Disability Rights
WASHINGTON
Washington's protection and advocacy system

# ALL OR NOTHING
# Ending Washington's Dependence On Involuntary Civil Commitment

**December 2021**

**Image Description:** *An empty hospital bed in a local emergency room with arm and leg restraints attached.*

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# Introduction

Over the course of a recent month in Washington State, nearly 2,300 people experienced such extreme behavioral health crisis as to trigger governmental investigation into whether they were a serious risk to themselves or others.[i] How many of those 2,300 people could have avoided crisis with more consistent community-based behavioral health treatment? How many were taken to an emergency room for a few hours, only to be cut loose without additional help? How many were not even lucky enough to get a health care response, but instead were arrested for minor crimes and thrown in jail?

Washington State has woefully inadequate behavioral health treatment and crisis response systems. The result is that many of us cannot receive the kind of care and supports that allow us to stay healthy and stable in our own communities. Instead, Washington over-relies on the most expensive and restrictive form of behavioral health treatment available: involuntary civil commitment. Since that system is our only well-resourced way of providing care to people in behavioral health crisis, it has become strained beyond capacity. Ironically, those patients with the most complex or pressing need for treatment are often denied care by that very system.

This report examines some of the gaps in Washington's behavioral health treatment and crisis response systems. It identifies the points at which our current involuntary civil commitment system breaks down. The report concludes with clear, sensible action Washington can take to provide the right care at the right time.

# About DRW

**Disability Rights Washington (DRW) is a private non-profit advocacy organization with a mission to advance the dignity, equality, and self-determination of people with disabilities and to pursue justice on matters related to human and legal rights. DRW has been specially designated to serve as the federally mandated Protection and Advocacy system for Washingtonians with disabilities, including behavioral health conditions.[ii] Under federal law, Protection and Advocacy systems have broad access authority to conduct investigations of abuse and neglect and to educate policy makes regarding the rights of people with disabilities.[iii] DRW is releasing this report in furtherance of its mission and federal mandate to protect and advocate for Washingtonians with disabilities.**

# Background

*Involuntary Treatment Act*

Involuntary civil commitment in the United States is a legal process for forcing a person with symptoms of a behavioral health condition to receive treatment.[iv] Civil commitment in Washington State is governed by the Involuntary Treatment Act (ITA). The process generally begins when a person in crisis is referred for an evaluation by a Designated Crisis Responder (DCR).

The DCR is empowered to investigate whether a person "as a result of a behavioral health disorder, presents a likelihood of serious harm or is gravely disabled…."[v] If these conditions are met, the DCR can file a petition to a court seeking to hold someone involuntarily for treatment pursuant to the ITA.[vi] If a DCR believes the risk of harm is imminent, they may order the person be held on an emergency basis. If they are held, it must be in a state-certified facility and for only 120 hours while a court petition for further detention is prepared.[vii] A court may then review the case to decide whether the person meets legal criteria for additional lengthier period of involuntary civil commitment.[viii]

Any person who is involuntarily committed is being held in order to get treatment. Therefore, they must be held at

Image Description: *Restraints for use with patients, hung on hooks in a hospitasll supply closet. Sign above the hooks reads, "Restraint locks and deadbolts to remain unlocked at all times."*

a facility specifically licensed and certified by the state to provide involuntary behavioral health treatment.[ix] In Washington, these include Evaluation and Treatment facilities, psychiatric hospitals, or hospitals with a specialized behavioral health treatment unit.[x]

While there are state licenses and state money given to the various facilities that provide treatment under the ITA, current state law does not require these facilities to accept ITA patients or to provide a justification for refusing care. Washington's Health Care Authority (HCA) oversees this system. HCA contracts with Managed Care Organizations (MCOs) and

Behavioral Health Administrative Services Organizations (BHASOs) to deliver crisis services and treatment to people pursuant to the ITA.

## *Single Bed Certification*

When a specially-licensed inpatient facility will not or cannot accept a patient for treatment under the ITA, the state may continue to hold the person involuntarily in a hospital emergency room or medical unit via a process called Single Bed Certification (SBC).[xi] SBCs allow a facility not otherwise licensed for involuntary behavioral health treatment to provide this treatment temporarily—sometimes only for a few days, but sometimes for weeks, months, or even more than a year.

