

Effective until March 31, 2018

~~[Rules in red italics will remain effective after March 31, 2018]~~

Chapter 388-865 WAC

COMMUNITY MENTAL HEALTH AND INVOLUNTARY TREATMENT PROGRAMS

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388-865-0232

Behavioral health organizations—General.

(1) Effective April 1, 2016, regional support networks (RSN) become behavioral health organizations (BHO). A BHO contracts with the department's division of behavioral health and recovery (DBHR) to administer behavioral health services within its service area.

(2) A BHO operates only in areas of the state that have not implemented the Washington apple health fully integrated managed care (FIMC) program. See chapter 182-538A WAC for rules that govern the FIMC program operated by the health care authority (HCA).

(3) BHOs, behavioral health agencies, and the BHO managed care plan must:

(a) Comply with chapters 70.96A, 71.05, 71.24, 71.34, and 71.36 RCW, which contain laws regarding substance use disorders, mental illness, and community mental health services.

(b) Meet the requirements in chapters 388-877, 877A, and 877B WAC regarding the licensure of behavioral health agencies and the certification of behavioral health services. An exemption of any section or subsection may be requested, subject to the criteria in WAC 388-865-0236. DBHR does not exempt any requirement that is part of statute.

(4) A BHO is responsible to ensure behavioral health services are responsive in an age and culturally competent manner to the substance use disorder treatment and mental health needs of its community.

(5) DBHR administers behavioral health services regionally if the criteria in WAC 388-865-0234 apply.

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(6) *The BHO managed care plan is the entity that operates the prepaid inpatient health plan (PIHP) medicaid behavioral health services.*

(7) *WAC [388-865-0238](#) and [388-877-0200](#) contain definitions for terms and phrases used in the BHO and the BHO managed care plan rules.*

(8) *Contact information can be found on the DBHR website at www.dshs.wa.gov/bhsia/division-behavioral-health-and-recovery.*

[Statutory Authority: RCW [70.02.290](#), [70.02.340](#), [70.96A.040\(4\)](#), [71.05.560](#), [71.24.035](#) (5)(c), [71.34.380](#), and 2014 c 225. WSR 16-13-087, § 388-865-0232, filed 6/15/16, effective 7/16/16.]

388-865-0234

Behavioral health organizations—When the division of behavioral health and recovery administers regional behavioral health services.

(1) If a currently operating behavioral health organization (BHO) chooses to stop functioning as a BHO, fails to meet state minimum standards specified in rule, or does not meet the requirements under RCW [71.24.045](#), the following is implemented:

(a) Under RCW [71.24.035\(16\)](#), the secretary:

(i) Is designated as the BHO until a new BHO is designated; and

(ii) Assumes the duties assigned to the region without a participating BHO.

(b) The division of behavioral health and recovery (DBHR):

(i) Administers behavioral health services within the region without a participating BHO; and

(ii) Continues to apply the BHO requirements in WAC [388-865-0232](#) through [388-865-0272](#) and the BHO managed care plan requirements in WAC [388-865-0370](#) through [388-865-0385](#).

(2) An individual who resides within the service area of a region without a participating BHO:

(a) May receive services, within available resources as defined in RCW [71.24.025\(2\)](#), from any provider of behavioral health services that is contracted with and licensed by DBHR; and

(b) Who is a Title XIX medicaid recipient is entitled to receive medically necessary behavioral health services without charge to the individual.

(3) This section does not apply to a region in which the health care authority (HCA) operates the Washington apple health fully integrated managed care (FIMC) program which provides fully-integrated physical and behavioral health services to medicaid beneficiaries through managed care. See chapter [182-538A](#) WAC for information on Washington apple health FIMC.

[Statutory Authority: RCW [70.02.290](#), [70.02.340](#), [70.96A.040\(4\)](#), [71.05.560](#), [71.24.035](#) (5)(c), [71.34.380](#), and 2014 c 225. WSR 16-13-087, § 388-865-0234, filed 6/15/16, effective 7/16/16.]

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388-865-0236

Behavioral health organizations—How to request an exemption of a minimum standard.

(1) A behavioral health organization (BHO), a licensed behavioral health agency, and the behavioral health organization (BHO) managed care plan subject to the BHO and BHO managed care plan rules may request an exemption of a minimum standard in WAC 388-865-0232 through 388-865-0272 and WAC 388-865-0370 through 388-865-0385 by submitting a request in writing to the director of the division of behavioral health and recovery (DBHR).

(2) The exemption request must include:

(a) The name and address of the entity that is making the request;

(b) The specific section or subsection of the rule for which an exemption is being requested;

(c) The reason why the exemption is necessary, or the method the entity will use to meet the desired outcome of the section or subsection in a more effective and efficient manner;

(d) A description of the plan and timetable to achieve compliance with the minimum standard or to implement, test, and report results of an improved way to meet the intent of the section or subsection;

(e) Documentation that the quality review team or behavioral health ombuds office was consulted and any resulting recommendations are included in the request; and

(f) A description of how an individual(s) affected by the exemption will be notified.

(3) DBHR's review of the request considers whether approving the exemption will impact accountability, accessibility, efficiency, individual satisfaction, and quality of care, or will violate state or federal law. The requester receives a determination notice from DBHR within thirty days from the date the exemption request was received.

(a) If DBHR grants the exemption request, the notice includes:

(i) The section or subsection of rule exempted;

(ii) The conditions of acceptance;

(iii) The time frame for which the exemption is approved; and

(iv) Notification that the exemption may be renewed upon request of the party that initially asked for the exemption. In this case, the requester must submit a renewal request to the director of DBHR before the time frame of the initial exemption expires, and meet the applicable requirements of subsection (1) of this section.

(b) If DBHR denies the exemption request, the notice includes the reason for the denial.

(4) DBHR cannot exempt any minimum standard that is required by:

(a) Statute; or

(b) Another state agency.

[Statutory Authority: RCW 70.02.290, 70.02.340, 70.96A.040(4), 71.05.560, 71.24.035 (5)(c), 71.34.380, and 2014 c 225. WSR 16-13-087, § 388-865-0236, filed 6/15/16, effective 7/16/16.]

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388-865-0238

Behavioral health organizations—Definitions.

The definitions in this section, WAC 388-877-0200, and WAC 388-877-0655 apply to behavioral health organizations (BHO) and the BHO managed care plan.

"Behavioral health organization" or **"BHO"** means any county authority or group of county authorities or other entity recognized by the secretary in contract in a defined region.

"Behavioral health organization (BHO) managed care plan" is the entity that operates the prepaid inpatient health plan (PIHP) for medicaid behavioral health services.

"Chemical dependency professional" or **"CDP"** means a person credentialed by the department of health as a chemical dependency professional (CDP) with primary responsibility for implementing an individualized service plan for substance use disorder services.

"Child" means a person under the age of eighteen years. For the purposes of the medicaid program, child means a person who is under the age of twenty-one years.

"Community support services" means services authorized, planned, and coordinated through resource management services including, at a minimum, assessment, diagnosis, emergency crisis intervention available twenty-four hours, seven days a week; prescreening determinations for persons who are mentally ill being considered for placement in nursing homes as required by federal law; screening for patients being considered for admission to residential services; diagnosis and treatment for children who are mentally or severely emotionally disturbed discovered under screening through the federal Title XIX early and periodic screening, diagnosis, and treatment (EPSDT) program; investigation, legal, and other nonresidential services under chapter 71.05 RCW; case management services; psychiatric treatment including medication supervision; counseling; psychotherapy; assuring transfer of relevant patient information between service providers; recovery services; and other services determined by behavioral health organizations.

"Consultation" means the clinical review and development of recommendations regarding activities, or decisions of, clinical staff, contracted employees, volunteers, or students by persons with appropriate knowledge and experience to make recommendations.

"County authority" means the board of county commissioners, county council, or county executive having authority to establish a community mental health program, or two or more of the county authorities specified in this subsection which have entered into an agreement to provide a community mental health program.

"Designated chemical dependency specialist" means a person designated by the behavioral health organization (BHO) or by the county alcoholism and other drug addiction program coordinator designated by the BHO to perform the commitment duties described in RCW 70.96A.140 and qualified to do so by meeting standards adopted by the department.

"Designated mental health professional" or **"DMHP"** means a mental health professional designated by the behavioral health organization (BHO) county or other authority authorized in rule to perform duties under the involuntary treatment act as described in RCW 10.77.010, 71.05.020, 71.24.025 and 71.34.020.

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"Ethnic minority" or "racial/ethnic groups" means, for the purposes of this chapter, any of the following general population groups:

- (1) African American;
- (2) An American Indian or Alaskan native, which includes:
 - (a) A person who is a member or considered to be a member in a federally recognized tribe;
 - (b) A person determined eligible to be found Indian by the secretary of interior;
 - (c) An Eskimo, Aleut, or other Alaskan native; and
 - (d) An unenrolled Indian meaning a person considered Indian by a federally or nonfederally recognized Indian tribe or off-reservation Indian/Alaskan native community organization;
- (3) Asian/Pacific Islander; or
- (4) Hispanic.

"Housing services" means the active search and promotion of individual access to, and choice in, safe and affordable housing that is appropriate to the individual's age, culture, and needs.

"Medical necessity" or "medically necessary" is a term for describing a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions in the recipient that endanger life, or cause suffering or pain, or result in illness or infirmity, or threaten to cause or aggravate a handicap, or cause or physical deformity or malfunction, and there is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the person requesting service. For the purpose of this chapter "course of treatment" may include mere observation or, where appropriate, no treatment at all.

"Mental health professional" means:

- (1) A psychiatrist, psychologist, psychiatric nurse or social worker as defined in chapters 71.05 and 71.34 RCW;
- (2) A person who is licensed by the department of health as a mental health counselor, mental health counselor associate, marriage and family therapist, or marriage and family therapist associate;
- (3) A person with a master's degree or further advanced degree in counseling or one of the behavioral sciences from an accredited college or university. Such person shall have, in addition, at least two years of experience in direct treatment of persons with mental illness or emotional disturbance, such experience gained under the supervision of a mental health professional;
- (4) A person who meets the waiver criteria of RCW 71.24.260, which was granted prior to 1986;
- (5) A person who had an approved waiver to perform the duties of a mental health professional that was requested by a regional support network and granted by the mental health division prior to July 1, 2001; or
- (6) A person who has been granted a time-limited exception of the minimum requirements of a mental health professional by the division of behavioral health and recovery.

"Mental health specialist" means:

- (1) A **"child mental health specialist"** is defined as a mental health professional with the following education and experience:

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(a) A minimum of one hundred actual hours (not quarter or semester hours) of special training in child development and the treatment of children and youth with serious emotional disturbance and their families; and

(b) The equivalent of one year of full-time experience in the treatment of seriously emotionally disturbed children and youth and their families under the supervision of a child mental health specialist.

*(2) A "**geriatric mental health specialist**" is defined as a mental health professional who has the following education and experience:*

(a) A minimum of one hundred actual hours (not quarter or semester hours) of specialized training devoted to the mental health problems and treatment of persons sixty years of age and older; and

(b) The equivalent of one year of full-time experience in the treatment of persons sixty years of age and older, under the supervision of a geriatric mental health specialist.

*(3) An "**ethnic minority mental health specialist**" is defined as a mental health professional who has demonstrated cultural competence attained through major commitment, ongoing training, experience and/or specialization in serving ethnic minorities, including evidence of one year of service specializing in serving the ethnic minority group under the supervision of an ethnic minority mental health specialist; and*

(a) Evidence of support from the ethnic minority community attesting to the person's commitment to that community; or

(b) A minimum of one hundred actual hours (not quarter or semester hours) of specialized training devoted to ethnic minority issues and treatment of ethnic minority individuals.

*(4) A "**disability mental health specialist**" is defined as a mental health professional with special expertise in working with an identified disability group. For purposes of this chapter only, "disabled" means an individual with a disability other than a mental illness, including a developmental disability, serious physical handicap, or sensory impairment.*

(a) If the consumer is deaf, the specialist must be a mental health professional with:

(i) Knowledge about the deaf culture and psychosocial problems faced by who are deaf; and

(ii) Ability to communicate fluently in the preferred language system of the consumer.

(b) The specialist for individuals with developmental disabilities must be a mental health professional who:

(i) Has at least one year's experience working with people with developmental disabilities; or

(ii) Is a developmental disabilities professional as defined in RCW 71.05.020.

*"**Peer counselor**" means a person recognized by the division of behavioral health and recovery (DBHR) as a person who:*

(1) Is a self-identified consumer of mental health services;

(2) Is a counselor credentialed under chapter 18.19 RCW;

(3) Has completed specialized training provided by or contracted through DBHR. If the person was trained by trainers approved by the mental health division (now DBHR) before October 1, 2004, and has met the requirements in subsection (1), (2) and (4) of

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this section by January 31, 2005, the person is exempt from completing this specialized training;

(4) Has successfully passed an examination administered by DBHR or an authorized contractor; and

(5) Has received a written notification letter from DBHR stating that DBHR recognizes the person as a "peer counselor."

***"Quality assurance and quality improvement"** means a focus on compliance to minimum requirements in rules and contracts, and activities to perform above minimum standards and achieve reasonably expected levels of performance, quality, and practice.*

***"Quality strategy"** means an overarching system and/or process whereby quality assurance and quality improvement activities are incorporated and infused into all aspects of a behavioral health organization's (BHO)'s operations.*

"Regional support network (RSN)"** no longer exists as of March 31, 2016. See **"Behavioral health organization (BHO)."

***"Residential services"** means a complete range of residences and supports authorized by resource management services and which may involve a facility, a distinct part thereof, or services which support community living, for persons who are acutely mentally ill, adults who are chronically mentally ill, children who are severely emotionally disturbed, or adults who are seriously disturbed and determined by the behavioral health organization to be at risk of becoming acutely or chronically mentally ill.*

***"Resource management services"** means the planning, coordination, and authorization of residential services and community support services for:*

(1) Adults and children who are acutely mentally ill;

(2) Adults who are chronically mentally ill;

(3) Children who are severely emotionally disturbed; or

(4) Adults who are seriously disturbed and determined solely by a behavioral health organization to be at risk of becoming acutely or chronically mentally ill.

***"Service area"** means the geographic area covered by each behavioral health organization (BHO) for which it is responsible.*

***"State minimum standards"** means minimum requirements established by rules adopted by the secretary and necessary to implement this chapter for delivery of behavioral health services.*

***"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.*

***"Tribal authority"** means, for the purposes of behavioral health organizations and RCW 71.24.300 only, the federally recognized Indian tribes and the major Indian organizations recognized by the secretary as long as these organizations do not have a financial relationship with any behavioral health organization that would present a conflict of interest.*

[Statutory Authority: RCW 70.02.290, 70.02.340, 70.96A.040(4), 71.05.560, 71.24.035 (5)(c), 71.34.380, and 2014 c 225. WSR 16-13-087, § 388-865-0238, filed 6/15/16, effective 7/16/16.]

388-865-0242

Behavioral health organizations—Payment for behavioral health services.

Within available resources as defined in RCW 71.24.025(2), a behavioral health organization (BHO) must ensure an individual's eligibility for and payment for behavioral health services meet the following:

(1) An individual who is eligible for medicaid is entitled to receive covered medically necessary behavioral health services without charge to the individual, consistent with the state's medicaid state plan or federal waiver authorities. A medicaid recipient is also entitled to receive behavioral health services from a behavioral health organization (BHO) managed care plan without charge.

(2) An individual who is not eligible for medicaid is entitled to receive behavioral health services consistent with priorities established by the department. The individual, the parent(s) of an individual who has not reached their eighteenth birthday, the individual's legal guardian, or the estate of the individual:

(a) Is responsible for payment for services provided; and

(b) May apply to the following entities for payment assistance:

(i) The health care authority (HCA) for medical assistance;

(ii) The behavioral health service provider for payment responsibility based on a sliding fee scale; or

(iii) The BHO for authorization of payment for involuntary evaluation and treatment services.

[Statutory Authority: RCW 70.02.290, 70.02.340, 70.96A.040(4), 71.05.560, 71.24.035 (5)(c), 71.34.380, and 2014 c 225. WSR 16-13-087, § 388-865-0242, filed 6/15/16, effective 7/16/16.]

388-865-0246

Behavioral health organizations—Public awareness of behavioral health services.

A behavioral health organization (BHO) or its designee must provide public information on the availability of mental health and substance use disorder services. The BHO must:

(1) Maintain information on available services, including crisis services and the recovery help line in telephone directories, public websites, and other public places in easily accessible formats;

(2) Publish and disseminate brochures and other materials or methods for describing services and hours of operation that are appropriate for all individuals, including those who may be visually impaired, limited English proficient, or unable to read; and

(3) Post and make information available to individuals regarding the behavioral health ombuds office consistent with WAC 388-865-0262, and local advocacy organizations that may assist individuals in understanding their rights.

[Statutory Authority: RCW 70.02.290, 70.02.340, 70.96A.040(4), 71.05.560, 71.24.035 (5)(c), 71.34.380, and 2014 c 225. WSR 16-13-087, § 388-865-0246, filed 6/15/16, effective 7/16/16.]

388-865-0248

Behavioral health organizations—Governing body responsible for oversight.

The behavioral health organization (BHO) must establish a governing body responsible for oversight of the BHO. The governing body must:

(1) Be free from conflict of interest and all appearance of conflict of interest between personal, professional and fiduciary interests of a governing body member and the best interests of the BHO and the individuals it serves.

(2) Have rules about:

(a) When a conflict of interest becomes evident;

(b) Not voting or joining a discussion when a conflict of interest is present; and

(c) When the governing body can assign the matter to others, such as staff members or advisory bodies.

[Statutory Authority: RCW [70.02.290](#), [70.02.340](#), [70.96A.040\(4\)](#), [71.05.560](#), [71.24.035](#) (5)(c), [71.34.380](#), and 2014 c 225. WSR 16-13-087, § 388-865-0248, filed 6/15/16, effective 7/16/16.]

