HOT TOPICS IN MENTAL HEALTH & LAW: CIVIL COMMITMENT

“Navigating Juvenile Involuntary Commitment in Washington State”

Presented by Shawgi Silver, MD, MPHS

April 1, 2025

CENTER FOR MENTAL HEALTH, POLICY & THE LAW
UNIVERSITY of WASHINGTON

ABOUT THE CENTER FOR MENTAL HEALTH, POLICY & THE LAW

The Center for Mental Health, Policy, and the Law (CMHPL) is housed within the University of Washington (UW) Department of Psychiatry and Behavioral Sciences in the UW School of Medicine.

The CMHPL's mission is to address the most urgent issues arising at the interface of mental health and the law, in order to help justice-involved people with mental illness lead full and productive lives.

Learn more on our website: https://cmhpl.psychiatry.uw.edu/

HOT TOPICS IN MENTAL HEALTH & LAW: CIVIL COMMITMENT

November 12, 12:00–1:00 p.m. PT
"Civil Commitment 101: Overview of History and Current Practices"
Shadoe Jones, JD

December 13, 12:00–1:00 p.m. PT
"Civil Commitment Through the Ethics Lens: How We Got Here"
Philip Candilis, MD

January 7, 12:00–1:00 p.m. PT
"Designated Crisis Responders and the Involuntary Treatment Act in Washington State"
Dawn Macready-Santos, LICSW and Laura Pippin, MSP

February 4, 12:00–1:00 p.m. PT
"Lived Experiences with Civil Commitment"
Carolynn Ponzoha, Karen Schilde, Laura Van Tosh

March 4, 12:00–1:00 p.m. PT
"An Academic-State-Community Partnership to Create a CBT Continuum of Care for Involuntary Committees in Washington State"
Sarah Kopelovich, PhD, ABPP

April 1, 12:00–1:00 p.m. PT
"Navigating Juvenile Involuntary Commitment in Washington State"
Shawgi Silver, MD, MPHS

May 13, 12:00–1:00 p.m. PT
"Policy Perspectives on Washington's Continuum of Care for Severe Mental Illness"
Manka Dhingra, JD

June 10, 12:00–1:00 p.m. PT
"A Panel Discussion on the Civil Commitment Hot Topics Series"
Manka Dhingra, Shadoe Jones, Sarah Kopelovich, Dawn Macready-Santos, Laura Pippin, Shawgi Silver, Laura Van Tosh

Learn more and register: bit.ly/cmhpl

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RECORDINGS & CONTINUING EDUCATION

- The recording and presentation slides will be made available on our website within 1 week. We will email attendees with the link.
- Continuing education is only available for attendees who attend the live Zoom session, not for those who watch the recording.
- Certificates of attendance will be available for attendees who indicated interest. You will receive an email from cmhpl@uw.edu with additional details.
- Continuing Medical Education is available:
  - UW faculty and staff ONLY: You received an email from cmhpl@uw.edu with instructions and will need to sign-in via text by 2:00 p.m. PT.
  - For non-UW learners, we will track attendance via Zoom. You do not need to log in or update your name on Zoom, as attendance is tracked with your unique Zoom link.

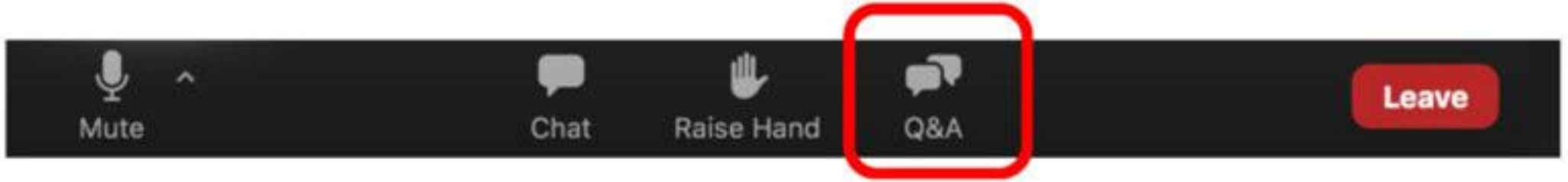
DISCLOSURES

Today's speaker, Shawgi Silver, has no financial relationships with an ineligible company relevant to this presentation to disclose.

