

ITA INVESTIGATIONS: CAN STANDARDIZED ASSESSMENT INSTRUMENTS ASSIST IN DECISION MAKING?

In 1973, the Involuntary Treatment Act (ITA) was passed in Washington State to:

- Provide prompt evaluation and timely and appropriate treatment of persons with serious mental disorders,
- Safeguard individual rights, and
- Protect public safety.¹

Involuntary civil commitments permit the state to commit a person to a mental hospital or institution against the individual's will when meeting certain legal criteria. To determine whether an individual meets the law's requirements, an investigator, or Designated Mental Health Professional (DMHP) must conduct a face-to-face interview. Individuals can be involuntarily committed to an inpatient psychiatric facility if they (1) present a likelihood of serious harm to themselves or others, or (2) are gravely disabled² and the DMHP believes this is due to a mental disorder.³

The ITA statute (RCW 71.05.020(25)) clarifies that serious harm exists when there is any substantial risk that physical injury will be inflicted. This risk may be established by recent overt acts, threats, or attempts to inflict physical harm, or behavior which places another individual in reasonable fear of sustaining harm.

Summary

In Washington State, specialized investigators, called Designated Mental Health Professionals (DMHPs), are responsible for determining if individuals can be committed for 72 hours under the state's Involuntary Treatment Act (ITA). The criteria established under the ITA statute (RCW 71.05) allow individuals to be involuntarily detained to a psychiatric facility if, as a result of a mental disorder, the individual is gravely disabled or presents a substantial risk of serious harm to him or herself or others.

A DMHP relies on both professional judgment and historical case records to determine the extent to which an individual may pose a risk. While protocols have been adopted for ITA investigations, at present, DMHPs do not use a standardized risk assessment instrument to determine the level of danger an individual may pose.

This report reviews both mental health and risk assessment instruments that potentially could be utilized in an ITA investigation. None of the risk instruments discussed here, however, have been validated for use within the general population. While we could not identify suitable instruments for ITA investigations within the research literature, other measures are discussed which may assist a DMHP in the investigation process. These options include expanded access to criminal records and centralized access to previous mental health investigation and commitment data.

¹ RCW 71.05.010

² In statute, "gravely disabled" refers to a condition "in which a person, as a result of a mental disorder: (a) is in danger of serious physical harm resulting from a failure to provide for his or her essential human needs of health or safety; or (b) manifests severe deterioration in routine functioning evidenced by repeated and escalating loss of cognitive or volitional control over his or her actions and is not receiving such care as is essential for his or her health or safety." RCW 71.05.020 (17).

³ RCW 71.05.150

If a person meets the criteria for a civil commitment and refuses voluntary treatment, he or she may be initially detained for up to 72 hours in one of two ways:

- 1) If the individual does not pose an imminent threat to him or herself or others, the DMHP may file a petition for initial detention with the county court. The judge may issue an order to detain the individual to an evaluation and treatment facility for 72 hours. In this case, the DMHP would serve the individual with this order and have the individual detained, or require a response within 24 hours.
- 2) If the DMHP believes that, as a result of a mental disorder, the person presents an *imminent* danger to him or herself or others, the DMHP may have the individual taken into emergency custody for a 72-hour initial detention.⁴

It is important to note that individuals who may be a risk to themselves or others cannot be committed if this risk is not the result of a mental disorder. Likewise, a mental illness alone does not constitute grounds for a detention if individuals provide for their own health and safety and do not represent a risk to others.

Designated Mental Health Professionals must be skilled in diffusing crisis situations and helping individuals see the value of voluntary treatment, if possible. If necessary, a DMHP must assess whether an involuntary detention is appropriate. This assessment requires both clinical judgment to determine the presence of a mental disorder and professional experience in establishing the level and likelihood of risk.

Currently, state DMHPs do not use a structured assessment instrument or tool to help establish the level of risk or dangerousness present in each investigation. To determine the relative merit of such instruments, the 2010 Legislature directed the

Washington State Institute for Public Policy (Institute), in collaboration with the Department of Social and Health Services (DSHS) and other applicable entities to “search for a validated mental health assessment tool, or combination of tools to be used by Designated Mental Health Professionals when undertaking assessments of individuals for detention, commitment and revocation.”⁵

To complete this assignment, the Institute worked with DSHS staff to convene a workgroup with representatives from county mental health crisis offices, the DMHP Association, Regional Support Networks, community mental health agencies, consumer representatives, and both prosecutors and public defenders involved with civil commitments. Appendix A includes a list of workgroup members and their affiliations.

Based on the Institute’s review of the research literature, interviews with practitioners, and feedback from workgroup members, this report addresses the following questions:

- 1) What are the requirements for ITA investigations and how do investigations differ across the state?
- 2) What does the research literature indicate about risk assessment for involuntary commitments?
- 3) What practical considerations and research criteria should be applied when evaluating instruments?
- 4) Which instruments may fit the circumstances and purposes necessary for ITA investigations?
- 5) Can DMHPs be assisted in their job through other improvements in the mental health system?

⁴ RCW 71.05.153

⁵ Laws of 2010, ch. 37 § 204 (3) (c)

Section I: ITA Investigations—Overview

In 2009, approximately 7,500 DMHP investigations resulted in 72-hour initial detentions and/or revocations. Over 150 county- or agency-employed staff serve as DMHPs throughout Washington State, providing around-the-clock responses to mental health-related crisis situations.

The state's 13 Regional Support Networks (RSNs) contract with county-based mental health agencies to conduct crisis response and ITA investigations. In all cases, a DMHP must possess a master's degree and have two or more years of experience in the social work and/or mental health field. Other qualifications are set by individual county governments for the DMHPs under their jurisdiction. While DMHPs do not have uniform training requirements, in past years, state funds have been used to run a one-week intensive training program for new DMHPs. The Washington DMHP Association and individual agencies also offer additional training sessions covering a variety of topics.

Every three years, DSHS is responsible for updating statewide protocols that guide the practice of DMHPs. The protocols are meant to "provide uniform development and application of criteria in evaluation and commitment recommendations."⁶

Referrals for DMHP investigations come from:

- County crisis telephone hotlines
- Hospital emergency departments
- Inpatient psychiatric departments
- Law enforcement officers
- Jails or detention centers
- Adult family homes or nursing homes
- Family members or community calls
- Other local social service agencies

According to the most recent DMHP protocols (updated in 2008),⁷ these referrals are screened to determine whether an investigation is necessary or other community crisis resources may be more appropriate. If an investigation is initiated, the DMHP must perform a face-to-face interview with the individual.⁸

As part of the investigation, the DMHP is required to begin the interview by informing the individual of his or her legal rights.⁹ For this requirement, the DMHP must:

- Identify him or herself by name and position,
- Inform the person of the purpose and possible outcomes of the investigation,
- Inform the individual of his or her right to remain silent, and
- Inform the individual of his or her right to speak to an attorney.¹⁰

Once an interview begins, the DMHP is responsible for determining the facts of the case and whether the present circumstances meet the criteria established for initial detentions. Some material may be collected by the DMHP prior to the interview. In most cases, the DMHP will interview or engage the person in a manner that illuminates the potential presence of a mental disorder. If the individual has a cognitive impairment or is a minor, the DMHP will determine if a guardian is available to help guide decision making.

