



June 2021

## Designated Crisis Responders and Ricky’s Law: *Involuntary Treatment Investigation, Decision, and Placement*

Before 2016, two separate systems existed for the involuntary commitment of individuals in crisis due to mental health (MH) or substance use disorders (SUD). The 2016 Legislature passed E3SHB 1713—called “Ricky’s Law”—to integrate both conditions into Washington’s existing Involuntary Treatment Act (ITA).<sup>1</sup> The legislation required the Washington State Institute for Public Policy (WSIPP) to evaluate the changes resulting from Ricky’s Law.

As part of the integration, Ricky’s Law (1) created the designated crisis responders (DCRs)—a single professional designation responsible for conducting all ITA investigations, both MH and SUD, and (2) established Secure Withdrawal Management and Stabilization (SWMS) facilities. WSIPP interviewed DCRs from across the state to learn about their experience when determining whether to detain people under Ricky’s Law and whether to place people in SWMS facilities.

**Section I** situates this report in WSIPP’s overall evaluation and provides background information about Washington’s ITA system, DCRs, and SWMS facilities. **Section II** explains our research approach and interview process. **Section III** highlights key findings from our DCR interviews and highlights key findings. **Section IV** summarizes the findings and discusses the limitations of this report.

<sup>1</sup> [Engrossed Third Substitute House Bill 1713, Chapter 29, Laws of 2016](#) and [RCW 71.05](#).

### Summary

The passage of Ricky’s Law modified Washington’s Involuntary Treatment Act (ITA), integrating the evaluation and detention processes for individuals with mental health (MH) and substance use disorders (SUD).

The integration created designated crisis responders (DCRs), a professional position responsible for conducting all ITA investigations. For this report, we interviewed DCRs working in every county in Washington State about their experience applying Ricky’s Law and placing patients in newly created secure withdrawal management and stabilization (SWMS) facilities.

From those interviews we identified six key takeaways:

1. The fewer high-quality local treatment options available in the community, the more likely a DCR is to detain.
2. Most people investigated for ITA present symptoms of both MH and SUD.
3. The SWMS placement process has improved since the first facilities opened.
4. There are few if any options for ITA SUD treatment for people experiencing acute medical and other health conditions.
5. In the ITA system, the investigation and initial detention phases were integrated, but the court and treatment phases were not.
6. A conflict between state and federal law is likely limiting communication between SWMS facilities and DCRs regarding client discharge.

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## I. Background

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In this section, we provide a brief background of behavioral health integration in Washington and discuss how this report fits into WSIPP's larger evaluation. We discuss the creation of the designated crisis responders (DCRs) position and the establishment of Secure Withdrawal Management and Stabilization (SWMS) facilities set forth in Ricky's Law. Further, we explain the DCRs' role in the involuntary treatment system and the function of SWMS facilities.

### Glossary of Terms

**Designated crisis responders (DCR)** are designated mental health professionals who are trained in holistic crisis investigation. DCRs evaluate individuals clinically to determine whether they meet criteria for ITA for either a MH or SUD condition. DCR's were established in 2018 and replace the former roles of designated mental health professionals or chemical dependency specialists.

**Evaluation and Treatment (E&T) facilities** are licensed facilities that provide emergency evaluation and treatment outpatient and/or inpatient care to persons suffering from a MH disorder.

**A mental health (MH) or mental disorder** is "any organic, mental, or emotional impairment which has substantial adverse effects on a person's cognitive or volitional functions."\*

**A substance use disorder (SUD)** is "a cluster of cognitive, behavioral, and physiological symptoms indicating that an individual continues using the substance despite significant substance-related problems. The diagnosis of a substance use disorder is based on a pathological pattern of behaviors related to the use of the substances."\*

**Secure Withdrawal Management and Stabilization (SWMS) facilities** are fully secured, licensed facilities that work to stabilize patients from a SUD-inspired behavioral health crisis. Facilities are operated by public or private provider agencies.

Note: \*SUD and MH definitions are from [RCW 71.05.245](#).

## Involuntary Treatment Act (ITA)

Washington's ITA defines the legal process and criteria under which individuals may be detained and civilly committed when found to be gravely disabled or a danger to themselves or others due to a behavioral health condition.<sup>2</sup> It defines specific criteria and due process protections that authorize involuntary detention to appropriate behavioral health (BH) treatment facilities for individuals who demonstrate grave disability or a risk of serious harm.<sup>3</sup>

Before Ricky's Law passed, an emergency SUD ITA detention process did not exist. Individuals with MH disorders could be detained immediately for treatment whereas the chemical dependency statute required a court order to detain individuals with SUDs. The discrepancy between the two ITA systems in the use of emergent commitment created a system in which SUD patients could leave the hospital before a commitment order was enforced.<sup>4</sup>

Washington had previously explored an integrated ITA system. The 2005 Legislature authorized the Department of Social and Health Services (DSHS) to establish crisis response pilot sites for integrated ITA treatment.<sup>5</sup> Two secure involuntary detoxification (detox) facilities were established to deliver acute or chronic detox and other services for individuals gravely disabled due to SUD or a co-occurring SUD/MH combination. WSIPP evaluated the effectiveness of these secure detox facilities and found that people detained at these facilities had improved outcomes (e.g., reduced hospitalizations, increased treatment participation, and increased employment) compared to clients in locations where secure detox was not available.<sup>6</sup>

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<sup>2</sup> RCW 71.05 and 71.34 for minors.

<sup>3</sup> Gravely disabled is defined as an individual's inability to care for basic needs that endangers one's health or safety and serious harm includes an imminent danger to self, others or property. RCW 71.05.245 and RCW 71.05.156.

<sup>4</sup> David Reed, Health Care Authority, Division of Behavioral Health and Recovery, Involuntary Treatment Act Program Manager (personal communication, May 2021).

<sup>5</sup> Engrossed Second Substitute Senate Bill 5763, Chapter 504, Laws of 2005, Sec. 101 and 70.96B RCW Dispositions.

<sup>6</sup> Mayfield, J. (2011). *Integrated crisis response pilots: Long-term outcomes of clients admitted to secure detox* (Doc. No. 11-05-3902). Olympia: Washington State Institute for Public Policy.

## Designated Crisis Responders

Prior to the passage of Ricky's Law, SUD crises were investigated by chemical dependency specialists (CDS) and MH crises were investigated by designated mental health professionals (DMHPs). DCRs are trained in holistic crisis investigation.<sup>7</sup> By creating the DCR professional designation, Ricky's Law effectively combined the functions of the two positions<sup>8</sup> tasked with conducting ITA evaluations before the systems were integrated. When an individual is referred for an evaluation under the ITA, DCRs determine whether individuals meet the criteria for ITA treatment.

DCRs must determine whether individuals would be best served at a MH treatment facility<sup>9</sup> or a SWMS facility for SUD. DCRs cannot detain a person for SUD when no involuntary treatment bed is available,<sup>10</sup> and individuals who do not meet the criteria for detention may choose to voluntarily detox or receive residential or outpatient treatment.

Throughout Washington, DCR services are divided by county and provided through Behavioral Health Administrative Services Organizations (BH-ASOs). Some agencies provide DCR services to multiple counties while others cover a single county. A list of agencies providing DCR services can be found in [Appendix A1](#).

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<sup>7</sup> [RCW 71.05.755](#).

<sup>8</sup> The DCR job classification replaced the DMHP classification, effectively combining the functions of designated mental health professionals (DMHP) and chemical dependency specialists (CDS). Agencies trained all former DMHPs to become DCRs. Substance use disorder professionals ([RCW 18.205](#)) replaced CDS; however, they were not trained to become DCRs unless they also met the DMHP criteria.

