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WASHINGTON'S INVOLUNTARY TREATMENT ACT: HOW TO WORK BEST WITH DESIGNATED CRISIS RESPONDERS & RICKY'S LAW UPDATES

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SPEAKER DISCLOSURES

- ✓ Any conflicts of interest?

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OBJECTIVES

1. Overview of Washington's ITA laws, intent and Designated Crisis Responder role.
2. Criteria for involuntary detention for treatment of a mental disorder or substance use disorder
3. How to make a DCR referral. How to present evidence.
4. Case study examples
5. Ricky's Law updates (SWMS facilities and utilization)

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INVOLUNTARY TREATMENT ACT: REVISED CODE OF WASHINGTON

- Adults: RCW 71.05 was enacted in January of 1974, with subsequent amendments.

- Minors: RCW 71.34 The law pertaining to minors (13-17yr) enacted in 1986 with significant amendments in 1995

- Ricky's Law- Passed in 2016 and implemented in 2018 allowing for ITA for SUD treatment by DCR.

LEGISLATIVE INTENT

RCW 71.05.010 Legislative intent.

- 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;
- To prevent inappropriate, indefinite commitment of persons living with behavioral health disorders and to eliminate legal disabilities that arise from such commitment;
- To provide prompt evaluation and timely and appropriate treatment of persons with behavioral health disorders;
- To safeguard individual rights;
- To provide continuity of care for persons with serious mental disorders;
- To encourage the full use of all existing agencies, professional personnel, and public funds to prevent duplication of services and unnecessary expenditures; and
- To encourage, whenever appropriate, that services be provided within the community.

(to protect rights of patient and public and provide care in least restrictive way in the community if at all possible)

CIVIL COMMITMENT LEGAL PROCESS

ADULTS

- Initial 120 hr detention
  - Hearing
- 14 day commitment
  - Hearing
- 90 day commitment
  - Hearing
- 180 day commitment
  - Hearing every 180 days

Discharge to 90 or 180 day Less Restrictive Alternative Order (LRO) at any point in the process also a consideration.

MINORS

120 hr-14day-180day, possible 180 day LRO

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WHERE ARE INDIVIDUALS DETAINED TO?

Treatment for mental disorder:

Evaluation and Treatment Facility (E&T) or

Psychiatric Hospital

Substance use disorder treatment:

Secure Withdrawal Management and Stabilization Facility (SWMS)

*Note that a facility may be licensed to provide both E&T and SWMS services in one facility.

DESIGNATED CRISIS RESPONDER (DCR)

- DCR given authority to detain a person for initial 120 hours for further evaluation and treatment
- Independent decision maker
- DCR vs MHP
- DCRs are not first responders but *are* essential services that must be provided 24/7 in all regions by BHASOs and some legal timelines exist for response

DCR LEGAL ROLE

- A referral can be made by anyone
- DCR accepts referral to determine if further investigation is needed
- DCR investigation process (reasonably available information and witnesses)
- DCR determines reliability and credibility of witnesses
- DCR interviews person being referred for investigation
- DCR makes decision to detain/not detain/any less restrictive options

LEGAL CRITERIA FOR INITIAL 120 HR DETENTION

1. Evidence of MENTAL DISORDER or SUBSTANCE USE DISORDER

2. Evidence of RISK (and this risk must be due to the behavioral health disorder)

- Serious likelihood of harm to self, others, property of others
- Risk of serious harm due to being gravely disabled

3. All less restrictive options have been considered and tried first if appropriate.

4. Imminence-risk is close at hand vs remote or distant

(also is a non-emergent detention where imminence lacking but serious risk of harm is present, not practiced in all counties)

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WHAT IS EVIDENCE?

- Evidence is something that a witness can speak to firsthand having seen or heard it directly.

- Description of the symptoms and behaviors vs ‘clinical speak’ is important.

- vs hearsay

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LEGAL DEFINITION OF MENTAL DISORDER

Mental disorder: "any organic, mental, or emotional impairment which has substantial adverse effects on an individual's cognitive or volitional functions."

A diagnosis is not required for detention

LEGAL DEFINITION OF SUBSTANCE USE DISORDER

Substance use disorder: Substance use disorder" means 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;

A diagnosis is not required for detention

Patient does not have to be sober for referral to DCR

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SUD-WHAT DETERMINES A PATTERN?

