POLICY 4.30 PROVIDING HEALTH CARE FOR JR YOUTH

Policy Committee Chair
Lori Kesl
Regional Administrator, Regions 1 & 2
Juvenile Rehabilitation

Approved

Rebecca Kelly, Acting Assistant Secretary
Juvenile Rehabilitation
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Authorizing Sources
RCW 9.02.100 (1)
RCW 13.04.047, 13.40.010 (f), 13.40.460
RCW 26.28.015 (5), RCW 69.40,
RCW 69.41.095, RCW 69.50, RCW 70.02,
RCW 70.24.340 (1), RCW 72.05.130
WAC 182.502, 182-531-1675
WAC 246-877-020
DCYF AP 7.05, DCYF AP 13.04, DCYF AP 13.06
28 CFR Part 115 PREA, Juvenile Facility Standards
NCCHC Standards

Information Contact
Andrea Ruiz
Policy, Planning & Lean Administrator
Juvenile Rehabilitation

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I. PURPOSE AND SCOPE

This document establishes policy relating to the provision of health care for Juvenile Rehabilitation (JR) youth and young adults[2] (referred to as "youth" throughout policy unless age specific). JR will provide youth excellent medical, dental, and mental health care that meets or exceeds community standards with compassion and respect for all, while also complying with the National Center for Correctional Health Care (NCCHC standards).[3]

All staff, contractors, volunteers, and interns working in or for JR are responsible for reviewing and complying with JR policies.

[1] 3/17/2022 Technical Edit: Added link to new DCYF Admin. Policy 13.06 Records Management & Retention.
[2] 9/17/2020 Technical Edit: Added "young adults" clarifying the policy also covers JR individuals ages 18+. [3] 8/14/2019 Technical Edit: Added medical mission statement

II. POLICY[4]

1. **JR staff, including health care staff, must comply with DCYF AP 13.04 and the privacy protections of the State Uniform Health Care Information ACT (RCW 70.02) and the requirements for managing confidential client health care information since JR.**
   1.1.
2. **JR will maintain a health center at each institution and a Medical Director. Each health center will maintain accreditation by NCCHC.**
3. **JR will attempt, when reasonable, to access a youth's health care insurance for health care expenses. (Attachment 2 – Medicaid Procedures)[5]**
   3.1. JR will ensure youth ages 19 and younger are screened for eligibility for state medical assistance when transitioned to a community facility or before being released to parole.

HEALTH SCREENING AT INTAKE

4. **JR must conduct a health screening within one hour of intake for youth entering institution placement. (PbS Standard H2, NCCHC Y-E-02).[6]**
   4.1. Health care staff must complete the Client Health Screen in ACT. The Client Health Screen is RN-generated and will be completed within 24 hours.
   4.2. If health care staff are unavailable within the youth's first hour, trained intake staff must complete the Intake Client Health Screening form in ACT.
   4.3. Staff will also conduct the health screening (as above) within one hour when youth returns:
      4.3.1. To an institution from a different JR residential facility
      4.3.2. To JR for a parole revocation
      4.3.3. From Authorized Leave
      4.3.4. From being away from JR supervision for more than 24 hours
   4.4. When a youth returns from a county detention facility, the youth will be offered the opportunity to check in with health care staff to discuss any medical concerns the youth may have. Health care staff will document the response in a medical progress note.
      4.4.1. Staff will ask youth returning to a community facility from a detention facility if they have any medical concerns relating to their stay in detention. If concerns are identified, staff will connect with health care staff at the institution or with a local clinician.

[4] 3/17/2022 Technical Edit: Removed HIPAA language since DCYF and JR are not HIPAA-covered entity, and replaced references from JR policies 1.40 and 2.40 (archived policies) with DCYF Admin Policy 13.06.
[5] 9/17/2020 Technical Edit: Added reference to new attachment for Medicaid procedures.
[6] 9/17/2020 Technical Edit: Removed statement 4.5 (no longer current practice)

PROVIDING BASIC HEALTH CARE

5. JR has authority and responsibility to provide basic and routine health care to residential youth.

5.1. JR may provide health education and preventive care that reasonably responds to a youth's health care needs. Urgency of need, safety, security, time, and resources will be considered.

5.2. Health assessments are required unless the youth refuses. Health care staff will authorize the scope of physically strenuous activity for youth who refuse health assessments.

5.3. Youth will receive annual physical and dental examinations.

6. Youth may refuse basic health care for conditions which do not significantly compromise the youth's health or pose a threat to the health or safety of others.

6.1. Youth must sign the Health Care Refusal (DCYF form 20-275) any time basic or routine care is refused. This form will be maintained in the youth medical file.

6.2. Health care staff completing Health Care Refusal with youth will specify the reason for recommended health care and possible results of refusal.

7. JR must verify, provide, and document legally required immunizations for youth attending school.

7.1. JR will request current immunization records from the Department of Health's statewide immunization information system, custodial parents, legal guardians, or school district.

7.2. Custodial parents and legal guardians may request an exemption from immunization by completing the Certificate of Exemption[7] (DOH Form 348-106).

7.3. Health Immunizations provided by JR Health care staff will be documented in the Immunization Registry maintained by the Department of Health.

8. Youth who are transgender, gender non-conforming or lesbian, gay, bisexual, queer or questioning must not be required to see a therapist solely because of their gender identity or sexual orientation.

PROVIDING SUPPLEMENTAL HEALTH CARE

9. JR may provide supplemental health care.

9.1. Requests for supplemental health care by youth, parents, or legal guardians must be in writing.

9.2. The request will be documented in the medical progress notes in the Automated Client Tracking (ACT) system.

9.3. The health care staff or JR Medical Director may make, and will review requests for supplemental health care. The Superintendent, Regional Administrator, or designee will approve or deny requests in consultation with the Medical Director.

9.4. Supplemental Health Care is subject to safety, security, and availability of resources.

[7] 3/14/19 Technical Edit: Updated DOH form name

9.5. The youth, parents, or legal guardians may be financially responsible for supplemental health care including staffing, security and transportation.

9.6. For youth who enter a JR facility with cosmetic issues (e.g., orthodontic care) and the youth, parent or guardian requests referral, evaluation, replacement or adjustment, JR will:

9.6.1. Continue with community appointments, if supplemental health care is requested and approved, or

9.6.2. Use temporizing measures to ensure there are no complications while the youth is in JR care.

PROVIDING EMERGENCY HEALTH CARE

10. JR must provide emergency health care.

10.1. Staff will respond, consistent with their level of training, if they identify a youth in need of emergency health care.

