



December 2020

## Involuntary Treatment Act for Substance Use Disorders in Washington State: *First Preliminary Report*

Before 2016, two separate systems existed for involuntary commitment of individuals in crisis due to mental health or substance use disorders. The 2016 Legislature passed E3SHB 1713—called Ricky's Law—to integrate both conditions into a statewide behavioral health system within Washington's 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,<sup>2</sup> including:

- Client outcomes (e.g., substance use, overdose, death, employment, housing, mental health services),
- System outcomes, and
- Cost-effectiveness and efficiency of an integrated involuntary behavioral health treatment system.

This report is the first of three and its purpose is two-fold. In [Section I](#), we provide background on Washington's behavioral health context and the main components of Ricky's Law. In [Section II](#), we review WSIPP's study assignment and research plan for our reports in June 2021 and June 2023.

### Summary

The passage of Ricky's Law modified Washington's Involuntary Treatment Act (ITA) for individuals with a grave disability or risk of harm due to a behavioral health disorder (i.e., mental health or substance use disorder [SUD]). The law changed the evaluation and emergent detention process for individuals with SUDs.

WSIPP is required to "evaluate the effect of the integration of the involuntary treatment systems for substance use disorders and mental health."

In this report, we examine the broad changes to Washington's ITA for SUDs that resulted from Ricky's Law. We provide background on Washington's behavioral health context and examine the main components of Ricky's Law. Then, we outline our basic research strategy to examine the effectiveness of this multi-component law.

Our second and third reports are due in June 2021 and 2023. We will examine the impact of Ricky's Law on: (1) Client outcomes (e.g., substance use, overdose, death, employment, housing, mental health services), (2) System outcomes, and (3) Cost-effectiveness and efficiency of the integrated involuntary behavioral health treatment system.

Suggested citation: Drake, E., Ellis, A. & Miller, M. (2020). *Involuntary Treatment Act for substance use disorders: First Preliminary Report* (Document Number 20-12-3401). Olympia: Washington State Institute for Public Policy.

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

<sup>2</sup> See legislative study assignment on [page 14](#).

## I. Background

---

In this [Section](#), we describe behavioral health integration in Washington, outline the main components of the involuntary treatment system, and discuss the impacts of Ricky's Law for involuntary behavioral health treatment. We limit our discussion to the concepts relevant for WSIPP to evaluate the law (presented in [Section II](#)).

### Behavioral Health Care Integration

In the past, public behavioral health services were administered by two separate divisions at the Department of Social and Health Services (DSHS), the Mental Health Division and the Division of Alcohol and Substance Abuse. In 2009, DSHS combined the two divisions into the Division of Behavioral Health and Recovery, which began the integration of behavioral health services in Washington. In 2014, the legislature passed a bill to integrate the purchasing of publicly funded mental health (MH) and substance use disorder (SUD) treatment in Washington.<sup>3</sup>

The behavioral health purchasing law affected key aspects of the state's Medicaid program—Apple Health—administered by the Health Care Authority (HCA).<sup>4</sup> The legislation authorized HCA and DSHS to coordinate and establish common geographical regions for Medicaid clients. These ten regions, called **Regional Service Areas (RSAs)**, fund the state's integrated physical and behavioral health care purchasing through **managed care contracts**.

Medicaid clients receive most services through **Managed Care Organizations (MCO)**. HCA contracts with **Behavioral Health-Administrative Service Organizations (BH-ASO)** to purchase regional behavioral health services.<sup>5</sup> **Behavioral Health Agencies (BHA)** are licensed treatment providers who deliver direct services to clients via BH-ASOs.

BH-ASOs offer a wide range of services for individuals (Medicaid clients and non-Medicaid clients) experiencing a behavioral health crisis or emergency.<sup>6</sup> Services include crisis response, assessment and stabilization, recovery support, peer services, outpatient treatment, and involuntary commitments.

---

<sup>3</sup> The Affordable Care Act of 2010 called for equity in access to treatment for Medicaid and Medicare clients. [Second Substitute Senate Bill 6312, Chapter 225, Laws of 2014, Sec. 3](#) integrated the purchasing of behavioral health treatment services. [E3SHB 1713 \(Ricky's Law\)](#), integrated the mental health and chemical dependency treatment systems.

<sup>4</sup> The Healthier Washington Initiative led to HCA's [Medicaid Transformation](#) to expand health care coverage.

<sup>5</sup> [Engrossed Second Substitute Senate Bill 5432, Chapter 325, Laws of 2019](#).

<sup>6</sup> Washington State Health Care Authority. (November 2019). [Behavioral health administrative service organization \(BH-ASO\) fact sheet](#).

## Glossary of Terms

Below is a list of terms used in the main body of this report. Please see the Appendix for a full list of terms. See also [RCW 71.05.245](#) for statutory definitions.

**Behavioral Health Agencies (BHA)** are licensed treatment providers who deliver direct services to clients via Behavioral Health-Administrative Service Organizations (BH-ASOs) (or Administrative Service Organizations (ASO)).

**Behavioral Health-Administrative Service Organizations (BH-ASO)** offer direct services including crisis hotlines and outreach teams and SUD treatment, including ITA assessments. There is one BH-ASO per RSA (except SW Washington). BH-ASO services can also be provided by Administrative Service Organizations (ASO).

**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 2014 and replace the former roles of designated mental health professionals or chemical dependency specialists (see [Exhibit 1](#)).

**Grave disability** is a legal criterion for involuntary treatment. Individuals with a grave disability cannot meet their essential health and safety needs due to a behavioral health crisis or experiences a sharp and escalating loss of function (see [RCW 71.05.020](#)).

**Imminent** means the state or condition is likely to occur at any moment or near at hand, rather than distant or remote (see [RCW 71.05.020\(27\)](#)).

**Less restrictive alternative (LRA)** describes an individualized treatment option in the community (e.g., outpatient treatment) that is less restrictive compared to commitment in a secure facility. The state is required to treat patients in the least restrictive setting possible. LRA orders are legally enforced orders and individuals can be revoked noncompliance leading treatment in an inpatient setting ([RCW 71.05.585](#)).

**Likelihood of harm to self or others** is a legal criterion for involuntary treatment. Individuals may be committed if they are likely to inflict serious harm, including physical behaviors or reasonable threats to themselves or others due to a behavioral health disorder.

**Managed care contracts** are pre-paid health services for Washington State fulfilled by MCOs, BH-ASOs, or ASOs.

**Managed care organizations (MCO)** are health care providers that offer direct physical and behavioral health care services (e.g., Amerigroup, Community Health Plan, Coordinated Care, Molina).

**Regional Service Areas (RSA)** are ten geographical regions, authorized and established by HCA and DSHS, for Washington State to purchase behavioral and physical health care through managed care contracts (formerly Behavioral Health Organizations and before that Regional Service Networks).