The current system is a modification of the longtime practice of psychiatric boarding of patients in beds not properly licensed for ITA patients. In 2014, the Washington State Supreme Court struck down this practice.[xii] The court found that people in need of specialized behavioral health inpatient care were instead being held in hospital hallways, emergency departments, or other medical units because there were no available licensed treatment beds.[xiii] In response, Washington now requires that any facility seeking a SBC must certify it is willing and able to provide timely and appropriate mental health treatment and that the person can receive such care at the facility, despite the lack of specialized licensure.[xiv]

SBCs have always been meant as a temporary stop-gap measure to allow the state some extra time to find an appropriate licensed inpatient facility bed. However, Washington has continued to see a steady increase in the use of SBCs for the past several years.[xv] The first half of 2016 saw an average of nearly 700 SBCs every month in Washington.[xvi] The same period in 2021 saw nearly 1,000 SBCs monthly.[xvii]

## *No Bed Report*

When an involuntary treatment bed cannot be found for someone—either at a licensed inpatient facility or through a SBC placement—that person must be released even though they were found to meet involuntary civil commitment criteria.[xviii] If this happens, a No Bed Report (NBR) is filed with the Health Care Authority and the involuntary hold is ended.[xix] The Health Care Authority then notifies the MCOs or BHASOs, who are then responsible for locating, engaging with, and trying to obtain treatment for the person who was released under the NBR.[xx]

Like SBCs, NBRs are also on the rise in Washington. From April 2017-March 2018, there was an average of 20 of these reports filed each month in Washington.[xxi] The same period in 2020-2021 saw an average of 71 reports filed monthly.[xxii]

# Methodology

**Disability Rights Washington has been working for years with patients screened or held pursuant to the ITA. We monitor facilities that provide involuntary, inpatient behavioral health care and facilities that provide care via SBC. DRW drew upon this knowledge and experience for this report, but also obtained and reviewed state records related to administering the ITA, including contracts and correspondence between the Health Care Authority and Managed Care Organizations/ Behavioral Health Administrative Services Organizations. In addition, DRW conducted individual investigations of patients receiving treatment via a SBC by interviewing these patients, observing their care firsthand, and reviewing their clinical records. Finally, DRW discussed issues related to the behavioral health treatment and crisis response systems with trusted community advocates, service providers, consumers of behavioral health services, and representatives from the state including the Health Care Authority.**

# Findings

### 1. Washington does not have adequate behavioral health treatment and crisis response systems.

More than one in five Washington residents are currently living with a behavioral health condition.[xxiii] In the last ten years, the state has seen a 36% increase in suicide.[xxiv] Behavioral health needs have worsened in light of the COVID-19 pandemic. For example, Washington's Department of Health reported a 16% increase in calls to crisis lines and a 24% increase in overdose related deaths in King County in the months after the COVID-19 pandemic began.[xxv] Despite these significant needs, Washington is ranked very poorly—46th among the 50 states—when measuring the prevalence of mental illness versus access to mental health care for adults.[xxvi]

In 2018, a state-commissioned report assessing behavioral health treatment needs found that Washington had less than half of the necessary "crisis beds" that can be an alternative to involuntary inpatient care.[xxvii] Although the report recommended an additional 462 crisis beds statewide, the state has opened less than 100 of those beds in the years since the report was released.[xxviii] Recommendations from a 2020 state legislative task force

highlighted the many ways that Washington lacks sufficient voluntary, community-based behavioral health treatment and crisis response services—for example, peer respite and Clubhouse services.[xxix] The state is also experiencing a massive shortage in behavioral health workforce, meaning many facilities and programs cannot hire sufficient qualified staff.[xxx]