388-865-0252

Behavioral health organizations—Advisory board membership.

(1) A behavioral health organization (BHO) must appoint advisory board members and maintain an advisory board in order to:

(a) Promote active engagement with individuals with behavioral health disorders, their families, and behavioral health agencies; and

(b) Solicit and use the advisory board members input to improve service delivery and outcome.

(2) The BHO must appoint advisory board members and maintain an advisory board that:

(a) Broadly represents the demographic character of the service area;

(b) Is composed of at least fifty-one percent representation of one or more of the

following:

(i) Persons with lived experience;

(ii) Parents or legal guardians of persons with lived experience; or

(iii) Self-identified as persons in recovery from a behavioral health disorder;

(c) Includes law enforcement representation; and

(d) Includes tribal representation, upon request of a tribe.

(3) When the BHO is not a function of county government, the advisory board must include no more than four county elected officials.

(4) The advisory board:

(a) May have members who are employees of subcontracted agencies, as long as there are written rules that address potential conflicts of interest.

(b) Has the discretion to set rules in order to meet the requirements of this section.

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(c) Membership is limited to three years per term for time served, per each advisory board member. Multiple terms may be served by a member if the advisory board rules allow it.

(5) The advisory board independently reviews and provides comments to either the BHO, the BHO governing board, or both, on plans, budgets, and policies developed by the BHO to implement the requirements of this section, chapters 71.05, 71.24, 71.34 RCW, and applicable federal laws.

[Statutory Authority: RCW 70.02.290, 70.02.340, 70.96A.040(4), 71.05.560, 71.24.035 (5)(c), 71.34.380, and 2014 c 225. WSR 16-13-087, § 388-865-0252, filed 6/15/16, effective 7/16/16.]

388-865-0254

Behavioral health organizations—Voluntary inpatient services and involuntary evaluation and treatment services.

A behavioral health organization (BHO) must develop and implement age and culturally competent behavioral health services that are consistent with chapters 70.96A, 71.24, 71.05, and 71.34 RCW.

(1) For voluntary inpatient services, the BHO must develop and implement formal agreements with inpatient services funded by the BHO regarding:

- (a) Referrals;*
- (b) Admissions; and*
- (c) Discharges.*

(2) For involuntary evaluation and treatment services, the BHO:

- (a) Must ensure that individuals in their regional service area have access to involuntary inpatient care; and*
- (b) Is responsible for coordinating discharge planning with the treating inpatient facility.*

(3) The BHO must:

- (a) Ensure periodic reviews of the evaluation and treatment service facilities consistent with BHO procedures and notify the appropriate authorities if it believes that a facility is not in compliance with applicable rules and laws.*

- (b) Authorize admissions into inpatient evaluation and treatment services for eligible individuals from:*

- (i) State psychiatric hospitals:*
 - (A) Western state hospital;*
 - (B) Eastern state hospital; and*
 - (C) The child study and treatment center.*

- (ii) Community hospitals.*

- (iii) Certified inpatient evaluation and treatment facilities licensed by the department of health as adult residential treatment facilities.*

- (iv) The children's long-term inpatient program (CLIP).*

- (c) Receive prior approval from the department's division of behavioral health and recovery (DBHR) in the form of a single bed certification for services to be provided to individuals on a ninety or one hundred eighty day community inpatient involuntary commitment order consistent with the exception criteria in WAC 388-865-0531.*

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[Rules in red italics will remain effective after March 31, 2018]

[Statutory Authority: RCW [70.02.290](#), [70.02.340](#), [70.96A.040\(4\)](#), [71.05.560](#), [71.24.035](#) (5)(c), [71.34.380](#), and 2014 c 225. WSR 16-13-087, § 388-865-0254, filed 6/15/16, effective 7/16/16.]

388-865-0256

Behavioral health organizations—Community support, residential, housing, and employment services.

*(1) **Community support services** as defined in WAC [388-865-0238](#). A behavioral health organization (BHO) must:*

(a) Develop and coordinate age and culturally appropriate community support services that are consistent with chapters [71.05](#), [71.24](#), and [71.34](#) RCW to ensure that the mental health and substance use disorder services listed in chapters [388-877A](#) and [388-877B](#) WAC can be accessed by all eligible individuals in the BHO's service area and are provided to eligible individuals directly, or by contract.

(b) Ensure prescreening determinations are conducted for providing community support services for individuals with mental illness who are being considered for placement in nursing facilities as required by RCW [71.24.025\(8\)](#).

*(2) **Residential services** as defined in [388-865-0238](#). A BHO must:*

(a) Ensure active search and promotion of individual access to, and choice in, safe and affordable independent housing that is appropriate to the individual's age, culture, and residential needs. This includes:

(i) Providing services to families of eligible children and to eligible individuals who are homeless or at imminent risk of becoming homeless as defined in Public Law 100-77, through outreach, engagement and coordination of linkage of services with shelter and housing; and

(ii) Assuring the availability of community support services, with an emphasis on supporting individuals in their own home or where they live in the community, with residences and residential supports prescribed in the individual service plan, including a full range of residential services as defined in RCW [71.24.025\(23\)](#).

(b) Ensure that eligible individuals in licensed residential facilities receive behavioral health services consistent with their individual service plan and are advised of their rights, including long-term care rights under chapter [70.129](#) RCW.

*(3) **Housing services** as defined in WAC [388-865-0238](#). A BHO must ensure active search and promotion of individual access to, and choice in, safe and affordable housing that is appropriate to the individual's age, culture, and needs. This includes:*

(a) Providing services to families of eligible children and to eligible individuals who are homeless or at imminent risk of becoming homeless as defined in Public Law 100-77, through outreach, engagement and coordination of linkage of services with shelter and housing;

(b) Assuring the availability of community support services, with an emphasis on supporting individuals in their own home or where they live in the community, with residences and residential supports prescribed in the individual service plan; and

(c) Coordinating with public housing entities, homeless continuums of care, and affordable housing developers.

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*(4) **Employment services.** A BHO must coordinate with the division of vocational rehabilitation or other local entities that support employment services to assure that individuals wanting to work are provided with recovery support-employment services under WAC 388-877A-0330.*

[Statutory Authority: RCW 70.02.290, 70.02.340, 70.96A.040(4), 71.05.560, 71.24.035 (5)(c), 71.34.380, and 2014 c 225. WSR 16-13-087, § 388-865-0256, filed 6/15/16, effective 7/16/16.]

388-865-0258

Behavioral health organizations—Administration of the Mental Health and Substance Use Disorders Involuntary Treatment Acts.

A behavioral health organization (BHO) must establish policies and procedures for administration of the Mental Health Involuntary Treatment Act and Substance Use Disorders Involuntary Treatment Act, including investigation, detention, transportation, court-related, and other services required by chapters 70.96A, 71.05 and 71.34 RCW. This includes:

(1) Ensuring that designated mental health professionals (DMHP) and designated chemical dependency specialists perform the duties of involuntary investigation and detention in accordance with the requirements of chapters 70.96A, 71.05 and 71.34 RCW.

(2) Documenting individual compliance with the conditions of mental health less restrictive alternative court orders by:

(a) Ensuring periodic evaluation of each committed individual for release from or continuation of an involuntary treatment order. Evaluations must be recorded in the clinical record, and must occur at least monthly for ninety day commitments and one hundred eighty day commitments.

(b) Notifying the DMHP if noncompliance with the less restrictive alternative order impairs the individual sufficiently to warrant detention or evaluation for detention and petitioning for revocation of the less restrictive alternative court order.

(3) Ensuring that the requirements of RCW 71.05.700 through 71.05.715 are met. [Statutory Authority: RCW 70.02.290, 70.02.340, 70.96A.040(4), 71.05.560, 71.24.035 (5)(c), 71.34.380, and 2014 c 225. WSR 16-13-087, § 388-865-0258, filed 6/15/16, effective 7/16/16.]

388-865-0262

Behavioral health organizations—Behavioral health ombuds office.

A behavioral health organization (BHO) must provide unencumbered access to and maintain the independence of the behavioral health ombuds service as set forth in the contract between the BHO and the division of behavioral health and recovery (DBHR). The BHO and DBHR must ensure the inclusion of representatives of individual and family advocate organizations when revising the terms of the contract regarding the requirements of this section. Behavioral health ombuds members must be current consumers of the mental health or substance use disorder system, or past consumers

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or family members of past consumers. The BHO must maintain a behavioral health ombuds office that:

(1) *Is responsive to the age and demographic character of the region and assists and advocates for individuals with resolving issues, grievances, and appeals at the lowest possible level;*

(2) *Is independent of agency service providers;*

(3) *Supports individuals, family members, and other interested parties regarding issues, grievances, and appeals;*

(4) *Is accessible to individuals, including having a toll-free, independent phone line for access;*

(5) *Is able to access service sites and records relating to individuals with appropriate releases so that it can reach out to individuals and help to resolve issues, grievances, and appeals;*

(6) *Receives training and adheres to confidentiality consistent with this chapter and chapters 70.96A, 71.05, 71.24, and 70.02 RCW;*

(7) *Continues to be available to advocate and support individuals through the grievance, appeal and administrative hearing processes;*

(8) *Involves other persons, at the individual's request;*

(9) *Supports individuals in the pursuit of a formal resolution;*

(10) *If necessary, continues to assist the individual through the administrative hearing process;*

(11) *Coordinates and collaborates with allied services to improve the effectiveness of advocacy and to reduce duplication when serving the same individual;*

(12) *Provides information on grievances to the DBHR and BHO quality strategy; and*

(13) *Provides reports and formalized recommendations at least biennially to DBHR and BHO advisory and governing boards, local consumer and family advocacy groups, the BHO quality review team, and the BHO provider network.*

[Statutory Authority: RCW 70.02.290, 70.02.340, 70.96A.040(4), 71.05.560, 71.24.035 (5)(c), 71.34.380, and 2014 c 225. WSR 16-13-087, § 388-865-0262, filed 6/15/16, effective 7/16/16.]

388-865-0264

Behavioral health organizations—Quality strategy.

A behavioral health organization (BHO) must implement a quality strategy for continuous quality improvement in the delivery of culturally competent mental health services. The BHO must submit a quality assurance and improvement plan to the division of behavioral health and recovery (DBHR). All changes to the quality assurance and improvement plan must be submitted to DBHR for approval prior to implementation. The plan must include all of the following:

(1) *Roles, structures, functions and interrelationships of all the elements of the quality strategy, including but not limited to the BHO governing board, clinical and management staff, advisory board, behavioral health ombuds service, and quality review teams.*

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(2) Procedures to ensure that quality assurance and improvement activities are effectively and efficiently carried out with clear management and clinical accountability, including methods to:

(a) Collect, analyze and display information regarding:

(i) The capacity to manage resources and services, including financial and cost information and compliance with statutes, regulations and contracts;

(ii) System performance indicators;

(iii) Quality and intensity of services;

(iv) Incorporation of feedback from individuals, allied service systems, community providers, the behavioral health ombuds office and quality review team;

(v) Clinical care and service utilization including consumer outcome measures; and

(vi) Recommendations and strategies for system and clinical care improvements, including information from exit interviews of individuals and practitioners;

(b) Monitor management information system data integrity;

(c) Monitor complaints, grievances and adverse incidents for adults and children;

(d) Monitor contractors and to notify DBHR of observations and information indicating that providers may not be in compliance with licensing or certification requirements;

(e) Immediately investigate and report allegations of fraud and abuse of the contractor or subcontractor to DBHR;

(f) Monitor delegated administrative activities;

(g) Identify necessary improvements;

(h) Interpret and communicate practice guidelines to practitioners;

(i) Implement change;

(j) Evaluate and report results;

(k) Demonstrate incorporation of all corrective actions to improve the system;

(l) Consider system improvements based on recommendations from all on-site monitoring, evaluation, accreditation, and certification reviews; and

(m) Review, update, and make the plan available to community stakeholders.

(3) Targeted improvement activities, including:

(a) Performance measures that are objective, measurable, and based on either current knowledge or best practice, or both, including at least those defined by DBHR in the contract with the BHO;

(b) An analysis of consumer care covering a representative sample of at least ten percent of consumers or five hundred consumers, whichever is smaller;

(c) Efficient use of human resources; and

(d) Efficient business practices.

[Statutory Authority: RCW [70.02.290](#), [70.02.340](#), [70.96A.040\(4\)](#), [71.05.560](#), [71.24.035](#) (5)(c), [71.34.380](#), and 2014 c 225. WSR 16-13-087, § 388-865-0264, filed 6/15/16, effective 7/16/16.]

388-865-0266

Behavioral health organizations—Quality review teams.

A behavioral health organization (BHO) must establish and maintain unencumbered access to and maintain the independence of a quality review team as described in this

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section and in the contract between the BHO and the division of behavioral health and recovery (DBHR). The quality review team must include individuals who currently receive or have in the past received behavioral health services, and may also include the family members of such individuals. The BHO must assure that quality review teams:

(1) Fairly and independently review the performance of the BHO and service providers in order to evaluate systemic issues as measured by objective indicators of individual outcomes in rehabilitation and recovery, including all of the following:

(a) Quality of care;

(b) The degree to which services are focused on the individual and are age and culturally appropriate;

(c) The availability of alternatives to hospitalization, cross-system coordination and range of treatment options; and

(d) The effectiveness of the BHO's coordination with allied systems including, but not limited to, schools, state and local hospitals, jails and shelters.

(2) Have the authority to enter and monitor any behavioral health agency contracted with a BHO.

(3) Meet with interested individuals and family members, allied service providers, including state or community psychiatric hospitals, BHO contracted service providers, and persons that represent the age and ethnic diversity of the BHO's service area to:

(a) Determine if services are accessible and address the needs of individuals based on sampled individual recipient's perception of services using a standard interview protocol. The protocol will query the sampled individuals regarding ease of accessing services, the degree to which services address medically necessary needs, and the benefit of the service received; and

(b) Work with interested individuals and other persons, if requested by the individual, service providers, the BHO, and DBHR to resolve identified problems.

(4) Provide reports and formalized recommendations at least biennially to DBHR, the behavioral health advisory committee and the BHO advisory and governing boards and ensure that input from the quality review team is integrated into the overall BHO quality strategy, behavioral health ombuds office services, local consumer and family advocacy groups, and provider network.

(5) Receive training in and adhere to applicable confidentiality standards.

[Statutory Authority: RCW [70.02.290](#), [70.02.340](#), [70.96A.040\(4\)](#), [71.05.560](#), [71.24.035](#) (5)(c), [71.34.380](#), and 2014 c 225. WSR 16-13-087, § 388-865-0266, filed 6/15/16, effective 7/16/16.]

388-865-0268

Behavioral health organizations—Standards for contractors and subcontractors.

A behavioral health organization (BHO) must not contract or subcontract for clinical services to be provided using public funds unless the contractor or subcontractor is licensed by the division of behavioral health and recovery (DBHR) for those services, or is individually licensed by the department of health as defined in chapter [18.57](#), [18.71](#), [18.83](#), or [18.79](#) RCW. The BHO must:

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(1) Require and maintain documentation that contractors and subcontractors are licensed, certified, or registered in accordance with state and federal laws;

(2) Follow applicable requirements of the BHO contract with DBHR;

(3) Demonstrate that it monitors contractors and subcontractors and notifies DBHR of observations and information indicating that providers may not be in compliance with licensing or certification requirements; and

(4) Terminate its contract or subcontract with a provider if DBHR notifies the BHO of a provider's failure to attain or maintain licensure.

[Statutory Authority: RCW [70.02.290](#), [70.02.340](#), [70.96A.040\(4\)](#), [71.05.560](#), [71.24.035](#) (5)(c), [71.34.380](#), and 2014 c 225. WSR 16-13-087, § 388-865-0268, filed 6/15/16, effective 7/16/16.]

388-865-0272

Behavioral health organizations—Operating as a behavioral health agency.

A behavioral health organization (BHO) may operate as a behavioral health agency when the BHO:

(1) Meets the criteria in RCW [71.24.045\(2\)](#) and chapters [70.96A](#) and [71.24](#) RCW; and

(2) Maintains a current license as a behavioral health agency from the division of behavioral health and recovery.

[Statutory Authority: RCW [70.02.290](#), [70.02.340](#), [70.96A.040\(4\)](#), [71.05.560](#), [71.24.035](#) (5)(c), [71.34.380](#), and 2014 c 225. WSR 16-13-087, § 388-865-0272, filed 6/15/16, effective 7/16/16.]

388-865-0370

Behavioral health organization managed care plan—Minimum standards.

To be eligible to contract with the department's division of behavioral health and recovery (DBHR), the behavioral health organization (BHO) managed care plan must comply with all applicable local, state, and federal rules and laws. The BHO managed care plan must:

(1) Provide documentation of a population base of sixty thousand medicaid eligible persons covered lives within the service area or receive approval from DBHR based on submittal of an actuarially sound risk management profile;

(2) If the BHO is not a county-based organization, the BHO must maintain licensure by the Washington state office of the insurance commissioner as a health care service contractor under chapter [48.44](#) RCW.

(3) Provide medically necessary behavioral health services that are age and culturally appropriate for all medicaid recipients in the service area within a capitated rate;

(4) Demonstrate working partnerships with tribal authorities for the delivery of services that blend with tribal values, beliefs and culture;

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(5) Develop and maintain written subcontracts that clearly recognize that legal responsibility for administration of the service delivery system remains with the BHO managed care plan, as identified in the contract with DBHR;

(6) Retain responsibility to ensure that applicable standards of this chapter, other state rules, and federal laws are met even when it delegates duties to subcontractors; and

(7) Ensure the protection of individual and family rights as described in chapters 70.96A, 71.05 and 71.34 RCW.