<sup>9</sup> MH involuntary treatment beds are located in either freestanding Evaluation and Treatment (E&T) facilities or

## SWMS Facilities

SWMS facilities are freestanding sites that provide detoxification and stabilization for those in crisis due to a SUD. Facilities provide care that includes admission services, medical detoxification treatment (when appropriate), coordination of services, and inpatient medical monitoring (physicians and nurses). Three SWMS facilities were operational when we conducted interviews with DCRs. The first two facilities opened in Lewis and Spokane counties in April 2018 and were operated by American Behavioral Health Systems (ABHS). Valley Cities Behavioral Health Care opened a facility in King County called "Recovery Place Kent" (RPK) in December 2019. A fourth facility, specifically for youth, is operated by Excelsior and opened in Spokane County in April 2021.<sup>11</sup>

licensed community hospital beds. Licensed community hospital beds tend to have greater access to medical care necessary to treat patients with severe medical comorbidities.

<sup>10</sup> This information is recorded by the DCR with a no-bed report.

<sup>11</sup> Our first report incorrectly indicated that Excelsior's Spokane County SWMS facility opened in September 2020 and that RPK opened in March 2020.

## [WSIPP's Evaluation](#)

The law requires WSIPP to submit three reports on the impacts of Ricky's Law. Our first report<sup>12</sup> provides a comprehensive background of Washington's Involuntary Treatment Act and behavioral healthcare integration in Washington. That report also outlines WSIPP's research assignment<sup>13</sup> and our intended research plan for all three reports. A summary of our research plan can be found in [Appendix A2](#).

This second report provides an in-depth look at the integrated ITA detention and placement processes from the DCR perspective. We present themes from interviews conducted with DCR managers and DCRs throughout Washington. The interviews provide an understanding of the mechanisms that may affect outcomes, provide an on-the-ground perspective of the implementation and ongoing application of Ricky's Law, and inform our approach for the third report.

The third report, which is due to the legislature in June of 2023, will provide a quantitative evaluation of the effect of the integration of the involuntary treatment systems for substance use disorders and mental health on client outcomes, system outcomes, and the cost-effectiveness of involuntary treatment.

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<sup>12</sup> Drake, E., Ellis, A., & Miller, M. (2020). *Involuntary Treatment Act for substance use disorders: First preliminary report* (Doc. No. 20-12-3401). Olympia: Washington State Institute for Public Policy.

<sup>13</sup> E3SHB 1713.

## II. Research Approach

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To answer questions about the implementation of Ricky's Law, how it is currently applied, and barriers to its application, we conducted interviews with DCR managers<sup>14</sup> and practicing DCRs.

Washington State Health Care Authority (HCA) assisted WSIPP with recruiting DCR managers for the interviews. We reached out to designated contacts at agencies providing DCR services and asked for their agency's participation in our study. Specifically, we requested that a DCR manager would participate in a one-hour interview and asked them to bring a practicing DCR to the interview if they were able.<sup>15</sup>

In February and March 2021, we spoke with at least one DCR working in every county in Washington for a total of 28 interviews with 48 individuals. Fifteen of the 28 interviews included multiple interviewees.<sup>16</sup> For simplicity, all interviewees are referred to as DCRs for the remainder of this report.

Broadly, we asked DCRs to explain the steps of an ITA investigation, how they interpret and apply Ricky's Law, their experience placing clients into SWMS facilities, and what changes to the ITA system might help them do their job better. Our interview goals were three-fold:

- 1) Talk to experts about the decision-making process for determining whether to detain individuals under Ricky's Law;
- 2) Learn from the experts about the process involved in placing a person in a SWMS facility, and;
- 3) Learn from the DCR perspective how the ITA system might be improved.

A standardized, open-ended interview instrument allowed us to ask the same broad questions (see [Appendix A3](#) for full interview instrument) of all interviewees and compare answers across interviews. This approach also gave us the flexibility to supplement our structured questions with clarifying questions as the interview progressed.<sup>17</sup> On average, the interviews took between 45 minutes and 1 hour and were conducted over Zoom.

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<sup>14</sup> We included anyone who supervises teams of DCRs as DCR managers. Often, a DCR manager is also a practicing DCR (i.e., they currently conduct ITA investigations). In cases where DCR managers were not practicing DCRs they held administrative positions that oversaw other DCR managers and were trained as certified DCRs.

<sup>15</sup> We left bringing a practicing DCR optional because often, only one DCR is on call. Thus, it could be prohibitive to schedule a practicing DCR for a one-hour interview during a shift.

<sup>16</sup> While we spoke with someone at every agency providing DCR services, this is not a representative sample of DCRs in Washington. DCR teams range from 2.5 to 54 FTE (See [Exhibit A1](#)). In each county, we spoke with the same number of DCRs but not the same percentage of total DCRs.

<sup>17</sup> The lead WSIPP interviewer conducted 25 of the 28 interviews. Each interview included an average of 2.25 WSIPP researchers to ensure consistent, high-quality interpretation of the interviews. Only three interviews were conducted with one WSIPP interviewer.

To encourage open and honest responses, we committed to interviewees that no person or agency would be identified or associated with specific responses in this report. Thus, information obtained from the interviews is presented and discussed at a high level. Specific quotes used to illustrate themes found across multiple interviews are not attributed to their source.<sup>18</sup>

We synthesized and consolidated our interviewer notes then coded and summarized the main themes described within each interview. The following section presents the main themes we heard from DCRs. While this report focused on interviews with DCRs, we also reached out to SWMS facility leadership to clarify procedural questions.

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<sup>18</sup>As of the publication of this report, we have destroyed all recordings, as promised to our interviewees.

### III. Findings

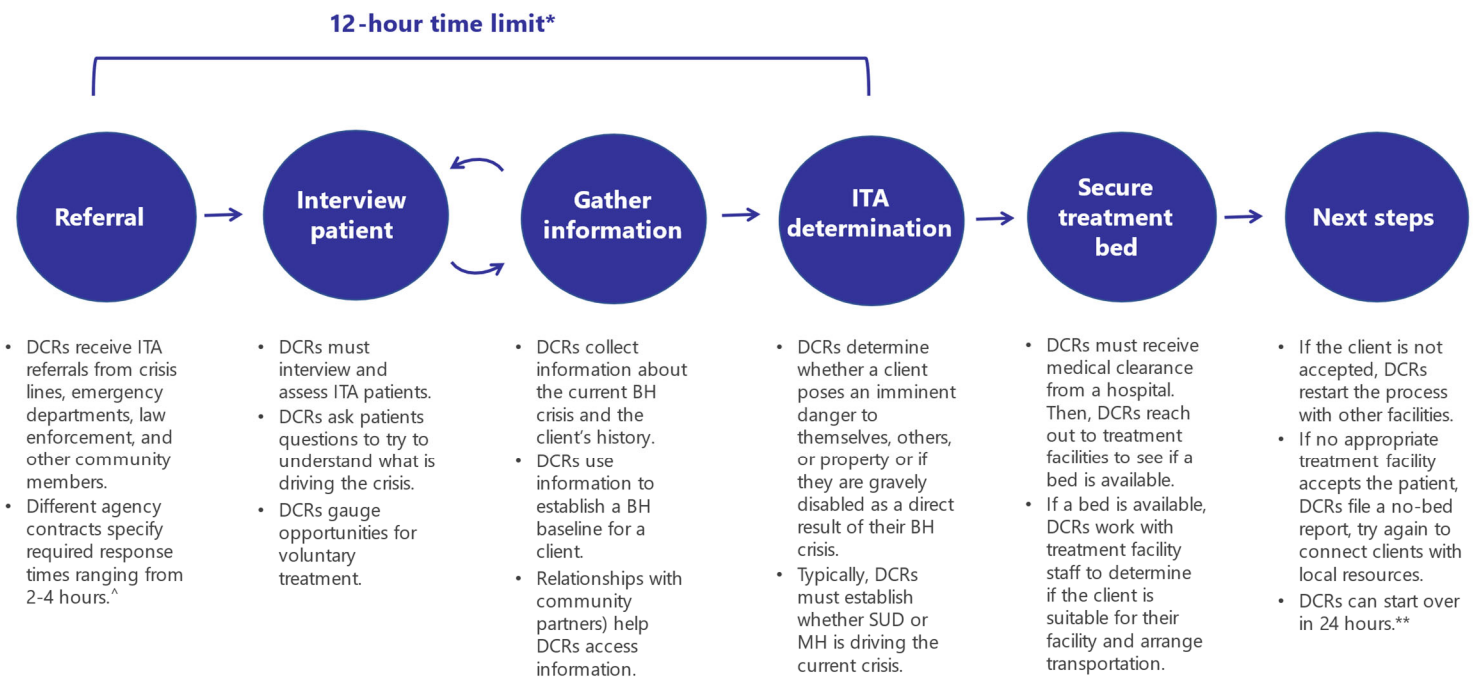
In this section, we describe themes that emerged from the DCR interviews. First, we present findings related to DCRs’ description of the ITA process. Then, we summarize suggestions from DCRs on how the ITA system might improve. We identify findings where DCR responses were both consistent and divergent, explaining the most common answers as well as situations where experiences differed along specific criteria (i.e., rural/urban). Throughout the section, exhibits are used to summarize overarching themes and highlight key takeaways.