May be evidenced by

- Using larger amounts
- Desire and unsuccessful attempts to stop use
- Great deal of time seeking, using, recovering
- Cravings, urges
- Failure to fulfill major role obligations (school, work, home)
- Giving up or reducing social activities, work or recreation
- Using in physically dangerous situations
- Continuing to use knowing use is causing physical or psychological problems
- Tolerance
- Withdrawal

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LEGAL GROUNDS FOR DETAINMENT (TYPES OF RISK)

- Danger to self:

A substantial risk of harm indicated by threats (written or verbal) or attempts to commit suicide or inflict physical harm on oneself.

- Danger to others:

Behavior which has caused harm or places other in reasonable fear of sustaining harm. Can be written, verbal, or actual assaultive acts.

- Danger to property of others:

Behavior which has caused substantial loss or damage to the property of others

- Grave Disability:

- Behavior which results in person being in danger due to failure to provide for essential needs for health and safety

  and/or

- Individual has shown deterioration in routine functioning evidenced by repeated and escalating loss of cognitive or volitional control.

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TIMELINES FOR DCR REFERRALS-HOW LONG CAN THE HOSPITAL HOLD A PATIENT FOR A DCR EVALUATION?

Person initially presenting voluntary:

6 hrs from the time a DCR referral is determined to be needed (not counting time prior to medical clearance)

Person brought in involuntarily by police:

12 hrs from time of referral to DCR (must be seen by a MHP in first 3 hours)

(not counting time prior to medical clearance)

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MAKING A DCR REFERRAL: PROVIDING EVIDENCE

- Making a referral means that you are alleging that this person has a behavioral health disorder creating serious risk of harm and there are no less restrictive settings or options to keep the person safe other than involuntary detention. You are willing to testify to this at any subsequent hearing.
- Have the chart or information readily at hand
- Plan to spend 15-20 minutes on the phone with the DCR
- Describe all personally observed or charted symptoms and behaviors of mental disorder or SUD
- Provide names and phone numbers of witnesses that personally observed symptoms and behaviors that you did not
- Provide lab work and speak to any abnormalities that indicate behaviors are/were risky
- Provide all voluntary options offered or tried including offering the patient voluntary hospitalization/treatment

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CASE 1: STEVE
GRAVE DISABILITY/DANGER TO PROPERTY

EVIDENCE OF MENTAL DISORDER:

"I observed the patient mumbling under his breath as we talked and he looked around the room multiple times appearing scared or worried. He told me that cameras have been planted in his walls. I asked him if he was talking to someone else and he said, "can't you hear them?" He then paced around the room, agitated and waving his arms."

EVIDENCE OF RISK:

When the police arrived at the home, the family explained that they came home from a weekend out of town. He had torn holes in the sheetrock in several rooms and there were exposed wires. The neighbor added that they had seen him running into the street yesterday waving for cars to stop and warning them of cameras planted in homes, almost being hit once. Tox screen negative at ER and no lithium level despite currently prescribed medications"

CASE 2: MARTIN
DANGER TO SELF AND GRAVELY DISABLED

EVIDENCE OF MENTAL DISORDER:

"When I talked to him, his face was sullen, and he cried throughout my interaction. He admitted he had only eaten a muffin a day for the last month, and I could see that his pants and shirt fit loosely. He appeared weak and tired. He admitted his mood, when I asked, was "low."

EVIDENCE OF RISK:

Police brought him to the ER after he called 911. When aid arrived, he was unconscious, and he required charcoal treatment then admission to a medical unit for observation . His labs were consistent with a suicide attempt by overdose on his psychiatric medications, described in a note addressed to his girlfriend found at the scene.

CASE 3: WILLIAM GRAVELY DISABLED

EVIDENCE OF SUBSTANCE USE DISORDER:

"I have seen him drink for over 10 years and during that time he has lost several jobs after showing up for work intoxicated, he now works odd jobs just long enough to purchase alcohol and then he is gone for days at a time. This pattern led to divorce, and he is estranged from his family. He says he is going to quit drinking several times each month and goes for several days, sometimes a week, but often he gets shaky and sweaty and so nervous that I worry something physically is wrong. He drinks at least a fifth of whiskey a day at this point. He went to inpatient treatment twice but left after just one day."