**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 non-profit contractors and administered by HCA.

*Terms are bolded the first time they appear in text.*

## Involuntary Treatment Act (ITA)

Washington State's 1973 Involuntary Treatment Act (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>7</sup> Since its original passage, statutory changes have impacted (1) who the ITA law applies to and (2) how involuntary treatment evaluations are delivered in Washington.<sup>8</sup> In this section, we discuss the impacts of Ricky's Law on the ITA.

### ITA Legal Framework

The ITA defines the specific criteria and due process protections that authorize involuntary treatment for certain individuals. Individuals must demonstrate grave disability or a risk of serious harm as a result of the behavioral health disorder.<sup>9</sup> **Serious harm includes a danger to self or others** (or property). A grave disability is defined as an individual's inability to care for basic needs that endangers one's health or safety.<sup>10</sup> [Exhibit 1](#) shows the legal framework for the behavioral health integration of Washington's ITA.

The law defines **imminent** as "... the state or condition of being likely to occur at any moment or near at hand, rather than distant or remote..."<sup>11</sup> When the **designed crisis responder (DCR)** determines that the risk of harm is imminent, the person can be immediately detained for treatment, and the DCR files a petition with the superior court.<sup>12</sup> These cases are referred to as "emergent." In practice, if the danger from the crisis is likely to manifest within 24 to 48 hours, the DCR typically will consider the case to be emergent.

The statute also allows for the non-emergent commitment of a person undergoing a behavioral health crisis. Through the non-emergent procedure, a petition is filed with the superior court for commitment rather than detaining the patient immediately. The use of the non-emergent procedures varies by region. The decision to commit a patient on an emergent or non-emergent basis is made at the DCR's discretion.

---

<sup>7</sup> [RCW 71.05](#) and [RCW 71.34](#) for minors.

<sup>8</sup> *Involuntary Treatment Act: Overview and current challenges: Work session before the Senate Behavioral Health Subcommittee, Senate, Washington State Legislature, 66th Legislature (January 18, 2019).*

<sup>9</sup> [RCW 71.05.156](#) and [RCW 71.05.245](#).

<sup>10</sup> The 2020 Legislature passed a bill that widens the criteria for grave disability and likelihood of harm when the number

of occupied treatment beds drops below 200 for three contiguous months allowing allows the system to reach more people in need, while also taking into account the MH ITA system's current capacity strains. These changes take effect in January 2021.

<sup>11</sup> [RCW 71.05.020\(27\)](#).

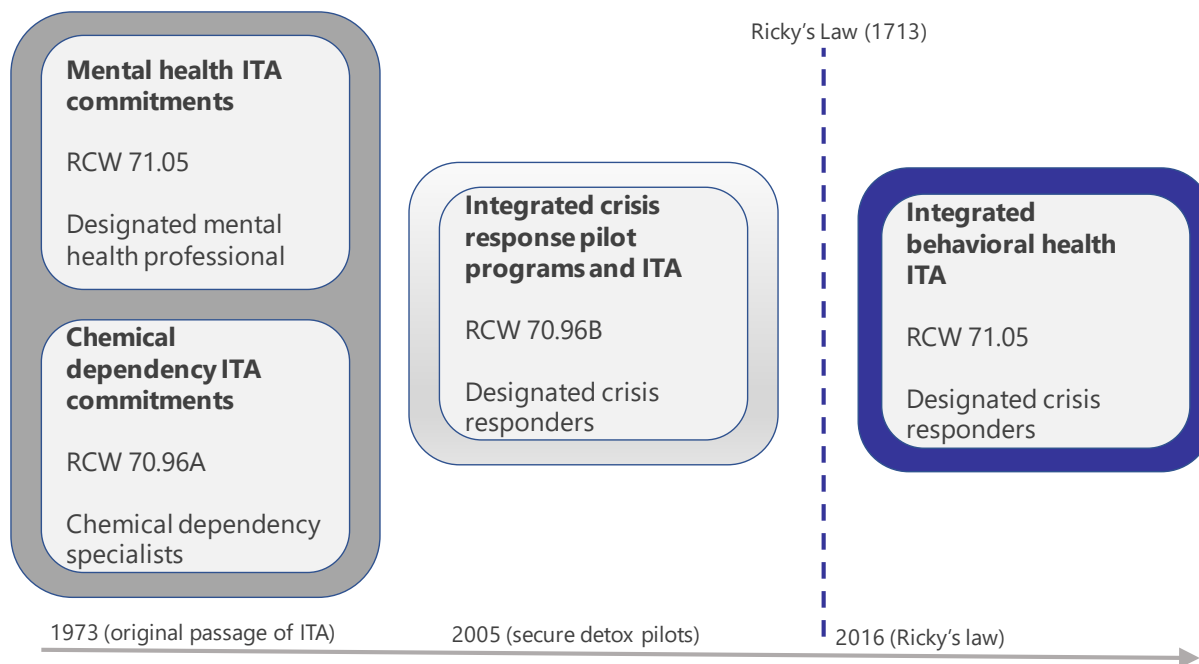
<sup>12</sup> This criterion will change from 72 to 120 hours in 2021.

*Chemical Dependency Statutes.* Before the enactment of Ricky's Law in 2016, the ability to commit a person under the ITA for an SUD existed but was infeasible in practice.<sup>13</sup> Stakeholders described the ITA system for SUD as siloed, under-resourced, and lacking appropriate facilities and legal enforcement tools to commit a person undergoing a SUD crisis.<sup>14</sup>

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 these two ITA systems in the use of emergent commitment created a "voluntary involuntary process," in which patients could leave the hospital before a commitment order or enforcement.<sup>15</sup>

### Exhibit 1

#### Ricky's Law impacts on Washington's ITA Legal Framework



<sup>13</sup> [HB 1713](#): Public hearing before the House Judiciary Committee, House of Representatives, Washington State Legislature, 65<sup>th</sup> Legislature (February 3, 2015). See also chemical dependency statutes [RCW 70.96A](#).

<sup>14</sup> Ibid. Ricky's Law gave designated professionals the ability to use ITA emergent detention for individuals with SUDs.

<sup>15</sup> Ibid., David Reed, Health Care Authority, Division of Behavioral Health and Recovery, Involuntary Treatment Act Program Manager.

<sup>15</sup> [Engrossed Second Substitute Senate Bill 5763, Chapter 504, Laws of 2005, sec. 101](#) and see [70.96B RCW Dispositions](#).

*Secure Detox Pilots.* The 2005 Legislature authorized DSHS to establish crisis response pilot sites for integrated ITA ([Exhibit 1](#)).<sup>16</sup> Two secure detox facilities were established to deliver acute or chronic detox and other services for individuals gravely disabled due to mental health, SUD, or a co-occurring combination. WSIPP previously evaluated the effectiveness of these secure detox facilities and found that clients had improved outcomes (e.g., hospitalizations, treatment participation, employment) compared to clients in locations where secure detox was not available.<sup>17</sup>

As shown in [Exhibit 1](#), the passage of Ricky's Law created a unified statutory framework for ITA crisis response. These statutory changes gave designated professionals the ability to initiate an emergent detention for individuals with SUDs who meet the imminence criteria of the law.<sup>18</sup> Further, the changes align the detention criteria of MH and SUDs, allowing the commitment of individuals with SUDs who are gravely disabled. Finally, the changes bring commitments under the same legal timetable.