### Applying Ricky’s Law

We categorized what DCRs told us about their work into four categories—**investigation, ITA determination, placement, and aftercare.** These categories generally follow the steps as explained by DCRs and outlined in **Exhibit 1.** For DCRs, some steps of the ITA process are outlined in RCW and have strict timelines while others are left to the DCR’s discretion. **Exhibit 1** summarizes the DCR process for investigating a person for ITA detention, making an ITA determination, finding a treatment bed, and steps after detention.

**Exhibit 1**

ITA Investigation Steps and Timelines



**Notes:**

\*Only applies to emergent referrals from an ED and does not include time before the person being investigated receives medical clearance. [RCW 71.05.153.](#)

\*\*RCW [71.05.160.](#)

<sup>^</sup>Response times vary by contract.



### Investigation

A DCR's investigation begins when they receive an ITA referral and ends when they determine whether an individual meets detention criteria.

*Referrals.* Some interviewees reported that their crisis referrals are routed through a regional crisis line that triages emergent from non-emergent calls. Others explained that their offices field all of the crisis calls for their designated area. In cases where DCR teams receive all crisis calls it was common for their office to also provide some behavioral health services.

*Locations.* DCRs receive referrals from a variety of sources and respond to calls in many locations. The majority of ITA referrals come from Emergency Departments (EDs) at local hospitals, but DCRs also reported frequently receiving referrals from law enforcement, behavioral health treatment providers, as well as family, friends, and community members.

About one-third of DCRs interviewed said that they respond to calls anywhere in their community. A handful of DCRs reported that, for safety reasons, they will not respond to calls within the community without law enforcement present.<sup>19</sup> After receiving a referral, DCRs begin collecting information about the client and their current behavioral health crisis.

*Information Collection.* During an investigation, DCRs seek both current and historical information about a client. While DCRs reported collecting information in a variety of ways, the two overarching methods included talking to people familiar with the situation or client and searching databases for historic information. DCRs consistently mentioned speaking with the following:

- Medical professionals (e.g., doctors and nurses in the ED),
- The person being investigated (i.e., get the person's understanding of what caused the crisis),
- Collateral contacts (e.g., family, friends, community members, and witnesses), and
- Law enforcement (when they are involved in the referral process).

When available DCRs also searched the following:

- Internal records (documentation of previous ER visits or other interactions with the DCR's agency),
- Criminal justice records (e.g., arrest and jail records, Department of Corrections), and
- Other behavioral health treatment provider's records (e.g., psychiatric history, SUD history).

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<sup>19</sup> Multiple DCRs referenced the 2005 killing of a DMHP.

In most cases, DCRs are limited to a few of the above sources of information and have only limited knowledge of a client's history. Many DCRs reported having limited access to criminal justice, behavioral health, and historical hospital records based on both relationships with community partners maintaining databases and/or the database system used by their agency. A standardized system that all DCRs can query does not exist. DCR agencies connected to larger BH agencies typically reported having access to more client information.

*History.* All DCRs examine the patient's history as a major part of their ITA evaluation, including whether the patient has a long-term SUD or chronic mental illness history. They try to identify whether the patient has had similar factors (e.g., prior detentions or suicidal thoughts) in previous behavioral health crises. As they gather history and information about a person's circumstances leading up to the crisis, DCRs try to understand the patient's risk and protective factors such as homelessness, social supports, financial situation, and access to treatment services.

*Baseline.* In situations where DCRs either had access to extensive history or had personal experience with a client, many reported using a client's baseline—their past pattern of behavior—to establish whether the patient's current presentation has deteriorated to the point they meet ITA criteria. Encountering a familiar patient was mentioned frequently—especially in instances where DCRs are working in additional capacities in local behavioral health systems.<sup>20</sup> In all circumstances, knowledge of a patient's baseline helps DCRs assess current risk.

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<sup>20</sup> During the interviews, some DCRs explained that they work as counselors or case managers in addition to their role as a DCR.

*Imminence of Harm and Risk.* Some DCRs described imminence as the starting point of an investigation and others said it was the most important, albeit the most unclear criterion for detention. DCRs most commonly interpret this to mean that the danger from the crisis will manifest within the next 12-24 hours. DCRs re-assess imminence throughout their evaluation of the patient.

Often, imminence was described as suicidal thoughts or active threats with a plan and intent to follow through with that plan. As an example, one DCR explained that a patient with psychosis may hear voices and that the risk is greater if the voices are telling the person to harm themselves.<sup>21</sup> DCRs also examine whether the client will return to the same circumstances or risks driving their current crisis.

DCRs explained that the standard for imminence can be especially complicated for people presenting SUDs because imminence can change throughout the investigation. For instance, the person may meet the criteria at the beginning of the investigation but cease to do so as they gradually regain sobriety.

<sup>21</sup> A handful of DCRs mentioned using assessment tools (e.g., the Columbia suicide severity rating scale or the Global Appraisal of Individual Needs (GAIN)) to assess suicidality.

## ITA Determination

After conducting the investigation, DCRs must determine whether ITA detention is necessary. Detention rates—the percentage of investigations resulting in detention—varied by agency with reported values ranging from around 5% to 40%.<sup>22</sup> While most of the detention criteria are outlined in RCW 71.05.020<sup>23</sup> and RCW 71.34.020,<sup>24</sup> DCRs must apply the law on a case-by-case basis.

## *Voluntary Options and Safety Planning.*

DCRs explained that they see it as their duty to preserve the civil rights of the people they investigate to the greatest extent possible and that they consider ITA commitment an option of last resort.<sup>25</sup> In practice, this means exploring all available less restrictive options (e.g., voluntary treatment, safety planning, step-down options) prior to making an ITA determination. Nearly every DCR we spoke with mentioned the ability to create a credible safety plan<sup>26</sup> as a key tool for diverting people away from ITA detention.

*Interpreting the Statutory Criteria.* A majority of respondents said that the statutory language of the ITA criteria is clear but leaves room for discretion in its application. Some cases fall into gray areas in which it is uncertain whether the investigated person meets the standard for commitment. Of the criteria, DCRs most often cited a danger to self and grave disability. DCRs can indicate in the petition<sup>27</sup> whether a person meets more than one criterion. [Exhibit 2](#) summarizes how DCRs interpret the statutory criteria for danger to self, danger to others, and grave disability.<sup>28</sup>

A DCR must demonstrate a link between the legal criteria the investigated person meets and a behavioral health disorder for a determination for detention to hold up in court.<sup>29</sup> DCRs report that this link can be challenging to demonstrate when the investigated person experiences medical comorbidities that could plausibly drive the crisis.

*Gray Area Cases.* There is no definitive cutoff point for ITA detention eligibility, and DCRs can and do disagree on some of the more complicated cases they encounter. DCRs commonly consult with one another and their supervisors for additional professional judgment on which path to take.

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<sup>22</sup> HCA reports that the statewide average is 50%. Some of this variation is likely due to variation in call screening described in [Referrals](#). Agencies where DCRs respond to all crisis calls tended to have lower detention rates than agencies where calls were routed through a crisis line.