None of the planners have relevant financial relationship(s) to disclose with ineligible companies whose primary business is producing, marketing, selling, re-selling, or distributing healthcare products used by or on patients.

QUESTIONS

To submit a question, please click the Q&A icon on Zoom.



Reminder: The series will conclude with a panel discussion and Q&A on June 10, 2025.

FINAL LOGISTICS

- The opinions expressed herein are the views of the speakers, and do not reflect an official position of the CMHPL or the UW. No official support or endorsement of the opinions described in this presentation from the CMHPL or the UW is intended or should be inferred.
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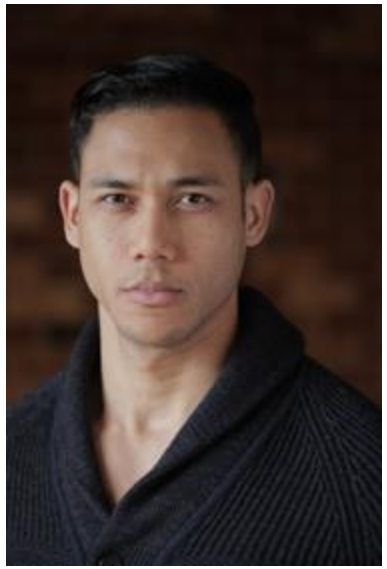
- Please complete the evaluation poll at the end of this session.

SHAWGI SILVER, MD, MPHS

Shawgi Silver, MD, MPHS, obtained his medical doctorate from Washington University in St. Louis School of Medicine. He went on to earn a Master of Population Health Sciences prior to completing medical residency at the same institution. He sub-specialized in child and adolescent psychiatry with a concentration in neurodevelopmental disorders at Seattle Children's Hospital and then completed an additional fellowship in forensic medicine at Oregon Health & Science University. He does work in worker's compensation, disability claims, fitness for duty evaluations, tort claims, and competency evaluations. His experience with testimony and depositions is an additionally distinguishing feature of his medico-legal work.



Navigating Juvenile Involuntary Commitment in Washington State

SHAWGI SILVER, MD, MPHS

Objectives

1. **Understand the Legal Framework:** Explain Washington State laws on **juvenile involuntary commitment**, including **RCW 71.34** and **Family-Initiated Treatment (FIT)**.

2. **Evaluate Ethical and Clinical Considerations:** Discuss the balance between **minor autonomy, parental rights, and state intervention** in psychiatric care.

3. **Apply Knowledge to Clinical Cases:** Use a **case study** to determine appropriate legal pathways and alternatives to hospitalization.

Emma's Story

- Emma was just 15 years old when she was brought to the emergency department after a suicide attempt.
- She had struggled with severe depression for years, and her parents, desperate to keep her safe, sought inpatient treatment.
- But Emma refused, insisting she wasn't a danger to herself.