The ITA statute requires that a mental disorder be present for an initial involuntary detention (commitment). The formal diagnosis of a mental illness is not required, however. Rather, any "organic, mental, or emotional impairment which has substantial adverse effects on a person's

⁷ Department of Social and Health Services (2008, December). *Protocols: Designated Mental Health Professionals*. Olympia, WA: Author. http://www.dshs.wa.gov/pdf/dbhr/mh/DMHP_Protocols_Final.pdf

⁸ Note here that DMHPs may conduct the interview accompanied by a second DMHP or law enforcement officer if safety concerns are present. Many DMHPs also serve as both a crisis intervention specialist and investigator.

⁹ RCW 71.05.360 (5) (b) (c)

¹⁰ Department of Social and Health Services, 2008, Section 200.

⁶ RCW 71.05.214

cognitive or volitional functions”¹¹ may be grounds for further investigation. Depending on the individual’s behavior, orientation, memory, cognitive deficits, or other adverse symptoms, the DMHP may administer the Mini-Mental Status Exam (MMSE) to confirm the presence of a mental disorder. Section II of this report discusses these instruments in further detail. The current DMHP protocols do not specify specific steps for this process, but direct the DMHP to rely on professional judgment, available evidence, and witness interviews to determine if a mental disorder is present and the patient meets commitment criteria.

If a mental disorder is identified in an individual, the DMHP must assess whether the person is gravely disabled or likely to cause serious harm to property, him or herself, or others. For over half of the detentions, grave disability was listed by the DMHP as one of the reasons for an involuntary commitment (Exhibit 1). The ITA statute indicates that a grave disability is present if an individual cannot meet his or her basic needs of health and safety¹² or has a severe deterioration in functioning caused by a loss of cognitive or volitional control.¹³

Exhibit 1
Grounds for Initial
Involuntary Commitments, 2009

Legal Reason	Detentions
Gravely disabled	4,103 (55%)
Dangerous to self	2,947 (39%)
Dangerous to others	1,504 (20%)
Dangerous to property	184 (2%)
Total	7,473

Note: Percentages do not add to 100 percent since multiple reasons for detention may be present in a single investigation.

Source: Institute analysis of DSHS/Division of Behavioral Health & Recovery (DBHR) data

¹¹ RCW 71.05.020 (26)

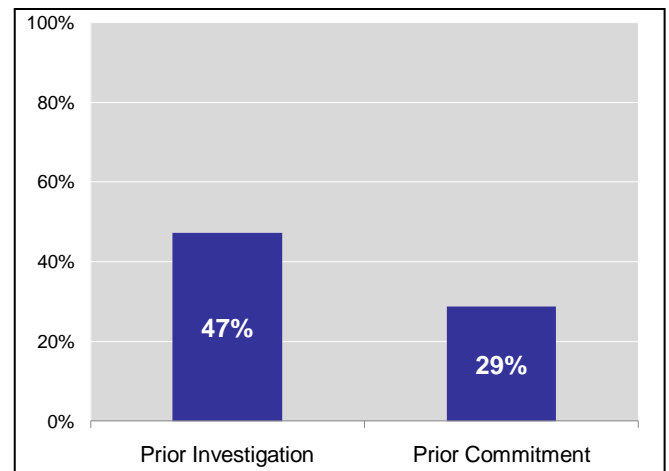
¹² RCW 71.05.020 (17) (a)

¹³ RCW 71.05.020 (17) (b). Individuals cannot be detained on the basis of severe deterioration in functioning unless the detention is essential for their health and safety.

To take an individual into custody, a DMHP must find that there is a substantial risk that the individual will inflict physical harm on his or her own person or upon another. The DMHP can consider “reasonably available history” in this determination or risk. This history may include records of prior commitments, determinations of insanity or incompetency, and violent acts that may have occurred within the last ten years. (The importance of historical information in the assessment process is discussed more fully in the subsequent sections of this report.)

Exhibit 2 displays the prevalence of individuals with prior investigations or commitments in each DMHP investigation.

Exhibit 2
Percentage of Investigations in 2009 With an
ITA Event in the Previous Two Years



Source: Institute analysis of DSHS/DBHR data
WSIPP, 2011

Of the 18,600 ITA investigations in 2009, nearly half (47 percent) of the individuals had an investigation in the last two years. For these same investigations, a commitment had taken place within the previous two years in 29 percent of cases. Also, in 10 percent of the investigations, the previous evaluation took place in a different county.