<sup>23</sup> [RCW 71.05.020](#).

<sup>24</sup> [RCW 71.34.020](#).

<sup>25</sup> This is consistent with the DCR training provided by HCA and [RCW 71.05.010](#).

<sup>26</sup> Safety planning involves 6 steps, including (1) identifying warning signs that indicate the safety plan should be used, (2) designing internal coping strategies to prevent the person from taking dangerous actions, (3) finding social contacts who can help distract from the crisis, (4) designating

family members and friends who can help during a crisis, (5) outlining BH professionals the person can reach out to, and (6) removing dangers from the person's environment, such as firearms or other means of harming oneself or others. [U.S. Department of Veteran's Affairs](#).

<sup>27</sup> If the DCR detains the client to an accepting facility, the DCR files a petition for detention, which is provisionally accepted. If the patient is to continue in treatment beyond the initial detention period, a petition is filed with the superior court for commitment to additional inpatient treatment.

<sup>28</sup> Danger to property was omitted from this exhibit because it was cited by DCRs as used infrequently.

<sup>29</sup> [RCW 71.05.153](#).

## Exhibit 2

### Summary of Responses about Applying ITA Criteria

**Danger to self:** DCRs described that danger to self must combine specific threats or actions demonstrating an intentional desire to hurt oneself, with imminence, including a plan and intent to follow-through. DCRs want to know if the person can stay safe in their situation and what has caused the person's escalation or deterioration from their baseline.

*Examples:*

- Tried to kill themselves or expressed an immediate plan to do so.
- Suicidal and mentioned having a gun on their bedside dresser.

**Danger to others:** This criterion requires a similar combination of specific threats and actions with imminence, but DCRs described it as requiring a higher standard of evidence to hold in court. The person needs to display actions or credible threats (rather than simply appearing enraged). Witnesses attesting to the danger are more important in this criterion.

*Examples:*

- Threatens violence after getting intoxicated regularly and has 18 prior arrests for assault stemming from an alcohol-related SUD.
- Walks into the street and threatens people with a weapon due to BH-driven psychosis.

**Grave disability:** For this criterion, DCRs assess whether the individual can take care of their basic well-being, health, and safety. A key distinction is that this does not mean that someone would be detained for living in such a manner that DCRs find suboptimal (such as in poor conditions on the street), rather, it means that the person living in a way that prevents them from meeting their own basic needs. One DCR put it bluntly, "we are not here to detain people for poor life choices." History and deterioration from the person's baseline behavior are key tools DCRs use to determine if the person meets this criterion.

*Examples:*

- No longer eats or drinks due to paranoia or is eating rotten food due to a deterioration in behavioral health.
- Becomes regularly high and drives the wrong way in traffic.

Note:

Source: WSIPP interviews conducted with DCRs in Washington State February-March 2021.

The availability of community inpatient and outpatient SUD treatment can impact how DCRs make difficult determinations. Their ability to refer someone to high-quality voluntary treatment has implications for what sorts of cases DCRs consider ITA applicable (See [Exhibit 3](#)). DCRs are more likely to detain when their only options are involuntary treatment or no treatment. For example, in a county with access to multiple less-restrictive community options and a stricter court environment, the DCR may take the most legally cautious approach when making a determination, opting not to detain in borderline cases where a high-quality voluntary option is available. For different, smaller offices with fewer resources, erring on the side of caution means detention.

### Exhibit 3

#### Key Takeaway 1—Availability of Local Treatment Resources Impacts ITA Determination

DCRs make each determination on a case-by-case basis given the client's history, the imminence of the current situation/presentation, and the availability of non-ITA options. **A DCR's willingness to detain is impacted by the availability of high-quality less-restrictive treatment options in their community.** This suggests that, while DCRs across the state operate under the same criteria, those in areas with fewer alternative options and resources may be more likely to detain than those in areas with more alternatives to ITA. One DCR in a rural county expressed this sentiment stating,

*"As you get more and more rural, and further away from the major population centers, you find that those resources completely dry up and it's either detention or sending them home."*

**Ongoing Implementation.** Most DCRs we spoke with began as Designated Mental Health Professionals (DMHPs) who specialized in treating people experiencing mental health crises. Many of these former DMHPs told us that they have faced a learning curve in applying the ITA for SUD, leading to some uncertainty. Several respondents expressed appreciation for the DCR training but thought that a two-day course was insufficient preparation to add SUD to their previously MH-exclusive portfolios. Some DCR teams have identified "champion" DCRs who have sufficient SUD experience to help less familiar team members gain confidence in applying Ricky's Law.

*Co-occurring Clients.* Co-occurring clients are those who present behaviors and symptoms of both MH and SUD. We asked DCRs to provide an informed estimate of the proportion of investigated people who present co-occurring disorders. On average they suggested that at least half (and likely closer to 80%) of the people investigated present co-occurring disorders.

#### Exhibit 4

##### Key Takeaway 2—Most People Investigated for ITA Present Co-occurring Disorders

When investigating individuals for ITA detention, DCRs must determine whether SUD or MH drives the current crisis. This determination dictates the type of facility where individuals are placed. **DCRs indicated that most of the people they investigate present co-occurring symptoms. That is, they present symptoms of both MH and SUD,** making it difficult to determine which type of facility to detain to. When asked about how many investigated people present co-occurring symptoms, one DCR summarized the response heard in most interviews,

*“It’s high. The percentage is high. I would actually go as far as to say, probably close to 80% of the people we see are co-occurring in some way, shape, or form.”*

Our interviewees explained that the most important factor in deciding where to detain a person whose presentation suggests co-occurring disorders is to determine which disorder drives the current crisis and detain accordingly. Because treatment for SUD and MH differ in most areas of the state, DCRs must indicate on the petition whether they are detaining for a MH- or SUD-driven crisis and seek an appropriate treatment bed. When DCRs investigate individuals presenting co-occurring disorders, determining if SUD or MH drives the current crisis and identifying the most appropriate treatment bed can be particularly challenging.

Given that many DCRs began their careers as DMHPs, their relative comfort with the MH side over the SUD side has implications for facility selection; MH involuntary treatment facilities tend to be the default option. On average, DCRs are more familiar with the admissions criteria and have deeper working relationships with the longer-running MH facility providers in their counties.

The relative number of SWMS to MH involuntary treatment beds is also a factor, especially for co-occurring patients. While nearly all DCRs explained that there are more MH than SUD crisis situations, the gap in the number of treatment beds is not commensurate; DCRs feel there are not enough SWMS beds given the prevalence of SUD. More than half of DCRs explained that if a patient was co-occurring and SUD was driving the crisis and they could not find a SWMS bed, they would try to place the client in a MH treatment bed if a sufficient case for mental disorder could be made.<sup>30</sup>

<sup>30</sup> The DCRs who stated they would try to place the person in a MH bed even if SUD was the primary driver of the current crisis if a sufficient case for mental disorder could be made

operate under the belief that getting the person into even a suboptimal bed is preferable to walking away. Some of these respondents worked in counties where the E&T and licensed

Co-occurring clients pose challenges for facilities as well. Some co-occurring clients may appear to be appropriate for SUD ITA detention while they are actively intoxicated however they may benefit from placement in a MH involuntary treatment bed after they become sober. When this occurs, it is uncertain whether the SWMS hold will apply and can result in having to change the hold from a SWMS to a MH facility.<sup>31</sup>

### Placement

Once DCRs decide to detain a person under the ITA, they search for a treatment bed. We asked DCRs to describe the process and barriers related to placing clients in SWMS facilities. When responding to our questions, DCRs often discussed both SWMS and MH involuntary treatment beds. That is, DCRs talked about placement in the behavioral health system as a whole, not just within the context of Ricky's Law. Thus, some responses include references to E&Ts and community hospitals.