[Statutory Authority: RCW 70.02.290, 70.02.340, 70.96A.040(4), 71.05.560, 71.24.035 (5)(c), 71.34.380, and 2014 c 225. WSR 16-13-087, § 388-865-0370, filed 6/15/16, effective 7/16/16.]

388-865-0375

Behavioral health organization managed care plan—Utilization management.

Utilization management is the way the behavioral health organization (BHO) managed care plan authorizes or denies substance use disorder treatment or mental health services, monitors services, and follows the level of care guidelines. To demonstrate the impact on individual access to care of adequate quality, a BHO must provide utilization management of the behavioral health rehabilitation services under 42 C.F.R. Sec. 440.130(d) that is independent of service providers. This process must:

(1) Provide effective and efficient management of resources;

(2) Assure capacity sufficient to deliver appropriate quality and intensity of services to enrolled individuals without a wait list consistent with the contract with the division of behavioral health and recovery (DBHR);

(3) Plan, coordinate, and authorize community support services;

(4) Ensure that services are provided according to the individual service plan;

(5) Ensure assessment and monitoring processes are in place by which service delivery capacity responds to changing needs of the community and enrolled individuals;

(6) Develop, implement, and enforce written level of care guidelines for admissions, placements, transfers and discharges into and out of services including:

(a) A clear process for the BHO managed care plan's role in the decision-making process about admission and continuing stay at various levels is available in language that is clearly understood by all parties involved in an individual consumer's care, including laypersons;

(b) Criteria for admission into various levels of care, including community support, inpatient and residential services that are clear and concrete;

(c) Methods to ensure that services are individualized to meet the needs of all medicaid recipients served, including methods that address different ages, cultures, languages, civil commitment status, physical abilities, and unique service needs; and

(d) Assure the BHO managed care plan retains a sufficiently strong and regular oversight role to assure decisions are being made appropriately, to the extent authorization of care at any level of care or at continuing stay determinations is delegated;

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(7) Collect data that measures the effectiveness of the criteria in ensuring that all eligible people get services that are appropriate to their needs; and

(8) Report to DBHR any knowledge it gains that the BHO managed care plan or behavioral health service provider is not in compliance with a state or federal rule or law.

[Statutory Authority: RCW [70.02.290](#), [70.02.340](#), [70.96A.040\(4\)](#), [71.05.560](#), [71.24.035](#) (5)(c), [71.34.380](#), and 2014 c 225. WSR 16-13-087, § 388-865-0375, filed 6/15/16, effective 7/16/16.]

388-865-0380

Behavioral health organization managed care plan—Choice of primary provider.

(1) The behavioral health organization (BHO) managed care plan must:

(a) Ensure that each individual receiving nonemergency behavioral health rehabilitation services has a primary provider who is responsible to carry out the individual service plan; and

(b) Allow individuals, parents of individuals under age thirteen, and guardians of individuals of all ages to select a primary provider from the available primary provider staff within the BHO managed care plan.

(2) For an individual with an assigned case manager, the case manager is the primary provider.

(3) If the individual does not select a primary provider, the BHO managed care plan or its designee must assign a primary provider not later than fifteen working days after the individual requests services.

(4) The BHO managed care plan or its designee must allow an individual to change primary providers at any time for any reason. The individual must notify the BHO managed care plan or its designee of the request for a change, and inform the plan of the name of the new primary provider.

[Statutory Authority: RCW [70.02.290](#), [70.02.340](#), [70.96A.040\(4\)](#), [71.05.560](#), [71.24.035](#) (5)(c), [71.34.380](#), and 2014 c 225. WSR 16-13-087, § 388-865-0380, filed 6/15/16, effective 7/16/16.]

388-865-0385

Behavioral health organization managed care plan—Behavioral health screening for children.

The behavioral health organization (BHO) managed care plan is responsible for conducting behavioral health screening and treatment for children eligible under the federal Title XIX early and periodic screening, diagnosis, and treatment (EPSDT) program. This includes:

(1) Providing resource management services for children eligible under the EPSDT program as specified in contract with the division of behavioral health and recovery; and

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(2) Developing and maintaining an oversight committee for the coordination of the EPSDT program that must include representation from parents of medicaid-eligible children.

[Statutory Authority: RCW [70.02.290](#), [70.02.340](#), [70.96A.040\(4\)](#), [71.05.560](#), [71.24.035](#) (5)(c), [71.34.380](#), and 2014 c 225. WSR 16-13-087, § 388-865-0385, filed 6/15/16, effective 7/16/16.]

388-865-0500 [see new WAC [388-877-1134](#)]

Inpatient evaluation and treatment facilities.

(1) The mental health division certifies facilities to provide involuntary inpatient evaluation and treatment services for more than twenty-four hours within a general hospital, psychiatric hospital, inpatient evaluation and treatment facility, or child long-term inpatient treatment facility.

(2) Compliance with the regulations in this chapter does not constitute release from the requirements of applicable federal, state, tribal and local codes and ordinances. Where regulations in this chapter exceed other local codes and ordinances, the regulations in this chapter will apply.

(3) This chapter does not apply to state psychiatric hospitals as defined in chapter [72.23](#) RCW or facilities owned or operated by the department of veterans affairs or other agencies of the United States government.

[Statutory Authority: RCW [71.05.560](#), [71.34.800](#), and chapters [71.05](#) and [71.34](#) RCW. WSR 04-07-014, § 388-865-0500, filed 3/4/04, effective 4/4/04. Statutory Authority: RCW [71.05.560](#), [71.24.035](#) (5)(c), [71.34.800](#), [9.41.047](#), [43.20B.020](#), and [43.20B.335](#). WSR 01-12-047, § 388-865-0500, filed 5/31/01, effective 7/1/01.]

388-865-0511 [see new WAC [388-877-1134](#) and [388-877-0365](#)]

Evaluation and treatment facility certification and fee requirements.

To obtain and maintain certification to provide inpatient evaluation and treatment services under chapter [71.05](#) and [71.34](#) RCW, a facility must:

(1) Be licensed by the department of health as:

(a) A hospital as defined in chapter [70.41](#) RCW;

(b) A psychiatric hospital as defined in chapter [246-322](#) WAC;

(c) A mental health inpatient evaluation and treatment facility consistent with chapter [246-337](#) WAC; or

(d) A mental health child long-term inpatient treatment facility consistent with chapter [246-337](#) WAC.

(2) Be approved by the regional support network, or the department's division of behavioral health and recovery (DBHR). Child long-term inpatient treatment facilities can only be approved by DBHR.

(3) Successfully complete a provisional and annual on-site review conducted by DBHR to determine facility compliance with the minimum standards of this section and chapters [71.05](#) and [71.34](#) RCW.

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(4) Pay the following certification fees:

(a) Ninety dollars initial certification fee, per bed; then

(b) Ninety dollars annual certification fee, per bed.

(5) Include the fees specified in subsection (4) of this section with the initial application, renewal application, or with requests for other services.

(a) Payment of fees must be made by check, bank draft, electronic transfer, or money order, payable to the department of social and health services, and mailed to the aging and disability services finance office at the address listed on the applicable application packet or form.

(b) The department may refund one-half of the application fee if an application is withdrawn before certification or denial.

(c) Fees will not be refunded when DBHR denies, revokes or suspends certification.

(6) For behavioral health agency licensing fees, program-specific certification fees, and other fees charged by the department, see WAC 388-877-0365.

[Statutory Authority: RCW [43.20A.550](#), [74.04.050](#), [74.08.090](#) and chapters [70.02](#), [71.24](#) RCW. WSR 14-18-014, § 388-865-0511, filed 8/22/14, effective 9/22/14. Statutory Authority: RCW [71.05.560](#), [71.24.035](#), [71.34.380](#), and [74.08.090](#). WSR 09-02-030, § 388-865-0511, filed 12/30/08, effective 1/30/09. Statutory Authority: RCW [71.05.560](#), [71.34.800](#), and chapters [71.05](#) and [71.34](#) RCW. WSR 04-07-014, § 388-865-0511, filed 3/4/04, effective 4/4/04.]

388-865-0520 *[see new WAC 388-877-0310]*

Certification based on deemed status.

The mental health division may deem compliance with state minimum standards for facilities that are currently accredited by a national accreditation agency recognized by and having a current agreement with the mental health division.

(1) Deeming will be in accordance with the established agreement between the mental health division and the accrediting agency, to include the minimum standards of this section and chapters [71.05](#) and [71.34](#) RCW.

(2) The mental health division retains all responsibilities relating to applications of new providers, complaint investigations, suspensions and revocations.

[Statutory Authority: RCW [71.05.560](#), [71.34.800](#), and chapters [71.05](#) and [71.34](#) RCW. WSR 04-07-014, § 388-865-0520, filed 3/4/04, effective 4/4/04.]

388-865-0526

Single bed certification.

At the discretion of the department, an exception may be granted to allow timely and appropriate treatment to an adult on a seventy-two hour detention or fourteen-day commitment in a facility that is not certified under WAC [388-865-0500](#); or for a maximum of thirty days to allow a community facility to provide treatment to an adult on a ninety- or one hundred eighty-day inpatient involuntary commitment order. For involuntarily detained or committed children, the exception may be granted to allow

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timely and appropriate treatment in a facility not certified under WAC [388-865-0500](#) until the child's discharge from that setting to the community, or until they transfer to a bed in a children's long-term inpatient program (CLIP).

(1) The regional support network (RSN) or its designee must submit a written request for a single bed certification to the department. In the case of a child, the facility must submit the written request to the department. The request must be submitted and approved by the department for a facility to accept an individual for timely and appropriate treatment under this section. If the department has assumed the duties assigned to a nonparticipating RSN, an entity designated by the department will perform the functions described in this section.

(2) A single bed certification may be issued to the facility for timely and appropriate mental health treatment when the following requirements are met in each instance where such certification is sought for an individual:

(a) The facility that is the site of the proposed single bed certification confirms that it is willing and able to provide directly, or by direct arrangement with other public or private agencies, timely and appropriate mental health treatment to the consumer for whom the single bed certification is sought; and

(b) The request for single bed certification describes why the consumer meets at least one of the following criteria:

(i) The consumer is expected to be ready for discharge from inpatient services within the next thirty days and being at a community facility would facilitate continuity of care, consistent with the consumer's individual treatment needs;

(ii) The consumer can receive appropriate mental health treatment in a residential treatment facility, as defined in WAC [246-337-005](#), and the single bed certification will be only to that facility; or

(iii) The consumer can receive appropriate mental health treatment in a hospital with a psychiatric unit, or a hospital that is willing and able to provide timely and appropriate mental health treatment, or a psychiatric hospital, and the single bed certification will apply only to that facility.

(3) In order to provide timely and appropriate mental health treatment, the facility receiving the single bed certification, or the public or private agency the facility has a direct arrangement with to provide mental health treatment, must:

(a) Implement standards for administration that include written procedures to assure that a mental health professional, as defined in RCW [71.05.020](#) or WAC [388-865-0150](#), and licensed physicians are available for consultation and communication with both the consumer and the direct patient care staff;

(b) Use a plan of care/treatment. The medical or clinical record must contain documentation that:

(i) An individualized mental health treatment plan was developed, when possible, collaboratively with the consumer. If the consumer is unwilling or unable to participate in development of the plan, documentation must be made in the record. Development of this plan may include participation of a multidisciplinary team, a mental health professional, as defined in RCW [71.05.020](#) or WAC [388-865-0150](#), or collaboration with members of the consumer's support system as identified by the consumer.

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(ii) A mental health professional, as defined in RCW 71.05.020 or WAC 388-865-0150, has had contact with each involuntarily detained consumer at least daily for the purposes of:

(A) Observation and evaluation; and

(B) Assessing whether the consumer is appropriate for release from involuntary commitment to accept treatment on a voluntary basis.

(c) Have standards for administration and monitoring of medication, including psychiatric medications. Consumers have a right to make an informed decision regarding the use of antipsychotic medication consistent with RCW 71.05.215.

(4) If a consumer requires medical services that are not generally available at a facility certified under this chapter, or at a state psychiatric hospital when a court has ordered a ninety- or one hundred eighty-day inpatient commitment, or at a facility that meets the requirements of subsections (2) and (3) of this section, a single bed certification may be issued to that facility for the consumer as follows:

(a) The single bed certification request must adequately describe why the consumer requires medical services that are not available at a facility certified under this chapter, or at a state psychiatric hospital when a court has ordered a ninety- or one hundred eighty-day inpatient commitment, or at a facility that meets the requirements of subsections (2) and (3) of this section;

(b) The facility that is the site of the requested single bed certification must confirm that it is willing and able to provide the medical services; and

(c) The facility has documented that one of the following has been met:

(i) With the authorization of the hospital, and consistent with any applicable hospital policies and procedures, the RSN assigns a mental health professional to provide the consumer appropriate mental health treatment at the facility, including observation and evaluation, during the period of time the consumer is provided medical services; or

(ii) The hospital provides medical services and a plan that addresses the consumer's mental health treatment needs until the consumer is medically stable and the RSN or its designee identifies an appropriate facility for the consumer that is one of the following:

(A) The hospital providing services;

(B) A facility that is certified as an evaluation and treatment (E & T) facility; or

(C) A facility that can meet the consumer's needs under the single bed certification criteria in this section.

(d) If a qualified medical professional determines that mental health treatment for the consumer is not clinically indicated, the requirements in (c) of this subsection do not apply. When the consumer is determined to be medically stable, the facility must ensure the requirements in (c) of this subsection are met.

(5) The department makes the decision and gives written notification to the requesting entity in the form of a single bed certification. The single bed certification must not contradict a specific provision of federal or state law.

(6) A consumer who receives services under a single bed certification under this section must be transferred to an evaluation and treatment facility if on a seventy-two hour detention or fourteen-day commitment, or to a state hospital if on a ninety- or one hundred eighty-day inpatient commitment, as soon as the attending physician considers the consumer medically stable and a bed becomes available, unless the treating facility

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consents to continue treatment and continued treatment in the current setting is consistent with the best clinical interests of the consumer.

(7) The department may make site visits at any time to verify that the terms of the single bed certification are being met. Failure to comply with any term of this exception may result in corrective action. If the department determines that the violation places consumers in imminent jeopardy, immediate revocation of this exception can occur.

(8) The RSN retains the responsibility for ensuring due process required by RCW 71.24.300 (6)(b).

(9) Neither consumers nor facilities have fair hearing rights as defined under chapter 388-02 WAC regarding single bed certification decisions by department staff.

[Statutory Authority: RCW 71.05.560, 71.24.035, 71.34.380, and chapter 71.05 RCW. WSR 15-14-087, § 388-865-0526, filed 6/29/15, effective 7/30/15. Statutory Authority: RCW 71.05.560, 71.24.035, 71.34.380, and 74.08.090. WSR 09-02-030, § 388-865-0526, filed 12/30/08, effective 1/30/09. Statutory Authority: RCW 71.05.560, 71.34.800, and chapters 71.05 and 71.34 RCW. WSR 04-07-014, § 388-865-0526, filed 3/4/04, effective 4/4/04.]

388-865-0531 [see new WAC 388-877-1136]

Exception to rule—Long-term certification.

(1) For adults: At the discretion of the mental health division, a facility may be granted an exception to WAC 388-865-0229 in order to allow the facility to be certified to provide treatment to adults on a ninety- or one hundred eighty-day inpatient involuntary commitment orders.

(2) For children: At the discretion of the mental health division, a facility that is certified as a 'mental health inpatient evaluation and treatment facility' may be granted an exception to provide treatment to a child on a one hundred and eighty-day inpatient involuntary treatment order only until the child is discharged from his/her order to the community, or until a bed is available for that child in a child long-term inpatient treatment facility (CLIP). The child cannot be assigned by the CLIP placement team in accordance with RCW 71.34.100 to any facility other than a CLIP facility.

(3) The exception certification may be requested by the facility, the director of the mental health division or his/her designee, or the regional support network for the facility's geographic area.

(4) The facility receiving the long-term exception certification for ninety- or one hundred eighty-day patients must meet all requirements found in WAC 388-865-0500.

(5) The exception certification must be signed by the director of the mental health division. The exception certification may impose additional requirements, such as types of consumers allowed and not allowed at the facility, reporting requirements, requirements that the facility immediately report suspected or alleged incidents of abuse, or any other requirements that the director of the mental health division determines are necessary for the best interests of residents.

(6) The mental health division may make unannounced site visits at any time to verify that the terms of the exception certification are being met. Failure to comply with any term of the exception certification may result in corrective action. If the mental

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health division determines that the violation places residents in imminent jeopardy, immediate revocation of the certification can occur.

(7) Neither consumers nor facilities have fair hearing rights as defined under chapter [388-02](#) WAC regarding the decision to grant or not to grant exception certification.

[Statutory Authority: RCW [71.05.560](#), [71.34.800](#), and chapters [71.05](#) and [71.34](#) RCW. WSR 04-07-014, § 388-865-0531, filed 3/4/04, effective 4/4/04.]

388-865-0536 [see new WAC [388-877-1126](#), [388-877-1164](#)]

Standards for administration—Inpatient evaluation and treatment facilities.

An inpatient evaluation and treatment facility must develop a policy to implement the following administrative requirements:

(1) A description of the program, including age of consumers to be served, length of stay and services to be provided.

(2) An organizational structure including clear lines of authority for management and clinical supervision.

(3) Designation of a physician or other mental health professional as the professional person in charge of clinical services at that facility.

(4) A quality management plan to monitor, collect data and develop improvements to meet the requirements of this chapter.

