

# **Chapter 4A:**

# **Mental Healthcare for**

# **Adults and Minor**

# **Children**

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For reference purposes, this chapter was prepared from laws, cases, and materials selected by the authors, which were available as of February 14, 2006.

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## Volume 1: Patient Care Information, Treatment and Rights

*Treatment of the mentally ill is one of the most significant problems facing the public today. We hesitate to frustrate professionals' efforts to treat mentally ill individuals as quickly and efficiently as possible... Nevertheless, we cannot forget the statutory and constitutional rights of individuals afflicted with...mental illness.*<sup>1</sup>

### 4A.1 Introduction

The law surrounding mental health care reflects the ongoing difficult balancing of the need to provide treatment to persons diagnosed with mental illness and the rights of those persons to refuse treatment. This chapter is intended to be an introduction to mental health law and does not endeavor to answer all of the outstanding questions. It begins with a description of the law of involuntary treatment for adults and covers what symptoms or severity of illness is required before a person can be involuntarily detained. The rights of adult persons with mental illness are covered, including rights to refuse treatment. The process to over-ride that refusal of treatment is also discussed. Voluntary treatment is briefly covered as well.

This chapter continues with a discussion of the treatment of children. A key element in Washington's children's mental health law is the right of children under the age of 18 to exercise some level of control over whether they receive mental health treatment. The age of the child in question is an important variable that impacts whether a parent can admit their child to a psychiatric hospital.

Finally, throughout the chapter, providers will find practical tips and advice on how to implement the law.

### 4A.2 Involuntary Mental Healthcare for Adults

Every state in the U.S. has a system to provide involuntary mental health care through detention and court-ordered treatment ("civil commitment") of individuals with mental illness. Civil commitment is one way to get services to persons in need of mental health treatment. However the resulting restrictions on a committed person's freedom of movement, and the potential stigma associated with being committed and labeled mentally ill by a court, results in a "massive curtailment of liberty."<sup>2</sup> Civil commitment processes and procedures must therefore take into account the rights of the individual and balance them with the rights of the state in providing treatment and protecting society.

Washington's system is unique because it removes the initial detention decision from physicians and places it in the hands of mental health professionals acting on behalf of county government.

#### 4A.2.1 Statutes

Involuntary mental health treatment is governed by statutes, rules, and case law. The information in this summary comes from the involuntary treatment statutes found in chapter 71.05 RCW (the "Involuntary Treatment Act" or "ITA"); the administrative rules in chapter 388-865 WAC, and the case law that interprets them.<sup>3</sup>

#### 4A.2.2 Overview

Involuntary psychiatric treatment is often called "civil commitment" because of the use of the civil legal system to require a person to undergo treatment. It is not a criminal or punitive process. Instead it is a system that

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<sup>1</sup> *In re Schuoler*, 106 Wn.2d 500, 514 (1986).

<sup>2</sup> *In re LaBelle*, 107 Wn.2d 196, 201 (1986) (citing *Humphrey v. Cady*, 405 U.S. 504, 509 (1972)).

<sup>3</sup> This chapter is only a summary of the major elements of the ITA and ITA for Minors, and must be read in conjunction with the relevant statutes and rules, chapter 71.05 RCW (ITA), chapter 71.34 RCW (ITA for Minors), and chapter 388-865 WAC. For example, the statutes contain detailed requirements for petitions and hearings, which are not repeated verbatim in this chapter. Washington's statutes are often incomplete or lack clarity, therefore, depending on the complexity of their issue, readers are advised to also consult the relevant case law.

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evaluates whether or not a person can care for themselves and safely live in the community, and if not, get them the inpatient or outpatient treatment that will allow them to do so. The preference throughout the system is for persons to receive treatment in the community and in the least-restrictive manner possible.<sup>4</sup>

While a person can enter the mental health system a number of ways (see Chapter 4C, *Commitment Based on Mental Illness* by Michael Finkle, for further discussion of how a person enters the mental health system from the criminal justice system), detention by a designated mental health professional (“DMHP”) is a frequent method of entry into the system. DMHPs are licensed mental health professionals appointed by a county and its Regional Support Network (“RSN”)<sup>5</sup> to evaluate and make decisions about individuals who may be in need of involuntary treatment.<sup>6</sup> Statewide protocols, published by the Washington Department of Social and Health Services (“DSHS”), provide guidelines to DMHPs in carrying out their duties.<sup>7</sup> When a referral is made, DMHPs investigate and evaluate the person in question to determine whether he or she meets the criteria for civil commitment.<sup>8</sup>

### Who Makes Detention Decisions?

In many states physicians have the ability to carry out the initial detention of an individual. In Washington, physicians and other providers can only refer a patient for evaluation for detention. The final decision of whether to detain an individual belongs to the DMHP.

If the person meets the criteria for commitment, the DMHP may<sup>9</sup> initiate detention of the individual for 72-hours of inpatient evaluation and treatment. At the end of this initial detention period, the individual may be released or may face a court hearing to determine if they should be committed for up to 14-days inpatient evaluation and treatment. Some individuals may receive up to 90 days of outpatient treatment at this stage (a ‘less-restrictive alternative’) instead of inpatient treatment. If the individual continues to require treatment they may be committed for a further 90-days and then successive 180-day periods of inpatient or outpatient treatment.

#### 4A.2.3 Who May be Civilly Committed?

The civil commitment decision is based on whether an individual has a mental disorder and whether, as a result of the mental disorder, the individual is ‘gravely disabled’ or presents a ‘likelihood of serious harm’ to

<sup>4</sup> See generally RCW 71.05.010.

<sup>5</sup> RCW 71.24.025(18). The RSNs are county-based entities that play a significant role in the public mental health system, administering benefits, developing provider networks, and prioritizing the use of limited resources. In the 2005 session, legislation was passed that will allow other entities to serve as RSNs. See RCW 71.24.320.

<sup>6</sup> “‘County designated mental health professional’ means a mental health professional appointed by the county to perform the duties specified in” chapter 71.05 RCW. RCW 71.05.020(6). The term “county designated mental health professional” as defined in RCW 71.05.020 was changed to “designated mental health professional” by 2005 c 504 § 104.

“‘Mental health professional’ means a psychiatrist, psychologist, psychiatric nurse, or social worker.” RCW 71.05.020(21). Standards for additional individuals who qualify as mental health professionals are found in WAC 388-865-0260, 388-865-0265.

<sup>7</sup> RCW 71.05.214. The CDMHP protocols are developed in consultation with representatives from various stakeholder groups and are updated regularly. Providers, consumers, and members of the public will also find them to be understandable and readable introductions to the civil commitment system. At the time of this publication the 2002 CDMHP Protocols are available on DSHS’s website at: <http://www1.dshs.wa.gov/mentalhealth/cdmhp.shtml>.

<sup>8</sup> RCW 71.05.150.

<sup>9</sup> The DMHP is not required to detain every person who meets the criteria for detention. RCW 71.05.040.

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themselves or to others. Whether a person has a mental disorder and is dangerous to either himself or others, or is unable to care for themselves, and is in need of involuntary treatment depends on the facts of each case and the expert opinions of the treating physicians and mental health professionals involved. In general, the mere presence of a mental disorder is not the only determinant of whether an individual may be committed.

Although it is clear that the State has a legitimate interest ... in protecting the community from the dangerously mentally ill and in providing care to those who are unable to care for themselves, it is also clear that mental illness alone is not a constitutionally adequate basis for involuntary commitment. ... [A] State cannot constitutionally confine without more a nondangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends.<sup>10</sup>

**Mental Disorder.** A **mental disorder** is “any organic, mental, or emotional impairment which has substantial adverse effects on a person’s cognitive or volitional functions.”<sup>11</sup> It includes mental illness such as depression, schizophrenia, and bipolar disorder. It also includes conditions such as dementia, developmental disabilities, and traumatic brain injury. Persons who are “developmentally disabled, impaired by chronic alcoholism or drug abuse, or suffering from dementia” have a “mental disorder” but they cannot be detained or committed solely because they have been diagnosed with one of these conditions.<sup>12</sup>

To result in an order of civil commitment, the mental disorder must have serious<sup>13</sup> negative effects on a person’s cognitive or volitional functions, resulting in them being either “gravely disabled” or presenting a “likelihood of serious harm” to themselves or others.

**Gravely Disabled.** “**Gravely disabled**” means a condition in which a mental disorder has such serious effects on a person that they are placed at risk of serious physical harm because they are unable to provide for their basic needs or because they experience a severe deterioration in routine functioning and are unable to exercise cognitive or volitional control over their actions.<sup>14</sup>

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<sup>10</sup> *In re LaBelle*, 107 Wn.2d at 201 (1986) (citations and internal quotation marks omitted).

"A finding of 'mental illness' alone cannot justify a State's locking a person up against his will and keeping him indefinitely in simple custodial confinement. Assuming that that term can be given a reasonably precise content and that the 'mentally ill' can be identified with reasonable accuracy, there is still no constitutional basis for confining such persons involuntarily if they are dangerous to no one and can live safely in freedom."

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

<sup>11</sup> RCW 71.05.020(22).