*Process.* Placing clients into either type of facility requires DCRs to follow the same process. First, DCRs must get a client medically cleared through an emergency department (ED). Next, they reach out to the appropriate facility to locate an available bed.<sup>32</sup> If a bed is available, DCRs provide client information to facility staff so they can determine whether the facility can accept the patient.<sup>33</sup> Then, if a client is accepted, DCRs must arrange secure transportation to the treatment facility.<sup>34</sup>

### Exhibit 5

#### Key Takeaway 3—The Process for Placing People in SWMS has Improved

**Most DCRs who have been involved with the ITA system since Ricky's Law passed stated that their understanding of the law has consistently improved over time.** This includes greater knowledge of which clients are appropriate for SWMS facilities, of what information SWMS facilities need to make their decisions, and of the communication process with facilities both before and after a placement consultation. One such DCR explained that, when SWMS first opened, they had a couple of inefficient and difficult experiences. However, after implementing additional SUD training sessions, leveraging the expertise of DCRs with SUD experience, and inviting a facility director to present to their staff, DCRs on their team became more comfortable detaining people to SWMS facilities.

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community hospital beds were more comfortable handling some level of SUD.

<sup>31</sup> RPK is dually-licensed to treat both SUD and MH patients, making this transition simpler. However, RPK staff also note that this model is very expensive. R. Geiger, Chief of Inpatient and Residential Services, Valley Cities Behavioral HealthCare (RPK) (personal communication, April 2021).

<sup>32</sup> A few DCRs explained that they sometimes reach out to see if beds are available before making a determination, but this response was uncommon.

<sup>33</sup> This process involves DCRs facilitating nurse-to-nurse conversations between a nurse from the ER providing medical clearance and facility nurses. It also involves faxing lab results, toxicology reports, and other information about clients to facilities.

<sup>34</sup> In nearly all cases, this is via ambulance. In rare occasions, most often in rural counties, law enforcement provides secure transport.



*Medical Clearance.* Providers require information about an individual’s medical situation and care needs before accepting them for involuntary treatment.<sup>35</sup> Individuals detained for involuntary treatment must be medically cleared by a physician prior to admission to a treatment facility, thus most ITA investigations take place at an ED. Medical clearance is the approval that the individual does not need to be admitted to or remain in the hospital and is safe to leave. This typically includes laboratory tests and toxicology screen results. However, there are no consistent, state-wide criteria defining medical clearance. DCRs report that what is necessary for medical clearance may vary by physician.

Medical clearance from a physician does not guarantee that an individual is medically appropriate for a SWMS or MH treatment facility. Depending on what tests and information are necessary for a physician to medically clear an individual, receiving facilities sometimes require additional medical information from a DCR before they can make an admission decision. DCRs facilitate communication between hospital and facility staff when additional information is required. Most BH treatment facilities are not equipped to deal with individuals experiencing certain medical situations.

*Exclusion Criteria.* Nearly half of DCRs identified client medical acuity as the biggest barrier to detaining a person to a SWMS facility. SWMS facilities may decline to accept a client for several reasons but many relate to a patient’s medical acuity.<sup>36</sup> SWMS facilities have limited capacity to care for a person with acute medical needs. The exclusion criteria mentioned most frequently by DCRs are people who—

- Require restraint;
- Are actively suicidal;
- Are pregnant;
- Are experiencing highly acute psychosis;
- Are experiencing dementia;
- Have diabetes;
- Have wounds that require frequent dressing changes;
- Require geriatric care;
- Are under 18 years old; and<sup>37</sup>
- Are over a certain weight.

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<sup>35</sup> Facilities must maintain a safe environment for their staff and those individuals already admitted to their facility. They try to admit everyone who they can safely provide quality care.

<sup>36</sup> Exclusion criteria varies by facility. RPK has a list of exclusion criteria that they share with DCRs. The list is not exhaustive and RPK can decline a client for reasons not

included on the list. ABHS identified some, but not all, of the characteristics listed above as exclusion criteria and noted that most generally, they try to take everyone.

<sup>37</sup> Excelsior opened a youth SWMS facility in April 2021 and is the only facility that accepts people under age 18 who are detained under the ITA for SUD.



## Exhibit 6

### Key Takeaway 4—No SUD Facilities for Certain Types of Patients

**DCRs report that when a person is experiencing an acute medical condition or co-occurring disorder and needs to be detained for SUD, there are few to no facilities available to provide the appropriate treatment.** Some reported a similar experience with E&Ts but with less frequency. One agency said that their local E&Ts have built capacity to handle patients with SUD symptoms, and another agency said there is a co-occurring facility in their county but that this facility is not licensed for initial ITA detentions.

*Communication.* Some DCRs explained that their experiences communicating with SWMS facilities have consistently improved (see *Process* above). Others identified barriers related to placement communications with SWMS facilities. One communication-related barrier is the time it takes DCRs to call facilities to inquire about bed availability. DCRs must call each facility separately to learn about bed availability. Some DCRs explain that this problem is partially mitigated because SWMS facilities geographically close to them send weekly (and sometimes daily) bed availability updates.<sup>38</sup>

Conversely, many DCRs noted that SWMS (and MH) facility staff do not always meet the time constraints facing the DCRs search for an involuntary treatment bed. This applies to both calling to see if a bed is available and discussing if a facility can accept a patient when a bed is available. As an example, one DCR recalled an occasion when over eight hours elapsed before facility staff examined the paperwork.

SWMS facilities explained that communication delays related to the acceptance decision often stem from the medical clearance process (see *Medical Clearance*). People investigated for ITA detention often have complicated medical histories and records that take a significant amount of time to review. SWMS facilities indicated that sometimes DCRs call with a referral before a client is medically cleared (see *Process*), and facility staff cannot review records until they receive the appropriate medical clearance and corresponding documents from an ED and DCR.

<sup>38</sup> This situation was described by some but not all DCRs. RPK explained to us that they view themselves primarily as a King County resource and frequently communicate with King

County DCRs. R. Geiger, Chief of Inpatient and Residential Services, Valley Cities Behavioral HealthCare (RPK), (personal communication, April 2021).

*Transportation and Location.* Almost half of DCRs mentioned transportation or the relative location of SWMS facilities as a barrier to placement. A statewide map of SWMS facilities can be found in [Appendix A4](#). The two most cited transportation issues include distance to the accepting facility and availability of affordable secure transport. Some DCRs mentioned that accepting facilities could be more than six hours away. Others stated that inclement weather makes sending patients across the state less tenable.<sup>39</sup> DCRs also noted ambulance transportation as difficult for several reasons. First, not all ambulance companies are willing to transport ITA patients. Second, an ambulance may refuse to transport out of the county let alone to the other side of the state. Third, ambulances are only paid for one way, and the expense of the return trip then falls to the receiving facility.

*Covid-19.* Although we did not specifically ask about Covid-19, half of the DCRs we interviewed mentioned it as a current barrier within the system. Discussions about Covid-19 ranged from having fewer in-person evaluations to facility closures due to outbreaks. COVID-19 testing is required for admission to facilities and some DCRs in rural counties noted that rapid-testing was not widely available at their local hospital early in the pandemic.<sup>40</sup>

*Single Bed Certification.* In some cases, when no bed is available for a MH detention, DCRs work with hospitals to perform a single bed certification—temporary ITA beds in hospitals willing and able to provide the person with timely and appropriate treatment. Single bed certifications allow DCRs to avoid releasing a patient who meets detention criteria allowing for reevaluation the following day. Hospitals cannot perform single-bed certification for SUD clients currently but will be able to do so starting in 2026.<sup>41</sup> A few DCRs cited the lack of single bed certifications as a problem for all types of ITA detentions because hospitals in their county cannot or will not perform them.

#### [Aftercare](#)

Around one-third of DCRs we interviewed explained that they see a lack of aftercare treatment, fewer court-ordered LRAs, and a lack of coordinated care as barriers unique to SUD ITA detention when compared to MH. Several DCRs described observing a cycle of repeat detentions for individuals in communities that lack services for voluntary inpatient or outpatient SUD treatment. Many DCRs described individuals who are detained just days after a detention period because less restrictive options are not available.

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<sup>39</sup> This was cited more frequently by DCRs in eastern Washington.