10.2. Superintendents, Regional Administrators, or designees will develop a local procedure to communicate emergency health care.

10.3. Health care staff and security, where available, will immediately respond to medical emergency calls.

10.3.1. For life-threatening emergencies, medical care must not be delayed by attempts to reach medical staff. Staff will call 9-1-1 first.

10.4. Superintendents, Regional Administrators and the Medical Director will jointly approve an emergency plan developed by the local Health Care Authority to provide emergency health care when and where health care staff are not on duty.

10.5. Emergency care will not be delayed. Attempts to notify the parent or legal guardian will be made after attending to the youth's medical needs.

PROVIDING GENDER-CONFIRMING HEALTH CARE

11. Gender-confirming health care will be considered a medical necessity. All care must be provided in alignment with the Health Care Authority's position (WAC 182-531-1675) and the community standard of care.[8]

11.1. All requests for gender-confirming health care must be:

11.1.1. Reviewed on a case-by-case basis

11.1.2. Consider the youth's age and remaining time in JR

11.1.3. Approved by the Medical Director before providing care

11.2. A youth's transgender identity will be considered as Protected Health Information and will be protected by relevant patient privacy laws.

[8] 9/17/2020 Technical Edit: Updated policy statement 11 to align with HCA and the community of care.

PROVIDING INVOLUNTARY TREATMENT

12. JR may provide involuntary treatment.

12.1. The health care staff is authorized to request involuntary treatment for youth when imminent danger of significant health risk is present.

12.2. Health care staff, Community Facility Administrator, contracted provider or designee will notify the Superintendent, Regional Administrator or designee and the Medical Director immediately of decisions to provide involuntary treatment.

12.3. For involuntary treatment of mental illness, staff will refer to Policy 4.31, *Administering Involuntary Psychotropic Medication to Youth*.

12.4. All trained JR staff are authorized to provide an opioid overdose reversal medication (e.g. Naloxone or Narcan) to youth if suspected to at risk of experiencing an opioid-related overdose as authorized under RCW 69.41.095.[9]

LEGALLY MANDATED TESTING

13. Staff[10] will complete and document mandatory DNA or HIV testing in ACT per Policy 4.40, *Determining the Need for DNA or HIV Testing*.

PARENT NOTIFICATION

14. Staff will use the parent orientation letter to notify parents or legal guardians of JR's authority and responsibility to provide basic health care.

14.1. JR will include an authorization form in the intake packet for parents to sign if they choose, authorizing JR to make supplemental health care decisions while the youth is in residence.

15. Youth consent to share information with parents or legal guardians must be obtained consistent with DCYF Admin Policy 13.06 Records Management and Retention.

16. Parents or legal guardians must be notified of the following, unless the youth is legally entitled to privacy and does not want the information shared[11]:

16.1. If a youth has a significant health condition,

16.2. If a youth requires emergency medical care,

16.3. Decisions regarding requests for supplemental health care.

17. Health care staff at the institution, the Community Facility Administrator, or designee will complete the notification and document the contact in ACT.

17.1. Staff will attempt to notify both parents or legal guardians.

17.2. Staff will refer to Client Relationships in ACT for parent or guardian information.

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[9] 8/30/2021 Technical Edit: Added #12.4 following the memo sent to all JR staff on 8/30/2021 regarding Narcan.

[10] 9/17/2020 Technical Edit: Removed "Health care" to align with current practice (varies by location).

[11] 9/17/2020 Technical Edit: Added "unless the youth is legally entitled to privacy and does not want the information shared" to align with medical requirements.

17.3. The notification will be completed by telephone. If contact cannot be made, a certified letter will be sent to parents or legal guardians no later than the end of the next business day.

18. For a significant health condition, the notification will be completed within 4 hours of diagnosis.

19. In the event a youth requires emergency medical care, notification will be completed within 4 hours of the event.

CONSENT FOR CARE

20. Youth under age 18 may consent for the following types of health care without obtaining parent consent:

20.1. Assessment;

20.2. Mental health treatment when the youth is age 13 or older;

20.3. Sexually transmitted disease (STD) treatment when the youth is age 14 or older;

20.4. HIV/AIDS treatment when the youth is age 14 or older; or

20.5. Birth control.

21. Parent consent is required for specific types of health care. Care cannot be provided unless consent is obtained.

21.1. Written consent of parents or legal guardians is required for supplemental health care if the youth is under age 18.

21.2. If necessary health care requiring general anesthesia is needed from a non- JR physician, JR health care staff may coordinate with the doctor to obtain consent from parents or legal guardian.

21.3. Written consent of parents or legal guardians is required for gender-confirming health care if the youth is under age 18.

22. JR will attempt to obtain consent for care from both parents. In the event both parents cannot be reached, consent from one parent must be combined with documentation JR was unsuccessful at contacting the other parent.

23. Consent for care may be obtained from a dependent youth's Child Welfare[12] caseworker in the event a youth requires supplemental care and parents cannot be reached.

23.1. If caseworker consent is required, staff will coordinate with the caseworker at least three weeks prior to the scheduled care, if possible, to support the caseworker in seeking a court order from the dependency court authorizing the care.

23.2. Caseworker consent is not required for routine or emergency health care for dependent youth.

[12] 9/17/2020 Technical Edit: Changed from Children's Administration to Child Welfare.

MEDICATION

24. Under no circumstances are stimulants, tranquilizers or psychotropic drugs administered for purposes of discipline, security, control, or for purposes of experimental research. (ACA Standard 4-JCF-4C-30)

25. Medications arriving for youth are to be reviewed and approved by health care staff or the health care practitioner.

26. Youth must have a physician's authorization before the use of any herbal supplements, remedies, vitamins, or minerals may be permitted.

26.1. Youth taking prescription medications must have the prescribing physician's authorization before the use of any non-prescription drug, herbal supplements, remedies, vitamins or minerals are taken in order to minimize drug interactions.

PRESCRIPTION OF OPIATES IN JR

27. JR medical staff may prescribe opiates to reduce suffering from acute pain. Prescribed opiates must be monitored to avoid the potential for addiction or addiction relapse.

27.1. Opiates will only be used for acute pain unless approved by the JR Medical Director or designee.

27.2. Opiates used for acute pain will be of the lowest strength to control the pain.

27.3. The duration of opiate therapy will not exceed three days unless approved by the JR Medical Director or designee.

27.4. Therapies including ice, immobilization, elevation, NSAID or acetaminophen will be used throughout the period of opiate therapy to reduce the need for opiate-based intervention.