Exhibit 3
Washington State Mental Health Commitment Process

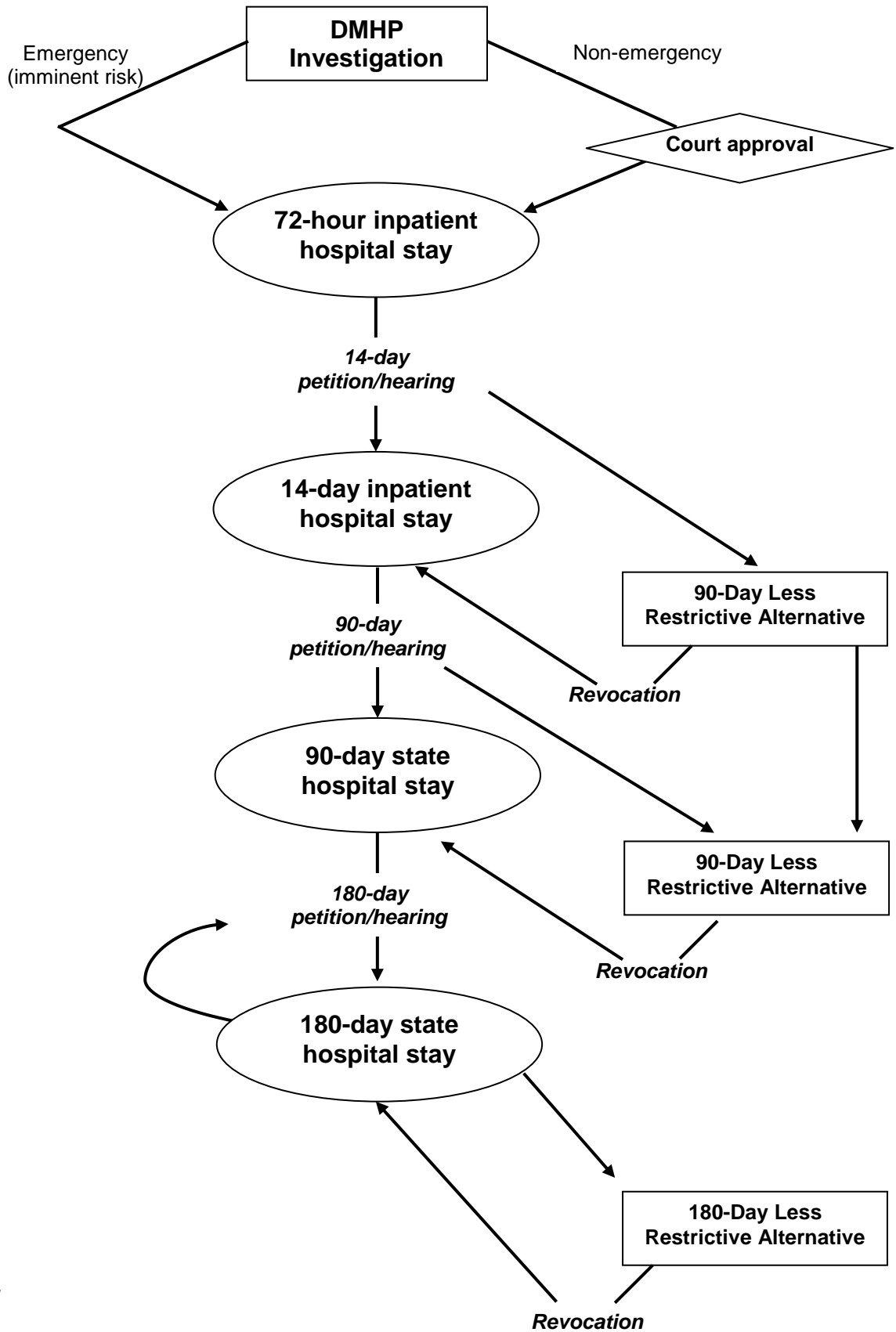


Exhibit 3 (previous page) shows the legal outcomes that may occur for an individual who has been initially detained under an involuntary commitment. If, at the conclusion of the 72-hour detention, the individual still presents a danger to him or herself or others, or is gravely disabled, the state may petition for an extended commitment.¹⁴ An individual could be detained involuntarily for up to 14 days, upon findings from a judge. Alternatively, a court may order a 90-day less restrictive alternative to detention, such as mandatory outpatient treatment. Subsequent petitions could keep an individual involuntarily detained for 90 or 180 days. A 90- or 180-day commitment would take place at one of the state psychiatric hospitals, Western or Eastern State.

Differences in ITA Investigation Approaches

Before discussing the role of the assessment process in ITA investigations, it is worth noting key differences in the operation and characteristics of the counties in which DMHPs work. These differences are evident in three areas:

1) Geography

Outside the urban counties, a DMHP may have to travel some distance in order to conduct a face-to-face investigation. In both urban and rural areas, if safety concerns are present, it is necessary to coordinate with local law enforcement. This may also extend the time required to complete an investigation.

The availability of inpatient psychiatric beds for detention differs significantly across the state. When an investigation leads to an involuntary detention, DMHPs must locate an available bed in one of three locations:

- a) **Hospital Inpatient Psychiatric Ward:** Several community hospitals with certified psychiatric units accept involuntary

¹⁴ An individual detained for an initial commitment can be released before the end of the 72-hour period if the mental health professional in charge of the evaluation and treatment facility believes the individual no longer poses a danger to him or herself or others.

treatment cases. These hospitals can manage individuals with medical needs and may be equipped to handle geriatric or other high-needs cases.¹⁵

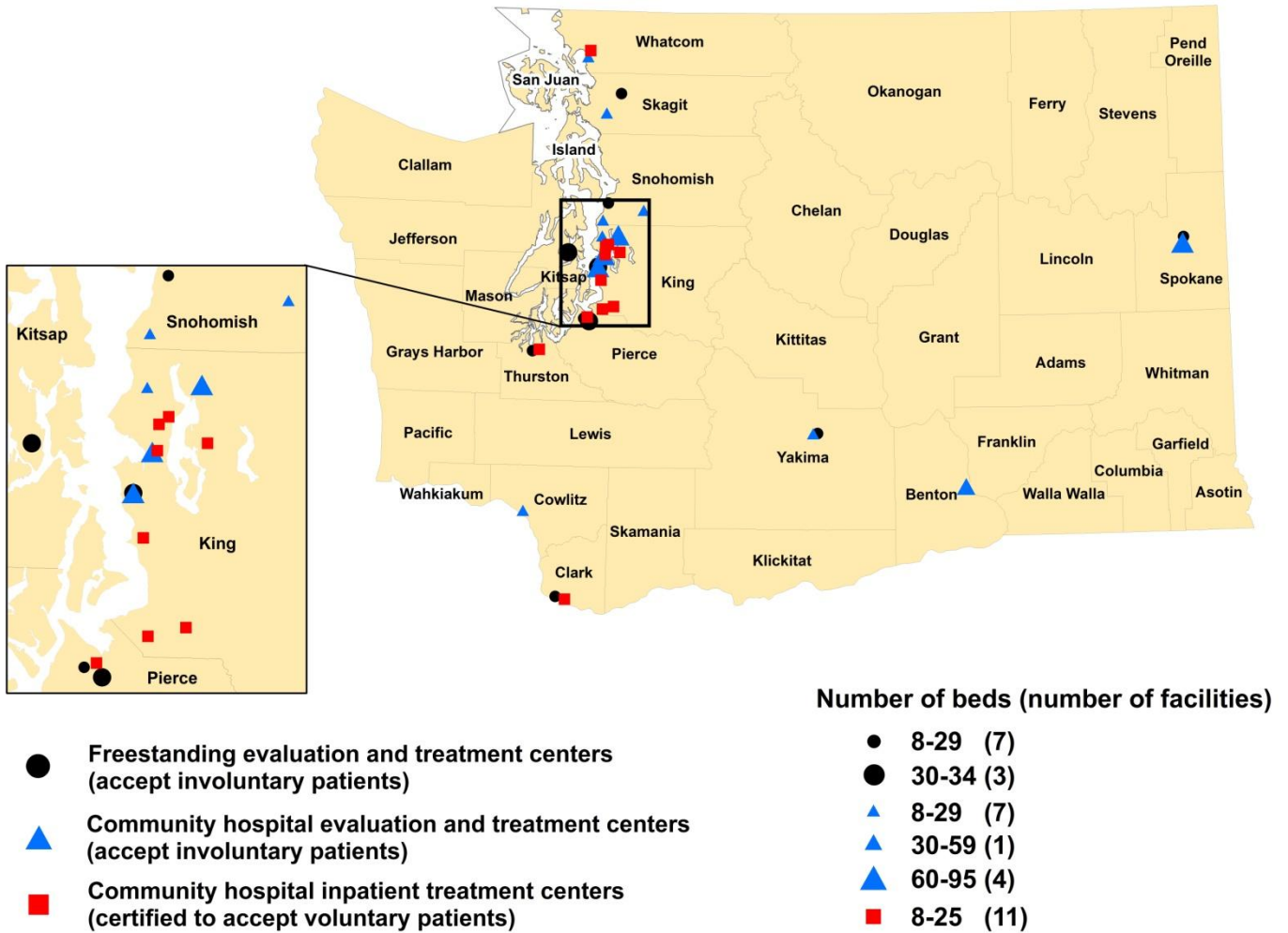
- b) **Freestanding Evaluation and Treatment Centers (E&Ts):** Several smaller, 16-bed facilities, called Evaluation and Treatment Centers are available for the purpose of detaining involuntary treatment cases. These facilities do not typically have the capability to support a patient's other medical needs.
- c) **Hospital Single-Bed Certification:** Other hospitals or medical centers throughout the state may provide care for involuntary treatment cases on a provisional basis. However, these facilities may not have the staff or resources necessary to meet all mental health needs for these patients. The DMHP must apply for a "single bed certification" and receive permission from DSHS and the hospital to have an individual admitted to these hospitals.