Without access to enough voluntary, community-based care and crisis alternatives, the state over-relies on expensive involuntary civil commitment using the ITA. This is unnecessary, wasteful, and harmful. In 2015, the Washington State Institute for Public Policy found that "the effective use of crisis diversion and other community-based services may reduce or prevent the need for acute inpatient hospital care."[xxxi] The U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) echoes this: "With non-existent or inadequate crisis care, costs escalate due to an overdependence on restrictive, longer-term hospital stays…. Extremely valuable psychiatric inpatient assets are over-burdened with referrals that might be best-supported with less intrusive, less expensive services and supports."[xxxii]

When there are sufficient behavioral health treatment and crisis services available, only the most in-need patients use involuntary inpatient beds. The vast majority of other people can be served and stabilized in much less costly and restrictive settings. Better yet, access to consistent behavioral health treatment and supports close to home may mean avoiding crisis altogether.

## 2. The ITA system often fails those most vulnerable and in need.

In theory, when someone has reached the point of civil commitment under the ITA, they have exhausted all other treatment and support options and must be held against their will in order to receive behavioral health treatment and prevent serious harm. One might therefore conclude that involuntary treatment beds are prioritized for patients with the most acute symptoms or complex issues. In reality, DRW has found that the facilities that are specifically licensed and certified to provide this care often cannot or will not treat these patients specifically because of the patient's complexity or acuity.[xxxiii]

There are entire categories of disability that Washington's licensed inpatient behavioral health treatment facilities appear to not accept as a general rule: people with intellectual or developmental disabilities, older adults with cognitive impairment, and individuals with significant chronic medical and psychiatric conditions.[xxxiv] Ironically, it is often the most in-need and vulnerable patients who get stuck in emergency rooms on extended SBCs or who end up released without care under a NBR.

In 2019, King County did an in-depth examination of the reasons given by their local specialized facilities for declining ITA patients.[xxxv] Common reasons were linked to behavior, including concerns about patient interactions, inadequate staffing for one-to-one monitoring, and concerns about "acuity."[xxxvi] "Medical" reasons were also very common, including patient use of canes, methadone or buprenorphine prescriptions, aberrations in EKGs, broken limbs in casts, and post-surgical care.[xxxvii] Facility staff have told DRW that patient use of a wheelchair or CPAP machine makes them ineligible for admission. Citing any kind of disability as the reason for denying people access to treatment raises significant discrimination questions.

When the state files a NBR and releases someone, the NBR must include written explanation for why the patient was refused admission for treatment. DRW obtained nearly one hundred NBRs filed in one county in 2020. In over one-third of the reports, facilities cited the acuity of the patient or a diagnosis of dementia, bipolar disorder, or developmental disability as justification for declining them. Again, these are disability statuses legally protected from discrimination.

