agreed upon arrangements) and for transportation of the inmate to the involuntary inpatient facility.

Forensic Evaluations

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

155.8 – Referrals of Individuals in the Re-entry Community Services Program (RCSP)

The Washington State Department of Corrections (DOC) may request an investigation for a DOC inmate designated as an RCS program participant. In order to qualify under RCW 72.09.370, the individual has been designated by the DOC through the RCS Statewide Review Committee as meeting criteria for dangerousness and has either:

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

The investigation shall occur not more than 10 days, nor less than five days, prior to the actual release of the designated RCS participant. A DCR must conduct a second investigation on the day of release if requested by the RCS Committee. When conducting an evaluation of an RCS participant, the DCR shall consider the person's history of judicially required or administratively ordered antipsychotic medication while in confinement. The fact that a person is identified as an RCS participant does not change the commitment criteria under RCW 71.05.

155.9 – Referrals of Veterans

During the 12-hour period in which an individual may be held in a facility pending evaluation by a DCR, the facility must inquire into the individual's veteran status or eligibility for veteran's benefits. If the person identifies as a veteran or is eligible for veteran's status, the facility must ask the person whether he or she is amenable to treatment from the Veteran's Health Administration (VHA). The DCR must receive the information and refer the person to a VA facility for treatment as appropriate.

160 – Reporting Suspected Abuse or Neglect

DCRs are mandatory reporters of suspected abuse or neglect. Individuals filing reports in good faith are immune from liability. Failing to make a mandatory report, or intentionally filing a false report, is a crime.

If a DCR has reasonable cause to believe that abuse, neglect, financial exploitation or abandonment of an individual has occurred, the DCR must make a report immediately, regardless of if any other reports have been made. If there is reason to suspect that sexual or physical assault has occurred, the DCR must also immediately make a report to the appropriate law enforcement agency as well as to DSHS.

Minors

Call 1-866-END-HARM (1-866-363-4276).

Call the intake number for your region. Find the number for your region here:

<https://www.dcyf.wa.gov/safety/report-abuse>

Adults

Call 1-866-END-HARM (1-866-363-4276).

Call 1-877-734-6277

Email apscentralintake@dshs.wa.gov

Report online at <https://www.dshs.wa.gov/altsa/home-and-community-services/report-concerns-involving-vulnerable-adults>

If the vulnerable adult lives in a facility or receives supported living services:

Call the DSHS Complaint Resolution Unit 1-800-562-6078

Or report online at the link above.

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

Detentions

200 – Notification of Guardians & Decision Makers

As soon as possible following the detention, the DCR advises the parents of a minor, or the guardian or health care decision-maker of the individual being detained of the rights of the detainee consistent with the provisions of RCW 71.05.217, RCW 71.34.355.

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

If the individual being detained is a member of a federally recognized tribe, and receives health care from IHCPs, follow procedure for notification in RCW 71.05.150(6) and the Tribal Crisis Coordination Plan.

205 – Procedure for Non-Emergent Detention

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

A DCR may take an individual into emergency custody when the individual presents an imminent likelihood of serious harm or is in imminent danger because they are gravely disabled as a result of a mental disorder [RCW 71.05.153(1)].

If an adult meets the criteria for detention but the likelihood of serious harm presented is not imminent, then the DCR may initiate a non-emergency detention. The DCR petitions the Superior Court for an order directing the DCR to detain the adult to an involuntary inpatient facility.

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

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

The DCR does not have to establish imminent harm as a requirement for the emergency detention of minors.

207 – Suspension of Firearm Rights

Firearm rights are suspended for six months when a petition for initial detention due to likelihood of serious harm is filed, but the individual is not subsequently committed for involuntary treatment on a 14- or 90-day order.

RCW 71.05.182 (1) A person who under RCW 71.05.150 or 71.05.153 has been detained at a facility for one hundred twenty hours for the purpose of evaluation and treatment on the grounds that the person presents a likelihood of serious harm, but who has not been subsequently committed for involuntary treatment under RCW 71.05.240, may not have in his or her possession or control any firearm for a period of six months after the date that the person is detained.

The client can petition for restoration under RCW 9.41.047(3). Firearm rights will be automatically restored at the end of six months.