<sup>12</sup> RCW 71.05.040. Disorders such as developmental disabilities, chronic impairment due to alcoholism or drug abuse, or dementia can support detention or commitment only if the condition causes the person to be gravely disabled or causes circumstances that present a likelihood of serious harm. RCW 71.05.040.

<sup>13</sup> “At one time or another every person exhibits some abnormal behavior which might be perceived by some as symptomatic of a mental or emotional disorder, but which is in fact within a range of conduct that is generally acceptable. Obviously, such behavior is no basis for compelled treatment and surely none for confinement.” *Addington v. Texas*, 442 U.S. 418, 427-428 (1979).

<sup>14</sup> “‘Gravely disabled’ means a condition in which a person, as a result of a mental disorder: (a) Is in danger of serious physical harm resulting from a failure to provide for his or her essential human needs of health or safety; 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(16). The seminal case on grave disability is *In re LaBelle*, 107 Wn.2d 196 (1986).

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Neither “cognitive” nor “volitional” are defined in the statute. However the CDMHP Protocols contain useful definitions. Cognitive means “the capacity to accurately know and perceive reality and understand fundamental consequences.”<sup>15</sup> Volitional means “the capacity to exercise restraint or direction over one’s behavior; the ability to make conscious and deliberate decisions.”<sup>16</sup>

To be gravely disabled it is not enough to show that treatment would be preferred or beneficial or even in the person’s best interests. The potential risk of harm to the person must be great enough to justify confining them in a psychiatric facility and restricting their liberty. Courts and DMHPs require recent, tangible factual evidence that the mental disorder<sup>17</sup> is currently affecting cognitive or volitional functioning, and causing the person to be unable to provide for essential needs such as food, clothing, shelter, or medical care. Evidence must show that the failure or inability to meet these needs presents a high probability that the person will suffer serious physical harm within the near future, unless involuntary treatment and confinement is provided.<sup>18</sup> Repeated hospitalizations, and repeated juvenile offenses, criminal charges, diversion programs, or jail admissions are given great weight when determining whether, if released, an individual would receive care that is essential to their health or safety.<sup>19</sup>

When a health care provider calls a DMHP, or files a petition for additional commitment, the DMHP, attorneys, and the court will look for documentation and testimony of personal observations by clinical professionals of the person’s signs, symptoms, or behavior. Professionals can rely on, and testify to, interviews with the patient, psychological or mental status exams, opinions and observations of others on the treatment team, observations of friends, family, and other caregivers, and the content of the person’s medical records. In general, the court will be considering factual evidence that is relevant to:

- whether the person’s mental disorder and its symptoms interfere with his or her ability to provide for basic needs and perform activities of daily living, such as maintaining adequate nutrition, hygiene, shelter, medical/mental health care, and managing finances
- whether the person’s judgment is impaired
- whether the person has adequate impulse control
- whether the person’s mood is affected (depression, mania, anxiety)
- whether the person is suffering from and acting on delusions or paranoia
- whether the person is suffering from, distracted by, or acting on internal stimuli, including visual or auditory hallucinations
- whether the person has a distorted perception of reality
- whether the person is oriented to time, place, and person, or whether there are symptoms of confusion
- the person’s capacity to learn and remember information
- the person’s level of cognitive functioning
- whether the person has insight into the mental disorder

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<sup>13</sup> 2002 CDMHP Protocols, p.14. Prior to statutory amendments in 2005, DMHPs were referred to as *County Designated Mental Health Professionals*, or “CDMHPs.”

<sup>16</sup> *Id.*

<sup>17</sup> To avoid erroneous commitment of a person due to a chosen lifestyle that the majority of people might perceive as eccentric, substandard or otherwise offensive, the failure or inability must be shown to arise as a result of a mental disorder, not because of other factors. *In re LaBelle*, 107 Wn.2d 196 (1986).

<sup>18</sup> *In re LaBelle*, 107 Wn.2d 196 (1986).

<sup>19</sup> RCW 71.05.285.

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- whether the person is capable of making rational decisions about their course of treatment
- whether the person is compliant with any treatment recommendations, including medications
- whether there are places or persons in the community available to support and assist the person with any deficits so that they can live in the community with assistance

Likelihood of Serious Harm. Mental illness does not in itself connote dangerousness, nor is it necessarily a relevant indicia of dangerousness. A person must present a likelihood of serious harm, based on factual evidence.<sup>20</sup> "Likelihood of serious harm" means:

- A substantial risk that: (i) Physical harm will be inflicted by an individual upon his or her own person, as evidenced by threats or attempts to commit suicide or inflict physical harm on oneself; (ii) physical harm will be inflicted by an individual upon another, as evidenced by behavior which has caused such harm or which places another person or persons in reasonable fear of sustaining such harm; or (iii) physical harm will be inflicted by an individual upon the property of others, as evidenced by behavior which has caused substantial loss or damage to the property of others; or
- The individual has threatened the physical safety of another and has a history of one or more violent acts[.]<sup>21</sup>

Great weight is given to any recent history of violent acts and any prior commitments in the past on the basis of "likelihood of serious harm," however neither of these may be the sole basis for concluding that a person presents a likelihood of serious harm.<sup>22</sup> The risk of danger must be substantial and the harm must be serious. As with grave disability, courts and DMHPs require recent, tangible factual evidence that the mental disorder is negatively interfering with the person's functioning. They will look for documentation or testimony of the personal observations by clinical professionals of the person's signs, symptoms, or behavior, including interviews with the patient, psychological or mental status exams, opinions and observations of others on the treatment team, observations of friends, family, and other caregivers, and the content of the person's medical records. They will be considering factual evidence that is relevant to the questions listed above for grave disability and is relevant to:

- whether the person has threatened or attempted to cause injury to himself or herself and in what way
- whether the person has threatened or attempted to cause harm to others and in what way
- whether the person has placed anyone in reasonable fear of harm to his or her person and in what way
- whether the person has actually caused physical injury to anyone else, and the seriousness of those injuries
- the most recent occurrence of any threat, attempt, or harmful behavior.

### 4A.2.4 The Detention and Commitment Process

The details of the involuntary treatment processes are contained in statute. Commitment begins with the initial detention lasting up to 72 hours and continues in successive stages of 14 days, 90 days, and 180 days. At each stage the person has due process rights including the right to counsel and the right to a hearing.

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<sup>20</sup> *In re Harris*, 98 Wn.2d 276 (1982).

<sup>21</sup> RCW 71.05.020(21).

<sup>22</sup> RCW 71.05.245. "'Violent act' means behavior that resulted in homicide, attempted suicide, nonfatal injuries, or substantial damage to property." RCW 71.05.020(36). "'History of one or more violent acts' refers to the period of time ten years prior to the filing of a petition under this chapter, excluding any time spent, but not any violent acts committed, in a mental health facility or in confinement as a result of a criminal conviction." RCW 71.05.020(18); *In re Pugh*, 68 Wn. App. 687 (1993).

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### 4A.2.4.1 Initial Detention

When a DMHP receives information that causes them to believe a person is, as a result of a mental disorder, gravely disabled or that they present a likelihood of serious harm to themselves or others, the DMHP investigates the allegations through interviews of anyone with relevant information, such as treatment providers and, of course, the person being investigated.<sup>23</sup> The DMHP also reviews any “reasonably available information.”<sup>24</sup> The person is advised of the rights associated with civil commitment, including the right to an attorney.

If the DMHP is of the opinion that the person’s condition presents an *imminent* likelihood of serious harm, or of being gravely disabled, and the person is not a good-faith candidate for voluntary treatment, the DMHP may immediately detain the person to an evaluation and treatment facility (“E&T”)<sup>25</sup> for up to 72 hours of evaluation and treatment, and must serve a notice of emergency detention containing the basis for the detention.<sup>26</sup> The next judicial day the DMHP must file with the court and serve on the person’s attorney a petition (or supplemental petition) for initial detention detailing the factual basis for detention, proof of service, and a copy of the notice of emergency detention.<sup>27</sup>

If the person does not present an *imminent* likelihood of serious harm or an imminent danger of grave disability, the DMHP may instead file a court petition and obtain a court order requiring the person to present to an E&T for 72 hours of evaluation and treatment.<sup>28</sup> If the person fails to appear as ordered, the DMHP may have them taken into custody by law enforcement.<sup>29</sup>

At the E&T the person is examined and evaluated by a physician and a mental health professional within 24-hours of admission to the facility.<sup>30</sup> If the professionals at the facility do not believe the person is gravely disabled or presents a likelihood of serious harm, they may discharge the patient. They may also transfer the patient to other needed care, such as medical care or chemical dependency treatment.

At the end of the 72 hours the person must be released from inpatient treatment unless (1) they provide informed consent to remain for further inpatient treatment or (2) the court orders further inpatient treatment under the following process.<sup>31</sup>

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<sup>23</sup> RCW 71.05.150(1)(a).

<sup>24</sup> RCW 71.05.212.

<sup>25</sup> RCW 71.05.360(5), RCW 71.05.150(2).

<sup>26</sup> In computing the 72-hour period, do not count Saturdays, Sundays, or holidays. RCW 71.05.180.

<sup>27</sup> RCW 71.05.160.