The statutory requirements for behavioral health integration, and the need for an emergent SUD ITA process, combined with the research evidence on the effectiveness of Washington's secure detox facilities, helped lay the pathway for Ricky's Law in 2016.

## Ricky's Law

The overarching goal of Ricky's Law is to integrate involuntary treatment for individuals with MH and/or SUDs.<sup>19</sup> An integrated civil commitment system allows individuals with SUDs to receive care and treatment when they are a danger to themselves or others on par with the treatment access available for persons with mental illness. The law resulted in many changes to the crisis response system and we describe a few here.

First, the statutory provisions for SUD treatment were added into the ITA law governing mental health ITA, creating a unified legal framework ([Exhibit 1](#)). One result of these changes is aligning the detention and commitment criteria for MH and SUD.

Second, a new professional category called designated crisis responders (DCR) was created.<sup>20</sup> DCR's are designated mental health professionals trained in holistic crisis investigation. DCRs evaluate individuals clinically to determine whether they meet the criteria for ITA for either an MH or SUD condition. [Exhibit 1](#) shows the changes in designated professional categories for crisis response.

---

<sup>16</sup> Ibid.

<sup>17</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.

<sup>18</sup> [RCW 71.05.153](#).

<sup>19</sup> All of the provisions of [RCW 71.05](#) and [71.34](#) apply to SUD.

<sup>20</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.

In 2015, Joel's Law<sup>21</sup> gave third parties (i.e., family members) the ability to file an appeal when crisis responder determines not to detain an individual for further mental health evaluation and treatment. Ricky's Law extended this ability to family members and guardians of individuals with SUDs.

Finally, Ricky's Law required **Secure Withdrawal Management and Stabilization (SWMS) facilities** be implemented in 2018 and 2019.<sup>22</sup> SWMS facilities evaluate and stabilize SUD patients in a crisis through a range of services including secure detox with medical professionals, evaluation, and treatment.

In summary, Ricky's Law modified the ITA system to address inconsistencies through a unified legal framework.<sup>23</sup>

### ITA for SUD Today

In this section, we provide an overview of the basic stages of ITA for SUDs under Ricky's Law; we describe the decision-making process of DCRs; and we describe SWMS facilities and ITA clients in the first year of implementation.

### Stages of ITA SUD

Designated crisis responders (DCR) are trained in holistic crisis investigation.<sup>24</sup> When an individual is referred for an evaluation under the ITA, DCRs determine whether individuals meet the criteria for ITA treatment.<sup>25</sup> [Exhibit 2](#) shows the basic stages of an ITA investigation and a brief explanation of each stage. See [Exhibits A1](#) and [A2](#) in the [Appendix](#) for more detailed flow diagrams of the system.

*ITA Investigation.* The purpose of the ITA investigation is to determine whether the individual meets the legal criteria for an emergent detention.<sup>26</sup> The DCR conducts an evaluation and a clinical behavioral health assessment of the individual's current presentation and risk factors. From this investigation, the DCR determines whether the individual suffers from a behavioral health disorder, presents a likelihood of harm to self or others or is gravely disabled, and refuses to seek appropriate treatment. The DCR also distinguishes whether the individual's risk is imminent (emergent) or non-emergent.

DCRs must determine whether individuals would be best served at an Evaluation and Treatment (E&T) mental health facility or a SWMS facility. DCRs cannot detain a person for SUD when no involuntary treatment bed is available.<sup>27</sup> Individuals who do not meet the criteria for detention may choose to voluntarily detox or receive residential or outpatient treatment.

---

<sup>21</sup> Engrossed Second Substitute Senate Bill 5269, Chapter 258, Laws of 2015. "Joel's Law."

<sup>22</sup> 2E2SSB 5720 changed the name of secure detox facilities to secure withdrawal management and stabilization (SWMS) facilities.

<sup>23</sup> *Status of secure withdrawal management & stabilization facilities and implementation of Ricky's Law: Hearing before the Behavioral Health Subcommittee to Health & Long Term Care, Senate, Washington State Legislature, 66<sup>th</sup> Legislature, (November 20, 2019).*

<sup>24</sup> RCW 71.05.755.

<sup>25</sup> The DCR job classification combines the functions of designated mental health professionals and designated chemical dependency specialists. The 2016 law created designated crisis responders (DCR) and designated mental health professionals (DMHPs) were renamed DCR's.

<sup>26</sup> RCW 71.05.153.

<sup>27</sup> This information is recorded by the DCR with a no-bed report.



## Exhibit 2

### Basic Stages of Involuntary Treatment Under Ricky's Law (E3SHB 1713)

#### Investigation RCW 71.05.153

Determine whether a person is suffering from a behavioral health crisis committable under the ITA.

DCRs receive referrals for investigations from many sources including hospital emergency departments. The DCR must determine if the individual:

- Suffers from a behavioral health disorder (mental health and/or substance use disorder),
- Presents a likelihood of harm to self or others, or is gravely disabled, and
- Refuses to seek appropriate treatment.

#### Initial detention RCW 71.05.180

Stabilization of patients undergoing behavioral health crises.

When the DCR finds that the individual meets the legal criteria for commitment, the DCR locates a bed at an Evaluation and Treatment (E&T) facility for MH disorders or a SWMS facility for SUD. For persons with co-occurring disorders, the DCR must determine which is the primary disorder and commit accordingly. A DCR may not commit a patient when no beds are available at an appropriate facility.

#### Additional commitment RCW 71.05.240

Provision of additional mandated treatment for those meeting ITA commitment standards over time.

If the treating facility believes the patient still meets ITA standards after the initial hold, it may file a petition signed by two professionals to extend treatment. This petition is heard in superior court, and the court may order a 14-day inpatient extension or a 90-day less restrictive outpatient alternative.

Note:

See the appendix for more detail.

**Initial detention.** The purpose of the initial detention period is to help individuals undergoing a crisis stabilize safely with appropriate care and treatment. 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 up to 14 days, or to outpatient treatment for up to 90 days.

Effective 2021, the time to the initial hearing will be extended from 72 hours to 120 hours.<sup>28</sup>

Facilities first become involved in the ITA process when a DCR calls to inquire if a treatment bed is available.<sup>29</sup> If a bed is available, the DCR may refer the patient to the facility. Facilities have discretion on the admission of clients.

<sup>28</sup> 2E2SSB 5720.

<sup>29</sup> This section is informed by R. Geiger, Vice President /Inpatient Services, Valley Cities and T. Pennypacker,

Program Manager, American Behavioral Health Systems, Inc., Chehalis (personal communication).



For example, facilities may decline patients who do not fit the treatment modality they offer or whose conditions go beyond their capabilities to assess and stabilize.