When the DCR provides notification of rights, they will include notification of the possibility of suspension of firearm rights. If the decision is made to detain due to likelihood of serious harm, at the time that the client is served legal paperwork, they will be provided with oral and written notification of the suspension of firearm rights.

Notice of Suspension of Firearm Rights

- Refer the client to their attorney with any questions regarding their rights or the legal process for firearm suspension or restoration.
- Give them the opportunity to sign the notice. They are not required to sign. Check the appropriate box if they decline or are unable.
- At a minimum, provide the respondent's full name and date of birth on this form. If additional information is available, provide that as well.
- This is a legal document and is filed with the court along with petition paperwork.
- Make note on the Return of Service that they have been served the notice by DCR of suspension of firearm rights.
- If the individual has a license or ID card, make a copy and file with the coversheet.

Notification of Local Law Enforcement

71.05.182(3) The designated crisis responder shall notify the sheriff of the county or the chief of police of the municipality in which the individual is domiciled of the six-month suspension.

71.05.182(4) The law enforcement agency, prior to returning the firearm, shall verify with the prosecuting attorney's office or DCR that the individual has not been previously or subsequently committed for involuntary treatment under RCW 71.05.240.

210 – Detention from a Licensed Residential Care Facility

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

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

215 – Detention to a Facility in another County

When a DCR detains an individual to an inpatient evaluation and treatment facility in another county, the detaining DCR must:

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

A link to a contact list of each County Prosecutor's Office can be found in Appendix B.

220 – Documentation of Petition for Initial Detention

For every investigation resulting in a detention, the DCR will serve the individual with their legal paperwork when that detention is complete; including proof of service of notice, notice of firearm suspension (if appropriate), and a copy of the notice of rights. This paperwork must also be provided to the individual's attorney and filed with the court of jurisdiction (the court in the county that the individual is detained to).

RCW 71.05.160(2)(b) If the person is involuntarily detained at an evaluation and treatment facility, secure withdrawal management and stabilization facility, or approved substance use disorder treatment program in a different county from where the person was initially detained, the facility or program may file with the court and serve the designated attorney of the detained person the petition or supplemental petition for initial detention, proof of service of notice, and a copy of a notice of emergency detention at the request of the designated crisis responder.

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

[RCW 71.05.160 and RCW 71.34.710(2)]

225 – Joel's Law

If a DCR makes the determination not to detain an individual (adult or minor) for emergent or non-emergent detention, or 48 hours have elapsed since the DCR office received a request for an ITA investigation and have not taken steps to detain the individual, an immediate family member, guardian, or conservator, or a federally recognized Indian tribe if the individual is a member of such tribe, may file a petition with the superior court of the county in which the investigation occurred or was requested to occur, for the individual's initial detention. If more than 10 days have elapsed since the investigation, or the request for the investigation, the entity seeking a Joel's Law petition may request a new investigation [RCW 71.05.201].

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

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

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

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

230 – Notification if Detained Individual has a Developmental Disability

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

See Appendix E.

235 – DCR Responsibilities if Detained Individual is a Foreign National

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

If an individual who has been detained is a foreign national, the DCR must advise the individual of his/her rights to contact consular officials from his/her home country and helps facilitate that contact if the individual being detained desires it (Vienna Convention).

If the individual who has been detained is a foreign national and is legally not competent the DCR must inform the consular official from that country without delay, whether or not the detained individual wants the consular official notified (Vienna Convention).

If the individual who has been detained is a citizen of any of the nations with Bilateral Agreements requiring “mandatory notification”, the DCR must inform the consular official from that country without delay, whether or not the detained individual wants the consular official notified. “Mandatory notification” countries, and consular contacts, are listed in Appendix I.

In all cases, the DCR documents:

- The date and time the foreign national was informed of his/her consular rights;
- The date and time any notification was sent to the relevant consular officer; and
- Any actual contact between the foreign national and the consular officer.

Additional contact information for foreign consular offices is located at the following link:
<https://travel.state.gov/content/travel/en/consularnotification.html>.