<sup>40</sup> HCA and The Washington State Department of Health (DOH) now ensure access to rapid COVID-19 testing for SWMS, E&T, and EDs.

<sup>41</sup> [Second Engrossed Second Substitute Senate Bill 5720, Chapter 302, Laws of 2020.](#)

## Exhibit 7

### Key Takeaway 5—The BH System has Room for Further Integration

**Many DCRs said that while the front-end of the ITA behavioral health system (investigation and detention) was integrated, the other portions (such as co-occurring treatment and robust follow-up care) were not.** One DCR summed up this sentiment, explaining,

*If you look back at the implementation of Ricky's Law, when they determined that these laws needed to be combined, they combined it on the front end where we're having one entity do the evaluation for both, but we did not combine it in the middle or the back end where we're talking about the treatment part of things, where really it should be the current facilities that are able to treat for mental health should be able to get substance use professionals in there and facilities that can manage the withdrawal components and actually have the substance use component where it's a one stop shop. Because we know we cannot tear the individual in half and just treat one and then the other.*

**Discharge Planning.** Multiple DCRs mentioned a lack of discharge planning—coordination prior to a person's discharge from a SWMS facility with voluntary SUD treatment options in counties where they were detained and/or live to ensure the individual continues to receive treatment—as a barrier in the ITA system.

SWMS facility staff connect people detained for SUD with resources and services in the counties where individuals live to help facilitate a "warm handoff" of services.<sup>42</sup> The services offered to clients in this scenario are always voluntary and are almost always with agencies outside of those where DCRs work. Thus, DCRs are not typically part of the discharge planning process unless they also work in an additional capacity.<sup>43</sup>

Ricky's Law requires that SWMS facilities notify the detaining DCR office and the receiving county DCR office when a person they detained is released. Responses from a majority of DCRs indicate that they are rarely notified when a client they detained to a SWMS facility is released and that SWMS facilities will provide no information about a client they detained after the client arrives at the facility unless the person detained has signed a release-of-information form for the DCR.

<sup>42</sup> Depending on a patient's presentation at the end of the initial 120-hour hold, and what happened at the initial court proceeding various scenarios can occur. Sometimes an individual detained on an SUD ITA is ordered to attend an extended ITA treatment for SUD. Other times, judges issue a less restrictive alternative (LRA) order which requires an individual to voluntarily attend treatment or be re-detained. If no court order is given, SWMS facilities must release the client at the end of the initial 120-hour detention in which

case the SWMS proceeds as explained above. T. Pennypacker, SWMS Administrator, ABHS (personal communication, April 2021).

<sup>43</sup> In less populous counties, it is not uncommon for DCRs to also serve as counselors or therapists. Some DCRs that do work in additional capacities also reported that they are not notified when someone they detained is discharged from a SWMS facility.

## Exhibit 8

### Key Takeaway 6—Conflict Between State and Federal Laws may be Restricting Information Flow in the ITA System

**A conflict between Washington State Code and federal privacy laws may be limiting communication between facilities and DCRs when a person is discharged from a SWMS facility.** Ricky's Law is unambiguous: [RCW 71.05.435](#) requires SWMS facilities to notify the detaining DCR office and the receiving county DCR office when they release someone from an ITA commitment. However, facilities are not notifying DCRs when a client is discharged, citing federal confidentiality requirements in [42 CFR Part 2](#).

Note:

HCA is actively pursuing a legislative change to align [RCW 71.05](#) with the requirements of [Part 2 42 CFR](#). D. Reed, Involuntary Treatment Act Program Manager, HCA (personal communication, May 2021).

In nearly all cases, DCRs do not receive discharge information on a person they detained to a SWMS facility after they are discharged. Upon discharge, SWMS works to facilitate treatment with other providers, but the DCR is not involved in this step. Many DCRs described situations where they find out a person is no longer in treatment because they are called to re-investigate the same individual. This disconnect appears to stem partially from the nature of the DCR role (i.e., focused on investigation, not follow-up) and partially from the conflict between [RCW 71.05.435](#) and [42 CFR Part 2](#) that prohibits facility staff from communicating information about a client's discharge (see [Exhibit 8](#)).<sup>44</sup>

*Court Ordered Less Restrictive Alternatives (LRA)s.* Courts can legally compel a person to attend an LRA treatment program in the community. Through this process, the court appoints a BH professional to oversee the LRA and monitor the person's compliance. If the overseer finds that the person is not in compliance with their LRA, that LRA can be revoked and the person re-detained without the need for a full investigation. While nearly all DCRs expressed not understanding the legal reasons why, many noted that their superior courts do not provide court-ordered LRAs for SUD clients, but do for MH clients. DCRs who mentioned this tended to express the belief that court-ordered LRAs helped improve outcomes for clients.

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<sup>44</sup> [42 CFR Part 2](#).

## DCR Ideas for ITA Improvements

In the previous section, we discussed a variety of barriers in the current ITA system that our interviewees identified. We asked DCRs to share their perspective on what changes might help improve the system. In this section, we present their most common responses. In general, DCRs expressed appreciation for improvements that have already been made to the system and welcomed the chance to provide further suggestions where they saw more opportunities.

*I appreciate that the information is cascading up [to the legislature] you know, I think that's helpful because DCRs and people working within the system really do need a voice... I for one appreciate the fact that the state has prioritized opening additional E&T beds. I mean that has helped, but we're still not where we need to be.*

### More Beds and Flexibility

When asked about what could make their job easier, the most common response from DCRs was to increase the number of beds available for placing all types of individuals in behavioral health crises. When asked follow-up questions, DCRs consistently explained that the system would benefit from more beds that can accept patients regardless of their presentation or medical acuity (see *Exclusion Criteria*) and that can provide co-occurring treatment (see *Co-occurring Clients*).

DCRs in rural counties expressed that a lack of beds and quality less restrictive step-down options close to their communities make ITA determinations particularly difficult. Some DCRs feel that ITA is often the only option but question whether sending someone in a BH crisis away from their community is effective. One respondent stated the following:

*...They're afraid they're going to get sent away... It's not just a trip across town to a stabilization center, it's a significant trip strapped down in a bus against your will—possibly medicated—not sure if your family is going to know where you're going, what the circumstances are, not sure if they're going to be able to have any contact with you while you're there, and you know it's very simple: sometimes the hospitalization process in and of itself can be just as traumatic as the crisis that the person is in because they are literally getting ripped from their entire community and support system... it would be very much helpful for us if we had more hospital diversion opportunities within our local community.*

### Centralized Systems

A few of the barriers that emerged during our DCR interviews related to gaps in stakeholder coordination including a lack of information available to, and exchanged between, stakeholders in Washington's BH system. DCRs offered the following suggestions to improve the quality of investigations and the efficiency of identifying available treatment beds.

*ITA Client Database.* We heard that DCRs have access to limited information when conducting ITA investigations (see *Information Collection*). Many DCRs suggested that a centralized ITA client database would allow better access to client history and baseline and improve client assessment.

*Centralized Bed Coordination.* Similarly, DCRs identified the bed search process as a bottleneck (see *Process*). Over half of DCRs stated that they would benefit from a centralized bed coordination hub—a system that would allow them to know which facilities had open beds without having to call each facility.

### Consistency

DCRs also conveyed a need for more consistency throughout the ITA system. DCRs frequently mentioned inconsistencies in medical clearance, communication with facilities, and facility exclusion criteria when describing processes they thought could be more consistent. A variety of other inconsistencies discussed also included how courts in different counties process ITA petitions, the forms necessary to place people into different facilities, and the access to reliable secure transportation.

*Medical Clearance.* DCRs identified medical clearance as one step in their investigation that is often inconsistent (*Placement—medical clearance*). Multiple DCRs pointed out that their criteria for detention are spelled out in RCW and explained that DCRs and facilities would benefit from similar language and consistency about medical clearance from hospitals. That is, DCRs expressed that it would be more efficient to place individuals if standard medical clearance criteria existed across the state.