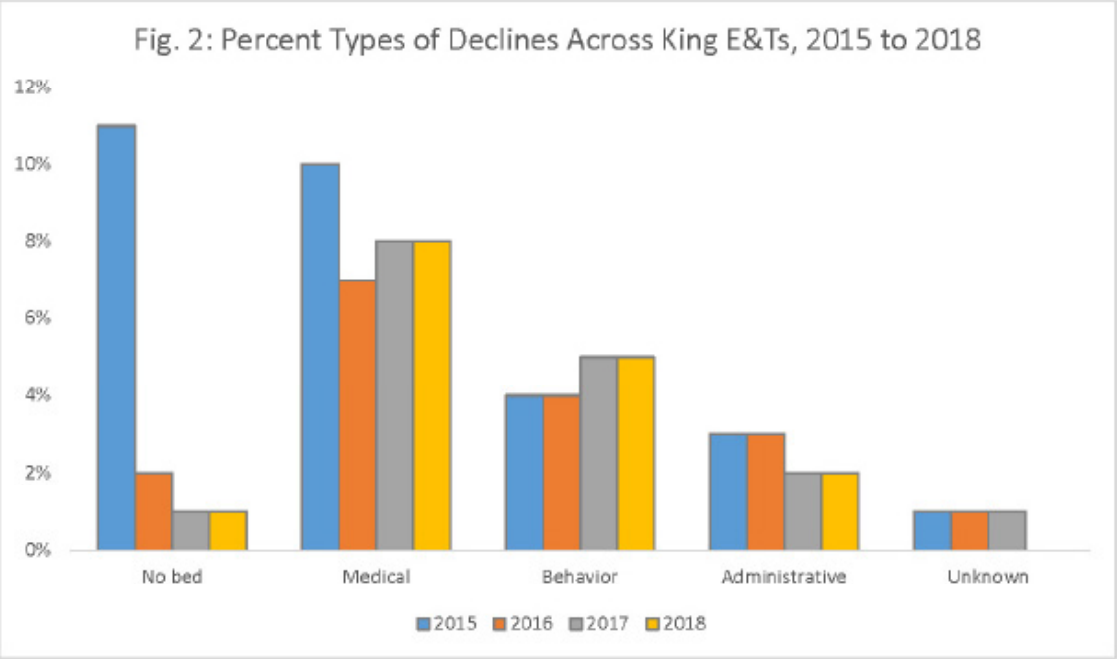


**Image Description:** ***Graphic from King County's 2019 report on local Evaluation and Treatment Facility Patient Declines, showing reasons for decline from 2015 to 2018.***

## 3. SBCs and NBRs are harmful and lack oversight.

The quality of care for people receiving involuntary behavioral health treatment under a SBC can vary wildly and is sometimes harmful. DRW has visited many patients held under a SBC in hospital emergency rooms and medical units. Although some are receiving psychiatric medication and other basic behavioral health treatment, others

are frequently secluded or restrained, held in locked cell-like rooms, or strapped to gurneys in hospital hallways. DRW investigated the treatment for one individual held on a SBC for multiple months at a local hospital who was tied to his bed for most of his stay in the facility. Notes from his medical records indicate a diagnosis of Autism "w/ violent behavior... requiring locked restraints most of the time."

There is insufficient oversight of SBCs. Despite the steady increase in SBCs over the past few years, there appears to be no state entity specifically responsible for making sure a facility is actually delivering appropriate behavioral health care to patients under a SBC. Approval for a SBC placement only requires a facility to confirm via written form that it is willing and able to care for a person under a SBC.[xxxviii] The form does not require a description of how the facility will meet the behavioral health needs of the patient despite not being licensed to provide such care. There is a technical review of the form to make sure it is filled out correctly, but state employees reported to DRW that there is no other verification or monitoring of whether the patient's treatment needs are actually met through the SBC.

Similar to SBCs, people who are the subject of a NBR may experience significant harm. A NBR is filed when a person in crisis is found by the state to meet criteria of involuntary civil commitment, but cannot get a treatment bed and must be released. DRW is aware of individuals released after a NBR who are arrested and incarcerated almost immediately. Worse, DRW knows of others who have died by suicide soon after the NBR release.

Like SBCs, there is a lack of oversight for people released with a NBR. State law requires the state to ensure that each BHASO or MCO "has implemented an adequate plan to provide evaluation and treatment services to a person who is released with a No Bed Report."[xxxix] This may include "development of less restrictive alternatives to involuntary commitment such as crisis triage, crisis diversion, voluntary treatment, or prevention programs reasonably calculated to reduce demand for evaluation and treatment under this chapter."[xl]

DRW looked more closely at several of the MCOs operating in the state and none had written plans or protocols governing how they engage with people released under a NBR, despite the legal requirement.[xli]

DRW did observe efforts by some MCOs to engage people, including phone calls and outpatient referrals for the individual, but these efforts were often unsuccessful and without follow up.

## Christopher's Story

***Disability Rights Washington recently investigated the experience of Christopher*, an individual with both a psychiatric diagnosis and developmental disability who was held on an emergency ITA basis. Christopher had been in several different state-run institutional settings for the past few years. Most recently, he was detained under the ITA at a local hospital but then released to a homeless shelter without additional safety planning. At the shelter, Christopher was almost immediately assaulted and had his belongings stolen. This led to him again being held on an emergency ITA basis, but in a different hospital. While at this second hospital, he was repeatedly put in restraints.***

***The state contacted a total of 14 facilities statewide trying to secure Christopher a licensed inpatient treatment bed or, alternatively, a SBC placement. All of the facilities declined to admit Christopher. Five of them declined him solely and specifically due to his diagnosis of developmental disability. One indicated they "ruled out for IQ under 70."***

***Eventually, Christopher got into a physical altercation with hospital staff. He was arrested and held in the Pierce County Jail where he suffered in solitary confinement for weeks before the state intervened and transferred him to the state psychiatric hospital. As of the date of publication of this report, Christopher remains in an expensive state psychiatric hospital bed without prospects for a community-based discharge placement. He has repeatedly expressed how miserable he is and said he wants to live in his own place with some support.***

* In the interest of protecting this person's privacy, Christopher is not his real name.