240 – Detention of Individuals who have Fled from Another State who were Found Not Guilty by Reason of Insanity and Fled from Detention, Commitment or Conditional Release

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

Less Restrictive Alternative Court Orders

300 – Rights of an individual Evaluated and Detained for a Revocation Hearing

When a DCR conducts a revocation evaluation, all of the rights discussed in Section 110 are available to the individual being revoked. In addition, the DCR informs the individual, in writing or, if possible, orally in a language understood by the individual, that:

- A revocation hearing to determine whether they will be detained for up to the balance of their commitment must be held within five days following the date of the petition to revoke the CR/LRA Court Order [RCW 71.05.590(5)(b)]. Consult with prosecutor of local jurisdiction for clarification regarding judicial versus calendar days.
- For minors, a revocation hearing must be held within seven calendar days following the date of petition to revoke the CR/LRA Court Order [RCW 71.34.780(3)].
- If the individual is on a CR/LRA issued by a tribal court, consult the tribal prosecutor for the correct procedure.

305 – Procedure and Criteria for Modifying, Enforcing, or Revoking a CR/LRA Court Order for Adults

Revocation (for CR/LRA Orders)

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

If an individual meets criteria for revocation and also meets criteria for a new initial detention, a DCR has the option of initiating a new 120-hour detention rather than revoking a CR/LRA court order [Superior Court Rule MPR 4.4].

- Complete and file the Petition for Revocation and accompanying paperwork, and attach a copy of the CR/LRA Court Order
- Serve the individual a copy of the paperwork
- Inform the outpatient treatment provider or other potential witnesses that their court testimony may be required at a subsequent revocation hearing. If the county where the hearing is to occur requires in-person testimony, the DCR informs the potential witnesses of the date, time and place of the hearing and telephone number of the prosecutor's office.
- The DCR may modify or rescind the order at any time prior to the hearing.
- Venue for revocation proceedings is in the county in which the petition is filed. Criteria for revocation:
 - That a flexible range of responses appropriate to the circumstances have been considered and attempted, and
 - The individual fails to comply with the terms and conditions of their CR/LRA Court Order;
 - The individual experiences substantial deterioration in their condition;

- There is evidence of substantial decompensation with a reasonable probability that the decompensation can be reversed by further inpatient treatment; or
- The individual poses a likelihood of serious harm

Modification and Enforcement (For CR/LRA and AOBHT orders)

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

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

[RCW 71.05.590]

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

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

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

- Determines that a minor is failing to adhere to the conditions of the court order for less restrictive alternative treatment or the conditions for the conditional release,
- Or that substantial deterioration in the minor's functioning has occurred;
- And may order that the minor be taken into custody and transported to an inpatient evaluation and treatment facility;
- File the order of apprehension and detention and serve it upon the minor and notify the minor's parent and the minor's attorney, if any, of the detention within two days of return
- Inform the minor at the time of service of the right to a hearing and to representation by an attorney;
- May modify or rescind the order of apprehension and detention at any time prior to the hearing.

The DCR files the revocation petition in the county in which the minor is detained. A petition for revocation of conditional release may be filed with the court in the county ordering inpatient treatment or the county where the minor on conditional release is detained.

[RCW 71.34.780]

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

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

- Closely monitoring CR/LRA Court orders by documenting in the individual's clinical record the need for revocation
- Providing the DCR with information needed to support petitions for further court-ordered less restrictive treatment

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

[RCW 71.05.320 and WAC 246-341]

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

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

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

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

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

- e) The individual was previously committed by a court detention for involuntary treatment in the previous 36 months (exclusive of hospitalization or incarceration time) that preceded the individual's initial detention date, and is unlikely to voluntarily participate in outpatient treatment without an order; and outpatient treatment is necessary to prevent relapse, decompensation, or deterioration that is likely to result in the individual presenting a likelihood of serious harm or the individual becoming gravely disabled, within a reasonably short period of time [RCW 71.05.320].

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

325 – Petitions for Extending a LRA Court Order for Adults

Prior to expiration of a CR, a new LRA petition may be filed under RCW 71.05.320(2) or (4). Successive 180-day commitments are permissible on the same grounds and pursuant to the same procedures as the original 180-day commitment. However, a commitment is not permissible if 36 months have passed since the last date of discharge from detention for inpatient treatment that preceded the current LRA.