<sup>28</sup> RCW 71.05.150. *In re Harris*, 98 Wn.2d 276 (1982). The person must be evaluated by a physician within 24-hours of the detention. RCW 71.05.210.

“Imminence” means “the state or condition of being likely to occur at any moment; near, at hand, rather than distant or remote.” CDMHP Protocols, p. 17.

<sup>29</sup> *Id.*

<sup>30</sup> RCW 71.05.210.

<sup>31</sup> RCW 71.05.210. A person must have the capacity (or be competent) to provide informed consent in order to agree to admission as a voluntary patient. *Zinerman v. Burch*, 110 S. Ct. 975 (1990).

**Provider Tip – Emergency Department Wait Times**

Hospital emergency departments are a common source of referrals to DMHPs. A DMHP has 6 hours from the time the hospital calls to refer a patient to complete their investigation and detain the patient.<sup>32</sup> The time it takes a hospital to evaluate a patient and determine whether or not to refer the case to a CDMHP is not counted against the time allowed to the DMHP. However, hospitals should be prepared to explain the reasons for any lengthy delay between the person's arrival, evaluation by ED mental health staff, and the referral to the DMHP.<sup>33</sup>

**Provider Tip – EMTALA and the ITA**

Failure to properly stabilize or transfer a detained patient from one facility to another is a common complaint. Psychiatric symptoms may indicate an emergency medical condition and hospitals must comply with the Emergency Medical Treatment and Labor Act's ("EMTALA") screening, stabilization, and transfer requirements when a person is evaluated in their emergency department for civil commitment and detained by a DMHP.<sup>34</sup>

**4A.2.4.2 14 Days of Inpatient or 90 Days of Outpatient Treatment**

A hearing must be held before the expiration of the initial 72-hour period in order to determine whether the person will be detained for an additional fourteen days of involuntary intensive treatment.<sup>35 36</sup> If the person meets the criteria for civil commitment, but no longer requires an inpatient level of treatment, an outpatient commitment alternative is available: 90 days of a less restrictive alternative to involuntary intensive treatment (known as an "LR" or an "LRA").<sup>37</sup> LRAs are used when a person's condition requires further treatment or monitoring but the person is not a good-faith candidate for voluntary outpatient treatment.

If a patient will not agree to voluntary treatment then any additional treatment, whether inpatient or outpatient, can only be ordered by the court.<sup>38</sup> Before filing a petition for continued treatment, the professional staff of the facility is responsible for evaluating the person and determining that the person

<sup>32</sup> RCW 71.05.050.

<sup>33</sup> See generally *In re C.W.*, 147 Wn.2d 259 (2002).

<sup>34</sup> For a comprehensive discussion of the EMTALA see *EMTALA: A Comprehensive Guide to the Emergency Patient Screening and Transfer Law*, by Jennifer Stiller, J.D. A white paper by Lowell C. Brown and R. Gregory Cochran, *The Impact of EMTALA's 2003 Final Rules and the 2004 Interpretive Guidelines on the Hospital Industry*, provides information on the changes to EMTALA after the publication of the more comprehensive guide. Both publications are available for purchase from the American Health Lawyers Association at [www.ahla.org](http://www.ahla.org).

<sup>35</sup> RCW 71.05.240. Continuances may be available, as contained in the statute.

<sup>36</sup> MPR 1.2. Continuances at different points in the commitment system may have additional requirements or restrictions, including different maximum lengths of time for the continuance. See e.g. RCW 71.05.210, 71.05.240, 71.05.310.

<sup>37</sup> RCW 71.05.230.

<sup>38</sup> For persons who have appointed agents under a mental health advance directive it may be possible for the agent to agree to inpatient or outpatient treatment under the authority of the directive. Further information about mental health advance directives can be found in Chapter 4B, *Mental Health Advance Directives*.

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continues to be gravely disabled or to present a likelihood of serious harm, as a result of a mental disorder.<sup>39</sup> The person must be advised that they need additional treatment and given the opportunity to voluntarily accept the treatment recommendations and participate in treatment in good faith.<sup>40</sup> If voluntary treatment is not possible, a petition for 14-day inpatient or 90-day outpatient treatment is filed by the facility or the DMHP and served on the person and their guardian if any.<sup>41</sup> The person has many of the same rights commonly associated with the criminal justice system, including the right to remain silent, the right to a copy of the petition with the allegations against them, the right to a hearing using the rules of evidence, the right to present witnesses and cross-examine witnesses, and the right to an attorney to assist in their response to the commitment petition, including a public defender if they are indigent.<sup>42</sup>

The petition must include sufficient facts to support the allegations that the person suffers from a mental disorder and that as a result the person presents a likelihood of serious harm or is gravely disabled. There must be evidence that the person is not a good faith candidate for voluntary treatment.<sup>43</sup> Petitions seeking inpatient treatment must explain why a less-restrictive (outpatient) alternative is not in the best interests of the person and the community.<sup>44</sup> Petitions seeking less-restrictive (outpatient) treatment must include details of the proposed arrangement.<sup>45</sup> All petitions must be signed by two physicians, or by a physician and a mental health professional, who have evaluated the person.<sup>46</sup>

### **Provider Tip - Continuances and the Right to Refuse Medications**

In the event of a continuance remember that the patient's right to refuse psychiatric medication applies to the new hearing date.<sup>47</sup> The patient should be advised of their right to refuse medications, and their wishes should be respected, prior to each hearing.

Beginning 24 hours before the hearing, the person has the right to refuse psychiatric medications.<sup>48</sup> At this hearing (called the 'probable cause' hearing<sup>49</sup>), the county prosecuting attorney will present the evidence, witnesses, and argument in support of the commitment.<sup>50</sup> Treating providers and facility staff are frequently subpoenaed to testify as to their observations and treatment of the person.<sup>51</sup> The defense

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<sup>39</sup> RCW 71.05.230(1).

<sup>40</sup> RCW 71.05.230(2). The preference is for persons to participate voluntarily in treatment. Therefore, the prosecutor must prove at the hearing that the person is not a "good faith" voluntary patient. *In re Kirby*, 65 Wn. App. 862 (1992).

<sup>41</sup> RCW 71.05.230(4), (5). The petition must meet all elements specific in RCW 71.05.230.

<sup>42</sup> RCW 71.05.300; *In re LaBelle*, 107 Wn.2d 196 (1986).

<sup>43</sup> RCW 71.05.230(2).

<sup>44</sup> RCW 71.05.230(4).

<sup>45</sup> *Id.*

<sup>46</sup> RCW 71.05.230(4). The professionals who sign the petition must be prepared to testify to the facts and allegations in the petition. RCW 71.05.230(1).

<sup>47</sup> RCW 71.05.210.

<sup>48</sup> RCW 71.05.210. The person may not refuse "any other medication previously prescribed" or "emergency lifesaving treatment." *Id.*

<sup>49</sup> RCW 71.05.240, RCW 71.05.250.

<sup>50</sup> RCW 71.05.130.

<sup>51</sup> RCW 71.05.360(9).

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attorney will present the person's response to the petition and cross-examine any witnesses who testify in support of the petition.

The court will order involuntary treatment if the prosecutor proves the allegations in the petition by a preponderance<sup>52</sup> of the evidence.<sup>53</sup> The period of involuntary inpatient treatment allowed under the order is for no more than 14 days.<sup>54</sup> If before the 14 days are exhausted the person no longer presents a likelihood of serious harm, is no longer disabled, or is determined to be appropriate for and willing to accept voluntary inpatient or outpatient treatment, the facility must release the person from commitment.<sup>55</sup> If, at the end of the 14-day period, the person requires further involuntary inpatient treatment the procedures for 90-day commitment, below, apply.<sup>56</sup>

### **4A.2.4.3 90 Days of Inpatient or Outpatient Treatment**

At this point in the civil commitment process, persons with mental illness begin to face significantly longer periods of commitment. This more serious restriction on their freedom of movement is matched by a corresponding increase in the due process rights and protections afforded to them. For the first time in the process, the person has the right to request a jury trial on the petition for continued treatment.<sup>57</sup> If requested, the court can appoint an expert to examine and testify on behalf of patient.<sup>58</sup> The court may also appoint a professional to assist the person in identifying and recommending appropriate and less-restrictive treatment alternatives to inpatient commitment.<sup>59</sup>

The burden of proof also increases. At this stage, the court will order commitment only if the petitioner proves the required elements by "clear, cogent, and convincing evidence."<sup>60</sup> In general, a person may be committed on the grounds that they are gravely disabled or that they present a likelihood of serious harm to themselves or to others.<sup>61</sup> Persons may also enter civil commitment at this stage from the criminal justice

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<sup>52</sup> A "preponderance" of the evidence means more probably true than not. *See e.g. Born v. Thompson*, 154 Wn.2d 749, 782 (2005).

<sup>53</sup> RCW 71.05.240. "The court shall also provide written notice that the person that is barred from the possession of firearms." *Id.*

<sup>54</sup> RCW 71.05.260.

<sup>55</sup> *Id.*

<sup>56</sup> *Id.*

<sup>57</sup> RCW 71.05.300.

<sup>58</sup> *Id.*

<sup>59</sup> *Id.*

<sup>60</sup> RCW 71.05.310.

