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Designated Examiner Source Book

# APPENDIX A

DHW Policies and Procedures

**COMMUNITY MENTAL HEALTH PROGRAM  
POLICY AND PROCEDURES MANUAL**

<b>SUBJECT: DESIGNATION OF DESIGNATED EXAMINERS AND DISPOSITIONERS</b>		<b>Section No. 7 Page 1 of 3</b>
<b>Community Mental Health Services</b>	<b>Reference:</b>	
<b>Effective Date: 05/28/2002</b>	<b>Approved By: Ken Deibert</b>	

**PURPOSE:** This policy describes the qualifications, selection process, and designation procedures for Designated Examiners and Dispositioners.

**POLICY:** It shall be the policy of the Division of Family and Community Services that Designated Examiners and Dispositioners be selected based on the following criteria:

I. **QUALIFICATIONS:** In accordance with § 66-317(e), § 66-317(f), and § 54-2303(a) Idaho Code, candidates for Designated Examiner or Dispositioner status must meet the following qualifications:

1. **Designated Examiners:** A Designated Examiner will be any person designated by the department director as specially qualified by training and experience in the diagnosis and treatment of mental or mentally related illnesses or conditions. Such persons shall be psychiatrists, licensed psychologists, licensed physicians, a holder of an earned master's level or higher degree in social work from an accredited program, a registered nurse with an earned master's level or higher degree in psychiatric nursing from an accredited program, a holder of an earned master's level or higher degree in psychology from an accredited program or a holder of an earned masters level or higher degree from a program in counseling, or other closely related field as determined by the Department of Health and Welfare.

Applicants must have at least two years' post-degree experience in a clinical health setting which includes the diagnosis or assessment of substantial disorders of thought, mood or perception, and involvement in the treatment of such disorders. Prior to appointment, a Designated Examiner must complete six hours of training approved by the State Regional Mental Health Program or by the State Hospital.

2. **Dispositioners:** A Dispositioner will be a Designated Examiner employed by or under contract with the Department of Health and Welfare and designated by the Department Director. The function of the dispositioner is to determine the appropriate location for care and treatment of involuntary patients.

A. **SELECTION CRITERIA:** Consideration for the selection of Designated Examiners and Dispositioners will include, but are not limited to, the following factors:

1. The applicant's working knowledge of the current edition of the Diagnostic and Statistical Manual of Mental Disorders, available treatment modalities, and available settings.
2. The applicant's adherence to the ethical standards of the applicant's profession.
3. The applicant's knowledge of legal requirements and procedures and client rights.
4. The applicant's ongoing availability to perform the duties of a Designated Examiner or Dispositioner.
5. The applicant's ability to perform examinations, assess likelihood of danger to self or others, grave disability and capacity to give consent, and to verbally explain such assessments.
6. For Dispositioners, the applicant's specific knowledge of available treatment alternatives, types of treatment available for appropriate placement and level of care requirements.

C. **INITIAL APPOINTMENT PROCEDURES:**

1. With the exception of Department employees, applicants will submit a letter requesting appointment to the Mental Health Program Manager for the examination and/or dispositioning of adults, or to the Family and Children's Services Program Manager for the examination and/or dispositioning of children or to the Administrator of the State Hospital.

If the applicant anticipates examination and/or dispositioning of both adults and children, only one letter is required. The letter should be submitted on the basis of the primary population which the applicant anticipates examining.

A Department employee will be recommended by the Program Manager or Hospital Clinical Director. A letter requesting appointment is not needed from the employee.

In addition to the letter requesting appointment, as indicated above, the following information must be included with the application.

- a. A current resume that shows the applicant's degree, the date that it was awarded, the school from which it was received and two years of required experience since the date the degree was awarded.
- b. Evidence of completion of the required six hours of training showing the date(s), place(s), number of hours of training and the qualification of the person(s) providing the training.

2. For regional recommendations, the Program Manager will verify the applicant's qualifications and, if satisfied, will complete and forward the Recommendation for Appointment Application (see attached form) to the Bureau of Mental Health and Substance Abuse for Adults or the Bureau of Children and Family Services for adolescents.
3. For state hospital recommendations, the State Hospital Clinical Director will verify the applicant's qualifications and, if satisfied, will complete and forward the Recommendation for Appointment Application (see attached form) to the hospital director who will review the application and if satisfied will forward the application to the Bureau of Mental Health and Substance Abuse for Adults or the Bureau of Children and Family Services for adolescents.
4. The respective Bureau will review the application for completeness. If complete, the Bureau will forward the application to the Administrator of the Division of Family and community Services.
5. Upon the Division Administrator's concurrence, written appointment will be made and transmitted to the applicant with notification given to the region or hospital.
6. For all incomplete or disapproved applications the Bureau will contact the Regional Program Manager or State Hospital Administrator of the condition of the application to assist in resolving any application problem.