27.5. Youth will be educated and involved in the decisions surrounding opiate use, especially those with histories of addiction to substances.

MEDICALLY ASSISTED TREATMENT (MAT) PROGRAM FOR YOUTH AT RISK OF OPIATE USE

28. Any youth with a possible opioid use disorder (OUD) should be evaluated and considered for medication treatment and psychotherapy.[13]

29. If a youth is diagnosed with an OUD at any time during their commitment, they may be offered medication support in addition to participation in JR substance use disorder (SUD) treatment. (see Attachment 1 for Guidelines)[14]

29.1. JR medical staff will designate staff authorized to refer youth for the medication support program. Referrals may also come from any individual including parents, guardians, other non-designated staff, or the youth.

29.2. Youth referred to the program will see a JR medical provider, who will evaluate the youth's willingness to participate in the program.

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[13] 1/5/2021 Technical Edit: Added statement #28 and updated guidelines.
[14] 9/17/2020 Technical Edit: Updated language from "identified opiate user" to "diagnosed with an opioid use disorder" and added guidelines.

29.3. Youth willing to have Naloxone (Narcan) in their possession or to receive a Naltrexone injection or Buprenorphine will receive education about the medication.

29.3.1. Education provided must include information about the effects of the medication, possible adverse effects, and procedures for use of the medication (when and how to use it).

29.4. Narcan may be issued to the youth at discharge from a JR institution or community facility or prior to transfer to a community facility.

29.5. Naltrexone injections or Buprenorphine may be given by a medical provider prior to discharge from a JR institution or community facility or prior to transfer to a community facility.

29.5.1. Medical staff at the institution will provide the youth with a trial dose of oral Naltrexone prior to leaving the institution to ensure tolerance.

29.5.2. Medical providers in the community will provide Naltrexone if needed for youth residing in a community facility. Community facility staff will not give injections.

29.5.3. Parents or guardians and community facility staff will be provided with information about Naltrexone and the possibility of continuing injections in addition to drug treatment.

29.6. JR will follow up with youth given Narcan and or Naltrexone via telephone to track usage of the medication and outcomes after leaving the institution.

MEDICATION MANAGEMENT

30. Medications, including non-prescription, must be controlled, secured and monitored.

31. Staff who distribute medication must:

31.1. Monitor youth taking medication;

31.2. Record medications offered according to orders in the medical record;

31.3. Document acceptance or refusal.

32. Medication must be stored in original containers and secured.

32.1. Topical, oral, inhalant, injectable, and suppository medications must be stored separately from each other.

33. Youth on prescription medications will be transferred or discharged with a 15 day or more supply of medication and a prescription for 30 days of medication.[15]

34. Health care staff must comply with the Washington State Board of Pharmacy Laws and Rules to control, secure, distribute, and monitor medication.

34.1. In facilities where non-health care staff supervise youth self-administering medication, and where the Washington State Board of Pharmacy Laws and Rules apply, youth will take medication directly from the pharmacy labeled container under supervision of staff.

[15] 3/14/19 Technical Edit: Updated medication supply amounts to align with Policy 6.31

35. Medication will be disposed of pursuant to the Washington State Board of Pharmacy Laws and Rules:

35.1. Unused regulated (DEA-controlled) medications must be disposed in a manner approved by the Board of Pharmacy and witnessed by two licensed medical staff.

35.2. Counting DEA-controlled medications (but not disposing of them) may be done by one licensed medical staff and one non-licensed line staff or two non-licensed medical staff, if two licensed staff are not available.

35.3. All other unused medication in bubble packs will be returned to a designated Police or Fire station for disposal.

35.4. Community Facilities will bring unused and discontinued medications to a designated location for controlled substance disposal. If no location is designated, CF's may follow local Department of Health guidelines for disposal.[16]

35.5. Disposal will be documented.

INFECTIOUS DISEASE PRACTICES

36. JR will ensure procedures are followed to minimize the spread of infectious diseases including prevention and monitoring.

36.1. JR will ensure youth have access to education regarding prevention and spread of communicable diseases, including sexually transmitted and blood borne illnesses.

36.2. JR may provide testing for HIV infection upon a youth's request. Counseling around HIV testing will be provided when indicated.

37. Staff with a reportable communicable disease in an infectious state as defined by the Department of Health must not be on duty until they have a physician's approval for returning to work.

MEDICAL QUARANTINE[17]

38. Youth may be medically quarantined if deemed necessary by the Medical Director or designee.

38.1. Youth may be medically quarantined in an institution health center if necessary.

38.2. Isolation rooms in units may be used for medical quarantine with the approval of the Medical Director or designee.

[16] 12/14/18 Technical Edit: Updated to clarify medication disposal protocols for community facilities
[17] 3/17/2022 Technical Edit: Changed references from medical isolation to medical quarantine to align with changes in JR Policy 5.50.

NOTIFYING THE MEDICAL DIRECTOR

39. Health care staff will verbally notify the Medical Director or designee within specified time periods.

40. The Medical Director or designee must be notified within 2 hours of:

40.1. Medical quarantine

40.2. Serious or life threatening medication errors

40.3. Youth considered for the involuntary administration of psychotropic medication, per Policy 4.31, *Administering Involuntary Psychotropic Medication to Youth* 40.4.

Placement of a youth on SPL 1

40.5. A suicide attempt

40.6. Transfers of youth to the emergency department of a hospital

40.7. Hospitalization of youth

40.8. Death of youth, per Policy 1.31, *Responding to the Death of a Residential Youth*.

41. The Medical Director or designee must be notified within 24 hours of:

41.1. Commitment or intake of a medically fragile youth

41.2. Parental requests to communicate with the Medical Director

41.3. A request for review through the Continuous Quality Improvement Program

41.4. Institutional transfer of a youth for health care.

42. The designee will be the health care staff on call. If the designee is notified, an email will be sent to the Medical Director for information purposes.

43. Medical Director notifications must be documented in ACT medical progress notes.

DOCUMENTATION OF HEALTH CARE

44. Documentation of health care will be maintained in the ACT Medical Database in compliance with the State Uniform Health Care Information ACT (RCW 70.02). Medical information will be managed by trained medical staff.

44.1. All contacts with clinicians will be documented, including, but not limited to medical, mental and oral health care.