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

- Evaluate the individual's current condition
- Consider the cognitive and volitional functioning of the individual prior to court ordered treatment
- Assess if the individual would accept treatment, or take medication if not on a court order and whether the individual has a history of rapid decompensation when not in treatment; and
- Consider the individual's history as well as their pattern of decompensation

If the petitioning DCR is to provide a declaration as an examining mental health professional, the case manager shall include a declaration by an examining physician. If the petitioning DCR is not providing a declaration, the case manager is to include declarations from one of the combinations of professionals from the following list:

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

If the petition is for substance use disorder treatment, the petition may be signed by a substance use disorder professional instead of a mental health professional. The declarants must have examined the individual. [RCW 71.05.290(2)]

Any of the above listed professionals may also be Indian Health Care Providers.

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

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

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

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

[RCW 71.05.285]

Confidentiality

400 – General Provisions on Confidentiality

Information gathered by the DCR is confidential under Washington State law and may not be disclosed to anyone unless specifically permitted by law, by a signed release, or by a court order signed by a judge. Statutory provisions related to confidentiality of behavioral health information and records can be found in multiple locations including, but not limited to RCW 70.02; RCW 70.02.230, RCW 71.05.445, RCW 71.05.620; RCW 10.77.065 and RCW 10.77.210, RCW 71.24; In the case of minors, RCW 70.02.240, RCW 70.02.250 and RCW 70.02.320. 42 CFR Part 2 applies to substance use records and information of both adults and minors.

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 and drug and alcohol abuse treatment information under 42 CFR Part 2. These laws generally regulate the release of such information without written authorization. The DCR will advise the individual of their rights under HIPAA and 42 CFR Part 2. The unauthorized release of confidential information may subject the DCR to civil liability and penalties.

Additional information regarding medical records such as 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 DCR may need to demonstrate an awareness of the problem so that the witness will talk about the situation.

Referents may be advised that the investigation has been completed.

405 – Sharing Information in a Crisis or Emergency Situation

HIPAA Privacy in Emergency Situations 45 CFR 164.512(j)

Standard. Uses and disclosures to avert a serious threat to health or safety -

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

(A) Is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public; and (B) Is to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

42 CFR § 2.51 Medical emergencies.

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

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

Whenever any individual is detained for evaluation and treatment pursuant to this chapter, both the individual and, if possible, a responsible member of his or her immediate family, personal representative, guardian, or conservator, if any, shall be advised as soon as possible in writing or orally, by the officer or person taking the individual into custody or by personnel of the evaluation and treatment facility where the individual is detained unless the individual is released or voluntarily admits themselves for treatment within one hundred twenty hours of the initial detention [RCW 71.05.217(5)].

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

RCW 71.05.203(3) A designated crisis responder or designated crisis responder agency must, upon request, disclose the date of a designated crisis responder investigation under this chapter to an immediate family member, guardian, or conservator of a person, or federally recognized Tribe if the person is a member of such Tribe to assist in the preparation of a petition under RCW 71.05.201.

415 – Sharing Information with Law Enforcement

Information may be shared with law enforcement in the following situations under RCW 70.02.230:

- If there is a crisis or emergent situation that poses a significant and imminent risk to the public. In this case, any information considered relevant to the situation or necessary for its resolution may be shared with corrections or law enforcement.
- If an individual being evaluated has threatened the health and safety of another or has repeatedly harassed another. In this case, the date of commitment, admission, discharge, or release may be disclosed, as well as any absence from a facility (authorized or unauthorized), may be shared with the appropriate law enforcement agency. Any information that is pertinent to the threat or harassment may also be disclosed.
- If law enforcement made the referral, and they make a request to find out the results of the investigation. In this case, the results shall be disclosed in writing if requested, including a statement of the reasons why the individual was or was not detained. A written disclosure shall occur within 72 hours of the completion of the investigation or the request from law enforcement or corrections representative, whichever occurs later.
- If an individual escapes from custody. In this case, as much information may be disclosed as is necessary for law enforcement to carry out their duties in returning the patient. [RCW 71.05.425(2)]
- If law enforcement requests information as part of an investigation of an Unlawful Possession of a Firearm case [RCW 9.41.040(2)(a)(iv)]. In this case, the only items that may be disclosed are the fact, place, and date of involuntary commitment; an official copy of the commitment orders; and an official copy of any notice (written or oral) given to the individual that they are now ineligible to possess a firearm.