(5) A policy management structure that establishes:

(a) Procedures for maintaining and protecting resident medical/clinical records consistent with chapter [70.02](#) RCW, "Medical Records Health Care Information Access and Disclosure Act" and Health Insurance Portability and Accountability Act (HIPAA);

(b) Procedures for maintaining adequate fiscal accounting records consistent with generally accepted accounting principles (GAAP);

(c) Procedures for management of human resources to ensure that residents receive individualized treatment or care by adequate numbers of staff who are qualified and competent to carry out their assigned responsibilities;

(d) Procedures for admitting consumers needing inpatient evaluation and treatment services seven days a week, twenty-four hours a day, except that child long-term inpatient treatment facilities are exempted from this requirement;

(e) Procedures to assure appropriate and safe transportation for persons who are not approved for admission to his or her residence or other appropriate place;

(f) Procedures to detain arrested persons who are not approved for admission for up to eight hours so that reasonable attempts can be made to notify law enforcement to return to the facility and take the person back into custody;

(g) Procedures to assure access to necessary medical treatment, emergency life-sustaining treatment, and medication;

(h) Procedures to assure the protection of consumer and family rights as described in this chapter and chapters [71.05](#) and [71.34](#) RCW;

(i) Procedures to inventory and safeguard the personal property of the consumer being detained, including a process to limit inspection of the inventory list by responsible relatives or other persons designated by the detained consumer;

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(j) Procedures to assure that a mental health professional and licensed physician are available for consultation and communication with both the consumer and the direct patient care staff twenty-four hours a day, seven days a week;

(k) Procedures to provide warning to an identified person and law enforcement when an adult has made a threat against an identified victim;

(l) Procedures to ensure that consumers detained for up to fourteen or ninety additional days of treatment are evaluated by the professional staff of the facility in order to be prepared to testify that the consumer's condition is caused by a mental disorder and either results in likelihood of serious harm or the consumer being gravely disabled;

(m) Procedures to assure the rights of consumers to make mental health advance directives, and facility protocols for responding to consumer and agent requests consistent with RCW [71.32.150](#);

(n) Procedures to ensure that the following requirements are met when an individual is brought to the facility by a peace officer under RCW [71.05.153](#):

(i) The individual must be examined by a mental health professional (MHP) within three hours of arrival;

(ii) Within twelve hours of arrival, a designated mental health professional (DMHP) must determine if the individual meets detention criteria under chapter [71.05](#) RCW; and

(iii) If the facility releases the individual to the community, the facility must inform the peace officer of the release within a reasonable period of time after the release if the peace officer has specifically requested notification and has provided contact information to the facility.

[Statutory Authority: RCW [10.31.110](#), [71.05.153](#), [71.05.190](#), chapter [74.09](#) RCW, and 2011 c 305. WSR 12-19-038, § 388-865-0536, filed 9/12/12, effective 10/13/12. Statutory Authority: RCW [71.05.560](#), [71.34.800](#), and chapters [71.05](#) and [71.34](#) RCW. WSR 04-07-014, § 388-865-0536, filed 3/4/04, effective 4/4/04.]

388-865-0541 *[see new WAC 388-877-1126]*

Admission and intake evaluation.

(1) For consumers who have been involuntarily detained, the facility must obtain a copy of the petition for initial detention stating the evidence under which the consumer was detained.

(2) The facility must document that each resident has received timely evaluations to determine the nature of the disorder and the treatment necessary, including:

(a) A health assessment of the consumer's physical condition to determine if the consumer needs to be transferred to an appropriate hospital for treatment;

(b) Examination and medical evaluation within twenty-four hours by a licensed physician, advanced registered nurse practitioner, or physician assistant-certified;

(c) Psychosocial evaluation by a mental health professional;

(d) Development of an initial treatment plan;

(e) Consideration of less restrictive alternative treatment at the time of admission; and

(f) The admission diagnosis and what information the determination was based upon.

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(3) A consumer who has been delivered to the facility by a peace officer for evaluation must be evaluated by a mental health professional within the following time frames:

(a) Three hours of an adult consumer's arrival;

(b) Twelve hours of arrival for a child in an inpatient evaluation and treatment facility;

or

(c) At any time for a child who has eloped from a child long-term inpatient treatment facility and is being returned to the facility.

(4) If the licensed physician and mental health professional determine that the needs of an adult consumer would be better served by placement in a chemical dependency treatment facility then the consumer must be referred to an approved treatment program defined under chapter [70.96A](#) RCW.

[Statutory Authority: RCW [71.05.560](#), [71.34.800](#), and chapters [71.05](#) and [71.34](#) RCW. WSR 04-07-014, § 388-865-0541, filed 3/4/04, effective 4/4/04.]

388-865-0545 [see new WAC 388-877-1118]

Use of seclusion and restraint procedures—Adults.

Consumers have the right to be free from seclusion and restraint, including chemical restraint. The use of restraints or seclusion must occur only when there is imminent danger to self or others and less restrictive measures have been determined to be ineffective to protect the consumer or others from harm and the reasons for the determination are clearly documented. The evaluation and treatment facility must develop policies and procedures to assure that restraint and seclusion procedures are utilized only to the extent necessary to ensure the safety of patients and others:

(1) Staff must notify, and receive authorization by, a physician within one hour of initiating patient restraint or seclusion;

(2) The consumer must be informed of the reasons for use of seclusion or restraint and the specific behaviors which must be exhibited in order to gain release from these procedures;

(3) The clinical record must document staff observation of the consumer at least every fifteen minutes and observation recorded in the consumer's clinical record;

(4) If the use of restraint or seclusion exceeds twenty-four hours, a licensed physician must assess the consumer and write a new order if the intervention will be continued. This procedure is repeated again for each twenty-four hour period that restraint or seclusion is used;

(5) All assessments and justification for the use of seclusion or restraint must be documented in the consumer's medical record.

[Statutory Authority: RCW [71.05.560](#), [71.24.035](#) (5)(c), [71.34.800](#), [9.41.047](#), [43.20B.020](#), and [43.20B.335](#). WSR 01-12-047, § 388-865-0545, filed 5/31/01, effective 7/1/01.]

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388-865-0546 [see new WAC 388-877-1118]

Use of seclusion and restraint procedures—Children.

Consumers have the right to be free from seclusion and restraint, including chemical restraint. The use of restraints or seclusion must occur only when there is imminent danger to self or others and less restrictive measures have been determined to be ineffective to protect the consumer or others from harm and the reasons for the determination are clearly documented. The evaluation and treatment facility must develop policies and procedures to assure that restraint and seclusion procedures are utilized only to the extent necessary to ensure the safety of patients and others:

(1) In the event of an emergency use of restraints or seclusion, a licensed physician must be notified within one hour and must authorize the restraints or seclusion;

(2) No consumer may be restrained or secluded for a period in excess of two hours without having been evaluated by a mental health professional. Such consumer must be directly observed every fifteen minutes and the observation recorded in the consumer's clinical record;

(3) If the restraint or seclusion exceeds twenty-four hours, the consumer must be examined by a licensed physician. The facts determined by his or her examination and any resultant decision to continue restraint or seclusion over twenty-four hours must be recorded in the consumer's clinical record over the signature of the authorizing physician. This procedure must be repeated for each subsequent twenty-four hour period of restraint or seclusion.

[Statutory Authority: RCW [71.05.560](#), [71.24.035](#) (5)(c), [71.34.800](#), [9.41.047](#), [43.20B.020](#), and [43.20B.335](#). WSR 01-12-047, § 388-865-0546, filed 5/31/01, effective 7/1/01.]

388-865-0547 [see new WAC 388-877-1126]

Plan of care/treatment.

The medical record must contain documentation of:

(1) Diagnostic and therapeutic services prescribed by the attending clinical staff.

(2) An individualized plan for treatment developed collaboratively with the consumer. This may include participation of a multidisciplinary team or mental health specialists as defined in WAC [388-865-0150](#), or collaboration with members of the consumer's support system as identified by the consumer.

(3) Copies of advance directives, powers of attorney or letters of guardianship provided by the consumer.

(4) A plan for discharge including a plan for follow-up where appropriate.

(5) Documentation of the course of treatment.

(6) That a mental health professional has contact with each involuntary consumer at least daily for the purpose of:

(a) Observation;

(b) Evaluation;

(c) Release from involuntary commitment to accept treatment on a voluntary basis;

(d) Discharge from the facility to accept voluntary treatment upon referral.

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(7) For consumers who are being evaluated as dangerous mentally ill offenders under RCW [72.09.370](#)(7), the professional person in charge of the evaluation and treatment facility must consider filing a petition for a ninety day less restrictive alternative in lieu of a petition for a fourteen-day commitment.

[Statutory Authority: RCW [71.05.560](#), [71.34.800](#), and chapters [71.05](#) and [71.34](#) RCW. WSR 04-07-014, § 388-865-0547, filed 3/4/04, effective 4/4/04.]

388-865-0551 [see new WAC 388-877-1118]

Qualification requirements for staff.

The provider must document that staff and clinical supervisors are qualified for the position they hold and have the education, experience, or skills to perform the job requirements, including:

(1) A current job description.

(2) A current Washington state department of health license or certificate or registration as may be required for his/her position.

(3) Washington state patrol background checks for employees in contact with consumers consistent with RCW [43.43.830](#).

(4) Clinical supervisors must meet the qualifications of mental health professionals or specialists as defined in WAC [388-865-0150](#).

(5) An annual performance evaluation.

(6) Development of an individualized annual training plan, to include at least:

(a) The skills he or she needs for his/her job description and the population served;

(b) Least restrictive alternative options available in the community and how to access them;

(c) Methods of resident care;

(d) Management of assaultive and self-destructive behaviors, including proper and safe use of seclusion and/or restraint procedures; and

(e) The requirements of chapter [71.05](#) and [71.34](#) RCW, this chapter, and protocols developed by the mental health division.

(7) If contract staff are providing direct services, the facility must ensure compliance with the training requirements outlined in (6) above.

[Statutory Authority: RCW [71.05.560](#), [71.34.800](#), and chapters [71.05](#) and [71.34](#) RCW. WSR 04-07-014, § 388-865-0551, filed 3/4/04, effective 4/4/04.]

388-865-0561 [see new WAC 388-877-1120]

Posting of consumer rights.

The consumer rights assured by RCW [71.05.370](#) and [71.34.160](#) must be prominently posted within the department or ward of the community or inpatient evaluation and treatment facility and provided in writing to the consumer, as follows:

"You have the right to:

(1) Immediate release, unless involuntary commitment proceedings are initiated.

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(2) Wear your own clothes and to keep and use personal possessions, except when deprivation is essential to protect your safety or that of another person.

(3) Keep and be allowed to spend a reasonable sum of your own money for canteen expenses and small purchases.

(4) Adequate care and individualized treatment.

(5) Have all information and records compiled, obtained, or maintained in the course of receiving services kept confidential.

(6) Have access to individual storage space for your private use.

(7) Have visitors at reasonable times.

(8) Have reasonable access to a telephone, both to make and receive confidential calls.

(9) Have ready access to letter writing materials, including stamps, and to send and receive uncensored correspondence through the mails.

(10) Not to consent to the administration of anti-psychotic medications beyond the hearing conducted pursuant to RCW [71.05.320](#)(2) or the performance of electroconvulsant therapy or surgery, except emergency life-saving surgery, unless ordered by a court of competent jurisdiction pursuant to the following standards and procedures: RCW [71.05.200](#) (1)(e); 71.05.215; and [71.05.370](#)(7).

(11) To dispose of property and sign contracts unless you have been adjudicated as incompetent in a court proceeding directed to that particular issue.

(12) Not to have psychosurgery performed under any circumstances."

[Statutory Authority: RCW [71.05.560](#), [71.34.800](#), and chapters [71.05](#) and [71.34](#) RCW. WSR 04-07-014, § 388-865-0561, filed 3/4/04, effective 4/4/04.]

388-865-0566 [see new WAC [388-877-1122](#)]

Rights of consumers receiving involuntary services.

The provider must ensure that consumers who are receiving inpatient services involuntarily are informed of the following rights orally and provided with a copy in the primary language spoken/used/understood by the person. "You have the right to:

(1) Remain silent and any statement you make may be used against you.

(2) Access to attorneys, courts and other legal redress, including the name and address of the attorney the mental health professional has designated for you.

(3) Immediately be informed of your right to speak with an attorney and a review of the legality of your detention including representation at the probable cause hearing.

(4) Have access to a qualified language interpreter in the primary language understood by you, consistent with chapter [388-03](#) WAC.

(5) Have a responsible member of your immediate family if possible, guardian or conservator, if any, and such person as designated by you be given written notice of your inpatient status, and your rights as an involuntary consumer.

(6) A medical and psychosocial evaluation within twenty-four hours of admission to determine whether continued detention in the facility is necessary.

(7) A judicial hearing before a superior court if you are not released within seventy-two hours (excluding Saturday, Sunday, and holidays), to decide if continued detention within the facility is necessary.

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(8) Not forfeit any legal right or suffer any legal disability as a consequence of any actions taken or orders made, other than as specifically provided.

(9) Not to be denied treatment by spiritual means through prayer in accordance with the tenets and practices of a church or religious denomination.

(10) Refuse psychiatric medication, except medications ordered by the court under WAC [388-865-0570](#) but not any other medication previously prescribed by an authorized prescriber.

(11) Refuse treatment, but not emergency lifesaving treatment unless otherwise specified in a written advance directive provided to the facility.

(12) Be given a copy of WAC [388-865-0585](#) outlining limitations on the right to possess a firearm."

[Statutory Authority: RCW [71.05.560](#), [71.34.800](#), and chapters [71.05](#) and [71.34](#) RCW. WSR 04-07-014, § 388-865-0566, filed 3/4/04, effective 4/4/04.]

388-865-0570 [see new WAC [388-877-1124](#)]

Rights related to antipsychotic medication.

All consumers have a right to make an informed decision regarding the use of antipsychotic medication consistent with the provisions of RCW [71.05.370](#)(7) and [71.05.215](#). The provider must develop and maintain a written protocol for the involuntary administration of antipsychotic medications, including the following requirements:

(1) The clinical record must document:

(a) The physician's attempt to obtain informed consent;

(b) The consumer was asked if he or she wishes to decline treatment during the twenty-four hour period prior to any court proceeding wherein the consumer has the right to attend and is related to his or her continued treatment. The answer must be in writing and signed when possible. In the case of a child under the age of eighteen, the physician must be able to explain to the court the probable effects of the medication.

(c) The reasons why any anti-psychotic medication is administered over the consumer's objection or lack of consent.

(2) The physician may administer anti-psychotic medications over a consumer's objections or lack of consent only when:

(a) An emergency exists, provided there is a review of this decision by a second physician within twenty-four hours. An emergency exists if:

(i) The consumer presents an imminent likelihood of serious harm to self or others;

(ii) Medically acceptable alternatives to administration of antipsychotic medications are not available or are unlikely to be successful; and

(iii) In the opinion of the physician, the consumer's condition constitutes an emergency requiring that treatment be instituted before obtaining an additional concurring opinion by a second physician.

(b) There is an additional concurring opinion by a second physician for treatment up to thirty days;

(c) For continued treatment beyond thirty days through the hearing on any one hundred eighty-day petition filed under RCW [71.05.370](#)(7), provided the facility medical director or director's medical designee reviews the decision to medicate a consumer.

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Thereafter, antipsychotic medication may be administered involuntarily only upon order of the court. The review must occur at least every sixty days.

(3) The examining physician must sign all one hundred eighty-day petitions for antipsychotic medications files under the authority of RCW [71.05.370](#)(7);

(4) Consumers committed for one hundred eighty days who refuse or lack the capacity to consent to antipsychotic medications have the right to a court hearing under RCW [71.05.370](#)(7) prior to the involuntary administration of antipsychotic medications;

(5) In an emergency, antipsychotic medications may be administered prior to the court hearing provided that an examining physician files a petition for an antipsychotic medication order the next judicial day;

(6) All involuntary medication orders must be consistent with the provisions of RCW [71.05.370](#) (7)(a) and (b), whether ordered by a physician or the court.

[Statutory Authority: RCW [71.05.560](#), [71.34.800](#), and chapters [71.05](#) and [71.34](#) RCW. WSR 04-07-014, § 388-865-0570, filed 3/4/04, effective 4/4/04.]

388-865-0575 [see new WAC 388-877-1128]

Special considerations for serving minor children.

Inpatient evaluation and treatment facilities serving minor children seventeen years of age and younger must develop and implement policies and procedures to address special considerations for serving children. These special considerations must include:

(1) Procedures to ensure that adults are separated from minors who are not yet thirteen years of age.

(2) Procedures to ensure that a minor who is at least age thirteen but not yet age eighteen is served with adults only if the minor's clinical record contains:

(a) Documentation that justifies such placement; and

(b) A professional judgment that placement in an inpatient evaluation and treatment facility that serves adults will not be harmful to the minor or to the adult.

(3) Procedures to ensure examination and evaluation of a minor by a children's mental health specialist occurs within twenty-four hours of admission.

(4) Procedures to ensure a facility that operates inpatient psychiatric beds for minors and is licensed by the department of health under chapter [71.12](#) RCW, meets the following notification requirements if a minor's parent(s) brings the child to the facility for the purpose of mental health treatment or evaluation. The facility must:

(a) Provide a written and verbal notice to the minor's parent(s) of:

(i) All current statutorily available treatment options available to the minor including, but not limited to, those provided in chapter [71.34](#) RCW; and

(ii) A description of the procedures the facility will follow to utilize the treatment options.

(b) Obtain and place in the clinical file, a signed acknowledgment from the minor's parent(s) that the notice required under (a) of this subsection was received.

(5) Procedures that address provisions for evaluating a minor brought to the facility for evaluation by a parent(s).

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(6) Procedures to notify child protective services any time the facility has reasonable cause to believe that abuse, neglect, financial exploitation or abandonment of a minor has occurred.