45. Each community facility will designate a staff member who will serve as a Health Care Liaison to support and document health care for youth who are accessing medical care in the community (NCCHC Y-C-08).

45.1. Health Care Liaisons will be given access to the medical database in ACT and provided additional training on use of the database.

45.2. Health Care Liaisons will document the following in medical progress notes:

45.2.1. Appointments in the community

45.2.2. ER visits

45.2.3. Changes to prescribed medication or dosage, including the reason for the change

45.2.4. Results of lab studies

45.2.5. Imaging reports

45.3. Health Care Liaisons will scan and upload any documents from community providers using ACT Document Uploader into the medical or mental health sections.

45.4. Health Care Liaisons will contact institution medical staff directly by phone and email prior to the time of a transfer if the medical information in ACT is incomplete or there are any urgent or serious medical concerns.

46. Health care staff will complete Health Care Transfer or Release in ACT. Health care staff will also complete and send the Certificate of Immunization Status (DOH Form 348-013) when release, discharge or transfer occurs, as follows:

46.1. When a youth is moved temporarily or permanently to another institution or minimum security facility, medical records will be sent with the Case File per DCYF Admin Policy 13.06 Records Management and Retention.

46.2. When a youth is released to a Children's Administration placement, a copy of the medical records will be sent to the youth's caseworker.

46.3. Upon request and unless precluded by DCYF Admin Policy 13.06 Records Management and Retention, when a youth is being released and will be residing in the home of a parent or legal guardian:

46.3.1. If the youth is under 18 years of age, copies of records should be given to the parent or legal guardian, with the exception of confidential information, including treatment for sexually transmitted diseases, mental health treatment and birth control depending on age as stipulated by WA state law.

46.3.2. If the youth is 18 years of age or older, copies of records should be given directly to the youth.

47. The Medical File is part of the JR Case File. Transfer of the Medical File will occur consistent with DCYF Admin Policy 13.06 Records Management and Retention.

48. Health care information will be shared between staff involved in the youth's care consistent with DCYF Admin Policy 13.06 Records Management and Retention.

48.1. Confidential identity and medical information must be handled in accordance with the State Uniform Health Care Information ACT (RCW 70.02), including, but not limited to, gender identity, sexual orientation and preferred pronouns.

PROVIDING MEDICAL CARE TO YOUTH IN THE YOUTHFUL OFFENDER PROGRAM

49. JR will provide all YOP youth with health services in alignment with this policy, including routine and emergency care.

49.1. JR will provide transportation and security for YOP youth who are going to outside medical appointments unless DOC makes alternate arrangements.

49.2. JR will consult with a Registered Nurse at the receiving facility or the DOC Utilization Management Office prior to any transfer for medical reasons.

49.3. JR will notify DOC within four hours if a YOP has had an emergency medical transport.

50. DOC may, at its option, retake custody of the youth for medical reasons.

50.1. If DOC elects to retake custody in order to provide necessary medical care within their facility, the JR Security Manager will coordinate with DOC for transport.

51. DOC is financially responsible for pre-authorized extraordinary (non-elective) and legitimate emergency care.

51.1. Pre-authorizations and approvals are coordinated by nursing staff, administrator or designee.

51.2. JR must notify the DOC Utilization Management Office of legitimate emergency care within four hours of transport to the Emergency Room and before any hospital admission.

51.3. Requests for reimbursement for eligible medical care must be made to DOC within 60 days of the date the cost was incurred.

52. JR will provide medical documentation to accompany the youth upon transport to another medical or correctional facility. Documentation must include the youth's name, DOC number, date of birth, any known allergies, current medication list, and description of current medical problem(s).

53. DOC will provide a supply of current medications when youth are transferred to JR.

PROVIDING MEDICAL CARE TO PREGNANT YOUTH

54. JR will provide medical care to youth who are pregnant.

54.1. Information about pregnancy and the post-partum period is covered by the State Uniform Health Care Information ACT (RCW 70.02) and must be treated as confidential. It must not be distributed beyond persons with a need to know.

55. On admission, a female youth who claims to be pregnant must be treated as such until a pregnancy test confirms pregnancy or not.

55.1. Pregnancy testing will be done within one working day of the youth's facility arrival.

55.2. The results of any positive pregnancy test must be provided to the Superintendent or designee in order to limit the use of restraints and ensure appropriate medical care is provided.

56. Youth who are pregnant or who report pregnancy must be informed of the legislation regarding use of mechanical restraint and use of restraints during transportation.

56.1. Intake staff will provide the Use of Restraints Limited for Pregnant JR Youth[18] brochure to the pregnant youth within seven days of admission to a JR facility.

57. Pregnant youth will receive specialized medical services[19] during pregnancy.

57.1. The treating medical practitioner will provide the date of estimated delivery.

57.2. The determination must be communicated in writing to the Superintendent and Transportation Administrator, and documented in the youth's medical file.

[18] 3/14/19 Technical Edit: Inserted brochure name
[19] 3/14/19 Technical Edit: Replaced OB-GYN with medical

57.3. A birthing plan[20] will be developed, in collaboration with the youth and medical provider, that incorporates supervision during labor, delivery, and hospital stays.

57.3.1. The documented birthing plan must be uploaded to the medical database and communicated in writing to the Appointing Authority, Community Facility Administrator, or designee.

58. Transportation of pregnant youth must be done in accordance with Policy 5.40, *Transporting Youth* and Policy 5.10, *Using Physical Restraints*.

59. Counseling staff, staff who were chosen to serve as a birthing coach, or a program manager escorting the youth may be present in the exam room or delivery room if the treating medical provider allows their presence during labor and delivery.

59.1. Staff may be present during routine medical checkups, consistent with custody requirements and with the consent of the youth.

60. The treating physician may order removal of mechanical restraints from a pregnant youth.

60.1. Staff must follow the order immediately.

60.2. Approved physical restraint may be used by staff if necessary per Policy 5.10, *Using Physical Restraints.*

61. If possible, the medical provider will estimate the final date of post-partum recovery period as soon as possible after delivery and provide the date to the Superintendent and the Medical Director.