420 – Sharing Information with Department of Corrections Personnel

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

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

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

At DOC's written request for information, within 24 hours, the DCR shall release "information related to behavioral health services" for DOC personnel to carry out their duties. This includes all "relevant records and reports" (i.e., all information and records compiled, obtained, or maintained in the course of providing services to either voluntary or involuntary recipients of services by a behavioral health service provider" [RCW 70.02.250, RCW 71.05.445, and WAC 246-341-0650].

When an individual receiving court-ordered treatment or treatment ordered by the Department of Corrections discloses to their behavioral health service provider that they are subject to supervision by the Department of Corrections, the behavioral health service provider shall notify the:

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

425 – Sharing Information to Protect Identified Individuals

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

- Call the individual/victim who has been threatened or harassed;
- Release information as is pertinent to the threat or harassment and date of detention if applicable;
- Inform the accepting facility of the threat and the identified victim's contact information;
- Document the notifications in the case write up;
- Make sure that the fact of release is noted in the case; and
- Call appropriate law enforcement agencies (both the law enforcement agencies of the victim and of the suspect).

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

Appendix A: 2020 Designated Crisis Responders Protocol Workgroup Members

Name	Organization
Brian Austin	Snohomish County Human Services
Kevin Black	Staff Counsel, Senate Behavioral Health Subcommittee & Long-Term Care Committee
Jim Bloss	National Alliance On Mental Illness Washington
Teresa Brooks	Stevens County
Tina Burrell	Washington State Health Care Authority, Child You and Family
Staci Cornwell	Frontier Behavioral Health, Spokane County
Kendra Cullimore	Coordinated Care Washington
Zephyr Forest	Washington State Health Care Authority
Julie Gamble	King County Crisis and Commitment Services
Jenise Gogan	Washington State DSHS, Behavioral Health Administration
Jeff Green	Washington State DSHS, Developmental Disabilities Administration
Jaclyn Greenberg	Washington State Hospital Association
Lynne Guhlke	Lincoln County and Ferry County
Heather Erb	American Indian Health Commission
Philip Hernandez	Kitsap Mental Health Services
Sarah Hicks	Kitsap Mental Health Services
Steve Hightower	Catholic Family and Child Services, Chelan County and Douglas County
Jeffrey Hite	Beacon Health Options
David Johnson	Washington State Health Care Authority
Kayla Kressler	Peninsula Behavioral Health
Jolene Kron	Salish Behavioral Health Administrative Service Organization
Stacey Lopez	United Health Care
Vicki Lowe	American Indian Health Commission
Lucilla Mendoza	Washington State Health Care Authority
Joan Miller	The Washington Council for Behavioral Health
Anne Mizuta	Washington Association of Prosecuting Attorneys

Samantha Noble	Washington Association of Designated Crisis Responders
Stacey Okihara	Frontier Behavioral Health, Spokane County
Linton Pedersen	Forks Hospital, Clallam County
Laura Pippin	Washington Association of Designated Crisis Responders
Kari Reardon	Cowlitz County Public Defenders
David Reed	Washington State Health Care Authority
Kalen Roy	Spokane Behavioral Health Administrative Service Organization
Colette Rush	Washington State Health Care Authority
Angela Sauer	Department of Corrections
Jason Schwarz	Snohomish County Office of Public Defense
Jessica Shook	Olympic Health & Recovery Services
Wendy Skarra	Washington State Department of Children, Youth and Families
Teresa Tilton	Compass health
Julie Tomaro	Washington State Department of Health
Ralph Waddell	Okanogan Behavioral Health Care
Allison Wedin	Washington State Health Care Authority

Appendix B: County Prosecutor's Office Phone List

Washington Association of Prosecuting Attorneys

<http://waprosecutors.org/prosecutordirectory/>

Appendix C: Requirements of Licensed Residential Care Facilities

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

Residents have a legal right to remain at licensed residential care facilities if their needs can be met. In certain circumstances, residents may also have a right to have their bed held during a temporary hospitalization. If the threat to the individual's health or safety 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 DCR is considering if the services and treatment needed by the resident can be provided by the facility as a less restrictive alternative.