<sup>61</sup> At the expiration of the 14-day period of intensive treatment, a person may be confined for further treatment pursuant to RCW 71.05.320 if:

- (1) Such person after having been taken into custody for evaluation and treatment has threatened, attempted, or inflicted:
  - (a) Physical harm upon the person of another or himself or herself, or substantial damage upon the property of another, and (b) as a result of mental disorder presents a likelihood of serious harm; or
- (2) Such person was taken into custody as a result of conduct in which he or she attempted or inflicted physical harm upon the person of another or himself or herself, or substantial damage upon the property of others, and continues to present, as a result of mental disorder, a likelihood of serious harm; or
- (3) Such person has been determined to be incompetent and criminal charges have been dismissed pursuant to RCW 10.77.090(4), and has committed acts constituting a felony, and as a result of a mental disorder, presents a substantial likelihood of repeating similar acts. In any proceeding pursuant to this subsection it shall not be necessary to show intent, willfulness, or state of mind as an element of the crime; or
- (4) Such person is gravely disabled.

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system for example, because they are incompetent to stand trial on felony criminal charges and present a substantial likelihood of repeating acts similar to the charges.<sup>62</sup>

For the court to order inpatient commitment, the petitioners must prove that the person meets one of the bases for commitment and must also prove that the best interest of the patient and the community could not be adequately served by a less-restrictive treatment option.<sup>63</sup>

### 4A.2.4.4 180 Days of Inpatient or Outpatient Treatment

At the end of the commitment under the 90-day order, the person must be released from inpatient or outpatient treatment unless a new petition for continued involuntary treatment has been filed.<sup>64</sup> The increased rights and procedural protections and rights that began at the stage of the 90-day commitment continue to apply to the petition and hearing on the petition for 180-day commitment, including the increased burden of proof and the right to a jury trial.<sup>65</sup>

The grounds that support an order of commitment change slightly at this stage. Unlike previous stages in the process, at this stage a person *may not* be committed based on allegations that the person presents a likelihood of serious harm to himself.<sup>66</sup> Successive one hundred eighty day commitments are permissible on the same grounds and pursuant to the same procedures.<sup>67</sup>

### 4A.2.4.5 Conditional Release or Revocation of an LRA

If during any inpatient commitment the treatment team believes a person can be appropriately served as an outpatient, the commitment order may be amended by agreement of the parties and entered by the court to release the person from inpatient commitment with the condition that the person receive outpatient treatment as a term of the release.<sup>68</sup> This conditional release lasts as long as the original inpatient order. The person may receive successive less-restrictive treatment orders when the conditional release expires, if petitions are filed and orders entered as discussed above.

The outpatient treatment provider is to notify the DMHP if “the person fails to adhere to terms and conditions of his or her conditional release or experiences substantial deterioration in his or her condition and, as a result, presents an increased likelihood of serious harm.”<sup>69</sup> The DMHP will order the person

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RCW 71.05.280.

<sup>62</sup> RCW 71.05.280(3).

<sup>63</sup> RCW 71.05.320(2).

<sup>64</sup> RCW 71.05.320(2). “A person who has been determined to be incompetent and criminal charges have been dismissed’ may enter the civil commitment system at this step if the person ‘has committed acts constituting a felony, and as a result of a mental disorder, presents a substantial likelihood of repeating similar acts’ RCW 71.05.320(1). These persons are often already at state hospitals for competency evaluation or restoration as discussed in Chapter 4C, *Commitment Based on Mental Illness*.

<sup>65</sup> RCW 71.05.320(2).

<sup>66</sup> See RCW 71.05.320(2) for the criteria at this stage.

<sup>67</sup> Id.

<sup>68</sup> RCW 71.05.340.

<sup>69</sup> RCW 71.05.340(3)(b).

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detained to an inpatient E&T for consideration of revocation of the conditional release or for modification of the terms of the conditional release.<sup>70</sup>

The DMHP may also order the person detained if the person:

- fails to adhere to the terms of a conditional release
- experiences a substantial deterioration in routine functioning
- experiences a substantial decompensation which is reasonably likely to be reversed by inpatient treatment, or
- poses a likelihood of serious harm.<sup>71</sup>

A petition for revocation will be filed by the E&T or the DMHP.<sup>72</sup> A hearing will be held no more than five days from the detention to determine whether the conditional release will be revoked.<sup>73</sup> The person will remain at the facility until the hearing.<sup>74</sup> The person has the same right to notice, hearing, and counsel as in an inpatient commitment hearing.<sup>75</sup> The court may order that the conditions of the release be modified or may require the person to return to inpatient treatment.<sup>76</sup> This new order will last until the ending date of the original order and conditional release.<sup>77</sup>

These procedures are also used for revocation of a less-restrictive alternative order to require a person to submit to inpatient treatment.<sup>78</sup>

### **Provider Tip – Testifying at Hearings**

At a revocation hearing, testimony is often needed from the outpatient provider about the person's compliance or non-compliance with the terms of their release, and whether there has been any deterioration in their condition. Be sure the DMHP knows how to reach you in case testimony is needed during a time you are not scheduled to work. Some courts will allow testimony by telephone.

#### **4A.2.4.6 Patient Rights**

Every person involuntarily detained or committed retains all rights not specifically denied him by the commitment.<sup>79</sup> Each person has the right to adequate care and individualized treatment.<sup>80</sup> The person is

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<sup>70</sup> RCW 71.05.340(3)(a).

<sup>71</sup> Id.

<sup>72</sup> RCW 71.05.340(3)(d).

<sup>73</sup> RCW 71.05.340(3)(c).

<sup>74</sup> Id.

<sup>75</sup> RCW 71.05.340(3)(d).

<sup>76</sup> RCW 71.05.340(3)(d).

<sup>77</sup> RCW 71.05.340(3)(e).

<sup>78</sup> RCW 71.05.340(6).

<sup>79</sup> RCW 71.05.360. *See also* RCW 71.12.570 (“All persons in an establishment as defined by chapter 71.12 RCW shall have no less than all rights secured to involuntarily detained persons by RCW 71.05.360 and 71.05.370 and to voluntarily admitted or committed persons pursuant to RCW 71.05.050 and 71.05.380.”); WAC 246-322-035(1)(d).

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presumed competent and able to provide informed consent to treatment while civilly committed, including psychiatric and medical treatment.<sup>81</sup> The person has the right to refuse treatment with psychiatric medications in general and in specific situations such as before a hearing.<sup>82</sup> They have a right to a reasonable choice of an available physician or other professional person qualified to provide such services.<sup>83</sup> As long as it does not create a danger, each person involuntary detained or committed has the right:

- To wear his or her own clothes and to keep and use his or her own personal possessions
- To keep and be allowed to spend a reasonable sum of his or her own money for canteen expenses and small purchases
- To have access to individual storage space for his or her private use
- To have visitors at reasonable times
- To have reasonable access to a telephone to make and receive confidential calls (consistent with an effective treatment program)
- To have ready access to letter writing materials, including stamps, and to send and receive uncensored mail
- To discuss treatment plans and decisions with the treatment staff
- To not have psychosurgery performed on him or her under any circumstances
- To dispose of property and sign contracts<sup>84</sup>
- To petition the court for release by using the habeas corpus process<sup>85</sup>

### **Provider Tip – Patient Rights Advocates Have Broad Access Rights**

Federal law mandates that each state designate a “protection and advocacy system” (“P&A”) to advocate for individuals with mental illness.<sup>86</sup> To help insure rights are protected, the federally-funded P&As are charged with investigation of alleged abuse, neglect, and rights violations in facilities; and use of legal and other remedies to address issues.

In order to investigate complaints and allegations of abuse or neglect, the state P&A has rights under federal law to access facilities that care for or treat individuals with mental illnesses. P&A staff also have the right to speak with patients, and to review health care records in specified circumstances.<sup>87</sup>

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<sup>80</sup> RCW 71.05.360(2).

<sup>81</sup> RCW 71.05.360(1)(b).

<sup>82</sup> RCW 71.05.210, RCW 71.05.215, RCW 71.05.217.

<sup>83</sup> RCW 71.05.360(4).

<sup>84</sup> RCW 71.05.360(10).

<sup>85</sup> RCW 71.05.360(13).

<sup>86</sup> See generally Protection & Advocacy for Individuals with Mental Illness (PAIMI): 42 U.S.C. 10801 – 10827; 45 C.F.R. 51.1 - 51.46. Protection & Advocacy for Individuals with Developmental Disabilities (PADD): 42 U.S.C. 15001 – 15045; 45 C.F.R. 1385.1 - 1386.25. Protection & Advocacy for Individuals with Traumatic Brain Injuries (PATBI): 42 U.S.C. 300d - 300d-53. See also Gary P. Gross, *Protection and Advocacy System Standing – To Vindicate the Rights of Persons with Disabilities*, 22 Mental & Physical Disability L. Rep. 674 (1998).