MEDICAL RESPONSE TO SEXUAL ABUSE OR HARASSMENT

62. Medical and mental health practitioners must report sexual abuse in accordance with Policy 5.90, *Applying the PREA Juvenile Standards in JR* and Policy 5.91, *Reporting Child Abuse and Neglect*. (PREA Standard 115.361 (d))

62.1. Medical and mental health practitioners will inform youth at the initiation of services of the practitioner's duty to report and the limitations of confidentiality. (PREA Standard 115.361 (d)(2))

63. JR must ensure all full- and part-time medical and mental health practitioners who work regularly in its facilities received specialized training. (PREA Standard 115.335 (a)) The training must include:

63.1. How to detect and assess signs of sexual abuse and sexual harassment

63.2. How to preserve physical evidence of sexual abuse

63.3. How to respond effectively and professionally to juvenile victims of sexual abuse and sexual harassment

63.4. How and to whom to report allegations or suspicions of sexual abuse or sexual harassment.

63.5. JR must maintain documentation medical and mental health care practitioners received the specialized training either from JR or elsewhere. (PREA Standard 115.335 (c))

[20] 3/14/19 Technical Edit: Added 56.3 regarding a birthing plan

63.6. Medical and mental health care practitioners must also receive the training mandated for employees or for contractors and volunteers depending on the practitioner's status with JR. (PREA Standard 115.335 (d))

64. When residents indicate on the Sexually Aggressive-Vulnerable Youth (SAVY) assessment (in accordance with Policy 3.20, *Assessing Sexually Aggressive or Vulnerable Youth*) they experienced prior sexual victimization or prior perpetration of sexual abuse, JR staff shall ensure the resident is offered an appointment with a medical or mental health practitioner within 14 days of completion of the SAVY. (PREA Standard 115.381 (a-b))

64.1. JR must conduct a mental health evaluation of all known youth-on-youth abusers within 60 days of learning of such abuse history, and offer treatment as recommended by mental health practitioners. (PREA Standard 115.383 (h))

64.2. Medical and mental health practitioners must obtain informed consent from youth over the age of 18 before reporting information about prior sexual victimization that did not occur in a JR residential setting. Mandatory reporting requirements apply for youth under the age of 18 (in accordance with Policy 5.91, *Reporting Abuse and Neglect*). (PREA Standard 115.381 (d))

65. JR must provide victims of sexual abuse timely and unimpeded access to emergency medical treatment and crisis intervention, guided by medical and mental health practitioners. (PREA Standard 115.382 (a))

65.1. If no medical or mental health care provider is on duty at the time of the report, first-responders must protect the youth and immediately notify the JR Medical Director and the Superintendent, Regional Administrator or designee in accordance with Policy 1.30, *Reporting Serious and Emergent Incidents*. (PREA Standard 115.382 (b))

65.2. Victims must be provided timely information about and access to emergency contraception and preventive treatment for sexually transmitted infection in accordance with professional standards of care. (PREA Standard 115.382 (c))

66. JR must offer medical and mental health evaluation and treatment as needed to all youth who were victims of sexual abuse in any prison, jail, or juvenile detention facility. (PREA Standard 115.383 (a))

66.1. Evaluation and treatment must include follow-up services, treatment plans, and referrals to needed services when transferred or released. (PREA Standard 115.383 (b))

66.2. Victims must be offered tests for pregnancy and sexually transmitted infection. (PREA Standard 115.383 (d, f))

66.2.1. If a victim is pregnant, she must be provided timely access to comprehensive pregnancy information and medical services. (PREA Standard 115.383 (e))

67. Treatment services in section 64[21] must be provided to the victim without financial cost, regardless of whether the victim names the abuser or cooperates with the investigation.(PREA Standard 115.382 (d), 115.383 (g))

[21] 07/13/2020 Technical Edit: Corrected section references.

III. DEFINITIONS

Basic or Routine Health Care: Level of health care as guided by national health care standards for juvenile correctional programs adopted by JR for residential youth.

Birthing Plan: A plan developed between JR staff, pregnant youth, and their medical provider documenting the supervision plan during the youth's labor and delivery, and related hospital stays. The plan may include specific staff who were chosen as a birthing coach or support, who may be in the delivery room during labor and delivery, or other agreed upon details.[22]

Buprenorphine: An opioid medication used to treat opioid addiction.[23]

Continuous Quality Improvement Program: Under the direction of the Medical Director, a group of health care staff and practitioners assembled to monitor and improve health care.

Emergency Health Care: Care, services, and supplies for an acute or unexpected health need requiring immediate evaluation or treatment by a health care practitioner.

Fentanyl: A powerful synthetic opioid similar to morphine but 80 to 100 times more potent. It is a prescription drug that is also made and used illegally.[24]

Gender Confirming Health Care[25]: Medical treatment that affirms a person's gender identity as experienced and defined by them. It may include, but is not limited to interventions to:

- Suppress the development of endogenous secondary sex characteristics.
- Align the patient's appearance or physical body with the patient's gender identity.
- Alleviate symptoms of clinically significant distress resulting from gender dysphoria.

Health Assessment: The process whereby the health status of a youth is evaluated, including but not limited to, a medical history, physical examination, and diagnostic testing as needed.

Health Care: Care, services, and supplies related to the health of a youth that includes medical, dental and mental health.

Health Care Authority: An individual at the facility designated the lead medical authority.

Health Care Screening: A screening process completed within 24 hours by medical staff in order to review the health status of newly arrived youth for health concerns.

Health Care Staff: Licensed, certified, or registered professionals employed or contracted to provide health care to youth within the scope of their professional training.

Intake Screening: Screening done by non-medical staff in the first hour of the youth's arrival to determine whether there is a need for immediate intervention.

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[22] 3/14/2019 Technical Edit: Added Birthing Plan definition
[23] 1/5/2021 Technical Edit: Added Buprenorphine definition
[24] 8/30/2021 Technical Edit: Added Fentanyl definition following the Narcan All Staff Memo.
[25] 1/19/2021 Technical Edit: Gender Confirming Health Care definition updated to align with policy 4.60.

JR Health Care Practitioners: Designated Physicians, Dentists, Advanced Registered Nurse Practitioners, or Physician Assistants contracted or employed by a JR facility to provide consultation or health care.

Medical Director: A licensed physician who is the JR health care authority responsible for oversight of health care and quality assurance.

Medically Fragile: A youth with an acute or chronic physical condition monitored closely and regularly by a medical provider.

Medical Quarantine: Removing a youth from programming and placing in a single room for the purpose of decreasing or eliminating the spread of infectious disease.[26]

Medication Support: A program where youth at risk for opiate use once they leave JR institutions are provided specific medications to help avoid opiate use and provide an antidote to death or disability due to opiate overdose.