Patients typically arrive at the fully locked and secure facility on a gurney. At the arrival area, staff performs an initial screening to ensure the patient fits the DCR's description and the facility's modality. A nurse performs an initial assessment similar to the intake process at a hospital emergency department. Staff search the patient's belonging for harmful items, wash and replace dirty clothes with clean ones, and orient the patient to where they are. Sometimes, patients require immediate medication to mitigate psychosis or to detox.

After the initial nursing assessment, staff shows the patient their room. Depending on the time of day, the patient may need to sleep, eat, or decompress from the experience of undergoing a behavioral health crisis and being committed under the ITA.

Throughout an individual's stay, licensed individual practitioners (LIPs) (e.g., psychiatric providers, medical providers, nurses, clinical social services, and SUD professionals) perform required evaluations to develop a treatment plan and criteria for discharge. The facility coordinates court information with other stakeholders for patients who need further treatment under the ITA.

*Additional Commitment or Less Restrictive Alternative.* The ITA requires treatment providers to care for patients in the least restrictive setting possible. Individuals are released when facility staff determine the patient no longer meets ITA criteria. If facility staff believes the patient still meets ITA standards after the initial hold, it may file a petition in superior court signed by two professionals to extend treatment.

The court may order the individual to an additional 14-day inpatient stay or to a 90-day less restrictive outpatient alternative to commitment. **Less restrictive alternatives (LRA)** allow individuals to receive outpatient treatment in the community when patients are determined to no longer require inpatient treatment at the time of petition.

The 2015 Legislature required WSIPP to study LRA non-emergent petitions for initial detention and LRA orders for outpatient treatment for mental illness. At that time, WSIPP found that LRAs were infrequently ordered and some courts did not have hearings for non-emergent petitions due to a lack of resources.<sup>30</sup> Also, the legal definition of imminent was broad enough, "the state or condition of being likely to occur at any moment or near at hand, rather than distant or remote..." that most cases could be deemed imminent.

Although rare, the ITA allows for additional commitment past the 14-day inpatient treatment and 90-day LRA.<sup>31</sup> The patient must continue to meet ITA standards for their SUD over a period of time long enough to detox out of their crisis state.

---

<sup>30</sup> Burley, M., Nicolai, C., & Miller, M. (2015). *Washington's Involuntary Treatment Act: Use of non-emergent petitions and*

*less restrictive alternatives to treatment* (Doc. No. 15-12-3401). Olympia: Washington State Institute for Public Policy.

<sup>31</sup> RCW 71.05.280.

### SWMS Facilities

Ricky's Law required the implementation of one SWMS facility by April 2018 and another by April 2019. [Exhibit 3](#) shows a statewide map with the clients served from each of the ten Regional Service Areas, the SWMS sites, and the dates that each facility came online.

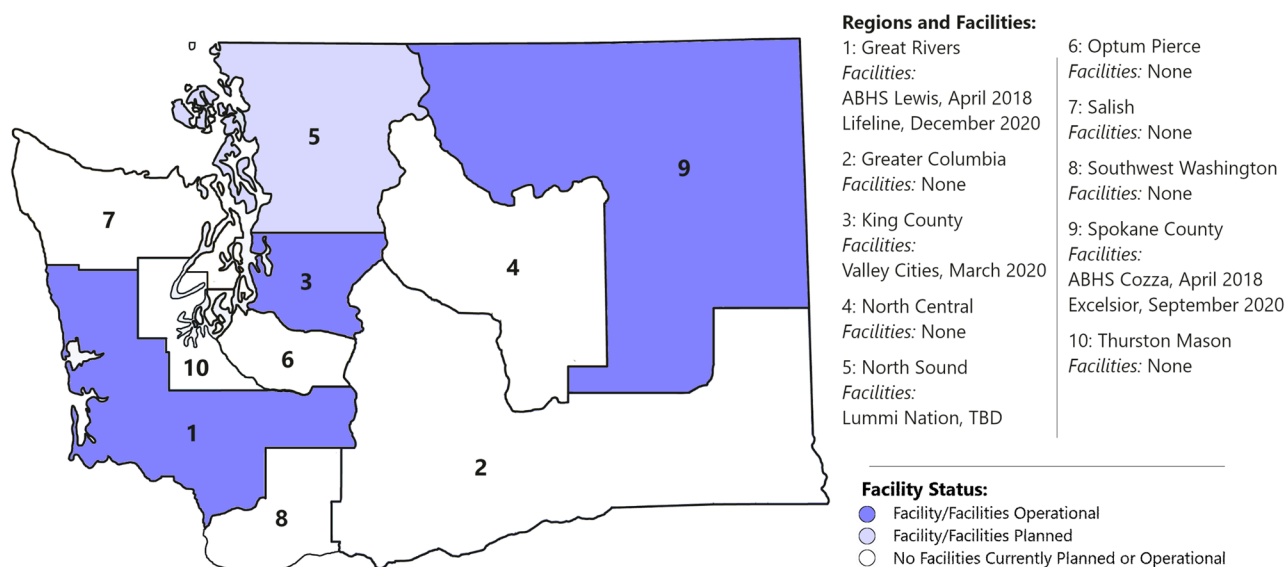
The SWMS facilities are 16-bed standalone sites that provide detoxification and stabilization for those in crisis due to a substance use disorder. Facilities provide care that includes 24-hour admission services, medication-assisted treatment (when appropriate), coordination of services, and inpatient medical monitoring (physicians and nurses).

During the creation of this report, there were three such treatment centers. A fourth (Excelsior, Spokane) opened in late September, and more are planned. The first facilities to open were operated by American Behavioral Health Systems (ABHS) and located in Lewis and Spokane Counties. Valley Cities Behavioral Health Care opened a facility in King County in March 2020.

Facilities have discretion when accepting clients. SWMS staff may decline services if the facility lacks an open bed or the necessary medical personnel to care for clients. Clients who are suicidal, homicidal, violent, or have co-occurring, complex medical conditions may also be declined services at the SWMS facility. If persons are declined at SWMS, they cannot be legally detained.

### Exhibit 3

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



## Clients

HCA monitors and reports data from SWMS facilities on the implementation of Ricky's Law.<sup>32</sup> Data from the second year of operation (October 1, 2019 to September 30, 2019) offers an overview of individuals admitted to SWMS facilities under the ITA for SUDs.<sup>33</sup>

There were 1,181 total admissions across the Chehalis, Spokane, and Valley Cities facilities during this time period. Chehalis served 638 patients across 5,243 bed days, Spokane served 457 patients across 5,445 bed days, and Valley Cities served 86 patients across 1,029 bed days.

Patients are majority male (59%) and between the ages of 25 and 44 (63%). [Exhibit 3](#) shows the percentage of patients coming from each RSA. Admissions were relatively even between eastern (519 patients) and western (573 patients) Washington. More patients came from urban counties (59%) than rural counties (41%).

Statewide, two-thirds of patients presented primary alcohol (34%) or primary amphetamine (33%) dependence, followed by opioid dependence (22%).<sup>34</sup> A slight majority of patients (53%) received medication-assisted treatment for opioid use disorder, with large disparities between Chehalis (29%) and the other two facilities (98% Spokane, 100% Valley Cities).