EVIDENCE OF RISK:

Last year he went into withdrawal when in jail for DUI and had to be transported to the hospital for seizures related to that. Today he drove to his friend's home, stumbled out of the car, smelled of alcohol, was very hostile and was holding his side wincing in pain. His BAL was quite high. He had to be medically admitted from the ER. His lab results are consistent with a serious and advanced liver condition. He has been aware of this issue and has not followed up on further diagnostics and treatment advised by a doctor last year. His drinking has only increased to manage the physical pain.

CASE 4: MATTHEW
GRAVELY DISABLED & DANGER TO OTHERS

EVIDENCE OF SUBSTANCE USE DISORDER:

"He dropped out of school earlier this year and has admitted to using IV heroin daily. We had no choice but to ask him to leave our home due to finding him passed out several times with needles in his room and we have younger children in the home. He is now homeless, and he prostitutes daily for money to buy drugs. He is allowed to visits us but must not be high, he can only stay a few hours then he gets intense cravings and despite promising to quit or get into treatment he just cannot stop.

RISK:

He has abscesses over his body from injecting heroin, one requiring 2 ER visits for infection in the past month. Yesterday his parents attempted to talk to him about getting into treatment, he became extremely angry and paranoid, and he punched his father in the chest and ran. Today he is at the ER after requiring Narcan when found down and unresponsive in an alley, with a black eye.

CASE 5: SHANE

GRAVELY DISABLED & DANGER TO OTHERS

EVIDENCE OF SUBSTANCE USE DISORDER AND MENTAL DISORDER (co-occuring):

26 yoa, started using methamphetamine at 17yoa. Started smoking, now injecting. Started hearing voices at 19 yoa only when intoxicated but by 21 yoa voices persisted for periods of 3 to 4 months during 2 periods of sobriety lasting 9 mo each. While the voices he hears day to day are tolerable and neutral however during periods of acute intoxication, no sleep and poor nutrition, they are severe and command in nature. He is currently enrolled in SUD outpatient treatment. Speaking with the SUD treatment provider, he had been attending treatment regularly however in the past 2 weeks he has shown up to group treatment high and disruptive multiple times and they had to ask him to leave. He has been homeless multiple times after relapsing and abandoning his housing. He has been also diagnosed with schizophrenia however refuses medications due to intolerable side effects.

RISK:

Last night he was sent to the ER by police after he was on an overpass with no shirt or shoes. He was reported to 911 by several callers driving by on a busy road as yelling and pacing. One driver had to apply brakes rapidly to avoid hitting him. He then punched the windshield of the car and stood in front of the car for some time yelling that the driver was the devil and had to be stopped causing fear to the driver. He broke his wrist, has cuts on his feet and is severely dehydrated requiring fluids in the ER. He was initially uncooperative and aggressive, he required emergency medication for safety. Currently he is calm, reports that command hallucination caused him to punch the car. He is still doing some RIS, mumbling under his breath and appears very anxious. He is now in much pain, wants to return home and says he will go back to outpatient treatment tomorrow. He denies that he has been using for the past 6 months prior to last night. “I’m fine, this is all a little dramatic and I’m sorry for that, just let me go.”

PLACEMENT TO INVOLUNTARY BED

DCR attempts to place individual in certified E&T or Secure Withdrawal Management and Stabilization facility

If there is no bed available a Single Bed Certification (SBC) may be obtained. The facility such as ER/medical unit is willing and able to provide adequate treatment services.

NOTE: There is no allowance for a SBC for a SUD detention. If there is no bed available, the DCR is not able to detain the individual (until July 2026)

A FEW NOTES REGARDING MINORS RCW 71.34

- For adolescents 13 – 17 years of age.
- Same criteria for detention without needing imminence
- Family Initiated Treatment (1998) gives parents the ability to hospitalize adolescent without the adolescent's consent. Hospital is not obligated to accept the patient based solely on family's request.

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JOEL'S LAW

A family member, guardian, conservator, or federally recognized tribe, of which individual is a citizen may petition the Superior Court to consider an individual be detained for the initial 120 hrs.

(family: spouse, domestic partner, child, stepchild, parent, stepparent, grandparent, or sibling)

Under these circumstances (may petition through county clerk's office)

1. DCR evaluated and didn't detain (past 10 days)

or

2. DCR has not evaluated within 48 hrs of the request

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RICKY'S LAW UPDATES

- SWMS facility utilization
- Where are the current and upcoming SWMS facilities?