**From:** [redacted]
**Sent:** Friday, May 14, 2021 4:36 PM
**To:** [redacted]
**CC:** [redacted]
**Subject:** RE: [redacted]udpate

External Email

Hello

As follow up from our meeting here is a list of the hospitals contacted and their responses:

1. Telecare: willing to screen, will call on Monday to discuss case
2. MDC: declined due to DD dx
3. Greater Lakes E & T declined due too high acuity
4. RI: Called today, don't have bed but are willing to look at the packet to see if he would be a good fit, has been faxed
5. Wellfound: declined due to acuity
6. South South: declined due to DD dx
7. Fairfax: declined due to DD dx
8. AMC: willing to screen, sent legal paperwork now
9. Cascade: had no acute beds today.
10. NAVOS: will not accept Pierce County detained patient
11. Harborview: will not accept Pierce County detained patient
12. Sacred Heart: full, no beds in the foreseeable future
13. Lourdes (Eastern WA): declined for DD dx
14. Smokey Point: rule out for IQ under 70 (patient is 54)

Image Description: *Email obtained in investigation into Christopher's involuntary hospitalization. This email is from a service provider outlining all of the treatment facilities that they have attempted to place Christopher for inpatient treatment and the facilities' reported reasons for refusing him.*

# Recommendations

**1. Washington must build robust community-based behavioral health treatment and crisis response systems to prevent and mitigate crisis and reduce reliance on the ITA system.**

Involuntary inpatient treatment is very expensive and is the most restrictive and coercive form of care that exists. Most importantly, it is not that good at accomplishing its goal.[xlii] It should therefore be the care of last resort, not the main avenue to receive longer-term stabilization and supports after a crisis.

Some in Washington have recognized this and recently undertaken efforts to expand community-based behavioral health treatment and crisis response. For example, House Bill 1477, which became law in 2021, notes that: "An improved crisis response system will reduce reliance on emergency room services and the use of law enforcement response to behavioral health crises and will stabilize individuals in the community whenever possible."[xliii] The law establishes a new crisis call center hub and expresses the legislature's intention to make future investments to the crisis response system, including:

- Mobile rapid response crisis teams
- 23-hour crisis stabilization units based on the living room model
- Crisis stabilization centers
- Short-term respite facilities
- Peer-run respite centers
- Same-day walk-in behavioral health services[xliv]

Washington has neglected to develop this infrastructure for many years. The Washington Supreme Court acknowledged that "[o]ur current involuntary civil commitment system has been regularly overwhelmed since it was first enacted by the legislature in 1979."[xlv] While developing the services people need may at this point be ambitious, it is achievable and imperative.

The state must ensure these services are fully funded and implemented statewide in a culturally competent manner that engages with all communities of color, especially Black and Indigenous communities. If the state answers its own call to build and fund voluntary, community-based services, Washingtonians will finally be supported and stabilized in their communities.

## 2. The state must effectively target existing bed capacity to those most vulnerable and in-need, not build more costly inpatient beds.

The specialized facilities licensed by our state to provide inpatient behavioral health treatment should be obligated to treat all patients who qualify for such care, especially those with complex behavioral or medical conditions. Indeed, these are the facilities that state and federal dollars fund to perform this service. The legislature should enact a meaningful obligation on treatment facilities, but only as part of a broader effort to build up the behavioral health treatment and crisis response systems and to end harmful use of SBCs and NBRs. If Washington's inpatient behavioral health treatment facilities need additional staffing, specialized training, medical equipment, or other assistance to meet their obligation to care for patients, then the state must assist.