Patients stayed ten days on average across the three facilities. Of the patients whose legal status at the point of discharge was reported, 66% were discharged on a voluntary basis and 28% were discharged to further ITA treatment (such as LRAs).

---

<sup>32</sup> Health Care Authority. (2019). *Involuntary Treatment Act for Substance Use Disorders: Secure Detox Report, April 1, 2018 to March 31, 2019*.

<sup>33</sup> The report indicates there are limitations with these aggregate data. HCA continues to work to improve data reporting practices related to the law.

<sup>34</sup> The dataset does not specify comorbid/secondary dependences, so the proportion of patients presenting more than one type of SUD is unknown.

## Implementation

The implementation and re-organization of Washington's behavioral health integration is ongoing. In this section, we discuss oversight of Ricky's Law and implementation issues that have arisen since its passage.

The ITA system for individuals with SUDs has evolved over time. The legislature established the legal and budgetary framework. State and local entities coordinate the administrative policy, technical training, and deliver services. Further, Ricky's Law required a complex multi-agency collaboration between state agencies (i.e., HCA, Department of Health [DOH]), local agencies including SUD treatment providers (i.e., BHA), behavioral health services, (i.e., BH-ASOs), and the courts.<sup>35</sup>

A statutorily defined task force provides ongoing oversight on the implementation of the law including contracting, licensing, technical training, and other functions.<sup>36</sup> HCA provides technical assistance and training through its Division of Behavioral Health and Recovery program.

[Exhibit 4](#) summarizes high-level implementation challenges based on these task force meetings, discussions with HCA and SWMS facility staff, and others. These and other barriers will be explored in greater depth for our 2021 report when we examine stakeholder views on the implementation of the law. We will conduct surveys and interviews of DCRs, SWMS facility staff, BH-ASO, MCO/ASO staff, courts, secure detox facilities, and treatment providers to gain insight into how the implementation of the integrated involuntary treatment system has progressed.

---

<sup>35</sup> The Division of Behavioral Health and Recovery (DBHR) was moved from the Department of Social and Health Services (DSHS) to the Health Care Authority (HCA).

<sup>36</sup> The Behavioral Health and Recovery Task Force ([Engrossed Substitute House Bill 1109, Chapter 415, Laws of 2019, Sec. 995.](#))

## Exhibit 4

### Ricky's Law: Implementation Challenges

The following are high-level implementation challenges identified by stakeholders. This information was collected from publicly available sources (e.g., legislative committee hearings and reports) and our initial discussions with HCA staff and SWMS facility staff this report (see citations below). We will conduct a more thorough investigation of implementation challenges in our subsequent reports in 2021 and 2023 (see [Section II](#)).

#### Recruiting SWMS Facilities and Providers

When Ricky's Law took effect in April 2018, fewer treatment providers signed on to operate SWMS facilities than anticipated. ABHS showed financial losses at its Spokane and Lewis County facilities during the first year of operation. Thus, the 2019 Legislature increased the per-client reimbursement rate from \$400 to \$650 ([ESHB 1109 Section 215 \(22\)](#)).

#### Transportation

With only two SWMS facilities statewide in April 2018, DCRs faced persistent issues in arranging patients' transportation from distant areas of the state. These issues were most acute in King and Snohomish Counties before the Valley Cities SWMS facility opened in March 2020. North Sound continues to report transportation issues and areas of eastern Washington are facing similar problems. The 2020 Legislature passed more funding for ambulance travel, later vetoed due to COVID-related budget cuts ([ESSB 6168 Section 215 \(69\)](#)).

#### Underutilization and Stakeholder Coordination

Some SWMS facilities have operated consistently under capacity. This finding is in stark contrast with the overburdened MH ITA system. Utilization issues may arise from stakeholder differences and understandings about who qualifies for commitment under the ITA for SUDs. In the Spokane County behavioral health organization (BHO), stakeholders convened to discuss and coordinate their collective understanding about the clients appropriate for detention. Subsequent training of personnel at emergency departments, E&Ts, and DCRs on Ricky's Law has improved the coordination and increased rates of occupied of beds. Providers and HCA staff are considering arranging similar discussions in western Washington.

#### Data Quality

HCA and providers both agree on the need for high quality data. Initial data collection and sharing has been informal and is not required by law leading to some early concerns over data reliability. HCA has created a new template for SWMS facilities for data entry and this practice has helped improve data access and quality.

#### COVID-19

COVID-19 led to a statewide decrease in evaluation personnel. The Lewis County SWMS facility shut down due to a lack of referrals; the Spokane SWMS facility also shut down briefly. Facilities have implemented screening processes and new protocols to contend with the challenges presented by COVID-19. HCA and the governor's office determined that the state could perform ITA hearings over video, and the legislature passed a bill confirming this ([ESHB 2099](#)).

#### Notes:

Sources: Behavioral Health and Recovery System Transformation Task Force and designated crisis responder (DCR) training. Division of Behavioral Health and Recovery, Behavioral Health Administration, and Department of Social and Health Services. Staff at the Division of Behavioral Health and Recovery at the Health Care Authority met with us to answer our questions via multiple meetings and emails. We also spoke with SWMS staff to acquire a deeper understanding of the ITA process at SWMS facilities for this report. See the Acknowledgments at the end of this report.

## II. Research Plan and Next Steps

Ricky's Law requires WSIPP to evaluate the impacts of integrating the ITA system (see sidebar).<sup>37</sup> This multifaceted law, discussed in [Section I](#), was implemented during a transformative era of integrating physical and behavioral health care. Thus, our research approach requires a multi-prong examination over an extended time period. In this [Section](#), we review WSIPP's study assignment and describe the basic research approach that we anticipate for our reports over the next three years.

### Study Assignment and Approach

WSIPP is required to evaluate the integration of the ITA system across three main areas including:

- Client outcomes (e.g., substance use, overdose, death, employment, housing, mental health services),
- System outcomes, and
- Cost-effectiveness of involuntary treatment.

We plan to implement a mixed methods research design incorporating both quantitative and qualitative research perspectives. Quantitative analysis measures "how much?" and qualitative analysis helps us understand "why?" A mixed methodology strengthens our overall research design by providing stakeholders' contextual understanding and perspective, an essential element for understanding the ongoing implementation of Ricky's Law (see [Section I](#)).<sup>38</sup>

<sup>37</sup> E3SHB 1713, Section 202.

<sup>38</sup> Wisdom, J., & Creswell, J.W. (2013). *Mixed methods: integrating quantitative and qualitative data collection and*

### **WSIPP Study Assignment**

*Evaluate the effect of the integration of the involuntary treatment systems for substance use disorders and mental health and make preliminary reports to appropriate committees of the legislature by [December 1, 2020](#), and [June 30, 2021](#), and a final report by [June 30, 2023](#).*

*The evaluation must include an assessment of whether the integrated system:*

- Has increased efficiency of evaluation and treatment of persons involuntarily detained for substance use disorders;*
- Is cost-effective, including impacts on health care, housing, employment, and criminal justice costs;*
- Results in better outcomes for persons involuntarily detained;*
- Increases the effectiveness of the crisis response system statewide;*
- Has an impact on commitments based upon mental disorders;*
- 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*
- 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.*

*E3SHB 1713, Section 202 (emphasis added)*

*analysis while studying patient-centered medical home models.* Rockville: Agency for Healthcare Research and Quality.