(7) Procedures to ensure a minor thirteen years or older who is brought to an inpatient evaluation and treatment facility or hospital for immediate mental health services is evaluated by the professional person in charge of the facility. The professional person must evaluate the minor's mental condition and determine a mental disorder, the need for inpatient treatment, and the minor's willingness to obtain voluntary treatment. The facility may detain or arrange for the detention of the minor up to twelve hours for evaluation by a designated mental health professional to commence detention proceedings.

(8) Procedures to ensure that the admission of a minor thirteen years of age or older admitted without parental consent has the concurrence of the professional person in charge of the facility and written review and documentation no less than every one hundred eighty days.

(9) Procedures to ensure that notice is provided to the parent(s) when a minor child is voluntarily admitted to inpatient treatment without parental consent within twenty-four hours of admission in accordance with the requirements of RCW [71.34.510](#).

(10) Procedures to ensure a minor who has been admitted on the basis of a designated mental health professional petition for detention is evaluated by the facility providing seventy-two hour evaluation and treatment to determine the minor's condition and either admit or release the minor. If the minor is not approved for admission, the facility must make recommendations and referral for further care and treatment as necessary.

(11) Procedures for the examination and evaluation of a minor approved for inpatient admission to include:

- (a) The needs to be served by placement in a chemical dependency facility;
- (b) Restricting the right to associate or communicate with a parent(s); and
- (c) Advising the minor of rights in accordance with chapter [71.34](#) RCW.

(12) Procedures to petition for fourteen-day commitment that are in accordance with RCW [71.34.730](#).

(13) Procedures for commitment hearing requirements and release from further inpatient treatment which may be subject to reasonable conditions, if appropriate, that are in accordance with RCW [71.34.740](#).

(14) Procedures for discharge and conditional release of a minor in accordance with RCW [71.34.770](#), provided that the professional person in charge gives the court written notice of the release within three days of the release. If the minor is on a one hundred eighty-day commitment, the children's long-term inpatient program (CLIP) administrator must also be notified.

(15) Procedures to ensure rights of a minor undergoing treatment and posting of such rights are in accordance with RCW [71.34.355](#), [71.34.620](#), and [71.34.370](#).

(16) Procedures for the release of a minor who is not accepted for admission or who is released by an inpatient evaluation and treatment facility that are in accordance with RCW [71.34.365](#).

(17) Procedures to ensure treatment of a minor and all information obtained through treatment under this chapter are disclosed only in accordance with RCW [71.34.340](#).

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(18) Procedures to make court records and files available that are in accordance with RCW [71.34.335](#).

Procedures to release mental health services information only in accordance with RCW [71.34.345](#) and other applicable state and federal statutes.

[Statutory Authority: RCW [71.05.560](#), [71.24.035](#), [71.34.375](#), [71.34.500](#), [71.34.510](#), [71.34.520](#), [71.34.610](#), [71.34.620](#), [71.34.630](#), [71.34.640](#), [71.34.650](#), [71.34.750](#), and 2011 c 302. WSR 12-21-133, § 388-865-0575, filed 10/24/12, effective 11/24/12. Statutory Authority: RCW [71.24.035](#), [71.05.560](#), and chapters [71.24](#) and [71.05](#) RCW. WSR 06-17-114, § 388-865-0575, filed 8/18/06, effective 9/18/06. Statutory Authority: RCW [71.05.560](#), [71.34.800](#), and chapters [71.05](#) and [71.34](#) RCW. WSR 04-07-014, § 388-865-0575, filed 3/4/04, effective 4/4/04.]

388-865-0576 [see new WAC 388-877-1130]

Minor children ages thirteen through seventeen—Admission, treatment, and discharge without parental consent—Evaluation and treatment facility.

(1) Under RCW [71.34.500](#), an evaluation and treatment facility may admit a minor child who is at least thirteen years of age and not older than seventeen years of age without the consent of the minor's parent(s) when:

(a) In the judgment of the professional person in charge of the facility, there is reason to believe that the minor is in need of inpatient treatment because of a mental disorder;

(b) The facility provides the type of evaluation and treatment needed by the minor;

(c) It is not feasible to treat the minor in a less restrictive setting or in the minor's home; and

(d) The minor gives written consent for the voluntary inpatient treatment.

(2) The evaluation and treatment facility must provide notice to the minor's parent(s) when the minor is voluntarily admitted. The notice must be in a form most likely to reach the minor's parent(s) within twenty-four hours of the minor's voluntary admission and advise the parent(s):

(a) That the minor has been admitted to inpatient treatment;

(b) Of the location and telephone number of the facility;

(c) Of the name of the professional staff member designated to provide the minor's treatment and discuss the minor's need for inpatient treatment; and

(d) Of the medical necessity for the minor's admission.

(3) The evaluation and treatment facility must:

(a) Review and document the minor's need for continued inpatient treatment at least every one hundred eighty days; and

(b) Obtain a renewal of the minor's written consent for the voluntary inpatient treatment at least every twelve calendar months.

(4) A minor admitted to an evaluation and treatment facility under RCW [71.34.500](#) may give notice of intent to leave at any time. The notice must be in writing, signed by the minor, and clearly state the minor intends to leave the facility.

(a) The facility staff member receiving the notice must:

(i) Immediately date it;

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(ii) Record its existence in the minor's clinical record; and

(iii) Send a copy to the:

(A) Minor's attorney, if the minor has one;

(B) County-designated mental health professional; and

(C) Minor's parent(s).

(b) The facility must ensure a facility professional staff member discharges the minor from the facility by the second judicial day following receipt of the minor's notice of intent to leave.

(5) The evaluation and treatment facility must obtain parental consent, or authorization from a person who may consent on behalf of the minor under RCW [7.70.065](#), before admitting a minor child twelve years of age or younger.

[Statutory Authority: RCW [71.05.560](#), [71.24.035](#), [71.34.375](#), [71.34.500](#), [71.34.510](#), [71.34.520](#), [71.34.610](#), [71.34.620](#), [71.34.630](#), [71.34.640](#), [71.34.650](#), [71.34.750](#), and 2011 c 302. WSR 12-21-133, § 388-865-0576, filed 10/24/12, effective 11/24/12.]

388-865-0578 *[see new WAC 388-877-1132]*

Minor children seventeen years of age and younger—Admission, evaluation, and treatment without the minor's consent—Evaluation and treatment facility.

(1) Under RCW [71.34.600](#), an evaluation and treatment facility may admit, evaluate, and treat a minor child seventeen years of age or younger without the consent of the minor if the minor's parent(s) brings the minor to the facility.

(2) The evaluation and treatment facility must ensure a trained professional person (defined in RCW [71.05.020](#)) evaluates the minor within twenty-four hours of the time the minor was brought to the facility.

(3) If the professional person determines the condition of the minor requires additional time for evaluation, the additional time must not be longer than seventy-two hours.

(4) If the evaluation and treatment facility holds the minor for treatment, the treatment must be limited to medically necessary treatment that the professional person has determined is needed to stabilize the minor's condition in order to complete the evaluation.

(5) The evaluation and treatment facility must:

(a) Notify the department within twenty-four hours of completing the minor's evaluation if the minor is held for inpatient treatment.

(b) Notify the minor being held for inpatient treatment of the right under RCW [71.34.620](#) to petition the superior court for release from the facility. The minor must be informed of this right before the department completes a review of the minor's admission and inpatient treatment (see subsection (7) of this section). If the minor is not released as a result of a petition for judicial review, the facility must release the minor no later than thirty days following the later of:

(i) The date of the department's determination under RCW [71.34.610](#); or

(ii) The date the petition is filed, unless a mental health professional initiates proceedings under Title [71](#) RCW.

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(6) The minor's clinical record must show documentation that the department and the minor were notified as required under (a) and (b) of this subsection.

(7) One of the following must occur when the department conducts a review under RCW [71.34.610](#).

(a) If the department determines it is no longer medically necessary for the minor to receive inpatient treatment, the department notifies the minor's parent(s) and the facility. The facility must release the minor to the minor's parent(s) within twenty-four hours of receiving notice from the department.

(b) If the professional person in charge of the facility and the minor's parent(s) believe that it is medically necessary for the minor to remain in inpatient treatment, the facility must release the minor to the parent(s) on the second judicial day following the department's determination in order to allow the parent(s) time to file an at-risk youth petition under chapter [13.21A](#) RCW.

(c) If the department determines it is medically necessary for the minor to receive outpatient treatment and if the minor declines to obtain such treatment, the refusal is grounds for the minor's parent(s) to file an at-risk youth petition under chapter [13.21A](#) RCW.

(8) The evaluation and treatment facility must not discharge a minor admitted under RCW [71.34.600](#) based solely on the minor's request.

[Statutory Authority: RCW [71.05.560](#), [71.24.035](#), [71.34.375](#), [71.34.500](#), [71.34.510](#), [71.34.520](#), [71.34.610](#), [71.34.620](#), [71.34.630](#), [71.34.640](#), [71.34.650](#), [71.34.750](#), and 2011 c 302. WSR 12-21-133, § 388-865-0578, filed 10/24/12, effective 11/24/12.]

388-865-0580 *[see new WAC 388-877-1138]*

Child long-term inpatient treatment facilities.

Child long-term inpatient treatment facilities must develop a written plan for assuring that services provided are appropriate to the developmental needs of children and youth, including:

(1) If there is not a child psychiatrist on the staff, there must be a child psychiatrist available for consultation.

(2) There must be a psychologist with documented evidence of skill and experience in working with children and youth available either on the clinical staff or by consultation, responsible for planning and reviewing psychological services and for developing a written set of guidelines for psychological services.

(3) There must be a registered nurse, with training and experience in working with psychiatrically impaired children and youth, on staff as a full-time or part-time employee who must be responsible for all nursing functions.

(4) There must be a social worker with experience in working with children and youth on staff as a full-time or part-time employee who must be responsible for social work functions and the integration of these functions into the individualized treatment plan.

(5) There must be an educational/vocational assessment of each resident with appropriate educational/vocational programs developed and implemented or assured on the basis of that assessment.

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(6) There must be an occupational therapist available who has experience in working with psychiatrically impaired children and youth responsible for occupational therapy functions and the integration of these functions into treatment.

(7) There must be a recreational therapist available who has had experience in working with psychiatrically impaired children and youth responsible for the recreational therapy functions and the integration of these functions into treatment.

(8) Disciplinary policies and practices must be stated in writing:

(a) Discipline must be fair, reasonable, consistent and related to the behavior of the resident. Discipline, when needed, must be consistent with the individualized treatment plan;

(b) Abusive, cruel, hazardous, frightening or humiliating disciplinary practices must not be used. Seclusion and restraints must not be used as punitive measures. Corporal punishment must not be used;

(c) Disciplinary measures must be documented in the medical record.

(9) Residents must be protected from assault, abuse and neglect. Suspected or alleged incidents of nonaccidental injury, sexual abuse, assault, cruelty or neglect to a child must be reported to a law enforcement agency or to the department of social and health services and comply with chapter [26.44](#) RCW.

(10) Orientation material must be made available to facility personnel, clinical staff and/or consultants informing practitioners of their reporting responsibilities and requirements. Appropriate local police and department phone numbers must be available to personnel and staff.

(11) When suspected or alleged abuse is reported, the medical record must reflect the fact that an oral or written report has been made to the child protective services of DSHS or to a law enforcement agency. This note must include the date and time that the report was made, the agency to which it was made and the signature of the person making the report. Contents of the report need not be included in the medical record.

[Statutory Authority: RCW [71.05.560](#), [71.34.800](#), and chapters [71.05](#) and [71.34](#) RCW. WSR 04-07-014, § 388-865-0580, filed 3/4/04, effective 4/4/04.]

388-865-0585 *[this is repealed –see RCW 71.25.040]*

Petition for the right to possess a firearm.

An adult is entitled to the restoration of the right to firearm possession when he or she no longer requires treatment or medication for a condition related to the involuntary commitment. This is described in RCW [9.41.047](#) (3)(a).

(1) an adult who wants his or her right to possess a firearm restored may petition the court that ordered involuntary treatment or the superior court of the county in which he or she lives for a restoration of the right to possess firearms. At a minimum, the petition must include:

(a) The fact, date, and place of involuntary treatment;

(b) The fact, date, and release from involuntary treatment;

(c) A certified copy of the most recent order of commitment with the findings and conclusions of law.

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(2) The person must show the court that he/she no longer requires treatment or medication for the condition related to the commitment.

(3) If the court requests relevant information about the commitment or release to make a decision, the mental health professionals who participated in the evaluation and treatment must give the court that information.

[Statutory Authority: RCW [71.05.560](#), [71.34.800](#), and chapters [71.05](#) and [71.34](#) RCW. WSR 04-07-014, § 388-865-0585, filed 3/4/04, effective 4/4/04.]

388-865-0600

Purpose.

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

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

388-865-0610

Definitions.

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

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

(a) Records and reports of inpatient treatment:

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

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

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

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

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

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

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

(b) Records and reports of outpatient treatment:

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

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

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

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

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

(c) Records and reports regarding providers and medications:

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

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

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

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

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

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

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

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

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

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

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

(i) Legal documents pertaining to chapter 71.05 RCW;

(ii) Legal documents pertaining to chapter 71.34 RCW;

(iii) Legal documents containing court findings pertaining to chapter 10.77 RCW;

(iv) Legal documents regarding guardianship of the person;

(v) Legal documents regarding durable power of attorney;

(vi) Legal or official documents regarding a protective payee;

(vii) Mental health advance directive.

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

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

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388-865-0620

Scope.

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

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

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

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

388-865-0630

Time frame.

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

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

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

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

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

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

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

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

388-865-0640

Written requests.

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

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

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

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

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

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

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

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

388-865-0700 [see new WAC 388-877-0730]

Clubhouse certification.

The mental health division certifies clubhouses under the provision of RCW [71.24.035](#). International center for clubhouse development certification is not a substitute for certification by the state of Washington.

[Statutory Authority: RCW [71.24.025](#), [71.24.035](#), and 2007 c 414. WSR 08-14-080, § 388-865-0700, filed 6/26/08, effective 7/27/08.]

388-865-0705 [see new WAC 388-877-0200]

Definitions.

The following definitions apply to clubhouse certification rules:

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"Absentee coverage" - The clubhouse provides a temporary replacement for the clubhouse member who is currently employed in a time-limited, part-time community job managed by the clubhouse.

"Certification" - Official acknowledgement from the mental health division that an organization meets all state standards to operate as a clubhouse, and demonstrates that those standards have been implemented.

"Clubhouse" - A community-based, recovery-focused program designed to support individuals living with the effects of mental illness, through employment, shared contributions, and relationship building. A clubhouse operates under the fundamental principle that everyone has the potential to make productive contributions by focusing on the strengths, talents, and abilities of all members and fostering a sense of community and partnership.

"Recovery" - The process in which people are able to live, work, learn, and participate fully in their communities (RCW [71.24.025](#)).

"Work-ordered day" - A model used to organize clubhouse activities during the clubhouse's normal working hours. Members and staff are organized into one or more work units which provide meaningful and engaging work essential to running the clubhouse. Activities include unit meetings, planning, organizing the work of the day, and performing the work that needs to be accomplished to keep the clubhouse functioning. Members and staff work side-by-side as colleagues. Members participate as they feel ready and according to their individual interests. While intended to provide members with working experience, work in the clubhouse is not intended to be job-specific training, and members are neither paid for clubhouse work nor provided artificial rewards. Work-ordered day does not include medication clinics, day treatment, or other therapy programs.

[Statutory Authority: RCW [71.24.025](#), [71.24.035](#), and 2007 c 414. WSR 08-14-080, § 388-865-0705, filed 6/26/08, effective 7/27/08.]

388-865-0710 *[see new WAC 388-877-0730]*

Required clubhouse components.

Required clubhouse components include all of the following:

(1) Voluntary member participation. Clubhouse members choose the way they use the clubhouse and the staff with whom they work. There are no agreements, contracts, schedules, or rules intended to enforce participation of members. All member participation is voluntary. Clubhouse policy and procedures must describe how members will have the opportunity to participate, based on their preferences, in the clubhouse.

(2) The work-ordered day.

(3) Activities, including:

(a) Personal advocacy;

(b) Help with securing entitlements;

(c) Information on safe, appropriate, and affordable housing;

(d) Information related to accessing medical, psychological, pharmacological and substance abuse services in the community;

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- (e) Outreach to members during periods of absence from the clubhouse and maintaining contact during periods of inpatient treatment;
- (f) In-house educational programs that use the teaching and tutoring skills of members;
- (g) Connecting members with adult education opportunities in the community;
- (h) An active employment program that assists members to gain and maintain employment in:
 - (i) Full- or part-time competitive jobs in integrated settings developed in partnership with the member, the clubhouse, and the employer; and
 - (ii) Time-limited, part-time community jobs managed by the clubhouse with absentee coverage provided.
- (i) An array of social and recreational opportunities.
- (4) Operating at least thirty hours per week on a schedule that accommodates the needs of the members.

[Statutory Authority: RCW [71.24.025](#), [71.24.035](#), and 2007 c 414. WSR 08-14-080, § 388-865-0710, filed 6/26/08, effective 7/27/08.]

388-865-0715 [see new WAC 388-877-0732]

Management and operational requirements.

The requirements for managing and operating a clubhouse include all of the following:

- (1) Members, staff, and ultimately the clubhouse director, are responsible for the operation of the clubhouse. The director must ensure opportunities for members and staff to be included in all aspects of clubhouse operation, including setting the direction of the clubhouse.
- (2) Location in an area, when possible, where there is access to local transportation and, when access to public transportation is limited, facilitate alternatives.
- (3) A distinct identity, including its own name, mailing address, and phone number.
- (4) A separate entrance and appropriate signage that make the clubhouse clearly distinct, when co-located with another community agency.
- (5) An independent board of directors capable of fulfilling the responsibilities of a not-for-profit board of directors, when free-standing.
- (6) An administrative structure with sufficient authority to protect the autonomy and integrity of the clubhouse, when under the auspice of another agency.
- (7) Services are timely, appropriate, accessible, and sensitive to all members.
- (8) Members are not discriminated against on the basis of any status or individual characteristic that is protected by federal, state, or local law.
- (9) Written proof of a current fire/safety inspection:
 - (a) Conducted of all premises owned, leased or rented by the clubhouse; and
 - (b) Performed by all required external authorities (e.g., State Fire Marshall, liability insurance carrier).
- (10) All applicable state, county, and city business licenses.
- (11) All required and current general liability, board and officers liability, and vehicle insurance.