Image Description: *Fenced outdoor recreation area for patients at a King County Evaluation and Treatment facility.*

We do not need more involuntary inpatient behavioral health beds in Washington and the state should not fund additional capital projects that result in any more beds of this type. Providing better voluntary, community-based, culturally-competent behavioral health treatment and crisis response services helps to avoid involuntary inpatient treatment. We might then finally understand how many people actually need inpatient beds and be better able to strategically target existing beds.

## 3. The state must provide oversight, accountability, and a path to end SBCs and NBRs.

When people experiencing crisis cannot access a continuum of stabilization and support services, they are often left to compete with others for an inpatient bed.The result is that many patients will instead end up receiving inadequate care via a SBC or no care at all after a NBR is filed. These practices lack oversight and accountability at the expense of patients. The state must chart a path to end the use of SBCs and NBRs within the coming year.

SBCs grew out of a practice of psychiatric boarding that the Washington Supreme Court deemed unconstitutional in 2014.[xlvi] Although the state created regulations and

paperwork in response, the practice of psychiatric boarding in hospital emergency rooms arguably continues under a new name with minimal oversight or accountability of the care provided. The state must create a detailed plan to drastically reduce the use of SBCs. In the short term, this plan must identify a knowledgeable state entity to provide meaningful oversight of the care that is provided to patients via SBC. The regulations governing SBCs must better spell out this care and ensure it is comparable to the care provided by licensed and certified inpatient facilities. Facilities that are found in violation of these requirements should be denied future SBC approvals.

Image Description*: A bed sitting in a hallway of the emergency department of a Thurston County area hospital.*

The state must also set a specific goal of zero NBR patients by a date certain and develop an aggressive plan to achieve this that does not include expanding the use of SBCs. As it works to end NBRs, the state must immediately enforce existing contracts with the MCOs and BHASOs to meaningfully provide care and support to someone released under a NBR. This care must be more than a few attempted phone calls and outpatient referrals. Instead, it must be face-to-face contact that better reflects the examples provided under current law.[xlvii]

# Conclusion

**Imagine a loved one, a neighbor, a colleague, or even yourself experiencing a behavioral health crisis so serious that it raises health and safety concerns. Someone in that situation should have immediate access to humane, effective treatment in as unrestrictive a setting as possible. Certainly the best option is to avoid anyone reaching that level of crisis to begin with. Unfortunately, Washington's current systems do not achieve these goals.**

**Washington must make significant investments in preventing and mitigating behavioral health crises, while also improving oversight of the existing ITA system. It must expand voluntary, community-based services while strategically managing existing inpatient resources, not simply build more inpatient beds. If we do not take these steps, our state will continue to fail the growing number of Washingtonians with behavioral health needs.**

# About the Authors

## Kimberly Mosolf

Image Description: *A headshot photo of Kimberly Mosolf.*

Kimberly Mosolf is the Director of Disability Rights Washington's Treatment Facilities Program, working on behalf of people with disabilities in hospitals, Residential Habilitation Centers, nursing homes, and assisted living facilities, among others. As class counsel in A.B. vs. D.S.H.S. (Trueblood), Kimberly also works to reform the forensic mental health system in Washington and to expand diversion opportunities for people with behavioral health conditions who are facing arrest and prosecution. She has also worked to reduce the use of force by police against people with disabilities. Before joining Disability Rights Washington, Kimberly practiced law in New York City where she worked on behalf of parents caught up in the child welfare system, people receiving government benefits, sex workers, and people with mental illness. Kimberly was born and raised in Seattle, WA. She is a graduate of Columbia University School of Law.

## Hannah Garland

Hannah Garland is a law student at the University of Washington School of Law. She graduated from Skidmore College in 2013 with a B.S. in Dance Performance and Choreography. In between undergrad and law school, Hannah worked in the fields of youth homelessness, family advocacy, and childcare. She is interested in the intersection between legal work and societal change. She has been a legal intern with Disability Rights Washington since June of 2021.