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

Topic	Website
Adult Family Homes	http://www.adsa.dshs.wa.gov/professional/afh.htm
Assisted Living Facilities	http://www.adsa.dshs.wa.gov/Professional/bh.htm
Skilled Nursing Facilities	http://www.adsa.dshs.wa.gov/professional/nh.htm
Descriptions of Adult Family Homes, Assisted Living Facilities and Skilled Nursing Facilities	http://www.adsa.dshs.wa.gov/pubinfo/housing/other
Resident rights provisions in statute	http://apps.leg.wa.gov/RCW/default.aspx?cite=70.129
Adult Family Home Professionals	http://www.adsa.dshs.wa.gov/professional/afh.htm
Assisted Living Facilities Professionals	http://www.adsa.dshs.wa.gov/professional/bh.htm
Skilled Nursing Facility Professionals	http://www.adsa.dshs.wa.gov/professional/nh.htm

Appendix D: DCR Intervention Checklist

The following guidelines and questions may be helpful to DCRs in evaluating an individual in a licensed residential care facility. For example, the dangerous behavior may not be due to a mental disorder but to other factors, such as an infection (e.g., urinary tract infections in residents with dementia), constipation, respiratory disorders, medication interactions, or environmental stressors.

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

Treatment Suggestions

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

Behavioral Health Intervention Suggestions

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

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

Appendix E: DSHS Developmental Disabilities Administration Contacts

Link to office locator (not organized by region, look for the nearest office to you):

<https://www.dshs.wa.gov/dda/find-dda-office>

Appendix F: Tribal Resources: Federally Recognized Tribes of Washington

List of federally recognized Indian tribes:

<https://goia.wa.gov/tribal-directory/federally-recognized-indian-tribes>

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

<https://goia.wa.gov/tribal-directory/washington-state-tribal-courts>

Link to the Indian Health Service Health Care Finder:

<https://www.ihs.gov/findhealthcare/?CFID=11021393&CFTOKEN=68353436>

Tribal Crisis Coordination Hub

[Tribal Affairs | Washington State Health Care Authority](#)

American Indian Health Commission - Tribal Services Profiles:

<https://aihc-wa.com/medicaid-system/tribal-services-profiles/>

Best practices

1. If the individual is identified as AI/AN, ask and determine tribal affiliation by asking the individual or the referent.
2. Identify if there is a Tribal Crisis Coordination Plan in place by contacting the tribe, Tribal Crisis Coordination Hub, Health Care Authority, BH-ASO, or local DCR agency.
3. Without delay notify the tribal contact of the decision to detain or not to detain according to protocols if any.
 - a. If there is a Tribal Crisis Coordination Plan, the DCR will comply with those protocols.
 - b. If there is not a Tribal Crisis Coordination Plan, the DCR will consult the Indian Health Care Provider to identify provider contact information and contact information for notification of their detention decision; and
 - c. If there is no Indian Health Care Provider, the DCR will consult a Tribal Council representative to identify provider contact information and contact information for notification of their detention decision.
4. Consult the guidance developed to conduct culturally appropriate evaluations for AI/AN individuals published by the HCA.
5. For questions or concerns, contact the Tribal Crisis Coordination Hub or the Health Care Authority.

Appendix G: Map of BH-ASO Regions

Link to the map of WA Administrative Service Organizations (January 2020)

<https://www.hca.wa.gov/assets/free-or-low-cost/19-0040-bh-aso-map.pdf>

Appendix H: List of Resources for Available History

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

Possible resources include:

- Information and records from crisis outreach providers, outpatient behavioral health providers (both mental health and substance use treatment) and other services, to include tribal government, Indian Health Care Providers, DCYF, and DDA.
- County or local law enforcement records. Some local law enforcement offices, jails and juvenile detention authorities may be able to share criminal history information.
- Washington State Patrol (WSP) information. The WSP provides criminal history information via the Internet through the Washington Access to Criminal History (WATCH) Program.
<http://www.wsp.wa.gov/crime/chrequests.htm>
- DCR office records. In addition to information regarding prior investigations and detentions under RCW 71.05, these records may include additional relevant information.
- Forensic evaluation reports conducted under RCW 10.77 are sent to the DCR office in the county where the criminal offense occurred. These reports contain recommendations regarding civil commitment and history.
- State psychiatric hospital records. The state psychiatric hospitals (Western State Hospital and Eastern State Hospital) maintain records of individuals who have been committed to the hospital under civil (RCW 71.05) and criminal (RCW 10.77) statutes. Staff (Medical Records Office, Admitting Nurse or other Admissions personnel) are available 24 hours a day at:
 - Western State Hospital: (253) 582-8900.
 - Eastern State Hospital: (509) 565-4000.
- Community support service provider, residential facility, or treating physician clinical records may contain relevant information.