<sup>87</sup> 45 C.F.R. 51.41, 51.42. For more information about P&As, generally, see the website of the National Disability Rights Network: [http://www.napas.org/P&A\\_Enabling\\_Laws/P&A%20CAP%20history%20home.htm](http://www.napas.org/P&A_Enabling_Laws/P&A%20CAP%20history%20home.htm)

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### 4A.2.5 Treatment with Involuntary Medication or Electroconvulsive Therapy

#### 4A.2.5.1 The Right to Refuse Treatment

“[E]very human being of adult years and sound mind has a right to determine what shall be done with his own body.”<sup>88</sup> That right, often called informed consent, continues through civil commitment.<sup>89</sup> In addition, the ITA specifically states that a committed individual retains the right to refuse electroconvulsive therapy and, in some situations, antipsychotic medication.<sup>90</sup>

At times there can be tension between these individual rights and the interests of the state. The law in this area balances the state and individual interests, and clarifies and elaborates on the circumstances that must exist before a person can be compelled to accept treatment with antipsychotic medication or electroconvulsive therapy, and what level of process and procedure is required to protect against erroneous involuntary treatment.

#### **Provider Tip – Informed Consent and Persons with Serious Mental Disorders**

All patients are presumed competent to provide informed consent. Their ability to understand and use information to make rational decisions based on their own values, culture, and other factors that are important to them is influenced by many variables, including their current symptoms, the complexity of the decision that must be made, and even the time of day.

If a patient is not able to sufficiently comprehend complex decisions with permanent outcomes, they may still be able to participate in their own care by making less complex decisions.

#### 4A.2.5.2 Involuntary Antipsychotic Medication

There is no single state or federal case that defines the minimum level of procedural due process for involuntary administration of antipsychotic medication.<sup>91</sup> In general, involuntarily detained patients have

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<sup>88</sup> *Smith v. Shannon*, 100 Wn.2d 26 (1983) (citing *Schloendorff v. Society of New York Hosp.*, 211 N.Y. 125 (1914), overruled on other grounds, *Bing v. Thunig*, 2 N.Y.2d 656 (1957)). See also *In re Ingram*, 102 Wn.2d 827 (1984); *In re Colyer*, 99 Wn.2d 114 (1983).

<sup>89</sup> Committed persons do not lose competency to make care and treatment decisions. RCW 71.05.360(1)(b). Even if a person lacks the capacity to give informed consent for themselves, their right to determine their care and treatment is exercised by a surrogate decision-maker, such as a guardian or agent appointed by a durable power of attorney for health care. RCW 7.70.065; *In re Ingram*, 102 Wn.2d 827 (1984); *In re Colyer*, 99 Wn.2d 114 (1983).

<sup>90</sup> RCW 71.05.217.

<sup>91</sup> The required minimum level of procedural due process is determined by weighing the factors laid out by the Supreme Court:

First, the private interest that will be affected by the official action; second, the risk of an erroneous deprivation of such interest through the procedures used, and the probable value, if any, of additional or substitute procedural safeguards; and finally, the Government's interest, including the function involved and the fiscal and administrative burdens that the additional or substitute procedural requirement would entail.

*Mathews v. Eldridge*, 424 U.S. 319, 335 (1976).

The leading case in the area of involuntary antipsychotic medication is *Washington v. Harper*, 494 U.S. 210 (1990), which overruled the opinion of the Washington State Supreme Court that a judicial hearing is always required before involuntary administration of antipsychotic medication, *Harper v. Washington*, 110 Wn.2d 873 (1988). The U.S. Supreme Court evaluated the Washington Department of Corrections procedures for involuntary administration of antipsychotic medication to prisoners and provided guidance that, while not directly applicable to civil commitment patients, can be used by states and providers to

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the right to refuse antipsychotic medication unless it is determined that the failure to medicate may result in a likelihood of serious harm or substantial deterioration and it has been determined that there is no less intrusive course of treatment in the best interest of the individual.<sup>92</sup>

[T]he State has a legitimate interest under its police and *parens patriae* powers in protecting the community from the dangerously mentally ill and in providing care to those who are unable to care for themselves[.]

The state does not have an interest in the involuntary administration of antipsychotic medication to persons who are not mentally ill, who are not dangerous, or who are able to care for themselves.

Procedural due process is the system used to ensure that the rights of the person are properly weighed against the state interest before a decision is made about providing involuntary antipsychotic medication. The level of individual protection achieved by the process must be sufficient to balance the curtailment of liberty that comes with the involuntary antipsychotic medication.<sup>93</sup>

Depending on where the person is in the ITA process, different procedures must be used for involuntary treatment with antipsychotic medication.

### 4A.2.5.2.1 Persons with 72-hour, 14-day, or 90-day ITA Orders

After evaluation of the person and determination of medical need for antipsychotic medication, the treating physician attempts to obtain the informed consent of the person for the proposed medication (i.e. the physician explains the risks and benefits of the medication, the likely effects and prognosis with medication, and the prognosis without medication).<sup>94</sup> If the person refuses or does not have capacity to provide consent, the treating physician must determine whether, in the professional opinion of the physician, both of the following are true:

- Failure to medicate may result in a likelihood of serious harm or substantial deterioration, AND
- There is no less intrusive course of treatment in the best interest of the person.

Treatment with antipsychotic medication may occur only if a second physician repeats the process of evaluating the person, determining the medical need for antipsychotic medication, attempting to obtain informed consent from the person and determining whether, in the physician's professional opinion, failure to medicate may result in a likelihood of serious harm or substantial deterioration, and that there is no less intrusive course of treatment in the best interest of the person.<sup>95</sup> If both physicians agree the criteria are

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guide development of involuntary medication rights. Post-*Washington v. Harper* cases, which approve or disapprove of a particular policy chosen by a state or facility, or which review whether a particular instance met a state's statutory procedures, also help define the parameters of the right to refuse involuntary antipsychotic medication. See e.g. *Hightower by Deller v Olmstead*, 959 F.Supp 1549 (N.D. Ga. 1996) (approving Georgia's physician-based procedures for involuntary medication); *Jurasek v. Utah State Hospital*, 158 F.3d 506 (10th Cir. 1998) (expressing approval of Utah's use of the process from *Harper*).

The Washington state case, *Harper v. Washington*, while overruled by the U.S. Supreme Court for at least one point of law, remains useful for its discussion of a person's right to refuse antipsychotic treatment and for its announcement that the due process requirements announced in *In re Schuoler*, 106 Wn.2d 500 (1986), apply to both ECT and antipsychotic medication. *Harper v. Washington*, 110 Wn.2d at 881-884 (1988).

<sup>92</sup> RCW 71.05.210, RCW 71.05.217.

<sup>93</sup> *In re LaBelle*, 107 Wash.2d at 201 (1986) (citing *O'Connor v. Donaldson*, 422 U.S. 563, 575 (1975)).

<sup>94</sup> RCW 71.05.215.

<sup>95</sup> RCW 71.05.215.

met, antipsychotic medication may be given for up to 30 days without the consent of the person.<sup>96</sup> Documentation must be included in the medical record of the physicians' evaluations of the person, their attempts to obtain informed consent, and the reasons why antipsychotic medication is being administered over the person's lack of consent.<sup>97</sup> If continued treatment is required beyond 30 days, the evaluation and informed consent process discussed above should be repeated and documented, again by two physicians. In addition, the medical director must review the decision to treat the person without their consent.<sup>98</sup>

**4A.2.5.2.2 Persons with a 180-day ITA Order**

Non-emergent involuntary medication for persons subject to a 180-day ITA order requires a hearing and court order.<sup>99</sup> The petition for an order allowing treatment with antipsychotic medication must be completed by the attending physician. The physician should expect to testify at the hearing.<sup>100</sup>

**Provider Tip – Timing of Medication Hearings**

When possible, providers should consider notifying the prosecutor and defense counsel in advance of filing a petition for involuntary medication. Because persons have a right to counsel and to have an expert witness testify on their behalf against treatment with antipsychotic medication, a hearing on the petition may be postponed until this defense witness is available and prepared.

At the hearing on the petition, it must be proven by clear, cogent, and convincing evidence that failure to treat the person with antipsychotic medication may result in a likelihood of serious harm or substantial deterioration and that the medication is necessary and will be effective. If the petition is granted, an order will be entered that will last as long as the current 180-day ITA order.<sup>101</sup> If the petition is denied, another petition can be filed at a later date. Successive petitions are allowable, and they may be scheduled to be heard at the same time as a petition for continued commitment.

When a person's condition is emergent and requires treatment before a court order can be obtained, antipsychotic medication may be administered without consent if:

- an emergency exists where the patient presents an imminent likelihood of serious harm, and
- the medically acceptable alternatives to administration of antipsychotic medications are not available or are unlikely to be successful; and
- in the opinion of one physician, the person's condition constitutes an emergency requiring treatment be instituted prior to obtaining a court order.<sup>102</sup>

<sup>96</sup> Id.

<sup>97</sup> RCW 71.05.215(2)(e).

<sup>98</sup> RCW 71.05.215(2)(c).

<sup>99</sup> RCW 71.05.217(7).

<sup>100</sup> In addition to testimony regarding the person's diagnosis, symptoms, and prognosis, physician testimony that includes references to literature, clinical guidelines, and professional standards, is useful to demonstrate necessity and effectiveness.

<sup>101</sup> RCW 71.05.217(7)(d).

<sup>102</sup> RCW 71.05.217(7)(f).