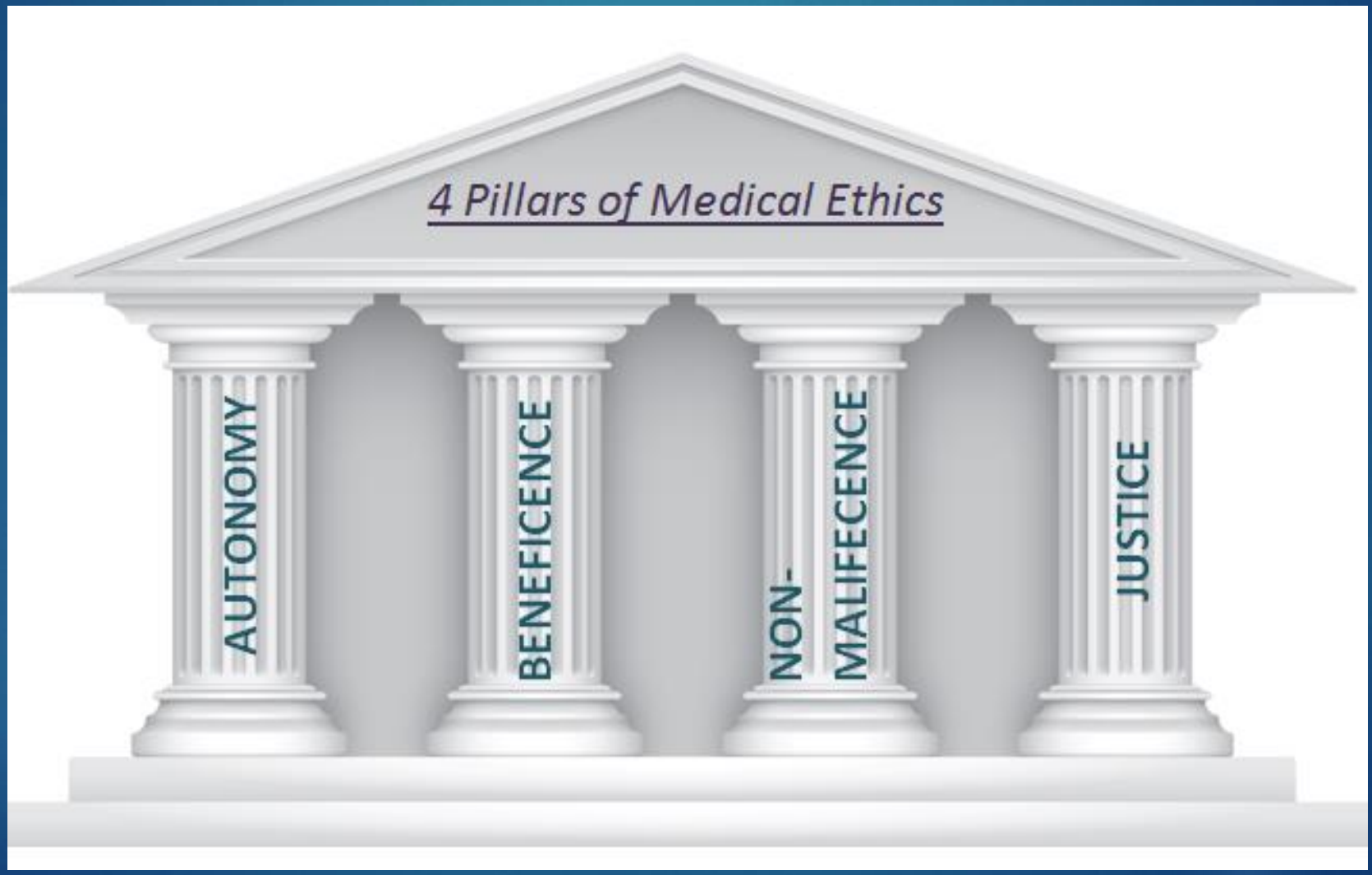
Autonomy vs. Safety

- Should a 15-year-old have the right to refuse life-saving treatment?
- At what age in Washington State is a juvenile responsible for their own mental healthcare decisions?
- How do we balance protecting a minor with respecting their autonomy?
- What role do parents play in gaining access to psychiatric treatment for youth ages 13–17?

The Four Core Principles

- Autonomy
- Beneficence
- Non-maleficence
- Justice

The "Four Pillars"



The Four Pillars Explained

- Autonomy
  - Respecting the patient's right to make informed decisions about their own healthcare.
- Beneficence
  - Doing good for the patient and promoting their well-being.
- Non-maleficence
  - Avoiding causing harm to the patient.
- Justice
  - Treating all patients fairly and equitably and ensuring that healthcare resources are distributed fairly.

Legal Principles

- Mostly the same as for adults and protected under the majority of the XIV Amendment (though not all elements are guaranteed to youth)

- Parens Patriae
  - Latin for "Parent of the Country or Homeland"
  - Legal doctrine that a state or court has a paternal and protective role over its citizens.

- Police Powers
  - Fundamental ability of a government to enact laws to coerce its citizenry for the public good

The Balancing Act

- Autonomy vs. Beneficence/Non-maleficence
- Constitutional rights vs. Medical Ethics
- Public safety vs. Individual Rights
- Parents' Responsibilities vs. Youth's Preferences
- Youth's choice vs. Medical Opinion

ITA Criteria

The youth…

- **Minor = ages 13–17**
- **Has a "behavioral health disorder"** as defined in RCW 71.34.020 **AND**

  In practice this typically translates to a mental health diagnosis that substantially impairs a person's cognitive, emotional, or behavioral functioning.
- **Poses a risk of serious harm** to themselves or others **OR**
- **Gravely disabled** due to their mental disorder.