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(12) An identifiable clubhouse budget that includes:

- (a) Tracking all income and expenditures for the clubhouse by revenue source;
- (b) Quarterly reconciliation of accounts; and
- (c) Compliance with all generally accepted accounting principles.

(13) Track member participation and daily attendance.

(14) Assist member in developing, documenting, and maintaining the member's recovery goals and providing monthly documentation of progress toward reaching them.

- (a) Both member and staff must sign all such plans and documentation; or
- (b) If a member does not sign, staff must document the reason.

(15) A mechanism to identify and implement needed changes to the clubhouse operations, performance, and administration, and to document the involvement of members in all aspects of the operation of the clubhouse.

(16) Evaluate staff performance by:

(a) Ensuring that paid employees:

- (i) Are qualified for the position they hold, including any licenses or certifications; and
- (ii) Have the education, experience and/or skills to perform the job requirements.

(b) Maintaining documentation that paid clubhouse staff:

- (i) Have a completed Washington state patrol background check on file; and
- (ii) Receive regular supervision and an annual performance evaluation.

[Statutory Authority: RCW [71.24.025](#), [71.24.035](#), and 2007 c 414. WSR 08-14-080, § 388-865-0715, filed 6/26/08, effective 7/27/08.]

388-865-0720 *[see new WAC 388-877-0734]*

Certification process.

The mental health division (MHD) grants certification based on compliance with the minimum standards set forth in this chapter.

(1) To be certified to provide clubhouse services, an organization must comply with the following:

(a) Meet all requirements for applicable city, county and state licenses and inspections.

(b) Complete and submit an application for certification to MHD.

(c) Successfully complete an on-site certification review by MHD to determine compliance with the minimum clubhouse standards, as set forth in this chapter.

(d) Initial applicants that can show that they have all organizational structures and written policies in place, but lack the performance history to demonstrate that they meet minimum standards, may be granted initial certification for up to one year. Successful completion of an on-site certification review is required prior to the expiration of initial certification.

(2) Upon certification, clubhouses will undergo periodic on-site certification reviews.

(a) The frequency of certification reviews is determined by the on-site review score as follows:

(i) A compliance score of ninety percent or above results in the next certification review occurring in three years;

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(ii) A compliance score of eighty percent to eighty-nine percent results in the next certification review occurring in two years;

(iii) A compliance score of seventy percent to seventy-nine percent results in the next certification review occurring in one year; or

(iv) A compliance score below seventy percent results in a probationary certification.

(b) Any facet of an on-site review resulting in a compliance score below ninety percent requires a corrective action plan approved by MHD.

(3) Probationary certification may be issued by MHD if:

(a) A clubhouse fails to conform to applicable law, rules, regulations, or state minimum standards; or

(b) There is imminent risk to consumer health and safety;

(4) MHD may suspend or revoke a clubhouse's certification, or refuse to grant or renew a clubhouse's certification if a clubhouse fails to correct deficiencies as mutually agreed to in the corrective action plan with MHD.

(5) A clubhouse may appeal a certification decision by MHD.

(a) To appeal a decision, the clubhouse must submit a written application asking for an administrative hearing. An application must be submitted through a method that shows written proof of receipt to: Office of Administrative Hearings, P.O. Box 42489, Olympia, WA 98504-2489. An application must be received within twenty-eight calendar days of the date of the contested decision, and must include:

(i) The issue to be reviewed and the date the decision was made;

(ii) A specific statement of the issue and regulation involved;

(iii) The grounds for contesting the decision;

(iv) A copy of MHD's decision that is being contested; and

(v) The name, signature, and address of the clubhouse director.

(b) The hearing decision will be made according to the provisions of chapter [34.05](#) RCW and chapter [388-02](#) WAC.

[Statutory Authority: RCW [71.24.025](#), [71.24.035](#), and 2007 c 414. WSR 08-14-080, § 388-865-0720, filed 6/26/08, effective 7/27/08.]

388-865-0725 *[see new WAC 388-877-0736]*

Employment-related services—Requirements.

The following employment support activities must be offered to clubhouse members:

(1) Collaboration on creating, revising, and meeting individualized job and career goals.

(2) Information about how employment will affect income and benefits.

(3) Information on other rehabilitation and employment services, including but not limited to:

(a) The division of vocational rehabilitation;

(b) The state employment services;

(c) The business community;

(d) Job placement services within the community; and

(e) Community mental health agency-sponsored supported employment services.

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(4) Assistance in locating employment opportunities which are consistent with the member's skills, goals, and interests.

(5) Assistance in developing a resume, conducting a job search, and interviewing.

(6) Assistance in:

(a) Applying for school and financial aid; and

(b) Tutoring and completing course work.

(7) Information regarding protections against employment discrimination provided by federal, state, and local laws and regulations, and assistance with asserting these rights, including securing professional advocacy.

[Statutory Authority: RCW [71.24.025](#), [71.24.035](#), and 2007 c 414. WSR 08-14-080, § 388-865-0725, filed 6/26/08, effective 7/27/08.]

388-865-0750 [see new WAC 388-877-1140]

Crisis stabilization unit certification.

(1) To obtain and maintain certification as a crisis stabilization unit (defined in RCW [71.05.020](#)) under chapter [71.05](#) RCW, a facility must:

(a) Be licensed by the department of health;

(b) Ensure that the unit and its services are accessible to all persons, pursuant to federal, state, and local laws; and

(c) Successfully complete a provisional and annual on-site review by the mental health division to determine facility compliance with the minimum standards of this section and chapter [71.05](#) RCW.

(2) If a crisis stabilization unit is part of a jail, the unit must be located in an area of the building that is physically separate from the general population. "Physically separate" means:

(a) Out of sight and sound of the general population at all times;

(b) Located in an area with no foot traffic between other areas of the building, except in the case of emergency evacuation; and

(c) Has a secured entrance and exit between the unit and the rest of the facility.

[Statutory Authority: RCW [71.05.020](#), [71.24.035](#), and 2007 c 375. WSR 08-14-079, § 388-865-0750, filed 6/26/08, effective 7/27/08.]

388-865-0755 [see new WAC 388-877-1140]

Standards for administration—Crisis stabilization units.

A crisis stabilization unit must ensure that the following standards for administration are met:

(1) A description of the program, including age of persons to be served, length of stay, and services to be provided.

(2) An organizational structure that demonstrates clear lines of authority for administrative oversight and clinical supervision.

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(3) The professional person in charge of administration of the unit is a mental health professional.

(4) A management plan to monitor, collect data and develop improvements to meet the requirements of this chapter.

(5) A policy management structure that establishes:

(a) Procedures for maintaining and protecting personal medical/clinical records consistent with chapter [70.02](#) RCW, "Medical records—Health care information access and disclosure," and the Health Insurance Portability and Accountability Act (HIPAA).

(b) Procedures for managing human resources to ensure that persons receive individualized evaluation and crisis stabilization services by adequate numbers of staff who are qualified and competent to carry out their assigned responsibilities.

(c) Procedures for ensuring a secure environment appropriate to the legal status of the person(s), and necessary to protect the public safety. "Secure" means having:

(i) All doors and windows leading to the outside locked at all times;

(ii) Visual monitoring, either by line-of-sight or camera as appropriate to the individual;

(iii) Adequate space to segregate violent or potentially violent persons from others;

(iv) The means to contact law enforcement immediately in the event of an elopement from the facility; and

(v) Adequate numbers of staff present at all times that are trained in facility security measures.

(d) Procedures for admitting persons needing crisis stabilization services seven days a week, twenty-four hours a day.

(e) Procedures to ensure that for persons who have been brought to the unit involuntarily by police, the stay is limited to twelve hours unless the individual has signed voluntarily into treatment.

(f) Procedures to ensure that within twelve hours of the time of arrival to the crisis stabilization unit, individuals who have been detained by a designated mental health professional or designated crisis responder under chapter [71.05](#) or [70.96B](#) RCW are transferred to a certified evaluation and treatment facility.

(g) Procedures to assure appropriate and safe transportation of persons who are not approved for admission or detained for transfer to an evaluation and treatment facility, and if not in police custody, to their respective residence or other appropriate place.

(h) Procedures to detain arrested persons who are not approved for admission for up to eight hours so that reasonable attempts can be made to notify law enforcement to return to the facility and take the person back into custody.

(i) Procedures to ensure access to emergency life-sustaining treatment, necessary medical treatment, and medication.

(j) Procedures to ensure the protection of personal and familial rights as described in WAC [388-865-0561](#) and chapter [71.05](#) RCW.

(k) Procedures to inventory and safeguard the personal property of the persons being detained.

(l) Procedures to ensure that a mental health professional (as defined in chapter [388-865](#) WAC) is on-site twenty-four hours a day, seven days a week.

(m) Procedures to ensure that a licensed physician is available for consultation to direct care staff and patients twenty-four hours a day, seven days a week.

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(n) Procedures to provide warning to an identified individual and law enforcement when an individual has made a threat against an identified victim, in accordance with RCW [71.05.390](#)(10).

(o) Procedures to ensure the rights of persons to make mental health advance directives.

(p) Procedures to establish unit protocols for responding to the provisions of the advanced directives consistent with RCW [71.32.150](#).

(q) Procedures to ensure that the following requirements are met when an individual is brought to the facility by a peace officer under RCW [71.05.153](#):

(i) The individual must be examined by a mental health professional (MHP) within three hours of arrival;

(ii) Within twelve hours of arrival, a designated mental health professional (DMHP) must determine if the individual meets detention criteria under chapter [71.05](#) RCW; and

(iii) If the facility releases the individual to the community, the facility must inform the peace officer of the release within a reasonable period of time after the release if the peace officer has specifically requested notification and has provided contact information to the facility.

[Statutory Authority: RCW [10.31.110](#), [71.05.153](#), [71.05.190](#), chapter [74.09](#) RCW, and 2011 c 305. WSR 12-19-038, § 388-865-0755, filed 9/12/12, effective 10/13/12. Statutory Authority: RCW [71.05.020](#), [71.24.035](#), and 2007 c 375. WSR 08-14-079, § 388-865-0755, filed 6/26/08, effective 7/27/08.]

388-865-0760 [see new WAC [388-877-1142](#)]

Admission and intake evaluation.

(1) For persons who have been brought to the unit involuntarily by police:

(a) The clinical record must contain:

(i) A statement of the circumstances under which the person was brought to the unit;

(ii) The admission date and time; and

(iii) The date and time when the twelve hour involuntary detention period ends.

(b) The evaluation required in subsection (2)(c) of this section must be performed within three hours of arrival at the facility.

(2) The facility must document that each person has received timely evaluations to determine the nature of the disorder and the services necessary, including at a minimum:

(a) A health screening by an authorized health care provider as defined in WAC [246-337-005](#)(22) to determine the health care needs of a person.

(b) An assessment for chemical dependency and/or a co-occurring mental health and substance abuse disorder, utilizing the global appraisal of individual needs - Short screener (GAIN-SS) or its successor.

(c) An evaluation by a mental health professional to include at a minimum:

(i) Mental status examination;

(ii) Assessment of risk of harm to self, others, or property;

(iii) Determination of whether to refer to a designated mental health professional (DMHP) or designated crisis responder (DCR) to initiate civil commitment proceedings.

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(d) Documentation that an evaluation by a DMHP/DCR was performed within the required time period, the results of the evaluation, and the disposition of the person.

(e) Review of the person's current crisis plan, if applicable and available.

(f) The admission diagnosis and what information the determination was based upon.

(3) If the mental health professional determines that the needs of a person would be better served by placement in a chemical dependency treatment facility then the person must be referred to an approved treatment program defined under chapter [70.96A](#) RCW.

[Statutory Authority: RCW [71.05.020](#), [71.24.035](#), and 2007 c 375. WSR 08-14-079, § 388-865-0760, filed 6/26/08, effective 7/27/08.]

388-865-0765 [see new WAC 388-877-1140]

Use of seclusion and restraint procedures within the crisis stabilization unit.

(1) Persons have the right to be free from seclusion and restraint, including chemical restraint within the crisis stabilization unit.

(2) The use of restraints or seclusion must occur only when there is imminent danger to self or others and less restrictive measures have been determined to be ineffective to protect the person or others from harm. The reasons for the determination must be clearly documented in the clinical record.

(3) The crisis stabilization unit must develop policies and procedures to assure that restraint and seclusion are utilized only to the extent necessary to ensure the safety of patients and others, and in accordance with WAC [246-337-110](#), [246-322-180](#), [246-320-745](#)(6), and [388-865-0545](#).

[Statutory Authority: RCW [71.05.020](#), [71.24.035](#), and 2007 c 375. WSR 08-14-079, § 388-865-0765, filed 6/26/08, effective 7/27/08.]

388-865-0770 [see new WAC 388-877-1142]

Assessment and stabilization services—Documentation requirements.

(1) For all persons admitted to the crisis stabilization unit, the clinical record must contain documentation of:

(a) Assessment and stabilization services provided by the appropriate staff;

(b) Coordination with the person's current treatment provider, if applicable;

(c) A plan for discharge, including a plan for follow up that includes:

(i) The name, address, and telephone number of the provider of follow-up services;

and

(ii) The follow up appointment date and time, if known.

(2) For persons admitted to the crisis stabilization unit on a voluntary basis, a crisis stabilization plan developed collaboratively with the person within twenty-four hours of admission that includes:

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(a) Strategies and interventions to resolve the crisis in the least restrictive manner possible;

(b) Language that is understandable to the person and/or members of the person's support system; and

(c) Measurable goals for progress toward resolving the crisis and returning to an optimal level of functioning.

[Statutory Authority: RCW [71.05.020](#), [71.24.035](#), and 2007 c 375. WSR 08-14-079, § 388-865-0770, filed 6/26/08, effective 7/27/08.]

388-865-0775 [see new WAC [388-877-0500](#), [388-877-0515](#)]

Qualification requirements for staff.

The provider is responsible to ensure that staff and clinical supervisors are qualified for the positions they hold at the crisis stabilization unit.

(1) The provider must document that all staff have:

(a) A current job description.

(b) A current Washington state department of health license or registration as may be required for his/her position.

(c) Washington state patrol background checks for employees in contact with persons consistent with RCW [43.43.830](#).

(d) An annual performance evaluation.

(e) An individualized annual training plan, to include at minimum:

(i) The skills he or she needs for his/her job description and the population served;

(ii) Training regarding the least restrictive alternative options available in the community and how to access them;

(iii) Methods of person care;

(iv) Management of assaultive and self-destructive behaviors, including proper and safe use of seclusion and/or restraint procedures;

(v) Methods to ensure appropriate security of the facility; and

(vi) Requirements of chapters [71.05](#) and [71.34](#) RCW, this chapter, and protocols developed by the mental health division.

(vii) If contract staff is providing direct services, the facility must ensure compliance with the training requirements outlined in subsection (1)(i) through (vii) in this section.

(2) Clinical supervisors must meet the qualifications of mental health professionals as defined in WAC [388-865-0150](#).

[Statutory Authority: RCW [71.05.020](#), [71.24.035](#), and 2007 c 375. WSR 08-14-079, § 388-865-0775, filed 6/26/08, effective 7/27/08.]

388-865-0780 [see new WAC [388-877-1122](#)]

Posting of rights.

The rights outlined in WAC [388-865-0561](#) must be prominently posted within the crisis stabilization unit and provided in writing to the person.

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[Statutory Authority: RCW [71.05.020](#), [71.24.035](#), and 2007 c 375. WSR 08-14-079, § 388-865-0780, filed 6/26/08, effective 7/27/08.]

388-865-0785 [see new WAC 388-877-1124]

Rights related to antipsychotic medications.

All persons have a right to make an informed decision regarding the use of antipsychotic medication consistent with the provisions of RCW [71.05.215](#) and [71.05.217](#). The crisis stabilization unit must develop and maintain a written protocol for the involuntary administration of antipsychotic medications, including the following requirements:

- (1) The clinical record must document:
 - (a) The physician's attempt to obtain informed consent for antipsychotic medication;
 - (b) The reasons why any antipsychotic medication is administered over the person's objection or lack of consent.
- (2) The physician may administer antipsychotic medications over a person's objections or lack of consent only when:
 - (a) An emergency exists. An emergency exists if:
 - (i) The person presents an imminent likelihood of serious harm to self or others;
 - (ii) Medically acceptable alternatives to administration of antipsychotic medications are not available or are unlikely to be successful; and
 - (iii) In the opinion of the physician, the person's condition constitutes an emergency requiring that treatment be instituted before obtaining a concurring opinion by a second physician.
 - (b) There is a concurring opinion by a second physician for treatment up to thirty days.

[Statutory Authority: RCW [71.05.020](#), [71.24.035](#), and 2007 c 375. WSR 08-14-079, § 388-865-0785, filed 6/26/08, effective 7/27/08.]

388-865-0800 [see new WAC 388-877-0200]

Triage facility—Definitions.

The following definitions apply to this chapter:

"Designated mental health professional (DMHP)" See WAC [388-865-0150](#).

"Mental health professional (MHP)" See WAC [388-865-0150](#).

"Peace officer" means a law enforcement official of a public agency or governmental unit, and includes persons specifically given peace officer powers by any state law, local ordinance, or judicial order of appointment.