Initial laboratory tests and toxicology screens are necessary to identify an individual's treatment needs. These are most often conducted in the ED. However, sometimes individuals will not consent to the tests. Getting individuals to agree to these tests poses a challenge. Per a DCR in eastern Washington:

*Barriers would be... people not willing to give us a urine sample. I think that's a really big one, when people know they have a set issue and they're brought to the ED, especially against their will, and they're worried that if they give a urine sample, they're worried about what the outcome may be. They may be on probation, they may be worried about something happening to their kids, they may be worried about just getting in trouble for having drugs or alcohol in their system... The physicians at our ER will not proceed with blood work or anything like that, because if the person is not willing to do it, we can't force them.*



**Timely Communication.** Similarly, DCRs expressed that increased consistency in the timeliness of communication with SWMS facilities would benefit DCRs and the people they investigate. Knowing how soon DCRs will hear back from SWMS facilities would help DCRs adhere to strict legal timelines and better serve people in an ongoing SUD crisis.

One interviewee suggested that a single role at each facility dedicated to the intake process would add efficiency to communications and minimize confusion:

*I think that also it would be beneficial if you had just one person that did intakes as opposed to when we call in we get a registered nurse, who is doing numerous busy things. He or she is very busy—they're doing medication distribution, they're doing intakes, they're trying to talk to us, they're facilitating admin at the same time. If each of these facilities had just one person that we could call 24 hours a day, various shifts obviously, that simply just did intakes, we think this would expedite our service.*

**Exclusion Criteria.** Most DCRs expressed an understanding of why SWMS facilities sometimes decline people based on their medical acuity and agree that each investigation and placement should be conducted on a case-by-case basis. However, many said they would benefit from a list of exclusion criteria that is updated consistently and distributed to all DCRs as SWMS facilities encounter new situations that exclude investigated people.

## Subsequent Legislation

Some of the suggestions offered by DCRs during our interviews were included in proposed legislation during the 2021 Legislative Session. Senate Bill 5397,<sup>45</sup> which was proposed but did not pass, would have required the following:

- Facilities (E&T and SWMS) with an open bed to admit a patient unless an exception applies, necessitating standard exclusion criteria across facilities of the same type;
- Behavioral health organizations to secure a safe placement or discharge for a person detained for involuntary treatment if no other placement is available; and
- That facilities (E&T and SWMS) provide medically necessary co-occurring disorder treatment to persons receiving involuntary treatment by July 1, 2022.

The summary of public testimony for SB 5397 provided in the Senate Bill Report,<sup>46</sup> prepared by non-partisan legislative staff, suggests that many of the barriers discussed by DCRs in our interviews have also been identified by others involved in Washington's ITA system. Those who testified in favor of the bill indicated that the bill would help more people with complex medical needs obtain BH treatment through the ITA system while those who testified against it expressed that the proposed requirements would overwhelm an already strained BH treatment system.

<sup>45</sup> Senate Bill 5397, 2021 Regular Session.

<sup>46</sup> Senate Bill Report SB 5397, February 2021.

Other legislation impacting Ricky’s Law did pass in 2021. Substitute Senate Bill 5073 aligned the adult and youth statutes for conducting an involuntary commitment interview by video; modified the minimum requirements for a court-ordered LRA by allowing a substance abuse evaluation to be provided instead of, or in addition to, a mental health evaluation; changed jurisdiction for involuntary commitment of someone who identifies as American Indian/Alaska Native to E&Ts within the boundaries of tribes; and allows E&T and SWMS facilities to transfer someone who is detained under the ITA to another facility type without first consulting a DCR.<sup>47</sup>

SSB 5073 also requires DCRs to ask adults who they investigate if they have a Mental Health Advance Directive (MHAD)—a legal document that describes what a person wants to happen if their behavioral health situation becomes so severe that they are unable to make care decisions on their own behalf.<sup>48</sup> RCW 71.32.010 describes them as, “an essential tool for an individual to express his or her choices at a time when the effects of a behavioral health disorder have not deprived him or her of the power to express his or her instructions or preferences.”<sup>49</sup>

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<sup>47</sup> Substitute Senate Bill 5073, Chapter 264, Laws of 2021.

<sup>48</sup> HCA. (2021). Health care services and supports, Mental health advanced directives.

<sup>49</sup> RCW 71.32.010.



## IV. Summary and Limitations

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The 2016 Legislature passed E3SHB 1713—called Ricky's Law—to integrate mental health and substance use disorders into a statewide behavioral health system for individuals in crisis under Washington's Involuntary Treatment Act.<sup>50</sup> This law also requires WSIPP to produce three reports evaluating the effects of Ricky's Law. For this second report, we interviewed DCRs, to gain context and understanding about the application of Ricky's Law and on-the-ground perspective about the ITA system.

We conducted 28 interviews with 48 DCR managers and DCRs working in every county throughout Washington. They answered open-ended questions related to the ITA investigation process, how they interpret Ricky's Law, their experience placing clients into SWMS facilities, and changes that could improve the ITA system.

We present various themes that emerged through the interviews and identify six key takeaways.

First, when fewer high-quality less restrictive treatment options are available in a community, DCRs expressed that the likelihood of detention is higher.

Second, DCRs indicated that more than half, and likely closer to three-quarters, of individuals detained under the ITA present co-occurring disorders. That is, most ITA detainees show symptoms of both mental health and substance use disorders.

Third, DCRs working in the ITA system suggested that certain aspects have consistently improved since Ricky's Law was passed in 2016. Improvements include DCR's understanding of which clients are appropriate for SWMS facilities, what information SWMS facilities need to make the decision, and communication with facilities both before and after placement.

Fourth, there are not enough treatment options for people with acute medical conditions. Current SWMS facilities do not have the capacity to provide medical treatment to people with acute medical conditions and there are no adequate treatment options. Similarly, there is not enough capacity to treat people presenting with co-occurring BH disorders.

Fifth, DCRs expressed that while their position's existence implies a move toward behavioral-health integration, the lack of co-occurring treatment facilities and coordinated follow-up care leaves room for continued integration.

Sixth, it appears that a conflict between RCW 71.05.435 (part of Ricky's Law) and 42 CFR Part 2 (federal confidentiality law) is prohibiting DCRs from being notified when clients are released from SWMS facilities despite the requirement in state law.

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<sup>50</sup> E3SHB 1713.

Lastly, DCRs explained that the ITA system could be improved by creating more co-occurring beds and treatment facilities for people experiencing acute medical conditions, developing centralized systems for bed availability and information on people under investigation, and establishing consistent expectations around medical clearance and communication timelines.

This study was limited by the scope and sample of our interviews. We spoke with all DCR managers and DCRs in every county. However, they may not represent all DCRs in Washington. Additionally, DCRs make up only one perspective in a complex system. While we were able to speak with SWMS facility leadership, for this report we did not receive perspective from the tribes, courts, medical practitioners, or advocates for people detained under the ITA. For the final evaluation, we aim to consider each of these perspectives as we develop our evaluation approach.



# Appendices

Designated Crisis Responders and Ricky's Law: *Involuntary Treatment Investigation, Decision, and Placement*

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## I. Agencies Providing DCR Services

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Exhibit A1, on the following page, summarizes which agencies provide DCR services to each county and provide the number of FTE DCRs the agency oversees. Contacts for agencies providing DCR services are publicly available on the HCA website.<sup>51</sup>

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<sup>51</sup> HCA. [Washington State Designated Responders Office Information](#). Updated April 6, 2021.