Involuntary Commitment for Juveniles (ITA) Initial Detention

A. **Initial Detention & Evaluation**

- A **Designated Crisis Responder (DCR)** can detain a minor for up to **12 hours** for evaluation.

- If criteria are met, the minor can be held in a **certified evaluation and treatment (E&T) facility** for up to **120 hours (5 days), excluding weekends/holidays**.

Involuntary Commitment for Juveniles (ITA) Continued Detention

B. Court Process for Continued Detention

1. **Petition for 14-day Commitment:** Filed if the minor still meets commitment criteria.
   - Requires a court hearing within 72 hours.
   - Minor is entitled to legal representation.
   - Parents/guardians must be notified but **cannot override the minor's legal rights.**
2. **Subsequent 180-day Commitment:**
   - If continued treatment is necessary, the court may approve a longer period.
   - Requires clear evidence that lesser restrictive alternatives are insufficient.

Rights of Minors in the Involuntary Commitment Process

A. Due Process Rights

- Right to **legal representation** (court-appointed attorney if necessary)
- Right to **challenge commitment** via a court hearing
- Right to **request less restrictive treatment options**
- Right to **confidentiality** (with certain legal exceptions)

B. Role of Parents/Guardians

- Parents have the right to be involved but **cannot unilaterally discharge a minor** under ITA.
- They **must be notified** of proceedings unless it poses harm to the minor.

Family Initiated Treatment (FIT)

- A way for youth and/or their parents to seek out behavioral health treatment
- Option to access medically necessary inpatient, residential, and outpatient services
- Applies only in cases of medical necessity
- Requires periodic review (legal safeguard for youth's civil liberties)

Particulars of FIT

- Parents can provide consent *on behalf* of the youth.
  - Under FIT, parents can provide consent on behalf of youth and consent from the youth is not required.
- The youth must still meet medical necessity before treatment can be initiated. However, does not require the same criteria as ITA of youth.
- The FIT process creates an additional access point and does not guarantee care on demand.

Legal Framework for Commitment of Youth RCW 71.34 (FIT)

- **RCW 71.34**
  - **Family-Initiated Treatment (FIT)**
  - **RCW 71.34.600 - 71.34.670**

- Allows parents or legal guardians to **admit a minor (13-17) for inpatient treatment without their consent**.

- Does **not** require a court order, but the minor must undergo **periodic clinical reviews** to determine if hospitalization remains necessary.

- Minors can petition for discharge after an initial review.

Legal Framework for Commitment of Youth RCW 71.34 (AIT)

- **RCW 71.34**
  - **Voluntary Treatment for Minors (RCW 71.34.500 - 71.34.530)**
  - **Adolescent Initiated Treatment (AIT)**

- Minors **aged 13-17** can **voluntarily** admit themselves to inpatient psychiatric treatment.

- Parents can **also** seek treatment for their minor, even if the minor refuses, through **Family-Initiated Treatment (FIT)**.

- Minors can request discharge, but a professional must determine whether they still require treatment.

Ethical and Clinical Considerations

- Balancing Autonomy and Protection
  - There is a wider context. This is just segment of the youth's life
- Ethical challenges in overriding a minor's treatment refusal
  - "Never worry alone" –John Ortberg
- Importance of **trauma-informed care**
  - Keep second-order consequences in mind
- Addressing cultural and family dynamics in commitment decisions
  - Consider interpreter
  - Consider navigator
  - Consider ethics consult

Alternatives

- **Crisis intervention and stabilization services** (mobile crisis teams, respite care)
- **Partial hospitalization programs (PHP) & Intensive Outpatient Programs (IOP)**
- **Community-based treatment options**
  - **Wraparound with Intensive Services (WISe)**
  - **Mobile Crisis Response Teams**
  - **Therapeutic Foster Care & Respite Services**
  - **Peer Support & Family Support Programs**

Emma's Story
Scenario 1

- After a long conversation with the hospital's psychiatric team, Emma begins to realize the depth of her struggles.
- Though hesitant at first, she decides to voluntarily admit herself for treatment under **Adolescent-Initiated Treatment (AIT)**.
- Over the next few weeks, she works with a therapist, starts medication, and joins a support group for teens dealing with depression.
- With time, Emma gains coping skills and a sense of control over her recovery. By the time she is discharged, she feels hopeful for the first time in years and begins working on rebuilding her relationship with her family, who have also received support and education about her mental health.