On any given day, finding an available bed in one of these facilities may be difficult. A related report shows how E&T centers operated at or above recommended capacity levels in 2009.¹⁶ Exhibit 4 (next page) displays the location, type, and relative capacity of facilities in Washington that were available for ITA patients in 2009. If the only available suitable bed is out-of-county, the individual being committed may have to be transported by ambulance to a hospital. Or, if no beds are available, detained individuals are often "boarded" in a hospital emergency department or medical unit until a bed becomes available.

¹⁵ Eastern State Hospital also has accepted individuals for 72-hour involuntary detentions. Western State Hospital, however, does not accept patients for initial (72-hour) commitments.

¹⁶ M. Burley. (2011). *How will 2010 changes to Washington's Involuntary Treatment Act impact inpatient treatment capacity?* Olympia: Washington State Institute for Public Policy, Document No. 11-01-3401.

Exhibit 4
Inpatient Psychiatric Beds in Washington State (2009)



Source: Washington State Hospital Association and DSHS Division of Behavioral Health and Recovery *WSIPP, 2011*

Legal and Court Systems

County courts may have different interpretations of what constitutes sufficient legal evidence for an involuntary detention. The DSHS Division of Behavioral Health and Recovery provides sample standard legal documents for all DMHP investigations,¹⁷ but county superior courts may have their own requirements for this process. In addition, approaches by county public defenders and prosecutors may differ from county to county, which leads to variation in detention decisions. In some courts, for example, arrest records may be considered hearsay and inadmissible as evidence. Also, cases may more likely be dismissed in some areas if statutory timelines are not met. For example, a law enforcement officer may detain an individual to a hospital or other facility for up to 12 hours, but that individual must be seen by a mental health clinician within three hours of arrival.¹⁸ If this does not occur, the case could be dismissed.

2) Community Crisis Resources

The decision about whether to detain a person involuntarily or persuade the individual to accept voluntary treatment (when appropriate) may depend in part on available treatment resources within the community. In some counties, individuals may elect to enter a *crisis diversion unit*, where they can stay for a specified period to meet urgent medication needs or see a licensed mental health professional. Also, *mobile outreach crisis teams* may be available to meet with the individual to diffuse a crisis situation and connect the person with needed treatment and support. If these resources do not exist in the region, a DMHP may have more limited options, and an inpatient detention may be the only realistic alternative for the investigation.

Assessments for Involuntary Commitments: Research Literature

While the majority of DMHP investigations involve a hospitalization for a grave disability, in about one in five cases the DMHP determines that there is a likelihood the individual may cause serious harm to others (see Exhibit 1). An assessment for violence or dangerousness to others remains a key part of the ITA investigation process.

Given the various circumstances and settings in which mental health and risk assessments may take place, it is worth examining the research literature regarding the connections between mental illness and future violence. After analyzing all studies (published since 1990) that investigated links between mental illness and violence toward others, Noroko and Baranoski (2007) found the following:

- 1) Substance abuse, alone and in combination with mental disorders, is consistently correlated with violence;
- 2) Sociodemographic factors contribute significantly more than mental health factors to violence; and
- 3) Research findings about the relationship between symptoms of mental illness and violence are inconsistent and conflicting.¹⁹

Without a clear guidepost to evaluate an individual's potential for violence, the DMHP must rely on accounts from third parties (friends, family members), information disclosed in an interview, and background or historical records. The DMHP must balance the need to be both thorough and efficient in the investigation process. The remainder of this report looks at whether other tools or resources could benefit a DMHP in conducting investigations. One tool previously suggested is an *actuarial instrument*, which gives specific statistical weighting to the

¹⁷ <http://www.dshs.wa.gov/dbhr/mhcdmhp.shtml>

¹⁸ RCW 71.05.153 (3)

¹⁹ M. A. Noroko & M. V. Baranoski (2008). The prediction of violence: Detection of dangerousness. *Brief Treatment and Crisis Intervention*, 8(1), 73–91.

presence of certain historical variables which assess the likelihood of risk. From a research perspective, a *valid* assessment should provide results that are generalizable in real-world settings.

In practice, however, Designated Mental Health Professionals are asked to investigate and assess risk for a wide spectrum of the population—from all age groups and social backgrounds and with various types of potential behavioral or physical health disorders. The circumstances of an investigation may vary considerably. As an example, a DMHP may be called to assess a nursing home patient who refuses to eat, or a young adult experiencing delusions and threatening to harm a family member.

We could not locate any research studies that validated the use of a particular assessment instrument in a community setting for such a broad population. The studies we did locate typically examined the reliability of an instrument in predicting violence for certain subpopulations (such as inpatient psychiatric patients, or those with a previous history of violence) in certain contexts (such as within an institution or following discharge to the community).