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If antipsychotic medication is administered in an emergency situation, a petition must be filed on the next judicial day.<sup>103</sup> If deemed necessary by the treating physician administration of antipsychotic medications may continue until the hearing is held,<sup>104</sup> although the person continues to have the right to refuse psychiatric medications, including the involuntary antipsychotic medication beginning twenty-four hours prior to the hearing.

### 4A.2.5.3 Electroconvulsive Therapy

If an individual does not, or cannot, consent, electroconvulsive therapy (“ECT”) may be administered only by court order, entered after a judicial hearing.<sup>105</sup>

[A] court can order imposition of ECT upon a nonconsenting involuntarily committed patient when the petitioning party proves (1) a compelling state interest to administer ECT<sup>106</sup>, and (2) that ECT is both necessary and effective for furthering that interest. [Four] state interests sufficiently compelling to justify overriding a patient’s objection to medical treatment... are: (1) the preservation of life; (2) the protection of interests of innocent third parties; (3) the prevention of suicide; and (4) maintenance of the ethical integrity of the medical profession.<sup>107</sup>

To aid the court in determining whether ECT is necessary and effective, evidence should be presented by the treatment team on the person’s prognosis with and without the ECT. Evidence must be presented about potential treatment alternatives that are available and whether these treatments are likely to be effective.<sup>108</sup> If the person has undergone ECT before, the court should be informed of whether that prior treatment was effective. In addition, the court must take into account the person’s wishes regarding the proposed treatment. Evidence of a person’s wishes includes previous and current statements by the person, whether they hold religious and moral values that might impact their decision, and the opinions of family members or other individuals who play a significant role in or influence the person’s life. “If the patient appears unable to understand fully the nature of the ECT hearing...the court should make a “substituted judgment” for the patient that is analogous to the medical treatment decision made for an incompetent person.”<sup>109</sup>

The procedural due process for the ECT hearing is similar to the general due process provided at any civil commitment hearing. For example, the person has the right to an attorney, to remain silent, to present evidence and cross-examine witnesses, and the rules of evidence apply.<sup>110</sup> The party requesting ECT must prove each element justifying the authorization of ECT with “clear, cogent, and convincing” evidence.<sup>111</sup>

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<sup>103</sup> Id.

<sup>104</sup> Id.

<sup>105</sup> RCW 71.05.217(7); *In re Schuoler*, 106 Wn.2d at 511 (1986).

<sup>106</sup> *In re Schuoler*, 106 Wn.2d at 508 (1986) (FN4).

<sup>107</sup> *In re Schuoler*, 106 Wn.2d at 509 (1986).

<sup>108</sup> *In re Schuoler*, 106 Wn.2d at 508 (1986). RCW 71.05.217.

<sup>109</sup> *In re Schuoler*, 106 Wn.2d at, 507 (1986). RCW 71.05.217.

<sup>110</sup> RCW 71.05.217(7). *In re Schuoler*, 106 Wn.2d 500 (1986).

<sup>111</sup> Id.

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### 4A.2.6 Mental Health Advance Directives and the ITA

Mental Health Advance Directives (“MHAD” or “directive”), discussed in Chapter 4B, *Mental Health Advance Directives* by Rohana Fines, are not legally effective during civil commitment. The terms of any MHAD are only advisory.<sup>112</sup> The choices a person makes in their MHAD do not limit any authority otherwise provided in Titles 10, 70, 71 RCW, or any other applicable state or federal law that allows the detention, commitment, or involuntary treatment of an individual.<sup>113</sup> This does not mean that advance directives may be ignored by providers of involuntary treatment. The information contained in a directive can be of substantial benefit to providers. Individuals have the opportunity to include information that will help providers in managing their inpatient stay and designing a patient-driven treatment plan. For example, a directive may include information regarding behavioral and medical interventions that have succeeded or failed in the past, alleviating the need for trials of therapies known not to work. The MHAD statute therefore encourages involuntary treatment providers to respect the provisions of a directive even when it is not binding.<sup>114</sup>

### 4A.3 Voluntary Mental Health Care for Adults

Mental health care, including inpatient psychiatric treatment, may be provided on a voluntary basis to persons who seek treatment.<sup>115</sup> However, voluntary mental health care differs significantly from other voluntary medical care because of the limitations on the ability of a surrogate decision-maker, such as a guardian or other agent, to provide informed consent for psychiatric treatment on behalf of a person who does not have the capacity to provide informed consent for themself.<sup>116</sup>

Voluntary patients have at least all of the rights afforded to involuntary patients, regardless of the type of facility they choose, including the right to informed consent and the right to refuse treatment.<sup>117</sup> Agents appointed by durable powers of attorney for healthcare can exercise the person’s right to informed consent for regular medical care, but they cannot admit a person to a psychiatric facility and cannot consent to antipsychotic medication.<sup>118</sup> Only an agent has been appointed through a MHAD can consent to antipsychotic medication, electroconvulsive therapy, or inpatient psychiatric treatment.<sup>119</sup> There are similar limitations on the powers of guardians.<sup>120</sup> Finally, a person may never be held by a residential treatment facility against their will.<sup>121</sup>

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<sup>112</sup> RCW 71.32.080; RCW 71.32.150; RCW 71.32.240.

<sup>113</sup> RCW 71.32.240.

<sup>114</sup> RCW 71.32.150(3)(b).

<sup>115</sup> RCW 71.05.050, RCW 71.12.560.

<sup>116</sup> One of the significant unanswered questions is where the line divides “mental health” treatment from “medical” treatment. An overly strict reading would result in unpredicted restrictions on medications and care that were likely never intended to be outside the authority of surrogate decision-makers. For example, an individual suffering cardiac arrest may become confused, combative, or agitated due to decreased oxygen to the brain. This impact on cognitive and volitional functions could arguably be a “mental disorder.” Yet it is routinely treated with the consent of a surrogate, and may include antipsychotic or other psychiatric medications as needed to alleviate the agitation and confusion. In the coming years, with the aging of the baby boomers, Washington may need to clarify the application of mental health law to these conditions, including Alzheimer’s and other dementias, or risk a generation of elders whose treatment and medications will be decided by the courts instead of their families and physicians.

<sup>117</sup> RCW 71.05.050, RCW 71.05.380, RCW 71.12.570 (“All persons in an establishment as defined by chapter 71.12 RCW shall have no less than all rights secured to involuntarily detained persons by RCW 71.05.360 and 71.05.370 and to voluntarily admitted or committed persons pursuant to RCW 71.05.050 and 71.05.380.”); WAC 246-322-035(1)(d). *See also* footnote 89, *supra*.

<sup>118</sup> RCW 11.94.010. *See also* RCW 71.05.030, RCW 71.05.050, RCW 71.05.380, RCW 71.12.560.

<sup>119</sup> RCW 11.94.010(3)(b).

#### **4A.4 Mental Health Care for Minor Children**

There are many different processes and systems that provide mental health or psychiatric care to children.<sup>122</sup> This section covers only the general process for voluntary and involuntary psychiatric hospitalization of persons under the age of 18, and does not include the juvenile justice or child welfare systems. The system for psychiatric treatment of minors is similar to the adult system discussed above, however there are several very important differences based on the age of the minor.

##### **4A.4.1 The Age of Consent for Mental Health Treatment**

The age of consent for mental health treatment in Washington is established by statute.<sup>123</sup> Any person 13 years of age or older is legally able to provide informed consent to inpatient or outpatient mental health treatment.<sup>124</sup> This age of consent affects a parent's ability to act as a surrogate decision-maker for their child, and limits parents' authority to hospitalize a child unless the child agrees.

Children Under 13. Children under the age of 13 may only be admitted to inpatient or outpatient mental health treatment with the consent of their parent or guardian.<sup>125</sup> These children are not subject to the involuntary treatment act.

Children 13 and Older. Children over the age of 13 may be admitted to inpatient or outpatient mental health treatment in three different ways:

- (1) minor-initiated treatment;
- (2) parent-initiated treatment; and,
- (3) involuntary commitment.

##### **4A.4.2 Minor-initiated Treatment**

Once a child reaches their 13<sup>th</sup> birthday they gain the legal right to consent to mental health services, both inpatient and outpatient.<sup>126</sup> In order for a minor to admit himself or herself to an inpatient evaluation and treatment facility, the clinician in charge of the facility must agree that the admission is medically necessary<sup>127</sup> and that there is no appropriate less-restrictive setting in which to treat the minor.<sup>128</sup> The minor does not need

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<sup>120</sup> RCW 11.92.043(5).

<sup>121</sup> RCW 11.92.190.

<sup>122</sup> See e.g. RCW chapters 13.32A, 13.34, 13.40, 74.09, 74.14A, and 74.14B.

<sup>123</sup> In 2005 the Legislature reorganized chapter 71.34 RCW to make it easier to use, grouping statutes together that relate to the same subject. There is little to no substantive change in the law.

<sup>124</sup> RCW 71.34.500(1), 71.34.530. Children under the age of 13 are not subject to the ITA and can be admitted to inpatient treatment *only* by their parent(s) or guardian(s). RCW 71.34.500(1).

<sup>125</sup> Id.