### Report Plan

The law requires WSIPP to submit three reports. See our report plan, overview, and purpose in [Exhibit 5](#). The [Appendix](#) provides a detailed description of each of the seven specific legislative requirements (research questions) anticipated for each report.

This report is the first of three reports. The second report due in 2021 will describe stakeholder perspectives. Our final report, due in 2023, will examine the effectiveness of integrating the ITA system.

### Report 2—Stakeholder Perspectives

The purpose of our qualitative analysis is two-fold. First, we aim to gain insight about how the implementation of the integrated involuntary treatment system has progressed. Second, we aim to use that insight to inform our quantitative evaluation of Ricky's Law. This approach to incorporate stakeholder engagement will allow us to better understand the complexity of the law, whether the law was implemented as intended, and identify efficiencies and barriers.

### Exhibit 5

WSIPP Report Plan, Goals, and Research Approach

	<b>Report 1</b> December 1, 2020	<b>Report 2</b> June 30, 2021	<b>Report 3</b> June 30, 2023
Report goal:	Provide an overview of the integrated behavioral health system and WSIPP's research approach	Describe the integrated behavioral health system from a qualitative perspective	Examine the effectiveness of ITA SUD, SWMS facilities, and system efficiency
Research purpose:	Describe our research plan for study assignment	Examine stakeholder perspectives and conduct a qualitative evaluation	Examine effectiveness of the law, system costs, and efficiency
Research approach:	Describe background and policy context	Surveys, interviews, and focus groups (e.g., DCRs, SWMS staff, treatment providers)	Conduct an outcome evaluation and benefit cost-analysis



Qualitative information will be gathered through surveys and interviews of the following stakeholders:<sup>39</sup>

- DCRs;
- SWMS facility staff;
- Licensed individual practitioners;
- MCO/RSA/BH-ASO staff;
- Agencies (HCA, DSHS, DOH);
- Patient advocates (e.g., Washington Recovery Alliance);
- Court staff including prosecutors, public defenders, judges; and
- Other relevant stakeholders

### Report 3—Treatment and cost-effectiveness

There are three main goals for quantitative analysis. First, we will conduct an evaluation to determine whether the integration of the ITA systems is effective at improving outcomes for clients relative to comparable clients who did not receive ITA treatment. Second, we will examine whether the law is cost-beneficial. Finally, we will also examine whether the integration of ITA results in enough capacity and resources statewide.

For an outcome evaluation, the “gold standard” is random assignment, in which individuals are randomly assigned to receive the intervention (in this case, involuntary SUD treatment through Ricky’s Law). Any observed differences in outcomes are due to the intervention and not to characteristics of the individuals or local environments. Random assignment is not possible for our study due to the statewide implementation of the law.

In lieu of random assignment, we will implement quasi-experimental methods to construct a reasonable comparison group. Our approach will be to compare clients detained under Ricky’s Law to very similar clients who did not receive the intervention.<sup>40</sup> We will not compare outcomes for involuntary and voluntary SUD treatment clients because those who volunteer for treatment are very likely more motivated to change.

---

<sup>39</sup> Within the resources planned for this assignment, we plan to gather as much information from as many people as possible to include diverse perspectives. For example, we

plan to include eastern and western Washington perspectives and a variety of staff.

<sup>40</sup> A high-quality research design must include a treatment and comparison group and an intent-to-treat analysis.

At a minimum, we will evaluate the effect of ITA treatment on the following outcomes:<sup>41</sup>

- Subsequent substance abuse,
- Overdose,
- Death,
- Employment,
- Homelessness, and
- Use of public mental health and SUD services, including psychiatric hospitalization.

Next, we will examine the costs and benefits associated with Ricky's Law using WSIPP's typical benefit-cost approach.<sup>42</sup> The first step of conducting benefit-cost analysis relies on the results of the outcome evaluation. From this information, we convert the magnitude of effectiveness into units of outcomes that can be monetized (e.g., number and cost of hospitalizations), which help provide a picture of the overall costs, cost savings, and other monetary benefits associated with Ricky's law.

Finally, we will also study the statewide implementation of Ricky's Law over time and assess how particular indicators have changed. For example, statewide capacity for involuntary treatment, utilization of ITAs, and the prevalence of LRAs.

## Next Steps

In January of 2021, we will begin work on our qualitative evaluation to examine the implementation of Ricky's Law. Our primary goal will be to gain a better understanding of stakeholder system knowledge. For example, we aim to learn more about the DCR decision-making process and how they operate in a SWMS 120-hour hold.

We also aim to understand who is considered appropriate for treatment under Ricky's Law from the perspectives of DCRs, courts, and providers. Better understanding these two areas will help inform our research design. Finally, we intend to gain a fuller understanding of the data available and needed to conduct our final outcome evaluation for 2023.

---

<sup>41</sup> It is not yet known what data and outcomes can be obtained for this study. Our investigation through 2021 and beyond will inform our full methodological plan. If possible, we would like to examine additional outcomes including DCR

investigations, involuntary secure detox facility detentions, and involuntary treatment (IT) commitments.

<sup>42</sup> <http://www.wsipp.wa.gov/BenefitCost>.

# Appendix

Involuntary Treatment Act for Substance Use Disorders: *First Preliminary Report*

## Appendix

Glossary of Terms.....	18
Involuntary Treatment Act: Key Steps after ITA Investigation ( <a href="#">Exhibit A1</a> ).....	20
Involuntary Treatment Act: Initial Intake and Crisis Investigation ( <a href="#">Exhibit A2</a> ).....	21
WSIPP Study Assignment and Report Plan ( <a href="#">Exhibit A3</a> ).....	22

## [Glossary of Terms](#)

### **Diagnoses & Related Terminology:** See [RCW 71.05.020](#)

[Behavioral health disorder](#): "either a mental disorder as defined in this section, a substance use disorder as defined in this section, or a co-occurring mental disorder and substance use disorder."

[Substance use disorder \(SUD\)](#): "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."

[Mental health \(MH\) or mental disorder](#): "means any organic, mental, or emotional impairment which has substantial adverse effects on a person's cognitive or volitional functions."

### **Treatments and Treatment-Related Systems:**

[Involuntary treatment](#): Legally required and enforced medical treatment which does not require the consent of the person treated. This can mean detention in an inpatient treatment facility or legally enforced outpatient treatment.

[No-bed report](#): A DCR cannot commit a patient if there is no bed available. In such situations, the DCR must file a no-bed report with information on the facilities they attempted to commit the patient at and why those facilities declined to accept the patient.