Image Description: *A headshot photo of Hannah Garland.*

# Endnotes

[i] Wash. Health Care Auth., *Data on ITA investigations* (2020).
[ii] *See* Protection and Advocacy of Individuals with Mental Illness (PAIMI) Act, 42 U.S.C. §10801 *et. seq.*; Developmental Disabilities Bill of Rights (DD) Act, 42 U.S.C. 15041 et. seq., and the Protection and Advocacy of Individual Rights (PAIR) Act, 29 U.S.C. § 794e.
[iii] 42 U.S.C. §15043(a); 42 U.S.C. § 10805(a); 29 U.S.C. § 794e(f).
[iv] Substance Abuse and Mental Health Servs. Admin., *Civil Commitment and the Mental Health Care Continuum: Historical Trends and Principles for Law and Practice 1* (2019), samhsa.gov/sites/default/files/civil-commitment-continuum-of-care.pdf.
[v] RCW 71.05.150(1).
[vi] *Id*.
[vii] RCW 71.05.153(1).
[viii] RCW 71.05.230 and RCW 71.05.320.
[ix] RCW 71.05.150.
[x] Wash. Health Care Auth., *Acute Mental Health Care*, https://www.hca.wa.gov/health-care-services-supports/behavioral-health-recovery/acute-mental-health-care-inpatient.
[xi] RCW 71.05.745; WAC 182-300-0100.
[xii] *Det. D.W. v. Dep't of Soc. & Health Servs.*, 81 Wn. 2d 201 (Wash. 2014).
[xiii] *Id*.
[xiv] WAC 182-300-0100.
[xv] Wash. Health Care Auth., *Single Bed Certification and no bed report (SBC) quarterly update: Quarter 2, 2021*, https://www.hca.wa.gov/assets/program/single-bed-certification-and-no%20bed-report-quarter-2-2021.pdf.
[xvi] Wash. Health Care Auth., *Single Bed Certification and no bed report (SBC) quarterly update: Quarter 1, 2018*, https://www.hca.wa.gov/assets/program/SBC-quarterly-report-2018-01.pdf.
[xvii] *SBC Update: Quarter 2, 2021*, *supra* note xv.
[xviii] RCW 71.05.750.
[xix] *Id*.
[xx] RCW 71.05.755.
[xxi] Wash. Health Care Auth., *Single Bed Certification and no bed report (SBC) quarterly update: Quarter 1, 2018*, https://www.hca.wa.gov/assets/program/SBC-quarterly-report-2018-03.pdf.
[xxii] Wash. Health Care Auth., *Single Bed Certification and no bed report (SBC) quarterly update: Quarter 1, 2021*, https://www.hca.wa.gov/assets/program/single-bed-certification-no-bed-report-quarter-1-2021.pdf.
[xxiii] RCW 71.24.890, Official Note Sec. 1(d).
[xxiv] *Id*. at Sec. 1(a).
[xxv] *See*, *e.g.*, Wash. Dep't of Health, *Behavioral Health Resources and Recommendations: Monthly Reports on Behavioral Health Situation*, https://www.doh.wa.gov/Emergencies/COVID19/HealthcareProviders/BehavioralHealthResources#heading58478; Sound Health, *Workforce Shortage in Community Behavioral Health Worsens Healthcare Crisis*, August 4, 2021, https://www.sound.

health/blog/2021/07/22/workforce-shortage-in-community-behavioral-health-worsens-healthcare-crisis/ .

[xxvi] Mental Health America, *Ranking the States* (2020), https://mhanational.org/issues/ranking-states#one.

[xxvii] Wash. Office of Fin. Mgmt., *2018 Capital Funding Prioritization and Feasibility Study* (January 2019), https://ofm.wa.gov/sites/default/files/public/publications/BehavioralHealthCapitalFundingPrioritizationandFeasibilityStudy0119_0.pdf. In this report, behavioral health crisis services include beds in crisis triage facilities, crisis stabilization units, and crisis respite facilities. The report determined the state had 346 of these beds, but needed 808.