### Exhibit A1

#### Washington Designated Crisis Responder Agencies by County and FTE: Current Snapshot During Interview Period

Agency name	Counties served	DCR FTE*
Adams County Counseling	Adams	6
Blue Mountain Counseling	Columbia	4
Catholic Family and Child Services	Chelan, Douglas	7
Central Washington Comprehensive Mental Health (Walla Walla)	Walla Walla	9
Central Washington Comprehensive Mental Health (Kittitas)	Kittitas	8
Clark County Crisis Services	Clark	9
Compass Mental Health	Island, San Juan, Skagit	6
Comprehensive Health Care	Klickitat, Yakima	19
Crisis and Commitment Services	King	54
Discovery Behavioral Health Care	Jefferson	2.5
Frontier Behavioral Health	Spokane	30
Good Samaritan Mobile Outreach Crisis Team (M.O.C.T.)	Pierce	15
Grant Mental Health Care	Grant	6
Lourdes Health Crisis Services	Benton, Franklin	9
N.E.W. Alliance Counseling Services (Ferry, Lincoln)	Ferry, Lincoln	6.25
N.E.W. Alliance Counseling Services (Stevens)	Stevens	4
Okanogan Behavioral HealthCare	Okanogan	6
Olympic Health and Recovery Services	Cowlitz, Grays Harbor, Lewis, Pacific, Thurston, Mason, Wahkiakum	22
Palouse River Counseling	Whitman	10
Pend Oreille County Counseling Services	Pend Oreille	4
Peninsula Behavioral Health	Clallam (east of Lake Crescent)	5
Quality Behavioral Health	Asotin, Garfield	4
Salish Regional Crisis Services	Kitsap	10
Skamania County Community Health	Skamania	8
Snohomish County Involuntary Treatment Program	Snohomish	17
West End Outreach	Clallam (west of Lake Crescent)	5
Whatcom Counseling and Psychiatric Clinic	Whatcom	9

Note:

Values for DCR FTE were provided by interviewees during the interviews. Values frequently change, and some agencies have additional staff who are trained as DCRs but do not work in that capacity.

## II. WSIPP Study Assignment and Report Plan

Exhibit A2 shows each legislative component to WSIPP’s study assignment and the corresponding research and report plan as of this writing. Information learned from the qualitative study will help to better inform our quantitative research approach for the final evaluation in 2023.

### Exhibit A2

#### WSIPP Study Assignment and Report Plan

WSIPP study assignment: (legislative language)		Study approach:	
		<u>Report 2 (2021):</u> Qualitative evaluation of stakeholder perspectives on ITA SUD	<u>Report 3 (2023):</u> Outcome evaluation and benefit-cost analysis of ITA SUD law and SWMS facilities
a	Has increased efficiency of evaluation and treatment of persons involuntarily detained for substance use disorders;	DCR perspectives on (1) efficiency and/or (2) system barriers.	(1) Effectiveness of treatment on outcomes (listed below), (2) Time to treatment, (3) Harm reduction measures (dichotomous and continuous), and (4) Net benefits.
b	Is cost-effective, including impacts on health care, housing, employment, and criminal justice costs;	Identify potential costs not measured in quantitative approaches.	Outcomes may include: • Subsequent substance abuse, • Overdose, • Death, • Employment, • Homelessness, and • Use of public mental health and SUD services, including psychiatric hospitalization.
c	Results in better outcomes for persons involuntarily detained;	DCR perspectives on improvement in outcomes for clients (those not measured by quantitative approaches).	
d	Increases the effectiveness of the crisis response system statewide;	DCR perspectives on the effectiveness of the crisis response system.	
e	Has an impact on commitments based upon mental disorders;	DCR perspectives on the impact on commitments for MH disorders.	
f	Has been sufficiently resourced with enough involuntary treatment beds, less restrictive alternative treatment options, and state funds to provide timely and appropriate treatment for all individuals interacting with the integrated involuntary treatment system; and	DCR and SWMS perspectives.	Cost-analysis including secure detox beds, treatment, supervision; and the alternative costs to ITA SUD; and a benefit-analysis of monetizable outcomes measured.
g	Has diverted from the mental health involuntary treatment system a significant number of individuals whose risk results from substance abuse, including an estimate of the net savings from serving these clients into the appropriate substance abuse treatment system.	DCR and SWMS perspectives.	System capacity utilization analysis (e.g., ITA petitions, secure detox beds over time) and benefit-cost analysis.

### III. DCR Interview Instrument

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#### Exhibit A3

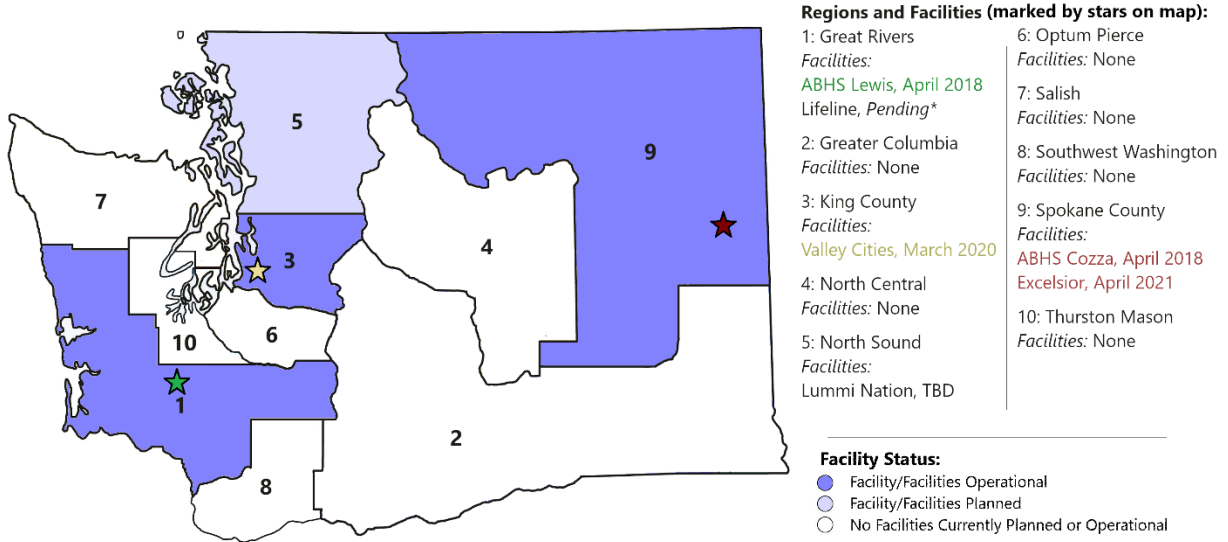
#### DCR Interview Instrument

1. What are the steps DCRs take when conducting an investigation? Can you give us some examples of locations that they typically respond to?
2. We're hoping to better understand what the ITA statutory language means in practice. The next couple of questions are to help us understand how to interpret the language.
  - a. When investigating someone for ITA detention, how do your DCRs apply the "danger to self, danger to others, danger to property" and "grave disability" standards?
  - b. Are there ever investigations where it's not clear whether the person you are investigating meets detention criteria and, if so, how are decisions in those cases?
  - c. About what proportion of the patients present co-occurring mental health and substance use disorders? In these co-occurring cases, how do DCRs decide which type of facility to detain the person to?
  - d. Let's say a patient is presenting co-occurring disorders, but a DCR has decided that SUD detention is most appropriate. If the DCR cannot place the person in a SWMS facility, how often would a DCR then attempt to place them in an E&T facility?
3. We also have a couple of questions about placing patients in a SWMS facility.
  - a. Tell us about the process of placing someone into a SWMS facility. What are the greatest barriers DCRs face to making these detentions?
  - b. What do DCRs do when a SWMS facility will not or cannot accept the patient?
4. What do you think DCRs need to make the ITA system work better? For them, the facilities, and those detained?

## IV. Statewide Map of Washington’s SWMS Facilities

### Exhibit A4

Statewide Map of Washington’s Secure Detox Withdrawal Management (SWMS) Facilities



Note:

\*Lifeline will begin operations as soon as they hire a director. D. Reed, Involuntary Treatment Act Program Manager, HCA (personal communication, April 2021).

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- Tammie Pennypacker, Program Manager, American Behavioral Health Systems, Inc., Chehalis
- David Reed, Involuntary Treatment Act Program Manager, Division of Behavioral Health and Recovery, Health Care Authority
- Allison Wedin, Involuntary Treatment Act Administrator, Division of Behavioral Health and Recovery, Health Care Authority

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