[Single Bed Certification \(SBC\)](#): SBCs are an additional option for DCRs when no treatment bed is available. DCRs may apply to place patients suffering from MH disorders in beds in approved facilities (such as hospitals) that are willing and able to provide treatment. This option is not available on the SUD side until 2026.

[Less restrictive alternative \(LRA\)](#): The state has the obligation to treat patients in the least restrictive setting possible. LRA orders allow ITA patients to be treated in a community setting. These remain legally enforced orders, and the authority overseeing an LRA may revoke it for noncompliance, which leads to the patient being treated in an inpatient setting.

### **Facilities & Personnel:**

[Designated crisis responder \(DCR\)](#): Designated behavioral health professionals trained in holistic crisis investigation. DCRs evaluate individuals clinically to determine whether they meet the criteria for ITA for either an MH or SUD condition. DCR's were established in 2014 and replace the former roles of designated mental health professionals or chemical dependency specialists.

Licensed individual practitioner (LIP): Independent personnel employed by ITA facilities to perform evaluation, stabilization, and treatment services. Examples of LIPs include psychiatric providers, medical providers, nurses, clinical social services, and SUD professionals.

Secure Withdrawal Management and Stabilization (SWMS) facility: Fully secured, licensed facilities that work to stabilize patients from a SUD-inspired behavioral health crisis. Facilities are operated by non-profit contractors and administered by HCA.

#### **Laws:**

Involuntary Treatment Act (ITA): Refers to Washington's statutory framework ([RCW 71.05](#) and [RCW 71.34](#) for minors) for authorizing the detainment of individuals who demonstrate an imminent likelihood of serious harm or grave disability as the result of a behavioral health disorder.

2E2SSB 5720 (2020): Extends the maximum length of the initial emergency hold from 72 to 120 hours. If the number of filled beds drops below 200 for three contiguous months, this triggers a provision in the bill that widens the criteria for grave disability and likelihood of harm. Brings MH and SUD crises under the umbrella term of behavioral health crisis and changes the name of SUD ITA facilities from secure detox facilities to secure withdrawal management and stabilization (SWMS) facilities.

Joel's Law – E2SSB 5269 (2015): Allows family members/guardians to petition for an individual's commitment when the DCR either fails to investigate a request for investigation within 48 hours declines to commit after an investigation.

#### **Legal Terms and Criteria:**

Likelihood of harm to self or others: An individual may be committed if they are likely to inflict serious harm to themselves or others due to a behavioral health disorder.

Grave disability: Provides for involuntary treatment when an individual cannot meet their own essential health and safety needs due to a behavioral health crisis or experiences a sharp and escalating loss of function.

Need for treatment standard: Refers to involuntary treatment due to an individual lacking insight into their illness and thereby lacking the ability to make an informed decision about treatment.

#### **Organizations and Agencies:**

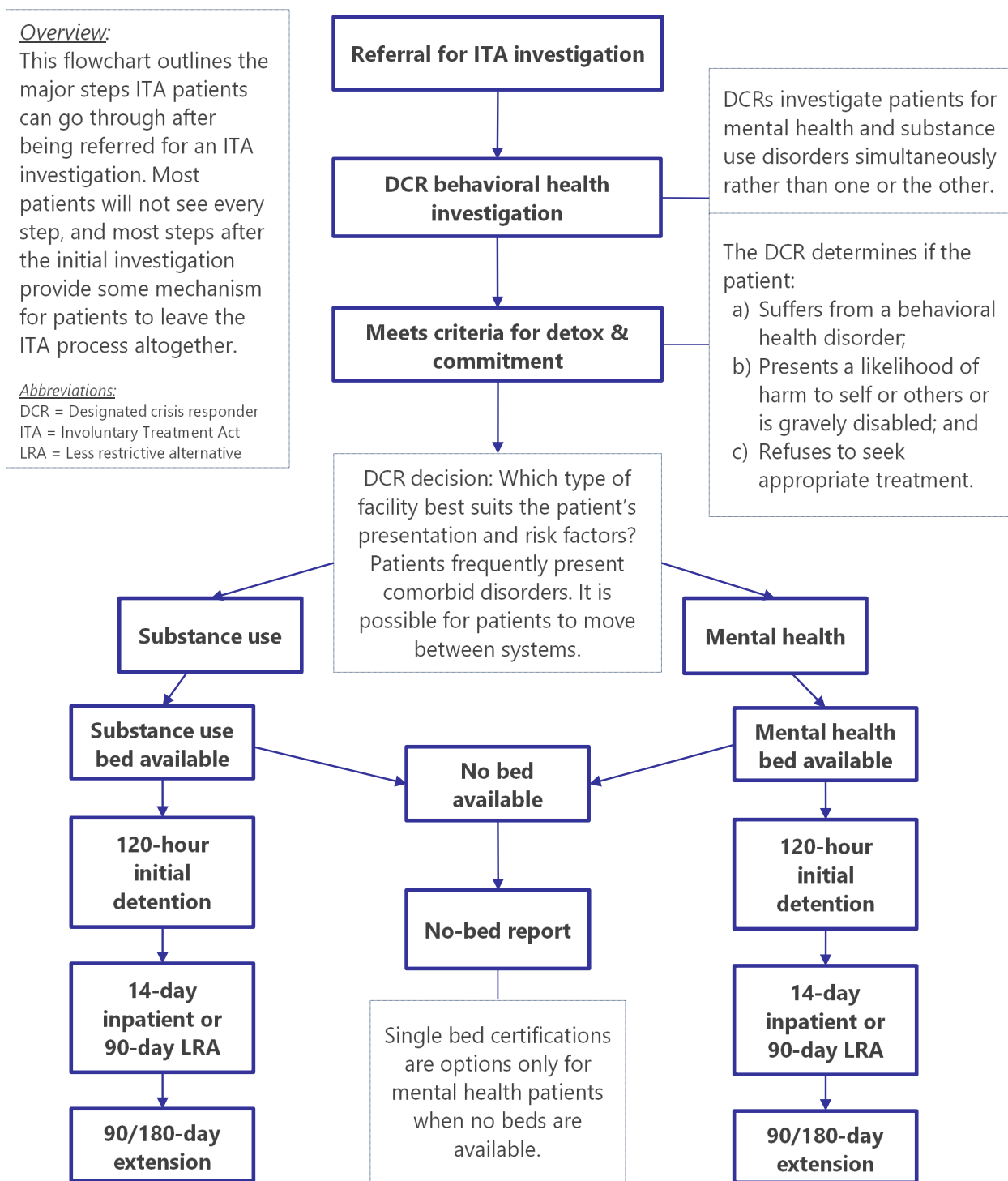
Regional Service Area (RSA): Ten geographical regions, authorized and established by HCA and DSHS, for Washington State to purchase behavioral and physical health care through managed care contracts (formerly Behavioral Health Organizations and before that Regional Service Networks).

Managed care organization (MCO): Health care providers that offer direct physical and behavioral health care services (e.g., Amerigroup, Community Health Plan, Coordinated Care, etc.).