D. **DURATION OF DESIGNATION:** All Designated Examiners and Dispositioners shall serve at the discretion of the Director and unless revoked by the Director. Initial appointments of each Designated Examiner or Dispositioner expire one (1) year from the date of designation, unless the Designated Examiner or Dispositioner reapplies for designation prior to that date. Subsequent designations of an individual shall expire three (3) years from the date of such designation. All designations of Dispositioners shall terminate when the Dispositioner ceases employment with the Department of Health and Welfare or when the Dispositioner's contract expires or is terminated.

E. **REAPPOINTMENT PROCEDURES:**

1. The Program Manager or designated State Hospital Clinical Director will assess the applicant's performance as a Designated Examiner and/or Dispositioner and, if satisfied will submit a request for reappointment to the Regional Director or State Hospital Administrator. It is not necessary to resubmit an updated resume showing the applicants qualifications nor is additional training required for reappointment.
2. The reappointment process will continue as outlined in Section C of this document, **INITIAL APPOINTMENT PROCEDURES**, beginning with paragraph 3.

STATE OF IDAHO
DIVISION OF FAMILY AND COMMUNITY SERVICES
RECOMMENDATION FOR APPOINTMENT
DESIGNATED EXAMINER / DISPOSITIONER

Applicant \_\_\_\_\_ Region \_\_\_\_\_

Address (street, apt. #) \_\_\_\_\_

(City, State Zip) \_\_\_\_\_

The applicant is a:

- Department Employee Non-Department Employee

This application is requesting approval for the applicant to be certified as a:

- Designated Examiner Dispositioner

This application is for: (Check either for Initial Appointment OR Re-appointment)

Initial Appointment

- A. The applicant has two years post-degree experience in a clinical health setting. (May include internship.)
B. Six hours of training in the DE process has been completed.

Date(s) of training \_\_\_\_\_

Place(s) training was held \_\_\_\_\_

Number of training hours \_\_\_\_\_

Person(s) and qualification(s) of person(s) providing training \_\_\_\_\_

Re-appointment

DISCIPLINE OF APPLICANT:

- Psychiatrist M.S.W.
Licensed Psychologist RN (Masters level)
Licensed Physician MA/MS (Psychology, Counseling)
Other closely related field - Masters level (indicate)

Based on the information provided and according to statutory and policy requirements I find this candidate qualified to perform the duties as a Designated Examiner and Dispositioner.

Program Manager/Clinical Director Date

Hospital Administrator Date

Bureau Program Specialist Date

ENCLOSURES (to be held in the Bureau) T or NA

Table with 2 columns: Enclosure description, Status. Row 1: Letter from non-department employee requesting appointment. Row 2: Current resume, ALL NEW applicants (not necessary for renewal)

## ADDENDUM FOR REFERRALS TO STATE HOSPITALS

Name of Patient: _____		Commitment date: _____	
Responsible person in region: _____		Where held pending commitment: _____	
Referring Agency(ies): _____		Referral Type: Psych. <input type="checkbox"/> CD <input type="checkbox"/> Dual Diagnosis <input type="checkbox"/>	
Service Providers (prior to admission): Case Management: Psychosocial Rehabilitation: Out Patient (i.e. Day Treatment):			
Why inpatient care? (What parts of presenting problem cannot be treated in the community?)			
Goals of hospitalization? (What needs to be achieved so client can return to community-based care?)			
Elopement Risk? Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Assault Risk? Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/>			
What has been tried to defer hospitalization, and what were the results?			
<b>TRANSPORT DATA</b> Expected date/time of arrival:  Transported by:  Description, if by bus or plane:		<b>ADVANCE DIRECTIVES</b> Does the client have a living will? <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Yes A durable power of attorney? <input type="checkbox"/> No <input type="checkbox"/> Unknown <input type="checkbox"/> Yes	
<b>PROPOSED DISCHARGE PLAN:</b>			
Initial suggested length of stay:			
Suggested living arrangements:			
Suggested follow-up care:			
Resources that need to be developed in order to implement the plan:			
Involved family and/or friends (name, address, phone):			
<b>CERTIFICATION OF NEED FOR INPATIENT MENTAL HEALTH SERVICES</b>			
Ambulatory/Outpatient resources available in the community or less restrictive settings have failed or do not meet the treatment needs of the client:			
Proper treatment of the client's psychiatric condition requires services on an inpatient basis under the direction of a physician and intensive monitoring by professional staff:			
Inpatient services can reasonably be expected to improve the client's condition or prevent further regression so that inpatient services will no longer be needed:			
Signature of Physician _____		Signature of Referral Agency Staff _____	
Date _____		Date _____	
Name of Physician (typed or printed) _____		Name of referral staff (typed or printed) _____	