Emma's Story
Scenario 2

- The **Designated Crisis Responder (DCR)** determines that Emma meets the criteria for **involuntary commitment** due to the severity of her suicide risk.
- Despite her initial anger and fear, the structured inpatient care helps stabilize her depression. Over the next 14 days, Emma receives therapy, medication adjustments, and supportive care.
- Slowly, she begins to feel relief from the overwhelming hopelessness that once consumed her. When she is released, she transitions into a **Partial Hospitalization Program (PHP)** and continues outpatient therapy.
- A year later, she's thriving in school, reconnecting with friends, and even helping others by volunteering for a youth mental health advocacy group.

Emma's Story
Scenario 3

- Emma refuses treatment, but her parents, desperate to help her, use **Family-Initiated Treatment (FIT)** to admit her to the hospital.
- Though resistant at first, she eventually opens up to her treatment team. The care team helps her understand that her parents' actions come from love and concern.
- Over the next few weeks, Emma starts to feel better—she finds comfort in journaling, music therapy, and group sessions where she meets other teens who understand her struggles. With time, she and her parents work on communication through family therapy.
- When she's discharged, Emma expresses gratitude that her parents fought for her when she couldn't fight for herself. A year later, she's in a much better place, pursuing her dream of becoming a counselor to help other struggling teens.

Key Takeaways

- The ITA provides strict criteria for juvenile involuntary commitment in WA State.
- Minors have **legal rights** that must be upheld during the process.
- Ethical considerations play a major role in decision-making.
- Alternative interventions should always be explored before commitment.
- Trauma-informed care is an essential aspect in any ITA process.

Objectives

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2. **Evaluate Ethical and Clinical Considerations:** Discuss the balance between **minor autonomy, parental rights, and state intervention** in psychiatric care.

3. **Apply Knowledge to Clinical Cases:** Use **case studies** to determine appropriate legal pathways and alternatives to hospitalization.

Thank you!

Always remember that medicine is a team sport and chiefly based in negotiation.

Resources

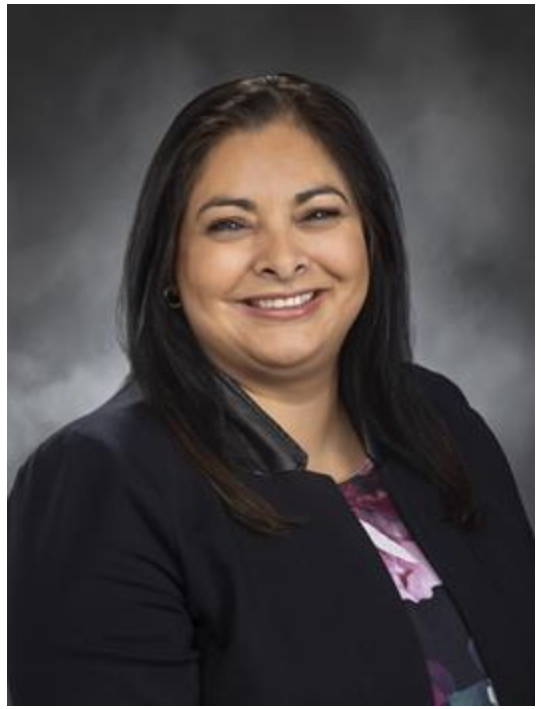
1. Washington State RCW 71.34 – Behavioral Health Services for Minors
2. Washington State Health Care Authority – Family-Initiated Treatment (FIT) Overview
3. Washington Courts – Involuntary Commitment Hearings and Legal Process
4. American Academy of Child and Adolescent Psychiatry (AACAP) – Involuntary Psychiatric Hospitalization of Children and Adolescents
5. National Alliance on Mental Illness (NAMI) Washington – Crisis Services & Advocacy for Minors

POLICY PERSPECTIVES ON WASHINGTON'S CONTINUUM OF CARE FOR SEVERE MENTAL ILLNESS

May 13, 2025, 12:00–1:00 p.m. PT

Senator Manka Dhingra, JD, will provide a brief history of Washington civil commitment laws, recent policy changes, and investments along the entire continuum of care for severe mental illness, including our 988 system and forensic mental health.

Learn more and get Zoom link: bit.ly/cmhpl



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