Health Care Authority (HCA): HCA purchases health care for Washingtonians who receive health care through Medicaid, the Public Employees Benefits Board, and other government programs. The Division of Behavioral Health and Recovery (DBHR) is the subdivision of HCA that focuses on behavioral health. In the context of Ricky's Law, DBHR has been primarily responsible for informing stakeholders/facilitating their involvement in the shift to integrating MH and SUD systems, training DMHPs to become DCRs, and setting up and managing SWMS facilities.

Behavioral Health Administrative Services Organization (BH-ASO, sometimes just ASO): HCA contracts with BH-ASOs to provide behavioral health services to all individuals within a region, regardless of ability to pay. BH-ASOs provide a regional MH/SUD hotline, crisis services including outreach teams, short-term services for publicly incapacitated people, and application of ITA statutes.

**Exhibit A1**  
Involuntary Treatment Act: Key Steps after ITA Investigation



## Exhibit A2

### Involuntary Treatment Act: Initial Intake and Crisis Investigation

#### Overview:

This flowchart details the commitment decision process and relevant authorities. Blue boxes indicate procedural steps, gray boxes provide further information, and the gray hash divides DCR and judicial/facility involvement.

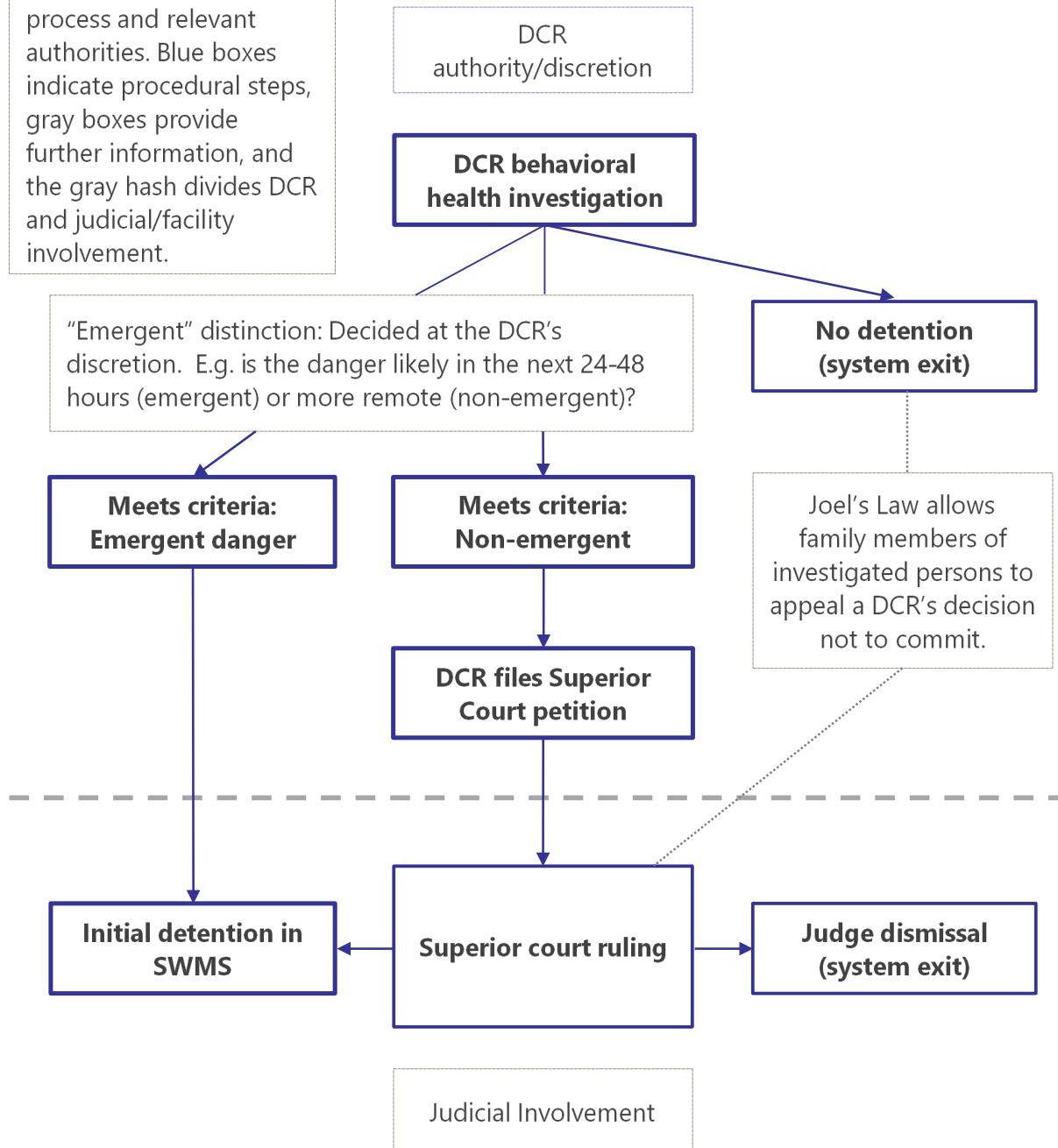


Exhibit A3 shows each legislative component to WSIPP’s study assignment and the corresponding research and report plan as of this writing. Information learned from the qualitative study will help to better inform our quantitative research approach for the final evaluation in 2023.

**Exhibit A3**  
WSIPP Study Assignment and Report Plan

<b>WSIPP study assignment:</b> (legislative language)		<b>Study approach:</b>	
		<b>Report 2 (2021):</b> Qualitative evaluation of stakeholder perspectives on ITA SUD	<b>Report 3 (2023):</b> 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;	Stakeholder 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;	Examine 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;	Stakeholder perspectives on improvement in outcomes for clients (those not measured by quantitative approaches).	
d	Increases the effectiveness of the crisis response system statewide;	Stakeholder perspectives on the effectiveness of the crisis response system.	
e	Has an impact on commitments based upon mental disorders;	Stakeholder perspectives on the impact on commitments for MH disorders.	Subsequent ITA petitions and cost of an ITA petition.
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	Stakeholder 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.	Stakeholder perspectives.	System capacity utilization analysis (e.g., ITA petitions, secure detox beds over time) and benefit-cost analysis.



## Acknowledgments

---

We thank the following subject matter experts who we consulted with for this study assignment and report:

- Zephyr Forest, SWMS Coordinator, Division of Behavioral Health and Recovery, Health Care Authority
- Richard Geiger, Vice President/Inpatient Services, Valley Cities
- 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

For further information, contact:

Name at 360.664.9075, [elizabeth.drake@wsipp.wa.gov](mailto:elizabeth.drake@wsipp.wa.gov)

Document No. 20-12-3401



## Washington State Institute for Public Policy

The Washington State Legislature created the Washington State Institute for Public Policy in 1983. A Board of Directors—representing the legislature, the governor, and public universities—governs WSIPP and guides the development of all activities. WSIPP's mission is to carry out practical research, at legislative direction, on issues of importance to Washington State.