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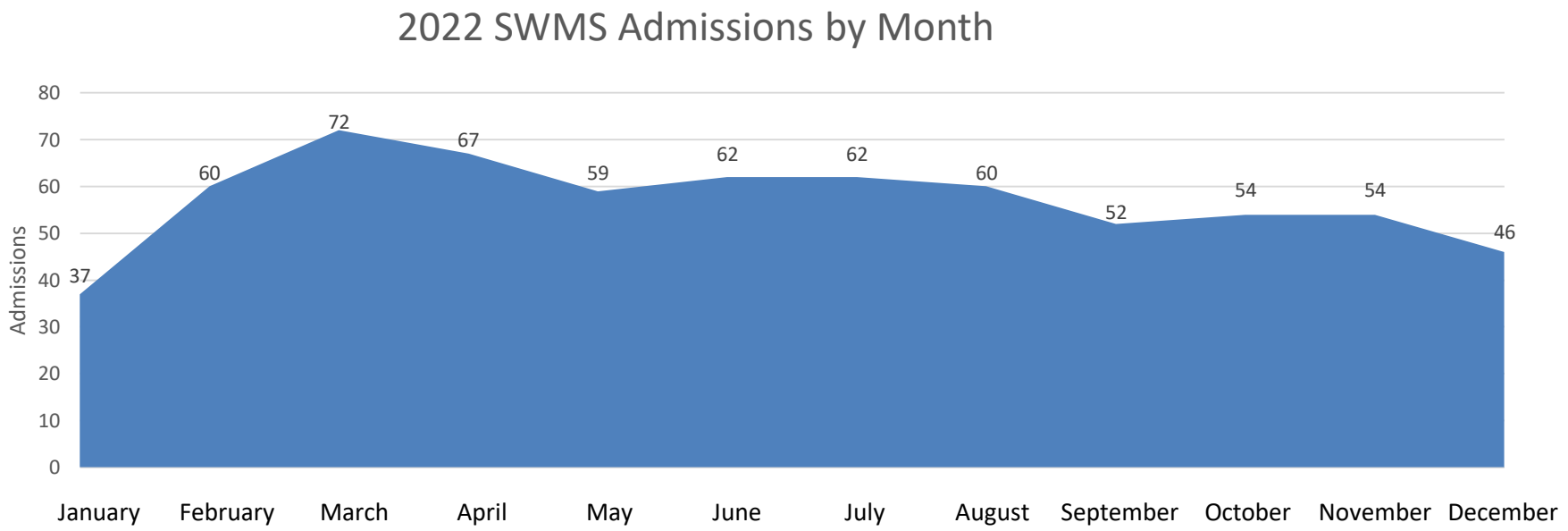
2022 ADMISSIONS VS UTILIZATION



Admissions	37	60	72	67	59	62	62	60	52	54	54	46
Utilization*	38.35%	47.17%	57.15%	48.55%	47.54%	45.22%	44.86%	40.96%	47.74%	49.36%	44.65%	57.76%

Source: SWMS Services Quarterly Reports, [Mental health reports | Washington State Health Care Authority]

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Legend

<u>Upcoming</u> – Three Rivers Benton; Lummi Nation (x2); Lifeline Connections Vancouver; Comprehensive Walla Walla

<u>Closed</u> – ABHS Cozza; Excelsior

<u>Open</u> – Recovery Place Kent; ABHS Parkside; ABHS Chehalis

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RESOURCES

- SWMS Contact

  ABHS Parkside: (509) 300-1221

  ABHS Chehalis: (360) 266-5029

  Recovery Place Kent: (253) 652-7294

- DCR Offices Contact Information

  Washington State Designated Crisis Responders contact list

- Ricky's Law Information

  Ricky's Law: Involuntary Treatment Act | Washington State Health Care Authority

  Joel's Law information

  Joel's Law fact sheet (wa.gov)

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HCA CONTACT INFORMATION

- Allison Wedin, ITA and Crisis System Supervisor, wedin.allison@hca.wa.gov

- Zephyr Forest, SWMS Coordinator, forest.zephyr@hca.wa.gov