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

The following information is from the U.S. Department of State website. For more detailed information, contact information for foreign consular offices, and fax sheets for notification, see the website:

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

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

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

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

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

Statement 2 – For foreign nationals from “mandatory notification” countries

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

Appendix J: Links to DCR Forms

Health Care Authority: Designated Crisis Responders

Sample legal forms

Single Bed Certification

Unavailable Detention Facilities Report (No-Bed Report)

<https://www.hca.wa.gov/billers-providers-partners/behavioral-health-recovery/designated-crisis-responders-dcr>

Appendix K: DCR Knowledge and Education

Knowledge Base: look for statutory and WAC references for requirements for DCR education

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

Education/Training:

- Psychopathology and psychopharmacology
- Knowledge of individual and family dynamics, life span development, psychotherapy and family crisis intervention
- Crisis intervention and assessment of risk associated with both mental health disorders and substance use disorders, including suicide risk assessment and assessment of danger to others
- Assessment of grave disability, health and safety, cognitive and volitional functions
- Competency with special populations: co-occurring disorders, developmental and intellectual disabilities, AI/AN, ethnic minorities, children and adolescents, older individuals, and LGBTQ individuals
- Substance use disorder
- Training in adolescent mental health issues, the mental health civil commitment laws, the criteria for civil commitment, and the systems of care for minors. Reference RCW 71.34.805
- Knowledge of local/regional mental health and substance use disorder treatment resources
- Professional ethics and knowledge of consumer rights
- Petition writing: factors, elements, and content
- Continuing education: Clinical and legal education related to DCR process
- Tribal sovereignty and considerations for working with American Indians and Alaska Natives

Appendix L: References and Resources

1. Current Diagnostic and Statistical Manual
 2. Washington State DCR Protocols, updated 2020
 3. Washington Administrative Code: WAC 246-341 "Behavioral Health Agency Licensing and Certification Requirements"
 4. Revised Code of Washington
 - a. Medical Records – Healthcare Information Access and Disclosure – RCW 70.02
 - b. Adult Involuntary Treatment – Chapter 71.05 RCW
 - c. Behavioral Health Services for Minors – Chapter 71.34 RCW
 - d. Criminally Insane – Chapter 10.77 RCW
 - e. Community Behavioral Health Services Act – RCW 71.24
 - f. Indian Lands Jurisdiction – Chapter 37.12 RCW
 - g. Firearms and Dangerous Weapons – Chapter 9.41 RCW
 - h. Guardianship 11.88 RCW
 5. Superior Court Mental Proceeding Rules (MPR)
 6. Washington State Case Law - Index to Cases
-
- Detention of A.S., 138 Wn.2d P.2d (1999) at 898 Defective Petitions. pp 911-914
Expert Witness pp. 915-922
Gravely Disabled pp. 901-906
 - Detention of Chorney, 64 Wn.App. 469, 825 P.2nd 330 (1992)
Good Faith Volunteer pp. 478-479
Burden of proof to show good faith volunteer pp. 477-478
 - Detention of C.K., 108 Wn.App. 65, P.2d (2001).
Legislative intent pp. 73-74, 76
Decompensation as evidence of grave disability pp. 72-73, 75-77
Less restrictive alternative pp. 74-77
 - Detention of D.F.F., 144 Wn.App 214, 183 P.3d 302 (2008)
Court rule which automatically made all ITA closed hearings (MPR 1.3) declared unconstitutional pp. 219-227
Factors ITA court should weight in deciding whether to close hearing on case-by-case basis listed pp. 222-223
 - Detention of Dydasco, 135 Wn.2d 943, P.2 (1998)
File petition three days before the end of the prior period for 90 and 180 day commitment whether inpatient or less restrictive alternative is requested pp.950-952
 - Detention of G. V., 124 Wn.2d 288, P.2d (1994)
Remedy for a potential interference with right to refuse medication prior to 180 day hearing pp. 293, 296
 - Detention of Kirby, 65 Wn. App. 862, 829 P.2d 1139 (1992)
Examples of evidence insufficient to support finding that person is not a good faith volunteer pp. 870-871
 - Detention of J. J., 179 Wn. App 579, 322 P.3d 22 (2014)