This limitation of direct research evidence does not mean that attempts to improve the assessment of dangerousness should not be pursued. One of the purposes of a structured interview or assessment instrument is to improve the consistency of information collected from an interview-based evaluation. Structured interviews/assessments reduce the variability in the phrasing of questions, coverage of certain topics, and collection of evidence. In addition, a structured approach is designed to improve the reliability of information across different investigators and regions. More reliable and consistent information is necessary to monitor outcomes and assess resource allocation.

It is important to recognize, however, that no one assessment technique or instrument will be superior for all investigations. The next section discusses the considerations for conducting risk assessments in community settings, reviews potential assessments for use in crisis situations, and outlines the strengths and limitations of various approaches.

Section II: Practical Considerations and Potential Assessments for Involuntary Treatment Act Investigations

In an inpatient setting, a clinician may have an extended period of time to conduct an evaluation of a patient. The evaluation can be completed in one long or several short sessions. The clinician likely has access to medical and other records, as well as the opportunity to consult with colleagues about the specifics of a case.

An investigation by a DMHP, on the other hand, takes place in a variety of community settings. The DMHP travels to hospital emergency departments, jails, crisis units, individuals' homes or places of work to assess the nature of a crisis and help resolve the issue in a way that will keep the public and the individual safe. In many cases, the individual is already agitated or upset, and the prospect of a short-term commitment may lead to further distress.

A Designated Mental Health Professional handles emergencies involving minors, persons with dementia or developmental disabilities, persons using alcohol or other drugs, medically fragile persons, and known violent individuals who may possess firearms, among others. During the course of an investigation, a DMHP may also have to reassure someone who is concerned with the welfare of a family member or other persons fearful for their own safety.

Given the complex and often unpredictable nature of investigations for civil commitments, the workgroup assembled for this review developed several criteria for evaluating potential assessments. These criteria are outlined in Exhibit 5. The guidelines for this assessment review were not prioritized. Rather, the identified factors were taken into account for purposes of screening potential instruments.

Exhibit 5
Criteria for Evaluating Community Mental Health and Risk Assessments

Criteria	Notes
Brevity	The time available for an ITA investigation may vary according to the setting and circumstances. Consequently, an assessment instrument should be relatively brief.
Observational	In most investigations, a highly structured assessment that asks an individual to answer numerous questions may not be beneficial. If the questions are not appropriate to the case, the course of the interview will be affected. In addition, many persons may not have the cognitive capacity to answer structured questions.
Reliability of Information	The assessment tool should only ask for information that can be reliably collected or readily discerned. A detailed psychological history or behavioral background may not be possible to collect during a crisis interview.
Training Required	Many published assessment instruments require an advanced degree in psychology or special training to administer. The clinical experience of DMHPs varies and instruments that require extensive training or advanced credentials are not suitable.
Validity	An assessment instrument should be well-established in the research literature and provide the DMHP with confidence that the constructs being measured match the treatment and public safety goals of the investigation. The instrument should have been used in similar settings for similar purposes with reliably consistent results.

Mental Health Assessments

Given these criteria, two types of instruments were reviewed for this analysis—mental health status assessments and assessments for risk of violence. As mentioned previously, individuals committed for an initial detention under the Involuntary Treatment Act must have a mental disorder present. If a DMHP suspects the presence of a cognitive or memory disorder, they will likely administer questions from a screening tool such as the Mini-Mental Status Exam (MMSE). The MMSE tests an individual's orientation, attention, calculation, recall, language, and motor skills. While the MMSE is a widely used and accepted test, it may not be appropriate in cases where a cognitive deficit is not present. In fact, an individual without a cognitive impairment may take offense at these types of questions, which would affect the course of the interview.

As mentioned previously, the DMHP is not required to come to a formal diagnosis regarding an observed mental disorder. Rather, if the DMHP believes there is any mental or emotional impairment that has “substantial adverse effects on an individual's cognitive or volitional functioning,” the DMHP should further investigate for the presence of risk or grave disability.²⁰ One of the more common, and simple, rating tools for this determination is the Global Assessment of Functioning, or GAF. The GAF assesses an individual's psychological, social, and occupational functioning on a hypothetical scale of 0 to 100. While the GAF is widely used and understood by those in the mental health field, it simply provides a measure of overall functioning, without detail about treatment needs or type of impairment. Several modified versions of the GAF have been developed, but these assessments have not been widely validated in the research literature. Exhibit 6 lists the various instruments considered and includes the strengths and limitations for each type of mental health assessment.

²⁰ RCW 71.05.020 (24)

Risk Assessments

Exhibit 7 includes a listing of instruments used to screen individuals for risk of violence. The instruments discussed in this section can be completed in a short period of time in a community setting. Unfortunately, we were unable to locate any instruments that have been validated in the context of investigations for civil commitments.²¹ Research in this area has focused on the assessment of risk within an inpatient psychiatric institution or in the community after discharge from a psychiatric facility.

While this section does not critique all instruments reviewed in this process, several instruments had unique properties and are worth mentioning. The Broset Violence Checklist (BVC), for example, is a short list of seven characteristics that have been shown to correlate with impending violent acts within a psychiatric inpatient setting. The Dynamic Appraisal of Situational Aggression (DASA) is a related instrument that combines elements of the BVC and other well-validated tools. The BVC and DASA instruments, however, are primarily designed for nurses monitoring patients within an institution and may not be informative for community-based investigations.

We also reviewed the Classification of Violence Risk (COVR) tool. The COVR is based on a “branching” model that asks about risk factors for violence based on responses to previous questions. The guided interview would only ask more detailed questions if known risk factors were present. The interview includes 106 potential risk factors, identified as part of the MacArthur Violence Risk Assessment Study.²² This instrument has also only been validated for use by psychiatric populations following discharge into the community and may not be practical for DMHP investigators.

²¹ Appendix B includes full citations for all assessments reviewed.