"Triage facility" is a short-term facility or a portion of a facility licensed by the department of health and certified by the department of social and health services under RCW [71.24.035](#), which is designed as a facility to assess and stabilize an individual or determine the need for involuntary commitment of an individual. A triage facility must

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meet department of health residential treatment facility standards and may be structured as a voluntary and/or involuntary placement facility.

"Triage involuntary placement facility" is a triage facility that has elected to operate as an involuntary facility and may, at the direction of a peace officer, hold an individual for up to twelve hours. A peace officer or designated mental health professional may take or cause the person to be taken into custody and immediately delivered to the triage facility. The facility may ask for an involuntarily admitted individual to be assessed by a mental health professional for potential for voluntary admission. The individual has to agree in writing to the conditions of the voluntary admission.

"Triage voluntary placement facility" is a triage facility wherein the individual may elect to leave the facility of their own accord, at anytime. A triage voluntary placement facility may only accept voluntary admissions.

"Short-term facility" is a facility licensed by the department of health and certified by the department of social and health services under RCW [71.24.035](#) which has been designed to assess, diagnose, and treat individuals experiencing an acute crisis without the use of long-term hospitalization. Length of stay in a short-term facility is less than fourteen days from the day of admission.

[Statutory Authority: RCW [71.05.020](#), [71.05.150](#), [71.05.153](#), [71.24.035](#), and 2011 c 148. WSR 12-19-039, § 388-865-0800, filed 9/12/12, effective 10/13/12.]

388-865-0810 *[see new WAC 388-877-1144]*

Triage facility—General requirements for certification.

Under chapter [71.05](#) RCW, the department certifies facilities to provide triage services that assess and stabilize an individual, or determine the need for involuntary commitment. The department does not require a facility licensed by the department of health (DOH) that was providing assessment and stabilization services under chapter [71.05](#) RCW as of April, 22, 2011, to relicense or recertify under these rules. A request for an exemption must be made to DOH and the department.

(1) To obtain and maintain certification as a triage facility (defined in WAC [388-865-0800](#)), a facility must:

- (a) Be licensed by the department of health (DOH) as a residential treatment facility;
- (b) Meet the requirements for voluntary admissions under this chapter;
- (c) Meet the requirements for involuntary admissions under this chapter if it elects to operate and be certified as a triage involuntary placement facility;
- (d) Ensure that the facility and its services are accessible to individuals with disabilities, as required by applicable federal, state, and local laws;
- (e) Admit only individuals who are eighteen years of age and older; and
- (f) Successfully complete a provisional and annual on-site review administered by the department's division of behavioral health and recovery (DBHR) and be determined by DBHR to be in compliance with the standards of this chapter and chapter [72.06](#) RCW.

(2) If a triage facility is collocated in another facility, there must be a physical separation. Physically separate means the triage facility is located in an area with no

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resident foot traffic between the triage facility and other areas of the building, except in case of emergencies.

(3) A triage facility must have, at a minimum:

(a) A written organizational structure that describes clear lines of authority of administrative oversight and clinical supervision.

(b) A designated person in charge of administration of the triage unit.

(c) A mental health professional (MHP) on-site twenty-four hours a day, seven days a week.

(d) A written program description that includes:

(i) Program goals;

(ii) Identification of service categories to be provided;

(iii) Length of stay criteria;

(iv) Identification of the ages or range of ages of individual populations to be served;

(v) A statement that only an individual eighteen years of age or older may be admitted to the triage facility; and

(vi) Any limitation or inability to serve or provide program services to an individual who:

(A) Requires acute medical services;

(B) Has limited mobility;

(C) Has limited physical capacity for self care; or

(D) Exhibits physical violence.

(e) A quality management plan to ensure the facility monitors, collects appropriate data, and develops improvements to meet the requirements of this chapter.

(f) Written procedures to ensure a secure and safe environment. Examples of these procedures are:

(i) Visual monitoring of the population environment by line of sight, mirrors or electronic means;

(ii) Having sufficient staff available twenty-four hours a day, seven days a week to meet the behavioral management needs of the current facility population; and

(iii) Having staff trained in facility security and behavioral management techniques.

(g) Written procedures to ensure that an individual is examined by an MHP within three hours of the individual's arrival at the facility.

(h) Written procedures to ensure that a designated mental health professional (DMHP) evaluates a voluntarily admitted individual for involuntary commitment when the individual's behavior warrants an evaluation.

(i) Written procedures that are in accordance with WAC [246-322-180](#), [246-337-110](#), [246-320-271](#), and [388-865-0545](#), if the triage facility declares any intent to provide seclusion and/or restraint.

(j) Written procedures to facilitate appropriate and safe transportation, if necessary, for an individual who is:

(i) Not being held for police custody and/or police pick up;

(ii) Denied admission to the triage facility; or

(iii) Detained for transfer to a certified evaluation and treatment facility.

[Statutory Authority: RCW [71.05.020](#), [71.05.150](#), [71.05.153](#), [71.24.035](#), and 2011 c 148. WSR 12-19-039, § 388-865-0810, filed 9/12/12, effective 10/13/12.]

388-865-0820 [see new WAC 388-877-1152]

Triage facility—Memo of understanding and other requirements.

This section applies to a facility that elects to operate as a triage involuntary placement facility.

(1) Memo of understanding requirements. The facility must have a memo of understanding developed in consultation with local law enforcement agencies, which details the population that the facility has capacity to serve. The memo of understanding must include, at a minimum, a description of the facility's:

(a) Capacity to serve individuals with medication, medical and/or accommodation needs;

(b) Capacity to serve individuals with behavioral management needs;

(c) Ability to provide seclusion and/or restraint to individuals (see WAC [388-865-0830](#));

(d) Notification procedures for discharge of individuals (see WAC [388-865-0850](#)); and

(e) Procedures for notifying the appropriate law enforcement agency of an individual's release, transfer, or hold for up to twelve hours to allow the peace officer to reclaim the individual.

(2) Individuals brought to a triage involuntary placement facility by a peace officer. The facility must have written procedures to assure the following:

(a) An individual detained by the designated mental health professional (DMHP) under chapter [71.05](#) RCW with a confirmed admission date to an evaluation and treatment facility, may remain at the triage facility until admitted to the evaluation and treatment facility.

(i) The individual may not be detained to the triage facility; and

(ii) An individual who agrees to a voluntary stay must provide a signature that documents the agreement.

(b) The individual is examined by a mental health professional (MHP) within three hours of the individual's arrival at the facility, and the examination includes an assessment to determine if a designated mental health professional (DMHP) evaluation is also required.

(c) If it is determined a DMHP evaluation is required, the DMHP must evaluate the individual within twelve hours of arrival. The DMHP determines whether the individual:

(i) Meets detention criteria under chapter [71.05](#) RCW; or

(ii) Agrees to accept voluntary admission. The individual must provide a signature agreeing to voluntary treatment.

(3) Individuals involuntarily admitted to a triage involuntary placement facility based on a peace officer-initiated twelve-hour hold. The facility must ensure each involuntarily admitted individual's clinical record:

(a) Documents the date and time the individual arrived at the facility and the date and time the examination by the mental health professional (MHP) occurred. The examination must occur within three hours of the individual's arrival to the facility (see WAC [388-865-0840\(2\)](#)).

(b) Documents the peace officer's:

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- (i) Determination for cause to have the individual transported to the facility;
 - (ii) Request to be notified if the individual leaves the facility and how the peace officer is to be contacted, or documentation of other person(s) permitted to be contacted, such as the shift supervisor of the law enforcement agency or dispatcher; and
 - (iii) Request that the individual be held for the duration of the twelve hours to allow the peace officer sufficient time to return and make a determination as to whether or not to take the individual into custody.
- (c) Contains a copy of the evaluation if the individual is determined by a designated mental health professional (DMHP) to meet detention criteria under chapter [71.05](#) RCW.

[Statutory Authority: RCW [71.05.020](#), [71.05.150](#), [71.05.153](#), [71.24.035](#), and 2011 c 148. WSR 12-19-039, § 388-865-0820, filed 9/12/12, effective 10/13/12.]

388-865-0830 *[see new WAC 388-877-1144]*

Triage facility—Seclusion and restraint.

A triage facility must declare to the department any intention to provide seclusion and/or restraint (see WAC [388-865-0810](#) (3)(i)).

- (1) The seclusion and/or restraint may only be used:
 - (a) To the extent necessary for the safety of the individual or others and in accordance with WAC [246-322-180](#) and [246-337-110](#), [246-320-271](#), and [388-865-0545](#); and
 - (b) When all less restrictive measures have failed.
- (2) The facility must clearly document in the clinical record:
 - (a) The threat of imminent danger;
 - (b) All less restrictive measures that were tried and found to be ineffective; and
 - (c) A summary of each seclusion and/or restraint event, including a debriefing with staff members and the individual regarding how to prevent the occurrence of similar incidents in the future.

[Statutory Authority: RCW [71.05.020](#), [71.05.150](#), [71.05.153](#), [71.24.035](#), and 2011 c 148. WSR 12-19-039, § 388-865-0830, filed 9/12/12, effective 10/13/12.]

388-865-0840 *[see new WAC 388-877-1146]*

Triage facility—Admission, assessment, and clinical record requirements for voluntary and involuntary admissions.

A triage facility must ensure the requirements in this section are met for each voluntary and involuntary admission. See WAC [388-865-0820](#)(2) for additional requirements for an individual brought to a triage involuntary placement facility by a peace officer. See WAC [388-865-0820](#)(3) for additional requirements for an individual involuntarily admitted to a triage involuntary placement facility based on a peace officer-initiated twelve-hour hold.

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(1) Each individual must be assessed for chemical dependency and/or a cooccurring mental health and substance abuse disorder as measured by the global appraisal on individual need-short screen (GAIN-SS) as it existed on the effective date of this section, or such subsequent date consistent with the purposes of this section. The clinical record must contain the results of the assessment.

(2) Each individual must be assessed by a mental health professional (MHP) within three hours of the individual's arrival at the facility.

(a) The assessment must include, at a minimum:

- (i) A brief history of mental health or substance abuse treatment; and
- (ii) An assessment of risk of harm to self, others, or grave disability.

(b) The MHP must request:

- (i) The names of treatment providers and the treatment provided; and
- (ii) Emergency contact information.

(c) The MHP must document in the individual's clinical record:

- (i) All the information obtained in (a) and (b) of this subsection.
- (ii) Sufficient information to demonstrate medical necessity. Medical necessity is defined in the state plan as "A term for describing a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions in the recipient that endanger life, or cause suffering or pain, or result in illness or infirmity, or threaten to cause or aggravate a handicap, or cause of physical deformity or malfunction, and there is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the person requesting service. For the purpose of this chapter "course of treatment" may include mere observation, or where appropriate, no treatment at all."

(iii) Sufficient clinical information to justify a provisional diagnosis using criteria in the:

(A) Diagnostic and Statistical Manual of Mental Disorders (2000) (American Psychiatric Association (DSM-IV-TR), 2000), as it existed on the effective date of this section; then

(B) DSM-5 as it exists when published and released in 2013, consistent with the purposes of this section. Information regarding the publication date and release of the DSM-5 is posted on the American Psychiatric Association's public web site at www.DSM5.org.

(3) Each individual must receive a health care screening to determine the individual's health care needs.

(a) The health care screening instrument must be provided by a licensed health care provider (defined in WAC [246-337-005\(22\)](#)). A licensed health care provider must be available to staff for staff consultation twenty-four hours a day, seven days a week.

(b) The individual's clinical record must contain the results of the health care screening.

(4) A qualified staff member (see WAC [388-865-0870](#)) must coordinate with the individual's current treatment provider, if applicable, to assure continuity of care during admission and upon discharge.

(5) Each individual's clinical record must:

(a) Contain a statement regarding the individual circumstances and events that led to the individual's admission to the facility.

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- (b) Document the admission date and time.
 - (c) Contain the results of the health care screening required in (3) of this section.
 - (d) Document the date and time of a referral to a designated mental health professional (DMHP), if a referral was made.
 - (e) Document the date and time of release, or date and time the twelve-hour hold ended.
 - (f) Document any use of seclusion and/or restraint and include:
 - (i) Documentation that the use of seclusion and/or restraint occurred only due to the individual being an imminent danger to self or others; and
 - (ii) A description of the less restrictive measures that were tried and found to be ineffective.
 - (6) A triage facility that declares any intent to provide seclusion and/or restraint to an individual may do so only to the extent necessary for the safety of others and in accordance with WAC [246-322-180](#), [246-337-110](#), [246-320-271](#), and [388-865-0545](#). See also WAC [388-865-0830](#).
 - (7) A triage facility must document the efforts and services provided to meet the individual's triage stabilization plan.
 - (8) A triage facility must document the date, time, and reason an individual's admission status changed from involuntary to voluntary.
- [Statutory Authority: RCW [71.05.020](#), [71.05.150](#), [71.05.153](#), [71.24.035](#), and 2011 c 148. WSR 12-19-039, § 388-865-0840, filed 9/12/12, effective 10/13/12.]

388-865-0850 *[see new WAC 388-877-1148]*

Triage facility—Triage stabilization plan.

A triage stabilization plan must be developed for each individual voluntarily or involuntarily admitted to a triage facility for longer than twenty-four hours. For an individual admitted twenty-four hours or less, the facility must document the results of the assessment performed by a mental health professional (MHP) required under WAC [388-865-0840](#).

- (1) The triage stabilization plan must:
 - (a) Be developed collaboratively with the individual within twenty-four hours of admission.
 - (b) Improve and/or resolve the individual's crisis in the least restrictive manner possible.
 - (c) Be written in a language that is understandable to the individual and/or the individual's support system if applicable.
 - (d) Be mindful of the individual's culture, life style, economic situation, and current mental and physical limitation.
 - (e) Have goals that are relevant to the presenting crisis and demonstrate how they impact the crisis by improving the individual's ability to function.
 - (f) Include any recommendation for treatment from the mental health professional (MHP) assessment provided with three hours of the individual's arrival at the facility.
 - (g) Include:

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- (i) The date and time the designated mental health professional (DMHP) evaluated the individual in accordance with the detention criteria under chapter [71.05](#) RCW; and
 - (ii) The DMHP's determination of whether the individual should be detained.
- (2) The individual's clinical record must:
- (a) Contain a copy of the triage stabilization plan;
 - (b) Contain charting that demonstrates how requirements of the individual's triage stabilization were met; and
 - (c) Document the services provided to the individual.

[Statutory Authority: RCW [71.05.020](#), [71.05.150](#), [71.05.153](#), [71.24.035](#), and 2011 c 148. WSR 12-19-039, § 388-865-0850, filed 9/12/12, effective 10/13/12.]

388-865-0860 [see new WAC 388-877-1150]

Triage facility—Discharge services for voluntary and involuntary admissions.

A triage facility must:

- (1) Provide discharge services for each individual:
 - (a) Voluntarily admitted to the facility; or
 - (b) Involuntarily admitted to the facility if the individual is not transferred to another facility.
- (2) Coordinate with the individual's current treatment provider, if applicable, to transition the individual back to the provider.
- (3) Develop a discharge plan and follow-up services from the triage facility that includes:
 - (a) The name, address, and telephone number of the provider;
 - (b) The designated contact person; and
 - (c) The appointment date and time for the follow-up services, if appropriate.

[Statutory Authority: RCW [71.05.020](#), [71.05.150](#), [71.05.153](#), [71.24.035](#), and 2011 c 148. WSR 12-19-039, § 388-865-0860, filed 9/12/12, effective 10/13/12.]

388-865-0870 [see new WAC 388-877-1144]

Triage facility—Staff requirements.

A triage facility must ensure each staff member providing services to individuals is qualified to perform the duties within the scope of their position.

- (1) The triage facility must document that each staff member has the following:
 - (a) A current job description.
 - (b) A current Washington state department of health license or credential as required for performing the job duties and meeting the specific responsibilities of the position.
 - (c) A Washington state patrol background check consistent with chapter [43.43](#) RCW.
 - (d) An annual review and evaluation of work performance.
 - (e) An individualized annual training plan that assures the employee is provided, at a minimum:

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(i) Training relevant to the skills required for the job and the population served by the facility.

(ii) Adequate training regarding the least restrictive alternative options available in the community and how to access them.

(iii) Training that meets the requirements of this chapter and RCW [71.05.720](#).

(iv) Training that meets the requirements of RCW [71.05.705](#) if the triage facility is performing outreach services.

(f) Adequate training regarding methods of health care as defined in WAC [246-337-005](#)(19).

(g) Adequate training regarding the proper and safe use of seclusion and/or restraint procedures if the triage facility employs these techniques. See WAC [388-865-0810](#) (3)(i) and [388-865-0830](#).

(2) The triage facility must ensure:

(a) Each clinical supervisor and each clinical staff member meets the qualifications of a mental health professional as defined in WAC [388-865-0800](#); and

(b) A clinical staff member who does not meet the qualifications for an MHP as defined in WAC [388-865-0800](#) is supervised by an MHP if the staff member provides direct services to individuals.

(c) A contracted staff member who provides direct services to individuals meets the requirements of this section.

[Statutory Authority: RCW [71.05.020](#), [71.05.150](#), [71.05.153](#), [71.24.035](#), and 2011 c 148. WSR 12-19-039, § 388-865-0870, filed 9/12/12, effective 10/13/12.]

388-865-0880 *[see new WAC 388-877-1122]*

Triage facility—Posting of individual rights.

(1) A triage facility must ensure the individual rights outlined in WAC [388-865-0410](#) are:

(a) Prominently posted within the facility;

(b) Available to any individual on request; and

(c) Provided to each individual being assessed and admitted to the facility.

(2) A triage facility that has elected to operate as an involuntary placement facility must meet the requirements in subsection (1) of this section and, in addition, ensure the individual rights outlined in WAC [388-865-0561](#) are:

(a) Prominently posted within the facility; and

(b) Provided in writing to an individual during the admission process.