- Detention of J. R., 80 Wn. App. 947, 912 P.2d 1062. (1996) Affidavits by treating and examining physicians' pp. 956-957
- Detention of J. S., 124 Wn.2d 689, 880 P.2d 976 (1994)
Power of court to order less restrictive alternatives. Note: DDD case p.698
Less restrictive alternative not required by constitution or statute pp.699-701
Less restrictive alternative not available p. 701
- Detention of J.S., 138 Wn.App.882, 159 P.3d 435 (2007)
Ability of patient to proceed as own attorney (pro se) in court hearings pp.890-898
- Detention of R. A. W., 105 Wn. App. 215, P.2d (2001)
Least restrictive alternative pp. 222-226
Jury instructions pp. 223-224
Gravely disabled pp. 224-226
- Detention of R. P., 89 Wn. App. 212, 948 P.2d 856 (1997)
Petitions for 180 day commitment must be accompanied by two affidavits p. 216
Contents of affidavits provide notice pp. 216-217
- Detention of R. R., 77 Wn. App. 795, 895 P.2d 1 (1995)
The DMHP was also employed as a case manager and the question was whether the employment as a case manager interfered with the DMHP's ability to properly evaluate RR's condition pp. 799-801
Burden of proof to show conflict of interest in revocations p. 801
- Detention of R.S., 124 Wn.2d 766, 881 P.2d 972 (1994)
Discusses RCW 71.05.040 detention of an individual on the basis of developmental disability pp. 770-771, 776
- Detention of R.W., 98 Wn. App. P.2d (1999) Comment on the evidence pp. 141, 144-145 Role of the jury pp. 144
- Detention of V. B., 104 Wn. App. 953, P.2d (2001)
Peace officer testimony pp. 963-964
Adequacy of due process procedures p. 953
State interest in use of officer p. 965
- Detention of W., 70 Wn.App.279, P.2d (1993)
Placement in certified facility p. 284
- Dunner v. McLaughlin, 100 Wn.2d 832, 676 P.2d 444 (1984)
Jury verdict pp. 844-845
Burden of proof pp. 845-846 Right to remain silent pp. 846-847
Amendments to 90 day petitions pp. 848-849
Admission at trial of prior commitment orders. Note: This holding differs from recent legislation pp. 851-852
- Harper (Washington v. Harper), 494 US 210 (1990)
Right to refuse antipsychotic medications
- In Re Harris, 98 Wn.2d 276, 654 P.2d 109 (1982)
Imminent danger pp. 282-284
Standard of dangerousness p. 284
Recent overt act pp. 284-285
Non-emergency summons procedure pp. 287-289

- In Re LaBelle, 107 Wn.2d 196, 728 P.2d 138 (1986)
Imminence p. 203
Grave disability – passive behavior p. 204
Danger to self and others – active behavior p.204
Explanation of RCW 71.05.020(1)(a) pp. 204, 206 Explanation of RCW 71.05.020(1)(b) pp. 205-208
Analysis of fact pattern in four gravely disabled cases pp. 209-225
- In Re Meistrell, 47 Wn. App. 100, 733 P.2d 1004 (1987)
Recent past mental history pp. 108-109
Substantial evidence p. 109
- In Re Pugh, 68 Wn. App. 687, 845 P.2d 1034 (1993), review denied, 122 Wn.2d 1018, 863 P.2d 1352 (1993)
Likelihood of serious harm Recent overt acts
- In Re Quesnell, 83 Wn.2d 224, 517 P.2d 568 (1973)
Role of GAL
Waiver of substantial rights p. 239
Presumption of competency p. 239
- In Re R., 97 Wn.2d 182, 641 P.2d 704 (1982)
Physician-patient privilege and physician testimony at ITA hearings pp. 186-199
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- Marriage of True, 104 Wn. App. 953, P2 (2001)
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