Naloxone (Narcan): An opiate antagonist that reverses the life-threatening effects of opiate overdose, including respiratory depression.

Naltrexone (Vivitrol)[27]: A long acting opiate antagonist used to facilitate adherence to opiate abstinence. Use of opiates during the four weeks after naltrexone injection results in little or no euphoria.

Significant Health Condition: Emergency health care, hospitalization, involuntary treatment, and refusal of health care that poses a significant risk to self or others.

Supplemental Health Care: Health care beyond basic health care.

Suboxone: A narcotic medication containing a combination of buprenorphine and naloxone used to block the effects of opioid medications sometimes used to treat opiate addiction.[28]

[26] 3/17/2022 Technical Edit: Replaced definition of Medical Isolation to Medical Quarantine to align with changes in JR Policy 5.50.
[27] 9/17/2020 Technical Edit: Added common brand name “Vivitrol”.
[28] 9/17/2020 Technical Edit: Added “Suboxone” as a new term and definition.

IV. REFERENCES

ACA Standard, 4-JCF-4C-30

Duty to Warn or Protect Standard

How to Administer Naloxone (Narcan) NCCHC Standards

PbS Standards

Washington State Board of Pharmacy Laws & Rules What is Fentanyl

V. RELATED JR POLICIES

Policy 1.31 - Responding to the Death of a JR Youth

Policy 3.20 – Assessing Sexually Aggressive or Vulnerable Youth (SAVY)

Policy 4.31 - Administering Involuntary Antipsychotic Medication to Youth

Policy 4.40 - Determining the Need for DNA and HIV Testing

Policy 5.10 – Using Physical Restraints with Youth

Policy 5.90 – Applying PREA Juvenile Standards in JR

Policy 5.91 - Reporting Abuse & Neglect of JR Youth

VI. FORMS AND DOCUMENTS

Document Title	**Available In ACT**	**Link to Form**
Certificate of Exemption		DOH Form 348-106
Certificate of Immunization Status		DOH Form 348-013
Health Care Refusal		DCYF 20-275 DCYF
JR Medicaid Eligibility		14-020 DCYF
Use of Restraints Limited for Pregnant JR Youth		JR_0009

ATTACHMENT 1 – POLICY 4.30 – PROVIDING HEALTH CARE FOR JR YOUTH

Guidelines for Medication Assisted Treatment of Opioid Use Disorder

Purpose
To provide a guideline for using medications for Opioid Use Disorder (OUD), specifically in the JR setting. It is not meant to replace specialty guidelines such as the American Society of Addiction Medicine (ASAM) guidelines.
https://www.asam.org/docs/default-source/practice-support/guidelines-and-consensus-docs/asam-national-practice-guideline-supplement.pdf

Assessment
All youth in JR will receive an assessment for OUD in the first 24 hours of arrival in the Client Health Screen. Those that identified as having a possible OUD will have further assessment by the facility drug and alcohol treatment counselor and the medical clinician.

Staff can bring any OUD concerns regarding youth to the attention of medical staff at any time. Investigation should also focus on route of administration, association with high-risk behaviors including relationship to incarceration, use of other drugs, and alcohol. Diagnosis of OUD is based on DMS 5 criteria.

DCYF Support
- Psychosocial counseling for addiction
- Follow up appointments in the community (as appropriate) for:
    - Inpatient and outpatient treatment for OUD
    - Narcotics Anonymous (NA), Alcoholics Anonymous (AA) and other support groups
    - Medication Assisted Treatment (MAT) centers
    - Mental health clinics
    - Medical clinics
- Tracking of MAT patients and report results quarterly

General Considerations for Medication Treatment
- Has an OUD diagnosis
- Continued craving for opiates or concern that opiates could not be resisted
- Patient is willing to take medication for OUD after being given options that explains the risks and benefits of both Naltrexone and Buprenorphine
- No allergies or significant side effects
- All are trained in the use of Naloxone and it is provided to them at release from JR
- All are provided ongoing psychosocial treatment and referrals on release from JR
- Pregnant youth require additional specialty consultation

Timing of Medication Initiation
- Medication for OUD may be started at anytime
- Consideration should be given to the risks of diversion in a JR setting
- If Buprenorphine is provided in JR, that facility should be prepared to monitor the use and test for compliance and diversion

Naltrexone

Criteria for Use of Naltrexone

Youth would benefit from a bridge to abstinence, buprenorphine, or continued Naltrexone.

Discontinuation of Naltrexone

- The patient should be counseled regarding the risk and benefits of discontinuation. Specifically, the patient should be warned tolerance to narcotic is low now and the risk of overdose is high.
- Alternatives to Naltrexone should be discussed
- Ongoing psychosocial therapy should be encouraged

Methadone

Methadone Guidelines

1. Arriving to JR on Methadone:
    - Clinician and MAT team shall evaluate the appropriateness of MAT and consider whether to taper off, continue medication, or convert to Buprenorphine.
    - If a youth's sentence in JR is less than 3 months:
        - Strongly consider continuing medication if conversion to Buprenorphine is not the best option.
        - Otherwise taper youth off medication (unless continuation is approved by the medical director)
2. JR will not start Methadone in an institution. If Methadone is determined to be the best MAT option, JR will hand off to a methadone clinic when the youth is discharged.
3. Approval required before initiating Methadone while in a CF by the JR clinician at the institution the youth resided and the JR medical director.

Buprenorphine

Criteria for Use of Buprenorphine

- Youth with a life-threatening OUD
    - Parenteral (injection or infusion) narcotic use
    - Violent or dangerous encounters in the pursuit of opiates
- Youth incarcerated for OUD associated crime
- No history of heavy use of sedatives such as alcohol or benzodiazepines
- No untreated significant mental health issues
- No history of significant suicidal ideation or attempts
- No history of diversion of medications
- Residents who have a history of cheeking, buying, or selling medications in residential environments should undergo careful review prior to the start of buprenorphine. Additionally, a clear plan for minimizing the potential for these activities while on buprenorphine should be developed if the decision is made to start this medication.
- JR medical director approval as per Policy 4.30

Use of Buprenorphine in JR

- Each dose is administered by staff and recorded on a medication administration record
- Storage complies with Washington State laws regarding schedule III medications
- Investigation of diversions should include drug testing that specifically includes Buprenorphine

Discontinuation of Buprenorphine

- The patient should be counseled regarding the risk and benefits of discontinuation
- If at all possible the tapering off of Buprenorphine should be managed by the prescribing clinician or a clinician with Buprenorphine certification
- Alternatives to Buprenorphine should be discussed
- Ongoing psychosocial therapy should be encouraged

Buprenorphine Guidelines

1. Arriving to JR on Buprenorphine:
   - Clinician and Medically Assisted Treatment (MAT) team shall evaluate the appropriateness of MAT and considers whether to taper off or continue medication.
   - If a youth's sentence in JR is less than 3 months:
     - Strongly consider continuing medication
     - Otherwise taper youth off medication (unless continuation is approved by the medical director).
2. JR youth determined to be good candidates for Buprenorphine (over Naltrexone) include:
   - Multiple failed inpatient treatment attempts or
   - heavy daily opiate use over years
3. Initiation of Buprenorphine at JR institutions only for one month or less prior to release from JR institution.
4. Approval required before initiating Buprenorphine in a CF by the JR clinician at the institution the youth resided and the JR medical director.