[Statutory Authority: RCW [71.05.020](#), [71.05.150](#), [71.05.153](#), [71.24.035](#), and 2011 c 148. WSR 12-19-039, § 388-865-0880, filed 9/12/12, effective 10/13/12.]

388-865-0900 *[see new WAC 388-877-1154]*

Competency evaluation and restoration treatment services—General.

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[Rules in red italics will remain effective after March 31, 2018]

(1) WAC 388-865-0900 through [388-865-0970](#) contains rules for agencies to gain and maintain certification to provide competency evaluation and restoration treatment services. When used in these rules, "agency" means:

- (a) A residential treatment facility (RTF);
- (b) A general hospital;
- (c) A private psychiatric hospital; or
- (d) An inpatient evaluation and treatment facility.

(2) Competency evaluation and restoration treatment services may be provided to an individual by an agency when the agency meets:

- (a) The certification and fee requirements in WAC [388-865-0910](#);
- (b) The administrative policy and procedure requirements in WAC [388-865-0920](#);
- (c) The agency staff requirements in WAC [388-865-0930](#);
- (d) The individual participant rights requirements in WAC [388-865-0940](#);
- (e) The admission and initial assessment requirements in WAC [388-865-0950](#);
- (f) The individual service plan requirements in WAC [388-865-0960](#);
- (g) The seclusion and restraint requirements in WAC [388-865-0970](#);
- (h) The agency is willing and able to provide treatment to the individual; and
- (i) All applicable federal, state, tribal, and local codes and ordinances.

(3) WAC 388-865-0900 through [388-865-0970](#) does not apply to state psychiatric hospitals as defined in chapter [72.23](#) RCW, facilities owned or operated by the department of veterans affairs, or United States government agencies.

[Statutory Authority: RCW [10.77.290](#), [71.24.035](#) and chapter [10.77](#) RCW, 2015 1st sp.s. c 7 and Trueblood et. al. v. DSHS et. al., Case No. C14-1178 MJP, U.S. District Court, Western District of Washington of Seattle. WSR 16-07-061, § 388-865-0900, filed 3/15/16, effective 4/15/16.]

388-865-0910 *[see new WAC 388-877-0365, 388-877-1154]*

Competency evaluation and restoration treatment services— Certification and fee requirements.

(1) An agency described in WAC [388-865-0900](#)(1) may provide competency evaluation and restoration treatment services to individuals under chapter [10.77](#) RCW when the department's division of behavioral health and recovery (DBHR) certifies the services. To obtain certification for these services, the agency must:

- (a) Be licensed by the department of health as:
 - (i) A residential treatment facility consistent with chapter [246-337](#) WAC;
 - (ii) A general hospital consistent with chapter [246-320](#) WAC;
 - (iii) A private psychiatric hospital consistent with chapter [246-322](#) WAC; or
 - (iv) An inpatient evaluation and treatment facility as provided in WAC [388-865-0511](#)(1) and consistent with chapter [246-337](#) WAC.
- (b) Demonstrate to DBHR that the minimum requirements in WAC [388-865-0900](#) through [388-865-0970](#) have been met;
- (c) Successfully complete a provisional and annual on-site review conducted by DBHR staff that determines the agency is in compliance with the minimum standards of WAC [388-865-0900](#) through [388-865-0970](#) and chapter [10.77](#) RCW; and
- (d) Pay the required certification fees:

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(i) Ninety dollars, per bed, due at the time of initial application; and
(ii) Ninety dollars, per bed, due twelve months after the date of the initial application approval and annually from that date forward.

(2) The agency must include the fees specified in subsection (1)(d) of this section with the initial application or a twelve month renewal application, as applicable.

(3) Payment of fees must be made by check, bank draft, electronic transfer, or money order, payable to the department of social and health services, and mailed to the department at the address listed on the applicable application packet or form.

(4) The department may refund one-half of the initial application fee or renewal application fee if an application is withdrawn before certification.

(5) The department will not refund fees when certification is denied, revoked, or suspended.

(6) For behavioral health agency licensure fees, program-specific certification fees, and other fees charged by the department, see WAC 388-877-0365.

[Statutory Authority: RCW [10.77.290](#), [71.24.035](#) and chapter [10.77](#) RCW, 2015 1st sp.s. c 7 and Trueblood et. al. v. DSHS et. al., Case No. C14-1178 MJP, U.S. District Court, Western District of Washington of Seattle. WSR 16-07-061, § 388-865-0910, filed 3/15/16, effective 4/15/16.]

388-865-0920 [see new WAC 388-877-1154]

**Competency evaluation and restoration treatment services—
Administrative policies and procedures.**

(1) In order to provide competency evaluation and restoration treatment services, an agency described in WAC [388-865-0900](#)(1) must develop, implement, and maintain administrative policies and procedures that:

- (a) Are in accordance with chapter [10.77](#) RCW;
- (b) Meet any applicable court orders; and
- (c) Meet the minimum requirements of WAC [388-865-0900](#) through [388-865-0970](#).

(2) The administrative policies and procedures must include at a minimum all of the following:

(a) A description of the competency evaluation and restoration treatment services to be provided, ages of individuals to be served, and length of stay criteria;

(b) An organizational structure that includes clear lines of authority for management and clinical supervision;

(c) Designation of a psychiatrist as the professional person in charge of clinical services at the agency;

(d) A quality management plan to monitor, collect data, and develop improvements to meet the requirements of WAC [388-865-0900](#) through [388-865-0970](#); and

(e) A policy management structure that establishes:

(i) Procedures for maintaining and protecting an individual's clinical record consistent with chapter [70.02](#) RCW and the Health Insurance Portability and Accountability Act (HIPAA);

(ii) Procedures for maintaining adequate fiscal accounting records consistent with generally accepted accounting principles (GAAP);

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- (iii) Procedures for management of human resources to assure that an individual receives individualized treatment or care by an adequate number of staff members who are qualified and competent to carry out their assigned responsibilities;
- (iv) Procedures for admitting an individual needing competency evaluation and restoration treatment services, seven days a week, three hundred sixty-five days a year;
- (v) Procedures to assure access to necessary medical treatment, emergency life-sustaining treatment, and medication;
- (vi) Procedures to assure the protection of individual participant rights as described in WAC [388-865-0940](#);
- (vii) Procedures to inventory and safeguard the personal property of the individual;
- (viii) Procedures to assure that a mental health professional and licensed physician are available for consultation and communication with the direct patient care staff twenty-four hours a day, seven days a week;
- (ix) Procedures to assure that seclusion and restraint are used only to the extent necessary to ensure the safety of an individual, and in accordance with WAC [388-865-0970](#);
- (x) Procedures to provide warning to an identified person and law enforcement when an adult has made a threat against an identified victim;
- (xi) Procedures to provide notification to the appropriate prosecutor and law enforcement in the event of unauthorized leave; and
- (xii) Procedures to assure the rights of each individual to make mental health advance directives, and agency protocols for responding to individual and agent requests consistent with RCW [71.32.150](#).

[Statutory Authority: RCW [10.77.290](#), [71.24.035](#) and chapter [10.77](#) RCW, 2015 1st sp.s. c 7 and Trueblood et. al. v. DSHS et. al., Case No. C14-1178 MJP, U.S. District Court, Western District of Washington of Seattle. WSR 16-07-061, § 388-865-0920, filed 3/15/16, effective 4/15/16.]

388-865-0930 *[see new WAC 388-877-0500, 388-877-0515]*

Competency evaluation and restoration treatment services—Agency staff requirements.

(1) In order to provide competency evaluation and restoration treatment services, an agency described in WAC [388-865-0900](#)(1) must ensure the clinical supervisor and other staff members employed by the agency are qualified for the position they hold and have the education, experience, and skills to perform the job requirements. Each staff member providing services must:

- (a) Have a current job description;
- (b) Have a current credential issued by the department of health for their scope of practice;
- (c) Pass a Washington state patrol background check consistent with RCW [43.43.830](#) if the position requires contact with individuals receiving competency evaluation and restoration treatment services;
- (d) Have an annual performance evaluation; and
- (e) Have an individualized annual training plan that includes at a minimum:
 - (i) The skills needed for the job description and the population served;

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(ii) Methods of resident care;

(iii) Management of assaultive and self-destructive behaviors, including proper and safe use of either seclusion or restraint procedures, or both; and

(iv) Meeting the protocols developed by the department in WAC [388-865-0900](#) through [388-865-0970](#) and other applicable requirements in state and federal law.

(2) If the agency contracts a staff member to provide direct competency evaluation and restoration treatment services to individuals, the agency and the contracted staff member must meet all the conditions in subsection (1) of this section.

[Statutory Authority: RCW [10.77.290](#), [71.24.035](#) and chapter [10.77](#) RCW, 2015 1st sp.s. c 7 and Trueblood et. al. v. DSHS et. al., Case No. C14-1178 MJP, U.S. District Court, Western District of Washington of Seattle. WSR 16-07-061, § 388-865-0930, filed 3/15/16, effective 4/15/16.]

388-865-0940 *[see new WAC 388-877-1156]*

Competency evaluation and restoration treatment services—Individual participant rights.

(1) An agency described in WAC [388-865-0900](#)(1) that meets the department's requirements to provide competency evaluation and restoration treatment services must develop a statement of individual participant rights to ensure an individual's rights are protected. The statement must incorporate at a minimum the following. You have the right to:

(a) Receive services without regard to race, creed, national origin, religion, gender, sexual orientation, age or disability;

(b) Practice the religion of choice as long as the practice does not infringe on the rights and treatment of others or the treatment services and, as an individual participant, the right to refuse participation in any religious practice;

(c) Reasonable accommodation in case of sensory or physical disability, limited ability to communicate, limited English proficiency, or cultural differences;

(d) Respect, dignity and privacy, except that agency staff members may conduct reasonable searches to detect and prevent possession or use of contraband on the premises;

(e) Be free of sexual harassment;

(f) Be free of exploitation, including physical and financial exploitation;

(g) Have all clinical and personal information treated in accord with state and federal confidentiality rules and laws;

(h) Review your clinical record in the presence of the administrator or the administrator's designee and the opportunity to request amendments or corrections;

(i) Receive a copy of the agency complaint and grievance procedures upon request and to lodge a complaint or grievance with the agency if you believe your rights have been violated; and

(j) File a complaint with the department when you believe the agency has violated a Washington Administrative Code (WAC) requirement that regulates facilities.

(2) Each agency must ensure the applicable individual participant rights described in subsection (1) of this section are:

(a) Provided in writing to each individual on or before admission;

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- (b) Posted in public areas;
- (c) Available in alternative formats for an individual who is blind;
- (d) Translated to a primary or preferred language identified by an individual who does not speak English as the primary language, and who has a limited ability to read, speak, write, or understand English; and
- (e) Available to any individual upon request.

(3) Each agency must ensure all research concerning an individual whose cost of care is publicly funded is done in accordance with chapter [388-04](#) WAC, the protection of human research subjects, and other applicable state and federal rules and laws.

(4) In addition to the requirements in this section, each agency enrolled as a medicare and/or medicaid provider must ensure an individual seeking or participating in competency evaluation and/or restoration treatment services, or the person legally responsible for the individual is informed of the medicaid rights at time of admission in a manner that is understandable to the individual or legally responsible person.

[Statutory Authority: RCW [10.77.290](#), [71.24.035](#) and chapter [10.77](#) RCW, 2015 1st sp.s. c 7 and Trueblood et. al. v. DSHS et. al., Case No. C14-1178 MJP, U.S. District Court, Western District of Washington of Seattle. WSR 16-07-061, § 388-865-0940, filed 3/15/16, effective 4/15/16.]

388-865-0950 *[see new WAC 388-877-1154]*

Competency evaluation and restoration treatment services—Admission and initial assessment.

(1) In order to provide competency evaluation and restoration treatment services, an agency described in WAC [388-865-0900](#)(1) must ensure that for each individual admitted for treatment, the agency obtains and includes in the individual's clinical record:

(a) A copy of the court order and charging documents. If the order is for competency restoration treatment and the competency evaluation was provided by a qualified expert or professional person who was not designated by the secretary, a copy of all previous court orders related to competency or criminal insanity provided by the state and a copy of any evaluation reports must be included;

(b) A copy of the discovery materials, including, at a minimum, a statement of the individual's criminal history; and

(c) A copy of the individual's medical clearance information.

(2) The agency is responsible for the individual's initial assessment. The initial assessment must be:

(a) Conducted in person; and

(b) Completed by a professional appropriately credentialed or qualified to provide mental health services as determined by state law.

(3) The initial assessment must include and document:

(a) The individual's:

(i) Identifying information;

(ii) Specific barriers to competence;

(iii) Medical provider's name or medical providers' names;

(iv) Medical concerns;

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- (v) Medications currently taken;
- (vi) Brief mental health history; and
- (vii) Brief substance use history, including tobacco use;
- (b) The identification of any risk of harm to self and others, including suicide and homicide; and
- (c) Treatment recommendations or recommendations for additional program-specific assessment.

(4) To determine the nature of the disorder and the treatment necessary, the agency must ensure that the individual receives the following assessments and document in the client's record the date provided:

- (a) A health assessment of the individual's physical condition to determine if the individual needs to be transferred to an appropriate hospital for treatment;
- (b) An examination and medical evaluation within twenty-four hours by a physician, advanced registered nurse practitioner, or physician assistant;
- (c) A psychosocial evaluation by a mental health professional; and
- (d) A competency to stand trial evaluation conducted by a licensed psychologist, or a copy of a competency to stand trial evaluation using the most recent competency evaluation, if an evaluation has already been conducted.

(5) The agency must also ensure the development of an individual service plan as described in WAC [388-865-0960](#).

(6) If a state hospital transfers an individual to an agency for competency restoration treatment, the agency must review the individual's completed admission assessment from the state hospital to assure it meets the requirements of subsection (3) of this section for initial assessments. The agency must update the assessment as needed. If the state hospital has not completed or has only partially completed an assessment for the individual, the agency must complete the assessment according to the requirements in subsections (2) and (3) of this section.

[Statutory Authority: RCW [10.77.290](#), [71.24.035](#) and chapter [10.77](#) RCW, 2015 1st sp.s. c 7 and Trueblood et. al. v. DSHS et. al., Case No. C14-1178 MJP, U.S. District Court, Western District of Washington of Seattle. WSR 16-07-061, § 388-865-0950, filed 3/15/16, effective 4/15/16.]

388-865-0960 *[see new WAC 388-877-1154]*

Competency evaluation and restoration treatment services—Individual service plan.

(1) An agency described in WAC [388-865-0900](#)(1) that meets the department's requirements to provide competency evaluation and restoration treatment services must ensure each individual admitted to the agency for restoration treatment services has an individual service plan:

- (a) Completed within seven days of admission; and
- (b) Updated every ninety days.

(2) The individual's clinical record must contain copies of or documentation of the following:

- (a) All diagnostic and therapeutic services prescribed by the attending clinical staff members;

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(b) The individualized treatment plan that identifies specific targets and strategies for restoring competency to include periodic assessments of gains on these targets; and

(c) Participation of a multidisciplinary team that includes at a minimum:

(i) A physician, advanced registered nurse practitioner (ARNP), or physician assistant certified (PA-C);

(ii) A nurse, if the person in (i) of this subsection is not an ARNP; and

(iii) A mental health professional.

(3) Participation of other multidisciplinary team members, which may include a psychologist and chemical dependency professional.

[Statutory Authority: RCW [10.77.290](#), [71.24.035](#) and chapter [10.77](#) RCW, 2015 1st sp.s. c 7 and Trueblood et. al. v. DSHS et. al., Case No. C14-1178 MJP, U.S. District Court, Western District of Washington of Seattle. WSR 16-07-061, § 388-865-0960, filed 3/15/16, effective 4/15/16.]

388-865-0970 [see new WAC [388-877-1158](#)]

Competency evaluation and restoration treatment services—Seclusion and restraint.

(1) An individual receiving either competency evaluation or restoration treatment services, or both, from an agency described in WAC [388-865-0900](#)(1) has the right to be free from seclusion and restraint, including chemical restraint except as otherwise provided in this section or otherwise provided by law. The agency must:

(a) Develop, implement, and maintain policies and procedures to ensure that seclusion and restraint procedures are used only to the extent necessary to ensure the safety of an individual and in accordance with WAC [246-322-180](#) or [246-337-110](#), whichever is applicable.

(b) Ensure that the use of seclusion or restraint occurs only when there is imminent danger to self or others and less restrictive measures have been determined to be ineffective to protect the individual or other from harm and the reasons for the determination are clearly documented in the individual's clinical record.

(c) Ensure staff members notify and receive authorization by a physician or advanced registered nurse practitioner (ARNP) within one hour of initiating an individual's seclusion or restraint.

(d) Ensure the individual is informed of the reasons for use of seclusion or restraint and the specific behaviors which must be exhibited in order to gain release from a seclusion or restraint procedure.

(e) Ensure that an appropriate clinical staff member observes the individual at least every fifteen minutes and the observation is recorded in the individual's clinical record.

(f) If the use of seclusion or restraint exceeds twenty-four hours, ensure that a physician has assessed the individual and has written a new order if the intervention will be continued. This procedure must be repeated for each twenty-four hour period that seclusion or restraint is used.

(2) The agency must ensure all assessments and justification for the use of either seclusion or restraint, or both, are documented in the individual's clinical record.

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[Rules in red italics will remain effective after March 31, 2018]

[Statutory Authority: RCW [10.77.290](#), [71.24.035](#) and chapter [10.77](#) RCW, 2015 1st sp.s. c 7 and Trueblood et. al. v. DSHS et. al., Case No. C14-1178 MJP, U.S. District Court, Western District of Washington of Seattle. WSR 16-07-061, § 388-865-0970, filed 3/15/16, effective 4/15/16.]