<sup>126</sup> RCW 71.34.500 through 71.34.530. See e.g. *Nash v. Sisters of Providence*, 117 Wn. App. 1093, 2003 WL 21791593, at \*4. (Wash.App. Div. 2) (Unpublished Opinion - RCW 2.06.040).

<sup>127</sup> RCW 71.34.500. "Medical necessity" for inpatient care means a requested service which is reasonably calculated to: (a) Diagnose, correct, cure, or alleviate a mental disorder; or (b) prevent the worsening of mental conditions that endanger life or cause suffering and pain, or result in illness or infirmity or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction, and there is no adequate less restrictive alternative available. RCW 71.34.020(12).

<sup>128</sup> RCW 71.34.500.

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the approval of their parent or guardian. Upon admitting the child, the facility must notify the minor's parents within 24-hours of the minor's admission in the manner most likely to reach the parent(s).<sup>129</sup>

The self-admitted minor may request discharge at any time.<sup>130</sup> The request must be in writing, although no specific language or form is required as long as the intent can be discerned.<sup>131</sup> The request must be recorded in the minor's medical record and copies must be sent to the minor's parent, attorney (if any), and to the DMHP.<sup>132</sup> The minor must be discharged by the second judicial day after the minor's requests discharge in writing.<sup>133</sup>

### 4A.4.3 Parent-initiated Treatment

Once a child has reached their thirteenth birthday, parents<sup>134</sup> and guardians can admit the child for treatment if they follow certain procedures.<sup>135</sup> A parent may bring their child to an E&T, acute hospital, or psychiatric hospital and request that the minor be admitted as an inpatient and evaluated to determine whether the minor has a mental disorder and whether inpatient treatment is medically necessary.<sup>136</sup> Evaluations typically take up to 24 hours but may be extended up to 72 hours if needed to complete the evaluation.<sup>137</sup> During this time, treatment is limited to the minimum required to stabilize the minor for evaluation purposes.<sup>138</sup> The consent of the minor is not required for this admission and evaluation.<sup>139</sup> If the evaluation indicates that inpatient treatment is medically necessary, the minor may be held for treatment and the minor's request to be discharged from this admission cannot occur without consent of their parent.<sup>140</sup> Parents may also initiate outpatient evaluation without the consent of the child.<sup>141</sup> The consent of the minor is not required for a physician or mental health professional to evaluate the minor, determine whether the minor has a mental disorder, and determine whether the minor is in need of outpatient treatment.

The law requires DSHS to "assure" that an independent physician or mental health professional, un-affiliated with the facility and with no financial interest in the minor's continued admission, reviews any parent-initiated inpatient admission to ensure the inpatient treatment is medically necessary.<sup>142</sup> The reviewer must be employed

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<sup>129</sup> RCW 71.34.510. The notice must contain: (1) The fact that the minor has been admitted to inpatient treatment; (2) the location and telephone number of the facility; (3) the name of a professional person on the staff designated to discuss the minor's need for inpatient treatment with the parent; and (4) the medical necessity for admission. *Id.*

<sup>130</sup> RCW 71.34.520.

<sup>131</sup> RCW 71.34.520(1).

<sup>132</sup> RCW 71.34.520(2).

<sup>133</sup> RCW 71.34.520(3).

<sup>134</sup> "'Parent' means: (a) A biological or adoptive parent who has legal custody of the child, including either parent if custody is shared under a joint custody agreement; or (b) A person or agency judicially appointed as legal guardian or custodian of the child." RCW 71.34.020(17). For children who have been adjudicated dependent and are in the custody of DSHS, DSHS obtains consent for admission from the parent or guardian, or seeks approval from the juvenile court. *See* RCW 13.34.320.

<sup>135</sup> RCW 71.34.600 though 71.34.660.

<sup>136</sup> RCW 71.34.600.

<sup>137</sup> RCW 71.34.600(1).

<sup>138</sup> RCW 71.34.600(3).

<sup>139</sup> RCW 71.34.600(2).

<sup>140</sup> *Id.* The facility must notify the DSHS of this admission, within 24-hours after completion of the evaluation. *Id.* At any time during the parent-initiated inpatient treatment, the minor must be discharged immediately upon written request of the parent(s).

<sup>141</sup> RCW 71.34.650.

<sup>142</sup> RCW 71.34.610(1). This provides some protection against erroneous admission (due process).

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by DSHS or by an agency under contract with DSHS. The review must take place no less than seven days from the date of admission, and no more than 14 days from the date of admission.<sup>143</sup> The review takes into account “the opinion of the treatment provider, the safety of the minor, and the likelihood the minor’s mental health will deteriorate” if released.<sup>144</sup> The reviewer will also consult with the parent(s) before making a final determination about the medical necessity of the admission.<sup>145</sup>

If this independent evaluation shows that inpatient treatment is not medically necessary the facility must release the minor to the parents within 24- hours of receiving notice of the results of the evaluation.<sup>146</sup> If the parent and professionals at the facility disagree and believe that further inpatient treatment is medically necessary the parent may file an “at-risk youth” petition and the release of the minor will be delayed until the second judicial day following the receipt of notice of the results of the evaluation.<sup>147</sup>

If the independent evaluation affirms the inpatient treatment, the minor has the right to petition a court for release from the facility, and the facility must inform them of this right.<sup>148</sup> The minor can file the petition no sooner than five days after the completion of the initial evaluation.<sup>149</sup> In considering the petition, the court will order the release of the minor unless a preponderance of the evidence shows that the admission is medically necessary.<sup>150</sup>

There is a maximum time limit on parent-initiated inpatient treatment.<sup>151</sup> In the absence of civil commitment proceedings, the minor must be released within 30-days of (1) the date of notice of the results of the independent evaluation or (2) the minor’s filing of a petition for release.<sup>152</sup>

Facilities and professionals do not have any obligation to provide parent-initiated treatment to a minor who does not consent, however the law states that the fact that the admission is not initiated by the minor is not an appropriate basis for refusing to treat the minor.<sup>153</sup> Providers who in good faith accept and treat a minor under the procedures for parent-initiated treatment cannot be sued by the minor for treating them without their consent.<sup>154</sup>

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<sup>143</sup> Id.

<sup>144</sup> RCW 71.34.610(2).

<sup>145</sup> Id.

<sup>146</sup> RCW 71.34.610(3).

<sup>147</sup> RCW 71.34.620(3). At-risk youth petitions are governed by 13.32A RCW. A parent might also consider filing an at-risk youth petition if the independent evaluation indicates that the released minor should receive outpatient treatment, but the child does not agree. Id. An at-risk youth petition seeking outpatient treatment will not delay discharge.

<sup>148</sup> RCW 71.34.620.

<sup>149</sup> RCW 71.34.620.

<sup>150</sup> Id.

<sup>151</sup> RCW 71.34.630.

<sup>152</sup> Id.

<sup>153</sup> RCW 71.34.600(4).

<sup>154</sup> RCW 71.34.660. “A minor child shall have no cause of action against an evaluation and treatment facility, inpatient facility, or provider of outpatient mental health treatment for admitting or accepting the minor in good faith for evaluation or treatment under RCW 71.34.600 or 71.34.650 based solely upon the fact that the minor did not consent to evaluation or treatment if the minor’s parent has consented to the evaluation or treatment.”

### 4A.4.4 Civil Commitment of Minor Children

Civil commitment begins in the same way for minors (13 years of age or older) as it does for adults. If the treating professionals evaluate the minor and determine that the minor has a mental disorder and is in need of immediate inpatient treatment they will first attempt to obtain consent for inpatient treatment from the minor.<sup>155</sup> If the minor will not consent and the professional believes the minor meets the criteria for civil commitment, the minor may be held for up to 12 hours in order to enable a DMHP to investigate, evaluate the minor, and detain them to an appropriate and available facility.<sup>156</sup> During this process the minor has similar rights to adults, including notice of their rights and a copy of the notice and petition for detention.<sup>157</sup>

Within 24 hours of their arrival at the facility, the minor must be evaluated by a “children’s mental health specialist as to the child’s mental condition and by a physician as to the child’s physical condition.”<sup>158</sup> The facility must take reasonable steps to provide or obtain medical treatment for any medical condition in need of immediate treatment.<sup>159</sup> The minor’s parents must be notified of their detention and admission.<sup>160</sup>

The minor must be advised of their rights within 12 hours of admission to the facility.<sup>161</sup> For example, the minor has a right to communicate and visit with their parents and others, unless the treating professionals determine that the communication or visit “would be seriously detrimental to the minor’s condition or treatment,” documents this determination in the clinical record, and notifies the minor’s parents.<sup>162</sup> The minor has the right to an attorney and may not be denied the opportunity to consult an attorney.<sup>163</sup>

If the facility believes that further inpatient diagnosis, evaluation, and treatment is necessary, the treating professionals may petition for 14-days of commitment.<sup>164</sup> A hearing must be held within 72 hours of the

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<sup>155</sup> RCW 71.34.700.

<sup>156</sup> RCW 71.34.710(1) – (3).

<sup>157</sup> RCW 71.34.710.

<sup>158</sup> RCW 71.34.710(4), RCW 71.34.720(1).

<sup>159</sup> RCW 71.34.720(1).

<sup>160</sup> RCW 71.34.710(3).