Pregnancy

Methadone and Buprenorphine During Pregnancy

- Youth arriving on Methadone and Buprenorphine should continue on the medications and no attempt to discontinue or taper off the medications should be made without direction from an obstetric addiction specialist.
- Initiation of these medications should only be done with consultation from an obstetric addiction specialist, the JR institution clinician, and the medical director.
- In addition to all the support provided as above, specialty follow up by an obstetric addiction specialist will arranged.

DMS 5 Criteria

Diagnosing OUD

Diagnosing OUD requires a thorough evaluation, which may include obtaining the results of urine drug testing and prescription drug monitoring program (PDMP) reports, when OUD is suspected.

It is also important to remember that OUD exists on a continuum of severity. As a result, a scale for assigning severity exists and is based upon the number of criteria that have been met (mild, moderate, severe). This severity distinction has treatment implications.

In order to confirm a diagnosis of OUD, at least two of the following should be observed within a 12-month period:

1. Opioids are often taken in larger amounts or over a longer period than was intended.
2. There is a persistent desire or unsuccessful efforts to cut down or control opioid use.
3. A great deal of time is spent in activities necessary to obtain the opioid, use the opioid, or recover from its effects.
4. Craving, or a strong desire or urge to use opioids.
5. Recurrent opioid use resulting in a failure to fulfill major role obligations at work, school, or home.
6. Continued opioid use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of opioids.
7. Important social, occupational, or recreational activities are given up or reduced because of opioid use.
8. Recurrent opioid use in situations in which it is physically hazardous.
9. Continued opioid use despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.
10. Exhibits tolerance (discussed in the next section).
11. Exhibits withdrawal (discussed in the next section).

Tolerance and Withdrawal Diagnostic Criteria

The last two diagnostic criteria, related to tolerance and withdrawal, are not considered to be met for individuals taking opioids solely under appropriate medical supervision.

Tolerance

Tolerance is defined as either: 1) a need for markedly increased amounts of opioids to achieve intoxication or desired effect, or 2) a markedly diminished effect with continued use of the same amount of an opioid.

Withdrawal

You can refer specifically to DSM-5 Criteria A and B for opioid withdrawal syndrome:

A. Either of the following:
    1. Cessation of (or reduction in) opioid use that has been heavy and prolonged (several weeks or longer), or
    2. Administration of an opioid antagonist after a period of opioid use.
B. Three (or more) of the following, developing within minutes to several days after Criterion A: dysphoric mood; nausea or vomiting; muscle aches; lacrimation or rhinorrhea; pupillary dilation, piloerection, or sweating; diarrhea; yawning; fever; or insomnia.

ATTACHMENT 2 – POLICY 4.30 – MEDICAID PROCEDURES

Screening and Enrolling JR Youth in Medicaid

Action by:	*Action*
Mental Health Coordinator (MH Coord)	1. **Obtains** authorization from youth to share information with HCA for Medicaid screening and enrollment within 14 days of the youth's arrival at the institution, and **documents** in ACT Medicaid module. 2. **Emails** the following information semi-monthly to hcajrsuspension@hca.wa.gov: • Tracking form with a list of new JR youth arrivals. • List of youth with a release or discharge date in the next 30 days.
HCA Rep.	3. **Screens** all new JR youth arrivals within 7 days from receiving the tracking form and does the following: • For youth with current Medicaid coverage: o **Enters** Provider 1, Managed Care Plan (MCP), and End Date into ACT to suspend coverage. • For Medicaid eligible youth without coverage: o **Notifies** the institution of eligibility and requests the JR Medicaid Eligibility Request (DCYF Form 14-020) for enrollment • For youth not eligible for Medicaid coverage: o **Selects** "*Is the Client Eligible for Medicaid*" ☐ YES or ☒NO and **enters** if they have other coverage (e.g. private insurance). 4. **Schedules** activation of coverage for youth with upcoming release or discharge dates.
MH Coordinator	5. **Completes** JR Medicaid Eligibility Request (DCYF Form 14-020) to enroll new arrivals without Medicaid coverage. 6. **Submits** form(s) to HCA and **documents** the date forms submitted in ACT.
HCA Rep	7. **Completes** the application enrollment process (contact MH Coordinator as needed) within 30 days of receiving the enrollment form(s); and 8. **Records** the outcome in ACT: • **Selects** "*Is the Client Eligible for Medicaid*" ☐ YES or ☐ NO If YES, **enters** Provider 1, Managed Care Plan and **enters** End Date.

Activating Medicaid for JR Youth Release or Discharge

MH Coordinator	For youth with suspended Medicaid coverage within 90 days of release or discharge: 1. **Educates** client and reviews: • the location of placement. • Managed Care Plan options available in the county of placement. 2. **Enters** MCP preference in ACT Medicaid module. 3. **Records** the following in ACT: • The date of Education Appointment. • Youth's MCP preference. • Any changes in placement.
HCA Rep	4. Upon receipt of youth MCP preference: • **Creates** a placeholder for the selected plan. • **Activates** plan upon release or discharge. • If placement has changed from initial JR admission, **advises** institution contact if re-enrollment is required. • **Documents** in the Medicaid module "upon leaving" section: o If youth left JR with Medicaid coverage. o If not, why they left without coverage.
MH Coordinator	If re-enrollment is required: 5. **Completes** requested re-enrollment forms Medicaid coverage. 6. **Submits** form(s) to HCA and **documents** the date forms resubmitted in ACT.
HCA Rep	7. Upon receipt of youth MCP preference, **activates** plan upon release or discharge.