²² <http://macarthur.virginia.edu/risk.html>

Exhibit 6
Potentially Relevant Mental Health Assessment Tools

Instrument Name/Creator	Description	Time to Complete	Strengths	Limitations
Mental Status				
MMSE (Mini-Mental Status Examination) Folstein (1975)	A 30-point scale designed to assess a client's cognitive performance—assesses orientation to time and place, attention, registration and recall, construction, and language.	5-15 minutes	Appropriate for dementia screening Effective in acute geriatric settings Validated tool for cognitive impairment	Insensitive to mild cognitive impairment Lack of diagnostic specificity May not be sensitive to education, literacy, or visual problems
3MS (The Modified Mini-Mental State Exam) Teng (1987)	Tests for both dementia and cognitive impairment. It is a 27-item questionnaire (19 MMSE plus 8 additional) that tests orientation to time and place, attention, concentration, long- and short-term memory, language, and abstract thinking.	5-15 minutes	Well validated Used nationally and internationally Used in a variety of settings (primary care, institutional, community)	No training aids available
Functioning				
(GAF) Global Assessment of Functioning Revised from Global Assessment Scale Edicott (1987)	Most widely used measure of psychiatric patient function. The GAF rates global functioning using a single score ranging from 1 (persistent danger of severely hurting self/others) to 100 (absence of symptoms to minimal symptoms).	5 minutes	Quick to administer Well known in field Strong research base in a variety of settings	Intended as generic, rather than diagnosis specific Has not been adapted over time; e.g. symptom research has not been incorporated in GAF Does not capture presence of positive and negative mental health factors
MIRECC GAF (Mental Illness Research, Education, and Clinical Centers Modified GAF) Department of Veterans Affairs, modified from Sullivan (1992)	Includes three scales for symptom severity, occupational functioning, and social functioning. This modified GAF was developed by VA researchers (in CA and AK) to improve treatment planning and performance measurement.	10-15 minutes	Assesses three domains of functioning Easily administered	Limited research to establish validity and reliability Analysis of results may be more complicated No training or guides

Instrument Name/Creator	Description	Time to Complete	Strengths	Limitations
K Axis (Modified GAF) Kennedy (2006)	Measures seven domains to test for levels of functioning in the following areas: psychological impairment, social skills, violence, ADL-occupational skills, substance abuse, medical impairment, ancillary impairment. Generates a GAF equivalent and a dangerousness level. Each subscale can also be used independently.	20 minutes	Multi-dimensional global assessment Generates GAF equivalent Includes dangerousness rating Includes violence and suicide factors in each subscale	Limited validity data available Licensing fee Requires training
Other				
BPRS (Brief Psychiatric Rating Scale) Ventura (1993) – UCLA	A clinician-based rating scale that assesses the presence/absence of psychiatric symptoms on a 7-point Likert scale. This scale is most frequently used in cases of schizophrenia.	20-30 minutes	Most researched instrument in psychiatry Rates a broad array of symptoms and is sensitive to change Validity and reliability well established	Designed primarily for individuals with psychiatric symptoms in inpatient settings Administered in context of a clinical interview Interview length and training required may not be suitable
BSI 18 (Brief Symptom Inventory 18) Derogatis (2000) – Pearson	A patient-reported instrument that measures somatization, depression, and anxiety in both inpatient and community settings.	4 minutes	Brief and easy to administer Abbreviated version of symptom checklist (SCL) Good overall screening for general levels of psychological distress	Relies on self-reports Used primarily to monitor mental health status during hospitalization and aftercare for patients with chronic conditions

Exhibit 7
Potentially Relevant Risk of Violence Assessment Tools

Instrument Name/Creator	Description	Time to Complete	Strengths	Limitations
<p>BVC (Broset Violence Checklist)²³</p> <p>Regional Secure Unit, Broset Norway (2003)</p>	<p>Short checklist that assesses risk of violence in next 24 hours. Rater scores presence (1) or absence (0) of confusion, irritability, boisterousness, physically threatening, verbally threatening, attacking objects</p>	<p>5 minutes</p>	<p>Well validated tool that predicts violence within next 24-hour period</p> <p>Extremely brief and observational-based</p>	<p>Designed for nurses in a psychiatric inpatient setting</p> <p>Other than risk of violence, binary (yes/no) responses provide limited information to assessor</p> <p>Ignores historical factors</p>
<p>COVR (Classification of Violence Risk)²⁴</p> <p>Psychological Assessment Resources (2002, 2005)</p>	<p>An interactive software program designed to inform clinical decisions about risk of violence to others. The interview includes 106 potential risk factors, including personal factors (e.g., demographic and personality variables), historical factors (e.g., past violence, mental hospitalizations), contextual factors (e.g., social support, social networks), and clinical factors (e.g., diagnosis, specific symptoms)</p>	<p>Estimated 10 minutes, but varies according to interview</p>	<p>Includes branching questions that are relevant, given previous answers</p> <p>Based on well-constructed MacArthur Violence Risk Assessment study that examines violence in community after discharge from civil psychiatric facilities</p>	<p>Developed and validated for use with acute psychiatric civil inpatient populations</p> <p>Requires laptop or personal computer</p>
<p>DASA (Dynamic Appraisal of Situational Aggression)²⁵</p> <p>Monash University, Australia (2006)</p>	<p>Assesses risk of aggression in an inpatient psychiatric setting within 24 hours. Combines elements of BVC, diagnostic-scale from HCR-20, and items derived from experiences at inpatient hospitals by researchers</p> <p>Combination of seven items: irritability, impulsivity, unwillingness to follow directions, sensitivity to perceived provocation, easily angered when requests are denied, negative attitudes, verbal threats</p>	<p>5-10 minutes</p>	<p>Combines elements of well-validated tools that have been shown to predict risk</p> <p>Brief instrument</p>	<p>Used primarily for risk monitoring by nurses in inpatient setting</p> <p>Requires period of observational time with individual</p>

²³ P. Woods & R. Almvik. (2002). The Broset Violence Checklist (BVC). *Acta Psychiatrica Scandinavica. Supplementum*, 412, 103.

²⁴ <http://www4.parinc.com/Products/Product.aspx?ProductID=COVR>

²⁵ <http://ecommerce.med.monash.edu.au/product.asp?pid=150&cid=11>

Instrument Name/Creator	Description	Time to Complete	Strengths	Limitations
<p>START (Short Term Assessment of Risk and Treatability)²⁶</p> <p>BC Mental Health and Addiction Services (2004, 2009)</p>	<p>A 20-item clinical guide for use in a wide variety of settings that is meant as a single assessment to help guide decision making in a variety of areas.</p>	<p>20 minutes</p>	<p>Applies to both inpatient settings and outpatient services</p> <p>Assesses strengths and vulnerabilities</p> <p>Provides broad range of information on dynamic risk and protective factors.</p>	<p>Intended for use by interdisciplinary team</p> <p>Limited research within US</p> <p>Poor statistical properties</p> <p>Not designed for assessment during crisis</p>
<p>V-RISK-10 (Violence Risk Screening 10)²⁷</p> <p>Centre for forensic psychiatry Oslo University Hospital, Ullevaal, Department of Psychiatry (2008)</p>	<p>Designed to be a brief and easy-to-use screening tool for use in short-term psychiatric settings. It is a two-page screen with 10 questions regarding a patient's violence, threats, substance abuse, major mental illness, personality disorder, lack of insight into illness, expressions of suspicion, lack of empathy, unrealistic planning, and future stress situation. Also includes overall clinical evaluation for risk (low/medium/high) and clinician suggestion for follow-up.</p>	<p>5 minutes</p>	<p>Detects risk in patients with no known history of violence</p> <p>Easy to use tool that does not require extensive training or expertise</p>	<p>Designed to measure violence after discharge from psychiatric facility</p> <p>Primary validation studies conducted outside United States</p>