<sup>161</sup> RCW 71.34.720(6).

<sup>162</sup> RCW 71.34.720.

<sup>163</sup> *Id.*

<sup>164</sup> RCW 71.34.730.

The petition must be filed in superior court, signed either by two physicians or by one physician and a mental health professional who have examined the minor, and must contain the following information :

- (i) The name and address of the petitioner;
- (ii) The name of the minor alleged to meet the criteria for fourteen-day commitment;
- (iii) The name, telephone number, and address if known of every person believed by the petitioner to be legally responsible for the minor;
- (iv) A statement that the petitioner has examined the minor and finds that the minor's condition meets required criteria for fourteen-day commitment and the supporting facts therefor;
- (v) A statement that the minor has been advised of the need for voluntary treatment but has been unwilling or unable to consent to necessary treatment;
- (vi) A statement recommending the appropriate facility or facilities to provide the necessary treatment; and
- (vii) A statement concerning whether a less restrictive alternative to inpatient treatment is in the best interests of the minor.

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admission (excluding Saturdays, Sundays, and holidays) in order for the admission to continue.<sup>165</sup> If the professionals do not petition for further commitment, the parent(s) may review of that decision in court.<sup>166</sup>

At the commitment hearing, the evidence in support of the petition is presented by the county prosecutor.<sup>167</sup> The parents have the right to oppose the petition and may be represented by an attorney at the hearing if they do. They have the right to court-appointed counsel if they are indigent.<sup>168</sup> The minor has the right to be represented by their own attorney at the hearing and has the right to present evidence question and cross-examine witnesses.<sup>169</sup> The minor should be present at the commitment hearing unless the minor, with assistance of an attorney, waives his or her presence at the hearing.<sup>170</sup> The rules of evidence, however, do not apply in this hearing.<sup>171</sup> The burden of proof is on the petitioners to show by a preponderance of the evidence that the minor meets the criteria for commitment.<sup>172</sup> If the court finds that:

- (a) the minor has a mental disorder<sup>173</sup> and presents a “likelihood of serious harm”<sup>174</sup> or is “gravely disabled”<sup>175</sup>;
- (b) the minor is in need of evaluation and treatment of the type provided by the inpatient evaluation and treatment facility to which continued inpatient care is sought or is in need of less restrictive alternative treatment found to be in the best interests of the minor; and
- (c) the minor is unwilling or unable in good faith to consent to voluntary treatment.

the court will commit the minor for further inpatient treatment or for less restrictive (outpatient) alternative treatment under appropriate conditions.<sup>176</sup> If treatment beyond the 14-day order is necessary, a petition for 180-

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RCW 71.34.730. “A copy of the petition shall be personally delivered to the minor by the petitioner or petitioner's designee. A copy of the petition shall be sent to the minor's attorney and the minor's parent.” *Id.*

<sup>165</sup> RCW 71.34.710(3), 71.34.740(1).

<sup>166</sup> *Id.*

<sup>167</sup> RCW 71.34.740(3). “If the minor has received medication within twenty-four hours of the hearing, the court shall be informed of that fact and of the probable effects of the medication.” RCW 71.34.740(7).

<sup>168</sup> RCW 71.34.740(5).

<sup>169</sup> RCW 71.34.740.

<sup>170</sup> *Id.*

<sup>171</sup> RCW 71.34.740(8).

<sup>172</sup> RCW 71.34.730, RCW 71.34.740(9).

<sup>173</sup> “Mental disorder” means any organic, mental, or emotional impairment that has substantial adverse effects on an individual's cognitive or volitional functions. The presence of alcohol abuse, drug abuse, juvenile criminal history, antisocial behavior, or mental retardation alone is insufficient to justify a finding of “mental disorder” within the meaning of this section. RCW 71.34.020(13).

<sup>174</sup> “Likelihood of serious harm” means either: (a) 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; (b) a substantial risk that 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 (c) a substantial risk that 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. RCW 71.34.020(11).

<sup>175</sup> “Gravely disabled minor” means a minor who, as a result of a mental disorder, 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 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 71.34.020(8).

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day commitment must be filed with the court at least three days before the expiration of the 14-day order.<sup>177</sup> Unlike adults, minors *do not* have an intervening step of a 90-day order. The minor and parents have the same rights for the 180-day hearing as in the 14-day commitment hearing.<sup>178</sup>

To order 180-day commitment, the court must find by clear, cogent, and convincing evidence that the minor:

- (a) Is suffering from a mental disorder;
- (b) Presents a likelihood of serious harm or is gravely disabled; and
- (c) Is in need of further treatment that only can be provided in a one hundred eighty-day commitment; and
- (d) that less-restrictive treatment in the community is not appropriate or available.<sup>179</sup> Successive 180-day commitments are allowed.<sup>180</sup> Petitions must be filed five days before the expiration of a previous commitment and a hearing will be held using the procedures for the original 180-day commitment.<sup>181</sup>

Similar to adults, the minor may be conditionally released and subject to reasonable conditions including outpatient treatment upon release.<sup>182</sup> The conditional release may be revoked if the minor fails to adhere to the conditions.<sup>183</sup>

### 4A.4.5 Patient Rights

As long as it does not pose a risk of harm to themselves or to others, minors have rights while in treatment that are similar to those discussed above for adults.<sup>184</sup> As with adults, these rights must be prominently posted in the evaluation and treatment facility.

### 4A.4.6 Access to Inpatient Treatment and the Children’s Long-Term Inpatient Program (“CLIP”)

Washington State funds a limited number of beds in inpatient treatment facilities, which are managed through the Children’s Long-Term Inpatient Program (CLIP).<sup>185</sup> These beds include Child Study and Treatment Center (CSTC), which is the only state owned and operated hospital for children. The state contracts with residential

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<sup>176</sup> RCW 71.34.740(10). If the court determines that the minor does not meet the criteria for commitment the minor must be released, unless the minor or the minor’s parents voluntarily admit them to treatment under the relevant processes. *Id.*

<sup>177</sup> (2) The petition for one hundred eighty-day commitment must contain specific information and factual allegations described in RCW 71.34.750. The petition must incorporate or be accompanied by affidavits containing detailed factual information about the signs, symptoms, and behaviors that support the allegations that the minor meets the criteria for civil commitment. RCW 71.34.750(2), (3). They must state whether or not less restrictive (outpatient) treatment is in the best interests of the minor. RCW 71.34.750(3). The petition and affidavits must be signed by two examining physicians (one of whom is a child psychiatrist) or by one examining physician and one children’s mental health specialist. RCW 71.34.750(3).

<sup>178</sup> RCW 71.34.750(4).

<sup>179</sup> RCW 71.34.750. If the minor does not meet the criteria for 180-day commitment, the minor must be released (unless the minor or the minor’s parents initiate voluntary treatment under the relevant procedures).

<sup>180</sup> RCW 71.34.750(5).

<sup>181</sup> RCW 71.34.750.

<sup>182</sup> RCW 71.34.730(10), (11), 71.34.770(1).

<sup>183</sup> RCW 71.34.770, 71.34.780. *See* RCW 71.34.780 for details of the revocation process.

<sup>184</sup> RCW 71.34.355.

<sup>185</sup> RCW 71.34.760.

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treatment facilities for the remainder of the CLIP capacity. A child becomes eligible for admission to the CLIP facilities when they are committed for 180 days.<sup>186</sup>

### Access to Services

More information on access to children's mental health services can be found on the Department of Social and Health Services Mental Health Division website and on the CLIP Administration website.

**DSHS MHD**                      <http://www1.dshs.wa.gov/mentalhealth/>

**CLIP**                                <http://www.clipadministration.org/>

#### 4A.4.7      **Involuntary Medication**

In general, involuntarily detained minors have the right to refuse antipsychotic medication and ECT unless it is determined that the failure to medicate may result in a likelihood of serious harm or substantial deterioration and it has been determined that there is no less intrusive course of treatment in the best interest of the individual. Depending on where the child is in the ITA process, different procedures must be used for involuntary treatment with antipsychotic medication. The rules for involuntary administration of antipsychotic medication to children are not as developed as they are for adults, however using case law and the adult statutes, facilities can develop constitutionally appropriate policies and procedures.<sup>187</sup>

#### 4A.4.8      **Electroconvulsive Therapy**

The ITA for minors makes very little mention of ECT for children. In general, the rules for adults are applied in the event a minor ever requires involuntary ECT.

#### 4A.5.      **Conclusion**

Mental health law, with its extensive procedures, reflects the tension between society's desire to care for those who cannot care for themselves, the need to protect the public from persons who may present a danger to others, the evolution of medical practice and our understanding of mental disorders, and respect and protection for the autonomy and rights of persons with mental illness. Should the current balance between these interests and factors changes in the future so to will mental health law.

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<sup>186</sup> RCW 71.34.760.

<sup>187</sup> "For the purposes of administration of antipsychotic medication and [ECT], the provisions of chapter 120, Laws of 1989 apply to minors pursuant to chapter 71.34 RCW." RCW 71.34.370. [1989 c 120 § 9. Formerly RCW 71.34.290.] *See also Harper v. Washington*, 110 Wn.2d 873 (1988); RCW 71.05.217(7).