[xxviii] Wash. Dept. of Social and Health Servs., *Presentation to the Behavioral Health Recovery System Transformation Task Force: Transforming Washington's Behavioral Health System, Community Capacity Updates*, September 25, 2020, https://app.leg.wa.gov/committeeschedules/Home/Document/222593#toolbar=0&navpanes=0.

[xxix] Behavioral Health Recovery Sys. Transformation Comm., *Proposed Recommendations for the Committee's Consideration* (October 2020), https://app.leg.wa.gov/committeeschedules/Home/Document/223723#toolbar=0&navpanes=0 .

[xxx] Id.; See also, UW News, *$38M set of gifts from Ballmer Group to address behavioral health crisis aims to bolster workforce, resources across Washington through UW-led programs*, May 14, 2021, https://www.washington.edu/news/2021/05/14/38-million-set-of-gifts-from-ballmer-group-to-address-behavioral-health-crisis-aims-to-bolster-workforce-resources-across-washington-through-uw-led-programs/.

[xxxi] Wash. State Inst. for Public Policy, *Inpatient Psychiatric Capacity and Utilization in Washington State*, 7 (January 2015), https://www.wsipp.wa.gov/ReportFile/1585/Wsipp_Inpatient-Psychiatric-Capacity-and-Utilization-in-Washington-State_Report.pdf.

[xxxii] Substance Abuse and Mental Health Servs. Admin., *National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit Executive Summary*, 2 (February 2020), https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-services-executive-summary-02242020.pdf.

[xxxiii] In health care terminology, acuity can refer the measurement of a patient's severity and intensity of condition and their resulting requirement for care. Higher acuity patients may need more care, so the ratio of nurse staff to patient is usually smaller. For discussion of the meaning of acuity, see C.W. Brennan & B.J. Daly, *Patient acuity: a concept analysis*, 65 J. Adv. Nurs. 1114 (2009).

[xxxiv] King Cnty. Behavioral Health and Recovery Div., *2019 King County E&T Decline Report, 14* (2019). DRW has also found this to be the case through past investigations.

[xxxv] *Id*.

[xxxvi] *Id*. at 5.

[xxxvii] *Id*. at 6.

[xxxviii] Wash. Health Care Auth., *Single Bed Certification Form*, https://www.hca.wa.gov/assets/program/WSH-SBC-e-Form.pdf.

[xxxix] RCW 71.05.755.

[xl] *Id; See also*, Wash. Health Care Auth., *Washington Apple Health Integrated Managed Care Contract*, Sec. 6.4.1, https://www.hca.wa.gov/assets/billers-and-providers/ahimc-medicaid.pdf.

[xli] As of September of 2021, it was DRW's understanding that Health Care Authority had demanded the MCO's written plans and procedures for responding to NBRs, specifically advising MCOs that the response must be rapid and clinical in nature and must include daily check-ins with the person, among other things.

[xlii] Investing in the time and space to provide voluntary treatment to people also has better long-term outcomes than forcing people into an involuntary treatment setting. Studies have shown that the length of stay, readmission risk, and risk of involuntary readmission were at least equal or greater for involuntarily admitted patients than voluntary. Involuntary patients also had higher rates of suicide, lower levels of social functioning, expressed more dissatisfaction with treatment, and questioned the justification for their hospital stay. *See*, e.g., T.W. Kallert, et al, *Involuntary vs. voluntary hospital admission: a systematic literature review on outcome diversity*, Database of Abstracts of Reviews of Effects (DARE): Quality-assessed Reviews, 2008, https://www.ncbi.nlm.nih.gov/books/NBK76143/ .

[xliii] RCW 71.24.890, Official Note Sec. 1(f).

[xliv] *Id*. at Sec. 2(b). The state should also incorporate into its reforms the 2020 national guidelines on behavioral health crisis care from the federal Substance Abuse and Mental Health Services Administration, which discusses in great detail how localities can build crisis services to avoid an over-burdened inpatient system. See, SAMSHA National Guidelines, supra note xxxii.

[xlv] *In re Det. D.W. at 205, supra* note xii.

[xlvi] *In re Det. D.W., supra* note xii.

[xlvii] RCW 71.05.755(2).