<u>For Youth Transitioning to a Community Facility (CF)</u>

Medicaid Liaison (or designee)	Once the youth is referred for CF placement: 1. **Completes** the first half of the Medical Services Authorization (MSA) form. 2. **Emails** it to HCAJRARequest@hca.wa.gov. 3. **Documents** submission date in ACT.
Regional Mental Health Coordinator (RMHC)	4. **Reviews** the youth's Medicaid history to make sure they were screened for Modified Adjusted Gross Income (MAGI) coverage eligibility during admission.
HCA Rep	5. **Documents** the Medicaid Part D (D-Track) start date in ACT.

For Youth Releasing from a Community Facility (CF) to Home

Medicaid Liaison (or designee)	1. **Submits** the second half of the MSA form to HCA within 14 days prior to release date. 2. **Documents** MSA submission date in ACT
HCA Rep	Upon receipt of the MSA form: 3. **Transitions** youth from Medicaid Part D to previous MAGI coverage for their community effective the day they release from the CF. 4. **Documents** the Medicaid "Upon leaving JR" section: • If youth left JR with Medicaid coverage. • If not, why they left without coverage.

Youth Returning to the Institution from a CF *(30 days or less)*

CF Staff	1. **Emails** to hcajrsuspension@hca.wa.gov within 24 hours (or next business day if after hours or holidays) indicating the youth has transferred back to the institution for more than 30 days.
HCA Rep	2. **Places** youth back into previous established Medicaid plan. 3. **Reassigns** coverage and suspends it. 4. **Notifies** the MHC the youth was placed back into suspension status.
RMHC	5. **Monitor** and **track** the youth to **determine** when the education appointment should be requested and scheduled.
	Within 24 hours or ASAP next business day, CF staff will notify/email HCA that a youth has been placed at an institution until they are discharged/released, documenting release date. HCA will assign the youth a Medicaid plan/coverage consistent with the youth's place of residence following discharge/release. HCA will notify the JR MHC with confirmation that the youth has been assigned Medicaid coverage; the coverage will be open/active in anticipation of discharge/release within 30 days. JR MHC will monitor/track the youth to determine when the education appointment should be requested/scheduled.

Youth Returning to the Institution from a CF

(and transitioning back to the current or different CF within 30 days)

NO NOTIFICATION OR ACTION REQUIRED
If the plan to transition back to a CF is cancelled, refer to the steps above.

GUIDANCE ON NEW DUTY TO WARN OR PROTECT STANDARD

May 2017: The Washington Supreme Court decision in Volk v. DeMeerleer, 386 P.3d 254, 187 Wn.2d 241 (2016), **alters the scope of the "duty to warn or protect" in at least three critical ways:**

1. It brings into question the groups of health care professionals who are subject to the duty to warn or protect in the voluntary inpatient and outpatient setting.
2. The duty now clearly applies in the voluntary inpatient and outpatient setting.
3. Most importantly, outside of the context of an involuntary commitment proceeding, the scope of persons to warn or protect now includes those that are "foreseeable" victims, not reasonably identifiable victims subject to an actual threat.

Facts of the case: The Volk decision involved circumstances in which a psychiatrist was treating a patient who had expressed suicidal and homicidal thoughts in the past. Many years later, and about four months after being last seen by the psychiatrist, the patient killed two individuals known to the patient. The patient had not voiced any thoughts to harm them. Representatives of the deceased filed a lawsuit against the psychiatrist for failing to protect them from the patient's violent actions. That lawsuit is still pending at the trial court, but the Supreme Court's decision established a new standard that is now binding on treatment providers.

In Volk, the Supreme Court held that, in the outpatient and voluntary inpatient treatment setting, the duty of health care providers to warn or protect potential victims of violence extends to all individuals who may be "foreseeably" endangered by a patient, even if no specific target was identified.

WSMA, Physicians Insurance and the Washington State Hospital Association will continue to pursue legislative, regulatory and judicial options to address the results of the Volk decision. Currently, legislative efforts to fund a study of the decision on the state's mental health treatment system are underway. Additional details on those options will be forthcoming.

The WSMA, Physicians Insurance, and the Washington State Hospital Association recommend that physicians and providers who treat patients with violent tendencies or ideations consider implementing the following guidelines *(these guidelines are intended to be general guidance and not legal advice)***:**

- ✓ Continue to use reasonable care to act consistent with the standards of your profession.
- ✓ Complete and update suicide and violence risk assessments with findings documented in the patient's medical record.
- ✓ Develop a policy and procedure to assess whether a patient has dangerous propensities, and use it consistently.
- ✓ Document in the patient's medical record why you reached your clinical decision and measures you have recommended to mitigate potential risk, even when you are assessing a patient who has violent tendencies or ideations and do not believe the patient will harm others.
- ✓ In all cases, carefully consider and document in the patient's medical record the measures taken to mitigate risk. Measures will fall into two categories: measures to treat the patient and measures to warn potential victims. Measures to treat the patient may include, but are not limited to: seeking to hospitalize the patient; seeking to initiate involuntary commitment proceedings;

scheduling more frequent visits or contacts with the clinic; starting injectable medication, etc. Measures to warn potential victims may include notifying law enforcement and notifying "foreseeable" victims.

- ✓ When you decide to issue a warning, notify law enforcement before contacting potential victims. Document in the patient's medical record your notification efforts and the individuals or groups notified.
- ✓ In Volk, the Supreme Court held that it is a jury's responsibility to determine who may be a foreseeable victim. We cannot, therefore, provide firm guidance on how to identify a foreseeable victim. In assessing the scope of foreseeable victims, consider people close to the patient, such as family members, work colleagues and others within the person's social circle. Depending on your assessment, notification to a broader group could be required. In that case, coordination with law enforcement may be necessary. You must assess every case individually.
- ✓ For any action taken, document in the patient's medical record the reasons the action is necessary to warn or protect foreseeable victims, and, if applicable, to prevent or lessen a serious and imminent threat to a person or the public's health or safety, as described above.

Finally, we recommend that you consider these points in a clinical context, act in good faith and document in the patient's medical record your thought process in sufficient detail to justify any course of action you decide to take, even if you feel that a patient has not triggered the duty to warn or protect potential victims.

Questions?

Washington State Medical Association: Tierney Edwards, JD, 206-956-3657, tee@wsma.org
Physicians Insurance: Risk Management, 800-962-1399, risk@phyins.com
Washington State Hospital Association: Taya Briley, 206.216.2554, tayab@wsha.org