²⁶ http://www.bcmhas.ca/research/research_start.htm

²⁷ http://www.forensic-psychiatry.no/violence_risk/index.html

Criminal History and Shared Data

When considering the range of risk assessments listed in Exhibit 7, it should be noted that a prior history of violence serves as one of the most powerful predictors of future dangerousness. The current ITA statute²⁸ recognizes the importance of historical records and directs DMHPs to consider “all reasonably available information and records regarding (1) prior recommendations for evaluation of the need for civil commitments, (2) history of one or more violent acts, and (3) prior determinations of incompetency or insanity.” In 2010, the Washington Legislature revised this chapter and expanded the scope of ITA investigations.²⁹ These changes, which take effect in 2012, allow the DMHP to detain an individual if his or her current symptoms or behavior:

- a) Are closely associated with symptoms or behavior that preceded and led to a past incident of involuntary hospitalization, severe deterioration, or one or more violent acts;
- b) Represent a marked and concerning change in the baseline behavior of the respondent; and
- c) Without treatment, the continued deterioration of the respondent is probable.³⁰

As discussed previously, information about an individual’s history of violence or mental illness is a critical piece of the ITA investigation. Unfortunately, a DMHP may not always have ready access to information that could inform an investigation. This section discusses two areas where information sharing could be expanded and improved—access to criminal justice records and improved sharing of commitment information.

²⁸ RCW 71.05.212

²⁹ Laws of 2010, ch. 280 (2SHB 3076)

³⁰ Laws of 2010, ch. 280 § 2 and 3

Crime Records

The Washington State Patrol (WSP) manages access to criminal justice records in the state of Washington. Any individual or organization can request information on convictions or pending charges that occurred within the last year. The Washington Access to Criminal History (WATCH) database can be accessed online for a fee of \$10 per search.³¹ This fee is waived for non-profit organizations and governmental entities.

Many DMHP offices currently access criminal conviction history through the WATCH database. This history, however, does not include non-conviction information such as arrests or concealed weapon permits. The WSP also oversees access to the National Crime Information Center (NCIC), which includes nationwide records of individual arrests. Only certified criminal justice agencies can view non-conviction criminal records through NCIC.

In 2008, the Washington State Legislature gave investigative authority to several state agencies outside law enforcement.³² These agencies need to access arrest records for purposes such as investigating fraud or abuse or conducting background checks. Agencies authorized for access under this legislation include:

- Department of Social and Health Services (public assistance fraud)
- Department of Labor and Industries (worker’s compensation investigations)
- Criminal Justice Training Commission (employment or peace officer certification)
- Office of Attorney General (Consumer Protection Act prosecutions)
- Employment Security Department (unemployment compensation abuse/fraud)
- Department of Licensing (licensing fraud)

³¹ <https://fortress.wa.gov/wsp/watch/>

³² Laws of 2008, ch. 74 (HB 2955)

In many counties, the DMHP office or RSN is able to request criminal background information from a local law enforcement agency. In a large jurisdiction, however, there are multiple law enforcement agencies, and it is not practical to contact each agency to determine a person's arrest history. Given that one of the main goals of an ITA investigation is to protect public safety, a DMHP should have ready access to the complete criminal history of a subject. While this access would likely require a statutory change, special authority has already been granted to organizations outside law enforcement. The importance of criminal history in risk assessments for violence is well established in the research literature.³³ Providing comprehensive criminal background information could improve assessment outcomes, enhance DMHP safety, and save both DMHPs and law enforcement time and resources.

Mental Health Records

County DMHPs and crisis offices report basic information about ITA investigations to the Regional Support Network (RSN), which sends these records to a state database. Each county office, however, operates independent data systems and does not have access to case records outside its county. Consequently, access to prior records regarding the subject of an investigation may not always be available. As part of this research effort, the Institute conducted an online survey of DMHP investigations that occurred during one week in late 2010. According to this survey, in 32 percent of investigations, the DMHP was unable to access information about previous investigations or commitments for an individual.

In some cases, an individual may also have a previous long-term commitment to the state psychiatric hospital. To obtain information on these commitments, however, the DMHP must

call the state hospital to make a records request and have information faxed. If an investigation occurs after business hours, it may not be feasible to obtain information about previous evaluations conducted at the state hospital. A secure, on-line case information system could be constructed to help determine, at a minimum, if an individual has a prior commitment to a state hospital, a previous finding of not guilty by reason of insanity (NGRI), or has ever been declared incompetent.

The state Division of Behavioral Health and Recovery already receives a limited amount of information about each DMHP investigation. This data could be made available in a searchable application that would provide DMHPs access to statewide information and outcomes of previous investigations. Such a system could offer additional information to a DMHP about previous patterns and outcomes that may be relevant in the current investigation and decision on whether or not to commit.

Alternatively, a central call center could be implemented where any state DMHP or crisis worker could call for information about a particular case. A review of mental health crisis services in King County suggested finding ways to "remove regulatory and agency-policy barriers to the sharing of information across agencies who are involved in mental health crisis prevention and intervention."³⁴ The report notes that many of these barriers may be based on real limitations to sharing information (such as health care privacy laws). In many cases, however, the perception of what information may or may not be disclosed can limit access to valuable evidence in an investigation. A centralized database or call-center could help bridge this divide and improve information sharing by making the proper information available to DMHPs, crisis workers, and law enforcement officials.

³³ A. Buchanan (2008). Risk of violence by psychiatric patients: Beyond the "actuarial versus clinical" assessment debate. *Psychiatric Services*, 59(2) 184–90.

³⁴ D. T. Satterberg, E. Vail, et al. (n.d.). *Examining the tools in the toolbox: A review of community supervision of dangerous mentally ill offenders*, p. 26. See: <http://www.leg.wa.gov/Senate/Committees/HSC/Documents/DMIOFinalReport.pdf>

DMHP Training and Investigation Protocols

The protocols for Designated Mental Health Professionals are designed to “provide uniform development and application of criteria in evaluation and commitment recommendations.”³⁵ These protocols were first developed in 1999, and DSHS is required by statute to update the protocols every three years. The last update was completed in December 2008,³⁶ and the protocols will be revised again in 2011.

The protocols clarify many of the legal terms and processes a DMHP must understand for the purpose of an ITA investigation. They describe an investigation in terms of the legal process a DMHP must follow. For example, the protocols outline the proper notification of legal rights during an investigation, the necessity of determining who is a legal decision maker, and the process of gathering statements and evidence from witnesses.

The protocols do not, however, discuss best practices for an investigation or specify critical pieces that should be gathered to determine the level of dangerousness present. Rather, the protocols direct the DMHP to make this assessment “based on an evaluation of the person, review of reasonably available history, and interviews of any witnesses.”³⁷

The upcoming DMHP protocol revision, which will occur in 2011, would be an excellent opportunity to outline the essential elements in an ITA investigation. The DMHP protocols’ workgroup includes members from the Department of Social and Health Services, the Washington Association of Designated Mental Health Professionals, Regional Support Networks, County Human and Emergency Services Departments, and legal representatives from Prosecuting Attorney and Public Defender offices.

This group could develop an investigation outline that specifies practices to follow in different types of investigations (danger to self, danger to others, grave disability) and establish common data elements to be collected in each investigation. A more detailed investigation protocol could help improve consistency in investigation in two ways.

First, this process could improve training opportunities. As mentioned previously, DMHPs have the opportunity to take a 40-hour intensive training course every year. This training, however, is not required and many DMHPs will receive training that is provided by the agency for which they work. A unified investigation protocol could be used in a variety of training settings and provide DMHPs across the state with common guidelines and expectations for conducting investigations.

Second, common investigation data and protocols could improve information for decision making. Reliable information about risk factors such as previous violence, substance abuse, prior hospitalizations, and other stressors could help identify which individuals would have successful outcomes. This analysis could also help determine how crisis intervention and inpatient treatment were related to subsequent rates of violence, suicide, or re-admission. At present, information collected during each investigation differs from county to county. A shared protocol that includes a common data set could assist in improving the knowledge base about outcomes of ITA investigations. While a validated tool does not currently exist for ITA assessments, there are many opportunities for enhancing and expanding the data currently collected as part of these investigations. This report highlighted available resources and outlined some of the options that may be beneficial in ITA investigations.

³⁵ RCW 71.05.214

³⁶ Department of Social and Health Services, 2008

³⁷ Ibid., p. 19

Appendix A: Mental Health Assessment Workgroup Members

Marc Bollinger – Deputy Director, Human Services Department, Cowlitz County

Kevin Black – Counsel, Senate Human Services and Corrections Committee, Washington State Legislature

Jan Dobbs – Emergency Services Director, Spokane Mental Health

Ian Harrel – Program Director, Behavioral Health Resources Acute Psychiatric Services

Pam Hutchinson – Emergency Services Manager, Compass Health

Chris Jennings – Public Defender, Pierce County

David Kludt – Program Administrator, Division of Behavioral Health and Recovery

Scott Kuhle – Emergency Services Director, Palouse River Counseling

Stephanie Lane – Consumer Advocate, Capital Clubhouse, Olympia

Debra Murray – Clinical Director, Chelan-Douglas Regional Support Network

Gregory Robinson – Senior Policy Analyst, Washington Community Mental Health Council

Ethan Rogers – Senior Deputy Prosecutor, King County

JoEllen Watson – Coordinator, King County Crisis and Commitment Services

Appendix B: Mental Health and Risk Assessment Citations

Brief Psychiatric Rating Scale (BPRS)

Ventura, J., Green, M.F., Shaner, A., & Liberman, R.P. (1993). Training and quality assurance with the Brief Psychiatric Rating Scale: "The drift busters." *International Journal of Methods in Psychiatric Research*, 3: 221-244.

Brief Symptom Inventory 18 (BSI 18)

Derogatis, L.R. (2000). *Brief Symptom Inventory 18 (BSI 18)*. San Antonio, TX: Pearson.

Broset Violence Checklist (BVC)

Woods, P. & Almvik, R. (2002). The Broset Violence Checklist (BVC). *Acta Psychiatrica Scandinavica Supplementum*, 412: 103.

Classification of Violence Risk (COVR)

Monahan, J., Steadman, H.J., Appelbaum, P.S., Grisso, T., Mulvey, E.P., Roth, L.H., et al. (2005). *Classification of Violence Risk*. Lutz, FL: Psychological Assessment Resources, Inc.

Dynamic Appraisal of Situational Aggression (DASA)

Ogloff, J. & Daffern, M. (2006). *Dynamic Appraisal of Situational Aggression: Inpatient Version*. Monash University (Australia), Centre for Forensic Behavioural Science.

Global Assessment of Functioning (GAF)

American Psychiatric Association. (1987). *Diagnostic and statistical manual of mental disorders, 3rd ed., revised (DSM-III-R)*. Washington, DC: Author.

Kennedy Axis V (K Axis V; Modified GAF)

Kennedy, J.A. (2003). *Mastering the Kennedy Axis V: A new psychiatric assessment of patient functioning*. Arlington, VA: American Psychiatric Publishing.

Mental Illness Research, Education, and Clinical Centers Modified Global Assessment of Functioning (MIRECC GAF)

Niv, N., Cohen, A.N., Sullivan, G., & Young, A.S. (2007). The MIRECC version of the Global Assessment of Functioning Scale: Reliability and validity. *Psychiatric Services*, 58: 529-535.

Mini-Mental Status Examination (MMSE)

Folstein M.F., Folstein S.E., & McHugh, P.R. (1975). "Mini-mental state": A practical method for grading the cognitive state of patients for the clinician. *Journal of Psychiatric Research*, 12(3): 189-198.

Modified Mini-Mental State Exam (3MS)

Teng, E.L. & Chui, H.C. (1987). A Modified Mini-Mental State (3MS) Examination. *Journal of Clinical Psychiatry*, 48: 314-318.

Short-Term Assessment of Risk and Treatability (START)

Webster, C.D., Martin, M-L., Brink, J., Nicholls, T.L., & Desmarais, S.L. (2009). *Short-Term Assessment of Risk and Treatability (START): Version 1.1*. Vancouver, BC: BC Mental Health and Addiction Services.

Violence Risk Screening-10 (V-RISK-10)

Centre for Forensic Psychiatry. (2008). *V-RISK-10 (Violence Risk Screening-10)*. Oslo, Norway: Oslo University Hospital.